Perspectives on the Economics and Sociology of Health: Contributions from the Institutionalist Approach of Economics of Convention - An Introduction

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Philippe Batifoulier & Rainer Diaz-Bone *

Abstract: *»Perspektiven auf die Ökonomie und Soziologie der Gesundheit. Beiträge des institutionalistischen Ansatzes der Ökonomie der Konventionen – eine Einführung«.* This article introduces the approach of economics and sociology of conventions (in short EC) as a neopragmatist institutionalism in the field of economics and sociology of health. For EC, conventions are regarded as institutional logics of valuation, valorization, and coordination, and EC emphasizes the empirical plurality of orders of worth and values actors rely on and institutions are built on. In particular, health, health care, and its institutions are closely linked to value issues and norms. Because of the pluralism of possible value systems and orders of worth, tensions and critiques are an important empirical phenomenon to be addressed in the health care system. The contribution sketches main positions and perspectives of EC in the analysis of values, medical professions, and ethics of datafication, quantification, classification (related to health and health care institutions), and of social inequalities as well as in the analysis of health policies and health capitalism. Furthermore, the COVID-19 pandemic and its consequences are discussed from the standpoint of EC and, finally, social trends and perspectives in times of the pandemic are outlined.[1]

Keywords: Economics of convention, sociology of conventions, valorization, health economics, COVID-19 pandemic, quantification, social inequality, neopragmatism, health capitalism.

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[1] For a presentation of classical pragmatism, see Misak (2013).

1. Introduction

The modern health care system emerged mainly in times of industrialization. It was invented to protect populations against the financial and medical risks resulting from different forms of illnesses. What is recognized as "illness" has changed over time – and still changes. This depends on the medical and political processes, which establish a form of "illness" in the medical and institutional classifications of the health care system. In the 20th century, major characteristics of the institutional design of the health care system in Europe have been to comprise whole populations and to include persons based on their professional status and the principle of solidarity thereby charging individuals based on their income and family status, but not in regard to their individual health risks. Evidently, there have been ways of medical treatment and former health institutions before industrialization. These have been precursors (e.g., for modern hospitals) that still partly exist today and leave their "institutional traces" in contemporary societies. Nowadays, the health care system is changing due to the impact of neoliberal politics, of datafication and digitalization (Ruckenstein and Schüll 2017; Sharon 2018; Timmerman and Kaufman 2020; Diaz-Bone et al. 2020), and also of changing life styles and of fundamental changes in the system of professions and labor organization. Also, health has proven to be considered as a new business sector promising high profits by the pharmaceutic industry. Health has evolved to be a new life style topic, transforming health to an end in itself and aligning everyday life style practices towards the self-quantification of health indicators and towards the individual self-optimization of one's body and soul (Ajana 2020).

The health care system as well as public debates on health and health related governance are coined by a plurality of ways how to design health care institutions and how to govern health care. This plurality of institutional and political logics can be named as a plurality of conventions. The institutional approach of economics of convention – in short EC[2] – has worked out a notion that conceives of conventions as logics of coordination, interpretation, and evaluation. Regarded this way, conventions are both the deeper structures of institutions and at the same time the devices for coordinating actors in situations.

One of the main objectives of EC is to regard values as endogenous to coordination (i.e., not as an external constraint or a given fact to coordination in situations) and to take values as ethical resources of individuals' coordination seriously. The health sector is precisely one of those domains in which

[2] In France, EC is named "économie des conventions"; in Germany, EC is also called "Ökonomie der Konventionen."

deontological and professional rules, social values, and the concept of ethics (medical, in this case) are omnipresent. Healthcare and social policy are strongly normative issues and economic analysis cannot ignore them. Because health policies are precisely one of those domains in which coordination, value judgments, and normative considerations cannot be separated, the concept of convention is well indicated to understand neoliberal health policy. The next section shortly introduces EC and its main concepts (section 2).[3] So far, outside of France, the applications of EC to the fields of health, sociology, and the political economy of health are not well known. Therefore, EC's perspectives and contributions to the analysis of health care and its institutions will be sketched (section 3). For some years now, the approach of EC has spread in Europe and has been by different scholars to health. As the contributions in this special issue demonstrate, the range of topics has also expanded (section 4).

The COVID-19 pandemic is a specific occasion that brings to the fore institutional and social tensions as well as public disputes about health-related values (section 5). Finally, some perspectives are developed on the basis of EC's perspective on the health care system and the contemporary pandemic (section 6).

2. Economics and Sociology of Conventions

EC can be conceived of as a pluralist and (neo)pragmatist approach for empirical analysis of social institutions, of their design, implementation, and usages. EC is part of the so-called new French social sciences, which are critical towards pre-given categories and ontologies. EC focuses the situational logics of coordination, interpretation, and evaluation, which EC calls "conventions." An important position of EC is not to regard institutions as external constraints on human action and coordination, but as dispositives for collective action, which need actors' interpretation and evaluation to be pragmatically applied in real situations. To do so, actors rely on conventions as logics and orders of justification (Boltanski and Thévenot 2006). The empirical coexistence of a plurality of conventions in real situations opens possibilities for critique and tension, but in most everyday situations, stable compromises between conventions do exist on which actors rely for their everyday routines. EC has been developed in France since the 1980s and has step by step been established in the international landscape of social scienc-

[3] Former Special Issues of *Historical Social Research* have also been devoted to EC. See Diaz-Bone and Salais (2011, 2012), Diaz-Bone, Didry, and Salais (2015), Diaz-Bone and Didier (2016), and Diaz-Bone and Favereau (2019). For open access to these special issues, see https://www.gesis.org/en/hsr/full-text-archive.

