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Implications of behavioural policy making in health promotion

From Entitled Citizens to Nudged Consumers? Re-examining State-citizen Relations in Health Policy in the Light of the Behavioural Turn

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Abstract:
Behavioural Public Policies (BPPs) seek to evoke behaviour change by altering people's choice architecture. As it is exemplified by the field, this *behavioural turn* in public policy comes at a cost since nudgers tend to disregard historical policy legacies and the specific shaping of state-citizen relations. Ultimately, behavioural interventions, as it is discussed within the areas of health promotion, health insurance provision and the doctor-patient-relationship, may lead to an undermining of liberal citizenship hallmarks such as trust, choice and voice. This calls for a cautious integration of BPPs into existing policy frameworks and requires collective agreement in advance.

Key words:
Behavioural policy making, nudge, health policy, state-citizen relations, citizenship

1. Introduction

There are growing indications that public policy making is currently witnessing a 'behavioural turn' (Bogliacino et al. 2016). Behavioural insights, i.e. precise knowledge on human behaviour in policy-relevant situations, have increasingly become a legitimate basis for designing policy frameworks in fields such as consumer protection, energy, health and tax (Oliver, 2013a). Thereby, information as a classic medium of public governance is utilized in a novel way: Informed by practical knowledge on individual behaviour policymakers apply behavioural instruments in order to address negative 'internalities rather than externalities' (Oliver, 2015, 704). At the same time, expert knowledge as the traditional source to structure policy fields and to achieve governance objectives has become less important. Around the globe, Behavioural Public Policies (BPPs) are currently developed, tested and evaluated by so-called nudge units (Halpern, 2015) signalling a pending shift in public policy making. In academia, behavioural interventions inspired by the theory of libertarian paternalism (Thaler and Sunstein, 2003; 2008; Sunstein, 2014) have so far triggered controversies at more fundamental levels. Scholars have particularly questioned *nudge tactics* from ethical (Selinger and Whyte, 2011; White, 2013), philosophical (Rebonato, 2012; 2014), sociological (Mols et al., 2015; Brown, 2012) and regulative (Jones et al. 2013; Leggett 2014) perspectives. Building up on the findings of these interdisciplinary works, this paper

sheds light on the impact of BPPs on the shaping of state-citizen relations. In this context, the following questions are relevant: Whom do behavioural policymakers (*nudgers*) address in the first place – citizens, consumers or just *humans*? How do state-citizen relations shift if behavioural interventions are applied within existing public policy frameworks? And, according to which rationales *nudgees* will be governed by the 'behaviour change state' (Leggett, 2014, 4)?

Theoretical implications of BPPs on the state-citizen relationship will be illustrated by examining the policy field of health, including both public health and healthcare provision. Traditionally, health promotion and health maintenance are extremely personal and intimate areas of public policy in which state power is delegated to health professionals dealing with citizens on behalf of the state. The probably best-known example is the doctor-patient relationship (Stavropoulou, 2012) where health services should be provided on the basis of mutual trust, respect and shared-decision-making. Nonetheless, state-citizen relations in health, like in other policy fields, are in a considerable state of flux due to the juxtaposition and overlapping of different (and often competing) policy rationales. Browsing through the history of western welfare states (Porter, 2005), it becomes evident that during different health policy phases policymakers perceived citizens to be, to various degrees, service recipients, co-producers, and consumers (Köppe et al. 2016). Currently, as it will be argued, the 'behavioural turn in public health policy' (Crawshaw, 2013, 622) may add an additional layer to the already fragmented state-citizen relationship in the realm of health. Due to the steep increase of the so-called non-communicable diseases (such as asthma, diabetes and obesity), changing people's health behaviour – their individual lifestyles and habits – has become policymakers' top priority. Likewise, nudging service users towards

better healthcare choices, i.e. tailored insurance schemes and treatments, is a key rationale of behavioural health policies (Cohen et al., 2016). As it is elaborated in this paper, behaviourally informed policy interventions have various implications for former hallmarks of 'health citizenship' (Oosterhuis and Huisman, 2014) such as universal access to and choice among services, trust-based relations to healthcare professionals and (collective) voice, as well as the potential to fundamentally change state-citizen relations in the policy field.

The paper starts by revisiting three distinctive phases of health policy making that have significantly shaped the state-citizen relationship until today: the establishment of health(care) as a social right, the promotion of healthy public policies and the deregulation of public health(care) systems (2). With respect to the current phase, labelled as knowledge- and behaviour-based health societies, different forms to apply behavioural health policies will be introduced (3). By discussing the examples of health promotion, health insurance provision and the doctor-patient-relationship it will be shown in which directions state-citizens relations may shift due to the increasing emphasis on behaviourally informed health policies (4). Drawing on insights from the health field, general repercussions of BPPs for the meaning of state-citizen relations in public policy making are addressed (5). Brief conclusions will follow (6).

