A public policy designed and run by a private entrepreneur. Tensions between public health and private interest in the battle against obesity in France

Henri Bergeron, Patrick Castel, Étienne Nouguez, Amy Jacob

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Henri Bergeron, Sciences Po — CSO — CNRS
Patrick Castel, Sciences Po — CSO — CNRS
Etienne Nouguez, Science Po — CSO — CNRS
Amy Jacob (English Translation)

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Abstract

By studying the case of obesity prevention, this paper aims to shed light on the reorganization of public health policies in France. This analysis of mechanisms by which a private operator establishes itself as a legitimate and leading actor (of a program now present in more than 200 cities) enables an insight into the articulation between policies carried out by the state and the municipalities on one hand, and an original mode of policy privatization on the other hand. This operator does not fit into the usual categories for analysis of policy but corresponds more to the figure of the private entrepreneur succeeding in creating a durable role for himself on the border of two heterogeneous worlds, which often find themselves in conflict, that of public health and the market.

Keywords

Obesity ; Public Health ; Public Policy ; Private Companies ; Public-Private Partnership ; France

Governance, privatization and public health policy

Research studies analyzing recent transformations of the state and the way state action is being reconfigured make much use of the notion of governance. Though researchers investigating this issue are not working within a perfectly homogeneous theoretical space and though the studies focus on what are often very different phenomena, this "second-order concept"[1] is often used to circumscribe and characterize three categories of change (among others); i.e., the greater role in shaping and implementing public policy now being played by 1) local communities and municipalities, 2) private-sector actors (businesses) and 3) international institutions, particularly the European Union.[2] These three developments, which may occur at different scales, are understood to undermine the state's ability to act autonomously,[3] to relativize its tutelary role in producing public goods and services, and to call into question its leadership position when it comes to orienting and coordinating actors involved in producing public action. The notion of governance enables us to apprehend public action heuristically as the product of competition/cooperation between different groups of public and private actors, groups often organized into (horizontal) networks and active in exchanges situated at various scales (local, national, international). While some segments of the state continue to play a major role in developing and implementing public policy, they are now operating "in plainclothes."[4] Furthermore, in several sectorial policies, the state is no longer the regulation centre. Lastly, the notion of governance helps renew our understanding of mediation and interaction between state and society, suggesting the relevance of moving beyond an institutional perspective focused exclusively on government powers and instruments and working instead to identify the negotiation and coordination mechanisms operative among "different groups, networks, sub-systems"; mechanisms "that will make government action possible."[5]

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[1] Patrick Le Galès, "Gouvernance," in *Dictionnaire des politiques publiques*, ed. Laurie Boussaguet, Sophie Jacquot, Pauline Ravinet (Paris: Presses de Sciences Po, 2004): 242-250.
[2] Fritz Scharpf, *Gouverner l'Europe* (Paris: Presses de Sciences Po, "Références" series, 2004): 242-250.
[3] Patrick Hassenteufel, *Sociologie politique: l'action publique* (Paris: Armand Colin, 2008).
[4] Patrick Le Galès, "Du gouvernement des villes à la gouvernance urbaine," *Revue Française de Science Politique* 45, no. 1 (Feb. 1995): 59.
[5] *Ibid.*

Several authors have focused on changes in relations between the state and the market[6] and on the role of private actors in producing public policy,[7] working to identify characteristics of the dynamics governing what has been termed a movement to "privatize" public action; e.g., market-sector companies' involvement in delivering public goods and services, "the transforming of state actors into private-sector ones,"[8] governments' increasing tendency to use knowledge, tools and standards developed in the market sector, and increased interdependence between public and private actors. This privatization phenomenon, which actually blurs the boundaries between public and private, is quite clearly at work in public policy touching the economy, that is, transportation, communications, energy policy, among others. But it has also been shown to be acute in other areas, such as internal and external security,[9] disease protection,[10] therapeutic and curative public health policy[11] and, in some countries, taxation.[12]

On the other hand, the many existing research studies of recent changes in the *public health* policy sector[13] have not observed or emphasized any privatization movement in this particular field, and those that have mentioned it have done so only in passing.[14] Some research has of course

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[6] Jan Koolman, "Introduction," *Modern Governance: New Government-Society Interactions*, ed. Jan Koolman (London: Sage, 1993): 1-8.

[7] Le Galès, "Du gouvernement des villes à la gouvernance urbaine."

[8] Hassenteufel, *Sociologie Politique*.

[9] On France, see Sébastien Roché, "Vers la démonopolisation des fonctions régaliennes: contractualisation, territorialisation et européanisation de la sécurité intérieure," *Revue Française de Science Politique* 54, no. 1 (Feb. 2004): 43-70. At the international level, see in particular Elke Krahmann, "Security: Collective Good or Commodity?" *European Journal of International Relations* 14, no. 3 (2008): 379-404.