es.[4] EC has been transdisciplinary in character from its beginning. The founders of EC have been trained as economists and the representatives of the second generation in France are also mainly economists. Outside of France, it was mainly sociologists who adopted this new approach and applied it to a wide range of topics in the social sciences. This is the reason for labeling EC also as "sociology of conventions" (Diaz-Bone and Thévenot 2010) and to think of economics and sociology of conventions as a wide-ranging approach in the social sciences. One of the foundational fields to develop and to apply EC has been the analysis of statistical categories, statistics, and quantification (Desrosières and Thévenot 2002; Desrosières 2011; Diaz-Bone and Didier 2016; Mennicken and Espeland 2019). Quantification has become the most important cognitive form in health care and health statistics has been an important "investment in form" (Thévenot 1984) in the health care system (Batifoulier et al. 2018; Da Silva 2018). With the rise of big data, this process has intensified (Ruckenstein and Schüll 2017; Sharon 2018). Laurent Thévenot has worked out a concept for the analysis of individuals' coordination with their personal environment, which he calls "regimes of engagement" (2006, 2014). These regimes are different to the conventions (understood as logics of coordination, evaluation, and valorization) because they are not related to the need of (public) justification. The concept of regimes of engagements proves to be highly fruitful in the analysis of health care practices – especially in regard of individuals using digital health care devices in their everyday life.

Critique on the "datafication" of health has also risen, and social research has critically addressed the datafication of health and big data in the field of health (Ruckenstein and Schüll 2017; Diaz-Bone et al. 2020). For EC, the health care system is special because health cannot be regarded as a simple commodity and the health care system is based on different normative orders (as laws, general principles, ethics), which EC can approach. Norms and values, but also critique as well as justifications, are therefore regarded as basic institutional foundations. This is the reason why EC can be regarded as a neopragmatist institutionalism to study the specific plurality of empirical normative realities: EC conceives of conventions as institutional logics but also as normative orders and EC studies the tensions between these normative orders as one of the driving forces of institutions and social processes (Boltanski and Thévenot 2006).[5]

[4] For introductions and overviews, see Storper and Salais (1997), Batifoulier (2001), Orléan (2004), Eymard-Duvernay (2006a, 2006b), Boltanski and Chiapello (2005), Boltanski and Thévenot (2006), Diaz-Bone (2018), and Batifoulier et al. (2016).

[5] As neopragmatism did (e.g., Putnam 2002), EC has developed a critical stance against the separation of facts and values in science too, pointing to the existence and need of epistemic values for empirical research (Diaz-Bone et al. 2020).

3. Convention Theory Applied to the Analysis of Health Care

Today, health issues are one of the most virulent research topics in the social sciences. In the field of economics and sociology of conventions, the analysis of health issues has already been established for some decades in France.[6] Nowadays, scholars in the growing field of EC in different European countries apply this approach to a huge range of topics in the analysis of health, health care, and health institutions.

By privileging a value-based standpoint, convention theory applied to the analysis of health adopts an original positioning within a tradition of institutionalist thinking that is usually centered on rules. The aim of contributions from the approach of convention theory is to account for the particular nature of health, an essential piece of individual and collective well-being. The health sector is an ideal topic for the institutional approach of economics of convention because healthcare and health policy are strongly normative issues.

Several researchers, mainly in France, have developed an economic approach that highlights the omnipresence of values in the field of healthcare. Because economic health policies are precisely one of those domains in which coordination, value judgments, and normative considerations cannot be separated, convention theory is well indicated to understand the specifics of the health sector.

3.1 Medical Ethics and Value-Based Analysis

Convention theory has made it possible to renew the conception of the physician as an economic agent. In the domain of healthcare and physician's behavior, ethical considerations are omnipresent. Every medical profession has a professional morality, supported by a "code of deontology" that stipulates the ethical attitude to be followed, a "Council of the Order" to enforce it, or, for the doctors, a "Hippocratic oath" that solemnly commits them to an ethical orientation.

What is there to do with this professional ethic? For medical sciences and many health care providers, this means that it is necessary to stop trying to rationalize the practice of medicine by imposing an economic view. Because of professional values and medical ethics, medicine governs the practicing

[6] The main contributions to the analysis of health from a convention theoretical standpoint have been published by French scholars (mainly from a network of scholars around Philippe Batifoulier and mainly in French). Main positions, arguments, and results are presented in this section. For a German presentation, see Diaz-Bone (forthcoming).

physician, not economics. Therefore, it is necessary to move away from an economic perspective in order to understand the behavior of the doctor. The economic analysis must be restricted to the calculation of costs.

On the contrary, for mainstream economics, economic analysis of health must be value-free. Mainstream health economics appears to have serious difficulty in taking medical ethics seriously because the standard figure of homo economicus is inappropriate to the formalization of behavior, which is far removed from the satisfaction of private interests (Batifoulier and Thevenon 2003; Batifoulier and Gadreau 2005; Batifoulier 2004). Within the homo economicus toolbox, medical ethics is reduced to an internalization of the patient's utility function into the utility function of the doctor. This instrumental medical altruism leads to consider otherness as a source of utility like any other. According to the "value-free" strategy, health economics adopts an egocentric orientation because of its conceptualization of interdependent utility functions, which means that the physician's utility increases when the patient's utility increases (Davis and McMaster 2007).

Against this conception, convention theory applied to the analysis of health considers that the mainstream toolkit is mostly deficient and the health care sector is an indicator of the deficiencies of the standard economic analysis (McMaster et al. 2015). The field of healthcare underscores the fact that human beings can suffer and that they are often particularly helpless in the face of illness, much less death. So, professional commitment and well-being of his/her patients are more of a physician's objective than self-interest is. Professional values and professional ethos govern the behavior of the doctor.

