Health, solidarity and justice : a discourse theoretical perspective

Kretzer, Lara Patrícia

Queen Mary, University of London
School of Law

Health, Solidarity and Justice

A discourse theoretical perspective

Ph.D. Thesis

Lara Patrícia Kretzer

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Abstract

This thesis analyses the relationship between health, solidarity, and justice from a discourse theoretical perspective. Jürgen Habermas links justice to free, uncoerced, and inclusive processes of discursive consensus building. The realisation of these rational discourses, however, depends on a sense of solidarity between participants: solidarity is the counterpart of justice. Yet, in modern capitalism solidarity is the scarcest social resource. This leaves societies with the task of reconstructing the conditions that would make solidarity, and therefore justice, sustainable. This thesis argues that health offers an important contribution to this project.

Habermas's universal pragmatics is used to analyse different concepts of health, and in adopting the perspective of the participant an intersubjective understanding of health is proposed. Placed within Habermas's theory of society, health is conceptualised as a sub-system of the lifeworld that contributes to social reproduction at the cultural, normative, and personality levels by: reproducing lay and medical knowledge; nurturing social solidarity through nets of formal and informal healthcare; and contributing to the development of personalities capable of and motivated to joining relationships of mutual recognition. These last two contributions reveal the relevance of health in fostering conditions for justice.

The growing literature on the social determinants of health is explored to the conclusion that the relationship between health and justice is reciprocal and closer than commonly assumed. This insight is then applied to the context of the right to health. The thesis refutes different liberal challenges to the right to health and explores the right from the perspective of Habermas's reconstruction of the system of rights and procedural paradigm of law. The thesis concludes that discourse theory provides a better understanding of the relationship between health and justice, and therefore, better grounds for interpreting health as a legitimate human right.

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Introduction

The world today is pervaded by large scale human tragedies. Not far in history from the moral shames of the holocaust and Hiroshima and Nagasaki and the commitment of a large number of the world's nations to the 'never again' embodied in the United Nations Declaration of Human Rights, humanity still watches mass loss of human lives due to hunger, genocide, and curable diseases. Commitments that at best have been only partly met are not the only reasons, however, that make preventable and human-made human suffering in such a scale even more morally disturbing today. Today, preventable human suffering and extreme deprivation exist side by side with unprecedented human plenty and human thriving. Moreover, technological advances bring human tragedies closer to home – in richer and medium income countries most people can watch everyday real images of human suffering that before could only be heard of or read about and therefore assimilated in our moral imagination in impersonal and attenuated ways. Yet, this increased awareness of preventable human suffering and deprivation worldwide, does not fully account for the moral uneasiness of our times.

The multitudes of interconnections that constitute the phenomena of globalisation expose more than the appalling realities in which millions of people around the world find themselves. They also help expose the ways in which people, locally and abroad, directly or indirectly, and intentionally or not, contribute to these realities. It is more difficult now than it has been in the past to hide our moral selves behind claims of ignorance and innocence. Local decisions are now known to affect people's lives beyond our localities. Environmental degradation is an oft-cited example, as indeed air and water pollution and their impacts on the health of others do not respect moral or political boundaries. There are a multitude of ways, some at first sight subtle, in which local policies and individual decisions can adversely affect the lives of people who are not usually included within the reach of our conventional moral considerations. In examining our individual and collective attitudes towards health we can identify many examples of these. Consumption of goods the production of which harms people's health in poorer corners of the world is one example. The casualness with which so many people deal with the moral questions related to the potential human impacts,

locally and abroad, now and on future generations' time, of new medical technologies is another.

Health is in fact paradigmatic of the contradictions and moral turmoil of our times. In a time where the 'human mastery of nature' has allowed the development of the technology that is releasing the human cloning project from the category of utopia, thousands of people die each day of cheaply preventable and curable diseases. The benefits of the extraordinary developments of human knowledge, of an unprecedented accumulated wealth, and of the emancipatory ideals of human rights – all highest ideals of modernity – are not being enjoyed by all. Indeed, for a significant part of the world's population, crucially in developing countries, the levels of basic sanitary conditions and life expectancy resemble the levels of two hundred years ago. Moreover, social institutions in charge of improving populations' health conditions both at the national and international levels have achieved only limited success.

Crises in health are most commonly thought to be financial, caused by the accelerating costs of medical care and unequal coverage. The reasons for much of the failure in improving health conditions across the globe, however, reach far beyond matters of cost and distribution. In the academic debate, apart from problems of lack of funding and economic viability, other issues such as lack of definition of obligations and accountability, the conceptual inappropriateness of the right to health, and even the lack of agreement on the definition of health itself are also commonly associated with this failure. Yet, more convincingly, there are also studies that associate crises in health with social inequality – independent of a given population's baseline wealth – and with the corrosion of solidarity as an important value for social cohesion and community's support for health policies and services. These studies suggest that crises in health also have a lot to do with the way people relate with each other rather than being solely caused by financial, bureaucratic, and conceptual problems.

A growing body of research have demonstrated, for example, that apart from the well-established correlations between social injustice, extreme deprivation, and poor health outcomes, health has a more complex set of social determinants.[1] Among the findings that point to this conclusion are data demonstrating that richer countries with

[1] See for example Wilkinson and Pickett, 2009.

wide income gaps have worse health outcomes than more egalitarian medium income countries. Furthermore, once a certain threshold is reached, increasing absolute wealth and increasing expenditure in health care do not always translate in better health outcomes. In other words, once a country reaches this threshold, wealth is not the main determinant of health, a finding that poses a challenge to the assumption that improving health conditions and access to health always involve excessively high costs. Data from these studies further demonstrate that different societies have different patterns of social cohesion, which constitute one of the explanations for the findings above: more cohesive societies have better health outcomes.

Rob Houtepen and Ruud ter Meullen also associate deficits in social cohesion and solidarity with crises in health systems. They point out that in Europe there is a widespread belief that healthcare systems are based on the value of solidarity. In the Netherlands, for example, solidarity as the basis of health systems, which initially was based on commonality such as membership in religious groups and workers unions, was progressively expanded to all as society and the health system increased in complexity and responsibilities were transferred to the state.[2] Yet, this extended social solidarity as the basis of the system of health care is progressively losing its attractiveness. It is being threatened by factors such as budgetary pressures, rising consumerism, and a growing individualistic culture.[3] Together, Houtepen and Meulen warn, not only do these factors threaten the maintenance of welfare structures, but they also threaten the very role and force of solidarity as a fundamental social value.[4] What they suggest is that the impacts of the corrosion in solidarity reach well beyond structures of health care, affecting society as a whole.

Linking their work on solidarity with the data about the poorer health outcomes of societies with low indexes of social cohesion and solidarity, it is possible to conjecture that vulnerable individuals living in less cohesive societies are exposed to a double risk: they are more likely to get ill and less likely to receive health care. Taken together, these studies also point to the conclusion that apart from increasing social

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[2] See Houtepen and Meulen, 2000a, pp. 329-330.
[3] Houtepen and Meulen, 2000a.
[4] Houtepen and Meulen, 2000a.

justice more generally, the way to improving health outcomes also passes by nurturing social solidarity. Both projects, i.e. the achievement of social justice and the strengthening of solidarity, inevitably involve a profound transformation in the way people relate with each other. Moreover, in a complex, globalised world, both projects depend on people being able to expand their moral horizons to also include those beyond geographical and cultural boundaries.

Exploring these relationships between health, solidarity, and justice in a complex world is therefore the focus of this thesis, and the critical theory of Jürgen Habermas provides the theoretical framework guiding this project. Habermas's discourse theory is ideally suited for this project. Two reasons for that are: (a) its intersubjective outlook, and (b) its construction of the relationship between justice and solidarity.

(a) Habermas rejects the individualism that grounds liberal theories and that influences current practices and proposes intersubjectivism as an alternative paradigm. This paradigm shift is accomplished through the development of his theory of communicative action, which emphasises the fundamental role that language plays in creating society and coordinating action. This communicative paradigm represents the overcoming of the individualist focus because of the emphasis it places on the interactive capacities of human beings as the generator of society and its transformations. It is through communicative interactions that individuals make sense of and shape the external world, society and their own unique identities. As a result of this emphasis placed on interactions, the relationship between the individual and society takes a different shape, as the individual is neither seen in antagonism with society nor completed dissolved in it. The implication of that to the study of health in its relationship with solidarity and justice is that these three concepts have to be construed taking this dynamic between individual and society into consideration, i.e. they must receive an intersubjective interpretation.

Health, for example, from an intersubjective perspective, can be construed as a sphere of interaction that exposes the vulnerability of the human condition and the inevitable interdependence of human beings. An intersubjective understanding of health thus, brings debates involving health also within the ethical-moral domain. Therefore, health is not only a technical, a medical matter. It is also ethical, moral and political.

(b) The intersubjective paradigm also reframes the relationship between justice and solidarity. Justice in Habermas's theory is linked with the perspective from which to judge whether patterns of interaction are equally good for all. In addition, this moral point of view is located in actual dialogical deliberation between autonomous individuals, who relinquishing violence and coercion must together take the responsibility of deciding the norms guiding their interactions. Yet, if these processes of deliberation are to work, they require that participants not only be free to expose their case and take a yes or no position. They must also be open to the perspective of others and feel motivated to leave their immediate interests aside to reach agreements that are equally good for all, i.e. individuals must be imbued with a spirit of solidarity and concern for the welfare of their fellow members of a communicative community committed to mutual understanding and cooperative action. Justice and solidarity, therefore, are inseparable partners in this project. One cannot be without the other. The implication for the study of health, solidarity and justice is that opens the analysis to seeing health not only as a demand of justice and as a product of social solidarity. If a health system conceived communicatively can be shown to be a privileged space for the nurturing of solidarity, then health contributes to justice too. If successful, this argument can provide a more solid support for universal inclusion and participation in the system by revealing that a solidaristic health system is equally in the interest of all, including those who benefit less from it.

Methodologically, this thesis adopts both the observer and participant perspectives, which complement and inform each other. Chapter 4 is the clearest example of the use of this dual perspective. It starts by exploring an intersubjective account of health by looking at data and insights produced by empirical works in medical sociology and medical anthropology. Later in the chapter this participant perspective is complemented by the observer perspective. Together, the insights gained with the help of both perspectives lead to the development of a model of health system inspired by Habermas's concept of communicative action and by his dual approach to society.

The use of this dual perspective also contributes to another methodological element of this thesis: its interdisciplinary orientation. To address the task of developing

a discourse theoretical account of the relationship between health, solidarity, and justice this thesis interacts with perspectives coming from different fields of knowledge, including moral theory, sociology, medical sociology, and medical anthropology. The intersection between normative theory and empirical health sciences is a rich and fruitful space, and its interdisciplinary character can provoke critically different reflections on health, justice, and society.

Habermas's critical theory, in fact, stimulates this interdisciplinary orientation. This is part of the reason why using discourse theory to explore the relationship between health, solidarity, and justice, broadens the scope of analysis on the subject. By incorporating a multitude of perspectives Habermas's theory conduces to a critical analysis that looks not only at how its conception of justice supports inclusive health care structures, but also how the patterns of social interactions in the health sphere can affect solidarity, and therefore justice. This leads to the conclusion that health and justice, construed intersubjectively and through their mutual links with solidarity, have a reciprocal relationship. In other words, not only justice affects health, but health can also affect justice, and solidarity is the common link that channels their interactions.

From the perspective of participants in the real world, the advantage of this broader understanding of the relationship between health, solidarity, and justice is that it brings the possibility of contributing to justice closer to home. In the different and shifting roles that individuals assume in their interactions in the health system, they can resist the commodification and instrumentalisation of healthcare practices as well as of health and its symbolic meanings, contributing therefore to maintain the health system as a social space in which social criticism, mutual recognition, and above all solidarity can flourish. A thriving solidarity, by its turn, is essential to achieving justice, not only in health outcomes but also more broadly.

1 Outline of chapters

The argument that health and justice enjoy a reciprocal relationship relies heavily on a number of arguments that are part of Habermas's discourse theory, including the intersubjective constitution of the self, the pragmatics of communication, the dual concept of society, the different forms of social reproduction and social

integration, the complementarity of law and morality. These arguments by their turn rely on a number of other arguments that are fundamental for the understanding of Habermas's theory. Fully grasping and unravelling the complexity of Habermas's work is no easy task, and I do not attempt to do it here. Yet, in Chapter 2 I do take the task of developing a review of the elements of Habermas's work that either directly or indirectly relevant to the purposes of this thesis. This review is not comprehensive and it leaves out a number of other interesting arguments. Yet, it is also not superficial in the arguments it addresses, and as a result, it takes a good part of this thesis. This is for a good reason: the arguments developed in the subsequent chapters depend on the understanding of Habermas's theory and how I use it to develop an understanding of health, solidarity and justice. Chapter 2, thus briefly reviews the theoretical foundations of the critical theory of Habermas from Kant to the Frankfurt School of Social Sciences, passing by Hegel and Marx. It then reviews how Habermas reframes classical themes in critical theory and how his communicative theory shapes his account of society, morality and justice, and law.

As Chapter 1 defines the account of justice and solidarity that is used in the thesis, Chapter 3 takes the task of exploring the meaning of health. As it finds out, there are a multitude of different definitions and perspectives on the subject, which make for a lively debate. This debate is explored to reveal the different agendas and worldviews behind different accounts of health. A dichotomy is identified between more scientific and technical accounts on the one hand and more holistic and social accounts on the other. The implications of this dichotomy are analysed in the context of the debate surrounding the WHO constitutional definition of health, which is presented as an illustration of the social model of health. Using Habermas's universal pragmatics the chapter concludes that there is no ultimate account of health. Different accounts may be valid according not only to their rational justification, but also to their appropriateness to the context and the language games that are relevant to this context. In the context of the WHO constitution, it is argued that the definition of health should be seen as a claim to rightness as opposed to a claim to truth, independently of the validity of the *substance* of the claim. The substance of the claim is criticised not because of its broad scope but because of the potential ethical particularism that it represents and the lack of focus on

the justice of the interactions that lead to the ill health of populations. The chapter concludes that an interpretation of health that is appropriate for the study of the relationship between health, solidarity, and justice must account for its intersubjective dimension.

Chapter 4 then takes the task of exploring an intersubjective account of health. The starting point of this task is the analysis of the contribution of the anthropological perspective on health of Arthur Kleinman and Robert Hahn. Their works demonstrate not only the importance of an intersubjective account of health, but also the importance of understanding health from the perspective of the participants, i.e. patients, families, carers, the public. They also reveal that health and the experiences of illness and healthcare are socially and culturally constructed; yet, regardless of how culture mediates these experiences in a varied different ways, these experiences retain a universal core, namely their intersubjective character. Finally they also expose how these experiences of illness and healthcare are imbued with moral and political meanings. The intersubjectivity of experiences of illness and healthcare is further explored through the analyses of the literature in medical sociology and medical anthropology on the subject of experiences of chronic and terminal illnesses and their impacts on the self and how social arrangements affect these experiences. This analysis concludes that health in its intersubjectivity can be a privileged space for social criticism and for the reconstruction of less egocentric and more solidaristic selves.

This hypothesis is then given more solid analytical form by placing health in Habermas's dual concept of society. Here, health is construed as a specialised sub-system of the lifeworld. This construction allows a broader understanding of health, its social roles, its crises, and its emancipatory potentials. Health broadly conceived is seen as contributing to the lifeworld's reproduction and at three different levels: cultural reproduction, social integration, and socialisation. At each of these levels, health makes use of different forms of knowledge, different moments of reason, and has different communicative functions and social contributions. The contribution of health towards social integration by nurturing solidarity and relationships of mutual recognition grounds the analysis of the relationship between health and justice in Chapter 5.

Chapter 5 analyses the relationship between health and justice by critically analysing Norman Daniels's recent works on the subject and the impacts of recent researches on the social determinants of health. Daniels's account of the moral importance of health as secondary to its role in protecting opportunities is criticised due to its focus on distributive justice and neglect of the broader moral relevance of health. The contribution of health to fostering solidarity is then juxtaposed to Daniels's account in order to identify that health enjoys a more significant relationship with justice. Because of the solidaristic character of health, the relationship between health and justice is then construed as reciprocal, insofar as justice is important to health and health is shown as to be also important to justice.

2 Further comments

The scope of Habermas's work is extraordinary. It encompasses a wide range of contributions to different fields of inquiry. By the same token, it invites comments and criticisms of an equally extraordinary magnitude. This thesis, therefore, does not assume the task of presenting a defence of Habermas's *oeuvre* nor of comparing it with competing theories. It already starts with the goal of seeing health and its social and moral implications through the lens of discourse theory. Yet, it does not assume that Habermas's work meets no difficulties. On the contrary, I agree with Joel Anderson, that 'every system of philosophical ethics has issues it handles well and issues that it handles awkwardly.'[5] Habermas's theory is no exception. His work, however, offers the most promising approach to analyse a world marked by differences, conflicts, injustices and lack of mutual understanding, but that is also home to so many examples of human decency, cooperation, solidarity, and tolerance. Habermas acknowledges the long and ongoing history of moral disasters that are a mark of human societies at the same time that he sees in the very core of human sociation the potential for mutual understanding and emancipation. In sum, this research aims at locating health – presently (still) in crisis – within Habermas's theory and evaluating how the relationship between justice, solidarity, and health can be approached under the premises of his theory. This should

[5] Anderson 2005, p 821.

be seen as a work of cooperation; a work that seeks to contribute to take Habermas's theory to further directions.

This research seeks to take Habermas's to further directions by filling a gap in the literature on Habermas. Developed at a more abstract and conceptual level, his work does not deal with the issue of health and its interconnections with justice and society as such. Some researchers, mainly in the field of medical sociology, are already compensating for this deficit by applying Habermas's theory more systematically to empirical researches on health.[6] This thesis, however, is located somewhere in between Habermas's more general and abstract theory and these more empirical researches. It goes a step down Habermas's theoretical formulations in applying them to a more specific subject such as health; yet, it still develops a perspective on the subject that is more general and abstract than more empirical studies in the field. In addition, inspired by the tradition of critical theory, the thesis interacts with both philosophical and empirical studies. More importantly, in including contributions from medical sociology and also from medical anthropology, this thesis is greatly enriched by the interdisciplinary flavour that these contributions bring.

Finally, the motivation behind this work is to contribute to the overall debate on health and justice. At a more personal level, as a developing country healthcare professional working in a social space in which the boundaries between ill-health and social injustice is difficult to define, this contribution symbolises a commitment to a much needed change in the patterns of interaction between human beings. Behind this motivation lies the conviction, against sceptics and nihilists, that an alternative society is still a possibility. This is a conviction, many times weakened and put to test, that I share with Habermas and with many other theorists whose inspiring works are informed by an inquietude against social injustices and the belief that egocentric individualism is a historical and social construction which does not fully account for the much broader and richer potentials of social and moral beings. In this sense, this work pays homage to a long history of utopian resilience.

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[6] See, for example, the essays in Scambler 2001a. As in Scambler's words, this collection 'sets out to begin to make good the neglect of Habermas's work within the specialist domain of medical sociology (p 1)'.

Chapter 2

THE CRITICAL THEORY OF JÜRGEN HABERMAS – FOUNDATIONS AND CENTRAL CONCEPTS

1 Habermas and the critical theory of the Frankfurt School

Although critical theory today represents a broad range of theoretical perspectives, it is typically associated with the research programme of the Frankfurt Institute of Social Research, also known as the Frankfurt School. The institute, founded in 1924, was dedicated to the development of a non-orthodox Marxist social theory based on a collaborative approach between philosophy and the empirical social sciences. The research programme of the Institute takes a critical stance towards orthodox and totalitarian strands of Marxism and it incorporates the humanistic legacy of Immanuel Kant and G. W. Friedrich Hegel, Max Weber's account of modernity, and Freudian psychoanalytical theory. In locating critical theory, Max Horkheimer asserts: 'critical theory is neither "deeply rooted" like the totalitarian propaganda nor "detached" like the liberalist intelligentsia'.[7] While maintaining the Marxist critique of capitalism and of the *bourgeois* society, the Institute expands the interpretation of capitalism beyond the economic realm. Capitalism is also seen as a pervasive cultural phenomenon, the social consequences of which extend beyond economic inequalities, also affecting society's scientific enterprise, social life and ultimately individuals' ego constitution.

The particular period of history in which Europe was embedded since the foundation of the Institute, marked by the rise of fascism and National Socialism, by wars, and by Stalin's totalitarianism exerted a major influence in the works of its first generation of theorists. The core members of the Institute fled Nazi German to work in exile in the USA, returning to Frankfurt in 1949. The experiences of the holocaust, but also of the rise of consumerism in America, marked the pessimistic tone of the works of the Institute that followed this period.[8]

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[7] Horkheimer, 1995, p. 223.
[8] See Adorno and Horkheimer, 1997; Habermas, 1987; Benhabib, 1986; Edgar, 2005a.

Habermas joined the institute in 1956, and he is considered the main voice of its second generation of theorists. The experience of the holocaust has also deeply influenced his work.[9] The realisation of the horrifying extent of the war crimes influenced his work as much as what he perceived as the uncritical return to normality of German society in the years that followed the war. Yet, in contrast with the first generation of the Frankfurt School, Habermas's work is characterised by a more positive approach to the potentials of modernity. He rejects his predecessors' nihilism and scepticism towards modern rationality and argues that the crises that affect society are not the result of an all-encompassing instrumental rationality and inexorable reification of social life in modernity. On the contrary, he argues that crises arise because of a one-sided approach to modern rationalisation. The possibility of human emancipation passes by the completion, and not the rejection, of the project of modernity.[10]

In order to overcome the negative view of modernity that characterised the later works of the first generation of the Frankfurt School, apart from the classical works that influenced critical theory, Habermas also incorporated insights from a wide range of theoretical developments of the 20th century – from psychoanalysis to systems theory, passing by American pragmatism, hermeneutics, and philosophy of language to name a few. The result is the development of a broad and influential theory of modern society. To understand Habermas's work, and how his different strands of arguments are brought together, it is necessary to discuss some of critical theory's classical frameworks which Habermas has appropriated and reinterpreted in the light of his communicative paradigm.

2 The Foundations of critical theory – central frameworks

2.1 Kant and the Enlightenment's reason

Kant's work has a strong influence in Habermas's work; most notably in Habermas's theory of morality. Kant is perhaps the most prominent and influential thinkers of the Enlightenment, famously heralding the role of reason in overcoming the obstacles to human freedom. According to Kant, the Enlightenment,

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[9] Habermas, 2004.
[10] Habermas, 1987; 1989a; 1989b.

> is man's emergence from his self-imposed immaturity. Immaturity is the inability to use one's understanding without guidance from another. This immaturity is self-imposed when its cause lies not in lack of understanding, but in lack of resolve and courage to use it without guidance from another. *Sapere Aude!* [dare to know] 'Have courage to use your own understanding' – that is the motto of enlightenment.[11]

For Kant, then, immaturity means the attitude of delegating to external sources, such as religious and public authorities, the task of providing one's life perspectives. This delegating attitude, he argues, can only lead to loss of freedom, as freedom is only possible in using one's own understanding, one's own reason.[12]

The central role accorded to reason by the Enlightenment is at the heart of an ongoing intellectual dispute, which today divides critical theory as the dispute between 'rationalists' – among whom Habermas is included – and post-modernists testify. Since Kant this dispute, among other issues, revolves around (a) the subject of reason and (b) the role of reason.

(a) Kant states that reason is an innate characteristic of the human being. Borrowing from the Cartesian model of reflexive self-consciousness (*ego cogito*), and its subject-object model of speculation, Kant argues that through rational reflection the individual can 'know' the world;[13] the sphere of a knowledgeable world including the natural world, social processes, and the subject itself. As a result, reason plays an important role in moral theory too. Rejecting traditional and taken-for-granted sources of moral normativity, Kant argues that the individual in autonomous self-reflection is able to grasp the rational moral point of view by projecting a universal moral perspective applicable to all.[14] This reflection allows the individual to 'know' the moral law which prescribes the right course of action, i.e. the categorical imperative: '[t]here is only one single categorical imperative and this is: act only on that maxim through which you can at the same time will that it should become a universal law'.[15] To act rationally and autonomously for Kant, is to choose to act in accordance with the universal moral

[11] Kant, 1784, p. 1.
[12] Kant, 1784.
[13] Habermas, 1987.
[14] Kant, 1993.
[15] Kant, 1993, paras 420–421.

law that the individual has grasped herself.[16] This absolute self-consciousness of the subject and the moral prescriptivism of Kantian moral theory is the focus of Hegel's critique of Kant, which still significantly influences the critics of modern thought.

b) In Kant's three critiques,[17] he reinforces the role of reason against dogmatism, and for Habermas, this marks an important point of reference for critical theory, namely the possibility of *rational scrutiny* of society and its institutions instead of judging them according to their conformity to pre-given sets of rules.[18] Kant also divides reason in three different moments: theoretical knowledge, practical reason and judgement. These three moments would correspond respectively to the capacity of the subject to develop objective knowledge about the natural world, moral insight, and aesthetic evaluation. As a result of these different moments of reason, spheres of knowledge are separated: morality, science, arts, and so forth. In addition, the separation of spheres also happens institutionally. In line with natural law tradition, Kant separates the domain of morality as the normative guide of private life, and the domains of law and politics as the normative guides of public life.[19]

Kant's differentiation of reason and consequent separation of the spheres of science, morality and art is also criticised by Hegel as a fragmentation of the ethical life. The echoes of this critique are found in the works of the first generation of the Frankfurt School and in much of the works of the critics of modernity – communitarians, feminists, and post-modernists included. Habermas, however, appropriates central insights of Kant's account of reason and its different moments. Combining this account with insights from Weber's theory of differentiation of modern society, Habermas reinterprets the different roles of reason in modern society and accounts for social pathologies as *misplacements* of reason in its different roles as opposed to challenging reason altogether.

This is not to say that Habermas is not critical of Kant. On the contrary, he also incorporates insights from Hegel's critique of Kant, such as the critique of Kant's

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[16] Kant, 1993.
[17] *Critique of Pure Reason*, *Critique of Practical Reason* and *Critique of Judgement*. See Habermas, 1987.
[18] Habermas, 1987.
[19] Habermas, 1997, pp. 18-9.

conception of the individual as a decontextualised being. Some of Hegel's critiques of Kant follow below.

2.2 The ambivalence towards the Enlightenment– Hegel and Marx

2.2.1 Hegel

Habermas sees Hegel as the first thinker to develop an adequate account of modernity and its contradictions.[20] In fact, Hegel's relationship with the reflexivity of modernity is ambivalent. He welcomes, on the one hand, modern developments such as civil society, the individual right to question norms and institutions, and the pluralism of life projects.[21] On the other hand, he is critical of (a) Kant and natural law theories for the modern culture of bifurcation and split in ethical life, and of (b) modern alienation and reification. Hegel's work is generally divided in two phases: the young Hegel, critic of modernity and its bifurcations, and the later Hegel, guided by (c) the idea of the all-encompassing *Geist*.

(a) It is in the first phase of his works that Hegel develops a critique of Kant and of natural right theories. For Hegel, the separation of the spheres of morality and legality amounts to a dissolution of the ethical life.[22] He describes modernity as a culture of bifurcation, manifested in the separation of inner nature and life in society, individual and the community, senses and understanding, inclination and will, necessity and freedom, fact and value, knowledge and faith, and so forth. According to Hegel, natural law theories are guilty of imposing arbitrary divisions in ethical life. Furthermore, Kant's moral formalism and abstraction make his theory ahistorical, blind to the historical contingency of the 'autonomous individual'. As a shortcoming of that, his theory fails to engage real people and fails to address the experiences of the community in the real world. [23] The premise of the ethical life constituting a totality underlies this Hegelian critique. Accordingly, Hegel sees in the overcoming of bifurcations the solution for modern crises. The premise of an ethical totality also supports his later

[20] Habermas, 1987b, pp. 23–44 and Edgar, 2005a, p. 195.
[21] Habermas, 1997, pp. 16–7.
[22] Benhabib, 1986, p. 27.
[23] See Edgar, 2005a, pp. 194–5 and Benhabib, 1986, Chapter 3.

development of a theory of history as the necessary process of *Geist* reconciliating with itself and regaining its lost unity.

(b) Labour for Hegel is the fundamental way through which the individual relates to her object, humanises it, and becomes conscious of herself:

> Man brings himself before himself by practical activity; ... This aim he achieves by altering external things whereon he impresses the seal of his inner being and in which he now finds again his own characteristics. Man does this in order, as a free subject, to strip the external world of its inflexible foreignness and to enjoy in the shape of things only an external realisation of himself.[24]

Because of that, Hegel associates the excessive development of modern industry and its mechanistic way of production with the alienation of the modern individual.[25] In contrast with individuals of less complex societies, who directly produce the goods to satisfy their own needs and in so doing make sense of the world and of themselves, modern individuals cannot fully relate the product of their work with their needs or themselves.[26]

Apart from labour, Hegel conceives another medium by which the subject relates with the world: interaction.[27] Through this medium, the relationship between subject and object that characterises labour gives way to a relationship *between subjects*. This is the realm of morality; the realm in which, through interaction, subjects reconciliate with each other.[28] Reconciliation for Hegel translates the recognition of the self in the other through relationships of love and mutual recognition. These relations are nonetheless fragile, and their disintegration leads to a failure in mutual recognition and a loss of sense of community. In other words, the subject is alienated from others.[29]

In the *Phenomenology of Spirit*, Hegel introduces the concept of reification, which translates the idea that in conditions of alienation the interaction between subjects takes the form of relations between subjects and objects. In failing to recognise

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[24] Hegel, *Aesthetics: Lectures on Fine Art*, cited in Sayers, 2003, p. 111. See more on labour in Hegel in Edgar, 2005a, p. 65.
[25] Sayers, 2003.
[26] Sayers, 2003. Interestingly, Hegel argues that the same applies to the wealthy, who consume goods produced by others (Sayers, 2003).
[27] Edgar, 2005a, p. 64.
[28] Edgar, 2005a, p. 67.
[29] Edgar, 2005a, pp. 66-7. Here too Hegel criticises the Kantian conception of the autonomous moral subject, which neglects the contextual social relationships that shape one's moral subjectivity

themselves in others subjects have the impression that the rules that govern their interaction are akin to the laws of nature. Under reification, subjects fail to realise that the rules governing their interaction are not natural, but a human-constituted social and historical reality.[30] As it will be seen below, Hegel's concepts of modern alienation and reification in modernity are profoundly influential in the works of Marx, Western Marxists and the Frankfurt School theorists.

(c) A more conciliatory relationship with modernity, moved by his concept of *Geist* as the subject of history, characterises Hegel's later work. For Hegel, despite all human suffering and lack of sense, history is a reasonable process, a dialectical progression whose ultimate goal is to achieve its final stage of freedom and reconciliation.[31] The subject of this history is *Geist*, or Being in its process of Becoming, and human history is the history of this development.[32]. Becoming is the process of Being reaching its unity with not-Being. Yet, to reach this final stage of unity, Being has to pass through a process of self-estrangement, of alienation from itself. This alienation, according to Hegel, is only possible with the creation of the world – the expression of its otherness. In the unfolding of world's history, Being progressively becomes self-conscious until the final stage of ultimate reconciliation with itself, the moment of ethical totality.[33]

The process of modern alienation, therefore, becomes for Hegel a necessary process of the historical *Geist*. Like *Geist*, human beings have to overcome alienation through reconciliation with what is seen as external to them. The overcoming of this division is for Hegel, a fundamental human drive.[34] In addition, Hegel believes that the reconciliation of *Geist* in modern societies can be achieved only by means of the State and its strong crisis management capacity. This privileging of administrative integration over political participation has attracted much criticism.[35]

2.2.2 Marx

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[30] Benhabib, 1986, Chapter 2; Edgar, 2005a, p. 65.
[31] Hanks, 2002, p. 6.
[32] Habermas, 1987, Chapter 2.
[33] Hanks, 2002, pp. 10–11.
[34] Hegel, *Aesthetics: Lectures on Fine Art*, cited in Sayers, 2003, p. 113.
[35] See Benhabib, 1986, Chapter 3, especially pp. 95–101; see also Edgar, 2005a, p. 195.

Karl Marx is, as Hegel, ambivalent towards the ideals of the Enlightenment. Although Hegel's critique of natural law theories and concept of alienation influence Marx greatly, he is also influenced by Kant's conception of human beings as autonomous and rational beings who require freedom to realise their full potentials.[36] Marx's critique, rather than doing away with modern ideals, aims at revealing their instrumentalisation to serve the ends of the *bourgeoisie* alone.[37] In fact, Marx sees an emancipatory potential in the normative and technical development of modern society. The *bourgeois* ideology of change and growth, as opposed to a traditional ideology of order and stability, is seen positively as a feature not to be overcome, but extended to all.[38] For Marx, the economy and the industry are human creations that should be brought under human control and serve the common good.[39] Marx builds his works from a range of different influences: apart from Hegel, Kant, and French socialism, his philosophy is also influenced by British political economy,[40] and an emphatic focus on political economy dominates his work.

Marx's work is majorly influential in the political and intellectual movements of the 20th century. Despite the failure of the totalitarian strand of socialism of the Soviet regime, Marxism still remains influential –mostly in revised forms – in many academic and political circles. The critical theory of the Frankfurt School, through its reinterpretation of Marx's work contributed to this ongoing influence. Two of the most important Marxian themes reviewed by the Frankfurt School are: (a) Marx's philosophy of history, and (b) Marx's materialistic interpretation of Hegel's concept of reification.

(a) Marx conceives human beings as free and creative beings who shape the world beyond mere physical need. Through creative, purposeful labour, human beings become fully human. Echoing Hegel, labour is for Marx the vital essence of human beings, the media for self-development and for world constitution. Furthermore, truly human labour is not done out of physical necessity, but done as an end in itself. The

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[36] Hanks, 2002, p. 9.
[37] This corruption of the ideals of modern revolutions makes him famously critical of the 'rights of man'.
[38] Habermas, 1987.
[39] Edgar, 2003, p. 193.
[40] Hanks, 2002, p. 9.

work of art, in particular, is for Marx the highest expression of the human essence.[41] In addition, through labour, human beings not only produce goods and creatively shape material objects, but they also produce social categories such as language, family and justice.[42] According to Habermas, because Marx focuses on the critique of the economy, he does not capture the role that other social domains play in sustaining and in resisting capitalism; this failure eventually limited his construction of an alternative to capitalism.[43]

In tune with Hegel, Marx sees the modern condition under capitalism as a barrier for the fully human realisation through labour. Capitalism alienates humans from the world and from themselves. Humans receive no satisfaction from their labour, and productive and creative life is distorted. Apart from the alienation from labour, workers are also alienated from other human beings, as their relations are now relations of competition *for* labour. More than that, struggling to maintain their physical existence, and only merely so, workers are ultimately alienated from their vital essence of human beings.[44]

Whereas for Hegel the solution lies in the overcoming of the bifurcation of ethical life, for Marx it lies in the overcoming of capitalism through the reappropriation of the social wealth accumulated by capitalism and put it at the service of human ends.[45] Although Marx incorporates Hegel's philosophy of history as the necessary unfolding of stages towards the ultimate freedom, he does so materialistically. Rejecting the idealism of Hegel's *Geist*, Marx conceives history as the unfolding of the dialectical relationship between forces of production. Following Hegel's dialectics which argues that every stage in history develops its own contradictions and the principles of its dissolution, Marx argues that the contradictions of capitalism will lead to its own dissolution, ultimately ending in the communalisation of the social and material wealth accumulated by capitalism. At this stage, the state, the political, and the juridical will become

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[41] Sayers, 2003 and Benhabib, 1986.
[42] Habermas, 1987.
[43] Habermas, 1987*;* Hanks, 2002, p. 5.
[44] Hanks, 2002, pp. 16–7.
[45] Habermas, 1987.

redundant.[46] In Marx, thus, the subject of history is not *Geist*, but humanity, and the revolutionary agent in the overcoming of capitalism in name of humanity is not the *bourgeoisie*, but the proletariat.

(b) In *The Capital*, Marx introduces a materialist version of Hegel's concept of reification: the fetishism of commodities in which socio-historical developments present themselves to social actors as natural orders. In Marx's interpretation, in capitalism the relationship between human beings acquires the logic of a relationship between things. To make exchanges possible, capitalism needs to establish the value of qualitatively different products and human labours in relation to a form of equivalent. Money, as the universal equivalent in capitalism, thus regulates all exchange relations, including human labour for wages. As everything has its value measured according to the universal equivalent of money, even social relations become mediated in the form of commodities. The rules regulating this process, notes Marx, appear to exist apart from themselves,[47] and as a result, human beings conceive *themselves* as commodities, and their consciousness become 'commodity consciousnesses'. Undermined of the possibility of self-determination, the individual becomes the economic individual.[48] Marx aims with this critique at 'defetishising' reality and returning it to the control of individuals. This materialistic interpretation of Hegel's reification will be taken up by Western Marxists, the Frankfurt School, and by Habermas. Habermas will reinterpret the category of reification in the light of his dual concept of society.

2.3 Modernity and the pathologies of reason – Weber

Weber's influence in Habermas's work is in great part due to his theory of modern differentiation, including the differentiation of reason in two forms, formal and substantive. This differentiation allows Weber to explain dysfunctions in social life in terms of the misplacement of these forms of reason, an insight that Habermas incorporates. According to Weber, processes of Western modernisation and industrialisation are marked by a progressive rationalisation of the formal kind, and it is the growing dominance of this form of rationality that leads to social dysfunctions.

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[46] Hanks, 2002, pp. 6–7.
[47] Hanks, 2002, p. 2.
[48] Hanks, 2002, pp. 4–5.

Formal, or purposive, rationality, which becomes progressively dominant in modern life, is characterised by practical assessments of reality and by an objectifying, means-to-an-end attitude towards it. With modernisation, reality is progressively apprehended and formulated abstractively, allowing the prediction and the control of phenomena. Ends become precisely calculated and achieved. The systematisation of means to desired ends, then leads to the development of laws, rules, and regulations that make possible the technological control over nature and strategic control over human beings.[49] This purposive rationality is also progressively extended to ethical life at the expense of a substantive, or value, rationality. Substantive rationality, involves moral and expressive assessments of reality, in which the conformity of an action is evaluated according to accepted values, without a necessary regard for the consequences of the action.

The progressive formal rationalisation results in loss of meaning and loss of freedom. Analysing the effects of rationalisation in the realm of religion, Weber argues that mystical and metaphysical processes are progressively subjected to rational assessment; their own propositions are required to become consistent internally and with a world thinking in terms of causal relations.[50] This process leads to a loss of meaning, or 'disenchantment' with ethical life. The realm of culture also suffers with a progressive differentiation between art, religion, sciences and ethics. Gradually, the social mediation among these spheres fails, and social meaning is also lost. Disenchantment, then, spreads to everyday life.[51] When formal rationality progressively spreads to the realms of law, the State and social organisations, it subjects the social to processes of increasing bureaucratic control, which individuals cannot avoid, reverse or control, being therefore condemned to live within an 'iron cage' of bureaucracy.[52] A loss of freedom then ensues.

Weber's tone is ultimately pessimistic as he perceives disenchantment as an irreversible process in which nothing seems to make sense to individuals. His pessimistic tone towards modern rationality and towards the insidious

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[49] Benhabib, 1986, pp. 182–85; Hanks, 2002, Chapter 1.
[50] See Edgar, 2005a, p. 218.
[51] Benhabib, 1986, pp. 182–85; Hanks, 2002, Chapter 1.
[52] Hanks, 2002; Edgar, 2005a.

instrumentalisation of all spheres life is later echoed by the first generation of the Frankfurt School, most notably in the post-war period.