2. Health Policy making, State-citizen Relations and the Role of Behaviour: A Brief Recent History

Current behavioural health policies 'do not supervene onto a blank (…) canvas' (Pykett et al., 2011, 309) but unfold within a field that is very much predetermined by policy legacies, collective knowledge and sociocultural heritage. Thus, modifications of state-citizen relations

in health, its norms, values and procedures, take place in relation to the status quo ante. In this section, three phases of health policy making, evolving from rather than substituting each other, will be recapitulated: the establishment of health as a social right and access to universal healthcare provision, the promotion of healthy public policies and the deregulation of public health(care) systems (see table 1). Each phase was based on different policy rationales that shaped state-citizen relations and framed people's behaviour at the time. Moreover, phases will be distinguished with regard to two other aspects: Applied policy approaches and instruments to address *health citizens* and the corresponding knowledge bases from which key insights were drawn in the policy making process (see John, 2017, 139). Reviewing previous health policies and reconfigurations of the state-citizen relationship against these criteria allows for a better understanding of what a shift towards behavioural health policies means within the policy field (see section 3). The subsequent argumentation is not limited to a particular welfare state or public health(care) system but makes references to the 'kindly welfarism of the post-war era' (Pykett, 2011, 218) as it emerged in the Western hemisphere.

Health and access to universal healthcare provision as social entitlements

The first phase concerned the building-up of the welfare state in the 1950s and 1960s in which health protection and the establishment of universal healthcare have been significant cornerstones (Porter, 2005). Symbolic achievements such as the foundation of the NHS in England (Klein, 2010) and a 'broad coverage and open-ended for-free-service' (Oosterhuis and Huisman, 2014, 34) in most other welfare states contained a twofold goal: On the one hand, universal access to health services was granted to citizens as part of their social citizenship package. Basically, a 'benevolent and competent state' (Le Grand, 1997, 155) that

provided standard solutions such as large-scale health protection schemes (e.g. in terms environmental, industrial and occupational safety) for standard risks. On the other hand, this progress was accompanied by the strategic governance goal to strengthen state discipline through universal and central regulation (Wagner, 1994). In this sense, the provision of a minimum degree of social security for citizens in the case of illness was not unconditional but attached to some behavioural provisions. Generally, welfare users were conceived as *pawns* (Le Grand, 1997) that were requested to adopt an attitude of profound humility and modesty towards welfare state arrangements; similar in health the figure of the *needy patient* was 'supposed to live up to [his/her] appellation and be patient' (ibid., 156). According to their formal sick role (Parsons, 1951), patients were conceived as 'docile figures with no responsibility for their predicament and minimal involvement in their own care' (Armstrong, 2014, 164). In line with a strict biomedical model that reduced the meaning of health to the absence of illness, patients were requested to be compliant to healthcare professionals' advices, while patients' individual agency was hardly envisioned by policymakers. Hence, there was a good sense of obedience and humble docility with regard to beneficiaries' behaviour at the time. To sum up, health policies in the classic welfare state guaranteed the *protection of entitled citizens* in the case of severe illness and disability on the basis of *institutional trust* and, often, blind faith in the competence of health professionals. The latter represented the unchallenged knowledge base: Physicians and therapists were engaged as experts on behalf of the emerging healthcare state that informed health policies and decided how healthcare service were delivered.

Promotion of healthy public policies

Within the second phase, stretching from the 1970s to the end of 1980s, state-citizen relations in the realm of health became more dynamic due to more participatory policies. Gradually, its counterpart superseded the entitled but passive citizen: the engaged citizen and co-producer. Above all, this creeping process of emancipation concerned patients' non-compliance towards physicians' advises and a challenging of healthcare bureaucrats' supremacy that led to a decreasing trust in the 'healthcare state' (Moran, 1999). For example, patient organizations and self-help movements pursued alternative visions of health and a civilization of healthcare systems that were perceived as rigid and inhumane (Ewert, 2015; Mold, 2015). Health behaviour was deemed as a site of resistance in the light of standardized and impersonal service offers. Participation, collective voice and empowerment became the guide values of 'self-caring, self-medicating patients who took increasing responsibility for their own treatment' (Armstrong, 2014, 169). Likewise, shared knowledge and collective agreements by health professionals and citizens became the legitimate knowledge basis for redesigning health policy frameworks. This was in line with the then new WHO doctrine according to which *health is made outside the healthcare system*, i.e. in people's everyday life worlds and local settings. As stated in the Ottawa Charter for Health Promotion (WHO, 1986), 'good health' depends on political, societal and environmental factors and requires people 'to take control of those things which determine their health'. The Ottawa Charter explicitly 'distanced itself from a narrow focus on individual behaviour change' (Van Den Broucke, 2014, 597). Instead, the dictum *making healthy choices easier*, nowadays straightforwardly associated with the application of behavioural policy tools, stood for 'deliberate and rational' (Armstrong, 2014, 168) actions by empowered citizen-patients eager to challenge the healthcare state.

Deregulation of public health(care) systems

The third policy phase put *healthy choices* centre-stage in the citizen-state relationship, though, ironically, detached the term from its originally meaning. Health policy reforms in the 1990s and 2000s advanced the deregulation of healthcare provision across Western welfare states and set economic incentives for welfare consumers – the then new synonym for entitled citizens (Baldock, 2003; Clarke, 2005). Within emerging health markets, systemic trust has been substituted with individual responsibility, likewise, the focus in public health arrangements shifted from voice to choice mechanisms. 'Choice and competition', as Le Grand (2007) put the policy rationale of this phase, have turned former *pawns* into *queens* that apply their consumer sovereignty in healthcare as they are used to do in the commercial sector. Moreover, beyond the area of publicly covered healthcare users were requested to invest in additional health services on private markets. Thus, market-savvy consumers became key addressees of the choice-preserving state that, with regard to the knowledge basis for policy making, primarily relied on economic rationality provided by health economists. However, the figure of the smart 'healthcare consumer' (Powell and Greener, 2009) has been sharply opposed by scholars that consider consumerist behaviour, i.e. making rational choices among services and professionals, highly inappropriate in the realm of health. For instance, Fotaki (2014, 1276) criticized the 'over-reliance on rational-calculative aspects of trust' in NHS choice policies that 'ignore the logic of care without offering a viable prospect for empowerment' (ibid., 1290). Also, libertarian paternalists criticize choice mechanisms in healthcare provision: Recently, Sunstein (2016, xiii) rejected a so-called 'choice-requiring paternalism' applied by health insurers and doctors that leave health consumers no choice but to choose services and treatments.