If we draw on convention theory, we can provide a theoretical elaboration of an economic analysis of the physician's behavior (Batifoulier and Da Silva 2014). Convention theory in healthcare develops an alternative to mainstream economics dealing with economic (and financial) dimensions. From a convention theorist's point of view, medicine is not unrelated to economics. Economic affairs are very important, even for physicians. It would be naive to believe that self-interest is external to practicing medicine. Many physicians show daily that they are close to financial attraction. Profit can be a main motivation and there are pecuniary influences on clinical judgment. Some doctors only focus on the well-being of patients. Others practice their art with financial motivations and may develop discretionary power that is not always in the patient's best interest. There is not a single form of rationality formalized by rational choice theory but a plurality of possible rationalities induced by the context of coordination. Medical rationality depends on coordination and cannot be considered as given.

Convention school approaches are developing an alternative theory that attempts to challenge the incapacity of mainstream economics to deal with values. Convention school in healthcare combines two orientations, eco-

nomic issues and how medicine works. The ethics of doctors is a coordinating institution and coordination is one of the most important economic problems. So, an economic analysis needs to recognize this essential issue and to introduce the problem of values into coordination. The solution of convention theory is to endogenize values within coordination. In order to capture the coordinating capacity of medical ethics, we need to re-integrate the three dimensions, strictly differentiated by mainstream economics: coordination, rationality, and values. Many contributions (Batifoulier and Gadreau 2006; Batifoulier et al. 2011) offer a way to renew the medical ethics analysis. They can be summarized as follows: the coordination between a doctor and a patient or between physicians depends on values in order to comprehend the interaction. This interpretation relies on a collective representation of references that we can call conventions or, in other words, a way of judging the situation and of judging oneself and the other party in that situation. So, for example, when a patient consults a physician, he knows that the doctor's behavior is governed by deontological rules. To be applied, these rules must have a *hic et nunc* interpretation, considering both the collective formed by the patient and the doctor and a wider collective consisting of the whole health care system; the whole allowing to evaluate the quality of the service provided (the length of the consultation or the level of fees, in particular). This understanding is not only cognitive but also evaluative, with the form of evaluation determining the importance of what the agent considers. Therefore, this interpretation will not be the same on every occasion or in every place. That is why we have to consider the plurality of possible representations and the impossibility of reducing medical ethics to a universal and invariable conception of ethical behavior. Ethics is neither immutable nor mechanical; it is very sensitive depending on its context.

The work undertaken on medical ethics, as a normative support to behavior, based on an interpretative rationality leads to a fresh reflection on the inability of public policy to control the growth in spending and inequalities in access to care. Neoliberal-oriented public policy tends to influence representations and assessment criteria, and consequently, they influence the definition of behaviors that are considered as complying with norms, including ethical standards. Medical ethics eventually changes and the conception of what legitimates action is changing (Batifoulier and Gadreau 2006).

The move towards a market-oriented health system modifies the definition of legitimate behavior, especially among doctors. New behaviors emerge, qualified by the parties involved as being in accordance with the ethics (Monneraud 2009). Now, these new behaviors can lead to increases in health spending and inequalities. For example, with the neoliberal reforms, the reform price is becoming an increasingly significant factor in the medi-

cal interaction and is setting a new deal with regard to fees and extra billing, both for doctors and hospitals.

3.2 The Good Doctor and Quality Conventions

There is a plurality of values acting as a conception of what is "good" in order to justify or criticize behavior or policy. According to EC, there are a small number of shared references, detached from particular interests, that can be called conventions, and these conventions are collective representations of a hospital or of the quality of a doctor.

With EC, one can question the quality of care in the hospital or what is a "good doctor": not to reduce it to an unambiguous definition and without prior deliberation.

All hospital reforms in Western countries are carried out in the name of quality of care. But it is a particular form of quality based on an industrial quality convention. This industrial quality justifies the standardization of care and the setting of the medical work in protocol (Da Silva 2018; Da Silva and Rauly 2016). It also legitimizes the regrouping of hospitals, which results in the closure of local hospitals and in particular maternity hospitals. The promotion of large specialized entities ("big is beautiful") highlights a particular concept of quality: industrial quality that promotes efficiency and performance. This positioning is legitimate for its supporters because it seems necessary to close (or privatize, as in Germany) a hospital that does few medical procedures and can be dangerous for the patients.

Such a vision of quality is related to the biomedical model which controls Western medical thought and its descriptions of care. Within this model, care is a treatment intended to ensure health. Illnesses are a consequence of some disruption to or malfunction of the biological process. Normativity is a biological normativity, forgetting the social determinants of the disease.

However, there are other definitions of quality of care and they are equally legitimate. Patients value "domestic quality" where quality care is care that is accessible in time (a quick appointment) and space (doctors available close to the patient's home). Patients refuse the closure of hospitals and the domination of industrial quality if the distance to care increases. Local care and being able to pay for it are important quality criteria.

EC's pluralistic approach invites one to analyze different healthcare quality conventions and a plural space of valorization. As the worth is not given and objective but constructed, EC focuses on the valorization/devalorization processes. Power and health policy not only give orders; they give orders of worth by defining what is more valuable and what is less valuable. This power, that Eymard-Duvernay (2016) has named "the power of valorization," is the key to understanding hospital reforms in Western economies.

A "welfare elite" and health bureaucracy delineate the scope of problems considered important as well as possible solutions. The industrial process and the "taylorization" of the work of healthcare workers (medical and nursing staff; Jeamet 2020) have deteriorated a "domestic" quality (by increasing the distance to healthcare) and a "civic" quality (by sacrificing the culture of public utilities). It is thus incorrect to say that the hospital reform has improved the quality of care. It has developed some qualities but has deteriorated others.

The valorization/devalorization processes in health care lead to dispossessing the doctor of his work. With technical guidelines and good practice guides, the quality of care is no longer defined in the medical act or its aftermath, but beforehand, by experts. The technical guidelines focus on the pathology rather than the patient, who is no more than a "case." By creating a distance between the care and the doctor, it deprives the doctor of part of his/her activity.