2.4 Reification – Lukács and the Frankfurt School

The rise of the totalitarian socialist regime in the Soviet Union, the failure of the revolution in other European countries, and the gloomy political situation of the early 20th century in Europe led many Marxists theorists to reformulate classical Marxian premises and to include non-Marxist theses into their work. That included parting ways with the economic orthodoxy and embracing a cultural interpretation of capitalism. György Lukács and the Frankfurt School represent this development in Marxist thought, and their broadened analysis of reification is an example of this paradigm change.[53]

Lukács criticises Marx for failing to grasp the capitalist power of social control that reaches beyond the economic realm.[54] According to Lukács reification is the distorted perception of all relations within capitalism as being relations between things. Bringing together Marx and Weber, Lukács abandons the orthodoxy by arguing that the Marxist concept of fetish of commodities and Weber's theory of formal rationalisation are aspects of the same process.[55] Beyond economic relations, in capitalism all spheres of social relations become reified.[56] Yet, contrary to Weber and closer to Marxism, Lukács argues that reification is not irreversible but a feature of capitalist society that can be overcome.[57]

The development of history and society is, for Lukács, a typical example of reification: being constructed along thousands of years of human activity, it is nonetheless perceived as the result of natural forces beyond human control.[58] Yet, the highest level of reification is manifested in the incapacity of human beings to realise the preconceptions of their own thought; the reification of thought in *bourgeois* philosophy and social sciences being a especial case in point.[59]

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[53] Edgar, 2005a, Chapter 1; Outhwaite, 1994, Chapter 1.
[54] Hanks, 2002, Chapter 1.
[55] Edgar, 2005a, Chapter 6.
[56] Edgar, 2005a, pp. 17-20.
[57] Edgar, 2005a, Chapter 6, especially pp. 215–26.
[58] Hanks, 2002, Chapter 1.
[59] Hanks, 2002, Chapter 1.

Although Lukács tries to adjust Marxist theory to the new contexts of capitalism, he is still attached to its orthodoxy for seeing the proletariat as the revolutionary agent. Although both are reified, the *bourgeoisie* and the working class perceive crises differently. According to Lukács, because the *bourgeoisie* leads a comfortable life, it is less able to realise its own objectification.[60] In contrast, the theorists at the Frankfurt School abandon the thesis of the proletariat as the revolutionary subject. Despite sharing with Lukács the importance of grasping capitalism beyond its economic realm, they are less confident than Lukács that capitalism is in crises. On the contrary, their focus of concern turns to its continuing stability.[61] The pervasiveness of modern instrumental reason is the main phenomena they associate with the possibility of the growing strength of capitalism.

For Horkheimer and Theodor Adorno, modern reason is committed to the instrumental achievement of ends, and in such a way that it becomes subjective to the choice of ends, validated in reference to their achievement, and refractory to criticism based on meanings and values.[62] Instrumental reason is so pervasive that it also becomes internalised by the super-ego. Because of this internalisation of an instrumental logic, Horkheimer and Adorno argue that self-preservation becomes the only rational choice to individuals. For self-preservation, the individual has to alienate itself from its natural impulses by submitting to and incorporating the logic of a technocratic, 'administered world'. In so doing, the individual too, just as reality, becomes predictable and subject to control and manipulation.[63] The manipulative power of the mass media and of the culture industry is an example of the manipulation of individual choices.[64]

Finally, the pervasiveness of instrumental rationality and its internalisation as super-ego impede individuals to critically apprehend reality and its reification. Contrarily to Lukács, Horkheimer and Adorno do not see reification as a feature of capitalism, but the very reason why capitalism becomes a historical possibility.[65] As they conclude, instead of freeing the world from the mythical, the Enlightenment itself

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[60] Hanks, 2002, Chapter 1.
[61] Edgar, 2005a.
[62] Edgar, 2005a, pp. 215-26.
[63] Edgar, 2005a, p. 224-25.
[64] Adorno and Horkheimer, 1997; see also Edgar, 2005a, Chapter 6.
[65] Edgar, 2005a, pp. 225-26.

'relapse into mythology'. Despite its claims of the power of reason to challenge metaphysics and traditions, the Enlightenment itself becomes dogmatic and ultimately self-destructive:[66]

> Enlightenment, understood in its widest sense as the advance of thought, has always aimed at liberating human beings from fear and installing them as masters. Yet, the wholly enlightened earth is radiant with triumphant calamity. Enlightenment's program was the disenchantment of the world. It wanted to dispel myths, overthrow fantasy with knowledge.[67]

For Adorno, freedom requires the recognition of the internalisation of authority and repression by the subject and the overcoming of the narcissistic self-relation through the reconciliation of self with 'nature', the otherness of society and reason.[68] Ultimately, however, neither Adorno nor Horkheimer hope that this disenchantment can be reversed. Overcoming this nihilism and conformism, while at the same validating elements of their powerful critique, is one of the purposes of Habermas in developing his communicative action theory. Freedom and reconciliation in Habermas will be construed as 'sociation without repression' through intact intersubjectivity and relations of mutual understanding and recognition.[69]

2.5 Philosophy of consciousness

Before discussing how Habermas proposes a change of paradigm in critical theory, a brief discussion about the concept of the philosophy of consciousness is needed. Philosophy of consciousness is a set of methodological presuppositions about the subject of enquiry that is shared by all the thinkers above and that Habermas seeks to overcome.

One characteristic of the philosophy of consciousness is the primacy given by theorists to the individual or the subject, who in relation-to-itself mentally represents and manipulates objects or the world external to itself. Two aspects of this perspective are important. The first aspect is its social atomism, which is the conception of individuals in separation from others and the social context. The interactive sphere of

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[66] Edgar, 2005a, p. 216.
[67] Adorno and Horkheimer, 1997, p. 1.
[68] Adorno and Horkheimer, 1997; see also Benhabib, 1986, Chapter 5.
[69] See McCarthy, 1989, pp. xviii-xxii.

individuals and the role of society in constituting the subject are therefore not contemplated.[70] Typical examples of this paradigm are the natural law metaphors of fully constituted individuals that come together with the objective of forming associations. In these metaphors, individuals are logically constructed as prior to society. Accordingly, the attachment of the individual with its social medium tends to be seen as instrumental to their natural and individual purposes. Kant is another example of this primacy attached to the subject. His moral theory, for example, is wholly based on the self-reflexive capacity of the individual, who is able – in monologue – to grasp the moral point of view. Habermas overcomes this monological construction of the moral point of view by locating it in the plurality of voices of interacting individuals.

The second important aspect of this perspective is the way in which the subject relates with the world: through a subject-object pattern of interaction. The subject objectifies and manipulates the world – external, social and internal – in order to grasp it.[71] Hegel's and Marx's concept of work are examples of this view. As seen above, both thinkers see work, the manipulation of the external world, as the way through which the individual overcomes bifurcation towards reconciliation or realises her full human essence. Habermas disagrees with this view that through objectification subjects constitute the world. He defends that it is in fact through interacting with each other that subjects constitute their world.

The lonely self of the philosophy of consciousness, therefore, makes sense of the world either by thinking and interpreting it – a cogitative self – or by working and transforming it – an acting self. In either case, the self is conceived abstractly, it is detached from its social peers, and it characteristically performs an objectifying (subject-object) interaction with the world, others and even oneself. The world, therefore, is seen as an object of the self's acts or interpretations.[72]

Finally, another form of manifestation of the philosophy of consciousness is the focus not on the subject, but on a macrosubject. In this case, individuals are merged into the unity of a single macrosubject. Hegel's and Marx's philosophy of history illustrate

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[70] See Habermas, 1995b, especially Chapter 2; Edgar, 2006, pp. 26-9; Finlayson, 2005, Chapter 3; Benhabib, 1986, Chapter 4.
[71] See Edgar, 2006, pp. 26-9; Finlayson, 2005, Chapter 3; Benhabib, 1986, Chapter 4.
[72] Habermas, 1995, pp. 10-53; 1987b, Lecture XI; Benhabib, 1986, Chapter 4.

well this concept of a macrosubject. For Hegel the macrosubject of history is *Geist* in the process of reconciliation with itself, whereas the macrosubject of history for Marx is humanity in its course of overcoming capitalism towards the ultimate utopia of freedom.[73]

According to Habermas, from Kant to Adorno and Horkheimer, all the thinkers discussed above subscribe, in different forms, to the philosophy of consciousness. This paradigm limits their analysis of social and political problems insofar as it prevents them to fully explore the role of interaction, of intersubjectivity, and of communication in shaping and maintaining social life. This shortcoming in their theories is what Habermas aims at overcoming through a paradigm change towards mutual understanding. This new paradigm allows him to reinterpret central critical theoretical themes in a broader and more positive light. This endeavour culminates in *A Theory of Communicative Action* and it profoundly shapes his subsequent works.

3 Habermas's discourse theory

Habermas's work is grounded on modernity, its ideals and its unfinished project. He identifies the emancipatory potentials at the heart of modern ideals and accounts for the social pathologies that have hindered their full realisation. Ultimately, his aim is to uncover the necessary conditions for the completion of the modern project of radical democracy.

Inspired by the philosophy of language, Habermas proposes a paradigm change in critical theory from the foundationalism of the philosophy of consciousness to the pragmatism of communication theory. Communicative action is the central concept that results from this paradigm shift. It is based on the role that language and communication play in structuring social interactions and coordinating actions. The development of the concept of communicative action, by its turn, is dependent on two other important frameworks that underpin Habermas's theories: intersubjectivity and post-conventional world orientation. Together these frameworks help Habermas reinterpret classical themes in philosophy and sociology, most notably critical theory's critique of capitalism and of modern rationality.

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[73] See Edgar, 2006, pp. 26-9; Finlayson, 2005, Chapter 3; Benhabib, 1986, Chapter 4.

A Theory of Communicative Action is Habermas's seminal work on the subject and it shapes his subsequent works in moral, legal and democratic theory. In this work, he accounts for the duality of modern rationality and proposes a dual model of social analysis based simultaneously on the methodologically distinct perspectives of lifeworld and systems theory. The goals are to reconstruct a critical theory that is better suited to the study of modern society in its growing complexity and set a proposal for social redirection guided by the concept of communicative action.

From a methodological perspective, *A Theory of Communicative Action* consists in the reconstruction of major works of the three thinkers whom Habermas's calls 'the founding fathers of modern sociology', namely Weber, George Herbert Mead and Émile Durkheim.[74] From Weber, and his Marxist commentators Lukács and the Frankfurt School theorists, Habermas incorporates perspectives on modern rationality; from Mead he incorporates insights from the theory of the communicative foundations of society; and finally, from Durkheim he incorporates analyses on social solidarity.[75] Habermas's reconstructions of these theories aim at freeing them from the shortcomings of the philosophy of consciousness.[76] A critical interpretation of Adorno's ideas of freedom and reconciliation, through which Habermas projects an ideal community of communication and of undamaged intersubjectivity and mutual understanding, adds an element of utopia and idealism to his theory of communicative action.[77]

The engagement with Weber, Mead, Durkheim and Adorno also leads to critical analyses of the works of a number of other influential thinkers in a broad array of fields, among which are: Ludwig Wittgenstein, Charles Sanders Pierce, John L. Austin, John Searle, Jean Piaget, Talcott Parsons and Niklas Luhmann. In fact, these critical 'dialogues' with classical and contemporary thinkers and the mediation of antagonisms between their contrasting theories are hallmarks of Habermas's method. As Thomas McCarthy describes, for Habermas these thinkers are

> still very much alive. Rather than regarding them as so many corpses to be dissected exegetically, he treats them as virtual dialogue partners from whom a great deal that is of

[74] Habermas, 1989a, p. xlii.
[75] Habermas, 1989a, p. 399.
[76] Habermas, 1989a, p. 399.
[77] Habermas, 1989b, pp. 1-2.

> contemporary significance can still be learned. The aim (…) is to excavate and incorporate their positive contributions, to criticize and overcome their weaknesses, by thinking with them to go beyond them.[78]

The result is a combination of historical and systematic reconstructions of ideas that if sometimes challenging to the reader, also brings a fascinating breadth and depth to his work. This richness is one of the reasons that make his work promising to the analysis of healthcare, its social role, and its relationship with justice. The elements of Habermas's work that are most relevant to this project are introduced bellow.

3.1 Critique of modern individualism and the intersubjective turn

In contrast with anti-modernist critical theory, Habermas does not regard the crises of modernity as resulting from the ideals of the Enlightenment. Rather, Habermas contends that these crises arise from the one-sidedness in their application.[79] The much-criticised individualism that flows from the liberal interpretation of modern ideals is one important example of this. While many critics claim that the modern focus on the individual has led to the egoistic and domineering practices that characterise Western culture, Habermas does not locate the problem in the process of modern individuation *per se*, but in the narrow understanding of what it entails.[80] He welcomes modern processes of individuation and the modern ideal of individual freedom to pursue one's life projects. Bringing the individual to the centre of the moral focus facilitated, for example, the break with the authority of rules *imposed* by aristocratic power, kinship ties, tradition, and religion in favour of *reflexive* sources of authority.[81] The problem arises when this process of individualisation is stretched so far as to detach the individual from her social background, as classical liberalism is a case in point.

In its classical expressions, liberalism has accounted for the process of socialisation through metaphors of pre-social individuals, who come together with the objective of forming associations in the name of prudence, stable conditions for trade, peace, or cooperation. These metaphors illustrate the centrality of the individual and the

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[78] McCarthy, 1989, p ix. See also Habermas, 1989a, p. xlii.
[79] Habermas, 1987b, especially Chapters I and XII, although all lectures offer interesting accounts of the normative content of modernity with a particular focus on the debate with anti-modernists.
[80] Habermas, 1990; 1995, pp. 10-53 and 149-204.
[81] Habermas, 1987b, Lectures I and XII.

derivative and instrumental character of society in the liberal school of thought. Habermas is critical of this theoretical self, who prior to socialisation is already constituted and fully aware of her interests.[82] For Habermas, this conception misses the point that the self can only become an 'I' by interacting with others.[83] According to this insight, individuals only form their personal identity through socialisation processes, as it is in the web of interpersonal relations that the self shapes and maintains its unique identity, from which therefore flow its own conceptions of the good. In other words, for Habermas, individualisation follows socialisation and not the other way round.[84]

The methodological solipsism of the 'unencumbered self', which liberals share with many other theories is, as seen above, an expression of the philosophy of consciousness. Habermas's intersubjectivist insight, in contrast, understands that the subject relates to others in a *subject-subject* pattern of interaction, and this interaction is fundamentally grounded in communication. He replaces the objectifying stance of the subject for a model of interaction in which subjects taking the alternating roles of hearers and speakers meet each other in a non-objectivating fashion. More specifically, it is in communicative practices of reaching an understanding with others that subjects interact to establish their relation with the world, with others and with themselves.[85] As he explains,

> In order to reach an understanding about something, participants must not only understand the meaning of the sentences employed in their utterances, they must also be able to relate to each other in the role of speakers and hearers – in the presence of bystanders from their (or from a) linguistic community. The reciprocal interpersonal relations that are established through the speaker-hearer perspectives make possible a relation-to-self that by no means presupposes the lonely reflection of the knowing and acting subject upon itself as an antecedent consciousness. Rather, the self-relation arises out of an *interactive* context.[86]

Intersubjectivity through linguistic communication, therefore, constitutes Habermas's dialogical answer to the methodological monologue of the philosophy of

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[82] Habermas, 1995b, p. 170.
[83] He develops this insight 'in dialogue' with Mead's theory of individuation. See more in Habermas, 1989b, pp. 37-42; 1995b, Chapter 7 'Individuation through socialization: on George Herbert Mead's theory of subjectivity'.
[84] Habermas, 1995, pp. 149-204.
[85] Habermas, 1989b, pp. 1-11; 1995, especially pp. 10-53.
[86] Habermas, 1995, p. 24.

consciousness.[87] Importantly, the theory of the intersubjective constitution of the self allows the critique of liberal individualism without forgoing the gains of individual freedom and individuation. More than that, this necessary mediation between the individual and her community also overcomes the old opposition between communitarianism and liberal individualism.[88] This is because relinquishing the monological self did not lead Habermas to embrace the view from the other end of the spectrum which accords the priority of the community or of an ethics of the good life. On the contrary, he rejects that in conditions of modernity it is possible to formulate an overarching conception of the good.[89] It is no longer possible to rely on sources of normativity based on tradition, religion, or metaphysics to provide a set of rules of conduct or a comprehensive view of what a worthwhile life is. In modernity, there is no pre-given and privileged standpoint enjoying the ability to grasp totality and the supremacy to conceive definitive claims to truth or rightfulness.[90] Rather, the modern plurality of world-views calls for the recognition of individual autonomy and demands that conflicting interpretations of reality and the definition of accepted standards of behaviour be solved in dialogical reflection.[91] As Habermas clarifies his standpoint,

> Discourse ethics occupies an intermediate position, sharing with the 'liberals' a deontological understanding of freedom, morality, and law that stems from the Kantian tradition and with the communitarians an intersubjective understanding of individuation as a product of socialization that stems from the Hegelian tradition.'[92]

In *A Theory of Communicative Action* and subsequent works classical concepts are reconstructed intersubjectively. The reconstruction of modern rationality, in which reason is grounded in communicative processes of reaching an understanding *with others*, is an important example of the centrality of the concept of intersubjectivity.

3.2 The theory of communicative action

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[87] See McCarthy, 1989.
[88] Habermas, 1990; 1987.
[89] Habermas, 1990; 1987.
[90] Habermas, 1987, especially Lecture XII.
[91] Habermas, 1989a, pp. 17-8; 1989b, pp. 486-87.
[92] Habermas, 1995a, p. 91.

Underpinning the political and economic transformations brought by modernity, such as civil liberties, the political power of free public debates, and private freedom of pursuing one's own concept of the good life, lies the concept of modern reason.[93] According to Habermas, it was modern reason what stood in opposition to taken-for-granted beliefs and the force of traditions of pre-modern times.[94] This modern process of 'rationalisation' was marked by the substitution of a once unified worldview – grounded on the sacred, hierarchical or traditional sources of authority – by differentiated, decentred and independent social spheres, such as the economy, politics, law, religion, and sciences. In becoming differentiated, these spheres started operating according to their own internal logic and independently from the other spheres. If on the one hand this process of progressive differentiation permitted an unprecedented accumulation of wealth and knowledge, on the other hand it posed a serious threat to social integration by failing to put in place alternatives to maintain a social cohesion previously secured by traditional forms of life and religious authority. [95] As critics of modernity point out, what resulted from these transformations promoted by modern reason was not fulfilment of the emancipatory promises of modernity. On the contrary, these transformations came at a cost of progressive loss of ethical meaning, loss of freedom and social disintegration.[96]

As seen above, most influentially Weber, later followed by Horkheimer and Adorno, develop this line of critique against modern rationality. While incorporating elements of Weber's critique, Habermas does not share Weber's negativity towards modern reason. Contrarily to most critics of modernity, in criticising modern transformations and their pathologies he does not reject the concept of reason altogether. Rather, he reclaims its emancipatory potentials.[97] As McCarthy points out, for Habermas 'the real problem is too little rather than too much Enlightenment, a deficiency rather than an excess of reason'.[98] It is a narrow understanding of modern reason and its lack of

[93] Habermas, 1987, Lectures I nad XII.
[94] Habermas, 1987, Lectures I and XII.
[95] Habermas, 1987, Lectures I and XII; 1989a.
[96] Habermas, 1989a, pp. 143-271.
[97] Habermas, 1987, Lectures I and XII.
[98] McCarthy, 1997, p. xv.

self-critical reference what prevented its emancipatory potential to be unleashed.[99] The project of modernity, he argues, needs to be critically completed and not abandoned.[100]

Habermas's project entails a reconstruction of the modern concept of reason. To do that, he reinterprets Weber's methodological distinction between the two forms of reason and differentiates reason into instrumental and communicative. Instrumental rationality is construed by Habermas as the goal-oriented rationality guiding the reasoning behind calculations of better means to given ends. Its inherent goal is, therefore, to produce a desired end. Communicative rationality, in contrast, is the rationality guiding communicative processes of reaching consensual agreement among social actors. Its inherent *telos* is mutual understanding. Unlike Weber, Habermas does not see the dominance of a goal-oriented rationality as an irreversible process or its use always undesirable. Under certain circumstances, the use of a goal-oriented rationality may be appropriate, as in the cases of technical-scientific studies and economic calculations. More fundamental to his reconstruction of modern reason is that he locates in communicative rationality the critical element of the project of modernity and places in it the possibility of social change.[101]

To better understand how Habermas justifies communicative reason and how reason is related to social pathologies, it is necessary to discuss Habermas's pragmatic theory of language in use – a 'universal pragmatics' that focuses on role that language plays in structuring the social world. This pragmatic account of language, when linked with the concepts of post conventional thinking and moral-cognitive development, grounds the concept of communicative action, to which communicative rationality is attached. Communicative action, by its turn, will be the guiding framework of his social, moral and legal theories. As it will be seen, Habermas uses the philosophy of language 'to save a concept of reason that is sceptical and post-metaphysical, yet not defeatist',[102] by pointing towards the insight 'that the unity of reason only remains perceptible in the plurality of its voices.'[103]

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[99] Habermas, 1987, Lectures I and XII; McCarthy, 1987, p vii-xvii.
[100] Habermas, 1987; Edgar, 2005a, p. 190.
[101] Habermas, 1989a; 1989b, pp. 486-87.
[102] Habermas, 1995b, p. 116.
[103] Habermas, 1995b, p. 117.

3.2.1 Universal pragmatics and communicative action

'Reaching an understanding is the common *telos* of human speech.'[104] This central insight of Habermas's account of language is a fundamental step towards his theory of communicative action. This is because it helps explain what makes rational agreements not only morally desirable, but *possible*. Furthermore, it is in the inherent structure of linguistic interaction that Habermas locates the unavoidable, intuitive, and 'always-already' orientation towards universality and impartiality.

Language, for Habermas, is the medium for the possibility of reaching an understanding, for social cooperation, and for the learning processes of the self.[105] It follows that language, or more specifically communication, is the fundamental medium for social generation. He builds from the premise, inspired by Mead, that it is through the development of our communicative competence, made possible by socialisation, that we relate with the objective world of affairs, with others and with ourselves.[106] Going beyond the competence for constructing sentences that make grammatical sense, individuals master the use of language as a means to relate with others. In everyday life, individuals make use of language not only to describe facts; they also agree and disagree about the rightness of norms and actions and the sincerity of claims. By making claims regarding the objective world, regarding values or norms, and regarding the speaker's own feelings and desires, participants interact with other.[107] Independently of whether participants agree on, challenge, or reformulate these claims, the pragmatic features revealed in the interaction are the orientation towards reaching an understanding with others and the inclination for coordinating actions in the light of reached agreements.

This orientation towards mutual understanding and cooperative coordination of action are inherent in the use of language. This is because our competence to use language entails the mastering of universal structures and rules that makes it possible for individuals to understand the meaning of what is being said. These 'transcendental' rules command the use of language for a wide range of different expressions, such as explanations, descriptions, arguments, evaluations, and commands, as each of these

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[104] Habermas, 1989a, p. 287.
[105] Habermas, 1995b, p. 153.
[106] Habermas, 1995b, pp. 149-204.
[107] Habermas, 1989b, pp. 102-41, especially p. 120.

different expressions requires the mastering of rules that are specific to their task. These rules are acquired through socialisation and are known to the individual at the intuitive and pre-theoretical level, i.e. individuals are able to follow them without being consciously aware that they are doing so. [108] That means that in communication, participants are 'always-already' using this pre-conscious know-how and cannot avoid using it if their goals are to be understood and to coordinate actions with others.

Uncovering, or reconstructing, these sets of rules and 'always-already' knowledge of them is the focus of Habermas's pragmatic approach to language – universal pragmatics. In contrast with semantics, which appreciates only the representational aspect of language, universal pragmatics aims at revealing how language structures society. According to the theory, linguistic meaning does not exist outside the interaction of participants. It depends on the speaker's utterance together with the position taken toward the utterance by the hearer, which can be a simple yes or no reply. Despite the utterance having an explicit content that refers to something in the world, the interpretation or understanding of its full meaning requires more than grasping this content alone. The full meaning of an utterance also depends on how this utterance is put forth by the speaker, i.e. whether it is an assertion, an explanation, a promise, a request, an advice, etc.[109] This 'intent' behind the utterance is its illocutionary component,[110] or the performative component of the speech. As Habermas summarises, 'understanding what is being said demands not only observation, but participation'.[111]

Furthermore, according to universal pragmatics, the meaning of sentences cannot be separated from language's inherent relation to validity. Validity in this context means that good reasons can be given and agreed upon in support of a statement. Participants cannot grasp the meaning of what is being said without being able to differentiate between a valid and invalid utterance.[112] This condition of acceptability,[113] or validity, of an utterance is linked with reasons – defining its rational core. As Habermas argues,

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[108] Edgar 1995, p 149.
[109] As William Outhwaite further explains, universal pragmatics is distinguished from linguistics by the fact that it studies utterances rather than sentences (1994, p 40).
[110] The illocutionary role establishes the mode of a sentence employed as a statement, promise, command, avowal, or the like. See Habermas, 1989a, p. 289.
[111] Habermas, 1992a, p. 27.
[112] Habermas, 1989a, p. 278.
[113] Habermas, 1989a, p. 297.

individuals evaluate utterances not by directly comparing its content with a state of affairs, but by evaluating the reasons given by the speaker in support of her statement. That means that a statement is only valid if good reasons can be given in support of it. Furthermore, the evaluation of the good reasons does not rely on the speaker alone, but also on the position that the hearer takes toward it. An argumentative process of mutual giving and taking of reasons, then, forms this interaction. Habermas further adds that 'in this process of evaluating reasons individuals cannot avoid appealing to standards of rationality, which they consider binding on all parties'.[114]

This varied and complex communicative interaction between participants implies that specific social and/or moral relationships are being established between them[115] – and that amounts to specific social actions. For example, certain types of speeches are regulative in character and establish obligations on the parties involved, such as promises, agreements, advices, and commands. They establish specific obligations on either or both participants.[116] Due to their performative content, speeches become social actions, or in other words, speech acts.[117] Speech acts are the basic social actions arising from the interaction between a speaker's utterance and the hearer's position towards it.

In aiming at reaching an understanding with others about something in the world, the speaker's utterance establishes a three-fold relation: (a) a reference to something in the world, (b) an interpersonal relationship with the hearer, and (c) the expression of the speaker's intentions or beliefs.[118] In other words, in aiming at reaching an understanding with others, the speaker (c) expresses her beliefs by communicating (b) with the hearer (a) about something in the world.[119]

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[114]Habermas, 1992a, p. 31.
[115]Habermas, 1989a; see also Edgar, 1995, p 141.
[116] Habermas, 1992a, p. 59.
[117]Speech acts are concepts that Habermas incorporates, and reinterprets, from J.L. Austin and John Searle. See Habermas, 1989a.
[118]Habermas, 1992a, p. 24.
[119]See Habermas, 1989a; 1992a, Chapter 2; 1995b, Chapter 4; 2000b.

Claims to validity[120]	**Truth**[121]	**Rightness**	**Truthfulness**
World perspective	Objective world	Intersubjective world	Subjective world
Domains of reality	External nature	Society	Inner nature
Linguistic function or speaker/hearer perspective	Expressing something about the world	Establishing interpersonal relationships	Expressing the speaker's intention
World attitudes	Objectivating	Norm-conformative	Expressive
Mode of language use	Cognitive	Interactive	Expressive
Classes of speech acts	Constative	Regulative	Representative
Moments of reason	Cognitive-instrumental	Moral-practical	Aesthetic-expressive
Issues dealt with	Truth	Justice	Taste
Type of knowledge embodied	Technical, empirical-theoretical	Moral-practical	Aesthetic-practical
Form of argumentation (in mending disturbances)	Theoretical discourse	Practical discourse	Therapeutic and aesthetic critique
Model of transmitted knowledge	Technologies, theories	Legal and moral representations	Works of art

Table 2.1 – Claims to validity in communicative action and their associated domains.[122]

[120] There is still a fourth type of validity claim, namely a claim to comprehensibility, which domain is language itself, and refers to whether an utterance is linguistically comprehensible (Habermas, 2000b). However, only the analysis of claims to truth, rightness and sincerity are emphasised by Habermas due to their pragmatic connotations.

[121] Claims to truth, despite their association with a goal-oriented rationality can be distinguished in relation to their action orientation into strategic and aiming at reaching an understanding (Habermas, 1989a). Here only the claims to truth linked with communicative (thus non-strategic) form of action is represented.

[122] See Habermas1989a, Chapter 3, 1992a, pp 25 and 116-94; 2000b; and also Outhwaite 1994, p. 49.

This three-fold relationship established by an utterance is connected with a three-fold world perspective as speech acts serve to (a) represent states and events in the (objective) world; (b) establish and renew relationships (social/intersubjective world) and (c) manifest personal experiences and beliefs (internal/subjective world).[123] By its turn, this three-fold relation between utterances and world perspectives makes simultaneously and implicitly three different 'validity claims' that are: (a) truth, (b) rightness or (c) sincerity. [124] This structure of action give participants a choice between (a) cognitive, (b) interactive and (c) expressive modes of language use, which correspond to three different classes of speech acts: (a) constative, (b) regulative and (c) representative.[125] These classes of speech acts by their turn permit participants to focus on issues of (a) truth, (b) justice or (c) taste. Finally, the attitudes adopted by participants in relation to the world are: (a) objectivating, (b) norm-conformative, and (c) expressive. In this complex communicative structure, the validity claims to truth, rightness and sincerity 'can then serve as guiding threads in the choice of theoretical perspectives for distinguishing the basic modes of language use, or the functions of language, and classifying the speech acts that vary with individual languages.'[126] Table 2.1 enlists these concepts and their associations in idealised cases.

The above is an account of idealised or 'pure cases' of speech acts. In the context of everyday life, however, language is used in still more intricate ways. Cognitive interpretation, moral expectations, and expressive statements tend to overlap and interpenetrate. Claims to truth, rightness and sincerity are usually made simultaneously, even if implicitly, and even if only one of them is chiefly thematised. In addition, the different rationalities, goals and perspectives of the other domains can sometimes serve good use: agents can approach the external world not only in objectifying but also in norm conformative or expressive ways, confront society in an objectifying or expressive way, and confront inner-nature in an objectifying or norm-conformative way. To illustrate this, Habermas cites non-objectivists approaches in human sciences which

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[123]Habermas, 1989a, p. 309. Habermas differentiates the external world into an objective and social world. Complementary to the external world is the concept of the internal world, to which the subject alone has privilege access (1989a, p. 278).
[124]Habermas, 1989a, p. 308.
[125]Habermas, 1989a, Chapter 3; 1992a; 2000b.
[126] Habermas, 1989a, p. 278.

bring moral and aesthetic criticism into play without undermining the primacy of truth; of utilitarian calculations of consequences playing a role within ethics; and of art used as political criticism. In fact, Habermas sees these counter-movements as potential agents of mediation mitigating the radical differentiation of reason.[127]

Having described this intricate account of language in use, the next step is to understand how it helps Habermas build his social theory. The concept of communicative action is what establishes the link between universal pragmatics and Habermas's social theory. Communicative action arises from the differentiation of social actions according to whether participants in performing them adopt a success-oriented attitude or an attitude oriented to reaching understanding.[128] The former characterises strategic action, through which participants adopt an objectifying, egocentric, attitude towards the world and others. The goal is to achieve one's desired ends and convince others to do what one desires. [129] Communicative action, conversely, is oriented to mutual understanding; it aims at a shared understanding of situations, establishing relationships, and maintaining a meaningful intersubjectivity.[130] In communicative action participants coordinate their plans cooperatively. As Habermas explains:

> I distinguish between communicative and strategic action. Whereas in strategic action one actor seeks to *influence* the behaviour of another by means of the threat of sanctions or the prospect of gratification in order to cause the interaction to continue as the first actor desires, in communicative action one actor seeks *rationally* to *motivate* another by relying in the illocutionary binding/bonding effect of the offer contained in his speech act.[131]

Furthermore, this cooperation is achieved through practices of freely engaging with others in giving and listening to reasons for and against given claims. These interactions are characteristically free from coercion and grounded on the rationally

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[127] Habermas, 1992a, p.18.
[128] Habermas, 1989a, p. 286.
[129] Habermas, 1989a, p. 274. There is in Habermas a difference between strategic and instrumental action. Whereas strategic action implies an orientation to success by the speaker (as opposed to an orientation to mutual understanding), instrumetal action implies a means-to-an-end rationality that is approapriately applied to *constative* speech acts in which the underlying attitude of particpants is nonetheless oriented to mutual understanding.
[130] Habermas, 1989a, p. 278.
[131] Habermas, 1992a, p. 58. Author's emphasis.

motivating force of reaching *mutual* understanding.[132] For Habermas, it is only in intersubjective processes of reaching an understanding with others that agreements become reflexive and legitimate.

This distinction between strategic and communicative action is fundamental in Habermas's reconstruction both of the Weberian account of modern differentiation and its pathologies and of the critical theoretical concept of reification. More importantly, the concept of communicative action will be the central thread of Habermas's social, moral and legal theories. An illustration of how communicative action shapes Habermas's work will be presented below in a discussion of its role in moral discourses. Before that, however, it is important to locate the concept of communicative action within the horizons of what Habermas calls post conventional worldview, as it is at this level of individual (and social) development that communicative actions can unfold.

3.2.2 Communicative competences, post conventional worldview and moral-cognitive development

As presented above, Habermas's work flows within the horizons of modernity. As a corollary, his theories are always developed within the boundaries of post-metaphysical presuppositions, which reject unifying principles and ultimate truths in favour of reflective and pragmatic perspectives. Completed self and world decentrations, which make room for these perspectives, characterise a post-conventional worldview.[133] This is because it is within the horizons of post-metaphysical presuppositions that both self and morality become fully autonomous; i.e. identity is formed and recognised in its 'irreplaceable singularity' and morality is detached from the authority and constraints of the contextual and the traditional. Habermas's moral, political and legal theories – based on the concepts of communicative action and rational discourses – rely heavily on these achievements of autonomy. To understand these theories it is important to understand

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[132] Habermas, 1990, pp. 35-41; Habermas, 1995b, Chapter 4; Edgar, 2005a, pp.153-57.

[133] The term post-traditional is also used to the same end. The terms post-metaphysical and post-conventional do have the same meaning, nonetheless both translate the idea of the completed transition from a conventional worldview, typically grounded on metaphysical presuppositions, to a post-conventional orientation, grounded on reflexive and pragmatic presuppositions. They also entail a decentration from the contextual.

how post-metaphysical thinking and the self and world decentrations that it presupposes support Habermas discourse theory.

The use of the different structures, categories and attitudes available to participants in communication, as discussed above, imply that participants have achieved a post-conventional worldview. That means that participants master the differentiation of validity claims that are unavoidably raised in speech acts and are able to competently mediate between them. As Outhwaite explains, 'interactive competence is central to ego identity and moral consciousness, liberating the adolescent from both ego centrism of early childhood and from sociocentrism of tradition-bound role behaviour.'[134].The mastering of the use of language with the goal of reaching an understanding, however, is not a given or a natural trait of the species. Rather, it consists in a set of competences that must be acquired by the child in actual interaction with the world and others in the course of her socialisation processes. As it will be seen below, the development of interactive competences is an important element for Habermas's discourse theory. In studying the development of these communicative competencies, Habermas explore the theories of cognitive and moral development of Piaget, Lawrence Kohlberg and Robert Selman.[135]

Habermas, therefore, adopts a constructivist approach towards the development of competences: competences are acquired through dynamic learning processes that follow a pattern of stages in which the child progressively replaces the interpretation of a particular situation in favour of a new or revised interpretation that proves to be superior. Furthermore, Habermas construes morality, like cognition, as a type of knowledge. The acquisition of cognition and morality result from *problem-solving* empirical-analytical or moral-practical situations that arise from the child's interaction with the objective world and with others. [136] The objective world and the normatively world of interpersonal interactions are presented to the child as resistances. These resistances constantly challenge and problematise previous interpretations and require the development of new ones.[137] These interpretive exercises also become progressively

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[134] Outhwaite 1994, p 51.
[135] Habermas, 1992a, pp. 116-94. See also Swindal, 1999.
[136] Habermas, 2003c, p. 8.
[137] Habermas, 2003a.

more complex, abstract, and general. The post-metaphysical end point of these developments is competent perspective-taking. That means that the individual is able to reach an understanding with others by competently adopting a participant, an observer and a hypothetical perspective.

A complex structure of 'world' and 'speaker perspectives' characterises the decentred worldview. [138] As seen above, in aiming at reaching an understanding with others participants must be able to adopt different attitudes to the world (objectivating, norm-conformative, expressive). At the same time, they are required to adopt these attitudes by taking turns in playing the roles of speaker, listener and by-stander.[139] This is the speaker perspective. These three roles correspond to the first and second person perspective of participants (speaker and hearer) as well as the third person perspective of the neutral observer. As Habermas explains, this complex and dynamic structure of perspectives

> develops from two roots: the observer perspective, acquired by the child as a result of his perceptual-manipulative contact with the physical environment, and the reciprocal I-thou perspectives that the child adopts as a result of interactions with reference persons (during socialization processes).'[140]

From the 'I-you' perspective, the child learns not only to perceive a situation from the perspective of the other: in this interaction, the child and her interlocutor realise and recognise they are a 'we'. The inclusion of the observer perspective to the interaction will allow the child to perceive (and objectify) this 'I-you' interaction, including her own participation, from the more abstract perspective of a social world. This perspective enables her to go beyond the reciprocity entailed by the second person perspective and to judge whether actions conform to generally recognised norms or expected roles. These shifting speaker perspectives are fundamental for the development of the self and moral identity of the speaker. While the first person perspective allows for the self-expression of the speaker, the adoption of a (objectivating) third person

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[138] Habermas, 1992a, p. 139.
[139] Habermas, 1992a, pp.138-41.
[140] Habermas, 1992a, p. 139.

perspective enables her ability for self-description and the reciprocity of the second person perspective enables her ability for self-explication.[141]

A further stage of growth in this complex perspective structure is achieved when the participant perspective of the first and second person combined with the social observer perspective of the third person is complemented by a hypothesising perspective. This hypothesising perspective finally completes the transition to the post-conventional worldview. At this stage, the interaction becomes more abstract and reflexive, and the decentration allowed by the completed speaker's perspective enables the child/young person to look critically at recognised social norms and roles expectations and to judge not only whether actions conform to these recognised norms but also whether they are valid in the first place. This perspective, which 'undermines the normative power of the factual', is suited for the identification of general and universal principles that merit general recognition. In other words, norms of action become subordinated to principles and not to conventional role expectations. Moral discourses are examples of interactions that demand from the speaker the mastering of this hypothetical perspective.

The post-conventional stage, thus, becomes the domain of principled morality, and apart from discourse theory, Habermas also includes in this domain other forms of Kantian moral theories, utilitarianism, natural rights theories, and contractarian theories. Habermas proceeds cautiously from this point: the difference between discourse morality and the other theories does not concern the stage of moral development that they presuppose, but in their location of the moral point of view. In contrast with these competing theories, the moral point of view of discourse theory is not located in an ultimate principle or justification, but is procedural. These differences, however, have to be dealt with through philosophical argumentation and not through the establishment of their place in constructivist stages of moral development.[142]

In addition, Habermas alerts to the risk of a naturalistic fallacy attached to conceiving moral development in the same naturalist perspective as cognitive development. Although both are conceived constructively, they are not similarly seen as

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[141] Swindal, 1999, p. 151.
[142] Habermas, 1992a, p. 175.

natural developments of the child. Habermas does not see the progression to a complete moral decentration as a natural or necessary development. Rather, he sees it as a development that depends on historical, local, and individual experiential contingencies. Although the intrinsic constructivist *logic* of the development of cognitive-moral competences is universal, Habermas argues that due to the specific patterns of their interactions different cultural traditions can either promote or hinder the full accomplishment of these competencies. As he observes, 'reaching an understanding requires a cultural tradition which communicative practices range across the whole spectrum of validity claims, world and speaker perspectives.'[143] Here, the importance of the lifeworld to processes of moral decentration starts becoming clear. The lifeworld is not only the source of contexts for practices of reaching an understanding and moral decision-making; the lifeworld also offers the *resources* for the realisation of these practices. This insight is particularly relevant to the thesis as it helps with the analysis of the social role of health, construed as a specialised sub-system of the lifeworld, in supporting conditions for justice (Chapters 4 and 5).