To sum it up: During each phase health policymakers addressed different prototypes of the ideal health citizen: First, the entitled citizen that enjoyed a minimum extent of healthcare services and protection against standard risks of harm; second, the empowered citizen that sought to be involved in the shaping of healthy environments and healthcare service delivery and third, the citizen-consumer that actively chose tailored services and products on emerging healthcare markets. In the next section, it will be asked how behavioural health policies, as they are fleshed out by nudge units, relate to this heritage.

(3) Nudging Health: Aligning People's Behaviour to Health Societies

To be sure, policy rationales and implications of the three phases discussed in the previous part have not expired but lost its formative power over time in the face of new health challenges and shifting policies. In present times, it has become a kind of common sense that 'health is present in every dimension of life' (Kickbusch, 2007, 156). As it has been argued, within *health societies* the 'expansion of health choices demands an ever higher degree of sophistication, participation and literacy' (ibid., 153) by citizens. Outside healthcare systems people are confronted with health-related lifestyle choices (most of all, concerning nutrition, physical exercise and stress regulation) while within healthcare systems choosing tailored insurance schemes and services has become a key feature of health citizenship. Health policymakers reply to these behavioural requirements by increasingly testing nudge tactics – the latest governance technique of 'governing the health of populations' (Crawshaw, 2013, 621). In contrast to previous health policies that addressed entitled citizens, active co-producers or responsible consumers (phase 1-3, table 1), behavioural health policies respond to fallible, impulsive and non-reflective human beings (Thaler and Sunstein, 2008, 21-4).

This marks a turnaround in state-citizen relations in health and healthcare: If people's agency, say and responsibility increased within policy phases 1-3, nudge tactics may be considered as the logical consequence of previous autonomy gains: As it is assumed by choice architects, knowledge- and behaviour-based health societies (phase 4, table 1) represent an imposition for many citizens requiring behavioural management and predefined choices by experts. Consequently, changing people's health behaviour and influencing their selection of healthcare services have become top priority while previous health policy rationales such as social security, participation or choice are gradually fading. Viewed 'as a form of light-touch, low-cost regulation' (Quigley, 2013, 599) in order to predict irrational behaviour, nudges intentionally restructure people's choice architectures without curtailing their liberty to choose freely (Thaler and Sunstein, 2008, 6). Leaving the advanced theoretical debate aside what counts as a genuine nudge and what not (Mols et al., 2015; Oliver, 2013b; 2015; Sunstein, 2014), the MINDSPACE framework (Cabinet Office and Institute for Government, 2010), developed by the British Government, will be used for the purpose of this paper. The framework entails an array of behavioural tools such as specific framing effects (messenger, salience) and the strategic use of norms, defaults and effects. The application of these tools makes it is 'more likely that a person will choose in one direction rather than another' (Quigley, 2013, 599), as it will be briefly demonstrated by three different health policy contexts: health promotion, health insurance provision, and the doctor-patient relationship.

When it comes to health promotion, behavioural policy interventions have raised much (critical) attention recently (Crawshaw, 2013; Quigley, 2013; White, 2016). As a proposed remedy to the steep increase of non-communicable diseases, nudge tactics promise a fast

and immediate change of people's problematic behaviour: Without nannying people or stipulating legislations, choice architects have an impact on what (and how much) people eat or how often they exercise – simply by shaping the contexts in which lifestyle choices are made. Since 'people's mistaken choices can produce serious harm' (Sunstein, 2014, 163), i.e. obesity and diabetes due to overeating and too little exercise, well-intended health nudges that are '*easily reversible*' (ibid., 151) seem uncontroversial at first sight. Respective examples such as smart lunchrooms (Wansink, 2013) or an actively-friendly built environment (Khan, 2011) are increasingly applied around the world (see for an overview: OECD 2017). Thus, in health promotion behavioural insights are used to 'deconvenience people's life' (Carter, 2015, 379) for their own good. As it is thought, nudging people to walk more, eat more vegetables and drink less alcohol allows them to ‚mindlessly move [their] way to better health' (ibid.).

In the context of health insurance provision nudgers aim to subtly influence people's individual healthcare choices since 'people often rely on rules of thumb to make their healthcare decisions' (Low and Yiling, 2012, 132). As a result, health insurance packages often do not fit to people's (long-term) need of healthcare provision. In order to counteract people's biases, heath insurers may enrol them automatically into particular insurance schemes, for instance, the chronically ill into so-called Disease Management Programs (DMPs). Such default settings stay active until the insured person opt-out of the respective scheme. However, behavioural science revealed that most insured persons are inclined to stick to the default that 'can be interpreted as a signal that it is the "normal" or recommended option' (Roberto and Kawachi, 2016, 11).