This evolution is in line with a "market trajectory." The industrialization of health care creates conditions of interchangeability between doctors (or even between doctors and other health-care professionals). In this way, it provides mechanisms of market judgment. By making commensurate what had been incommensurate, competition is activated, along with the possibility of exploiting it. The most eloquent example is provided by the establishment of activity-based pricing in public hospitals and the "new governance" required by "new public management" criteria. Funding is based on a flat rate according to a catalog of pathologies, regardless of the number of days of hospitalization required. This technique comes from diagnosis-related groups of the USA and is applied everywhere: "Fallpauschale" (Flat rate per case) in Germany since 2003, "T2A" ("tarification à l'activité", activity-based funding) in France since 2004. These tools of standardization promote the comparison of one hospital with any other, to put them into competition with each other and produce rankings and downgrading. Care must be cost-effective, and a "good" hospital doctor should be both a skilled medical practitioner and also a professional who brings money to the hospital.

3.3 Health Policy, Values, and Capitalism

How can an analysis of health policy be value-free? The institutionalist approach of economics of convention is heavily value-laden. We argue that these values essential to our being are consistent with and necessary to the promotion of individual dignity and consistent with caring and with a conception of health as a fundamental right. By contrast, mainstream health economics emphasizes market transactions. Health interactions are assumed to be similar to market transactions, so institutions are conceived of

as being incentives only. The health policy agenda is to find the right incentives to move closer to market functioning.

Conversely, the main protagonists in the world of health, doctor, and patient do not spontaneously operate in a commercial mode. The marketization offensive needs to transform the heart of the health care relationship, seeking to get both doctors and patients to adopt a commercial attitude. Several contributions (Batifoulier et al. 2011; André et al. 2016; Domin 2006) expanded this analysis on health insurance. In mainstream economic theory, the patient's opportunism at the source of waste is the expected reaction of individuals because they are assumed to be entirely rational and so under all circumstances looking to use health insurance to get the best for themselves. By considering that health insurance is a problem because it leads to unnecessary consumption owing to the fact that it is by and large free, its existence is not under discussion, only its harmfulness. The consequences of this economic policy are immediate: we must reduce a person's health cover and resort to healthcare that is more expensive. Making the patient pay is a fashioned strategy that is founded on mainstream theory in which the patient has no depth. He or she does not make judgments, only calculates. However, when it comes to health, patients are a long way removed from homo economicus, who has no problems of birth and survival or of passions associated with fear of illness and death, because he is immortal from the outset. The provident consumer has nothing in common with the anxious patient. Individuals are far from clear-sighted: they may make choices in opposition to their own interests and maybe that are bad for their health (in sugar, fats, etc.). Humans are terribly human and may be driven by emotions, social values, ethical judgments, etc. (Batifoulier 2013, 2015).

This completely self-interested individual does not fit in with an analysis in which access to care is a means of human flourishing. In contrast, as EC argues, socially embedded and value-based doctor-patient relationships help to explain doctors' and patients' choices. The doctor-patient relationship is a social and value-loaded relationship as opposed to a market relationship between atomistic individuals. EC highlights people's reflexivity and the type of collectivity to which we belong. Health care systems are not positioned in a vacuum of values (Batifoulier et al. 2007).

The emphasis on values is not only a means of criticizing neoliberalism. It is also a way to understand its expansion in the health sector. Although the market concept of health is the subject of much criticism, it is in constant development (Batifoulier 2014; Batifoulier and Domin 2015). The corporatization of the hospital (Domin 2015, 2018), which will prioritize the profitability of care over public health considerations, is strongly criticized. The development of private insurance is very unequal and inefficient. If the neoliberal conception resists criticism, it is precisely because it manages to present itself in the register of justifications described by Boltanski and

Thévenot (2006), mainly market and industrial justifications. Neoliberal policy also needs moral justifications.

This is why the dynamics of the health sector are also that of capitalism, which develop by recovering some criticisms and not others (Batifoulier et al. 2019; Vahabi et al. 2018). Citizen claims in the field of health cannot be satisfied with the capitalism of the Fordist period. Capitalism must therefore reinvent itself in order to develop. "Health capitalism" would then be the expression of a new dynamics of contemporary capitalism (Batifoulier et al. 2018; Da Silva and Domin 2016). Far from being a constraint to the development of capitalism, health can largely contribute to it. Therefore, thinking about tomorrow's health system means understanding what is at stake in this field by considering the embedding of health systems in a capitalist universe. Health is a key to a central understanding of capitalism.

Studying the future of capitalism cannot dispense with an analysis of the role of values. This is why EC framework is well-equipped to conduct this analysis.

3.4 Health, Quantification, and Categorization

As Alain Desrosières has argued, to quantify is to introduce a convention and then to measure (Desrosières 2008, 10). Therefore, classifications and quantifications – seen from the standpoint of EC – are not just a mirror of given social facts. Both are based on conventions as normative orders and both have normalizing impact in situations (Diaz-Bone 2016). This way, classifications and quantifications are important devices in processes of valorization and devalorization (Eymard-Duvernay 2016). Quantifications and classifications can serve collective action aiming for a common goal and a common good. The precondition for this is an agreement about the measurement conventions that will be the adequate foundation for the generation and application of numbers and categories. If this precondition is implemented, actors agree on the measurements and the reality of measured and categorized "facts"; this means the adequacy of indicators and categories.

Evidently, organizational, national, and international coordination of health standards, health research, and health provision would be impossible without numbers and categories, which form the cognitive infrastructure of modern knowledge as knowledge about health (Batifoulier et al. 2018). From the empirical perspective of EC, it will be always a (more or less stable) compromise of *different* conventions, which will work as a foundation for coordination and evaluation of data governance. From actors' perspective, deliberations should not only achieve agreement on legitimate and acceptable conventions, but also result in pragmatic compromises supported by different "stake holders" as governments, medicals, health enterpris-

es, health researchers, and citizens – as patients (Domin 2006; Batifoulier 2014). For EC, deliberations in real situations are mostly different, which is a first explanation for upcoming tensions and critique. This is the starting point for empirical institutional analysis (Batifoulier et al. 2018).