3.2.3 Communicative action and moral discourses

The more differentiated the world becomes the greater are the possibilities for dissent and conflict.[144] Adding to that, a post conventional world orientation offers no privileged standpoint from which to judge issues of truth and rightfulness.[145] In the light of the need for non-violent conflict-resolution, Habermas tries to answer the question of how moral judgments are possible in a post conventional world. The interactive answer cannot rely on *substantive* moral principles. Rather, in using the presuppositions of universal pragmatics and communicative action, Habermas aims at demonstrating that the answer lies in procedural – as opposed to prescriptive – mechanisms of conflict-resolution. Habermas then introduces the concept of moral discourses as the procedures through which moral questions and questions of justice are legitimately dealt with. The normativity 'always already' embedded in forms of communication aimed at reaching an understanding grounds these discourses, and it is this inherent normativity what

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[143] Habermas, 1992a, p. 175.
[144] Habermas, 1995b, p.140.
[145] Habermas, 1987, Lecture XII.

justifies discourses as mechanisms of moral conflict resolution in post-conventional conditions.

Habermas's focus, as a result, is not on anticipating the substance of the outcome of moral conversations but on reconstructing the rules that regulate *the form* of such conversations.[146] Substantive moral principles, or principles of justice, have to be debated and justified in real discourses by participants themselves. What is relevant for the construction of Habermas's moral theory is that whichever principles participants in moral discourses agree on, they will 'always-already' do so by making use of implicit rules of argumentation. As Habermas argues, 'it is these rules alone that transcendental pragmatics is in a position to derive.'[147]

These rules are not conventions, but inescapable pragmatic presuppositions of rational discourses. As seen above, in taking part in communication participants implicitly *recognise each other* as participants. There is also a *symmetry* and *reciprocity* implicit in the acknowledgement that they all have to follow the same rules if they aim at being understood.[148] Furthermore, if the aimed consensus is to be based on the normative force of the better reasons, then only the *inclusion of all* involved in the dispute at hand, as well as the *absence of all coercion*, can guarantee that all relevant reasons are exposed so as to secure that the better argument is mutually built.[149] As Habermas argues, in agreements obtained by force, 'what comes to pass manifestly through outside influence or the use of violence cannot count subjectively as agreement. Agreements rest on common convictions.'[150] Robert Alexy is also interested in reconstructing these normative presuppositions of argumentation, and he suggests that from these presuppositions follow rules such as: everyone is allowed to take part in discourses, everyone is allowed to question or introduce any assertions and express their needs and desires, and no speaker may be prevented from exercising these rights.[151]

The participants' orientation towards reaching an understanding with others is

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[146] Habermas, 1992a, p. 91.
[147] Habermas, 1992a, p. 86.
[148] Habermas, 1992a; see also Swindal, 1999, p. 140.
[149] Habermas, 1989a; 1992a, p. 89; 2003c, Chapter 6.
[150] Habermas, 1989a, p. 288.
[151] Habermas, 1992a, Chapter 3. On the contribution of Alexy's work to Habermas's theory see also Habermas, 1996.

also an important requirement of moral discourses. This is because reaching an agreement with others without appealing to coercion or manipulation implies not only the mutual recognition that all are free and equal members of a moral community, but also the openness to temporarily set aside one's own convictions and self-interests in order to perceive things from the point of view of others. In moral discourses a mediation is sought between 'one's inalienable right to say yes or no' and the concern for the position of others. In that, discourses are not so much exercises of balancing needs and interests, as they are an opportunity for shaping and reshaping new values, needs and interests.[152] This process of *exchanging* of reasons and perspectives does not amount to strategically trying to convince others of the rightness or truth in one's conviction; it is rather a process of cooperative and *mutual* development of convictions. In other words,

> (...) nothing better prevents others from perspectivally distorting one's own interests than actual participation. It is in this pragmatic sense that the individual is the last court of appeal for judging what is in his best interest. On the other hand, the descriptive terms in which each individual perceives his interests must be open by others. Needs and wants are interpreted in the light of cultural values. Since cultural values are always components of intersubjectively shared traditions, the revision of the values used to interpret needs and wants cannot be a matter for individuals to handle monologically.[153]

Disputing claims and reaching moral consensus are dynamic and ongoing processes. Despite enjoying the momentary binding strength of truth, agreements are always subject to further disputes and revaluations whenever new contexts and conflicts demand so. For Habermas, 'the moment of unconditionality that is preserved in the discursive concepts of a fallibilistic truth and morality is not an absolute, or it is at most an absolute that has become fluid as critical procedure.'[154] In being fluid and always open to reconsideration, they also become ongoing learning processes. Furthermore, sometimes agreements cannot be reached, and the disputes at hand may need to be temporarily settled by other forms of fair compromises until a consensus can result from these ongoing debates.

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[152] Habermas, 1992a.
[153] Habermas, 1992a, pp. 68-9.
[154] Habermas, 1992, p. 144.

The emphasis on moral consensus, however, does not mean that discourses aim at making people to think homogenously. On the contrary, the maintenance of differences is the very assumption behind discursive settlements of disputes. As Habermas argues, '(t)he intersubjectivity of linguistically achieved understanding is by nature porous, and linguistically attained consensus does not eradicate from the accord the differences in speaker perspectives but rather presupposes them as ineliminable.'[155] In fact, the relationship between rational discourses and differences exhibit in Habermas a positive character. Discourses contribute to differentiation and individuation in society. As he remarks, 'for the transitory unity that is generated in the porous and refracted intersubjectivity of a linguistically mediated consensus not only supports but furthers and accelerates the pluralisation of forms of life and the individualisation of lifestyles'.[156] Furthermore, communicative practices play an important role in integrating plural societies and it is in the intersubjectivity of communication that individuals form their own identity and secure the recognition of this identity by others. As Habermas argues,

> Communicative action is not only a process of reaching an understanding; in coming to an understanding about something in the world, actors are at the same time taking part in interactions through which they develop, confirm, and renew their memberships in social groups and their own identities. Communicative actions are not only processes of interpretation in which cultural knowledge is 'tested against the world'; they are at the same time processes of social integration and of socialization.[157]

Granted, the imposition of authority, use of force, or use of manipulation can also strategically settle disputes – and frequently do so in the reality of the everyday life. However, they *can* also be settled by means of communicative interactions. As seen above, the use of language with the orientation of reaching an understanding is the *telos* of human speech;[158] it is 'the original mode of language use', upon which the instrumental use of language is parasitic.[159] Therefore, although the empirical conditions are repeatedly a reminder that not all forms of moral conflicts resolutions are

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[155] Habermas, 1992, p. 48.
[156] Habermas, 1992, p. 140.
[157] Habermas, 1989b, p. 139.
[158] Habermas, 1989a, p. 287.
[159] Habermas, 1989a, p. 288.

communicative, Habermas insists that a plural society that *chooses* to renounce violence, oppression, and manipulation in favour of peaceful conflict resolution, these intrinsic rules to the communicative use of language are unavoidable.

It is also important to clarify that these rules of argumentation are idealised conditions to guarantee the legitimacy of the outcomes of discourses. They are elaborated at a level of abstraction that does not match imperfect empirical conditions. Habermas acknowledges the limitations imposed by the reality of everyday life. He is aware that 'participants are not Kant's intelligible characters but real human beings driven by other motives in addition to the one permitted motive of search for truth'. [160] The practical difficulties of getting everyone involved to participate, the impossibility of making sure that participants step aside their own interests, and securing that there is no resort to coercion and manipulation are examples of the difficulties imposed by the contingencies of everyday life. However, these ideal conditions are not supposed to be projected as a utopia to be realised. Rather, their role is to stand as normative points of reference. Habermas alerts to the dangers of incorporating transcendental illusions into the concept of these ideal conditions of communication.[161] He insists that such idealising presuppositions 'must not be hypostatized into the ideal of a future condition in which a definitive understanding has been reached (...) this concept must be approached in a sufficiently skeptical manner.'[162] Although reality can only approximate these conditions, the projection of their ideal content provides participants with a critical reference of what a post-metaphysical moral point of view entails.[163] As critical references, they can also 'point to practices that without which strategic action will result.'[164]

There is a final limitation regarding these ideal conditions for discourses. They can only answer 'the epistemic question of *how* moral judgments are possible'. However, they cannot answer 'the existential question of what it means to be moral,' and they cannot obligate participants to engage in moral argumentation or motivate them

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[160] Habermas, 1992a, p. 92.
[161] Habermas, 1992, pp. 144-45.
[162] Habermas, 1992, p. 144.
[163] Habermas, 1990, pp. 35-41. The role of healthcare in fostering these conditions is one of the main arguments of the thesis and will be developed in Chapters 4 and 5.
[164] Habermas, 1995a, p. 31.

to act morally. The capacity of moral judgments to motivate action, thus, does not depend only on itself. The motivating force of good reasons is only too weak to guarantee that participants *act* accordingly. Habermas is aware of that and argues that motivation to act also depends on other contingencies, such as participants' identity formation, particular circumstances, interest positions, and types of social institutions involved.[165] This is another link to the concept of the lifeworld, and its role in motivating action is used in the analysis of health and the role it plays in society.

3.3 Lifeworld, system, and the pathologies of modernity

The second objective of *A Theory of Communicative Action* is the development of a two-level model of society that integrates the insights of two different paradigms in social theory: lifeworld theory and systems theory. This integration aims at a broader analysis of modern society and its crises. Habermas ties this two level model of society to his theory of communicative action in two steps. First, Habermas establishes the complementary status of the concept of lifeworld to the concept of communicative action insofar as the lifeworld is conceived as the space in which communicative practices are embedded (3.3.1). In a second step, Habermas demonstrates that the concept of lifeworld alone cannot account for the complexity of modern transformations and different mechanisms of social integration. The concept of system is then introduced as a complementary analytic tool (3.3.2). In this dual perspective account of society, communication plays the important role of the medium through which the lifeworld is stabilised, since different types of discourses, validity claims and rationality operate within its different spheres and contribute in distinctive ways to its reproduction. That is set in contrast with the reproduction of the system, which is steered by the non-linguistic media of money and administrative power of the state. These differentiated steering media and their associated rationalities operate in society *simultaneously*, and they help Habermas account for the different modes of social integration, for social pathologies, and finally also for the locus of potential solutions to modern social crises (3.3.3). As it will be seen, this account represents Habermas reinterpretation of two classical critical

[165] Habermas, 1995a, pp. 33 and 77.

theoretical themes: the Weberian critique of modern rationalisation and the 'Weberian-Marxist' concept of reification.

3.3.1 Communicative action and the lifeworld

The lifeworld can be described as the world as lived, perceived and experienced by participants.[166] As Edgar further describes it, it is 'the stock of skills, competences and knowledge that ordinary members of society use, in order to negotiate their way through everyday life, to interact with other people, and ultimately to create and maintain social relationships.'[167] The lifeworld is linked to communicative action as not only it provides participants with a symbolic space within society in which conflicts arise and communication unfolds, but it also provides participants with the resources they make use of when evaluating and solving conflicts. In addition, through everyday communication and amendments of broken common understandings, the lifeworld is reproduced and stabilised. In short, communicative action is a medium for the reproduction and stabilisation of the lifeworld.[168] Because of this link between the lifeworld and communicative action, the lifeworld becomes also the link between communicative action and society: 'the connection of action theory to the basic concepts of social theory can be rendered secure by means of the concept of the lifeworld'.[169]

The lifeworld as the symbolic space within society that constitutes the common background of convictions, values, assumptions, and customary practices and skills about the world of participants, represents their contextual horizons of action.[170] These shared taken-for-granted background assumptions work at the subconscious, pre-reflexive, level and they allow individuals to navigate their everyday lives without having to establish and re-establish the validity and meaning of every fact and circumstance they face. [171] These unproblematic internalised assumptions only become conscious and thematised when particular assumptions of commonality breaks, leading to a conflict-situation in which the establishment of new common understandings

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[166] The definition of the lifeworld in Habermas is not clear-cut. For a comparison of his communicative approach to the lifeworld and more traditional approaches, see Habermas, 1989b, 119-40.
[167] Edgar, 2006, p. 89.
[168] Habermas, 1989a, p. 337.
[169] Habermas, 1989a, pp. 278-79.
[170] Habermas, 1989b, pp. 119-26 and 135; 1995b, pp. 16-7.
[171] Habermas, 1989a, p. 335.

become necessary. According to Habermas, individuals can never fully grasp the lifeworld as the meaningful social whole, and just as language, individuals can never completely step out of it and objectify it in order to understand it in its totality.[172] On the contrary, individuals rely on common background assumptions to be able to deal with conflicts. While certain assumptions become problematised, others will serve as resources that participants make use of to negotiate new common understandings. In characterising the lifeworld as a pre-reflexive background, Habermas quotes Wittgenstein:

> The child learns to believe a host of things. I.e. it learns to act according to these beliefs. Bit by bit there forms a system of what is believed, and in that system some things stand unshakeably fast and some are more or less liable to shift. What stands fast does so, not because it is intrinsically obvious or convincing; it is rather held fast by what lies around it.[173]

Having established that communication is the medium through which the lifeworld reproduces itself, Habermas places communicative action's complex linguistic interactions of speaker and world perspectives within the concept of lifeworld, so that they can be analysed from the lifeworld's perspective too. By linking different communicative perspectives with different spheres of the lifeworld, it is revealed that communication serves three functions in society: (a) reproducing culture and keeping traditions alive, (b) social integration or the coordination of the plans of different actors in social interaction, and (c) socialisation and interpretation of needs.[174] As Habermas explains:

> In coming to an understanding with one another about their situation, participants in communication stand in a cultural tradition which they use and at the same time renew; in coordinating their actions via intersubjective recognition of criticizable validity claims, they rely on memberships in social groups and at the same time reinforce the integration of the latter; through participating in interaction with competent reference persons, growing children internalize the value orientations of their social groups and acquire generalized capabilities for action […].[175]

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[172] Habermas, 1989b, p. 125.
[173] Cited in Habermas, 1989a, p. 337. Original: Wittgenstein, 1969, p. 16 (para 103).
[174] Habermas, 1992a, p. 25.
[175] Habermas, 1989b, p. 208.

Claims to validity	**Truth**	**Rightness**	**Truthfulness**
Relation to structural components of the lifeworld	Culture[176]	Society[177]	Personality[178]
Domains of knowledge (differentiated expert cultures)[179]	Modern-science	Law, politics, ethics, morality	Arts, art criticism
Contributions of communicative action to the reproduction of the lifeworld	Reproduction of culture	Social integration	Socialization: identity and motivations for actions
Contribution to 'self' development	Cognitive capacities	Interactive capacities	Ego development; development of affections and motivations
Pathologies (due to disturbances in the lifeworld's reproduction)	Loss of meaning	Anomie, alienation	Psychopathologies, withdrawal of motivation
Dimension from which to evaluate crises	Rationality of knowledge	Stabilisation of social solidarity	Personal responsibility
Resources that become scarce in crises	Meaning	Social solidarity	Ego strength

Table 2.2 – Communicative action and its relationship with the lifeworld using different claims to validity as a guide.[180]

[176] Culture in Habermas refers to the stock of knowledge that participants make reference to when coming to an understanding about something in the world (1989b, p. 138).
[177] Society means the legitimate orders that regulate group membership and secure social solidarity (1989b, p. 138).
[178] Personality encompasses the competences that make an individual able to speak and act as well as define and assert her own identity (1989b, p. 138)
[179] Other systems of action such as religion, education, and the family, although also specialised, cut across and are associated with the three structural components and reproductive functions (see text).
[180] See Habermas,1989a, Chapter 3, 1989b, Chapter 6; 1992a, pp. 25 and 116-94.

Table 2.2 demonstrates schematically some of these language-lifeworld relationships and their contribution to the reproduction of the lifeworld. As observed, three structural components divide the lifeworld analytically, namely culture, society, and personality. These three structural components are associated with three different functions of language, three validity claims (truth, rightness and sincerity respectively) and three different world perspectives (objective, intersubjective and subjective respectively). These associations demonstrate the link Habermas establishes between communicative action and the concept of society through the concept of the lifeworld. As each component of the lifeworld is associated with different types of discourse and its different moments of reason, these different lifeworld-communication interactions serve a different role in social reproduction and integration. Crises – perceived by the lifeworld through manifestations such as loss of meaning, crises of legitimation, and confusion – arise from disturbances in these reproductive processes.

Under the aspect of cultural reproduction, new situations of a semantic dimension are placed in continuity and coherence with current stock of knowledge, which can be measured in terms of the rationality of the knowledge accepted as valid. Disturbances in cultural reproduction can be manifested by a loss of meaning. Under the aspect of social integration, legitimate processes of regulation of interpersonal relations deal with new situations of a social dimension. Disturbances can be manifested by anomie, dissolution of social solidarity, and social conflicts. Finally, under the aspect of socialisation, new situations associated with personal interactive capacities or integrity of individual life-histories are managed through the acquisition of general competences for action and harmony with collective forms of life. Disturbances in the socialisation process can be manifested by psychopathologies and alienation, in which 'the personality system can preserve its identity only by means of defensive strategies that are detrimental to participating in social interaction'.[181]The resources that become scarce during crises in these three reproductive levels are respectively: meaning, social solidarity, and ego strength.[182]

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[181] Habermas, 1989b, p. 141.

[182] Habermas, 1989b, p. 141.Each level of reproductive processes also affects, positively or negatively, the other two levels. For a complete discussion of these complex interactions, and the compensations or pathologies they give rise to, see Habermas, 1989b, pp. 140-48.

The lifeworld and its reproductive dynamics can be further analysed from the perspective of specialised action-systems and from a division into public and private spheres. Specialised action-systems result from the modern process of differentiation in the spheres of knowledge. In becoming specialised, these different action-systems tend to remain attached to specific patterns of interactions between the lifeworld and communicative action; as a result, they contribute distinctively to the reproduction of the lifeworld. Habermas divides these systems into two categories: (a) systems like science, morality, and art, which tend to specialise in different validity aspects of everyday communicative action (truth, rightness, or sincerity), and accordingly contribute differently to the reproduction of the lifeworld (see Table 2.2); and (b) systems like religion, education, and the family, which generally contribute to the reproduction of the lifeworld at all levels, i.e. cultural reproduction, social integration, or socialization. Action systems belonging to the latter group, although individually specialised for cultural reproduction (education) or socialization (family) or social integration (law) are not totally differentiated in their operation. According to Habermas, each of these systems 'also concomitantly satisfies the function of the other two and thus maintains a relation to the totality of the lifeworld'.[183] In Chapter 4, health is placed along this group of action-systems too instead of located within the domain of modern-science. This allows the analyses of its broader social reproduction and stabilisation functions, and ultimately its relationship with justice.

Finally, two subsystems can further divide the lifeworld: the public and the private spheres. Interpersonal relations of intimacy between relatives, friends, and acquaintances characterise the private sphere. The public sphere has a complementary relation to the private sphere, from which the public is recruited. The public sphere is not specialized in any reproductive function per se, rather it is the *social space* generated in communicative action.[184] The private and the public spheres too take part in the production of social meaning and in social integration. Their interaction with society from the perspective of the system is further analysed below.

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[183] Habermas, 1996, p. 360.
[184] Habermas, 1996, Chapter 8.

3.3.2 The mediation between two paradigms: system and lifeworld

The participant and the social observer perspective are classical analytical paradigms in social theory. These two different paradigms refer to the different perspectives social theorists adopt when studying society. The participant perspective, which in Habermas's work is represented by the lifeworld perspective discussed above, looks at society from the internal perspective of the social actors themselves. From this perspective, society and its developments are interpreted from within, from the *internal* perspective of the acting subjects who try to make sense of their world and understand how their identities, pattern of interactions, commonalities and conflicts shape and transform society. The focus is on social *meaning*, and the objective is to *interpret* from within how participants perceive society and its transformations, and how these transformations impact on participants' everyday lives. [185] Additionally, as seen above, in Habermas the lifeworld goes beyond being the space for internal interpretations; it is also the space in which processes of socialisation and social integration take place.[186]

The social observer perspective, conversely, looks at society from the *external* perspective of a detached social observer who analyses society as a complex whole. From this perspective, the functional mechanisms and driving processes of society take place independently from social actors' conscious control. The focus is on understanding the *operating logic* of macrostructures – such as culture, the economy, the state and the legal system – and how they shape society. [187] Systems theories of society exemplify this approach. Typically, this school of thought analyses society as a complex system composed by distinct, independent, self-perpetuating, and self-regulating closed systems such as economy, state administration, law, and scientific knowledge.[188] According to this perspective, the lifeworld becomes redundant in the face of the increasing complexity of society and growing differentiation of systems that become refractory to external influence. In Habermas, the system perspective is constructed as a complementary perspective to the lifeworld, which allows him to account for the *material reproduction* of society. Material reproduction operates through the medium of

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[185] Habermas, 1989b, pp. 113-18.
[186] Habermas, 1989b, p. 139.
[187] Habermas, 1989b, pp. 113-18.
[188] Habermas, 1989b, pp. 199-282.

instrumental rationality and through interconnections and action consequences that are not intended or even perceived by individuals.[189] For the system's reproduction purposes, norm-conformative attitudes are neither necessary nor possible.[190]

In Habermas's view, however, either perspective is insufficient to interpret the complexity of modern society. The internalist or the lifeworld view runs the risk of never being able to see beyond a particular context, failing to appreciate causes, connections, and consequences that lie beyond the horizon of a particular everyday practice and beyond the conscious control and understanding of participants. 'This internal perspective screens out everything that inconspicuously affects a sociocultural lifeworld from the outside;' and as he argues, it cannot be expected that in the modern society individuals fully grasp or intentionally maintain its complex material reproduction.[191] On the other hand, an exclusively external or systemic view fails to appreciate that the functional domains of the system need to be institutionalised in the lifeworld. It also fails to appreciate the impacts and constraints imposed on these domains of functional reproduction by the lifeworld. Either view, therefore, can only provide a partial account of the crises of modern society.[192]

Habermas therefore aims at overcoming the limitations of the antagonism between lifeworld and system by developing a perspective that mediates between them. He proposes that society should be conceptualised *simultaneousl*y as lifeworld and system. Only this way Habermas finds it possible to account for the growing complexity of modern society, appreciating not only functional differentiation and its impacts at the macro level, but also the meanings, impacts and resistances to these transformations from the perspective of participants at the micro level of everyday life. This dual approach to society also accounts for different mechanisms of social integration and analyses the patterns of interaction between the system and the lifeworld as the potential loci of social crises. In distinguishing social and system integration, he explains: 'in one case the action system is integrated through consensus, whether normatively guaranteed

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[189] Habermas, 1989b, Chapter 6.
[190] Habermas, 1989b, p. 154.
[191] Habermas, 1989b, p. 118.
[192] Habermas, 1989b, p. 151.

or communicatively achieved; in the other case it is integrated through the normative steering of individual decisions not subjectively coordinated.'[193]

It is worth noting that his distinction between lifeworld and system is not a factual account of modern society but a *methodological* approach to the study of society and its crises.[194] It offers a broader perspective from which to look at the question of how society and its reproduction and integration are possible in conditions of growing complexity, pluralism and post-conventional thinking. This dual-methodological approach is observed throughout Habermas's work. An illustration of this approach can be observed in the following quotation, in which he analyses liberal and social rights simultaneously from both perspectives:

> Historically speaking, liberal rights crystallized around the social position of the private property owner. From a *functionalist* viewpoint, one can conceive them as institutionalizing a market economy, whereas from a *normative* viewpoint they guarantee basic private liberties. Social rights signify, from a *functionalist* viewpoint, the installation of welfare bureaucracies, whereas from a *normative* viewpoint they grant compensatory claims to a just share of social wealth. (...)[195]

Analytically, this dual perspective also arises as a necessary tool in the study of social transformations. As seen above, in the course of modernity, a de-unification of the world and a growing complexity and differentiation of spheres of knowledge occur. In these processes, two levels of differentiation can be devised. First, the growing complexity of society leads to the development of a domain specialised in material reproduction of society –the system – which becomes uncoupled from the lifeworld. The second level of differentiation is observed with the increasing differentiation that occurs *within* the lifeworld and the system themselves. The increasing rationalisation of the lifeworld leads to its differentiation into the three structural components of culture, society and personality, and the growing complexity within the system leads to the formation of the sub-systems of economy and state administration.

According to Habermas, two sub-systems emerge from the growing internal differentiation that occurs within the system: (a) the economy, which is steered by the

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[193] Habermas, 1989b, p. 150.
[194] Habermas, 1989b, pp. 348-49.
[195] Habermas, 1996, p. 78

medium of money, and (b) the state administration, which is steered by the medium of power. Although increasingly specialised, these two subsystems are interdependent and share the function of maintaining the material reproduction of society. They do so through the regulatory role of the economy and public administration and in contrast with the reproduction of the lifeworld, which is guided by communicative rationality, these two functional subsystems are guided by the logic of instrumental rationality.

Characteristically then, the system's contributions to social stabilisation occur 'at the back of the participants', [196] i.e. without the need of their conscious will. As Habermas explains,

> Modern societies are integrated not only socially through values, norms, and mutual understanding, but also systemically through markets and the administrative use of power. Money and administrative power are systemic mechanisms of societal integration that do not necessarily coordinate actions via the intentions of participants, but objectively, "behind the backs" of participants. Since Adam Smith, the classic example for this type of regulation is the market's "invisible hand".[197]

It is worth noting that the system is not an entity that regulates society through its self-generated laws. It represents the space in which complex nets of activities of material reproduction of society take place. These activities characteristically do not require or involve the conscious and continuous rational reflection and consensus reaching of participants. In fact, they relieve participants from the burden of dealing with this growing complexity and therefore overtaxing their communicative resources. In this way, participants can devote their communicative resources to areas that require mutual understanding and communicative regulation. This already points to the fact that the system, contrarily to the lifeworld, does not generate or reproduce social meaning, as it is merely the space for *material* reproduction.[198] Whereas effectiveness guides systemic mechanisms of regulation, legitimacy guides communicative mechanisms of regulation that operate at the level of the lifeworld.[199]

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[196] Habermas, 1989b, pp. 119-97.
[197] Habermas, 1996, p. 39.
[198] Habermas, 1989b, p. 138.
[199] Habermas 1996, Chapter 8.

The system, therefore, relies on the lifeworld and its structures of communication to generate legitimacy, influence and commitment.[200] This can be achieved, for example, through the exchanges between the system and the public and private spheres of the lifeworld. From the perspective of the system, the public and the private spheres interact and have a relationship of interdependence with the corresponding functional spheres of state administration and economy. The public and the private spheres generate respectively social commitment and political influence, which they exchange for goods, services and organisational accomplishments of the administrative and economic systems.[201]Law and democracy, as it will be seen, also have an important role to play in this mediation between lifeworld and system, especially in the legitimation of the latter.[202]

Finally, a corollary of this dual social-perspective is that the instrumental rationality that runs the system's activities is not conceived *a priori* as detrimental. On the contrary, it constitutes the appropriate form of rationality that this space has to rely on in order to maintain its material integration functions. As Habermas argues, here in contrast with Weber and Horkheimer and Adorno, it is not the system's instrumental rationality *per se* which is responsible for the crises of modern society. Crises only arise when the logic of the system's steering media of money and power are extended beyond the boundaries of the system and colonise the lifeworld at the expense of communicative rationality.[203]

3.3.3 The colonisation of the lifeworld

According to Habermas, pathologies arise when (a) the penetration of economic and administrative rationality in areas of action that specialises in cultural transmission, social integration and child-rearing/socialisation occur at the expense of mutual understanding as the mechanism of coordinating action, and when (b) the differentiation of expert cultures of the lifeworld becomes split-off, in an elitist fashion, from

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[200] Habermas, 1989b, pp. 301-31.
[201] Habermas, 1989b, pp. 301-31, including Figure 39 (p. 320). On the interactions between system and the private and public spheres see also Habermas, 1996, Chapter 8.
[202] See Habermas, 1996.
[203] Habermas, 1989b, pp. 145 and 277.

communicative action in everyday life.[204] The development of social pathologies associated with modern differentiation, therefore, can result from two different processes: the colonisation of the lifeworld by systems' media, and the increased rationalisation of the lifeworld itself.

Crises arising from the first process are seen as an irony of processes of societal differentiation in which 'the rationalization of the lifeworld makes possible a heightening of systemic complexity, which becomes so hypertrophied that it unleashes system imperatives that burst the capacity of the lifeworld they instrumentalize.'[205] The fact that system and lifeworld become uncoupled, however, does not mean that the lifeworld unavoidably becomes dependent on the system. The uncoupling implies at first only that there is a differentiation in types of action coordination – consensus or functional interconnections. From this point, both directions of dependency are possible: in one direction the system maintenance can be subject to the normative restrictions of the lifeworld, and on the other direction the lifeworld can be subjected to systemic constraints of material reproduction.[206] However, when the latter direction occurs, i.e. when systemic mechanisms through their inner logic constraints and instrumentalise the lifeworld, they inevitably give rise to a 'structural violence' that hinders intersubjective understanding by distorting and restricting communication.[207] Ultimately, this structural violence lead to the development of social pathologies such as apathy, cultural impoverishment, loss of meaning, and dysfunctional personality constitution translated by psychopathologies.[208]

The incorporation of functional media into the lifeworld generates crises and pathologies because these media cannot create or substitute meaning to the lifeworld. In other words, the economy and state administration cannot compensate for the breakdown in communicative rationality.[209] These distortions in the symbolic reproductive capacities of the lifeworld leads to situations associated with the objective, intersubjective and subjective worlds being pre-judged, or 'reified', by participants. This

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[204] Habermas, 1989b, p. 330.
[205] Habermas, 1989b, p. 155. See further at pp. 185-97.
[206] Habermas, 1989b, p. 185.
[207] Habermas, 1989b, p. 187.
[208] Habermas, 1989b, pp. 145 and 480.
[209] Habermas, 1989b, p. 576.

process of functional instrumentalisation of the lifeworld Habermas calls the colonisation of the lifeworld.[210] To avoid it, the lifeworld needs to hold to the role of defining the pattern of the social system as a whole, and for that, the lifeworld needs to anchor the system in its communicative institutions.[211]

Distortions arising from the second type of societal differentiation do not involve the unbalance between system and lifeworld, but unbalances *within* themselves. The rationalisation of the lifeworld or the increased complexity of functional systems, have no pathological connotations *per se*. Pathologies only arise from them in cases when (a) the increased differentiation within the mechanisms of system integration leads to the fragmentation of individuals who are split into a variety of different functional roles they have in society, and (b) the differentiation of the lifeworld's spheres of knowledge into expert cultures leads them to become isolated from everyday communication and unmediated with each other. Habermas argues that '[t]he lifeworld must be defended against extreme alienation at the hands of the objectivating, the moralizing, *and* the aestheticizing interventions of expert cultures.'[212] The mediation between the cognitive-instrumental, moral-practical, and aesthetic-expressive dimensions as well as the overcoming of the isolation of science, morals, and art without detriment to their internal rationality can only be achieved through incentives to the mediating role of everyday communicative practices.[213]

Habermas's theory also points at the potential solution to these modern pathologies. Rejecting the claim that the dominance of instrumental rationality is an irreversible process, he argues that society has an alternative: the decolonisation of the lifeworld.[214] This decolonisation can be achieved by exposing the colonisation of the lifeworld and by creating the conditions for communicative rationality to flourish. The reconstruction of a vibrant public sphere is a key element to this project. According to Habermas, thriving debates and opinion-formation grounded on communicative rationality can influence the development of laws and policies that are legitimate and

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[210] Habermas 1989b, p. 185-97.
[211] Habermas, 1989b, p. 154.
[212] Habermas, 1995b, p. 18.
[213] Habermas, 1992a, p. 18.
[214] Habermas, 1989b, pp. 301-74.

meaningful to the lifeworld. By their turn, these legitimate laws and policies contribute towards creating and maintaining conditions of communication within this vibrant public sphere by keeping the system under normative influence and control of the lifeworld.[215]

In summary, the fundamental goal for Habermas towards a new form of social integration is the creation and support for the conditions for rational communication. As the next section analyses, mutual recognition and social solidarity are fundamental steps towards this end.

3.4 Communicative action, justice and solidarity

3.4.1 Habermas's theory of justice and the moral point of view

Kantian moral theory and the theory of communicative action are the two frameworks guiding Habermas's theory of justice. From Kant, Habermas incorporates a deontologic universalism. From communicative action he brings the idea of a communicative reason, which allows the 'pragmatisation' of the Kantian moral point of view. Whereas in Kant the moral point of view is located in the individual autonomous self-reflection, the moral point of view in Habermas is located in dialogical argumentative deliberation between autonomous individuals.

Following Kant, Habermas considers morality the domain of what is right or just. Following the pragmatic insights of communicative action, communication is seen as the medium that regulates conflict-resolution on matters of what is right or just. As in Kant, morality is an autonomous sphere of knowledge. That means that morality requires a form of argumentation distinct of its own, in which what is at issue is not whether a claim is true, correct, truthful, artistic or scientifically sound; what is at issue is whether the norms a claim makes reference to are just or right.[216] Morality then, serves the purpose of solving conflicts that involve universalisable interests in matters of justice, i.e. conflicts about what actions are right or just, which relevance applies to all individuals irrespective of contingencies of time and place.

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[215] Habermas, 1989b, pp. 301-74; see also the model of circulation of power later developed in *Between Facts and Norms* (1996, Chapter 8).
[216] Habemas, 1992a, pp. 36-7.

Discourse theory conceives morality as a mutually constituted source of normativity that serves to protect the vulnerability of individuals *and* the net of intersubjectivity in which they are socialised.[217] This is because this identity-constituting net of intersubjectivity gives rise to the mutual dependence of individuals who rely on each other for mutual recognition. It explains how exposed and vulnerable they are to being harmed by others. Habermas states that:

> I conceive of moral behaviour as a constructive response to the dependencies rooted in the incompleteness of our organic makeup and in the persistent frailty (most felt in the phases of childhood, illness, and old age) of our bodily existence. Normative regulation of interpersonal relations may be seen as a porous shell protecting a vulnerable body, and the person incorporated in this body, from the contingencies they are exposed to. Moral rules are fragile constructions protecting *both* the physis from bodily injuries and the person from inner or symbolical injuries.[218]

To protect the individual, and also the net in which she stabilises her personality, Habermas's conception of morality requires the cooperative search for consensus on matters of justice. This cooperation, by its turn, also serves as a mechanism of social integration. As it will be seen, this cooperation is embodied in the concept of solidarity. Solidarity, thus, is closely tied with justice.[219]

Habermas's reconstruction of the Kantian moral point of view maintains that conflicting claims must be adjudicated fairly and impartially. Impartiality translates the idea that a moral judgment requires the freedom from external coercion and manipulation (force of traditions, attachments to particular groups) as well as from internal compulsions and self-deceptions (such as emotions, conceptions of the good, self-interests).[220] Furthermore, Habermas's moral point of view is deontological, universal, cognitive, and formal. It is deontological because it focuses on the binding character of ought claims, i.e. it specifies what is the right or wrong action through commands and norms of action. It is universal because it specifies norms that every rational being must be able to will and these norms apply to all, prevailing over local or conventional norms. In Habermas's words, 'justice determines the perspective from

[217] Habermas, 1992a, p. 199; 2003a.
[218] Habermas, 2003a, pp. 33-4.
[219] See Habermas, 1992a; Regh, 1997.
[220] See Regh, 1997, Chapter 2.

which certain ways of acting and interacting are judged to be "equally good for all members"'.[221] The moral point of view is also formal because it does not specify substantive moral principles, but only the procedure which test the legitimacy of such principles. Finally, it is cognitivist because in conceiving morality as a form of knowledge, the scrutiny of reasons given to accepting norms grounds their justification. [222] In other words, nothing coerces participants except for the force of the better argument.[223]

Although most Kantian moral theories share these characteristics, there are two fundamental differences that discourse theory sets from them. First, the moral point of view is not located in the individual self-reflection or in the reflection of the expert theorist; it is located instead in actual processes of moral argumentation that requires the participation of all involved. Accordingly, only participants in actual moral discourses can define the substance of moral norms. Habermas's theory, therefore, can be seen as a dialogical reinterpretation of Kant's categorical imperative. Second, the procedure reconstructed by Habermas also requires from participants the 'other-perspective-taking', which helps secure the universality and impartiality of the process. In other words, what is distinctive to discourse theory is that the moral point view requires not only the actual participation of all, but the mutual concern of all for all involved.[224]

As the discourse principle (D) states:

> Only those norms may claim to be valid that could meet with the consent of all affected in their role as participants in a practical discourse.[225]

To this principle that conflicts should be dealt with through argumentation, Habermas adds a rule of argumentation (U) that emphasises and secures the universalist character of moral norms:

> For a norm to be valid, the consequences and side effects of its general observance for the satisfaction of each person's particular interests must be acceptable to all.[226]

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[221] Habermas, 2003c, p. 262.
[222] Habermas, 1992a, Chapter 3; Regh, 1997.
[223] Habermas, 1992a, p. 198.
[224] Habermas, 1992a, Chapter 3; Regh, 1997.
[225] Habermas, 1992a, p. 197.
[226] Habermas, 1992a, p. 197.

Whereas D translates the general communicative action intuition that valid norms, whether moral or legal, must secure agreement of all, U captures the moral insight that norms must pass the test of universal validity; i.e. that they are not just 'a reflection of the prejudices of adult, white, well-educated, Western males of today.'[227]

Habermas emphasises that U is not a moral norm per se; it is a validity test, which finds its justification on the analysis of the presuppositions of argumentation. He argues that 'the idea of impartiality is rooted in the structures of argumentation themselves and does not need to be brought in from the outside as a supplementary normative content.'[228] Another way in which U is fundamental to the impartial justification of norms is its demand for an exercise of mutual perspective taking in which the interests, needs, and position that others occupy must be considered before a norm is mutually agreed upon. As Regh notes, without this perspective taking, it would be difficult to differentiate the discourse theoretical point of view from forms of consensus that admit of strategic considerations and coincident individual purposes.[229] This radical *inclusiveness* – i.e. the inclusion of others both at the sphere of actual interaction and at the sphere of moral concern – secures the impartiality of the process.