Within the doctor-patient relationship, the 'cornerstone of medical practice' (Stavropoulou, 2012, 314), behavioural policies may be used to nudge patients towards specific treatments and therapeutic decisions (e.g. for or against a surgery or a medication). If patients can choose among different medical options at the same time (e.g. a range of surgery options), behavioural tools could be deployed to facilitate patients' decisions. According to Sunstein (2016, xii), in these sensitive healthcare contexts 'an insistence on active choosing is a form of paternalism' that most patients experience as a burden. Nudge advocates propose '*simplified active choosing'*, i.e. asking 'people whether they want to make a choice among treatments, or instead rely on the standard approach' (ibid., xiii) as a welcomed remedy for the doctor-patient relationship. Indeed, many patients seem to appreciate such decision aids in therapeutic contexts (Zamzow, 2016). Besides defaulting people into a certain treatment doctors may also influence patients' therapeutic decisions by reframing the information they give to patients. Hence, doctors can utilize social norms by telling patients how other patients have decided in similar situations, likewise, they can make some information more salient (e.g. *90 per cent of the patients that choose this treatment have fully recovered*) while putting less emphasize on other facts (e.g. *ten per cent of the patients reported heavy side effects*). As it became obvious, behavioural interventions differ in the field of health and healthcare: Comparing smart lunchrooms straightforwardly with nudging patients' towards serious healthcare decisions (e.g. for or against chemotherapy in the case of cancer) would be an improper abstraction. Instead, with a view on the state-citizen relationship in health, context-specific implications of behavioural interventions can be identified. As it is argued in the next section, there are a few situations where nudging people may increase the wellbeing and welfare of *responsible citizens,* whereas in others, the same approach means 'to engage with the citizen-fool rather than the querulous citizens' (Jones et al., 2013, 174).

Phase	Policy Rationale	Approaches and Instruments	Base of Knowledge for Policymaking	State-citizen Relation	Role of Behaviour
Establishment of health and access to universal healthcare provision as a social right	Social security and protection	Equal access to (limited) healthcare services and health protection measures (both provided at large scale)	Expert knowledge by healthcare professionals	Benevolent state vs. entitled citizens	Low; service provision is based on institutional trust and faith in the competence of healthcare professionals
Promotion of healthy public policies	Participation	Empowerment, deliberation, voice	Collective agreements on shared knowledge	Healthcare state vs. active citizens and co-producers	Medium; collective health behaviour as a resource to reclaim autonomy
Deregulation of public health(care) systems	Choice and competition	Marketization, economization, individualization	Economic rationality	State-induced healthcare markets vs. responsibilised consumers	Rather high; access to services depends on 'good choices'
Knowledge- and behaviour-based health societies	behavioural change	Nudge tactics	Behavioural science; big data	(Health) Experts 'nudge' error-prone users	High; health and healthy lifestyles become an individual duty

Table 1: Shifting state-citizen relations in public health policies

(4) Shifting Differently: State-citizen Relations and Behavioural Health Policies

Following the basic assumption that different phases of health policies were driven by different policy rationales (see table 1), one can consider the actual shaping of health contexts as a sort of amalgam where policies and rationales materialize to different degrees. By taking the examples introduced in the previous section it will be shown that enriching context-specific health policies with behavioural insights, i.e. integrating a behavioural policy layer to an existing policy framework, inevitably leads to a changing of these amalgamations. Thus, applying behavioural instruments to health policies has diverse rather than uniform implications for state-citizen relations, ultimately leading to a patchy and (even more) inconsistent health citizenship – unified only around the principle that 'citizen's behavior and involvement as a "co-responsible" are becoming critical determinants of success' (Evers and Guillemard, 2012, 24).

Health promotion: From enabled citizens to individuals with behaviour problems?

So far, behavioural insights have the biggest impact in the area of health promotion where key issues such as nutrition, physical exercise and stress management seem largely compatible with nudge tactics.[1] Thaler and Sunstein (2003; 2009) have further contributed to this impression by somewhat overstretching the example of choice architectures' design in cafeterias. Especially, when considering the US literature on behavioural health policies (Cohen et al., 2016; Roberto and Kawachi, 2016), one is inclined to assume that altering people's choice architectures is the primary (if not only) approach to promote health. However, behavioural change policies are just one possible form to shape state-citizen

[1] A reader recently published by the OECD (2017) provides an overview of health nudges BPP examples. Likewise, a google picture research of nudge examples results in plenty of hits depicting health nudges such as rainbow-colored stairs (or those that look like a racetrack) and symbols that encourage healthy eating or non-smoking. Apparently, the term nudge is strongly associated with healthy behaviour.

relations in health promotion. Historically, large-scale prevention programs (e.g. vaccinations against communicable diseases) aimed to protect citizens from harm in order to safeguard employability and making men *fit for duty* in wartime. In the same spirit, major branches of the then emerging welfare state, such as environmental and industrial safety, measure to prevent work-related accidents, and consumer protection was built up representing an important pillar of people's social citizenship status (Oosterhuis and Huisman, 2014). With the shift from risk prevention towards health promotion policies (due to the transition from communicable to non-communicable diseases) state-citizen relations changed. As stated in the Ottawa Charta (1986), the key policy rationale was no longer to protect citizens' health but to empower them to become their own health promoters. Policymakers hoped that, ideally, active citizens would collectively shape their daily life worlds such as neighbourhoods, working places and schools in a way that allows them to cultivate healthy behaviours. In this respect, the so-called settings approach for health promotion (Dooris, 2009; 2013) reads very much as a manual for enabling citizens individually and collectively – in sharp contrast to nudge tactics (Ewert, 2017). Though, in health promotion 'the momentum, in the 1990s and early 2000s, seemed to shift back to health behaviourist perspectives' (De Leeuw and Clavier, 2011, ii241). As noted by Clavier and de Leeuw (2013), health promoters underestimated both what it means to change health policy processes towards structural change and the impact of market-preserving health policies that ‚change the citizen into a consumer' (Kickbusch, 2007, 152).