There are many historical and contemporary examples. Social conflict is the driving force for the health insurance system, since this kind of conflict about the recognition and treatment of work-related diseases has intensified since the times of early industrialization (Batifoulier et al. 2018, 2019). Here, social conflict is related to the classification of diseases and to the inclusion of new forms of sicknesses. Health classifications, therefore, have changed step by step, including new categories and relying on new conventions about how to conceive of and how to categorize health and disease.

Quantification in the health care branch has advanced its economization (Da Silva 2018). The economization and medicalization of health care have brought in the phenomenon of pharmaceutical lobbies engaging for the lowering of diagnostic thresholds. A simple strategy to extend markets for pharmaceuticals is increasing the number of patients by changing diagnostic thresholds for diseases. Such politics of quantification are possible because of the lobbying power companies have, as Welch, Schwartz, and Woloshin (2011) have shown for the US.[7] These examples demonstrate why the definitions of health and disease are a core issue for EC, because EC focuses on social processes of categorization and quantification, which frame the qualities and ontologies of both.

Medical technologies have developed over the past few centuries and medical health care nowadays is provided on a high-tech level (at least in Western societies). With the rise of digitalization and the Internet, the datafication of health has accelerated. The number of technical devices as health apps or wearables has accumulated to an enormous extent.[8] There are more and more medical health companies, NGOs, and health data infrastructures

[7] Due to the lowering of the diagnostic thresholds for diabetes (fasting sugar), hypertension (systolic and diastolic blood pressure), hyperlipidemia (total cholesterol), or osteoporosis (T score), the corresponding numbers of patients have increased 14%, 35%, 86%, and 85% respectively (Welch et al 2011, Tab. 2.1). For convention theorists, the critical question would be to ask for the link of these changes of diagnostic thresholds to the common good. Did the new diagnostic thresholds improve health conditions and quality of life or have more people suffered more checkups and screenings, painful treatments, and surgeries without the experience of an improved life quality?
For the example of the body weight, the introduction of the body mass index (BMI) can be regarded as such a change of a threshold. But there is evidence that the implementation of this threshold, what to consider as overweight, does not improve the quality of life, because life expectancy is not higher for humans, who fit to the BMI (Flegal et al. 2013).

[8] See Timmermans and Kaufman (2020) for a sociological review of health technologies. The authors also point to the link between the benefits of different kinds of health technologies and social inequality.

in the field of digitalized health, and the number of data producers has risen, too. The consequences are a lack of coordination, a lack of transparency, and a growing influence of private actors in the field.[9] As the COVID-19 pandemic has already made evident, health data production, gathering, and analysis have become an important dispositive for governance and a prospering economic branch. Public policies responding to the pandemic are based on available numbers of infection rates, daily cases of newly infected, and death casualties. Again, depending on different measurement conventions how to collect, proceed, and verify data, the quantification results will be different. Data from official statistics institutes are generated differently as data from private institutions or NGOs.[10]

Big Internet companies (such as Google) and pharmaceutical companies have built up their own divisions for digital health analytics, engaging in fields such as "life science," "mHealth," and "eHealth" (Sharon 2018), pursuing the "promises" of "big data" (Mayer-Schönberger and Cukier 2013). Medical research is more and more conceived of as data-driven medical research and health data; therefore, it is regarded not only as a mirror of health, but as a new kind of resource and valuable in itself (Ruckenstein and Schüll 2017).

In difference to public administrations and governmental organization, the globally operating companies have the technological, financial, and knowledge resources to implement huge projects in the named fields. The result is a trend towards a privatization of health data infrastructures, health data, health research, and health governance.[11] Linked to this privatization is a turn to the privatization and opacity of the decision on how to ground data in conventions. In these cases, the link between data governance and the common good is not transparent. Also, data and access to data is regarded as a companies' asset. It follows that a substantial part of data-driven businesses is coined by an informational asymmetry, privileging companies and not public and civic interests. Here, quantification and categorization are in danger of being *ad hoc,* which means missing a scientific and publicly

[9] For more on the problem of national coordination and its effect on health data governance (standards, storage, access and analysis, protection of data privacy, etc.) with regard to Germany, see Schepers and Thun (2019).

[10] For example, in March 2020, German media questioned the statistical data of the webpage of Johns Hopkins University, which were delivered more quickly but deviated from the official statistics of the Robert Koch-Institut (RKI, Berlin). The issue at stake was who had "better figures," the Robert Koch-Institut or Johns Hopkins University (See https://www.faz.net/aktuell/gesellschaft/gesundheit/coronavirus/coronavirus-hat-johns-hopkins-bessere-zahlen-als-das-rki-16696370.html).

[11] Although the new power asymmetries are admitted, some scholars also insist on not regarding this privatization as a problem only in the sense of a new cleavage into the "data poor" and the "data rich," because individuals have also been empowered, as the phenomenon of the quantified self should make evident (see Ruckenstein and Schüll 2017).

sound basis and therefore being invalid to serve as a knowledge basis for collective action.

An important example is the application of artificial intelligence (AI) in the field of health policy, where algorithms are employed by companies to optimize entrepreneurial decisions. Ismael Al-Amoudi and John Latsis ask, "How will the introduction of Al affect our communities' capacity to discuss, challenge and decide on the norms governing health policy?" The core problem these authors identify is the missing (or opaque) normative basis for the design of algorithms.