Here too Habermas's theoretical assumptions need to be placed within his post-metaphysical framework. Post-conventional morality cannot provide participants with a comprehensive set of norms and establish the hierarchy between them, but it expects participants to reach cooperatively their own – even if fallible – judgements. With the transition from conventional to post-conventional forms of life, the focus on substantive conceptions of justice has shifted to the focus on the procedure for impartially judging competing claims to justice.[230]An implication of this post-conventional moral point of view is that in the process of modern differentiation, the moral and the ethical spheres became differentiated and autonomous. The moral sphere involves moral discourses, in which participants jointly evaluate the rightness of norms. The ethical sphere, on the other hand, involves ethical discourses, including issues of recognition of individual or group identities and their self-realisation and conceptions of the good life. These ethical

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[227] Habermas, 1992a, p. 197.
[228] Habermas, 1992a, pp. 76-7.
[229] Regh, 1997, p. 40.
[230] Habermas, 2003c, p. 262.

discourses can only be assessed and dealt with from the internal perspective of a particular form of life.[231]

In contrast with discourses involving concrete forms of life, moral discourses in conditions of pluralism and post-conventional thinking require a decentred attitude from participants. That means that participants have to abstract the problematised norm or broken common understanding from their contextual roots so that they can be evaluated and ultimately validated through the projection of their conditions of validity to a universal community of moral agents. This decentration entails not only that participants put aside their own interests, but also that they take the perspective of every other participant in discourse. This ability of abstraction and other-perspective taking allow both the validation of norms that are equally good for all, but also allows the critical attitude towards the norms or practices of one's own particular society.[232] Furthermore, this differentiation between the moral and ethical sphere favours a growing tolerance towards different forms of life and the recognition of every individual's uniqueness at the same time that it makes possible the cooperative search for universal interests and nonviolent conflict resolution.[233] A post-conventional morality, however, also comes at a cost. In the separation of morality from the substance of the ethical life the motivation for action is lost. In other words, although decentred argumentation can generate conviction, it cannot ensure that participants act upon the norms they established. This is the motivational deficit problem that post-conventional moralities face.[234]

Before discussing how Habermas deals with this motivational deficit, it is important to approach yet another important aspect of Habermas's theory justice: solidarity. After analysing that solidarity too suffers from the same motivational problem it will be addressed how the interplay between justice, solidarity and lifeworld can address the motivational deficit of a post-conventional morality.

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[231] It is worth noting that for Habermas, ethical and moral judgments differ only in their degree of contextuality. Although his moral theory concentrates on questions of justice, it does not remove issues of the good life or self-understanding from rational evaluation. See more in his universal pragmatics and communicative action theory.
[232] Habermas, 1992a; see also Hohengarten, 1995.
[233] Hohengarten, 1995.
[234] Habermas, 1992a; 1995a.

3.4.2 Solidarity

Modern society has three major forces of *macrosocial* integration: money, administrative power and solidarity.[235] Of those, only solidarity is rooted in the lifeworld. For this reason, solidarity is the one at risk of disintegrating because of the social differentiation and the growing colonisation of the lifeworld by the system's media in modern capitalism. Society, therefore, needs to cultivate new forms of solidarity if still committed to non-oppressive conflict-resolution.[236] The way forward, according to Habermas, is to strengthen communicative practices of mutual understanding:

> In complex societies, the scarcest resources are neither the productivity of a market economy nor the regulatory capacity of the public administration. It is above all the resources of an exhausted economy of nature and of a disintegrating social solidarity that require a nurturing approach. The forces of social solidarity can be regenerated in complex societies only in the forms of communicative practices of self-determination.[237]

To be sure, not any form of solidarity is appropriate for the task of modern social integration. The concept of solidarity that Habermas is appealing for is post-conventional. Society can no more rely on conventional concepts of solidarity, commonly grounded on benevolence,[238] on charity (what Houtepen and Meulen describe as 'asymmetrical helping relations'),[239] or on exclusivist identities (such as kinship, nationality or religion). This later connotation, in particular, concerns Habermas the most: the tragic history of the 20th century is an alert to the dangers of forms of solidarity grounded on group membership. In a decentred and plural society,

> solidarity loses its merely particular meaning, in which it is limited to the internal relationships of a collectivity that is ethnocentrically isolated from other groups – that character of forced willingness to sacrifice oneself for a collective system of self-assertion which is always present in premodern forms of solidarity. The formula, "Command us Führer, we will follow you," goes perfectly with the formula, "All for one and one for all" – as we saw in the posters of Nazi

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[235] Habermas, 1996, p. 150.
[236] Habermas, 1996.
[237] Habermas, 1996, p. 445.
[238] Habermas, 1990, pp. 41-7.
[239] Houtepen and Meulen, 2000, p. 330.

> Germany in my youth – because fellowship is entwined with followership in every traditionalist sense of solidarity.[240]

Habermas's concept of solidarity is radically inclusive; it is necessarily extended to strangers in time and space. This decentration redefines solidaristic attachments based on common identity into a universalist solidarity 'with everything wearing a human face'.[241] It is grounded on the recognition of individuals' co-dependence in a lifeworld they shape and share and that form their identities and secure their autonomy. The commitment to solve conflicts peacefully through communicative practices is the basis for the regeneration of a post-conventional solidarity. As Habermas argues,

> in a secularized society that has learned to deal with its complexity consciously and deliberately, the communicative mastery of […] conflicts constitute the sole source of solidarity among strangers – strangers who renounce violence and, in the cooperative regulation of their common life, also concede one another the right to *remain* strangers.[242]

This moral inclination towards the recognition of others and their needs links solidarity with justice. Justice and solidarity, thus, are intertwined concepts; it is not possible to conceptualise one without resorting to the other. This is because justice can only be achieved through moral discourses if the intersubjective web which relates individuals with each other and which secures mutual recognition is intact. If the individual relies on intersubjective interactions to develop and protect her individuality, justice cannot protect the individual without also protecting this important web of intersubjective relationships.[243] Habermas argues that from the perspective of discourse theory, 'justice requires solidarity as its reverse side;'[244]

> [i]t is a question not so much of two moments that complement each other as of two aspects of the same thing. (…) *Justice* concerns the equal freedoms of unique and self-determining individuals, while *solidarity* concerns the welfare of consociates who are intimately linked in an intersubjectively shared form of life – and thus also to the maintenance of the integrity of this form of life itself. Moral norms cannot protect one without the other: they cannot protect the

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[240] Habermas, 1990, p. 47.
[241] Habermas, 1990, p. 47.
[242] Habermas, 1989, p. 308.
[243] Habermas, 1990, pp. 46-7.
[244] Habermas, 1990, p. 47.

> equal rights and freedoms of the individual without protecting the welfare of one's fellow man and of the community to which the individuals belong.[245]

Justice and solidarity have the same root – the vulnerability of subjects who individuate through socialisation.[246]

According to Habermas, two conditions make discursive agreements possible: the individual's inalienable right to say yes or no and her overcoming of her egocentric viewpoint. Without the first, consensuses are merely factual rather than impartial and universal. Without the latter, no 'other-perspective-taking', and therefore, universal agreement can emerge. These two conditions, representing the respect for the individual autonomy and the recognition of individuals' interdependence, are internally connected and accounted for by discourse theory.[247] It is also bridges Kantian justice with the communitarian insights on the embeddedness of individuals.

The importance of solidarity to the possibility of justice and social integration in modern society is also emphasised by Hauke Brunkhorst. He argues that only solidarity can solve the two inclusion problems that arise from the process of functional differentiation of modern societies: the de-socialisation of the individual that results from a growing process of individualisation, and the exclusion of whole segments of the population from the benefits achieved by modernity, characterised by social and economic deprivation.[248] The role solidarity plays in addressing questions of justice and social integration in modern society is crucial to the analysis of the relationship between healthcare and justice.

This important contribution of social solidarity to justice, however, also faces the post-conventional motivational problem. The question about what motivates participants to act based on what is moral, right or just rather than on what is individually convenient or profitable, here takes the shape of the question about what motivates participants to act also based on the consideration for the interests and welfare of others. Furthermore, as Seyla Benhabib notes, the difficulty that discourse ethics faces, as well as any procedural and abstract theory of morality, is that it presupposes a concern for others as

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[245] Habermas, 1990, p. 47. Author's emphasis.
[246] Habermas, 1992a, p. 200.
[247] Habermas, 1992a, p. 202.
[248] Brunkhorst, 2002, pp. 1-9 and 79-101.

a fundamental condition for conflict-solving procedures, yet in conflict-situations it is precisely mutual understanding what has been broken.[249] In other words, if mutual understanding can be a difficult achievement at the best of times, how to expect, or even demand it, during times of conflict? To address this question the next section links discourse ethics to the lifeworld.

3.4.3 Justice, solidarity and the lifeworld

The purpose of this section is to address the criticism that the formalism of Habermas moral theory and the decentration it demands is far too detached from everyday life's contexts to be meaningful to individuals. As seen above, the motivation deficit is one unwelcome consequence of his narrowed view of the moral domain.

The understanding that ethical and moral spheres are completely separated in Habermas, which generate many criticisms, is probably only partly accurate. His argument that morality and ethics became differentiated with the transition to a post-conventional worldview does not imply that these spheres became refractory or closed to each other. On the contrary, in different opportunities Habermas signalled the importance of ethical forms of life for the achievement of justice. Here, the concept of lifeworld becomes once more relevant to the discussion. This is because it is in the lifeworld that the mediation between the two spheres of morality and ethical life takes place.

First, moral conflicts arise amidst the ethical horizons of the lifeworld. They arise in situations in which different and equally legitimate moral principles, which are already internalised into the ethical understandings of a form of life, seem to be equally relevant yet in conflict. In these cases, although the decentration required by the moral point of view will be necessary to re-validate these principles in the light of the new circumstances, the application of these abstract principles to concrete contexts of action will require a different form of clarification. Habermas introduces, after Klaus Günther, the concept of discourses of application that work as a complement to discourses of justification.[250] In discourses of application, the principle of appropriateness takes the

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[249] Benhabib, 1986.
[250] See more on discourses of application and the principle of appropriateness in Günther, 1993.

place that (U) occupies in discourses of justification.[251] What must be decided at this stage is not the validity of the abstract principles relevant to the case (their validity has already been ascertained during the justification stage), but the appropriateness of each in the light of all relevant features of a particular situation.[252]

Habermas gives the example of different and legitimate principles of distributive justice that exist, such as 'to each according to his needs', 'to each according to its merits', and 'equal shares for all'. Although these principles of justice can be justified from the perspective of universalisability, they may not be equally appropriate in all situations involving distributive claims; if anything because they cannot anticipate all future contexts-situations in which they may be relevant. 'Only in their application to particular contexts will it transpire *which* of the competing principles is the most appropriate in the *given* context.'[253] As he further illustrates, families tend to decide their internal conflicts of distribution based on need rather than merit, whereas at the level of society the reversal of this priority may be judged appropriate in certain contexts. 'It depends on which principle best fits a given situation in the light of the most exhaustive possible description of its relevant features'.[254] Discourses of application, therefore, serve this task of linking a decentred morality with the ethical context.

There is a second aspect in which the lifeworld is important in the mediation between morality and ethical life. It involves the question of the loss of moral motivation in the context of pluralism and post-conventional morality. Facing this problem, Habermas argues that post-conventional universalist moralities are dependent on forms of life that support the translation of moral convictions into moral action. He points out that: '[o]nly those forms of life that meet universalist moralities halfway in this sense fulfil the conditions necessary to reverse the abstractive achievements of decontextualization and demotivation.'[255] As he adds, moral motivation depends on the affective psychological development of individuals, which by its turn is contingent on socialisation in forms of ethical life that foster and reinforce sensitivity to the claims of

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[251] Habermas, 1995a, p. 37.
[252] For the implications of discourses of application and the principle of appropriateness to the legal context, see Habermas, 1996, Chapter 4.
[253] Habermas, 1995a, p. 152.
[254] Habermas, 1995a, p. 152.
[255] Habermas, 1992a, p. 109.

others. 'There has to be a modicum of congruence between morality and the practices of socialization and education.'[256] They must promote the necessary superego controls and social competence of ego identities.[257] In other words, the horizons of an ethical form life are what make decentred morality possible. It is also the space where individuals find the motivation to act morally.

Furthermore, morality also depends on the socio-political institutions of the lifeworld, i.e. they must be compatible with a post-conventional morality. For Habermas, certain institutional arrangements simply will not foster this compatibility: '[m]orality thrives only in an environment in which post-conventional ideas about law and morality have already been institutionalized to a certain extent.'[258] As he argues,

> Often lacking are institutions that would facilitate discursive decision-making. Often lacking are crucial socialization processes, so that the dispositions and abilities necessary for taking part in moral argumentation cannot be learned. Even more frequent is the case where material living conditions and social structures are such that moral-practical implications spring immediately to the eye and moral questions are answered, without further reflection, by the bare facts of poverty, abuse, and degradation. Wherever this is the case, wherever existing conditions make a mockery of the demands of universalist morality, moral issues turn into issues of political ethics.'[259]

In other words, the processes of socialisation and acquisitions of ego competencies are strong links to justice conceived discursively. Fundamentally, what this insight reveals is that the everyday practices and institutional arrangements of the lifeworld are also accountable to the very possibility of justice. This insight plays an important part on the argument developed in Chapters 4 and 5 about the relationship between health and justice.

Finally, Habermas seems to reverse what is only an apparent primacy given to morality at the expense of the ethical life when he answers the question of why should we want to be moral? His reply is that the importance of morality is not in itself a moral judgement. Rather, it is a judgement that is part of the ethics of what it is to be human:

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[256] Habermas, 1992a, pp. 207-08.
[257] Habermas, 1992a, pp. 207-08.
[258] Habermas, 1992a, pp. 207-08.
[259] Habermas, 1992a, p. 209.

> Without the emotions roused by moral sentiments like obligation and guilt, reproach and forgiveness, without the liberating effect of moral respect, without the happiness felt through solidarity and without the depressing effect of moral failure, without the 'friendliness' of a civilized way of dealing with conflict and opposition, we would feel, or so we still think today, that the universe inhabited by men would be unbearable. Life in a moral void, in a form of life empty even of cynicism, would not be worth living. This judgment simply expresses the 'impulse' to prefer an existence of human dignity to the coldness of a form of life not informed by moral considerations.[260]

Moral universalism, therefore, is a historical achievement of ethical forms of life that facilitated this development. The implication of that is that the incorporation of moral principles into concrete forms of life is an achievement of *collective efforts* of political movements. Viewed as such, it places the choice and possibility of maintaining the conditions for justice on our shoulders, and the weight of this demanding autonomy, although challenging, seems to point towards emancipation and reconciliation.

3.5 Law and the system of rights

Against the charge of idealism directed to his discourse theory of morality, Habermas is aware of the difficulties that such demanding account of morality encounters in being applied to the real world. A post-conventional-morality according to Habermas has only a weak force in motivating action and its capacity for regulating and integrating complex societies which do not rely on a unifying worldview is limited. Habermas identifies, for example, three unprecedented difficulties that moral agents face in the process of appropriating and putting into practice post-conventional moral norms. First, post-conventional morality only provides a procedure for impartiality judging conflict situations, and while in these discursive processes certain abstract principles may not be fundamentally disputed, their subsequent contextual application in the light of the complexities of each case may overtax the individuals' analytical capacity. Second, individuals are required by a post-conventional morality to act according to moral insights mutually and rationally agreed on, yet if these insights are against individuals' immediate interests or inclination, motivation to act upon them may fail. Third, as societies become more complex, putting in practice moral duties, especially positive

[260] Habermas, 2003a, p. 73.

ones, may require an organisational effort that individuals alone, despite favourable inclination, cannot meet.[261]

Uniquely suited to address these weaknesses or morality is modern law.[262] In *Between Facts and Norms*, Habermas presents a positive interpretation of law and its fundamental roles in modern society. In this work, the legal system is not construed as one more colonising force which strips the lifeworld from meanings through a process of juridification of everyday life.[263] Instead, law is presented as an important medium for social integration and stabilisation of behaviour expectations in societies that are too complex to secure integration through morality and systemic media alone:

> Today legal norms are what is left of the crumbled cement of society; if all other mechanisms of social integration are exhausted, law still provides some means for keeping together complex and centrifugal societies that otherwise would fall to pieces. Law stands in as a substitute for the failures of other integrative mechanisms – markets and administrations, or values, norms, and face-to-face communications. [264]

Furthermore, law contributes to social integration as a mediator between lifeworld and system. According to Habermas the legal system can channel communication, opinion-making, and influence from the public and private spheres into the special codes of the system as well as translate these codes to the communicative spheres of the lifeworld.[265] Even more positively, if successful in securing communicative liberties and in encouraging and channelling public debate and opinion formation in complex societies, law is contributing to social integration by taking advantage of 'a permanent risk of dissensus to spur on legally institutionalized public discourses'.[266]

The reason why modern law is seen as uniquely suited to complement morality rests in its formal properties. According to Habermas, modern law has a dual character: on the one hand it is positive, i.e. it consists in a system of rules that is backed by threats and can be enforced, and on the other hand it is legitimate, i.e. it embodies appeals to

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[261] Habermas, 1996, Chapter 3.
[262] See Habermas, 1996; Habermas, 2001, Essay 5; 2003c, introduction.
[263] See Habermas, 2001, Essay 5; Edgar, 2006, pp. 79-85.
[264] Habermas, 1999b, p. 329.
[265] Habermas, 1996, Chapter 8.
[266] Habermas, 1996, p. 462.

reasons that all citizens could find acceptable. As a result, it may secure compliance through two mechanisms:[267]

> The double reference of legal validity to de facto validity as measured by average acceptance, on the one hand, and to the legitimacy to the claim to normative recognition, on the other, leaves addressees with the choice of taking either an objectivating or performative attitude toward the same legal norm.[268]

Therefore, from the perspective of the actor who acts strategically, legal norms stands as external constrains (securing *de facto* recognition), whereas from the perspective of the actor acting communicatively, law is respected because it embodies norms that deserve recognition. Therefore, the legal validity of a norm implies that two elements are simultaneously guaranteed: the legality of the behaviour, which can be enforced, and the legitimacy of the rule, 'which always makes it possible to follow the norm out of respect for the law.'[269]

The structure and form of modern law, therefore, are capable of dealing with the cognitive indeterminacy of a post-conventional morality which is based on abstract principles and which nevertheless requires appropriate application to real and complex conflict situations. The coercive power of law makes up for the motivational deficit of post-conventional morality, and the institutional framework of the legal system, apart from defining rules and systematising decisions, produces a system of accountabilities that refers to individuals and to corporations and public agencies, addressing this way the need for combined and cooperative implementation of duties.[270]

Yet, the inevitable question posed to modern law in its supplementary function to a post-conventional morality regards its source of legitimacy. To answer that, Habermas derives the legitimacy of modern law from the principles of discourse theory. In bringing the discourse principle[271] into play in legal discourses, the principle assumes the form of the principle of democracy:

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[267] Habermas, 1996, Chapter 1.
[268] Habermas, 1996, p. 30.
[269] Habermas, 1996, p. 31.
[270] Habermas, 1996, Chapter 3.
[271] Just those action norms are valid to which all possibly affected persons could agree as participants in rational discourses (Habermas, 1996, p. 107).

> Only those laws count as legitimate to which all members of the legal community can assent in a discursive process of legislation that has in turn been legally constituted.[272]

This principle, which arises from the interpenetration of the discourse principle and the legal form, [273]establishes a procedure for legitimate law-making and for guiding the establishment of basic rights that makes possible a community's self-organisation under the rule of law.[274] This interpenetration leads to the conceptualisation of a logical genesis of a system of rights,[275] a circular process in which the legal form and the mechanism for producing legitimate laws are co-originally constituted.

In this conceptual, logical, reconstruction of the system of rights, Habermas arrives at the rights citizens must grant each other if they want to legitimately organise and regulate their interactions under the medium of positive law. The first three categories of rights generate the legal form itself by awarding citizens the status of legal persons. They include: (1) rights to the greatest possible measure of equal individual liberties; (2) rights of membership in a voluntary association under the rule of law; and (3) rights to legal protection. These rights establish the horizontal relationships that citizens must have with each other *before* any introduction of a functionally necessary state authority and before the establishment of further rights to which all are subject to, i.e. at this first step citizens grant each other the status of addressees of the law. Only in a second step legal subjects become authors of the legal order by granting each other (4) rights to equal political participation. These rights, therefore, enable citizens to change and expand their rights and duties. Finally, to secure citizens' equal opportunities to exercise rights form (1) to (4), another category of rights is implied: (5) 'basic rights to the provision of living conditions that are socially, technologically and ecologically safeguarded'.[276] These five categories of rights are purposively general and abstract, lacking more specific contents. Although to be effective and actionable, specific contents must be given to rights; this is a task that must be democratically left to citizens themselves to fulfil.[277]

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[272] Habermas, 1996, p. 110.
[273] Habermas, 1996, p. 121.
[274] Habermas, 1996, p. 111.
[275] Habermas, 1996, p. 121.
[276] Habermas, 1996, pp. 118-31.
[277] Habermas, 1996, p. 130.

Two important issues are attached to this reconstruction of rights: the relationship between rights and popular sovereignty and the relationship of rights with morality. First, the development of these five categories of rights represents an attempt at bridging the gap between the internal relation between human rights and popular sovereignty. Here Habermas refers to the age-old tension between the classical liberal moral reading of human rights (going back to John Locke) and the emphasis on popular sovereignty of classic republicanism (going back to Aristotle and Jean-Jacques Rousseau), both of which provide normative frameworks that legitimise legal orders. The first framework emphasises private autonomy and individual liberties (equivalent to rights 1 to 3 of Habermas's reconstruction) whereas the latter emphasises the civic autonomy of individuals and their practice of self-determination (emphasising category 4 of Habermas's reconstruction). As the reconstruction of the system of rights reveals, however, private and public autonomies presuppose each other:[278]

> The internal relation between democracy and the rule of law consists in this: on the one hand, citizens can make appropriate use of their public autonomy only if, on the basis of their equally protected private autonomy, they are sufficiently independent; on the other hand, they can realize equality in the enjoyment of their private autonomy only if they make appropriate use of their political autonomy as citizens. Consequently, liberal and political basic rights are inseparable.[279]

Second, as Habermas's reconstruction of the systems of rights already signals, human rights are conceived as legal rights. Despite their legal status, rights maintain fundamental links with morality; as Habermas explains, human rights are 'Janus-faced, looking simultaneously toward morality and law'.[280] Habermas traces the modern understanding of human rights back to the Virginia Bill of Rights and to the 1776 American Declaration of Independence, and to the 1789 Declaration des droits de l'homme et du citoyen', which were inspired by modern natural law and principally that of Locke and Rousseau.[281] Despite seeing human rights as the basic rights that constitute the legal orders of constitutional democracies, and structurally belonging therefore to a positive legal order, for Habermas rights share with morality their form of validity. First,

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[278] Habermas, 1996, Chapter 3; 2001, Essay 5.
[279] Habermas, 2001, p. 118.
[280] Habermas, 2001, p. 118.
[281] Habermas, 1997, p. 137.

like morality they are addressed to persons as human beings and nor as citizens, claiming a *universal validity*, i.e. a validity that goes beyond the boundaries of legal communities. In addition, both moral norms and rights are *justified* by moral argumentation. That means that at the level of justification, rights are not subject to pragmatic and local cultural constraints; they have to project norms that are equally good for all. Yet, just as other legal rules, rights also enjoy the dual character of *de facto* recognition and recognition out of the respect for its normative content.[282]As it will be seen in Chapter 5, the interpretation of rights as legal categories has important implications in the academic debate about the status of rights, including the status of the right to health.

Finally, Habermas concludes *Between Facts and Norms* by providing a further illustration of the implications of the internal relation between private and public autonomy: an account of the inadequacies of the mutually competing liberal and welfare-state paradigms of law. The liberal paradigm, privileging the economic arrangements of society, crystallises around private law and especially so around property rights and contractual freedom. The welfare paradigm, which was developed as a response to the distortions resulting from the untamed capitalist system, aims at compensating citizens from growing inequalities of the capitalist system through regulation of the economic and through granting citizens with social rights. Yet, in doing so, the welfare paradigm creates distortions of its own by generating welfare dependencies and over intrusive bureaucracies. Despite their differences, for Habermas, the inadequacies of both paradigms have the same origin: both paradigms focus on the private autonomy of individuals at the expense of the internal relation between private and public autonomy.[283] In his words,

> Between the two received paradigms, the only controversial issue is whether private autonomy is best guaranteed straight away by negative freedoms, or whether the conditions for private autonomy must be secured through the provision of welfare entitlements.[284]

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[282] Habermas, 1997.
[283] Habermas, 1996, Chapter 9; 1999b.
[284] Habermas, 1999b, p. 334.

To address this common failure, Habermas proposes a third paradigm of law; a procedural paradigm that 'crystallises neither around the private competitor on markets nor around the private client of welfare bureaucracies'.[285] His procedural model emphasises a heightened democratic participation in law-making and administration. As he justifies:

> In highly differentiated societies with an intransparent diversity of interests, it is an epistemic requirement for the equal distribution of liberties for everybody that those citizens affected or concerned first get themselves the chance to push their cases in public, and articulate as well as justify those aspects which are relevant for equal treatment in typical situations. Briefly, the private autonomy of equally entitled citizens can be secured only insofar as citizens actively exercise their civic autonomy.[286]

In more democratic law-making processes, deliberation must be open to the input from civil society and to sufficiently inclusive informal public opinion.[287] Only by having the space for influencing policies and laws modern subjects can abide by legal rules they accept; only then citizens can also see themselves as authors of the laws to which they are subject.[288]

4 Conclusion

Habermas's work is surely broader and more complex than what could be presented above. For this reason, this chapter had only the limited task to introduce the reader to the aspects of Habermas's work that are relevant to the arguments developed in the thesis regarding health and its relationship with justice. To achieve that, the role that health plays in society also needs to be explored. In discourse theory, the sociological concern for understanding society and its integration and reproduction is never detached from questions about the right and the just. These two enquiries – the sociological and the philosophical – are interdependent. To that end, the next chapter starts by exploring the debate regarding the meaning of health. Understanding the debate surrounding this concept is fundamental for understanding the analysis of what health, conceived

[285] Habermas, 1999b, p. 334.
[286] Habermas, 1999b, p. 334.
[287] See Habermas, 1996, Chapter 8.
[288] Habermas, 1996.

intersubjectively, means and what social roles it plays in society (Chapter 4). The answers to these enquiries provide the base for the analysis of the relationship between health and justice in Chapter 5. The links between the theoretical aspects of Habermas discussed above and the arguments developed in this thesis are briefly presented below.

To analyse the debate about the meaning of health, Chapter 3 relies on Habermas's theory of the roles of language, speech acts, and the different validity claims and relationships with the world that they establish. This analysis leads to the conclusion that health has no categorical definition. There are a multitude of definitions and interpretations of its meaning and their validity are dependent on their rational justification and appropriateness to the context. Furthermore, the diversity of accounts of health is seen as positive, allowing the critical mediation between the different moments of modern rationality. In addition, this analysis about the different meanings of health points to the intersubjective conceptualisation of health that is appropriate to the purpose of analysing its relationship with justice.

Having analysed the different meanings of health, an intersubjective interpretation of the concept is developed in Chapter 4. To understand the social role of health, Habermas's theory of society – in its dual interpretation as system and lifeworld – is relied upon. This dual interpretation makes it possible the conceptualisation of health as a sub-system of the lifeworld which contributes to social integration at the level of the lifeworld's three structural components. Here, Habermas's insights on processes of socialisation of the individual and her moral development are also employed to argue that health has an important role in fostering the conditions for moral discourses, insofar as it consists in a system in which relationships of solidarity and care for others are nurtured. The lack of mediation between the different valid discourses that permeate the health system and the increasing encroachment by the system's media permit the analysis of crises in health.

Finally, in Chapter 5 the relationship of health and justice is explored, and the role health plays in social integration will serve as the basis for this analysis. The concept of the right to health and its controversies are thus analysed in the light of this relationship. Habermas's moral and legal theories form the guide to the analyses of this concluding chapter.

Chapter 3

A DISCOURSE THEORETICAL PERSPECTIVE ON THE DEBATE ABOUT THE DEFINITION OF HEALTH

1 Introduction: what is health?

Health enjoys no uncontroversial definition. As many other concepts relevant to the human condition in modern capitalism, such as happiness, needs satisfaction, dignity and even freedom, its definition seems to lie in the worldview of the beholder. Whereas some may define health as a condition of normal functioning of the human body, others may define it as broadly as to encompass a state of physical, mental, social and even spiritual well-being of the individual and the collective. In debating the meaning of health, some may value conceptual rigour and concepts that can be operationalised, whereas others may be interested in widening its scope and linking it to wider social issues. More than an illustration of the conditions of pluralism in society, these differences also reveal different political agendas and the different normative assumptions that follow from them. The importance of understanding the debate surrounding concepts central to health, such as healthcare and illness, is that the ways of defining such concepts influence health policies and bioethical standards worldwide.[289] As Robert Hahn illustrates,

> a society in which sickness is thought to be defined by human experience and caused by human interactions – physiological as well as social – may attend more to its social organization and the understandings of its patients in addressing prevention and cure. How we think of sickness and different kind of sickness shapes our response, diagnosis, and treatment.[290]

Yet, defining health is no easy task. As Lennart Nordenfelt observes, health is a notoriously vague concept.[291] It is an idea difficult to conceptualise without an appeal to other concepts that can themselves be vague. Many find it hard to define health without appealing to concepts such as normality or to 'opposites' of health such as disease or

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[289] See Blaxter, 2004, p. 3; Nordenfelt, 2007a, p. 5.
[290] Hahn, 1995, p. 19.
[291] Nordenfelt, 2007b, p. 30.

illness. Normality, for instance, is not an uncontroversial concept. It raises more questions than answers: normality for what or for whom? It can also convey a variety of different meanings, such as average, most representative, most common, optimal, habitual.[292] In sum, it only seems to transfer the controversy from one concept (health) to another (normality).

The tendency to define health through its opposites, as in the classical 'health is the absence of disease,' illustrates a negative construction of the concept, in which health is defined by the absence of something else, such as disease or illness. Here again, concepts such as disease, illness, and sickness are not easily definable and many theorists do not use them interchangeably. As Mildred Blaxter describes, disease is more commonly associated with the medical equivalent of a condition, i.e. the pathology. Illness is associated with the subjective experience of such a condition, and sickness is associated with the social role taken by those who are defined as diseased or ill. These three concepts, however, are not always symmetrical. One can, for instance, have a medical diagnosis of a condition, say, hypercholesterolemia,[293] and not feel ill at all. On the other hand, one may be feeling ill, say, tired and sad, without having any recognised medical diagnosis to associate it with it. In addition, when diseased or ill, people may not always assume conventional and expected sick roles. Whereas some may assume the role of patient and seek medical help, others may choose not to do so. In the same way, society may treat a diseased person as a less functional member independently of whether she feels ill or disabled at all.[294]

In contrast with the 'absence of disease' framework, many prefer to construct health as a positive concept that also encompasses values such as happiness, balance, and wellbeing with oneself and one's community. This characterisation of health as a positive state has broader social connotations in comparison to accounts that tend to focus on diseases and that limit health to the realm of science and medical practices.

The debate between these two opposing views is not a modern development. The history of this antagonism is long, dating back to the classics. The term hygiene, for

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[292] See more in Blaxter, 2004, p. 4.
[293] High blood cholesterol levels.
[294] See Blaxter, 2004, pp. 20-2.

example, derives from the Greek goddess Hygeia. Hygeia, according to the medical historian René Dubos, watched over the health of Athens and symbolised the 'virtues of a sane life in a pleasant environment, the ideal of *mens sana in corpora sano*.'[295] The myth of Hygeia is juxtaposed by Dubos to the myth of Asclepius, the Greek god of healing, who according to the legend was the first physician. In contrast with Hygeia, Asclepius did not teach wisdom and virtues but mastered the use of knives and the curative benefits of plants.[296] For Dubos, the two ancient Greek myths symbolise the two classical approaches to health and medicine that still have currency today; one focusing on the positive relationship between health and virtue and between the individual and the environment and the other focusing on the cure of diseases.[297]

Classic Greek thinkers profoundly influenced this old dichotomy. The parallel influences of Aristotle via Galen and Atomists via René Decartes contributed to the Western dichotomical holistic and scientistic approach to health. Aristotle described health as an important factor leading to the state of *eudaimonia*,[298] and his work heavily influenced Galenic medicine[299] and its theory of the balance of humours (yellow bile, black bile, phlegm and blood), the disruption of which would explain patients' conditions.[300] This theory, which was influential in medical practice until at least the 18th century, was based on Aristotle's account of the four qualities – hot, cold, moist and dry – belonging to the four elements – earth, air, fire, and water. Health and balance with nature were then seen as closely linked and part of the same thing. It was in contraposition to the works of Greek Atomists that Aristotle developed his views of nature. Greek Atomists believed that the property of objects could be explained in relation to their ultimate particles (atoms) and that the particular arrangements of these particles composed the observable characteristics of objects. This atomistic view influenced the mechanical philosophy of Descartes, whose approach to nature, including the human body, was characterised by the explanation of events in terms of matter and motion. Illustrative of his approach to nature is his view of the heart as an engine

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[295] Dubos, 2001, p 7.
[296] Dubos, 2001, p 7.
[297] See Dubos, 2001, p. 7.
[298] See Bok, 2008.
[299] The term refers to the medical practice based on the works of Galen, a 2nd century Rome physician.
[300] See Seale, Pattinson and Davey, 2001, pp. 20 and 60.

responsible for distributing tiny particles (the blood) around the body.[301] According to his critics, the (negative) impacts of Cartesian philosophy are still pervasive in biomedicine with its 'mechanistic' view of the body as a machine which can be repaired or have its parts replaced.[302]

The holistic approach is then more inspired by the ideals (or illusions) of perfect health and happiness and of harmony with nature that flourished throughout history; echoing myths of paradise on earth and passionate appeals for a return to nature.[303] Rousseau, for whom man in the 'natural state was good, healthy, and happy' and for whom 'hygiene' is 'less a science than a virtue',[304] is an example of such idealisations. Contemporary alternative medicine movements, with their focus on 'natural' therapies and the criticism of the biomedical model are another example of the search for a lost harmony with nature.[305]

A different approach is taken by those who feel more inspired by the medical developments of the 19th century, especially on the field of microbiology. The discovery of microorganisms informed the development of the theory of specific aetiology and the associated philosophy that all diseases have causes and patterns of presentation and evolution, creating bodily disturbances that can be categorised, identified and treated.[306] This is also the moment that represented the shift from medical care being offered at home by different healing practitioners – bedside medicine[307] – to the era of the institutionalisation of care, in which medical treatment became centred in hospitals under the guidance of formalised medical professionals.[308] Today, it is this approach to health which prevails with the formalisation and institutionaliation of healthcare, and it is of special appeal to those that reject the inclusion of holistic values such as happiness and social wellbeing on the definition of health.[309]

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[301] See Seale, Pattison and Davey, 2001, pp. 96-7.
[302] See Blaxter, 2004, pp. 16-9.
[303] See Dubos, 2001, pp. 4-5.
[304] Rousseau, cited in Dubos, 2001, p. 4.
[305] See Seale, Pattinson and Davey, 2001, pp. 31-3.
[306] See Dubos, 2001, p. 6, Seale, Pattinson and Davey, 2001, pp. 49-52.
[307] See Seale, Pattinson and Davey, 2001, pp. 47-8.
[308] Seale, Pattinson and Davey, 2001, pp. 49-52.
[309] See the discussion below. Darwin and its theory of evolution are also frequently evoked by scientists in support of a scientific establishment of natural species' behaviour and goals (see the example of Boorse's theory of health discussed below). Interestingly, it is also used by other theorists to emphasise the

The objective of this chapter is to address this dichotomy between a scientific and a social model of health with a view to construct an approach to the concept informed by discourse theory. To do that, this chapter analyses the debate from the perspective of Habermas's theory of language in use. The result of this analysis (a) concludes that apart from their rational justification, the validity of these different claims about health depends on the appropriateness of the claims to the context and (b) proposes a mediation between these conflicting approaches. It is argued that different approaches to health can be valid and that this diversity should be seen as a positive feature and not a hindrance to the development of health policies. Furthermore, distortions arise when one form of discourse becomes dominant and refractory to the critical outlook of the other.

The chapter starts with an analysis of different accounts of health. Starting with lay accounts it is argued that they can provide an important contribution to the understanding of the intersubjective dimension of health. An analysis of biomedical accounts of health will follow with a focus on the agenda that lies behind their assumed value-neutrality. It is argued that a value-neutrality will not be able to protect the internal logic of biomedicine against the influences of the economic and administrative system. Next, the social model of health is also analysed with a special focus on its critique of biomedicine. The WHO definition of health is then presented as an illustration of the social model and the controversy that it generates serves as an illustration of how this controversy operates in actual context. The concluding analysis places the controversy created by the WHO definition within Wittgenstein's theory of language-games and Habermas's universal pragmatics. This analysis points to the conclusion that in the context of the WHO's constitution, the appropriate interpretation of the definition of health should involve the recognition that it is a claim to rightness as opposed to a claim to truth, i.e. it should be interpreted as a normative statement as opposed to a descriptive one. It is argued that this does not invalidate the use of cognitive-instrumental approaches to the concept in the context of everyday activities of the organisation. The substantive content of the definition, however, is criticised due to

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importance of human adaptation to one's external environment, including the social environment (see Dubos, 2001, pp. 6-7).

its lack of focus on the justice of the interactions among social actors and how these interactions affect people's health. However, it is proposed that the definition should stand due to its important historical normative reference. Finally, it is concluded that a discourse theoretical interpretation of health with the objective of exploring its relationship with justice should focus on the intersubjective dimension of health and its normative implications. The development of this intersubjective account of health is the subject of the next chapter.

2 Exploring different accounts of health

2.1 Lay accounts

People have different conceptions of what health means and their conceptions normally exhibit a combination of ideas stemming from traditional knowledge, personal experiences, and more scientific accounts. Information about health and diseases provided by different actors, such as formal healthcare providers, governmental health institutions, patients' associations, drugs and alternative therapies industries, are widely available and filtered into individuals' reservoir of cultural knowledge. This process has been powered by the use of the internet as a source of healthcare information by patients and the public at large. Because of this broad array of sources of information about health that lay individuals have access to, as Blaxter defines, 'lay beliefs can be better defined as commonsense understandings and personal experience, imbued with professional rationalisations.'[310]

Blaxter reached this conclusion after a 1990 survey, in which 9,000 people in the UK were interviewed about their understanding of health.[311] A qualitative analysis of a randomly selected 10 per cent sample revealed that people had a variety of understandings about the meaning of health and that these understandings tended to change during the life course of the individual. Understandings also tended to vary according to age, gender, class, and education. Furthermore, the respondents commonly had more than one understanding of health. Blaxter divided the results into five main categories. (a) The first category represented those who defined health as not being ill,

[310] Blaxter, 2004, p. 46.
[311] Health and Lifestyle Survey, published in Blaxter, 1990. See also Blaxter, 2001.

which was more common in individuals who thought that their health was in good shape. b) The second category represented those who associated health with physical fitness or vitality. This association was more commonly made by younger people, and in fact, 'fit' was the most common word used by men under 40. c) The third category expressed the view of health as social relations. This association between health and social relationships was mostly made by women. Younger women tended to link health as good relationships with family and children, whereas elderly women tended to emphasise the link between health and the ability to retain an active place in the social world and care for others. d) The fourth category represented those who associated health with function. Health was linked by them with the ability to do things, and in this group the respondents tended to place less emphasis on feelings. Elderly people tended to emphasise retaining mobility, self-sufficiency, care for oneself, and continuing work despite one's age. Young men tended to emphasise health as the ability to do hard work. Finally, e) the fifth category represented the most common definition of health provided in all age and gender groups except for young men. In this category health was viewed as psychosocial well-being. Happiness, confidence and emotional stability were all feelings and states associated with health. Apart from these five categories, Blaxter also identified a group who felt unable or less motivated to answer the questions, and most individuals within this group tended to think that their health was in poor condition. Further findings were that the poorest and disadvantaged showed to be more likely to say that their health was poor, and that the holistic view was more commonly conveyed by higher educated people or people on less manual jobs.