How do recent behavioural health policies unfold against this backdrop? Nudge-based and participatory approaches share the assumption that context matters in health promotion since 'we are constantly being acted upon by innumerable physical, social, environmental,

and informational influences' (Quigley, 2013, 609). However, nudge advocates rarely address people as active citizens that engage themselves in the making of healthy publics through collective voice (de Leeuw and Clavier, 2011). Instead, they gently steer 'citizens to make welfare promoting choices' (Straßheim et al., 2015, 259) in terms of health-related lifestyles and habits. In contrast to clear-cut paternalist policies such as banning soft drinks and fast food (Wikler and Eyal, 2013), health nudges *simulate* civic virtues such as self-determination, participation and self-responsibility because, in the end, it is still the individual (and not the policymaker) who decides whether to pursue healthy behaviour or not. Thereby, behavioural health promotion ultimately leads to an impoverished meaning of health citizenship since it pays no attention to collective agreements on health issues. For example, the former restrictive Swedish alcohol policy (i.e. state-licensed sales partners, high prices) was historically rooted in the temperance movement that succeeded to contain the consumption of alcohol in the country. If healthy policies are exclusively informed by scientific insights on human behaviour, there remains no space for self-imposed limitations (or collective agreements) by citizens.

Nudges towards healthy lifestyles may also be 'prone to backfire' (Mols et al., 2015, 89) and thus might cause lasting damage to state-citizen relationships: If people become aware that they are stealthily nudged by state authorities towards ends (e.g. quitting smoking, eating vegetables, exercising regularly) other than their own, trust – the currency for keeping state-citizen relations intact – will be exhausted soon (ibid.). Furthermore, as Jones et al. (2013, 175) have claimed, nudge tactics in health promotion and beyond may degrade certain groups such as the social disadvantaged to kinds of "second-class citizens" while those people 'who are able to self-govern [are] left to make their own decisions'.

Health insurance provision: From entitled citizens to nudged consumers?

State-citizen relations in health insurance systems are traditionally based, at least in corporate welfare states[2], on social entitlements that determine who receives which services under which condition. Accordingly, entitled citizens enjoy access to healthcare if necessary on medical grounds but have less influence concerning the range of services to choose from. Moreover, citizens' involvement in the governance of health insurances is ensured through mechanisms of collective voice expressed in self-administration boards (Haarmann et al., 2010). Unlike health promotion that is very much shaped by the discourse of empowerment, the area of health insurance provision has been heavily impacted by public management reforms that strengthened competition among funds and equipped insured citizens with more choice concerning insurance tariffs (e.g. for dental care or treatment by a chief physician) of a certain provider (ibid.; Ewert, 2011). Likewise, citizens' options to exit insurance funds and become a member of another fund have been expanded. As a result of these reforms, choosing insurance funds and tariffs requires individual knowledge and market competence. This led to high-quality health insurance provision increasingly depending on the competence to *make good choices* while having social entitlements alone is not sufficient. Speaking in terms of state-citizen relations, in health insurance systems the responsible consumer (or *homo economicus*) has substituted the former role model of the entitled citizen (Newman and Kuhlmann, 2007). This shift has been sharply criticized because it infringes the principle of health equity since less informed and less educated people often lack the competences to choose tailored insurance schemes (Köppe et al., 2016).

[2] The following statements refer to state-citizen relations in health insurance systems such as France, Germany and the Netherlands.

In this context, the employment of behavioural policy tools, e.g. by defaulting people automatically in insurance tariffs that – in the eye of the insurers – fit their needs best, appears to be an attractive solution. '[A]utomatic enrollment in (…) in health care plans' (Sunstein, 2014, 133) relieves people from applying consumer behaviour in an area where making decisions is a complex endeavour. For example, the chronically ill may be automatically defaulted into disease management programs that safe costs by avoiding double examinations or incorrect drug prescriptions and promise evidence-based care. Especially, 'personalized default rules' that are 'very narrowly targeted' (ibid., 99) on people's previous healthcare coverage may be a solution when available choices seem unmanageable. Furthermore, if the insured voluntary use smart technologies – wearable gadgets such as cell phones, watches and bracelets that monitor their real-life health behaviour in real-time – insurers' possibilities to personalize healthcare coverage further increase (Kratzke and Cox, 2012). However, there is a thin line between the nudged consumer who benefits from an intelligent assignment to personalized health insurance tariffs that otherwise might not be chosen, and the fooled consumer that is defaulted into a tariff that is financially advantageous for the health fund but fails to benefit the insured. Bearing in mind that 'unprincipled companies can (and do) use defaults to exploit customers' (Goldman et al. 2008, 105) it would be rather naive to expect benevolent and welfare-promoting nudges by otherwise strictly efficiency-oriented insurance companies.