> The fact that AI operates as a normative black box generates a puzzle: how can AI reach normatively binding decisions if the latter cannot be discussed, justified, criticised and compromised upon by the people affected by its decisions? By addressing this question, we hope to make a contribution to the ethics of AI as we know it. [...] We encounter a problem, however, when the decisions entrusted to AI involve normative considerations. Whenever AI operates as a normative black box, its decisions cannot be evaluated purely in terms of achieved efficiencies. AI's normative decisions must also be evaluated, through public discussion, on the face of its congruence with principles and values shared within the human community affected by its decisions. (Al-Amoudi and Latsis 2019, 120-4)

Al-Amoudi and Latsis show that AI can improve medical capacities, for example in skin cancer diagnosis, and AI (in combination with big data) is already implemented in many national health care systems, as is the case in the UK (Al-Amoudi and Latsis 2019, 125). However, the authors also have dangers in mind when discussing AI. They point to the Swiss example, where the health insurance company Helsana has tried to invent more attractive insurance rates, depending on customers' willingness to have their health behavior be tracked and analyzed by AI algorithms (Al-Amoudi and Latsis 2019, 128).

4. Contributions in this HSR Special Issue

The contributions in this special issue present an internationalizing field of researchers in economics and sociology of health, who all rely in different ways on economics and sociology of conventions.[12] The articles cover topics of the transformation of the health care system, work and professions in the field of health, and the impact of datafication and digitalization of health. A

[12] For more recent publications relying on EC in the field of health, see Hanisch and Solvang (2019), Livi (2019), Schneider et al (2019), Urasdettan (2019), Ajana (2020), Nilsen and Skarpenes (2020), Levay et al. (2020), O'Keefe and David (2020), and Siffels (2020). The forthcoming publication of Valeska Cappel and Karolin Kappler presents German contributions from sociologists in the field.

core issue for conventions' theoretical research – of course – is the question of values and valorization, which all contributions address.

The first contribution of *Philippe Batifoulier* (Paris), *Jean-Paul Domin* (Reims), and *Amandine Rauly* (Reims) sketches the historical transformation of the French health care system since the post war period. They describe the formerly "Fordist convention" as a national compromise, which organized health insurance until the late 1970s on the basis of national solidarity. Since the 1980s, this principle of solidarity has been criticized and undermined. This prepared the emergence of the "liberal convention" and the introduction of complementary health insurance, which became more and more important and displaced the principle of solidarity. This transformation of the health care insurance caused increasing social inequalities.

The following article of *Philippe Batifoulier* (Paris), *Louise Braddock* (Cambridge), *Victor Duchesne* (Paris), *Ariane Ghirardello* (Paris), and *John Latsis* (Reading) "Targeting 'lifestyle' conditions. What justifications for treatment?" presents how the standpoint of economics of convention can be applied as critique against instrumental economic ways of argumentation in health care policies. With obesity as an example, the authors argue that lifestyle conditions should not be considered as a free individual choice and taking care of one's health should not be regarded as an individual responsibility only (and diseases as obesity should therefore not be a reason for stigmatization). Instead, the authors argue for a humanist refoundation for the justification of healthcare that also includes the social and economic origins of diseases, as individuals are not free to choose. In affinity to David Wiggins (and Amartya Sen), the authors finally call for respecting the vital needs of individuals and their equipment with resources to entertain capabilities to protect their vital needs.

The French health system reforms are analyzed by *Nicolas Da Silva* (Paris) in his article "The industrialization of 'liberal medicine' in France. A labor quality conventions' approach." He focuses on the institutional transformation of labor quality conventions in the health care system. He proposes understanding this transformation as a change of the quality standards, which are applied to evaluate the labor of health care personnel. His diagnosis is the industrialization of healthcare, which should be understood as the transition from an inspired/domestic convention to an industrial convention of health care quality that enables a constellation of the industrial and the market convention, an industrial/market compromise.

Peter Streckeisen (Zurich) brings in a perspective from economic sociology to the analysis of professional careers of medics. In his contribution, "Medicine and Economic Knowledge: The Relevance of Career in the Study of Transformations in the Healthcare System," he presents biographical interviews and their interpretation. This way, he can track the transformation and economization of the (Swiss) health care system. Following the work of

Da Silva, Streckeisen highlights the growing impact of the industrial convention and the market convention.

The role of conventions in the public debate about community health care and community health care workers (especially in low-and-middle-income countries) is studied by *Tine Hanrieder* (Berlin and London) and *Eloisa Montt Maray* (Berlin) in their article "Digitalizing Community Health Work: A Struggle over the Values of Global Health Policy." The authors apply content analysis to public health literature and discover the tensions between different quality conventions. The focus is on the question of how the invention of digitalization and digital devices ("mHealth") in the field of community health care can be related to the general conflict between fairness (equity) and efficiency.[13]

Eva Nadai (Olten), *Anna Gonon* (Olten), *Robin Hübscher* (Olten), and *Anna John* (Olten) analyze the regulation and valorization of work of disabled and low-skilled workers in their article, "The social organization of work incapacity. Incapacities in the Swiss social insurance system and in the workplace." They show how employers exert influence on the social welfare institutions, which in turn have an impact on the dispositives of valorization of labor. Also, they point to the contrast of health-related and skills-related in/capacity and to the different ways how they are evaluated and valorized.[14]

Nowadays, preventive health care discourses suggest individuals take care of their own physical fitness. To be sportive is an important lifestyle element for many social groups. *Anne Vatter* (Halle) and *Walter Bartl* (Halle) study the critiques of fitness centers articulated by their clients in their contribution "Justifying physical activity (dis-)engagements: Fitness centers and the latent expectations of (former) members." For this, Vatter and Bartl interviewed former and current members of fitness centers. In the analysis of these critiques, the tensions between different regimes of engagements and orders of worth are identified.

Self-quantification as a new health movement is studied by *Johannes Achatz* (Furtwangen), *Stefan Selke* (Furtwangen), and *Nele Wulf* (Furtwangen). In their article, "Adjusting reality. The contingency dilemma in the context of popularized practices of digital self-tracking of health data," the authors argue that the use of self-quantifying technology is accompanied by the increase of lifeworld contingency and produces (new) dependencies and vulnerabilities. Therefore, the authors focus on the situation of digital self-tracking and its different levels.