An interesting aspect revealed by Blaxter's findings is that lay people's different concepts of health are not dissimilar to the different categories of definitions of health given by experts.[312] As observed, some constructed health broadly whereas others associated it more with not being ill or maintaining the capacity to function. As it will be seen, experts too define health in terms of the absence of disease, as functioning capabilities, or associate it with states such as happiness and wellbeing and relationships with others. An important difference, however, is the flexibility of lay individuals in

[312] Perhaps this is due to people's increasing exposure to expert opinion, or perhaps it represents the bias of filtering these views through the academic lens.

incorporating, simultaneously, different accounts of health. It is possible that the different information they are exposed to and the great impact of personal experiences of health and disease allow their views to be more fluid and open to changes.

The critical potential of lay ideas about health may reside precisely on this openness to different accounts. Gareth Williams and Jennie Popay, for example, defend this thesis and argue it is at this level that the experiential domain of health takes place, which can provide not only important insights about the forces that influence health but also a source of challenge to professional and systemic hubris.[313] As they remark, 'the knowledge people have of the impact of social forces upon them contains an understanding of the complex interplay of biography, history, locality and the broader social divisions of class and gender.'[314] Employing a Habermasian framework, they conclude that there is a 'range of ways in which lay knowledge embodies resistance to the colonisation of the lifeworld by either the state or market forces.'[315]

A similar discussion on the interface between health, the lifeworld and system is advanced in Chapter 4, where people's experiences of health, illness and healthcare are further discussed, although with a focus on the experiences of illness. These experiences help us explore and uncover the intersubjective meaning of health, which allows us to reinterpret the relationship of health and justice in Chapter 5. The expert definitions of health are the focus of the next sections. These expert accounts are divided into biomedical and social.

2.2 Scientific accounts: the biomedical model

In most Western societies, the dominant concept of health follows the scientific model, and more specifically, the biomedical. As Blaxter points out, in practice, the definition of health has always been the 'territory of those who define its opposite',[316] i.e. the practitioners of medicine as a science. This is because theirs is the perspective which

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[313] See in Williams and Popay (2001) a series of examples in which despite the resistance by the authorities and the scientific establishment, communities succeeded to demonstrate the link between environmental conditions and ill-health based on their daily experiences, including the example of the fundamental contribution of workers and their unions in the recognition of a series of diseases associated with the work environment.
[314] Williams and Popay, 2001, p. 40.
[315] Williams and Popay, 2001, p. 40.
[316] Blaxter, 2004, p. 10.

becomes institutionalised in law and administration.[317] Characteristically, this institutionalised account of health is more strongly focused on the concept of disease than in the concept of health. One of the results of this negative construction[318] is that biomedicine assumes as the main role of health promotion the treatment of diseases. This leads critics to point to another shortcoming of the biomedical model: by focusing on diseases, biomedicine tends to approach them independently of patients, who are conceived as their 'carriers'.[319]

In its classical form, the main principles of biomedicine are: (a) the doctrine of the specific aetiology, or the idea that all diseases are caused by an identifiable cause, such as bacteria, parasites, toxins, metabolic disturbances, and traumas; (b) the assumption of the generic disease, or the idea that within the human species each disease has universal and distinguishing features; (c) the view of ill health as deviation from normal measurable biological variables; and more importantly, (d) scientific neutrality or the belief that it is a value-free science.[320] Blaxter points out that in reality, contemporary biomedicine tends to be less mechanistic than its classical principles suggest, having incorporated, for example, the idea of multiple and interacting causes as well as accepted that diseases can also have psychological and social causes.[321] Yet, these changes did not fundamentally challenge the biomedical paradigm, especially its scepticism towards values and towards 'the social'. But should the biomedical paradigm change at all? To address this question, different biomedical definitions of health are explored followed by the identification of the common agenda behind them. The next chapter will give us the opportunity to further this analysis by positioning biomedicine within Habermas's account of the lifeworld.

The contemporary biomedicine's shift from claims to a solidly scientific and value-free approach to one more accommodating of values can be illustrated in the works of two of the most influential thinkers within the debate on the scientific definition of health, namely Christopher Boorse and Nordenfelt. In Boorse's work,

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[317] Blaxter, 2004, p. 10.
[318] Here negative is used in the sense of being defined by the absence of something else as opposed to having its own characteristics.
[319] Blaxter, 2004, pp. 10 -11.
[320] Blaxter, 2004, pp. 11-14.
[321] Blaxter, 2004, pp. 14-16.

which precedes Nordenfelt's, health is negatively defined as the absence of disease, and it is the concept of disease which therefore receives his focus of attention. Nordenfelt in contrast, incorporates value-categories in seeing health as a positive concept associated with individual wellbeing and capacity to achieve her life's essential goals. Furthermore, patients' values are also included in his theory. Because of their apparent differences, their accounts are denominated within the field of philosophy of medicine as naturalist and normativist respectively.[322] Despite these differences, as George Khushf notes, they share the same fundamental aims of forging a definition of health within the scientific paradigm and, more importantly, of setting boundaries to what counts as health in order to protect medical knowledge and authority against external interferences.[323] However, as it will be argued, the strategy they use with the purpose of shielding biomedicine from external interference, namely the appeal to value-neutrality, is unlikely to succeed in modern capitalism.

Boorse first established his account of health in 1977, arguing that as a medical concept, health must be defined by the absence of disease. Furthermore, he states that this construction of health is essentially value-free.[324] Having established that 'health is normal functioning, where the normality is statistical and the functions biological,'[325] he focuses his attention on what counts as abnormality, i.e. disease:

> [a] disease is a type of internal state which is either an impairment of normal functional ability, i.e. a reduction of one or more functional abilities below typical efficiency, or a limitation on functional ability caused by environmental agents. [326]

Normal functional ability refers to the functionality of bodily organs. Organs are healthy when they make their 'species-typical' contribution to the individual's crucial biological goals, i.e. survival and reproduction. Species-typical, by its turn, is defined by appeal to evolutionary biology and measured in statistical terms. His commitment to the establishment of value-free concepts becomes evident when he argues that '[i]f diseases

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[322] Within the logic of the debate aimed at a scientific definition, naturalism represents the idea of a purely biological perspective whereas normativism represents the inclusion of some *evaluative* criteria, although not necessarily moral or ethical.
[323] See Khushf, 2007.
[324] Boorse, 1977, p. 542.
[325] Boorse, 1977, p. 542.
[326] Boorse, 1977, p. 567.

are deviations from the species biological design, their recognition is a matter of natural science, not evaluative decision,'[327] and when he further argues that '[o]ur conception of disease required no value judgement about what forms of human life are admirable or desirable.'[328] The problem with positive ideas of health, he concludes, is that they are 'not discoverable, but only advocable.'[329]

Nordenfelt takes issue with Boorse's definition by claiming that it is not only the individual survival and reproduction what is at stake, but also her quality of life and welfare. In adding these positive values, Nordenfelt is rejecting the idea that health is value-free. He argues that apart from its objective elements, health also encompasses evaluative and extra-biological elements, such as the individual's ability to reach her most vital goals in life. Significantly, these goals are to be established by the patient herself; although the word vital is carefully used as a qualifier in order to avoid counterintuitive conclusions such as that any need, however uncommon or unrealistic, would count as much as basic needs or that the individual needs to realise all her goals in life in order to be considered healthy.[330] Furthermore, in going beyond Boorse's concept of diseases, a broader range of patients' problems, such as pain, suffering, and disabilities, which may also impact in the patient's ability to achieve her goals, are accounted for in his definition.[331].

This is how Nordenfelt positively defines health:

> A is completely healthy if, and only if, A has the ability, given standard circumstances, to reach all his or her vital goals. [332]

It is only after defining health that he proceeds to define disease. At this stage his scientific focus becomes more noticeable:

> A has a disease if, and only if, A has at least one organ which is involved in such a state or process as tends to reduce the health of A. The disease is identical with the state or process itself.[333]

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[327] Boorse, 1977, p. 543.
[328] Boorse, 1977, p. 571.
[329] Boorse, 1977, p. 572.
[330] Nordenfelt, 2007b.
[331] Nordenfelt, 2007a, p. 8.
[332] Nordenfelt, 2007a, p. 7.
[333] Nordenfelt, 2007a, p. 7.

It is worth noting that for Nordenfelt health means something different, and broader, than for Boorse. By including the extra-biological ends of patients' capabilities, he potentially expands the number of conditions that would fit into his definition of disease. Moreover, in Nordenfelt's account a condition would be qualified as a disease even if it does not affect the survival or reproduction of the individual, therefore also accommodating disabilities and mental conditions.

Whereas his concept of disease seems to be more in tune with modern developments in biomedicine and its new disease trends, some critics are still particularly wary of the inclusion of any 'extra-biological end' to a definition of health. Thomas Schramme for example, although agreeing with Nordenfelt that health cannot be only descriptive of organs dysfunctions, claims that Nordenfelt's definition is too demanding. In addition, he claims that Nordenfelt's definition leads to implausible consequences. He illustrates this criticism with the example of 'someone with epilepsy whose only vital goal consists in being well respected by others and who happens to live in a society where epilepsy is judged as a sign of sainthood is healthy'.[334]

His critique of Nordenfelt reveals the major concern expressed by many in the field against any such broad definition of health: that it risks opening the gates of 'medicalisation of all kinds of problems in life'.[335] For this reason, Schramme supports the view that health should be exclusively a medical term:

> Medical normality should be our sufficient criterion of health, and pathology the necessary condition of ill health. Both criteria can be vindicated without any relation to subjective goals in a naturalist theory.[336]

Noticeable in his attempt at avoiding the 'medicalisation' of the social is the typical biomedical appeal to 'normality' and emphasis in excluding 'subjective goals'.

The concern against medicalisation with its risk of supporting oppressive policies, such as the pathologising of homosexuality and political dissidence, is also expressed by Khushf, and this concern brings him to analyse the debate from a very interesting perspective. He claims that apart from the risk of medicalisation, there are at

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[334] Schramme, 2007, p. 15.
[335] Schramme, 2007, p. 15.
[336] Schramme, 2007, p. 15.

present other important threats to 'older medical ethical values' and practices.[337] These threats are the increasing pressures coming from the socioeconomic and administrative fronts of the medical system, such as managed care and total quality review strategies. He fears that pressures coming from these two fronts are affecting the traditional scientific and ethical core of medicine.[338]

According to Khushf, medical practice has traditionally been able to insulate itself from external challenges by emphasising the fact-value divide. In medicine this divide is in 'hyper-form' and the perpetuation of this dichotomy has been fundamental for the self-understanding of biomedicine. As he argues, it is the biomedical assumed neutrality and objective facts-based analysis that allow its independence from the influence of other systems. In the context of contemporary biomedical practice, this dichotomy is perceived by him as key to the biomedical resistance to an ever growing 'intrusion' of administrative and economic strategies in the medical practice. As he illustrates, medicine based in evidence helps professionals do the job of justifying the cost of treatments to saving-savvy insurers better than the appeal to ethical considerations for any individual patient.[339] In sum, this dichotomy makes it possible to biomedicine to shun external values by framing conflicts in objective-scientific manners.[340]

Looking from the perspective of the fact-value divide, Khushf concludes that both Boorse's and Nordenfelt's accounts are actually very similar. He argues that both represent and defend a similar model of interaction between science, medicine and society, in which the fact-value divide plays the important role of setting the boundaries between them. [341] Khushf identifies the fact-value divide expressed in different ways in the work of the two theorists. Boorse's account is heavily based on the classical scientific ideals of traditional medicine. According to this view, health and disease are seen as a matter of scientific investigation and they are presented as facts. By being

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[337] Khushf, 2007, p. 26.
[338] Khushf, 2007, p. 22.
[339] The use of evidence based medicine can also work the other way round, as it can be used by insurers to justify the refusal of costly treatments to patients unlikely to clinically benefit from them. In any case, the dispute 'appears' to be technical and not ethical, which is mainly Khushf's point.
[340] Khushf, 2007, p. 21.
[341] Khushf, 2007, pp. 19-20.

conceived as facts they become free from any biases brought by values.[342] As Boorse advocates, 'we must avoid confusing empirical questions with deep normative issues about the goals of human life and the role of health professionals in achieving them.'[343]

Khushf identifies the fact-value divide in Nordenfelt's work by reframing it in the pure-applied science framework. While pure science is devoid of value-analyses, applied science by putting pure science into practice inevitably incorporates evaluative questions, such as: what are the objectives of the given application? He places Nordenfelt's work within the applied science model. In Nordenfelt's work, the goals of medicine are to facilitate the achievement of individuals' life goals through medical intervention. Yet, as Khushf identifies, as soon as that end is given, how to achieve them becomes for Nordenfelt a matter for scientific investigation and technical procedure: '[a]s soon as the matters which are open to evaluation are decided upon a standard is established which can be used for purely empirical investigation.'[344]

Khushf then concludes that the expression of the fact-value divide in Nordenfelt's is superior to Boorse's. He argues that Nordenfelt's account is more in touch with contemporary biomedicine by including the individual and her goals, and thus merging medical science with the 'bioethical consensus' characterised by individual autonomy.[345] As he claims, '[t]he contemporary ethos supporting more patient autonomy thus becomes a vehicle for specifying the ends that are necessary for the appropriate technical intervention.'[346] Notably, Khushf identifies the bioethical focus on the individual as a welcome help in getting medical practice insulated from administrative and economic intrusion. As he adds, '[w]e find here a critical function of [Nordenfelt's] health concept.'[347]

There are two very interesting aspects in Khushf's arguments. One regards the way he, in aiming at protecting traditional medical values, constructs patient autonomy and the way he seizes it in defence of the integrity of the internal logic of the biomedical model. The second regards the high moral ground he seems to ascribe to traditional

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[342] Khushf, 2007, pp. 19-20.
[343] Boorse, 1977, p. 572.
[344] Nordenfelt (1995) cited in Khushf, 2007, p 23.
[345] Khushf, 2007, p. 23.
[346] Khushf , 2007, p. 23.
[347] Khushf, 2007, p. 23.

medical practice and the consequent negative stand towards influences coming from outside its traditional boundaries.

Patient autonomy and their role in the medical encounter are still framed by Khushf in traditional paternalistic fashion. It does not seem to imply a new relationship of symmetry between the medical professional and the patient. It seems instead to translate a relationship based on a combination of paternalism and instrumentalism. Note, for example, Khushf's choice of words:

> [p]atient autonomy does not mean they have a say in the science. We allow patients to advance their ends, and to guide how such ends might help prioritize possible courses of action. But physicians are the *masters of the means*; they know the science, and have the requisite knowledge and skill to *instrumentally advance the ends*.[348]

The 'bioethical consensus on patient autonomy' is used to emphasise the importance of medical authority, i.e. patient's autonomy seems instrumental to the end of maintaining the integrity and authority of biomedicine. Limits to autonomy are promptly put in place lest it becomes, along with administrative and socio-economic factors, another source of 'threat' to biomedical integrity: As he observes:

> [t]he physician-patient interaction is seen as a scientifically grounded practice, *directed* by the clinician. Patients values come in as a second strand, guiding potential 'medically indicated' courses of action towards the advancement of patient ends. Socio-economic factors are in turn, seen as necessary, providing the conditions for an effective medical intervention, but they are not supposed to *intrude* into the process of clinical decision-making and *distort* the *integrity* of that core clinical interaction.[349]

Also worth noting is Khushf's use of language, which could not be more telling of his view of the high moral ground of medicine and of the potentially threatening character of external influences. Words such as intrusion, distortion, protection, and insulation are metaphors used to describe the antagonism between the threat from outside and the 'integrity' of the inside.

The threats posed to biomedicine by the economic-administrative fronts, and although less explicitly, also from (too much) patient autonomy, lead Khushf to conclude that the debate between naturalists and normativists should not be focusing on

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[348] Khushf, 2007, p. 22, emphasis added.
[349] Khushf, 2007, p. 22, emphasis added.

concept definitions, but on how to respond to these threats. As he concludes, it will not be possible for medicine to sustain the classical fact-value divide as expressed by Boorse, and as a result the debate should move a lot deeper, focusing instead on the question of '[h]ow can we sustain older medical ethical values in this altered context?'[350]

The different biomedical accounts of health above analysed share a fundamental characteristic, although to a lesser degree in Nordenfelt: a resistance to what cannot be dealt with through its own logic and its own language. External influences are not only seen as non-belonging, but also as unwelcome interferences in biomedicine. In response to the increasing pressures from outside, Khushf presses for a revaluation of the role of medicine in society and for ways to protect it from undue outside influence.

While I agree with his assertion that a debate over the role of biomedicine in society is of essence, I disagree that it should start from the premise that the biomedical integrity must be protected from other spheres. Although I share with Khushf the opinion that the logic of the market in healthcare is destructive, I see empowering patients and the call for symmetry in their relationships with healthcare professionals as welcome social transformations that can only add to the integrity, but also legitimacy, of the system. If we place Khushf's concerns about the integrity of biomedicine within Habermas's theory of the colonisation of the lifeworld, we will conclude that the resistance to the colonisation of biomedicine by the economic and administrative logics cannot be achieved by sustaining the dominance of instrumental logic and value-neutrality in biomedical practices. On the contrary, it is in fostering symmetrical relations of mutual recognition among professionals and patients and in welcoming dialogical value-analysis that biomedicine can find its strength and shelter against its colonisation. Furthermore, as it will be seen in chapter 4, the inclusion of moral evaluations and the strengthening of patient autonomy do not entail the abandonment of the scientific logic *per se*, but the adjustment of the scope of this logic and of its place within the lifeworld. This argument is pursued in more depth in the next chapter.

2.3 Holistic accounts: the social model

[350] Khushf, 2007, p. 26.

Social models of health and illness here represent a series of approaches that contrapose the traditional biomedical model. Characteristically to the social model, health is not completely defined by its opposite, disease. As Blaxter summarises, according to the social model of health 'concepts of health and ill health are asymmetrical: they are not simply opposites. The absence of disease may be part of health, but health is more than the absence of disease'.[351] In espousing a holistic approach to health and illness, a central tenet of the social model becomes the rejection of what they characterise as the technicist and mechanicist approach of biomedicine and its institutionalised support by healthcare systems, government and the law. Typically, holistic accounts focus on health and its positive aspects which may include different ideas of individual and social well-being and the recognition that individuals are not machines or bearers of an aggregate of organs, but beings shaped by values, purposive actions, and in continuous interaction with the social world.[352]

Social model accounts of health and disease are also characteristically sceptical of the biomedical assumption of value-neutrality, of its excessive focus on biological processes, of its emphasis on 'cures' rather than on 'prevention', and of its enthusiasm with expensive new technologies. As Blaxter observes, this distrust of a 'Frankenstein technology that could run out of control' guided the new, social model of health.[353] The social model strongly rejects the mechanicism of the biomedical model and its metaphor of the body as a machine, as it sees disturbances in the body of a person as involving her whole system, including the complex network linking her biological, psychological and social context.

Another important characteristic of the social model of health, and interestingly this is shared with many within the biomedical model, is its criticism against the medicalisation of the world. Surely, the threat of medicalisation and its consequences are perceived in different ways by these two models. The main difference is that for social model, biomedicine is not the victim, but precisely the heart of the problem.

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[351] Blaxter, 2004, p. 19.
[352] See more in Blaxter, 2004.
[353] Blaxter, 2004, p. 17.

The medicalisation of the social world thesis is at the centre of the criticism directed to biomedicine by one of its fiercest critic, Ivan Illich. Illich argues that the practice of the medical professions, through its mechanistic focus on disease and expensive technologies has 'become a major threat to health.' He points out that the biomedical contributions to the improvement of health conditions have been far less important than changes in the wider environment such as better housing, work conditions, and nutrition. He concludes that more harmful than medical iatrogenesis, is the 'social and cultural iatrogenesis led by the excessive medicalisation of society.'[354]

The medicalisation of society is frequently associated with the development of oppressive social policies under the excuse of health concerns as seen in the infamous history of many mental health policies. Works in the area abound, and an oft cited example is the Soviet use of psychiatry to control political dissidence. Within the social model debate, biomedicine and its claimed value-neutrality are often accused of colluding with authorities in making such oppressive practices possible. Influenced not only by the works of Illich, but also of Michel Foucault,[355] feminists, Marxists,[356] and post-modernists, the social model encompasses a wide gamut of perspectives. In their own ways, different social model positions have in common the criticism of the increase in medical authority on everyday life, or 'medical imperialism'. Biomedicine and the medical profession are accused, among other criticisms, of being 'agents of the state control'; they are blamed for transforming into medical pathologies female conditions such as childbirth and menopause; and criticised for the development of pharmaceutical 'treatments' for an ever growing array of psychosocial conditions such as attention disorder in children and male erectile (dis)function.[357]

However, not every commentator working within the broad umbrella of the 'social model' rejects completely biomedicine's contribution to human welfare.[358] While critical of many aspects of biomedicine, some claim that critics tend to overlook the social contributions brought by biomedicine in many areas. They argue that biomedicine

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[354] Illich, 1974.
[355] See Foucault, 1961, 1963.
[356] See Navarro, 2001.
[357] See Blaxter, 2004; Seale, Pattinson and Davey, 2001; and Myers and Stafford, 2007.
[358] See Blaxter, 2004, pp. 42-3.

also helped offer a better understanding of previously socially stigmatised conditions such as alcoholism, post-traumatic stress disorder (as opposed to the social stigma of cowardice), infertility (challenging religious explanations), and chronic fatigue syndrome (as opposed to the stigma of malingering) [359] The contribution against the stigmatisation of certain conditions, however, comes at a cost. For example, biomedicine removes the blame from individuals suffering from combat post-traumatic stress disorder by transforming these conditions into diseases. Yet, by transforming an issue regarding social values into a scientific matter, biomedicine removes the debate from the public domain altogether. In doing so, the relevant moral issues involved, such as how human beings respond to and are so severely affected by the horrors of war and the extent to which society deems these responses 'normal' or 'deviant', acceptable or shameful, are not discussed, but put aside. In other words processes of communicative reflection about social practices and how they affect individuals are by-passed. With that, the opportunity to challenge prejudices and foster empathy, toleration, and mutual recognition are also lost. In addition, from the perspective of the patient, although she is protected from social judgment, it comes at a cost of the delegitimation of her suffering. [360] As the medical anthropologist Arthur Kleinman puts it,

> when a psychiatrist transforms the misery that results from political calamity – say, the horror of the Cambodian genocide or the numbing routinization of poverty in urban ghettos – into major depressive disorders, posttraumatic stress, or sociopathic personality disorder, the anthropologist claims that, notwithstanding technical and ethical intentions to the contrary, psychiatry ends up delegitimating the patient's suffering as moral commentary and political performance.[361]

This example also illustrates another important tenet of the social model: that health and diseases are not facts but social and cultural constructions. Whether a condition is seen as a disease or a socially undesirable trait of character depends on particular social contexts. As Blaxter points out, health and diseases have been constructed in different ways historically and culturally. Regardless of their biological substrate, their interpretations, and more importantly, how societies react to them, vary

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[359] See Seale, Pattison and Davey, 2001, pp. 155-66; Pierret, 2003.
[360] See a similar critique in the context of psychiatry and psychotherapies, which reframe emotions and utterances into demoralising signs and symptoms, in Crossley (2000). See a critique of psychiatry's medicalisation of the sadness and an account of the role of suffering as social critique in Kleinman, 1995.
[361] Kleinman, 1997, p. 96.

broadly. As she concludes, 'what counts as a disease or abnormality is not a "given" in the same sense as biological fact is given. It depends on cultural norms and culturally shared rules of interpretation.'[362] Even within the same society, very different cultural interpretations are found. From the perspective of current medical knowledge, for example, there are different accounts in the official healthcare system, alternative practitioners, or lay members of society. The social-construction model of health points out that when the individual is ill, she is ill in the eyes of her society and according to norms established by it of what counts or not as an illness. Similarly, social norms dictate the appropriate responses to her. Furthermore, if what counts as a disease is attached to ideas of what is undesirable or unacceptable, then what counts as a disease in a given social context, thus requiring appropriate medical intervention, may be seen as no disease at all in another context, thus receiving no attention from experts. Moral and aesthetic values also tend to play a role in defining what counts as a disease. Blaxter cites the example of obesity, seen as a medical condition in Western societies while it is seen as an attractive trait and symbol of status in other societies.[363] Even within Western history, standards always varied of what counts as a desirable body weight and what type of body shape becomes a medical condition.

The association throughout Western history of social deviance with disease is also well recorded. Disability, homosexuality, [364] and female physiology and sexuality,[365] have all been considered 'deviant' from the (male) norm and codified as diseases. Feminists, for example, denounce the fact that it is the male body and physiology that are seen as the norm against which the female body and physiology are compared. As a result, female conditions such as menstruation and menopause are generally constructed as deviant or pathological. Another interesting example of how social contexts shape the concepts of health and disease is given by the sickle cell trait which happens to minimise the impacts of malaria. In areas where malaria has a high incidence, and in contrast with everywhere else in the world, this inherited condition is seen less as a

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[362] Blaxter, 2004, p. 28.
[363] See Blaxter, 2004, p. 34.
[364] See in Hahn (1995, p. 18), for example, how until 1973 homosexuality was codified as a disease in the American Association's Diagnostic and Statistical Manual of Mental Disorders.
[365] See Blaxter, 2004, pp. 37-8.

disease and more like a protection.[366] As Blaxter concludes, 'the meaning of health is neither simple nor unchanging'.[367]

Social institutions too vary their responses according to the shifting perspectives on health and disease. An example, although better applied to the context of more industrialised nations, is given by the epidemiological transition in the leading causes of death from infectious to chronic and degenerative diseases.[368] With the aging of the population and increase in life expectancy, there has been a higher incidence of disabilities or chronic conditions, which in contrast with the classical infectious disease model are not passive of a medical cure. Medical interventions in these cases focus mainly on alleviating symptoms, diminishing disability, and increasing adaptability to the environment. This illustrates how social developments can change how health and disease are conceptualised. The history of mental health and HIV/AIDS policies also testify the shifting views of what health and disease entail.[369]

The social model of health represents an enormous, varied and fascinating body of work in the fields of sociology and anthropology of health and illness.[370] Common, however, is their belief on the relevance of the social, cultural, and economic factors in playing a role in health promotion and disease causation. The WHO definition of health epitomises this social model, and the debate it generates, as an illustration of the dichotomy between the scientific and social models, are the focus of the next section.

2.4 A political account: the WHO definition

> The States parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples:
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> Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

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[366] See Blaxter, 2004, p. 35, Hahn, 1995, pp. 59-60.
[367] Blaxter, 2004, p. 3.
[368] See more in Blaxter, 2004, p. 32.
[369] The subject of the social construction of mental illness and mental health policies is broadly and fascinatingly explored in the literature. See more, for example, in Foucault, 1961 and Kleinman, 1991. On HIV/AIDS see Sontag's analysis of the social perception of the condition (1991b).
[370] There are, of course, a number of other fascinating accounts of health produced outside the fields of sociology and anthropology. See Amartya Sen (1993) and Martha Nussbaum (2000), for example, who conceive health as an important capability.

> The employment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.[371]

The delegates to the draft of the constitution of the WHO, motivated by the 'never-again' post-war political moment of general condemnation of the atrocities and widespread human suffering and destitution caused by the war, chose to define health not only broadly but also in distinctively utopian fashion. As Sissela Bok reviewed,[372] the health impacts of the war, including the mass destruction of Hiroshima and Nagasaki, and the appalling conditions of extreme deprivation and ravaging epidemics around the world, profoundly resonated with the delegates. In face of the horrors witnessed,[373] an agreement was reached that no account of people's health or efforts to improve it are possible without considering the broader factors that influence it.[374] This broad definition takes issue with the reductionist approach to health by rejecting the disease-focused interpretation and by ascribing positive qualities to it. It brings into view a more holistic conception of people's health as a reflexion of their mental state and social environment as much as their physical state.

Particularly representing a unique historical moment of optimism and of a sense of new beginning for humanity,[375] the WHO definition of health has since its first days met strong criticism. It is frequently challenged as being too broad, utopian, abstract, and economically unrealistic.[376] Common examples of arguments raised against it is that it conflates health with factors that may influence it, that it is unrealistic, and that it is counterintuitive to believe that a state of complete physical, mental and social wellbeing, however defined, can be achieved at all times for any single person, let alone for the entire world's population. Another common criticism is that this definition does not do

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[371] Preamble, Constitution of the WHO, 1948.
[372] See Bok (2008) for a fascinating historical review and analysis of the drafting of the WHO constitution.
[373] Some of the delegates had witnessed firsthand the horrors of the war. Bok cites the example of the Yugoslav physician Andrija Štampar who spent the War years imprisoned by the Nazis. Štampar, along with four other physicians, including Sir Wilson Jameson, the 'architect of the national health' in Britain, led the preparation of the drafts. See Bok, 2008.
[374] Bok, 2008.
[375] Bok, 2008. At that stage the Cold War had not yet begun, '[and] it was still possible to hope for unprecedented global collaboration among governments of the world' (2008, pp. 590-91).
[376] See Bok, 2008, Daniels, 2008, Callahan, 1973, Schramme, 2007, Bircher, 2005.

well the job of clarifying what health is and that its wide scope and abstractness only serves to make the concept of health more difficult to grasp. In addition, controversies are only fuelled by the use of the abstract concept of wellbeing, especially when it is qualified as 'complete' and when the physical, mental and social aspects of it are to be taken into account.[377] How can such a comprehensive state of wellbeing ever be measured?

Cultural sensitivities also come into play: if definitions of wellbeing by and large vary among different cultures, which and whose definitions are to be applied to all?[378] As the preamble to its constitution seems to suggest, is the WHO conflating health with particular values such as happiness? In stating that health is 'basic to the happiness, harmonious relations and security of all peoples', it incorporates positive values that suggest the influence of classical accounts, in which health is important to human flourishing and constitutive of the good life. But are these accounts meaningful to all, or do they only represent a particular cultural heritage?

More severe than the criticism against its conceptual confusion is the assertion that this abstract and idealised definition of health makes progresses in the field of health promotion more difficult. Some critics challenge its applicability to concrete and everyday practices of measuring and comparing health data and healthcare policies. The WHO definition is thus accused of being counterproductive and of having a dispersive effect on efforts and resources directed to health promotion. This line of criticism already begins to reveal the central concern about such a broad definition. More than in the awareness of the practical impossibility of securing that every person is born healthy and stays healthy during her lifetime,[379] the main problem of this definition lies in the economic viability of such high standards and expectations. Johannes Bircher, for example, despite recognising the contribution given by the WHO definition of extending health to the mental and social dimensions, maintains that 'the unlimited idealistic aspect of the definition gives no help, when services for individual health needs have to be balanced against available resources'.[380] In justifying his call for a less demanding

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[377] See Bok, 2008.
[378] See Peter, 2001.
[379] See more on this line of criticism in O'Neill, 2002.
[380] Bircher,2005, p. 338.

definition[381] he insinuates that the WHO definition may be contributing to the escalating costs of healthcare in developed countries:

> Since the WHO-definition of health requires complete physical, mental and social well-being, in today's societies everybody is a patient and it is not surprising that the demands made on the health care system by the public are unlimited. This presumably is one of the reasons for the growing costs of health care in developed countries.[382]

From the regularity of this line of argument, it comes as no surprise that the WHO definition face even fiercer opposition when it is associated with the category of rights in the form of a right to health. Awarding such an already demanding definition of health the status of an entitlement, only adds to the controversy, fuelling the opposition coming from those who consider the WHO definition unrealistic and economically too demanding. [383]

Finally, the concern about the medicalisation of the social world also takes part in this debate. For many, the inclusion of the social domain in the definition of health carries with it the risk of incorporating under the domain of health-promotion policies the responsibility for addressing a whole gamut of problems of the social world.[384] The risk of medicalisation raises the concern that the WHO definition can contribute to legitimise oppressive social policies under the excuse of health promotion. Bok, for example, considers that:

> We need only look at totalitarian societies, or at any society in which members of one gender, religious orientation, political party, or ethnic background have lain down the rules for what is and is not social well-being, to see the risks involved – as in the Soviet mental health hospitals in which dissidents were imprisoned, classified as 'mentally ill'.[385]

Yet, Bok also concedes, despite her disagreement with the substance of the definition, that any fair analysis of the WHO definition of health must be located within

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[381] 'Health is a dynamic state of wellbeing characterized by a physical, mental and social potential, which satisfies the demands of a life commensurate with age, culture, and personal responsibility. If the potential is insufficient to satisfy these demands the state is disease' (2005, p. 336).
[382] Bircher, 2005, p. 340.
[383] See more on this line of criticism, especially as applied to the right to health, in Chapter 5.
[384] Bok, 2008, Daniels, 2008, Callahan, 1973.
[385] Bok, 2008, p. 593. She observes that even in democracies and well-run healthcare systems abuses in the name of health promotion can take place (2008, p. 596).

the historical context in which it was established.[386] At that historical moment, technical concerns of how to make health promotion policies more efficient were not the driving motivation behind the drafting of the organisation's constitution. Rather, it was the rejection of the moral disasters of war and poverty along with the acknowledgment of the richness of human needs and of the complex relationship between health and social conditions what received pride of place. Under the spirit of international cooperation that characterised the moment, delegates felt motivated to secure the moral and political commitment to the protection of people's health understood in its wide scope. In other words, the WHO definition can be seen as a historically situated political choice to prioritise a morally relevant definition over a bio-medically accurate one.

Critics of the definition, however, could still ask whether it is not the capacity of health policies to effectively improve people's health the ultimate measure of (moral) achievement of such organisations. In the name of such pragmatism and efficiency, many defend a 'down to earth' definition of health. The idea behind this move towards a technical definition is to eliminate moral-philosophical disputes in order to make assessments, health measurements and policy making more viable and more efficient. This strategy of by-passing normative disagreements, however, seems to rely on the assumption that problems generated by the lack of an objective or consensual definition of health are at the heart of failures in health promotion policies. It does not take a political realist or a Marxist, however, to challenge this assumption and consider whether such failures do not in fact result from society's political and economic arrangements. Nonetheless, in a world characterised by diversity and by conflicts, norm-free definitions and the language of efficiency will always have an appeal.

In sum, these disputes about the WHO definition of health illustrate the old dispute between the social and the technical model of health, also framed as a dispute between normativity and efficiency. Placing these disputes within Habermas's discourse theory, the next section analyses whether the choice between one or the other model of health, or between one or the other *telos*, is necessary and whether, in exploring the relationship between health and justice, this thesis should make this choice. To this end, Habermas's universal pragmatics frames the analysis.

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[386] Bok, 2008.

3 The appropriateness of different accounts of health

As seen in the sections above, there are a multitude of accounts of health and disease. At the institutional level, these differences give space for controversies such as the debate surrounding the WHO definition. The goal of this section is to analyse how discourse theory can contribute to this debate. This is accomplished by analysing the controversy involving the WHO definition of health using Habermas's universal pragmatics. This analysis concludes that different accounts of health can be valid,[387] depending on the appropriateness to the context of their particular validity claims. From this perspective, the WHO definition should be relieved from the burden of having to provide a golden standard definition of health able to be operationalised and to guide every WHO activity. Finally, this section concludes that for the purposes of analysing the relationship between health and justice, an intersubjective account of health is appropriate.

The Wittgensteinian concept of language-games[388] provides a useful starting point to the analysis of the WHO definition of health. The concept of language-games translates the idea that what matters in any assertion is less its truth or linguistic sense and more the appropriateness of using that assertion in a particular context. Therefore, different set of rules govern the use of language in different situations. As Andrew Edgar explains, 'the rules that govern the use of language in the expression of religious beliefs differ from those governing scientific experiments, or poetry or journalism'.[389] In other words, in each of these contexts, making a meaningful statement involves the use of rules that are appropriate and distinctive to the 'language-games' that operate within each of these areas. Here, the speaker's competency in using the language appropriately to the context is more important than the knowledge of the linguistic rules that govern forming a grammatically meaningful sentence. This is what differentiates 'language-games' theory from classical linguistics, and its important insight on the use of language is one of the influences of Habermas's universal pragmatics. Habermas's furthers the impact of this theory of competent communication by linking it to social generation.

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[387] Valid in the sense of deserving the rational recognition from those involved.
[388] See more on Wittgenstein's theory, especially as an influence on Habermas's work in Habermas, 2002, Chapter 3; 2000b; Edgar, 2005a, pp. 140-45.
[389] Edgar, 2005a, p. 141.

As seen in Chapter 2, according to Habermas, every utterance is also a social action (or speech-act) in which the speaker, hearer and 'bystander' establish a specific relationship with others and with the world. Different speech acts, such as advice, statements, questions, promises, requests, and commands, have distinct performative contents, conveying not only specific information but also creating distinct commitments to action among participants. Furthermore, these speech-acts are conveyed within the context of specific language-games. The speech-act of giving an advice, for example, follows different rules within the language-game of intimate personal relationships than in the language-game of professional consultations. In either case, however, in communicating participants raise three different validity claims, truth, rightness and truthfulness, each of which are more or less thematised according to the specific context.

The application of these theoretical considerations to the controversy about the WHO's constitutional definition of health suggests that the analysis of the chosen definition must include the appreciation of the language-games and nature of the speech-acts involved in this particular context. From this perspective, the agreement reached on the definition of health must be seen as guided by the language-games governing the context of political agreements of cooperation among nations as opposed to the language-games governing the establishment of technical or scientific definitions. In addition, the validity claims made by the delegates and the commitments to action they purported to establish must be seen primarily as claims to rightness generating normative commitments among the parties involved.

If accepted that the main claim to validity made by the WHO definition of health represents a claim to rightness as opposed to a claim to truth, it follows that its meaning makes a reference to a norm rather than a reference to a proposition of a fact. The validation of the claim made by the definition, therefore, is not mediated by deductive and constative assessments but by norm-conformative and regulative ones. The claim 'murder is wrong' can help illustrate this argument.[390] Here, the chief claim to validity is a claim to rightness. The claim does not imply that murder is wrong in the factual sense (as in, say, 'the victim died'). The statement that murder is wrong, thus, appeal to a

[390] Habermas, 1992a, pp. 57-62.

norm of action, which substance can be validated or challenged regardless of the specific way it was conveyed. From this perspective, stating that health is not only the absence of disease but a complete state of physical, mental and social wellbeing, should be understood not as a claim to a factual or objective truth that health is so, but as a roundabout way of expressing, for example, the commitment towards the improvement of people's health conditions by addressing the wider scope of factors that affect their health, including social and political institutions and the conflicts they generate.

Discussing the exact substance of the norm the WHO definition makes appeal to is, of course, an interpretative exercise that goes beyond the purpose of this thesis. Here it is sufficient to make the point that seeing the WHO definition of health as a norm-confirmative claim, regardless of the soundness of its *substance*, is more appropriate to the task of evaluating the organisation's constitutional definition. An implicit assumption is that the main role of constitutional documents is to manifest the normative principles (moral, political or legal) guiding its bearers. An account of health in a different context, say, within a scientific environment would demand a different interpretation. For example, in the context of a scientific debate about the clinical follow-up of patients who underwent a particular medical treatment, the definition of health employed for the purposes of this evaluation, could be appropriately interpreted as a claim to truth.

The same logic can be applied to the context of the everyday works carried by the WHO, in which technical definitions of health may often be more appropriate than broader accounts. For the purpose of defining health measurements that would guide the actions or monitor the effectiveness of given policies, for example, context specific definitions would be more appropriate. As the changing pattern of diseases from the infectious model to the disability model illustrates, different accounts of health and disease – and as a result also different types of measurements and policy end-goals – will be more appropriate to address specific realities. The impacts of most infectious diseases may be better evaluated by measurements of morbidity or mortality; however whenever chronic diseases are at issue, measures of wellbeing, disability, and functional capacities may be more appropriate.