Even if one, despite its inherent potential for misuse, agrees to nudge tactics by health insurances, the problem of excluding the utilization of voice mechanisms by the insured remains. In corporate welfare states the insured traditionally had less options to choose from, though this limitation was balanced by opportunities to co-design insurance schemes

and tariffs through collective voice. Nudge, if used by health funds as a primary tool to address the insured, deprives citizens of the right to voice concerns in the administration of health insurances from the outset. Usually, defaults such as standard insurance tariffs for those who feel overwhelmed by active choosing, are non-transparent and non-deliberatively designed by insurance managers that seek to place a new product on the health insurance market. Summed up, in the light of behavioural policies, state-citizen relations in health insurance provision, until recently heavily influenced by welfare consumerism, may shift towards a customized relationship where corporate actors routinely nudge consumers that were formerly addressed as collective citizens.

Doctor-patient relationship: From shared-decision-making back to doctor-knows-best?

At first glance, the deployment of behavioural policy tools in health promotion and health insurance provision shares an ostensible harmlessness: Nudging people towards healthier lifestyles and insurance tariffs tailored to their needs seems fairly acceptable, if one takes out potential caveats concerning normative premises and misuses of behavioural policy making. Applying nudges within the doctor-patient relationship is for many reasons a more 'sensitive issue' (Kesselheim, 2016, 219): At stake are noble principles such as patient autonomy, trust-based interactions and shared-decision-making. As it is feared, behavioural interventions may 'undermine the doctor-patient relationship' (ibid., 220) in its current form that is 'complex and multi-faceted' (Stavropoulou, 2012, 323) and distinctively marked by an 'empowerment of the patient's role' (ibid., 314). In this view, doctors that nudge patients towards decisions on medical treatments and therapies are falling back into a paternalistic role model considered out-dated in present time, in which benevolent professionals decide unilaterally about the affairs of needy patients. If nudged by health professionals, patients

are not addressed in a holistic manner that is based on trust, dialog and shared-decision-making. As White (2016, 77) concluded, 'even the most knowledgeable professionals (…) cannot know the true nature of people's interest and how each person choses to balance health concerns', consequently health nudges are coercive in nature. In sharp contrast, nudge advocates argue that patients may prefer not to decide awkward health issues such as cancer treatment and would otherwise be exposed to a 'choice-requiring paternalism ' (Sunstein, 2016, xiii). Thus, health nudges, if 'done carefully and guided by the highest-quality evidence' (Kesselheim, 2016, 220), are legitimate means of doctors that act on behalf of their patients. However, this view lacks persuasiveness since it disregards the core of the patient-doctor relationship that is described as 'relational trust between individuals' (Fotaki, 2014, 1289).

To be sure, in theory, patients may be 'exercising their royal powers by delegating authority to someone else' (Le Grand, 2006, 75), though such an act would require patients' conscious and deliberative decisions in advance. Behavioural policy tools that unfold its effects by influencing people covertly (Oliver, 2013b; 2015) work precisely the reverse: Patients are typically nudged without consenting to the form and the content of the nudge. On the contrary, 'greater transparency might undermine nudges' (Gingerich, 2016, 102) that per definitionem aim to bypass people's reflecting and rational capacities (Hausman and Welch, 2010). Reconciling 'governance by stealth', as Mols et al. (2016) circumscribe nudge, and trust in doctor-patient relationships seems almost impossible, particularly in the light of competing rationalities that define the process of healthcare service delivery. In practice, patients can hardly determine on which basis they are nudged: medical evidence, doctors' professional experience or simply operational efficiency? There are good reasons to assume

that externalities such as financial incentives (or pressure) may facilitate the application of health nudges since 'the doctor-patient relationship is the key cog' (Kesselheim, 2016, 219) in healthcare spending. In fact, even doctors with the best intentions to serve their patients and contribute to their benefits are not immune against influencing factors such as the expected economic return of medical treatments.

For example, the steep increase of back surgeries (about 25 per cent from 2008 to 2013) in German hospitals (Bayrischer Rundfunk, 2015) appears in a different light, knowing that a surgery is much more profitable for hospitals than any non-surgery treatment. Would it be surprising, if doctors – being not only accountable to patients but also to the economic performance of healthcare providers – feel slightly inclined to nudge patients with back pain into surgeries? In addition, it might be asked whether patients that have been unconsciously nudged into a certain therapy will actual show compliance in the treatment process. Since health and recovery are very much related to patients' personality, values and beliefs, nudge interventions subtly applied in doctors' surgery or the hospital may not be in line with patients' social norms (Mols et al., 2015), and hence not lead to positive results but intensify an alienation process between doctors and patients. Taken together, there are compelling arguments that health choices 'should be designed as transparently and neutrally as possible' (White, 2016, 79).

After assessing the impact of behavioural interventions to state-citizen relations in three areas of health policies, the next section investigates lessons learned that could be generalized to other fields of public policy.