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[13] See Hanrieder (2016) for the analysis of global health policy from the perspective of convention theory.

[14] For more publications of this Swiss research, see also the monographs of Nadai et al. (2019) and Canonica (2020; open access https://www.chronos-verlag.ch/public-download/2631).

Valeska Cappel (Lucerne) describes and interprets the consequences of datafication of health. She argues that datafication and big data in the field of health results in a new form of everyday coordination and evaluation, which she calls "digital daily health" and which she regards as a form (in the sense of Thévenot 1984). In her contribution, the difference between the promises of datafication and the everyday usage of digital health devices (as health apps and wearables) is worked out from a pragmatist standpoint. Cappel identifies different scenarios, how daily digital health can be conceived of as health measurement, and how public regimes and private regimes are linked. A main result of this contribution is an in-depth look into the process of quantification of health data and the problems of its fragmentation and its incoherence.

How practices and devices (self-tracking apps) are mobilized in self-tracking is studied by *Eryk Noji* (Hagen), *Karolin Kappler* (Hagen), and *Uwe Vormbusch* (Hagen) in their contribution, "Situating Conventions of Health: Transformations, Inaccuracies and the Limits of Measuring in the Field of Self-Tracking." They track problems of accuracy in the measuring of health-related aspects (food and emotions), thereby referring to conventions and objects as intermediaries. The authors point to the importance of regimes of engagement (as logics "below" the level of orders of justification) and demonstrate the limits of the measurements by self-tracking in everyday life.

The collection of contributions is completed by the article "Economics of convention meets Canguilhem" from *Rainer Diaz-Bone* (Lucerne), which works out the relevance of Georges Canguilhem's work for EC. Canguilhem points to the problem of positivism to deliver a substantial concept of health. He conceives of health as the capability to create and invent norms for living in their milieu. As EC does, Canguilhem interprets the coordination of individuals in regard to their health as organized by norms and values in their milieus, which actors can influence themselves.

5. The COVID-19 Pandemic

In 2020, the COVID-19 virus spread out over the world. Worldwide, many millions have been infected, more than one million people died so far, and the pandemic burdens public and private life in many countries.[15] The COVID-19 pandemic articulates itself not only as an over-stressing charge of the health care system (which has been already in crisis in countries like the

[15] So far, the deadliest pandemic in modern times has been the "Spanish flu" in 1918, causing more deaths than the battles of the First World War (Barry 2005; McMillen 2016).

UK), but as a crisis of collective forms of coordination, interpretation, and evaluation.

With its hundreds of thousands of deaths and the threat it poses quickly and massively, the health crisis appears extraordinary. But it highlights evidences or regularities that the ordinary situation tended to mask. The COVID-19 crisis arrived as a reminder of the fundamentals. It reminds us that humans are mortal, which the rational choice theory cannot conceptualize. Unlike homo economicus, which is invincible and which has no birth and no death, individuals suffer and are often particularly helpless and weakened in the face of illness. The pandemic also serves as a reminder that those whose fever brings them to consult do so not because they know they are well-covered by health insurance, but because they are anxious. There is nothing similar between the nervous patient and the judicious consumer of the mainstream approach (Davis and McMaster 2017). The pandemic is also a reminder that health care is not "pleasure shopping" like some everyday consumer goods. In health care in particular, individuals cannot be reduced to "pleasure machines" or utility maximizers (Hodgson 2013).

This anthropological vision, widely disseminated in mainstream economics, is at odds with the recognition that the population has expressed for caregivers by applauding them every night in some countries. The crisis has highlighted the divergence between this vision of health adopted by economic policies and the way it is experienced by populations.

The COVID-19 crisis is not only a pandemic. It is also the one in which the mainstream economy thinks about health, in its different dimensions, and consequently how politics considers health. The COVID-19 health crisis is a total and multidimensional crisis. According to the pragmatic approach, values and facts are necessarily linked (Putnam 2002). One cannot understand the COVID-19 crisis by adopting a dogmatic position about values. To insist on values as facts, as EC does, is to insist on the empirical reality of a plurality of values. The tragedy would have been even greater by reasoning from a single mode of coordination. With the crisis, the defense of human life has taken priority over budget shrinkage in order to defend what citizens consider to be fundamental rights.

In their responses to the crisis, some scholars and politicians have ignored the plurality of values, arguing that to get out of the crisis, health (and the possibility of contamination) should be exchanged for economic activity and the equilibrium should be chosen according to a cost-benefit calculation. This conception puts forward only the criterion of efficiency when there are many other criteria put forward by the population. There is no optimal lockdown policy.

This technical conception evacuates political deliberation. But the historical construction of health protection systems is not the result of calculation but of social need and social struggles. In France, as Da Silva (2020) shows,

there would not have been a social security system in 1945 if it had been necessary to rely on cost-benefit calculations in a country ruined by war.

The conventionalist approach illuminates how social actors allude to moral values, or "orders of worth" – that represent a "common good." During the crisis, in keeping with the approach of economics of convention, orders of worth have signaled their existence in language and claims of individuals.

The framework of orders of justification (Boltanski and Thévenot 2006) was developed to understand when a conception of the common good based on one principle of justification is criticized according to criteria based on another. In terms of human rights, all individuals should have access to health care according to the "civic repertoire." But other orders of worth matter: the "industrial order" (increasing efficiency and expertise), the "project related order of worth" (innovation and experimentation in particular for treatments), the "domestic order of worth" (doing good for family and relatives), and even a "market order" enhancing wealth creation.

To emerge from the crisis is also to appeal to a plurality of values. Equality, solidarity, and responsibility are important values that governments have invoked as a way out of the crisis and as a way to reduce lockdown measures. Welfare mentality is shaped by collective values, and the engagement and commitment of the people is based on a plurality of values, as shown by the use of a collective effort procedure in Norway called "Dugnad" (Nilsen and Skarpenes 2020).