This argument has two important implications. First, it relieves the WHO definition of an impossible task: setting a golden standard concept of health against which every healthcare practice, research enterprise, and policy making in the field can be evaluated. While I agree with the argument that the way health is conceptualised impacts on how societies respond to it, I do not see as realistic the expectation that the WHO should establish a universal understanding of health able to serve the purposes of operationalising all of its policies. On the contrary, the definition serves expectations of a different kind. Second, accepting that different activities being carried by the WHO (or by any other organisation working towards health promotion) demand different interpretations of what counts as health, points beyond confusions and focuses on the potential benefits of these differences. By operating with different, but rationally validated accounts of health, institutions are giving space to a critical mediation between different views, avoiding the one-sidedness associated with the modern radical differentiation of spheres of knowledge and thus preserving the stock of communicative resources of the lifeworld. As seen in Chapter 2, preserving the integrity of the lifeworld against the encroachment of system media passes by nurturing communicative practices and individuals' communicative competencies in dealing with complex conflict situations.

A sceptic or political realist can challenge this perspective on the basis that it is utopian and unrealistic. Within the 'language-game' of international politics, she could argue, normative statements should be taken with a pinch of salt, as they serve more to pay lip service to moral ideals and less to express a genuine (and practical) commitment to them, which from the perspective of discourse theory, would be an instance of the use of strategic action by the parties involved. Yet, even if this critique does represent more or less accurately the state of affairs in international law and politics at the time (and certainly still current), it does not challenge the viability of this communicative perspective on the debate. Rather, it gives it an occasion to clarify a few points.

First, and in reply to the realist challenge, it can be argued that regardless of having hidden agendas, the delegates to the WHO constitution chose to make an appeal to normative principles, such as peace, cooperation, happiness, wellbeing, and health as a right, in order to legitimise these hidden agendas. This suggests that these principles

are not empty symbolisms or that appeals to them are merely a formality. On the contrary, it supports the view that these principles possess public recognition. Therefore, despite the delegates' hidden agendas, these principles are always open to be called to be realised, even if in revised form, by active and communicatively steered public spheres.

Second, the proposed interpretation of the WHO definition of health as a claim to rightness does not amount to a defence of the substance of the claim. This interpretation, based on the idea of context-appropriate interpretations of validity claims, is a theoretical analysis which simply argues that if claims to validity demand different and context-appropriate interpretations of what they entail, then the WHO's constitutional definition of health should be interpreted as a regulative type of speech act that appeals to a norm-conformative understanding of health. This is a different analysis from the evaluation of whether the substance of the norm is coherent with any particular political theory or whether it has universal assent. In any case, the validation of the *substance* of the norm is subject to its rational justification in a debate with competing theories.

Third, in relation to the substance of the claim, as the appeal to classical accounts of health and substantial ideals of the good life demonstrates, the values underpinning the WHO definition of health may not find universal appeal. They may, for instance, resound better with some ethical-political theories than with others. Communitarians and virtue ethics theorists may find it more appealing than libertarians or post-modernists. From the perspective of discourse theory, the normative substance of the WHO's definition is also not without its problems. In contrast with the formality of discourse theory, the WHO definition emphasises substantive definitions of wellbeing. In doing so, it not only invites criticisms directed to the substantive definition of needs – always problematic in a plural and multicultural society – but it also fails to place an emphasis on whether the patterns of interaction between people and between people and social institutions, which affect health outcomes in varied ways,[391] are just. Despite these criticisms, the WHO definition has the advantage over more technical accounts of health, of not only associating health with values but also, and more fundamentally, of

[391] See an analysis of how social arrangements can affect health outcomes in Chapter 5.

making the political decision of bringing the social to the centre of the debate about people's health conditions.

What the discussion about the WHO definition of health hoped to accomplish was to illustrate that interpretations of what health entails in any given context requires the analysis of what language-games and speech-acts are involved and what kind of claims to validity are mainly thematised. As a result, accounts of health and their interpretations will vary according to changing circumstances. In the context of the WHO constitution, I support the view that it cannot provide a definitive and fully operational definition of health, and that its role instead is to provide a normative guidance of what health protection and promotion entail. Despite the disagreements with the substance of the norm that the definition makes appeal to, I defend that the WHO definition should stand as it is; as a witness of a period in history that represented the overcoming of a terrible conflict and that made the hope for global cooperation and renewal of moral commitments possible, even if this commitment was fragile and the period of optimism short lived.

Bok reaches a similar conclusion. Despite rejecting that the definition can serve any practical purposes, she commends its historical value. As she analyses, '[i]t can offer a much-needed reminder of the hopes present at the founding of the WHO for all that nations could do together to improve health around the world [...].'[392]Yet, this potentially positive historical role of the definition seems overshadowed by Bok's concerns about its attached risk of legitimating oppressive social practices disguised as health promotion. Despite being also a critic of the medicalisation of the social world, I feel less predisposed to accept this argument in defence of a narrower or more operational understanding of health. The fear of medicalisation should not curb our moral imagination. The appeal to normatively neutral definitions, in its various forms and different agendas, is not a 'strategy' likely to function. Neither the WHO definition of health nor the biomedical definition of health will alone be the guardian against abuses. The legitimacy of oppressive practices under the excuse of health promotion will not be judged solely by whether it is in line with the WHO definition. In democratic societies that abide by the rule of law, oppressive social practices, whether disguised as

[392] Bok, 2008, p. 596.

health promotion or any other 'public interest', will be judged against so many other important principles regulating our social and political lives together. This is when the ideas of justice and rights are especially resonant. Agreeing with Habermas, I believe that only a thriving and communicatively competent public sphere, guided by presuppositions of justice and solidarity, can provide the protection against institutional oppressive practices. The important role of health in sustaining such presuppositions is the core argument of this thesis and it is developed in the next two chapters.

4 Conclusion

This chapter began with the discussion of different accounts of health, focusing on the debate between biomedical and social accounts. It ends with the conclusion that health has no ultimate definition. As Edgar argues, health is 'an essentially contested concept'.[393] In his words,

> To claim that 'health' is essentially contested is to claim that debate over the definition of 'health' is possible and fruitful. Definitions are rationally defensible, and insofar as protagonists can put forward reasons to support their opinions, the truth, relevance and validity of these reasons can be scrutinised, accepted, revised or rejected.

Different interpretations of health can be debated and validated by participants depending on their rational justification, but also on the appropriateness of these interpretations to the context in which they are made. From the perspective of individuals, as seen above, health can have as many meanings as there are ethical orientations, and its meaning and validity is attached to the individual self-understanding alone. In contrast, in the context of an international organisation of cooperation among nations, and in a context in which issues of rights and universal interests are involved, any legitimate analysis of health has to account for its normative implications and the claims raised should therefore be primarily understood as claims to rightness. Furthermore, from a discourse theoretical perspective, the substance of the norms that the definition of health raises should reflect the evaluation of whether healthcare practices and the pattern of interactions among the social actors involved are just. In addition, taken as a whole, different perspectives can contribute to the ongoing debate

[393] Edgar, 1998, p. 197.

about health, and the mediation between their claims has a critical role in avoiding one-sided and domineering perspectives.

From these conclusions, it can be concluded that for the purpose of exploring how health, solidarity, and justice are related, a normative conceptualisation of health is called for. The next chapter argues that a normative conceptualisation of health necessarily entails an account of its intersubjective dimension. This intersubjectively understanding of health is then placed within Habermas's theory of society in order to explore its social roles and its relationship with justice.

Chapter 4

HEALTH, SOCIAL INTEGRATION AND SOLIDARITY

1 Introduction

A three-month-old girl was diagnosed with leukemia and a bone marrow transplant was recommended. Despite the availability of two excellent transplant facilities in the area she lived, her family's health-insurance company referred her to a transplantation centre located in another state. The baby's family protested, however with no success, against the company's decision, alleging that relocating to another state for the several months long treatment would severely disrupt family life, as it would be financially burdensome and it would deprive the baby and her mother from the support of their family and local friends. To keep his job, the father could not join his wife and daughter; the mother had to negotiate a pay cut; and the baby's older sister, who at the time was presenting behavioural problems, was separated from her parents and sent to live with relatives in another state. The treatment went well initially, and along the six-month's treatment, the family formed a bond with the transplantation centre. After a relapse, however, the baby was sent to further treatment in yet another out of state medical facility, as the transplantation centre in which the baby was initially treated was no longer the insurance company's centre of reference in the region. By the end of the treatment, the father had lost his job, the mother had to quit her job, the older sister had her behaviour problems aggravated, and the family lost their home and savings.[394]

This is a true story; it is a story of a family, living in the wealthiest country in the world, and profoundly affected by a severe disease and by their country's system of 'corporate care'. The physical suffering of the child was but one of the hardships endured by her and those close to her, as the experience also affected their family life emotionally, financially, and socially. The decision of the insurance company to send the child for treatment at facilities that made more financial sense for the company deprived this family of the support and comfort of each other and of their friends in a

[394] See Illingwoth, 2005; Weston and Lauria, 1996.

time of crisis. They were driven into financial insecurity. They were led to question their social worth, and to question the justice and soundness of a healthcare system committed foremost to optimising shareholders' profits.

This story introduces this chapter because it translates well the idea that health is a relational concept. Health and its related phenomena – such as illness and healthcare – involve the interaction between the ill, their family and friends, carers (professional and informal), and social institutions. Experiences of illness and healthcare, therefore, are essentially intersubjective; what people feel and how people feel in the face of illness – their own or of others, however close or strange these others are – and how we respond to these experiences are intersubjectively mediated social actions. If in the last chapter it was concluded that health has no ultimate definition, but a number of meanings that can be rationally articulated and defended, this chapter concludes that health, as a sub-system the lifeworld, has an inevitable intersubjective core, capable of shaping selves and patterns of social interactions. In addition, by describing the experience of illness and healthcare from the perspective of participants, this story supports the argument that in the face of illness individuals become even more vulnerable to and dependent on the net of interpersonal interactions that form and sustain their inner and their social world.

This search for an intersubjective understanding of health builds from last chapter's conclusion that the analysis of the relationship between health and justice requires a conceptualisation of health that accounts for its normative dimension, i.e. the patterns of interactions between social actors. These patterns of interactions associated with health related phenomena can be analysed from the different perspectives of social observer and of the participant. In this chapter both perspectives are adopted. The participant perspective guides the first part of the chapter, in which individuals' experiences of illness and healthcare and their moral connotations are explored. The social observer perspective is adopted in the second part of this chapter, which places health in Habermas's dual model of society. Health, as concluded in the last chapter, is a broad concept that encompasses a variety of perspectives on the subject, from scientific to social models, the validity of which is attached to their rational recognition and appropriateness to the context. This chapter further develops this insight and proposes a model of interpretation of health that makes room for the analysis of these different

perspectives and their respective social locus and social role. That is achieved by conceiving health as a specialised sub-system of the lifeworld that affects the lifeworld's reproduction and at three different levels: cultural reproduction, social integration, and socialisation. At each of these levels, analyses of matters involving health related phenomena involve different forms of knowledge, different moments of reason, and different communicative functions and social contributions. The contribution of health towards social integration by nurturing solidarity and relationships of mutual recognition informs next chapter's analysis of the relationship between health and justice.

2 The intersubjectivity of health

2.1 The importance of the perspective of the participant – some anthropological insights

In search for an intersubjective account of health, an interesting starting point is the analysis of how the differences between the technically/scientific and the socially/normatively oriented approaches to health are represented in the medical anthropology of Arthur Kleinman and Robert Hahn.[395] In their works, the framework of the debate is very similar – the efficiency, objectivity, and supposed value-free nature of what is technical and scientific being at odds with the complexity, subjectivity, and assumed value-laden nature of what is social, cultural, and political. The difference lies in the level at which the debate is carried. In contrast with the social observer perspective of both the scientific and social models of health discussed in the last chapter, Kleinman's and Hahn's anthropological methodology looks at the micro-level perspective of interactions between patients, families, and healthcare professionals, placing a special emphasis on how cultural meanings shape these interactions. The antagonism between the scientific and social accounts is represented by the antagonism between biomedicine on the one hand and individual's experiences of health, illness, and healing on the other.

Both Hahn and Kleinman share a critical view of the biomedical notion of health, illness, and healing. By understanding health as the absence of pathologies or of

[395] See Hahn, 1995 and Kleinman,1981; 1995.

dysfunctions in the body, biomedicine also tends to see healing as the correction of these disturbances, and as a result, the role played by socio-cultural factors, if at all considered, are of secondary relevance.[396] Alternatively to the biomedical model of health, 'which marks its progress in terms of smaller and smaller units of observation',[397] Hahn proposes 'a *complementary* move in the opposite direction to include the mind, human relations and society, and the broader environment.'[398] His objective is to expand the dominant model of health, allowing for the inclusion of other interpretations. In proposing a complementary move he also signals that in this expanded interpretation, biomedical accounts are also part of it; one perspective among many. Although he acknowledges the contribution of the biomedical model to the improvements of health conditions worldwide, he does not assume that biomedicine holds the ultimate truth.[399] His criticism of biomedicine is primarily directed to its technicism, which excludes the perspective of the patient, and in doing so, it loses not only a critical tool but also the capacity to carry out its activities in a meaningful way to patients.[400]

In contrast with the biomedical account of health and disease, for Hahn, it is the perception and experience of the patient what counts. As he argues

> What counts as sickness and health may differ for a four-minute miler, a lower limb amputee, an opera singer, and most the rest of us. What *causes* the sickness may be environmental conditions or pathogens, the patient's physiology, or harmful behaviours. What *defines* the event for which we seek a cause, however, may be not the patient's body, behaviours, or potentially harmful environmental occurrences – its possible causes – but rather his or her subjective experience and values.[401]

Kleinman is also critical of the 'ethnocentrism and reductionism of biomedicine' and its disregard for the patient's perspective.[402] In addition, he criticises biomedicine for its recurrent collusion with oppressive social practices. In his analyses, he aims at revealing 'how clinicians rework patient's perspective into diseases diagnosis and

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[396] Hahn, 1995, p. 95.
[397] Hahn, 1995, p. 39.
[398] Hahn, 1995, p. 39, emphasis added.
[399] Hahn, 1995, p. 27.
[400] Hahn, 1995.
[401] Hahn, 1995, p. 5, author's emphasis.
[402] Kleinman, 1995, p. 9.

treatments that reproduce the health profession and its political-economic sources,'[403] distorting in so doing the moral world of the patient and of the community.[404] Similarly to Hahn, he uses cultural analysis as a source of critique of social and political practices. Concepts of health, illness, and suffering are seen as forms of cultural experiences, and more importantly, Kleinman casts them as relationships between person and society. In having deep political and moral connotations, Kleinman construes suffering as critique; a critique to which biomedicine is blind. In codifying the experience of illness and suffering as narrated by the patient and her family into the internal language of biomedicine, the biomedical practitioner is denying and discounting the moral reality of suffering and the social critique it conveys.[405] The link between illness and suffering and the social-political context is thus lost. Depression, for example, is interpreted by Kleinman as an expression of interpersonal stress; 'rooted as much in social and political processes than in clinical ones'.[406] Having studied depression and its cultural expressions both in the US and in China he concludes, '[d]epression, too, I recast as a relationship between person and society.'[407]

Both Hahn and Kleinman use cultural analysis to criticise biomedicine and the social-political reality. Hahn, for example, criticises the focus on the individuated person of biomedicine by juxtaposing Western with non-Western cultures in which persons are conceived as 'inextricably linked with other beings, human and non-human.'[408] As he observes, 'whereas disturbances in the capacity for *independence* may be thought of as pathological in the West, disturbances in the capacity for *interdependence* may be regarded as pathological elsewhere.'[409] Cultural analysis, therefore, allows him to turn a critical look at Western culture and biomedicine. In addition, in interpreting health, illness, and healing as culture-bound concepts, Hahn is sceptical towards universal systems for understanding and categorising diseases.[410] Yet, this cultural analysis does not lead him into cultural relativism. On the contrary, in performing cross-cultural

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[403] Kleinman, 1995, p. 95.`
[404] Kleinman, 1995, pp. 95-6.
[405] Kleinman, 1995, p. 32.
[406] Kleinman, 1995, p. 11.
[407] Kleinman, 1995, p. 11.
[408] Hahn, 1995, p. 5.
[409] Hahn, 1995, p. 5, author's emphasis.
[410] Hahn, 1995, p. 32.

analyses, he argues, anthropologists 'seek a wider audience for the voice of others;'[411] and '[b]y representing a broader range of human variation, [*anthropologists*] may expand Western ideas about humanity.'[412] His goal is, therefore, to promote mutual respect and communication across boundaries.[413]

Kleinman too is sensitive to the contextual mediation of meaning and experiences while not subscribing to moral or cultural relativism. Just as he criticises biomedicine's 'purely biological metaphor for pain,'[414] he also criticises a purely cultural account, i.e. a description of cultural differences that is not also engaged in critically exploring the personal and interpersonal meanings of illness and suffering and their relationship with the social and political context. As he argues, 'if there is no purely 'natural' course of disease, there also can be no purely 'cultural' symptomatology.'[415] His goal instead is to broaden the analysis[416] so as to reveal the moral and intersubjective resonances of suffering.

Exploring the intersubjective experience of illness and suffering is at heart of Kleinman's work, and the normative implications of this approach are of great interest to this thesis. Kleinman's privileging of the intersubjective perspective and his interpretation of the relationship between the social, the psychobiological, and the personal levels and its moral implications bears similarities with Habermas's conceptualisation of the intersubjective constitution of self and society and its connection with the lifeworld. In Kleinman's words:

> 'experience (…) is only in part subjective. A developing child in her or his cultural context is part of an ongoing flow of intersubjective feelings and meanings; in a sense, the child awakens cognitively and affectively within that flow. How to orient him – or herself, what to orient to, the child's sense of what is most relevant result from the development of moral sensibility to this social space. Ethnic as well as personal identity emerge in this process of entering into and finding a structured space within the flow of experience. Social status, gender, and the micropolitical ecology will inflect those identifications, as will personal temperament. We will become ourselves as well as participants at home in the world. And this plurality of influence is

[411] Hahn, 1995, p. 2.
[412] Hahn, 1995, p. 2.
[413] Hahn, 1995, p. 2.
[414] Kleinman, 1995, p. 101.
[415] Kleinman, 1995, p. 101.
[416] Kleinman, 1995, p. 54.

> the basis of the novelty an indeterminacy of experience. But learning to live within and through the vital medium that emerges when symbolic forms interact with psychobiology places our lives squarely in the flow of things, bound to others and to the moral meanings that define a world of exigency and expediency.' [417]

As these anthropological insights demonstrate, the importance of exploring an account of health from the perspective of patients and their families or carers – i.e. the perspective of the participant – is that it contributes to reveal the inevitable intersubjective character of health and its moral and social-political connotations. In revealing that, it allows a broader understanding of the roles health plays in society, and as a result, it also allows a broader understanding of the relationship between health and justice. The next section explores the perspective of the participant by analysing individual's experiences of illness and healthcare and how cultural and social arrangements affect these experiences.

2.2 The perspective of the participant – the experience of illness

In a 2003 review of researches about the experience of illness in the field of medical sociology, Janine Pierret notes an increasing interest on the subject as well as a progressive shift on its focus.[418] Pierret identifies that since the 1970s pioneering studies on the experiences of chronic illness, there has been a move from a focus on the subjective experience of the individual to a focus on the interactional aspects of these experiences, and more recently, also an increasing interest in exploring how social structures affect these experiences. Studies are increasingly taking into account, for example, how socio-cultural variables such as age, gender, class, ethnic group, and social context shape the illness experience.

Characteristically, studies on the experience of illness cut cross the boundaries of disciplines, benefiting from contributions from the social sciences, anthropology, psychology, and public health among others. Sharing an 'insider's orientation' towards their subject, these studies focus mostly on chronic and terminal illness, such as epilepsy, Alzheimer's, heart disease, cancer, and HIV/AIDS, and reveal how these

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[417] Kleinman, 1995, p. 124.
[418] Pierret, 2003.

conditions disrupt patient's lives, demanding from them mobilisation of resources, the renegotiation of their relationships, and the construction of a new biography. Common themes that surge in the analysis of the subjectivity of illness experience are the search for meaning and causes of the disease (why me now?), the impacts of the condition on the self and on identity (including the concept of 'loss of self', stigma, and shame), the withdrawal from the public domain, loss of social status, discredit ('Are you sure you can do it?', 'Are you sure you cannot work?'), and the loss of private bodily boundaries. Apart from illness and pain, the experience of a frustrating medical care can also contribute to the complete transformation of the subject's world of experience and self-perception.[419]

Individuals that have a chronic or life-threatening disease can suffer because of their condition either directly – as a result of the pain or of feeling unwell – or indirectly because of actual or fear of limitations that the condition may impose on their lives, such as physical impairment, dependency on the care of others, social isolation, and financial hardship.[420] A chronic condition can severely disrupt the routine of patients and of those close to them, as it changes their taken-for-granted assumptions and behaviours, requiring adjustments and new behaviours.[421] It threatens their everyday activities and life plans, and the feelings of uncertainty regarding the future can bring anxiety to them. In addition, for the often necessary changes that allow the patient to maintain her normal activities and receive appropriate care, the patient relies on others – family, friends, carers, and co-workers.[422]

These adjustments may involve acquiring the understanding of what the disease entails in terms of symptoms, consequences, and treatments. It may also involve reconstructing one's life history and plans, realigning their past with the present and dealing with the uncertainty of the future.[423] It may also involve dealing with an altered sense of self and taking the challenge of reconstructing a new one.[424] In many different ways a disease can affect the individual's sense of self. It may result from visible

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[419] Pierret, 2003; Charmaz, 1983; Blaxter, 2004, Chapter 3.
[420] Hahn, 1995, pp. 5 and 29; Pierret, 2003, Charmaz, 1983.
[421] Pierret, 2003, p. 7.
[422] Pierret, 2003.
[423] Pierret, 2003; Frank, 1995.
[424] Pierret, 2003.

changes in the physical appearance (e.g. tumours, skin conditions) or bodily functions (e.g. incontinence, use of illeostomy), which threatens the privacy of the body. It may involve the stigma and shame attached to certain conditions, such as epilepsy or Parkinson's, which may lead to a withdrawal from public life and social isolation.

Stigma and fear of social discrimination are often also extended to family and carers (e.g. autism, mental conditions).[425] In fact, chronic diseases affect family members in varied other ways, usually involving a rearrangement in their daily activities and their roles in the family. Apart from providing help with the direct care of the chronically ill, family members become an essential source of emotional and financial support. Within them, women are most often the first care-givers. In a study describing the experience of families in the East End of London, in which a member was terminally ill, Michael Young and Lesley Cullen describe:

> Terrible as it was for their wives when their husbands became ill with cancer, at least they did not have to change their role of carer, housekeeper, cook, companion. They did not know in advance how to do the more demanding nursing they now had to do – this had to be learned the hard way, by doing it and failing and taking advice and doing it again; but they did know how to look after a home and make a dying husband not only comfortable but feel as much respected, as loved, as he had ever been. If anyone in East London could choose the setting in which to endure a long-drawn-out illness without too much misery, and with some compensation for the inevitable setback, he would be a man and at home.[426]

Having always assumed the caring role in the family, when they see themselves in the receiving end of care, women resent not being able to care for others and struggle in renegotiating their new role in the household.[427]

The way women respond to chronic and terminal illness, both in the role of carers and patients, illustrates that the experience of illness, whether lived by the patient or by the carer, is closely tied to cultural meanings and role expectations. The role of cultural values and attitudes in shaping illnesses experiences is the subject of the next section.

2.2.1 The experience of illness and cultural meanings

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[425] Pierret, 2003.
[426] Young and Cullen, 2001, p. 337.
[427] Pierret, 2003. Tong, 2001, Young and Cullen, 2001.

As Hahn points out, the experience of illness is influenced by a combination of conscious and unconscious meanings attached to it, which result from memories of experiences of illness in oneself and others and from the incorporation of established social meanings.[428] The sense of deligitimation that many patients feel, for example, can be a reflection of a society oriented towards ideas of success, independence, strength, and winning. As Kleinman observes in relation to American society, 'not to rise is a threat to social persona and social esteem; it is often experienced by members of the American middle class as a shameful moral weakness.'[429] This type of social orientation is associated with a social tendency to see the ill as unproductive and resource demanding, and as a result, the individual self-worth is affected in the face of chronic illness and increased dependency because she feels as a burden on others. Other social meanings attached to diseases that can contribute to the chronically ill's feelings of delegitimation are the ancient and universal tendency to see the patient as responsible for her own fortune and at moral fault, and the idea that disease and suffering are opportunities to demonstrate the strength of the patient's character.[430]

The association between disease and weakness or socially unacceptable behaviour is more evidently observed in the history of many sexually transmitted diseases, including syphilis, AIDS, and more recently cervical cancer.[431] In *Illness as a Metaphor*, Sontag describes how a number of diseases have been associated with punishment in the social imaginary. In literary metaphors, for example, tuberculosis often 'provided a redemptive death for the fallen'.[432] More current examples of the tendency to associate disease with punishment are the association between smoking and lung cancer and alcoholism and liver disease. In addition, in a long history of punitive interpretations of diseases, cancer has endured a multitude of myths, including psychological theories, still current in various forms, that associate cancer with the renunciation of instincts and with repression of feelings such as loss and bereavement, depression, rage, dissatisfaction with personal relationships. These accounts, criticises

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[428] Hahn, 1995, p. 29.
[429] Kleinman, 1995, p. 132.
[430] See Sontag, 1991a' Blaxter, 2004, p. 62.
[431] Sontag, 1991b.
[432] Sontag, 1991a, p. 42.

Sontag, have the negative effect of placing the responsibility on the sufferer not only for getting ill, but also for getting better.[433]

The tendency to expect patients to react bravely and to 'fight' the disease is a common element of the association between diseases and moral character and integrity.[434] As Edgar points out, Western culture feels uncomfortable with the concept of failure, and therefore, tends to encourage stories of survival and 'good fights'.[435]This pervasive military metaphor of 'fighting the disease', is for Sontag an illustration of how culture affects the way society approaches diseases and how it can place further burdens on the ill. She describes how the military metaphor, used in a varied of medical contexts, begun with the identification of bacteria as agents of disease, which 'invade' the organism and trigger the activation of the body's own 'defences'. This metaphor of 'invasion' is still routinely used to address cancer, which 'infiltrates' the body and 'colonises' other sites (the metastases), thus justifying 'aggressive' treatments (such as radio and chemotherapy) to 'win the battle against the disease'.[436] Alongside medicine, patients too are expected to rise to the challenge and bravely fight against cancer.

Sontag's main concern with diseases as metaphors is that although not all of them are morally reprehensible, they are cultural constructions that create stigmas and place undesirable burdens on the ill.[437] As she observes, 'cure is thought to depend principally on the patient's already sorely tested or enfeebled capacity for self-love'.[438] In addition, these views can also be dangerous insofar as they can compromise individuals' ability to understand and chose available courses of treatment.[439] Edgar expresses a similar concern in relation to the cultural emphasis on stories of success and of courage. He argues that although these stories can be important, 'this positive image

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[433] Sontag, 1991a.
[434] Sontag, 1991a; 1991b; Blaxter, 2004, p. 62.
[435] Edgar, 2005b, p. 170.
[436] Sontag, 1991a, pp. 67, 95.
[437] Sontag, 1991a; 1991b. Sontag is particularly eager to eradicate the use of military metaphor in the context of illness but also beyond (1991a, p. 96; 1991b, p. 179). See also in these two works how she establishes the link between the military metaphor and capitalism and consumerism, and her critique of the use of cancer to describe corrupt and unjust social orders, such as descriptions of Stalinism and Nazi-German cancers growing within society. She states that 'the people who have the real disease are also hardly helped by hearing their disease's name constantly being dropped as the epitome of evil (1991a, p. 85).'
[438] Sontag, 1991a. p. 48.
[439] Sontag, 1991a, p. 48.

becomes as oppressive as the old stereotype.'[440] Hopelessness can be oppressive too, but images of success and unfailing resilience can place new burdens on those feeling less able to adjust to their condition.[441] He proposes that the collective story-telling of chronic illnesses reflect also the uncertainties and anxieties of what these conditions entail, including the acknowledgement of the possible 'meaninglessness of suffering', so as to broaden the resources available to patients *and* the community to understand and respond better to these conditions. As he remarks,

> Public story-telling appropriate to chronic illness, and thus stories that can find a way to articulate contingency and a disrupted future without the illusions of sentimentality or false hope, may be necessary in order to allow chronic illness to be recognised within the community as a whole. The struggle to understand illness, and to live well despite it, may thereby be understood as a communal task.[442]

From the perspective of the sufferer, the importance of broadening cultural and communicative resources about chronic diseases is that she relies on these resources to rebuild a sense of self as the next section demonstrates. The important insight that expanding these resources is a communal task is also emphasised as the intersubjective character of health and the role it plays in society are discussed.

2.2.2 The experience of illness and changes in self identity

Many studies about the illness experience cluster around the concept of 'loss of self'. In a classical study produced by Kathy Charmaz, she describes how patients experience the progressive disintegration of their former self-image 'without a simultaneous development of equally valued ones.'[443] As these patients lose control of their lives, loss of self-esteem and self-identity ensue. Major causes of the loss of self are the restricted life individual's experience, the social isolation, the experiencing of discredit, and becoming a burden to others.[444] As a patient covered by Charmaz who depended on dyalitic treatment describes:

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[440] Edgar, 2005b, p. 170.
[441] Edgar, 2005b, p. 170.
[442] Edgar, 2005b, p. 171.
[443] Charmaz, 1983, p. 168.
[444] Charmaz, 1983.

> This [the dialysis machine] is an ego destroyer. You come, and you're depending on a machine to keep you going, and if you don't, then you don't go. I mean that's all there is to it … I know that sometimes I feel less than human, having to go through the process. And I would like to take a vacation from it for 2, 3 or 4 weeks and not have to come for that length of time (...) but I can't do that. Travelling is very hard, getting away and just normal things that people do. And so it makes me think from time to time that I'm less than human, and again I work my way out of that, but it is a constant struggle to [do so].[445]

The impacts on the self resulting from these restrictions and dependency on others are felt even more severely in societies that value individualism, independency, individual hard work, and merit.[446]

Yet, the experience of chronic illness does not always lead to permanent loss of self; in the process of adjusting to their condition, patients may also find new meanings to their lives. This search for new meanings also includes understanding the causes and meanings of their condition. According to Blaxter, most chronically ill try to fit their condition within their understanding of the world and try to accommodate it in their identity and life history. In the process of searching for meanings biomedicine offers them only limited help, because although it can elaborate on medical causes, it cannot provide a *meaning* for the disease, it cannot answer the question of 'why me?'.[447] As Kleinman remarks, '[h]ere the technical rationality cannot contain the participatory reasoning of the patient who seeks to understand not how, but why, not causal mechanisms but ultimate meaning, not reason for treatment failure but chance for salvation.'[448] This gap is filled by the patients themselves, and they do so with the help of their personal, interpersonal, and cultural resources.

The beliefs that individuals form about their conditions, the (moral) meanings they attach to it, are important as they shape the way individuals respond to their condition, from the way they relate with themselves and others to the way they interpret, validate, and accept medical treatment. In the same way, understanding and validating these meanings are fundamental to professionals and carers in their relationship with the patient. Kleinman describes a story of a patient of his, whose wife and daughter

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[445] Cited in Charmaz, 1983, p.173.
[446] Charmaz, 1983.
[447] See Kleinman, 1995; Blaxter, 2004, pp. 66-70; Frank, 1995.
[448] Kleinman, 1995, p. 133

convinced him to look for medical help.[449] The patient was a decorated war veteran who could not come to terms with his experiences in the war, in which as he described 'he was made over into a killer'. The incongruence between the atrocities he had committed and his moral beliefs and ethical self-understanding destroyed his own sense of moral integrity; it destroyed his humanity. According to Kleinman, since the patient's remorse was 'accompanied by almost all the cardinal symptoms of depression,' an appropriate treatment was initiated, to which the patient complied and clinically responded well. Yet, the treatment did not change his regret about his past, which the patient identified as being his real problem:

> I can put it away again. I don't feel the same pressure. I can sleep, and eat, and fornicate again. But you know as well as I do that what's bothering me can't be treated or cured. Job said: 'I will maintain my integrity. I will hold on to my righteousness.' I did neither. I soiled myself as I was soiled. I lost my humanity as those around me did the same. You don't have any answers. Nor do I. Save to live with it. To realize I did the worst is to understand how ordinary men do bad things. How ordinary Americans were so anti-Semitic at that time. How ordinary Germans did what they did during the Holocaust. How all of us are capable of murder. In the midst of war when all hell breaks loose and you are empowered to act with impunity, you can do horror and be decorated for it.[450]

The possibility of having the treatment change the way he felt about his past amounted to joining society's hypocrisy and moral failure in its denial of what war does: it transforms ordinary men into killers. Accepting that he could not change his past and that he had to live with it and with its consequences was the moral choice he made. He complied with the treatment for the symptoms of depression, but he refused to change *the moral meaning* of his disease. In analysing his patient's story, Kleinman wonders whether the patient wanted him to acknowledge the same: that his suffering 'was not disease but tragedy.'[451] To his suffering, there was no healing.

Apart from searching for causes, establishing biographical continuities, and finding moral meanings for their experiences, patients adjusting to chronic illnesses also have the task of reworking their lost selves. Arthur Frank famously compared the

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[449] Kleinman, 2006, pp. 27-45.
[450] Kleinman, 2006, p. 35.
[451] Kleinman, 2006, p. 44.

experience of chronic illness with the loss of the 'destination and map' that guided the individual's life plans,[452] and as a result individuals who experience chronic illness have to repair this discontinuity by creating a new self. In dealing with their chronic or severe illnesses, for example, individuals may refocus on the people and on things that matter most to them. In this process they may rediscover relationships, face unsolved issues in these relationships, establish new ones, challenge past attitudes and commit to new ones, and give a meaning to the rest of the life they have. This is not an easy accomplishment, and according to Kleinman, despair, isolation, and withdrawal are more common consequences of severe chronic illnesses than fully positive transformations. He observes that most commonly individuals oscillate between hope, denial, courage, giving up, rage, and submission.[453] Kleinman argues that there is a fine line between hope and despair; yet, he maintains that the experience of chronic illness *have the potential* for remaking individual's lives in a meaningful way.

He illustrates this point by describing the story of a patient, who years after recovering from a severe drug addiction, was diagnosed with HIV.[454] Despite her initial shock and feelings of shame and all the 'big ups and downs' that accompany the experience of a chronic illness, she managed to reconstruct her broken relationship with her sons, daughter, and husband. Since the diagnosis she also became more aware of the sheer volume of human misery around her, and she became actively involved in activism on behalf of AIDS and drug abuse programmes. In her analysis,

> [...] AIDS has been devastating, no question: a reality check of the most basic kind [...] Yet it's also been about something else. In some inexplicable but transporting way, AIDS has taken me to a different place: a place of truth, deep truth, and kindness – love, really.[455]

In reconstructing her lost self, she both looked intently inwardly and outwardly to discover the things that were most meaningful to her. Mending relationships and fighting human misery became a source of meaning to her life. In analysing and finding meaning to her condition she evaluated that beyond a character flaw her former selfishness reflected the typical hyper-individualism, narcissism, and blindness to unjust

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[452] Frank, 1995.
[453] Kleinman, 2006.
[454] Kleinman, 2006, pp. 141-61.
[455] Kleinman, 2006, p. 154.

human conditions of her socio-cultural context. In interpreting this story, Kleinman concludes that illnesses can provoke the overcoming of self-centredness and of the denial of human misery everywhere. The experience of chronic and severe illnesses may generate a moment of recognition that for anyone 'there can be no secure domain, safe from the dangers that beset most people.'[456] This recognition of human vulnerability and the recognition that anyone is subject to catastrophic life-changing, point out to next's section discussion of an important and universal feature of experiences of illness and healthcare; namely, their intersubjectivity.

2.3 The intersubjectivity of experiences of illness and of healthcare

As observed above, the meanings that are attached to illnesses and to suffering are to a large extent mediated by culture. Yet, there is at the core of these experiences an element of universality: their intersubjective character. As Kleinman claims,

> The cultural meanings of suffering (e.g., as punishment or salvation) may be elaborated in different ways for current-day Sri Lankan Buddhists or medieval Christian, but the intersubjective experience of suffering, we contend, is itself a defining characteristic of human conditions in all societies.[457]

In the inevitable intersubjectivity of the experiences of illness and healthcare, no one can avoid the shifting roles of first, second, and third person. Not only do the ill get to recognise the universal vulnerability of the individual constitution, but also potentially all those around them. The way Kleinman's client responded to her illness, for example, touched many around her: friends, family, colleagues, and even those who have only heard about her story. Her illness experience, in different ways and in different degrees, affected them all; it not only transformed her former egocentric self, but contributed to shape the self of others too.

The intersubjectivity of illnesses experiences calls into attention that chronic illnesses and the prospect of death, apart from the ill, can affect and transform others too. In the different roles that individuals assume when interacting with the chronic ill, the experience of illness will have some impact, even if a glimpse of reflection. For

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[456] Kleinman, 2006, p. 157.
[457] Kleinman, 1997, p. 101.

those close to the ill, the impacts can be deep and long-lasting, and as Kleinman remarks, '[e]ven death is followed by bereavement and the further and influential trajectory of the remembered past.'[458] Even individuals who are not intimate with the ill may feel compelled to partake in the experience by acting on their feelings of responsibility towards those who are frail and ill. Young and Cullen, for example, describe in a study about dying and caring at home how terminally-ill patients living on their own and who had no children or contact with relatives still alive, usually got help from women neighbours until the very end. In analysing the significance of responses from neighbours and comparing them to responses from family, they conclude:

> What we did not expect – and this is perhaps the most striking conclusion – was that the imminence of death could bring out the same kind of solidarity amongst neighbours. Their actions belong more to altruism than duty. Such unselfishness is a continuation of what used to be ordinary neighbourliness in this district. But as well as that, death is not only an extraordinary event for the dying but brings out extraordinary behaviour in other people. The close intimacy between carer and cared for generates its own feelings which both take the place of, and reinforce, obligation. There can also be something very special and love-inspiring about the imminence of death. Death can bring out life-giving qualities.[459]

These feelings of responsibility towards the ill and vulnerable and the orientation towards acting on them can also be motivating factors in the choice of one's profession. In a study about the nursing profession working in a general medical ward at a hospital in the Midlands, David Field demonstrated the high level of emotional involvement with the ill, which involved grieving after their deaths and in some cases keeping in touch with the families of patients who had died or with terminally ill patients who had been discharged to be taken care of at home.[460] He observes that there is a certain predisposition to care in those who join healthcare professions; yet, a 'detached concern' may be encouraged by their training and in the course of their professional lives. In the occasions, however, in which the type of working arrangements facilitated greater emotional connection and the care for the 'whole person', Field analyses that it came as mutually beneficial to patients and carers, who felt validated in their role and personal

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[458] Kleinman, 1995, p. 100.
[459] Young and Cullen, 2001, p. 339.
[460] Field, 2001.

ethical predisposition. This is illustrated in the words of a nurse who cared for a patient who had no relatives or friends:

> We had a patient who was there over a year – and we were all very close to 'C'. I saw him from when he came in, to getting really better, then going down again. It was awful because there was nothing I could do; I just had to sit and hold his hand. At that time we were all taking it in turns to sit with him as long as we could cos' we just didn't want him to die on his own. Nobody wanted just to go in and find him dead. [...] So I sat with him and held his hand. And I remember the staff nurse coming in and asking me if I had nothing better to do. So I said 'No. Not at this moment, no.' So she said 'would you mind going and finding something to do?' I remember it so clearly. I really hated her, because this man was dying. I'd been with him all this time and why should he die alone? All she was content with was giving him BPO's, and he still had an enema the day he did die. Well he died that afternoon. I felt awful – this poor little man – and just as I went behind the curtains he just said - he grabbed hold of my arms (he got very little movement in that hand), and he just put his hand on mine and whispered 'I love you'. And then he died in the afternoon. I thought 'well it's all worthwhile' because at least he realized that somebody cared.[461]

By acting according to her ethical orientation, and rejecting the staff nurse's privileging of efficiency over a good death this nurse felt that she reaffirmed humanity both in the patient and herself. From this perspective, both the illness and its ultimate outcome were intersubjective experiences. For the nurse and the patient, but also for 'third' persons who witnessed or heard about this recount, this experience was filled with meaning. Other important features of the intersubjectivity of the illness experience that this story illustrates are the relationships of care giving involved in them.