(5) Making public policies for citizens (that behave as humans)

A good part of nudge's stunning success story stems from libertarian paternalists' simply disarming and simultaneously very practical grasp on the human nature. Taking Kahneman and Tversky's (1974) findings on peoples' cognitive limitations and the relation among automatic and rational thinking (Kahneman, 2011) as a blueprint, 'benevolent nudging becomes a moral duty' (Leggett 2014, 6) for behavioural policymakers because, whether we like it or not, *humans are just like this*. Even when speaking about *citizens* nudge advocates (usually using the term *people*) seem to have humans in mind that are 'unrealistically optimistic (…) about their own behavior' (Sunstein, 2014, 45). However, libertarian paternalists' well-meant approach to address 'the Homers among us' (Thaler and Sunstein, 2008, 24) comes to its limits once behavioural insights are deployed within existing public policy frameworks. As it has been shown in the previous section, in practice, behavioural policies encounter people that have acquired a citizenship status which strongly predetermines their relation to state authorities, public agencies and health professionals. Thus, public policy addresses citizens that may indeed be persistent cognitive misers but, nonetheless, enjoy state protection and are endowed with rights and entitlements. Consequently, BPPs may bypass people's rational capacities 'by relying on unconscious anomalies in decision-making' (White, 2013, 95), while (at least) from a normative stance their citizenship status cannot be circumvented by policymakers.

Hence, it may be asked whether behavioural policies will ultimately lead to an 'impoverished vision of citizenship' (Jones et al., 2013, 178) where individuals merely obtain the right to be benevolently nudged for their own good (i.e. 'health, wealth and happiness' as Thaler and Sunstein, 2008, promise) or whether something like a behaviourally-informed citizenship

model – referring to behavioural insights without being one-sidedly dominated by them – will emerge at the horizon.

How could such a model (if envisioned) be conceptualised? First of all, it has to be accepted, as Oliver (2013b, 688) claimed, that 'behavioural economic policy should not be narrowed to nudges'[3]. In this regard, 'using behavioural science to improve the way in which policies are applied' (Hallsworth, 2016, 42) could be a middle ground that shows a way out of the dilemma whether 'to nudge or not to nudge' (Hausman and Welch, 2010). In terms of BPPs' implications for state-citizen relations it becomes evident that the latter are determined by an amalgam of mixed policy rationales (see previous section) that can hardly be ignored by behavioural policymakers. Rather than being narrowly focused on individual behaviour change, and, therewith, gradual undermining citizenship, behaviourally informed policies have to engage with co-existing rationales such as (social) protection, collective voice and informed choice. Or put differently: How can behavioural insights make a meaningful contribution to revitalise those rationales? Or do BPPs inevitably reinforce a citizen image that is necessarily marked by the role model of a 'somewhat reactive consumer' (Room, 2016, 115)? As it is shown by making references to constructive critiques on behavioural politics spawned by authors such as Leggett (2014), Oliver (2013b; 2015), John et al. (2009; 2011) and Room (2016), alternative ways of shaping state-citizen relations through behavioural science are conceivable.

If we consider (social) security and protection as basic functions to be fulfilled by the state in relation to its citizens, public policymakers may also demonstrate sensitivity to behavioural

[3] To some extent as a pre-emptive defence, Michael Hallsworth (2016, 41), Director of Health and Tax at the Behavioural Insights Team in the UK, has recently indicated that the relationship of behaviour science and policy consists of 'more than nudging'.

insights, if they seek 'to *protect* citizens against proliferating attempts to shape their behaviours and subjectivity' (Leggett, 2014, 15). Also Oliver's (2013b) *budge* concept – ‚behavioural economic-informed regulation designed to budge the private sector away from socially harmful acts' (ibid., 698) – seeks to protect citizens from behavioural manipulations by corporate actors. In contrast to nudge, such a policy approach strengthens citizens' maturity by educating them 'with regard to the many behaviour change interventions they are subject to' (Leggett, 2014, 15). In this case, rather than targeting 'lifestyle-focused health culprits' (Quigley, 2013, 620) with ever more sophisticated ''counter-nudges'' (Oliver, 2013b, 687), policymakers, well aware that people are (too) easily nudgeable, would take on the role of citizens' advocates. However, the implementation of such a stop sign policy, as indispensable it might be in the face of an "army" of unprincipled nudgers, turns citizens once again into *pawns* (Le Grand, 1997) whose agency to voice concerns and make active welfare choices tends to be disrespected. As a remedy, two different suggestions (one rather pragmatic and one rather utopian) for reinventing active citizenship in the light of the behavioural turn are proposed.

First, John et al. (2009, 362) argue in a quite conciliatory manner that a combination of 'nudge *and* think' is necessary to adequately respond to bounded rationality. Since this proposal includes deliberation on 'the way that collective and institutional settings help determine the success or failure of a nudge' (ibid., 369), it may prevent citizens from being downgraded to mute nudgees in the long-term. Considering the fact that behavioural policymaking has been so far a fairly elitist project (de facto refining mechanisms of power *over* rather than *through* people) a reconciliation with approaches of participatory

democracy is currently difficult to imagine.[4] For example, Jones et al. (2013) criticize the rather shallow rhetoric of the UK government that implies a blending of behaviour change policies and new forms of citizen involvement (such as co-production) as an attempt 'to further embed transactional, consumer-based state-citizen relations' (ibid., 171). In contrast, Moseley and Stoker (2013, 9) claim that nudge policies can only be applied effectively if confirmed by citizens who 'should have the final say in deciding on the content of these nudges, both in terms of the behaviours that those Nudges are seeking to encourage, and the particular form that the Nudges should take'. Future empirical studies will show whether citizen-led behavioural policy making becomes a realistic option or whether an elitist and privileged group of choice architects continue to nudge 'the behaviour they want to see' (White, 2013, 101).