In a same way, the use of contact-tracing apps as a means in order to contain the spread of COVID-19 is not only a problem of temporary sacrifice of privacy because it is the conception of privacy that is the subject of different visions of the common good (Siffels 2020).

The discovery of vaccines inevitably opens a debate on what is a quality vaccine. This important dispute is informed by the notion of quality convention. There is no single answer to this question, but a plurality of values acting as a conception of what is a "good vaccine." According to EC, a good vaccine is the result of the researcher's inspiration for a scientific project. A good vaccine can also be considered good because it is cheap with a good price-quality ratio. If we insist that a good vaccine must allow access to the greatest number of people as an essential drug, then we must question the pharmaceutical industry's ownership of patents. A good vaccine is also easy to use and can be stored without the need for very low temperatures.

Discussing vaccines, lockdown, quarantine, teleworking, compensation, homeschooling, etc. cannot be done without the pluralist approach of values at work in this outbreak.

6. Perspectives

The COVID-19 pandemic not only exposed the importance of health issues, it showed that health issues constrain capitalism. It now becomes more difficult to make profit as the world has entered a time of epidemics. The current period could only be seen as a brief moment of radical uncertainty in order to go back to the world prior to the crisis ("business as usual"). However, COVID-19 has been named SARS-CoV-2 and there has already been an epidemic of SARS (CoV-1) and many other pandemics (H1N1, HIV, MERS-CoV, etc.). We are in a period where we will have to live with epidemics due to the weakening of health care systems, increasing globalization, and, in particular, the massive destruction of the planet in search of short-term profit (and the ensuing consequences, e.g., environmental pollution, climate change, and refugee crises)].

Debating about health is not like debating about any other economic sector. Of course, health is an important part of the financialized capitalism. Commodification and privatization are close to the health care systems around the word. The pharmaceutical industry, private health insurances, and for-profit hospitals are powerful players in capitalism, and health is a means like any other to make a profit. But health is much more than that.

The health capitalism has important and specific effects. Health is not a sector like any other but is a central sector. It has the potential to change capitalism and to bring about the emergence of a new capitalism that Robert Boyer (2002, 2020) has called "anthropogenetic" because it aims to reproduce man through human labor.

In an anthropogenetic world, health (also education and culture) has specific characteristics that induce a key role in capitalism. These are important economic aspects because of their weight for economic growth and for the number of jobs they create, but also because of their capacity to generate well-being, quality of life, and life expectancy. The anthropogenetic way is centered on the production of humanity for humanity.

This health-based capitalism can be analyzed in two possible ways. On one hand, the anthropogenetic world is a new way of life, increasing public and private health expenditures for the well-being of citizens. It gives more importance to states and citizens. On the other hand, the anthropogenetic world is only another form of the financialized capitalism, developing new markets for a capitalism in search of new markets and transforming claims in health democracy into a means of reproduction of capital. According to this viewpoint, the development of the Internet of things in health care or the digitalization of health led to a surveillance capitalism (Zuboff 2019).

The conventionalist approach can illuminate this debate in two ways. First, health-based capitalism is a value-based capitalism. Boltanski and

Thévenot's (2006) orders of worth identify different visions about moral orientations and can help to identify different conceptions of common good within the anthropogenetic model of development. Far from a binary perspective categorizing health policy in a market repertory or in a civic order of worth, the pluralist framework of EC highlights other several orders of justification in line with the health-based capitalism (industrial order, domestic order, project order, etc.). This health capitalism involves competing conceptions of the common good.

Second, health capitalism can be a new spirit of capitalism. As Boltanski and Chiapello (2005) have shown, the accumulation of capital needs an ideology that justifies engagement in capitalism providing attractive life prospects (not only material benefits) and moral reasons. Capitalism transforms itself by integrating critique.

The COVID-19 pandemic showed how criticism from the perspective of the supremacy of health could change the normal course of business to the point of stopping economic activity. Is the recuperation of this critique the basis of the new dynamics of capitalism? The affirmation of health as "good in itself" (in French "bien en soi", Dodier 2003), a specific modality of living well (Ricoeur 1996), a Hippocratic and macro-social value (Batifoulier et al. 2011), or the importance of the vitalist logic (proliferating life, Sharon 2018) show that capitalism cannot evolve without integrating the claim for good health.

To understand this fundamental evolution, EC is an important contemporary approach. Convention theorists' research can be carried out to find out whether this critique of health updates the "artistic critique" (Boltanski and Chiapello 2005) by emphasizing concern for the self and the healthy body. It does not bring back the "social critique" because health-based capitalism is still largely a capitalism with inequalities. The COVID-19 crisis is exacerbating pre-existing health inequalities (although state policies against the negative effects of the pandemic have been released, which so far have proven to be insufficient) and the COVID-19 related health risks are also advanced by social inequalities:

> In many countries, in particular in urban settings, space for living is unequally distributed, with low income earners generally having less space [...]. Socially disadvantaged populations living in shared accommodations (e.g. shelters) are as well regarded to be at higher risk for infection. Working conditions can also be linked to differing infection risks. Key workers such as nurses, or those working in the logistics sector, retail and public transport, continued to work even during the pandemic and are generally in the middle to low income groups. Working from home, a recommended

> measure to reduce infection risks, is an option open mainly to people on higher salaries and with higher qualifications. (Wachtler et al. 2020a, 4)[16]

Lower education levels, bad living conditions, and worse working conditions induce lower health conditions (Case and Deaton 2020). If everyone shares the concern for good health, the image of the "beautiful body," emphasized in the "vitalist" order of worth, has been shown to be conditioned by the material conditions of existence. But the call for an anthropogenetic way seems to be a call mainly from the most educated and least vulnerable people. If so, why is this focus of an anthropogenetic way differentially distributed in regard to the social or professional position?

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