These relationships of care giving in contexts of health and illness are not limited to healthcare professionals or formal carers. Broadly conceived, everyone is a carer; everyone is cared for. During the course of their lives everyone experiences different and shifting relations of healthcare with others. As newborns, and from there for many years, people depend entirely on the general care of others. When they become adults and already see themselves as autonomous beings, they once more depend on the care of others during either occasional or chronic illnesses. Frailty of age, too, makes people reliant on the care from others. Age, biological constitution, lifestyle, social-economic

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[461] Field, 2001, p. 345.

context, and even chance are factors which determine how much people will be dependent on healthcare and other forms of support from others. Particular combinations of these factors also determine that some people will become more dependent on healthcare than others.

It is not only the ill who have access to the meaning of healthcare. Although the ill may come to develop a deeper experiential understanding of what illness and healthcare entail, everyone else has access to their meanings too. Again, meanings are intersubjectively constituted by first, second, and third persons. Even when individuals are not in the receiving end of care-giving, they may participate in different ways in the net of healthcare. Individuals can be caring for others, either directly as care givers or indirectly by contributing to make the process of care-giving easier or possible. Relieving the first care giver of some of his chores is one example of contribution to this end. We need to think of a father whose boss allows him to leave work to care for his daughter who has a fever, or a neighbour who volunteers to help with the house keeping so that a husband can look after his wife. Supporting a healthcare system through the payment of taxes or by taking part in cooperative insurance schemes are further examples of contributions that make healthcare possible.

People also participate in healthcare experiences in the role of witnesses. Children that grow in households in which one of its members has a chronic condition and need special care from others, for instance, are experiencing healthcare by witnessing how adults shape and negotiate their interaction under these circumstances and how social arrangements contribute to make their experiences of illness and healthcare easier or harder. They are witnessing first hand, and also internalising, a representation of how society responds to human vulnerability and dependence. The same applies at the broader social level: irrespective of their feelings about it, people cannot help witnessing the impacts of illnesses on others and how society responds to them.

In addition, experiences of illness and healthcare inevitably involve different forms of responses from others. Even healthy adults will every so often experience an acute, even if mild, illness which will elicit a response from others. These responses may be as simple and positive as the expression of empathy or the exchange of

'concoctions' that help alleviate symptoms. Yet, they are not always positive. They can also be as demeaning as a patronizing attitude or as hurtful as an expression of repulse. Therefore, while some people may feel respected and cared for, others may experience isolation, neglect, lack of sympathy, and be denied care. The experience of the family that introduced this chapter is an illustration of how certain responses can be also devastatingly negative.

In sum, in this net of interactions that shape and give meaning to illness experiences and to healthcare, everyone is a participant playing different and shifting roles. In the context of health, illness, and healthcare, people always interact with each other: people chose whether to take responsibility for others; people may share the other's pain; people may share the joy of improvements, even if they are only small; people may grieve; people may withdraw; people may question the fairness of social arrangements; people may stand for others; and people may even chose not to care. Whichever way people respond, these responses are meaningful social actions, and they are filled with moral connotations.

It is in the context of their everyday lives that people face 'resistances', or critical junctures, which precipitate profound questionings to what surround them. Among the many circumstances that can represent these critical junctures – such as the loss of loved ones, unemployment and financial hardships, experiences of violence and discrimination – illnesses and the need for healthcare too can break personal and interpersonal taken-for-granteds, demanding a reconstruction of meanings at these both levels. As Kleinman points out, illnesses threaten the comfort of people's existence at the most intimate level – their bodies.[462] Illnesses can shake people's denial of human 'existential vulnerability'; they become 'resistances' to patterns that were previously taken-for-granted or unquestioned, precipitating reflections about the meanings of one's life and of living with others. As the story of the patient with HIV illustrates, because through experiences of illness and healthcare the individualistic orientation of the self weakens, loosens its grip, they open spaces in which social critique, mutual recognition, and solidarity can find fertile soils to flourish. They are personal crises with social implications.

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[462] Kleinman, 2006, p. 5.

If this argument is viable, then it is possible to hypothesise whether health intersubjectively construed, cannot be seen as a privileged domain for social criticism and for the transformation of interpersonal interactions towards relationships of mutual recognition and solidarity. This hypothesis, however, requires three interrelated considerations. First, to be sure, not everyone reacts to the 'resistances' posed by chronic illness, in oneself or others, by engaging in critical reflection about their meaning and about the fairness of the contextual social arrangements that can make these experiences more difficult. People do not always look at those who are ill and see in that an occasion for self and social critique. People do not always see experiences of illness and of healthcare as moral learning processes. The way people reconstruct their selves in the face of chronic or severe illness, the way people respond to experiences of illness and healthcare, and the possibility for social critique arising from these critical junctures depend on resources available to people, including culture, patterns of interaction they have with others, and their own personality. Culture, society, and personality, therefore, affect the transformation into new selves and they affect the possibility for social critique.

Second, in no way does this hypothesis assume an intrinsic teleology of illness or suffering. It does not place this unfair and even instrumental burden on the ill by understanding that their suffering serves a broader purpose or by expecting them to respond in any particular way. Illness and suffering are not construed opportunities for reflection and self-improvement. In asserting that these experiences of illness and healthcare are filled with meaning, it considers that as inevitable, even if undesirable, constituents of the human condition, these experiences present themselves as resistances to the flow of people's lives; they are critical junctures, which provoke breaks in common understandings, and therefore motivate questionings, rational reflection, and the establishment of new understandings. These processes are intersubjective, they are mediated by communication, and they can impact differently at different levels. Hence it is possible to conceive that transformations can be more important at the level of personality and identity constitution and reflect very little in the overall social and cultural arrangements. On the other hand, it is also possible to conceive that every so often these processes motivate a broader challenge to reality, provoking a significant

change in social arrangements, even if some individuals do not incorporate the change at the level of identity. The huge contribution of the gay movement towards the de-stigmatisation, better prevention, and access to treatment of HIV/AIDS through the organisation of self-help groups and patients' advocacy, the promotion of debates, and political activism, is an example of significant ruptures at the social level, provoked by the experiences of illnesses of individuals who chose to challenge established meanings and attitudes. Despite this fantastic achievement, it is possible that some individuals with HIV still think of their condition as a punishment for their sins. To summarise this point, the hypothesis that is being raised is not that experiences of illness and healthcare are opportunities for change; they are rather critical junctures in which common understandings are challenged and in which people may *chose* to take the responsibility for constructing new understandings and new paradigms. Seen from this perspective, experiences of illness and healthcare are not void of meaning. Despite having no intrinsic purpose, they do have meanings, even if not always positive ones.

Finally, the third consideration regards the limitation of this perspective if analysed solely from the perspective of the participant. Although well suited for revealing the multitude of meanings that health, illness, and healthcare have to individuals, it fails to fully account for how 'macro-institutions' such as health policies, healthcare services, biomedical technology, associations, and the media, interact and affect the experiences at the participant level, and also for how these participants' experiences can affect these macro-structures. As considered above, culture and society do affect these experiences; however, the dynamics of how they do so cannot be grasped by the participant perspective alone. That requires the complementary perspective of the social observer.

In fact, in concluding her review about the literature on the experience of illness, Pierret observes that the macro-level of analysis has not been studied as much in the field and suggests that this is a gap to be bridged. To that end, she further considers that

> [t]he challenge is to define a paradigm and methodology for handling problems related to the social structure. This entails working out theories about the interrelations, reciprocal effects and feedback between subjectivity, cultural factors and social structure.[463]

In response to this call I argue that Habermas's communicative paradigm and its complementary dual model of society is well suited to provide a framework for this analysis. His framework allows both the analysis of how culture, society, and personality affect experiences and the analysis of how the challenges posed by these experiences can be translated into broader social change. The next section attempts at sketching how Habermas's framework could be applied to the study of health and society, and its implication to the relationship between health and justice.

3 Health and the lifeworld

Modernity has been marked by the progressive differentiation of knowledge and value spheres. This de-unification of the worldview meant that sciences, law and morality, and the arts became spheres of knowledge reproduced by their own specialised logic. Medicine is one example of this de-unification of the world. Whereas in pre-modern times concepts of health, and the explanation for diseases and their treatments were not separated from mythical, religious, and the private and inner world of patients, in modernity health becomes progressively more institutionalised, professionalised, closely associated with the scientific paradigm, and therefore detached from other spheres of knowledge. This is not to say that these differentiated spheres became irrelevant to each other. They still interact, however, predominantly in a state of conflict rather than in state of mediation. With the development of new medical technologies, for example, new ethical conflicts arise; yet, in plural societies debates within the spheres of ethics and morality find it difficult to establish consensuses while following the fast pace of the development of new technologies, hindering their regulative role. In addition, despite all the accumulation of knowledge about diseases and their treatment, biomedicine has not always secured that individuals accept its expert knowledge as valid or as more important than their personal experiences and accounts, which many times results in non-adherence to treatment and failures in health policies. Therefore, if on the one hand

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[463] Pierret, 2003, p. 17.

the differentiation of spheres of knowledge in health made the extraordinary technological advance in biomedicine possible, on the other hand, this advance came at a cost of generating increasingly complex conflicts and lack of appropriate mediation between biomedicine and the other spheres.

Alongside this differentiation in the lifeworld's value spheres, modernisation also involved the increasing detachment of the system from the lifeworld. That meant that the system's economic and administrative imperatives became progressively independent from the control of lifeworld, and in a reversal of this logic, they begun to colonise the lifeworld. The effects of this colonisation are also felt by biomedicine. As the economic and administrative logics colonise it, conflicts become aggravated, and its own logic is threatened. The attempts at holding to the value-neutrality of medical practice and of upholding traditional medical values as a way to prevent the interference of the administrative and economic logic is an illustration, as discussed in the last chapter,[464] of this process of colonisation as perceived by medical practice.

One of the problems with the rationalisation of the modern world, which as seen in Chapter 2 has been the focus of critique in social and critical theory at least since Weber, is the privilege given to the steering capacity of a means-to-an-end rationality, reflected by the positivist and scientific approaches to law, politics, and sciences in general. As a result, medicine, attached to a technicist discourse, and eventually also encroached by the media of money and power, became the institutionalised voice of health and healthcare practices. Yet, as the previous chapter and section analysed, there are alternative paradigms of health which mediation with biomedicine can be seen as a critical tool against the one-sidedness and distortions provoked by the predominance of the biomedical paradigm. This argument needs to be further developed, and this is accomplished by placing health and its related phenomena within Habermas's theory of society. In doing so, the framework developed supports this argument by accounting not only for the different forms of discourses in health and for the different forms of reproduction of health practices but also for the pathologies that arise when one form of discourse and associated practice predominate. Finally, in placing health in Habermas's theory, it is be possible to address whether the hypothesis developed in the last section,

[464] See Chapter 3, section 2.2.

namely that health can be a privileged domain for social criticism and for fostering relationships of mutual recognition and solidarity, is plausible. The relevance of this argument becomes clearer in the analysis of the relationship between health and justice.

3.1 Health as a sub- system of the lifeworld

Starting from the premise that reality is shaped by diverse forms of interactions, in *Patients and Healers in the Context of Culture* Kleinman proposes a conceptual model of health care as a cultural system. He observes that in every culture, health and illness; individuals' beliefs, experiences and responses to illness; and the individuals and institutions involved in healing are systematically interconnected. The totality of these socially organised responses to disease defines what he calls the healthcare system. In addition, how individuals perceive, label, explain, attach moral meanings, and treat sickness forms the system and at the same is constrained by it. In his words,

> the health care system, like other cultural systems, integrates the health-related components of society. These include patterns of belief about the causes of illness; norms governing choice and evaluation of treatment; socially-legitimated statuses, roles, power relationships, interaction settings, and institutions.[465]

Kleinman's model places an emphasis on the perspective of the participant and on culture. Illness and healing are construed as cultural experiences, and patients' and healers' actions and interactions are interpreted within their cultural horizons. Despite the focus on the micro-level, internal, and cultural perspective, Kleinman acknowledges that large scale social, political, economic, and epidemiological factors are relevant in shaping these experiences, yet he does not aim at explaining them.[466] The purpose of his conceptual model is rather to facilitate cross-cultural analyses and descriptions of variations in content of these beliefs, moral meanings, and patterns of behaviour.

Kleinman's emphasis on interactions as constituters of reality, his expanded scope of what health entails, and his focus on the moral significance of experiences in healthcare, show similarities with some elements of Habermas's social theory, and for this reason, his model of healthcare as a cultural system is a good starting point for our

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[465] Kleinman, 1981, p. 24.
[466] Kleinman, 1981, Chapter 2.

broader analysis of health and its role in society. Yet, the purpose of this section is to complement the participant perspective discussed in the section above, with the observer perspective so as to better account for precisely these large scale phenomena and how they affect experiences and patterns of behaviour at the micro-level. To that end this thesis proposes that health be placed within Habermas's dual account of society and be construed as a sub-system of the lifeworld. In this way, it maintains Kleinman's insight on the interactive – or intersubjective – constitution of a health system that both forms and constraints individuals interactions and responses, while at the same time it expands the analysis beyond the cultural, internal and micro-level focuses by including in this framework the structural components of society and personality and the interplay of the health system with the sub-systems of economy and state administration.

Health as a sub-system of the lifeworld includes, among others, the official healthcare system, either public or private; it includes biomedicine but also lay knowledge and alternative therapies as domains of knowledge and practices of care; it includes nets of informal healthcare, formed by family, friends, volunteers, and everyone else who contribute in helping someone who is ill through the period of illness; it involves the norms of conduct governing the interactions in the system; it includes drug and equipment companies, medical schools, and medical research; and it also involves individuals' roles (health professional, informal carer, patient) and individuals' experiences of illness and healthcare. To make sense of this broad and complex structure that forms the health system, its different parts are associated with the structural components of the lifeworld and their associated communicative rationalities and linguistic functions to reveal how the dynamics of the health system and its role in society.[467] Table 4.1 schematically illustrates some of these associations.

[467] The multitude of practices, institutions, and functions that form the sub-system of health characterise it as both a system of knowledge and an action-system.

Claims to validity	**Truth**	**Rightness**	**Truthfulness**
Relation to structural components of the lifeworld	Culture	Society	Personality
Domains of knowledge (differentiated expert cultures)	Biomedicine, lay knowledge, alternative therapies, social sciences specialised in health related phenomena	Morality, law, bioethics, medical ethics, professional codes of conduct, healthcare regulations	Narratives, personal accounts of experiences of illness and healthcare
Moments of reason	Cognitive-instrumental	Moral-practical	Aesthetic-expressive
Health-negative phenomena	disease	Sick role, pattern of interactions with others	illness
Linguistic function	Development of theories, diagnostic and treatment protocols, measurements of responses	Establishment of care relationships (patient and professional or informal carer), inter-professional relationships, patient support groups, development of bioethical consensus, laws, and regulations	Expressing actor's experiences of illness and healthcare
Breaks in common understandings	Falsification of medical knowledge and cultural beliefs about diseases	Social critique: Challenge posed to healthcare policies, stigmas, *meaning* of right to health	Biographical disruption, loss of self, self-critique
Contributions to the communicative reproduction of the lifeworld	Reproduction of medical knowledge	Sustaining social solidarity, mutual recognition	Self-transformation: motivations for actions
Contribution to 'self' development	Cognitive capacities	Interactive capacities, support for healthcare structures and practices	Ego development; development of empathy and concern for others

Table 4.1 – The health system, communicative action, and the lifeworld using claims to validity as a guide.

As seen in the last chapter, according to Habermas the lifeworld is reproduced – i.e. its meanings and values are communicatively stabilised among individuals and transmitted from generation to generation – through three forms of actions: a) cultural reproduction – through which traditions, cultural meanings, expert knowledge, and skills are passed on; b) social integration – through which we legitimise norms of cooperation and interaction; c) socialisation – through which individuals form their personal and collective identity. In addition, different sub-systems are specialised in contributing towards these forms of reproduction in different ways. Therefore, although interconnected with others sub-systems, law and the arts, for example, tend to be more specialised in contributing towards, respectively, social integration and socialisation. In contrast, other sub-systems may contribute to all three forms of lifeworld's reproduction, such as family and education. I propose that health be construed as a sub-system of the latter type, i.e. specialised in all three forms of reproduction. Contrarily to a narrow association of health with biomedicine or health services in general, the health system is here broadly conceived; as a result, its role in the reproduction of the lifeworld goes beyond the cultural transmission of medical knowledge and also encompasses social integration and socialisation.

Taking the association between communicative action's claims to validity and the structural components of the lifeworld as a guide, it is possible to differentiate between expert domains of knowledge in health, and from there identify its different functions and contributions to the reproduction of the lifeworld. Thus, biomedicine alongside lay knowledge, alternative therapies, and the social sciences specialised in health constitute the domains of knowledge associated with culture and with its cognitive instrumental rationality and claims to truth.[468] At this level, knowledge serves to the development of theories about health and disease, treatments, and measurements of health status or of effectiveness of interventions. Breaks in common understandings motivating new consensuses, therefore, are characterised by the falsification of knowledge. New research, for example, can challenge current medical theories and

[468] It does not mean that these expert know ledges are equally valid. Their claims to truth are subjected to validation through rational discourses, mediated by the cognitive instrumental moment of a communicative rationality aimed at mutual understanding. Note that there is a difference between this form of rationality and strategic rationality; see table 2.1.

treatments, provoking the development of new consensuses on medical protocols. At this level of culture, health interacts with communicative action and contributes to the reproduction of the lifeworld through the reproduction of medical, lay, alternative, and social scientific knowledge.

Society and its associated claims to rightness are associated with domains of knowledge specialised in establishing the norms of interaction among actors in the system. This is the domain of interpersonal relationships in health; it is responsible, for example, for establishing care (between patient and professional or informal carer) and inter-professional relationships. Law, morality, bioethics, professional codes of conduct, are examples of expert knowledges associated with health and society. These expert knowledges are guided by a moral-practical rationality and make claims to rightness. Breaks in common understandings at this level are characterised by social critique and challenge to norms, including for example, challenges to the fairness of health policies, to the rightness of stigmatising and discriminating laws, and to the appropriateness of the interpretation given to the substance of right to health. In association with communicative action, health contributes to the reproduction of the lifeworld at this level by promoting social integration. This is achieved, based on the conclusions of the previous section that the intersubjectivity of the experiences of illness and healthcare can provide a space for social critique and for social solidarity and mutual recognition to be nurtured and sustained.

Finally, personality is the privileged domain for the expression of subjective experiences and feelings and for development of self-identity. Here, narratives and personal accounts are validated according to their sincerity, and breaks in common understandings at this level are generated, for example, by the loss of self, by self-critique, or by biographical disruption, requiring the repair work of creating a new identity, a new self. This process of repairing the self characterises the contributions of health to the reproduction of the lifeworld by motivating self-reflection and the renovation of the self with less egocentric orientation and motivated to act on the basis of reaching mutual understandings and of the concern for others.

To elaborate further on the social roles of health, the analysis based on the participants' experiences of illness and healthcare developed above needs to be retaken.

As demonstrated, health related phenomena provoke challenges to taken-for-granted and common understandings about the social and inner world, which demand a process of (intersubjective) repair that can have important moral and social-political implications. If this analysis is sound, then it follows that health can contribute to a lifeworld-mediated social integration by fostering social solidarity through its intersubjective nets of formal and informal healthcare, through the critique it poses to social arrangements perceived as unjust. In the same spirit, it contributes to socialisation by motivating a transformation of the self, from a self-focused to a more socially aware orientation, contributing thus to the development of personalities capable of participating in relationships of mutual recognition and motivated to act upon moral agreements. Therefore, the health system's contributions to the reproduction of the lifeworld at the level of social integration and socialisation are important roles health plays in society, and these roles inform its relationship with justice.

Some important considerations about this health system framework need addressing. First, the different domains of knowledge in health although differentiated, interact with and influence each other. For example, science can contribute to the moral debate about the link between deprivation and ill health by providing useful empirical data. The development of technology can affect individuals' experiences of illness and healthcare; the development of a safer drug or user-friendly portable equipments, for example, can make it possible to patients to receive chronic treatment at home instead of at hospital, making the experience less burdening for the patient. Dialysis done at home is an example of that. A given collective's self-understanding can place through law limits in technology, such as Japanese laws which still express the Japanese cultural estrangement with the scientific diagnosis of brain-death, affecting thus the practice of organ transplantation in the country.

Secondly, the logic of these different domains often operates simultaneously. During the health professional and patient encounter, for example, different forms of discourses and validity claims are raised. A technical account regarding the details of a treatment is provided while at the same time respecting the patient's autonomy and validating her fears and anxieties. In public health, too, different types of discourses may overlap in the analysis of a particular policy, involving technical considerations and

objective measures, moral or ethical aspects of the policy; and issues of how the policy affects or is affected by a particular group identity.

These two considerations point towards the importance of mediation between different types of discourse. As discussed in the last chapter, different language-games and validity claims may be at play, therefore, the rational validation of different discourses and their appropriate use in relation to the context can define their legitimacy. Furthermore, their mediation offers a critical tool in guarding against the predominance of one form of expert knowledge over the other.

Another consideration regards the idealised character of the model. This model, of course, is only an analytical tool from which to study health and society. Admittedly, in the way it was presented it does have an idealised content, however only in relation to the direction of changes facilitated by health and its related phenomena. This is because it is also possible to conceptualise experiences of illness and healthcare as reproducing the lifeworld not in its communicative capacities, but in its colonised form. In other words, it is possible that the distortions observed in the field of health serve only to reinforce the deficiencies in social integration and socialisation by corroding solidarity and supporting egocentric individualism. In this scenario, health would be a substratum facilitating the reproduction of these distortions. The direction of the contributions of health to the reproduction of the lifeworld, therefore, can take the opposite direction than the one presented above. Yet, the argument that health has a role in the reproduction of the lifeworld that goes beyond the transmission of medical knowledge remains untouched. Health would still contribute to the reproduction of practices at the level of society and personality, although in a disintegrative way. What is crucial, however, is that whatever direction this contribution takes, the conclusion is the same: that fostering solidarity, provoking social critique, and nurturing relationships of mutual recognition also passes by the resistance against the colonisation of the health system by the system's imperatives and against the encroachment of the logic of one form of expert knowledge, i.e. biomedicine, in the spheres mediated by communicative rationality.

There are two ways in which distortions and pathologies can arise in the health system: the colonisation of the health system by the system's media and the

encroachment of technical and scientific discourses on the spheres mediated by moral-practical and self-expressive moments of reason. As any sub system of the lifeworld, health interacts with the system. It relies on the system for money and regulations, and in return, it contributes to providing the system with legitimacy. Yet, this balance can be altered, and the health system can become colonised and reliant on the strategic rationality that steers the system. The results of this colonisation are distortions in the health system, which affect the participants' experience of illness and healthcare. The bureaucratisation of the welfare state and the rise of the managerial and corporate approach to healthcare services are examples of this colonisation. Reforms towards fitting these services into the managerial-corporate logic are introduced with the justification of making services more effective and within budget. The language employed by healthcare systems illustrates the new logic taking over. As Sue McGregor observes,

> language and metaphors reflecting this philosophy prevail in all public, private and civil dialogue, especially in health care policy: spending cuts, dismantling, de-indexing, deficit cutting, haves and haves-not, competitiveness, downsizing, declining welfare state, inefficiencies, inevitability, closures, chopping services, de-insured, user-pay-fees, two-tier healthcare, for-profit healthcare, escalating costs, free markets, erosion of health care, being forced to make difficult policy choices, unfortunate necessities and justifiable sacrifices. Indeed, neoliberal rhetoric has a plausible ring to the uninformed (...).[469]

It follows that the incorporation of the steering logic of the system also turns patients and future patients into clients. As clients of the state or insurance companies, patients do not fully participate in the development of policies and establishment of priorities. In either case, they stand mostly passively in the receiving end of services. In one case they participate through the exchange of votes-for-services, choosing among different manifestos, and in the other case they participate through their power of purchase, choosing among different plans. Some extend their participation by complaining against the quality of the services or claiming fairer shares of them. The spirit of this cliental participation, however, is not of cooperation or mutual recognition of needs but

[469] McGregor, 2001.

competition for limited resources, and services are seen as entitlements or desert rather than social resources.

Another form of distortion leading to pathologies in the health system is represented by the domineering status of biomedicine within the health system. As the discussion of the social model of health illustrates, there are a wide range of distortions in the field of health attributed to the narrow approach of biomedicine, from the medicalisation of the social world to the legitimation of oppression and prejudice against the mentally ill, women, ethnic minorities, the poor, and homosexuals.[470] Kleinman and Hahn too, point out that the predominance of the biomedical account has had the effect of alienating patients, promoting an adversarial climate,[471] colluding with big business,[472] constraining ethical deliberation about healthcare and medical technology, and of distorting the moral world of patient and community by translating patients' perspectives and suffering into diagnostic categories.[473]

The colonisation by the market and the dominance of biomedicine, in fact are closely tied phenomena. In commenting about genetic engineering and how it can affect the 'self-understanding of the species', Habermas calls into attention the problems raised with the funding of scientific research and the transformation of biotechnology into an investment. The dynamic of this association between capital market and biotechnology poses a risk to the slow-paced ethical-political public opinion formation.[474] The association of a renewed Darwinism with a free trade ideology, he argues, threatens to supersede the ethical debate and regulation of biotechnology: '[t]he issue today, of course, is no longer the overgeneralisation of biological insights by social Darwinists, but rather the weakening of the "sociomoral restrictions" placed on biotechnological progress for medical as well as economic reasons.'[475]

This is not to say that these sharp critiques of the biomedical model invalidate it altogether. On the contrary; both Hahn and Kleinman acknowledge the contributions of biomedicine to the improvement of health conditions worldwide, and Habermas too sees

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[470] See Chapter 2, section 2.3.
[471] Hahn, 1995, especially Chapters 6 and 10
[472] Hahn, 1995, Chapter 10; Kleinman, 1995, p. 95.
[473] Kleinman, 1995, p. 95, also Chapter 2.
[474] Habermas, 2003a, p. 18.
[475] Habermas, 2003a, p. 21.

the contribution of the sciences. In challenging common sense illusions (traditional, mythical, religious), the sciences lead to transformations in individuals' self-understandings and social changes, such was the case with Darwin's theory of evolution, which seriously challenged anthropocentric and religious worldviews.[476] In addition, the need for regulations in response to technological innovations tends to be associated with the development of post-traditional conceptions of law and morality.[477] One of the advantages of the framework of health as a sub-system of the lifeworld lies precisely in establishing the scope and limits of the biomedical authority and its language games, allowing both for the validation of its contributions and for the critique of the distortions it creates when its steering logic is misplaced or colonised by the system.

In addition to accounting for the pathologies in the field of health and the possibility of overcoming them, this framework points to the possibility of social changes that go beyond health. It suggests that a decolonised health system steered by communicative rationality can be an important locus for the renewal and support of solidarity and for the reconstruction of selves capable of and motivated to interacting with others in relationships of mutual recognition. In sustaining solidarity and mutual recognition, the health system provides the resources to make individuals' experiences of illness and of healthcare less disruptive, less painful, and less isolating as well as it facilitates the reconstruction of new and more positive selves. Beyond that, the nurturing of an ethical orientation towards solidarity and mutual recognition contributes to social integration and provides participants with the motivation to both join moral discourses and act upon their agreements.

4 Conclusion

This chapter aimed at constructing an account of health and its role in society from the perspective of Habermas's discourse theory. This account adopted the participant's perspective and analysed experiences of illness and healthcare in order to reveal the inevitable intersubjective character of these experiences and their potentially self-and social transformative nature. This analysis led to the proposal of construing health as a

[476] Habermas, 2003a, p. 105.
[477] Habermas, 2003a,

privileged locus for social change. In shifting to the observer perspective and placing this intersubjective understanding of health in Habermas's dual model of society, the chapter proposed a conceptual model of health as a sub-system of the lifeworld, associated with the three structural components of culture, society, and personality. In doing so it was possible to identify the important roles health plays in integrating society by reproducing lay and medical knowledge; fostering social solidarity through nets of formal and informal healthcare; and contributing to the development of personalities capable of participating in relationships of mutual recognition.

This discourse theoretical model of a health system can offer an important contribution to the analysis of health, its modern pathologies, and its emancipatory potentials. It also points to the direction of how these pathologies can be avoided and these potentials realised. If the possibility for moral discourses relies on ethical orientations of the lifeworld that meet the requirements of a post-conventional morality and justice halfway, this model suggests that a decolonised health system can contribute to this task by fostering the ethical orientation towards values of solidarity and mutual recognition. The impacts of this argument on the analysis of the relationship between health and justice and the right to health are the subject of the next chapter.

Chapter 5

HEALTH, JUSTICE AND THE RIGHT TO HEALTH

Justice is good for our health. This is one of the main arguments of Norman Daniels's works on the relationship between health and justice. In his later works Daniels reaches this conclusion by analysing the findings of a growing body of research on the social determinants of health.[478] These researches provide important empirical data demonstrating that health statuses of individuals and populations are more deeply associated with broader issues of social justice than commonly assumed. Of special notice in these researches is the identification of the close relationship between social inequalities within a society and the poorer health conditions of its population. In producing these findings about broader social determinants of health, these studies have posed serious challenges to many works on the subject of health and justice and they also make it increasingly more difficult to separate theories on the ethics and justice of health from theories of justice in general. These impressive findings, therefore, have contributed to the reorientation of many studies in the field, including Daniels's work, which became less focused on issues of fairness in healthcare distribution and more focused on the fairness of social determinants of health and on the importance of health.

Even more so since this reorientation, Daniels's work represents one of the best efforts in the liberal field in persuasively linking justice and health and accounting for the normative implications of this relationship for social policies. This chapter is thus also dedicated to support Daniels's broadening perspective on the relationship between health and justice while critiquing his typical liberal emphasis on distributive justice. By linking the intersubjective account of health and its associated concept of health as a sub-system of the lifeworld with Habermas's theory of justice and solidarity this chapter argues that the relationship between health and justice requires an understanding of justice that goes beyond principles of distribution. In concluding this analysis, to Daniels's insightful claim that justice is good for health, I advance the complementary claim that health is also good for justice.

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[478] Daniels, 2008; 2009; Daniels, Kennedy and Kawachi, 1999.

Given that solidarity, which is a counterpart of justice in Habermas's theory, is the scarcest social integrative resource in modern capitalism, the role that health plays in fostering solidarity and relationships of mutual recognition is seen as a fundamental contribution to the possibility of rational discourses and therefore, for justice itself. This contribution points to a dynamic and reciprocal relationship between health and justice. The concept of the right to health is then explored as an illustration of how this communicative relationship between health and justice can contribute to the debate on the legitimacy of the right to health. The chapter argues that this reciprocal relationship between health and justice challenges the commonly held justification for the right to health based solely on the recognition of health as a necessary condition to the individual exercise of civil and political rights.

1 The relationship between health and justice

It is well documented that the health conditions of populations are affected by economic and political instability. As Thomas Pogge notes, for a significant part of the world's population, who live in conditions of extreme economic deprivation and often also in conditions of political instabilty, the levels of basic sanitary conditions and life expectancy still resemble the levels of two hundred years ago.[479] But even in less poverty-stricken countries, periods of economic recession are commonly associated with a deterioration of the health of vulnerable groups due to material hardship, psychosocial effects, and changes in the population's pattern of behaviours.[480] Use of drugs, alcoholism, depression, and violence are all associated with economic instability. The worsening of the health conditions and significant reduction of life expectancy that occurred in the countries of the former Soviet Union after its dissolution, for example, offer a good example of the close relationship between economic instability and health. In the early 1990's these countries went through a period of dramatic social and economic transformations, with rising unemployment, inflation, insecurity, and marked increase in social inequalities. Between 1990 and 1994, the mortality rate in Russia, for example, increased 39%, and the life expectancy was reduced in more than six years for

[479] Pogge, 2001, p. 13
[480] Blaxter, 2004, pp. 101-3.

men and three years for women.[481] The effects on the health conditions of these countries have been long-lasting and only recently improvements are observed.[482]

Hazen Ghobarah *et al*. also demonstrate the important role of political conditions in influencing health conditions of populations. In a study consisting in a regressive analysis of data collected from 179 countries they studied the relationship between public health performances and other social measures such as level of democracy and civil and international conflicts.[483] Among their findings are that democracies tend to spend more on their citizen's health than autocracies. A democratic government at the 95th percentile on the polity score, for example, allocates 49% more resources to health than a dictatorship at the 5th percentile on the score. [484] They also demonstrated that enduring international rivalry largely impacts on the public health expenditures in health. Pakistan, for example, allocates less than 1% of its Gross Domestic Product to public health.[485] The mere contiguity to any country experiencing civil war results in lower levels of public health performances.[486] In addition, they demonstrate that international conflicts and security threats affect public investments in health due to allocation of significant resources on military and defense capabilities, to disruption on the provision of safe water and food, to destruction of healthcare and sanitary facilities, to substantial flight of trained professionals, and to the resulting masses of displaced people. In many countries the mortality rates among refugees is five to twelve times the normal rate.[487]

In addition, recent studies have shown that the relationship between socio-economic conditions and health is relevant to the population of richer and democratic countries too. These data point particularly to the growing relevance of inequalities within societies as a strong determinant of health. As Richard Wilkinson and Kate Pickett describe,

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[481] Notzon *et al*, 2001.
[482] Blaxter, 2004, 103; Wilkinson and Pickett, 2009, p. 87;
[483] Ghobarah, Huth and Russet, 2004.
[484] Ghobarah, Huth and Russet, 2004, p. 80.
[485] Ghobarah, Huth and Russet, 2004, p. 82.
[486] Ghobarah, Huth and Russet, 2004, p. 87.
[487] Ghobarah, Huth and Russet, 2004, pp. 85-7.

> When health inequalities first came to prominence on the public health agenda in the early 1980s, people would sometimes ask why there was so much fuss about inequalities. They argued that the task of people working in public health was to raise overall standards of health as fast as possible. In relation to that, it was suggested that health inequalities were a side issue of little relevance. We can now see that the situation may be almost the opposite of that. National standards of health [...] are substantially determined by the amount of inequality in a society. If you want to know why one country does better than another, the first thing to look at is the extent of inequality.[488]

In *The Spirit Level*, Wilkinson and Pickett review the results of a series of studies about the social determinants of health, placing a special focus on the close relationship between health and social inequalities that these studies establish.[489] Their analysis of these extensive data shows a remarkable relationship between economic development and life expectancy and health statuses of populations. While in poorer countries, life expectancy tends to increase significantly on the early stages of economic development and rising living standards, this relationship tends to weaken at the level of middle-income countries, until completely disappear as countries get richer. Although life expectancy continues to rise in these countries – it increases by between two to three years with every ten years – this rise is not associated with economic development, i.e. life expectancy and health indexes improve with time regardless of further increase in wealth.[490] Analysing the 2006 United Nations Human Development Report, they point to the clear association between national income per person and life expectancy, which starts reducing significantly from around $10,000 and levels off beyond $25,000. Virtually no further gains are observed after this point. More interestingly, these data demonstrate striking discrepancies across countries. A country as rich as the United States, for example, has no better life expectancy than a country as Costa Rica, which is less than a fourth as rich.[491] These data suggest that the relationship between economic development and health is just one of the variables that account for the status of health of different countries.

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[488] Wilkinson and Pickett, 2009, p. 30.
[489] Wilkinson and Pickett, 2009.
[490] Wilkinson and Pickett, 2009, p. 6.
[491] Wilkinson and Pickett, 2009, pp. 6-7.

Although wealth and increasing living standards are still chiefly relevant in poor countries, as countries become more affluent, other factors such as culture and social policies, also seem to play important roles in determining population health indexes.[492] This finding has some important implications. Not only do these data challenge the libertarian claim that increasing levels of wealth tend to spread benefits to all including the worst-off, but they also seem to suggest that once a country has crossed a certain income threshold, *how* equally wealth is distributed matters more than how big it is in average or absolute terms. Going back to the example of Costa Rica, which is a country which has a more equitable distribution of income than the United States and the United Kingdom, data show that despite its significant lower income per person in comparison with these two countries, Costa Rica actually enjoys a higher life expectancy than them.[493] In fact, as Daniels, Bruce Kennedy and Ichiro Kawashi analyse, the widening income differences in the United States and the United Kingdom may be associated with the deceleration of their life expectancy improvements.[494]

Wilkinson and Pickett point to a paradox in these findings: while significant differences in wealth among richer countries do not correlate with differences in life expectancy rates, differences in wealth *within* any of them, is clearly and systematically linked with differences in life expectancy. Most notably, this finding is not only associated with the poor living conditions to which some are exposed; although those living in poverty do have a lower life expectancy than the richer, this trend extends to those outside poverty levels in almost every society. That means that even middle income groups in a country with high average wealth but high income inequality may enjoy lower health standards than comparable, or even poorer, groups in countries with lower income inequality.[495]In other words, what seems to matter is not the amount of wealth people have, but their position in the social ladder.