Second, insights concerning the enormous impact of environments and settings on people's behaviour have evoked calls not to nudge citizens but to *nuzzle* them as 'creative and agile actors' (Room, 2016, 113). This kind of bold and utopian approach sketches out a vision how to reshape society (instead of individual behaviour) in a way that provides 'well-being and security' and recognizes people's 'wish for voice not choice' (ibid., 125). Devised as a decidedly anti-nudge concept nuzzle 'asks government to think of citizens as (…) the eager and responsible authors of their own destinies' (ibid., 118) instead of mere 'implementers of existing policy' (Byrne et al. 2016, xii). This indeed requires policy frameworks where people are not nudged around for better or worse reasons but empowered as citizens that collectively work on the structural causes of behavioural shortcomings within their life

[4] Remarkably, Reisch et al. (2017, 2) concluded from a recent study that ‚if individuals believe that a nudge has legitimate goals and conforms to the interests or values of the majority, they are overwhelmingly likely to favour it'. A logical consequence from this finding would be to involve people in the design of nudges in order to ensure their support.

worlds. According to Room the latter are non-linear and complex systems with unevenly distributed possibilities to take influence. Speaking in libertarian paternalists' terms: Choice architectures may be inevitably side effect of modern societies but leaving the task of shaping them to the usual suspects (i.e. big government and corporate actors) is not.

Finally, when it comes to the design of public policy and state-citizen relations, behavioural policymakers may benefit from reconsidering classic economist thinking such as Hirschman's (1970) study 'Exit, Voice, and Loyalty. Responses to Decline in Firms, Organizations, and States'. By pointing out the importance of customers' 'loyalist behavior' (ibid., 92) in response to ill-performing agencies, Hirschman shares the perception of the human with behavioural economists and recognizes people's irrational behaviour. However, he did not stick to a dichotomous conception of human action, as it is suggested by the division of system 1 and 2 (Kahneman, 2011), but identified more differentiated kinds of human behaviours to 'avoid[…] social losses as well as human hardship' (Hirschman, 1970, 3). According to Hirschman, policy designs should allow citizens likewise to exit (then the term for choice), voice or stay loyal in relation to public organizations and stakeholders. Particularly policy investments in the 'art of voice' (ibid., 43) that tap into citizens' mental capacities for recuperation and innovation will, as Hirschman points out, pay off in the long-term. Using Hirschman's triad concept as a baseline, it seems possible to shape state-citizen relationships in more dialogical ways than current behaviourally informed policies make us believe. For example, health funds may deliberatively develop (i.e. in close cooperation with the insured) user-friendly insurance tariffs that allow choice and voice in terms of healthcare coverage while simultaneously, acknowledging people's in-born inertia and laziness to make switches among insurance schemes.

To sum up, by ‘tricking or fooling someone into a certain decision’ (White, 2013, 95) behavioural public policies undermine key citizenship features. In its pure and simple form, nudge policies – being trapped in a narrow mind-set that conceives people as cognitive misers – lack procedures to cultivate mutual trust, communication and partnership within state-citizen relations. By contrast a behaviourally informed citizenship model, taking humans' flaws and its systematic exploitation into account, sets out to explore new forms of protecting individuals from coerced behaviour change strategies and maintains to engage collective citizens in the process of public policy making.

(6) Conclusion

As Straßheim et al. (2015, 259) have noted, ‘behavioural approaches promised a renewed state-science-citizen relationship’ by ‘taking human failings as a starting point’ (Mols et al., 2015, 84) for policy interventions designed in the light of behavioural insights. In this utopia of a brave new world, policymakers can ceaselessly draw from a well-stocked knowledge reservoir about individual behaviour that allows them to forge nudges whenever causing a change in people’s behaviour seems opportune. Thought through to its logical conclusion, future public policymaking may then become a fully automatic process in which to the benefit of all individual human behaviour is fabricated on the basis of the standardised evaluation of big data. However, in reality the implementation of BPPs collides, as it has been shown for the health field, with a dense thicket of multi-layered policies that have deeply shaped state-citizens relations and have repercussions for the present. Despite its powerful rhetoric that implies to redirect individual behaviour effortlessly by gentle nudges, BPPs that are unmindful towards the historical legacy of a policy field cannot circumvent

preceding policy rationales but have to refer and engage with them. In practice, *nudgeworthy* individuals – perhaps pursuing a problematic lifestyle marked by unreasonable choices (*Though, who defines what this exactly means?)* – may turn out to be stubborn, querulous and dissenting or just ignorant citizens. In this regard, republican-leaning US-citizens that responded towards government attempts to nudge energy efficiency behaviour by further increasing their energy consumption are a telling (and warning) example (Costa and Kahn, 2013). There are limits to designing public policies similar to online shopping portals (informing users about other users' purchasing decisions) and supermarkets (placing premium products at eye level) because in the public sphere, more than elsewhere, people tend to scent and critically eye subliminal attempts of shaping their behaviour. As Mols et al. (2015, 89) concluded, nudges 'are prone to backfire', if people's identity as citizens is, consciously or not, disregarded. Against this backdrop, it follows for the future of behavioural policymaking a request for modesty concerning the potential of behavioural interventions and a better understanding of the policy contexts in which they should be applied. Rather than following a self-referential logic, whereupon supposedly ill-intended nudges (e.g. by the commercial sector) are merely counterbalanced by well-meaning nudges (e.g. by government agencies), behavioural interventions require a cautious integration into existing policy frameworks. In democratic and citizenship-based societies this necessitates collective agreements on BPPs in advance: Whose behaviour should be changed into which directions based on what kind of evidence?

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