What would explain this finding? Daniels, Kennedy and Kawashi point to the pattern of distribution of social goods such as education and broader life opportunities as important factors associated with the finding that inequality matters more than absolute

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[492] Wilkinson and Pickett, 2009, p. 8; see also Daniels, Kennedy and Kawashi, 1999, p. 220.
[493] See Wilkinson and Pickett, 2009, Figure 1.1; Daniels, Kennedy and Kawashi, 1999, p. 222.
[494] Daniels, Kennedy and Kawashi, 1999, p. 222.
[495] Wilkinson and Pickett, 2009, pp. 13 and 25.

or average wealth. They refer to data that demonstrate that in the United States the most inegalitarian states invest less in human capital. They have a larger uninsured population and they invest less in education and social safety nets. They note that adult literacy is a strong predictor of life expectancy, and that gender disparities in access to education further decreases life expectancy and health achievements, a trend that is also observed across the globe.[496]

Wilkinson and Pickett, however, point to another direction. They demonstrate through their analysis of extensive empirical data that problems such as violence, mental illness, drug use, teenage births, obesity, and poor educational performance are clearly more common among the poorer; yet, these problems have little or no relation with levels of average income in a society, i.e. this is still true even if the poorer in a given society are richer than middle income groups in other societies.[497] Therefore, the matter does not seem to rest on living standards; rather it seems to rest in how people compare with each other in the same society.[498]

They further illustrate this hypothesis by analysing the classic Whitehall studies, which consisted in the long-term follow up of the health status of British civil servants.[499] These studies demonstrated an important correlation between service hierarchy and diseases and death rates. Those in jobs of lower status suffered more from heart diseases, some cancers, chronic lung diseases, depression, suicide, sickness absence from work, and back pain. Factors such as poverty and unemployment, access to healthcare, or lifestyle did not explain these findings, as the study population had both relatively stable jobs and full access to healthcare services. Furthermore, although those in lower status jobs were in fact more obese, heavier smokers, less physically active, and had higher blood pressure, these risk factors accounted for only a third of their increased risk of heart disease. One of the explanations for these findings is that the differences in health statuses and death rates between people occupying posts of different hierarchical statuses would be associated with levels of job stress and people's sense of control over

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[496] Daniels, Kennedy and Kawashi, 1999, p. 224.
[497] Wilkinson and Pickett, 2009, pp. 11-3.
[498] Wilkinson and Pickett, 2009, pp. 13 and 25.
[499] Ref whitehall

their work.[500] Since the Whitehall studies, a number of different studies have focused on understanding these findings, having also associated lower social status with worst health profiles affecting not only people at the bottom of the social hierarchy. Wilkinson and Pickett conclude that from the very bottom to the very top of the social ladder, those who are above any given point have better health than those who are below this point. This trend, therefore, applies not only to 'blue-collar workers'; senior administrators do also live longer than those in professional and executive grades.[501]

Likewise social status, researches in the field agree that social integration is another important determinant of health. Wilkinson and Pickett, for example, point out that at the individual level, the quality of the relationships that people have with others affects health too. In reviewing a number of studies on the subject, they show that social isolation is not good for health, and that the opposite, such as having friends and partners and taking part in social associations and support groups, protects health. Social support is associated with better recoveries from heart attacks; people with friends are less likely to catch a cold; and physical wounds heal faster if people have good relationships with their partners.[502]

Focusing on the social level, they also reviewed studies that support the thesis that social relationships are important for health, and these findings would help explain the impacts of social inequalities on the health profile of populations. As they point out, inequalities weaken community life, reduce trust between people, and increase violence.[503] Daniels, Kennedy and Kawachi also link the worst health profiles of inegalitarian societies with the corrosion of social cohesion.[504] Referring to a number of studies in the field, they demonstrate that high income inequality is associated with lower political participation, lack of investment in human capital and social safety nets, and low interpersonal levels of trust.[505] Trust, as Wilkinson and Pickett note, is closely associated with levels of economic equality: where there is more inequality, people seem to be less caring of one another, there is less mutuality in relationships, and

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[500] Wilkinson and Pickett, 2009, pp. 75-6.
[501] Wilkinson and Pickett, 2009, pp. 75-6.
[502] Wilkinson and Pickett, 2009, p. 76.
[503] Wilkinson and Pickett, 2009, p. 45.
[504] See also Williams, 2000.
[505] Daniels, Kennedy and Kawachi, 1999, p. 224.

therefore there is less trust. Trust, they argue, is fundamental to social cooperation; as studies show, people who trust others are more likely to donate time and money to help others and they are also more likely to support the legal order. Trust also makes people feel more secure living in their communities, which affects health.[506] Research evidence in the United States, for example, demonstrate that the risk of death is lower in poorer neighbourhoods characterised by high levels of trust and active community life, regardless of their level of social deprivation.[507]

In making the point that absolute wealth is unrelated to improved health outcomes in countries that reached a certain stage of economic development, Wilkinson and Pickett further add that in rich countries levels of spending on healthcare and the availability of high medical technology are not related to indexes of population health. As they illustrate, the United States, which contains less than 5% of the world's population, spends between 40-50% of the world's total expenditure on health. Yet, the United States performs poorly in many health indicators in comparison to middle-income and rich countries.[508]In fact, studies have found that black men living in some poor American neighbourhoods have lower life expectancies than men living in some undeveloped countries.[509]

They finally conclude, considering that average levels of income and that expenditure in health and in high medical technology contribute little to determining mortality and health in a society, that it is inequality what matters, i.e. 'more egalitarian societies tend to be healthier'.[510] The implication of this conclusion is that tackling poverty is not enough to improve health indexes and reduce health inequalities. Apart from eliminating poverty, this conclusion calls for better income distribution, regardless of the total amount of wealth of any given society.

Daniels too agrees that social determinants of health and health inequalities matter; yet, he argues that demonstrating the correlation between inequalities and poor health does not provide the answer to the important question of whether these

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[506] Wilkinson and Pickett, 2009, pp. 78-9.
[507] Wilkinson and Pickett, 2009, pp. 56-7.
[508] Wilkinson and Pickett, 2009, 79-85; see also Daniels, Kennedy and Kawachi, 1999.
[509] Wilkinson and Pickett, 2009, p. 80.
[510] Wilkinson and Pickett, 2009, p. 81.

inequalities are unjust. As he remarks, 'correlation alone will not support judgments about injustice.'[511] In order to evaluate whether inequalities are unjust, it is necessary to understand their mechanisms. He observes, for example, that whereas inequalities that result from social exclusion and discrimination, such as gender, race and ethnic inequalities, are easier to be accepted as unjust, socio-economic inequalities may pose harder questions. This is because few people are radical egalitarians. Most people seem to accept some levels of socioeconomic inequalities, and some even see them as desirable incentives to harder work. Others are prepared to accept different levels of social inequalities provided they do not affect people's health. As he reflects,

> Few people are radical egalitarians opposing all forms of such inequality. Many who are not at all troubled by significant inequalities in income, wealth, or opportunities for a higher quality of life are particularly troubled by health inequalities. They believe that a socioeconomic inequality that otherwise seems just becomes unjust if it contributes to health inequalities. Is every health inequality that results from unequally distributed social goods unjust?[512]

For Daniels, the answer to the question of 'when are health inequalities unjust?' is fundamental to guide public health policies under resource constraints.[513] In providing a framework to answering this question Daniels employs John Rawls's principles of justice as fairness to the context of health, and as a result, he proposes that 'health inequalities across demographic groups are unjust when they result from an unjust distribution of the socially controllable factors affecting health'.[514] Looking from the perspective of justice as fairness,[515] Daniels argues that health is special for justice insofar as it protects opportunities. Since Rawls's principles of justice require societies

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[511] Daniels, 2008, p. 80.
[512] Daniels, 2008, p. 81.
[513] Daniels, 2008; 2009.
[514] Daniels, 2009, p. 36; 2008, Chapter 3.
[515] Rawls theory of justice as fairness involves a decision-making process in which people reach a consensus on the principles of justice that regulate the basic structure of society. To secure impartiality in the process, the 'contractors' reach a consensus on the choice of principles behind a veil of ignorance, blind to their particular circumstances such as gender, race, wealth, and social status. According to Rawls, people in this position would rationally choose two main principles of justice: (a) the equal right to basic liberties (including political liberties, freedom of speech, and freedom of person) and (b) principles of distributive justice based on the equality of opportunities and aiming at the greatest benefit to the least advantaged. Inequalities are then only justified when the better-off by producing more and gaining more also improve the conditions of the worst-off (the so-called difference principle).

to protect individuals' opportunities, meeting health needs, including the fair distribution of social determinants of health, becomes a requirement of justice.

Although ambitious, given the scope of what justice might require in terms of health policies, the relationship that Daniels establishes between health and justice, in being based on health's contribution towards the fair distribution of opportunities, is seen by some commentators as counter intuitive and restrictive. To assume that securing opportunities is all there is in the relationship between health and justice neglects the important other reasons why people attach a moral value to health and healthcare. In many cases, individuals do not receive healthcare to protect their enjoyment of life's opportunities. Some patients, for example, receive healthcare to alleviate suffering and even to contribute to a good death (one needs to think of a terminal patient who receives oxygen and pain-killers in her final days for the mere purpose of relieving her agony). In fact, a great deal of effort and money is spent in the treatment of patients who will not have their opportunities increased by healthcare, as it is the case of severely neurologically impaired individuals. As Shlomi Segall puts it,

> Most patients treated by healthcare systems are individuals in the twilight of their lives. [...] An often-cited figure is that, in the US, 30% of healthcare expenditure is currently spent on patients in the last six months of their life. [...] Healthcare in that case cannot be said to provide opportunity, equal or otherwise, to pursue life plans. The effect of successful treatment of patients who are in the last weeks of their lives is not so much that of giving them opportunity to pursue their life plans, but rather that of alleviating their pain and suffering and that of postponing death as long as possible.[516]

Therefore, linking the fairness of meeting health needs to the protection of the enjoyment of life's opportunities carries a bias in favour of people who can be treated, who can be compensated, or who can claim preventive measures to maintain an active and productive life. Daniels replies to this line of criticism by reaffirming that what is crucial for the purposes of justice is the relation between health and opportunities; yet, whenever the protection of opportunities cannot be claimed as the justification, other values, such as compassion and benevolence, should compensate for that. These charitable values, however, are not attached to justice. This solution receives many

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[516] Segall, 2007, p. 346.

criticisms. Some egalitarians such as Dani Filc, for example, reject it by arguing that leaving the most vulnerable to depend on social beneficence as opposed to a sense of justice, is neither fair nor acceptable from an egalitarian point of view.[517]

Daniels's extension of Rawls's theory of justice to health, however, does not focus on equality of treatment, but on equality of opportunities, regardless of the outcomes and regardless of distributive inequalities, provided these inequalities secure the greatest benefit to the worst-off. Yet, this scope for accepting wide social inequalities poses a question on the compatibility of his theory with the very growing awareness of the impacts of social determinants of health which motivates his broadening perspective on health and justice. As seen above, much of this literature points to the relevance of relative inequality on health. If what matters for health is more income equality among the population, how can that be reconciled with a Rawlsanian conception of justice?[518]

Daniels's association of health with the protection of opportunities is the focus of sharp criticisms. One of the difficulties of his argument is its emphasis on distributive justice, which leads him to overlook other potential moral links between health and justice. He does, of course, devote a significant part of his argument to the analysis of the moral importance of health in order to associate it with justice. Yet, because he captures the moral importance of health through the framework of Rawls's second principle of justice, from the start the relationship between health and justice is ensnared in a distributive logic, attached to the protection of opportunities, and therefore less open to seeing health as more intrinsically related to justice. As a Rawlsanian, of course, he could have attached a more important moral meaning to health by associating it with the first principle, i.e. by construing it as a basic liberty.[519] He could have justified this construction by arguing that health may be more directly relevant to liberty and self-determination than placing limits to government interferences, for example.[520] In

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[517] Filc, 2007, p. 62.
[518] See Rid and Andorno, 2009, p. 1.
[519] A number of authors use Ralws's theory of justice to explore the relationship between health and justice. Apart from being associated with equality of opportunities, as in the case of Daniels, health has also been construed as a basic liberty and distributed according to the difference principle. See more in Filc, 2007.
[520] See Filc, 2007, for an account of this line of argument.

addition, he could have argued that contractors, because behind the veil of ignorance, would not know their actual position, i.e. they would not know whether they are healthy or chronically ill or whether they live in a society with universal access to health or are uncovered. As a result, they would rationally choose to support a system of universal coverage that would provide the best health protection for all within budgetary constraints. To be sure, this argument would still be framed within distributive lines, but at least he would have avoided the counter intuitive claim that the protection of opportunities is all that is in the link between health and justice.

He does not take this route, however. As he explains,:

> The special importance and unequal distribution of healthcare needs, like educational needs, are acknowledged by connecting the needs to institutions that provide for fair equality of opportunity. But opportunity, not healthcare or education remains the primary social good.[521]

Therefore, what matters for justice is not health *per se*, but opportunity.[522] The importance of health for justice is only instrumental, i.e. health is a demand of justice only insofar it protects the real good – opportunity. That he needs the backup of other values extrinsic to justice, such as benevolence, to compensate for the cases that do not fit into his account is already an indication that he may have narrowed the relationship between health and justice a bit too much.

Granted, fair distribution of opportunities is a good principle of justice. Few would disagree that protecting life's opportunities is a good thing or equally in the interests of all. Likewise, criticising his focus on distributive justice does not imply a denial of the inevitable distributive connotations of health policies and healthcare services. One way to address this issue is to place these distributive connotations within Habermas's distinction between discourses of justification and discourses of application, in which they would fit into the domain of discourses of application that *follow* discourses of justification; it is in the latter that the moral relevance of health would have to be first established by participants.

This preceding analysis on the moral importance of health can take advantage of the concept of health system developed in the last chapter, in which the deeply moral

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[521] Daniels, 2008, p. 57.
[522] See more on this critique of Daniels's account of the moral importance for health in Wilson, 2009.

nature of the intersubjective experiences of health, illness, and healthcare were revealed along with the contributions of the health system to social integration by fostering solidarity and by facilitating the reconstruction of selves more capable of joining relationships of mutual recognition. The question of the relationship between health and justice, therefore, can take the form of: why supporting the health system is equally in the interests of all? This universalist question combined with the insights about the important social roles of the health system, leads to the appraisal of the relationship between health and justice from a broader perspective. Apart from asking what justice demands from societies regarding the health system, participants can also ask whether, and if so how, support for the health system contributes for justice.

As seen in Chapter 2, Habermas establishes a close relationship between justice and solidarity. From the premises of discourse theory, justice cannot protect the individual without also protecting the net of intersubjectivity that the individual depends on to both form and recognise her unique identity. Justice and solidarity are therefore counterparts. Solidarity in Habermas's work is not equated to benevolence or charity, and its role is not to compensate for gaps in justice. Rather, it represents the necessary conditions of mutual recognition and concern for others that must be met if discourses are not to be steered strategically. As also seen, in modern capitalism solidarity is a scarce resource, which threatens the possibility of universal agreements and of communication free from coercion or manipulation. For this reason, solidarity needs to be renewed and nurtured, and this is a task for the lifeworld.

Lifeworld's institutions, including the institutions of the health system, in operating on a communicative and inclusive basis rather than on the differentiation of clients' status or ability to pay, play an important part on this project. They are privileged spaces for communicative practices and in times of crises, they offer the reassurance of the cooperative basis of society; they reaffirm social commitments to protect individuals in their vulnerability in the face of the uncertainties of life and of the deficinecies of social arrangements. Well structured safety and welfare nets, therefore, work as buffers against difficult times.[523] They make it easier for individuals to get through adversities, and in carrying the message that society is a cooperative and

[523] Blaxter, 2004, pp. 102-3; see also Kleinman, 1995, p. 12.

supportive project, they contribute to maintain society stable and cohesive. They generate trust. More importantly, in protecting both the individual and their net of intersubjectivity, these structures become vital spaces for the renewal and for the reproduction of solidarity.

The lifeworld, therefore, is the space in which practices conducive to solidarity can take place, and the practices involved in the health system, as seen in the last chapter, are specially positioned to this project of renewal and of sustaining solidarity. In contributing to fostering solidarity, the health system also contributes to justice, and from this perspective, it can be concluded that the relationship between justice and health is reciprocal. It flows from both directions, i.e. a post-conventional justice supports health practices that are solidarity and equally in the interests of all, at the same time that health practices of universalist orientation help sustain the internalisation of a post-conventional justice by creating the space for social solidarity to flourish. The relationship between justice and health, therefore, is dynamic, and solidarity is the link which keeps this relationship flowing in both directions. In sum, just as justice is good for health, health is good for justice.

2 The right to health

Having established a relationship between health and justice, this section briefly access whether this perspective has any implication to the controversial right to health. Despite being largely recognised in domestic and international law, it still stirs controversy for a number of different reasons, including the lack of funding and economic viability, the lack of definition of obligations and accountability, the lack of moral obligation to fulfil this positive claim, the conceptual inappropriateness of the right to health, and even the lack of agreement on the definition of health itself. This section analyses the challenges to the right to health presented by Onora O'Neill and Thomas Pogge's institutional approach to rights and attempt to bring socio-economic rights within the negative rights categories as an opportunity to explore whether Habermas's conceptualisation of rights offers a more promising approach to the right. Before that, a brief account of the status of the right to health is developed.

The World Health Organization,[524] states in the preamble of its constitution that '(t)he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'.[525] More modestly, in the Universal Declaration of Human Rights, healthcare is mentioned in Article 25 (1) which states that 'every person has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services…'[526] The right was eventually reinforced and broadened at the United Nations by the International Covenant on Economic, Social and Cultural Rights, in which Article 12 binds the States Parties to 'recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[527] In addition, Article 12.2 of the Covenant establishes the provisions that states are required to make to realize it: Article 12.2 (a) provides for the right to maternal, child and reproductive health; Article 12.2 (b) provides for the right to healthy natural and workplace environments; Article 12.2 (c) provides for the right to prevention, treatment and control of diseases; and Article 12.2 (d) provides for the right to health facilities, goods and services.

The right to health with its broad scope has been also recognised in many International Treaties and incorporated into various domestic jurisdictions. It is recognized *inter alia*, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965; in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979; in article 24 of the Convention on the Rights of the Child of 1989, in Article 11 of the European Social Charter of 1961 (as revised); Article 16 of the African Charter on Human and Peoples' Rights of 1981; and Article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural

[524] Hendriks, 1998, p. 389.
[525] See WHO, 1946.
[526] UNDHR.
[527] CESCR, 2000, p. 1.

Rights of 1988.[528] Moreover, currently 192 countries are members of the World Health Organization abiding by its constitution.[529]

Despite this wide recognition, the status of the right to health as a positive right is still contested. To the mainstream jurisprudence, with a few exceptions coming from jurisdictions such as South Africa and Latin America, the right to health, along with other socio-economic rights, is seen more as an aspiration or a moral right rather than a legal right proper. While civil and political rights are generally understood as negative, cost-free, allowing immediate implementation, precise in meaning and non-ideological, socio-economic rights are generally considered positive, resource demanding, of progressive implementation, vague, and ideological.[530] Historically, this dichotomic approach is reminiscent of the creation in 1952 by the 'Separation Resolution' of two separate covenants on human rights under the United Nations[531], the Covenant on Civil and Political Rights and the Covenant on Socio-Economic and Cultural Rights. This separation reflected the political normative dispute over the hierarchy of rights between capitalist and socialist countries in the post-war context.[532] This separation was later rejected by the 1993 Vienna Declaration, which states that: '(a)ll human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis'.[533] This step, however, did not represent the end of the debate, now facing a post-cold war scenario. With the end of the cold war, for many, the priority of Civil and Political Rights seemed reinforced.[534]

This is not to say that courts have not have not made decisions taking socio-economic rights into consideration. The European Court of Human Rights, in the case *Airey and Ireland,*[535] for example, which involved the debate whether the right to a fair

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[528] CESCR, 2000, p. 1.
[529] See WHO: http://www.who.int/countries/en/
[530] See Koch, 2003, p 5.
[531] See Evans, 2002.
[532] For an account of the different inputs to the debates leading to the Universal Declaration of Human Rights by capitalist and socialist countries, as well as developed and developing countries, see Morsink, 1993. See also Evans, 1998; Koch, 2003.
[533] See United Nations (1993) World Conference on Human Rights, Vienna Declaration and Programme of Action.
[534] Evans, 2002.
[535] E.C.H.R. Series A, No. 32, Judgement of 9 October 1979

trial in civil lawsuits would involve the right to legal aid for people of reduced financial means, stated that there are no clear-cut divisions between civil and political rights and social and economic rights and that the fulfillment of a right under the Convention would sometimes require positive action. The Court stated that

> [t]he court is aware that the further realization of social and economic rights is largely dependent on the situation – notably financial – reigning in the state in question. On the other hand, the Convention must be interpreted in the light of present day conditions and is designed to safeguard the individual in a real and practical way as regards those areas with which it deals. Whilst the Convention sets forth what are essential civil and political rights many of them have implications of a social and economic nature (…) the mere fact that an interpretation of the Convention may extend into the sphere of social and economic rights should not be a decisive factor against such an interpretation; there is no watertight division separating that sphere from the field covered by the Convention.[536]

Ida Koch observes, however, that the recognition of socio-economic rights as justiciable rights seems to apply only 'to situations where the social rights appear as necessary fulfillment elements in civil rights, and often, the criteria for accepting the social fulfillment elements as part of the civil rights are not very transparent.'[537] As she concludes, socio-economic rights, therefore, are not legitimated on their own right, which tends to reinforce the priority of civil and political rights. Moreover, matters of socio-economic deprivation which are not evidently tied to a compromise in the exercise of a civil or political right do not receive legal protection and enforcement. As Koch remarks, 'those who are '"only" hungry, homeless or without health care cannot count on having the legitimacy of [their] claim enforced by the judiciary'.[538]

This functionalist dependence of socio-economic rights to the exercise of civil and political rights can be observed in the European Court case of *D. v The United Kingdom*[539] which involved an AIDS patient in terminal stage facing expulsion to his home country (St. Kitts in the Caribbean) in which no treatment for his condition was available. The Court ruled in favour of the patient; however not on the basis that in being allowed to stay in the UK he would be able to receive the needed medical

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[536] See *Airey v. Ireland,* cited in Koch, 2003, p. 22.
[537] Koch, 2003, p. 25.
[538] Koch, 2003, p. 25.
[539] E.C.H.R. Reports 1997-III, Judgment of 2 May 1997.

treatment that otherwise would be unavailable to him. The decision revolved around the political issue of expulsion and was finally based on the grounds that his removal would violate Article 3 of the European Convention which prohibits inhumane treatment.

In fact, the prohibition of inhumane and degrading treatment alongside the right to life, the right to private and family life,[540] and the principle of non-discrimination have being more commonly been appealed to when dealing with cases involving human health,[541] reinforcing the fact that the courts are generally very reluctant to acknowledge that the positive claims they entail can be justiciable.[542] Furthermore, in the few instances that they do acknowledge so, as Aart Hendriks points out, they tend to restrain themselves to issues of the bare minimum content of the right,[543] and when the case is decided against the fulfillment of the positive right, there is generally the acknowledgment of the limitations of resources as well as the acknowledgement of the limited role of the courts in matters of policies of welfare institutions.[544]

2.1 Health as a relational right

O'Neill's skepticism towards the right to health starts with the expression 'right to health', as the right can sound absurdly unrealistic if literally interpreted as the right of everyone to be healthy with the according obligation on people or states to assure it for all. As she claims, the right to health is 'literally speaking incoherent (…) a fantasy that overlooks the fact that no human action can secure health for all' and that 'there can be no human obligation to do so, and hence, no right to health'.[545] Against this literal interpretation of the meaning of the right, Virginia Leary argues that the right to health is simply a shorthand expression translating propositions such as a right to health care, a right to health protection or a right to healthy conditions. She adds that in the context of Human Rights law, the right does not receive such literal interpretation.[546] In addition,

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[540] See *Lopez Ostra v. Spain*, E.C.H.R. Series A No. 303 C, Judgment of December 1994; *Guerra v. Italy*, E.C.H.R. Series I No. 64, Judgment of February 1998;
[541] For a general account of National and International Courts approaches to the right to health see Hendriks, 1998, and to their approach to socio-economic rights more generally, see Koch, 2003.
[542] Hendriks, 1998, p 401.
[543] Hendriks, 1998, p 402.
[544] See Koch, 2003.
[545] See O'Neill, 2002, p 10.
[546] See Leary, 1994.

the Committee on Economic, Social, and Cultural Rights has also clarified that 'the right to health is not to be understood as a right to be *healthy*'.[547] It also qualifies the right's normative content by commenting that its interpretation

> takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.[548]

Apart from its conceptual awkwardness, O'Neill has more reasons to be sceptical about the right. She considers, for example, that the proliferation of rights that followed the Universal Declaration of Human Rights is detrimental to the concept, because it trivialises people's understanding of rights and delays action due to the lack of objective meaning of many of these rights and the lack of identification of their correspondent obligation bearers. She argues that

> (a) common problem with rights based approaches is that rights are usually identified using highly ambiguous substantival phrases such as "right to life" or "right to health", "right to development" and "right to work", "right to equal opportunity" and "right to access", as well as latterly "right to know" and "right to not know". Most of these phrases have multiple interpretations: they cannot be disambiguated without sorting out *who* has to do *what* for *whom* – in short by specifying which *obligations* correspond to various more specific interpretations of each supposed right. Taking rights as basic to ethics, including health ethics, does not get close enough to the action.[549]

Thus, for O'Neill the language of rights by focusing on the recipient does not properly address pressing moral issues, such as world hunger, because it does not specify *who* has the correlative obligation of fulfilling these rights.[550] She argues that

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[547] CESCR, 2000, p. 2.
[548] CESCR, 2000, p. 3.
[549] See O'Neill, 2001a, p. 42.
[550] Pogge, 1992, p. 233.

morality is better construed in the language of duties,[551] and making reference to Kant's categorical imperative she argues that moral agents act out of duty for its own sake. Other elements such as obligations, rights, claims, virtues, capacities, dispositions and conducts of agents, therefore, have only a conditional value and are themselves derived from duty.[552] It follows from this perspective that rights have always correlative duties, but duties sometimes meet no correlative rights. As she explains, the advantage of this approach is that duties go beyond rights, amplifying thus the content of morality.[553]

Using the example of world hunger O'Neill argues that people do have a duty to help; however, as she states this duty is owed to no person in particular. The helper can determine *who* and *how* to help. Therefore, in the case of hunger, no one has a specific claim against anyone, and especially not against someone who is already helping someone else.[554] If there is no claim, she argues, there is no right, and for this reason the language of obligations are more adequate to address important moral issues. When rights are promulgated without allocation of correlative obligations, and O'Neill points out that many of them cannot do so, they cannot be claimed from others and therefore amount to 'manifesto rights'.[555] The lack of allocation of responsibility for realising the right to health, adds therefore, for her scepticism towards the right.

Pogge, disagrees with O'Neill, arguing that in situations in which a right has to remain unfulfilled, for lack of conditions to help for example, it does not mean that there is no such right. It only means that there is a conditional content attached to that claim, meaning that the right can be fulfilled only under feasible conditions. For example, if every better-off person is already helping the hunger the most they can, and some people still remain hungry because the help is not enough due to genuine lack of conditions, the better-off will not be violating the remaining hungry people's rights. It does not mean in this case that there is no right to be free from hunger or that the right is a manifesto

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[551] Pogge, 1992, p. 233.
[552] As Pogge emphasises, according to the Kantian tradition, duty is the primary source of morality.(1992) pp. 234-6.
[553] Pogge, 1992, p. 237.
[554] This is in contrast with other duties such as not to submit a person to torture, according to which everyone has an absolute duty towards everyone, yet the victim of the violation of this right have a specific claim only against specific persons, i.e. those who were directly involved or supported the practice (1992).
[555] Pogge, 1992, p. 240.

right; rather it means that although having a morally legitimate and genuine right, these remaining hungry people have no claim against others.[556] He argues therefore, that rights sometimes can be unspecified and conditional to feasible conditions and that both languages of rights and duties can be rightly employed to address important questions such as world hunger.[557]

O'Neill's approach relies heavily on individuals' self-allocation of duties. In a modern complex world in which it is increasingly difficult for individuals to identify to whom they owe obligations, however, her focus on obligations rather than rights may not necessarily be more effective. In addition, this approach does not eliminate motivational deficits, as there is no good reason to believe that focusing on moral duties and obligations instead of rights will be empirically more persuasive to the unwilling better off, who may just as well deny they bear such obligations. This problem of motivation is better addressed by Habermas, who argues that fulfilling rights cannot be safely left to moral rules. He conceives rights as legal categories, which associating their moral character with the facticity of law, and therefore, are better suited to address the question of motivation and fulfillment of rights.[558]

As a result, this individual centered conception of bearers of obligations tends to be deficient in conceiving collective or institutional duties of rights fulfillment. For Pogge, the best presentation of morality conceives people not merely as individual moral agents but also as coexisting participants in social institutions and social practices.[559] This is because in doing so the importance of human arrangements in the violation of rights is brought into view.[560] Therefore, according to him, moral agents not only have duties towards others individually but also have the collective duty to work

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[556] In other words there is a right but not a corresponding claim. Here Pogge differentiates rights from claims. The former are fundamental and held unconditionally whereas the latter only arise or are generated in particular circumstances specified by the former. He gives the example of the right to the fruits of one's labour. One has also a claim to the fruit of one's labour when one is working; yet those who do not work have no claim to make against anyone, but they unconditionally hold the right, which will generate claims when one starts working (1992, p. 234).
[557] Pogge, 1992, pp. 238 and 247.
[558] See Flynn, 2003; Habermas, 1995a, p. 68; 1996.
[559] Pogge, 1992, p. 246.
[560] Pogge, 1992 , p. 246.

for just social arrangements.[561] The correlative right also exists – people have the right to live under just social arrangements, which allow them to fulfill their basic needs.[562]

Thus, under Pogge's institutional model individuals not only have to refrain from causing direct harm to others but also have to refrain from supporting, participating or simply being indifferent about institutions that contribute, support or directly harm others. This approach brings an interesting light to liberal perspectives on human rights. First, it broadens the concept of harms and responsibilities – people have duties and carry the responsibility of not harming others not only by their own direct actions, but also by not indirectly supporting policies and institutions that harms others. This concept of harms and responsibilities addresses more adequately the impersonal mode of human rights violations which characterizes the current world order. Furthermore, Pogge's reinforces the connection between realisation of human rights and democracy by assigning a vital role to citizenry participation.[563]. He allocates a fundamental role to the citizenry in condemning negligent and unjust governments and policies and in refraining from participation in institutional arrangements that violate the rights of others. For Pogge, a committed citizenry is crucial in securing human rights. As he argues:

> (w)hat is needed to make the object of a right truly secure is a vigilant citizenry that is deeply committed to this right and disposed to work for its political realisation (...) and (if need be) replace or reorganize their government so as to safeguard secure access to these objects for all.[564]

Pogge claims that an advantage of his focus on duties of non-participation in institutional orders that violate human rights is that his theory, in contrast with mainstream liberalism, does not categorise socio-economic rights as 'manifesto rights'. This is because he attempts at incorporating socio-economic rights within the domain of negative duties, and therefore, also at bringing socio-economic rights in line with liberalism. As he states,

> (t)his institutional understanding narrows the philosophical gap because it does not sustain the thought that civil and political human rights require only restraint, while social and economic human rights also demand positive efforts and costs. Rather, it emphasizes negative duties across

[561] Pogge, 1992 , p. 246.
[562]Pogge, 1992 , p. 246.
[563] Pogge, 2002, p. 63.
[564] Pogge, 2002, p. 62.

> the board. Human agents are not to collaborate in upholding a coercive institutional order that avoidably restricts the freedom of some so as to render their access to basic necessities insecure without compensating for their collaboration by protecting its victims or by working for its reform.[565]

Yet, one of the problems with bringing socio-economic rights within the category of negative rights is that this categorization may not be adequate to address conditions of extreme deprivation and suffering, in which simply refraining from doing harm is not enough. Here Habermas's relationship of justice and solidarity grounds a more promising approach:

> Just as justice and solidarity are simply sides of the same coin, so too negative and positive duties spring from the *same* source. If rights and duties are to foster the integrity of individuals who are by their very nature socialized, then the constitutive social context of interaction is not something secondary for those whose lives and identity are made possible and sustained by it. Omissions are no less a potential threat to personal integrity than injuries actively inflicted.[566]

For Habermas,[567]rights are relational categories, representing the normative standards of relationships between people. As the individualistic concept of rights gives way to a discursive understanding and mutual allocation of rights and responsibilities, negative rights do not enjoy privilege over positive rights.[568] This relational character of rights is also supported by Martha Minow. In her words,

> Interpreting rights as features of relationships, contingent upon negotiation within a community committed to this mode of solving problems, pins law not on some force beyond human control but on human responsibility for the patterns of relationships promoted or hindered by this process. In this way, the notion of rights as tools in continuing communal discourse helps to locate responsibility in human beings for legal action and inaction.[569]

The right to health, therefore, should also be interpreted in relational terms. It represents our normative commitments to support a structure of care that helps people in periods of illness, in which pain, physical discomfort, and loss of identity and autonomy may occur. These experiences of illness are also resistances that put to test people's

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[565] Pogge, 2002, p. 70.
[566] Habermas, 1995a, p. 68.
[567] Habermas 1996, especially pp 409-27.
[568] Habermas, 1995a, pp. 68-9.
[569] Minow, 1990, p. 309.

understanding of the world. A solidaristic system of health not only provides comfort and support for the ill, it also reaffirms the cooperative basis of society. The right to health thus represents this commitment to protect not only our autonomy but also the space in which relations of mutual recognition and solidarity can be fostered. The reciprocal relationship between health and justice, revealed through a discourse theoretical perspective provides good and more solid reasons for upholding the right to health as a legitimate human right.

Conclusion

This thesis started by reflecting on the moral uneasiness of our times caused by the awareness both of the preventable large scale human suffering and deprivation in times of plenty and of the possibility that through our increasingly complex interconnections we may be contributing to these tragedies. That we are increasingly individualised and yet increasingly interconnected in ways that escape our full awareness and understanding poses an important moral question to the late modern individual. How can we regulate our lives together in a world of increasing complexity, pluralism, and functional interconnections? We cannot rely on any particular unified set of rules, and in addition, as moral agents it becomes increasingly difficult to identify all those to whom we owe moral accountability. As studies show that modern life itself affects people's health in a variety of ways, identifying precisely how much each one of us is responsible for that becomes an impossible exercise. Nevertheless, regardless of whether modern life arrangements are fair or unjust, or whether some people are naturally more vulnerable or directly harmed, the mere fact that social arrangements or life in society in itself contribute to these situations or aggravate them does pose a question of moral accountability. The weight of this question may well exceed the resources of conventional ethical horizons. How far can ethics of face-to-face encounters or old dichotomies between positive and negative duties take us? To what extent are they (unwillingly) condoning reality? Does not this paradox of increasing individualisation on the one hand and increasing interconnection and interdependence on the other demand that we reframe or at least expand our moral horizons?

The premise of this thesis is that Habermas's discourse theory offers the best alternative to address these questions. Because his account of individuation through socialisation, and indeed his intersubjective paradigm, do not construct the individual either in tension or absorbed by society, but rather interrelated with it, his theory is in a better position to analyse the moral challenges of the modern world. His intersubjective paradigm leads him, for example, to construct the relationship between justice and solidarity as one of partnership and interdependence. In contrast with liberal constructions of justice in which values of benevolence and charity are called as

backups to address the distortions that an individualist ethics generates, solidarity in Habermas is not simply a complement to justice, but its counterpart. It is grounded on the insight that individuals cannot be protected in their uniqueness without protection of the net of intersubjectivity that forms and protects their very identities. From this perspective, we find good reasons to be concerned with the fate of others and with protecting them even when their conditions are not caused by perceived injustices. Hence, we have good reasons to believe that caring for the health of others and that caring for the vulnerable and the ill matters for justice. This is because justice conceived discursively relies on a solid ethical orientation of solidarity with others. Further implications of this perspective on the relationship between justice and solidarity is that it makes no sense of categories of negative and positive duties, and it includes within the focus of our moral concerns 'everything that wears a human face'.

Habermas's post-conventional and procedural account of morality is not without its problems. As seen above, it has only a weak force for motivating action. The mere awareness of duties towards others do not secure that modern individuals will act upon it. This motivational deficit has to be compensated by an ethical orientation that supports and incorporates post-conventional premises, and this ethical orientation needs to be nurtured by the everyday practices of the lifeworld.Therefore, justice relies on the lifeworld as the source of much needed solidarity and orientation towards mutual recognition. To realise this radically inclusive conception of justice, one that understands that an individual's freedom cannot be bought by the oppression of others, is a project that places the possibility for emancipation in the communicative practices of everyday life. Furthermore, the responsibility for taking up this project is placed on our shoulders.

In thinking how our everyday practices can be set towards this project of emancipation, this thesis explored the role that health plays in this project. With the help of Habermas's discourse theory this thesis concluded that an uncolonised health system plays an important role in reproducing the lifeworld and in fostering the conditions for justice by providing a space for social criticism, by exposing the vulnerability and interdependence of our selves, by contributing to the process of socialisation by facilitating the reconstruction of less egocentric selves, by remind us of the cooperative

basis of society, and by nurturing solidarity. In doing so, the health system establishes a reciprocal relationship with justice. As justice is important for its maintenance, its maintenance is important for justice. This relationship, by its turn, gives us good reasons not only to support the system in the shifting roles we play in it, but also to resist its commodification and bureaucratisation.

Habermas's theory served well for the purpose of analysing the relationship of health, solidarity, and justice. The wide scope and complexity of his theory offers a range of tools that make possible an analysis of health in all its complexity. In this thesis, for example, his theory allowed an analysis of the debate on the definition of health, concluding that health has no definite definition, but a multitude of interpretations which can be equally legitimate, depending on the validity of reasons given in their support and on their appropriateness to the context. Therefore, the concept of health in a medical research environment may be different, yet equally legitimate to the interpretation of health in the context of a bioethical debate. In the context of analysing the relationship of health with justice and solidarity, an appropriate interpretation must take account of its normative dimension. For this thesis this normative dimension was captured by an intersubjective understanding of health. This intersubjective understanding led to the analysis of the experiences of health, illness, and healthcare from the perspective of the participants, which revealed the deeply moral and political character of health. These moral and political characters pointed to the relevance of health to justice.

Habermas's dual concept of society also allowed the development of a model of health system as a sub-system of the lifeworld that incorporates the different types of interactions, knowledge generation, and institutions associated with health. These different constitutive parts of the health system were associated with different structural components of the lifeworld, different moments of reason, different types of discourses, and different forms of contributions to society. The contributions towards social integration by nurturing solidarity and socialisation by facilitating the reconstruction of selves capable of joining relationships of mutual recognition and of taking responsibility for others permitted the link between health and justice. This dual concept of society also permitted the identification of the distortions in the health system as processes of

colonisation by the system media, and the analyses of the consequences of this colonisation both from a functional and normative point of view. If the health system is to maintain its emancipatory potentials and its reciprocal relationship with justice, it is concluded that these processes of colonisation need to be resisted. In sum, in its choice of methodology this thesis concludes that the discourse theoretical method is both a powerful instrument for social analysis and critique and an alternative approach that inspires the possibility that a new reality can be generated.

The debate on health and its relationship with justice is not new. It has been widely studied from a multitude of angles. Health has been linked with justice by being conceived as a capability, as a right, as instrumental to opportunities, as a virtue, as a basic need, and even as having no link with justice at all. Yet, there is a very limited literature interpreting the relationship between health and justice from a discourse theoretical perspective. Contributing to fill in this gap was one of the purposes that this thesis hopes to have accomplished.

This contribution is a work in progress, of course. The analysis here developed has a lot to benefit from an exchange of ideas with critics from different disciplines and theoretical orientations. It can also benefit by the insights gained by the application of its concepts to more specific debates such as: (a) the (different) implications of this interpretation of health and justice at the domestic and international level; an analysis that would also benefit from Habermas's reinterpretation of Kantian cosmopolitanism; (b) the implications of this perspective on bioethical debates, of which the commodification of the body and its parts would be specially illustrative of an attempt of systemic colonisation and the resistance that it finds from the lifeworld; (c) the application of the discourse theoretical model of health systems here developed to the analysis of different contributions of self-help groups in either supporting the solidaristic basis of health systems or in reinforcing bureaucratic clientelism and exclusivist policies; (d) the importance of increasing public participation in health systems; and (e) the implications of profit-based healthcare systems, considering that the analysis developed in thesis seems to imply that such form of organisation, especially in its corporate form, may be at odds with the values of an uncolonised health system.

Finally, this thesis concludes that preventing the moral tragedies that characterise modern society, requires, as Habermas defends, that we make good the emancipatory ideals of modernity. The success of this project depends on the protection of the integrity of the lifeworld against economic and administrative encroachment; it implies creating the conditions for a socialisation within the premises of a radically inclusive morality and the nurturing of solidarity and of relationships of mutual recognition. Protecting the lifeworld is our task and responsibility, and the health system can offer a much needed help if we succeed in rejecting the systemic encroachment of this deeply meaningful space. The right to health should also be seen under these premises, i.e. as a right that represents the commitment to protect not only our autonomy but also the space in which relations of mutual recognition and solidarity can be fostered and thus allowed to give their contribution to social integration and to the possibility of justice. It may be no easy task, but is one that we cannot afford to evade.

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