[10] Patrick Hassenteufel, "L'Etat mis à nu par les politiques publiques?" in *Les temps de l'Etat*, ed. Bertrand Badie and Yves Deloye (Paris: Fayard, 2007): 311-329 and *Sociologie Politique*.

[11] Patrick Le Galès, Alan Scott, "Une révolution bureaucratique? Autonomie sans contrôle ou 'freer markets, more rules,'" *Revue Française de Sociologie* 49, no. 2 (2008): 301-330. In English, "A British bureaucratic revolution? Autonomy without control, or 'freer markets, more rules,'" *Revue Française de Sociologie* 51, no. 5 (2010).

[12] Béatrice Hibou, "Retrait ou redéploiement de l'Etat," *Critique internationale* 1 (1998): 151-168.

[13] What territorial entities should be in charge of public health policy and what that policy should encompass are perpetually debated questions in France (cf. Didier Fassin, "Comment faire de la santé publique avec des mots: Une rhétorique à l'œuvre," *Ruptures* 7, no. 1 [2000]: 58-78). We do not enter into those professional, specialized debates here. For the purposes of this article, public health policy is defined cursorily and restrictively as any policy aimed primarily at combating public health risks (epidemics in particular) and preventing pathologies or disorders of all sorts in a given population. Our primary concern here is actions of the second type: preventive.

[14] Noting, for example, the role of public relations agencies since the 1970s in developing campaigns for the Centre Français d'Education pour la Santé; see Luc Berlivet, "Une biopolitique de l'éducation pour la santé: La fabrique des campagnes de prévention," in *Le gouvernement des corps*, ed. Didier Fassin and Dominique Memmi (Paris: Editions de l'EHESS, "Cas de figure" series, 2004): 37-74, and "Uneasy Prevention: the Problematic Modernization of Health Education in France after 1975," in *Medicine, the Market and Mass Media: Producing Health in the Twentieth Century*, ed. Virginia Berridge and Kelly Loughlin (London: Routledge, 2005): 95-122.

stressed how the (regulator) state,[15] via the work of agencies specialized in health risk management, has helped diffuse managerial know-how[16] and market logic (while also making it possible to enact "norms opposed to the market").[17] A number of studies have stressed the strength of resistances between interest groups on the one hand and coalitions of market actors on the other in processes of passing legislation or adopting public health policies.[18] Others have drawn attention to the involvement in France of organizations whose status is technically private—namely, not-for-profit associations founded in accordance with the Law of 1901—recalling that they have long been extremely active in matters involving French public health policy.[19] But most studies of new health policies have been more interested in the role of patients (e.g., in the fight against AIDS and other pathologies), characteristics of the sciences that inform public health surveillance and protection policies, socio-political processes of constructing public health problems, institutional management of "public health crises," and the increasing involvement of the European Union echelon and international organizations.[20] The

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[15] Patrick Hassenteufel prefers the concept of regulator state to the notion of governance, deeming the latter vague and polysemic and therefore open to the type of criticism that was once made of the "concrete action system" concept developed by Michel Crozier and Erhard Friedberg. For Hassenteufel, the tropism of analyses using this concept leads them to neglect "the specificities of political resources and purposes of political undertakings" as well as the "hierarchical ordering phenomena involved in political power inside the state" (*Sociologie politique*, p. 270). Nonetheless, the "regulator state" concept includes one of the essential conclusions of governance research, namely, a loss of state ability to take autonomous action (though it can still steer policy to some extent).

[16] Daniel Benamouzig, Julien Besançon, "Administrer un monde incertain: les nouvelles bureaucraties techniques, le cas des agences sanitaires," *Sociologie du Travail* 47, no. 3 (2005): 301-322; Thomas Alam, Quand la vache folle retrouve son champ: Une comparaison transnationale de la remise en ordre d'un secteur d'action publique, doctoral thesis in political science, Lille, Université de Lille 2, 2007.

[17] Hassenteufel, *Sociologie politique*, p. 271.

[18] On alcohol and tobacco see Luc Berlivet, Une santé à risques: L'action publique contre l'alcoolisme et le tabagisme en France (1954-1999), doctoral thesis in political science, Rennes, Université de Rennes I, 2000; Constance Nathanson, "Collective Actors and Corporate Targets in Tobacco Control: a Cross-National Comparison," *Health Education and Behavior* 32, no. 3 (2005): 337-354. Relations between industries and public health authorities have also been studied in connection with European Union policy for regulating medicines (Boris Hauray, *L'Europe du médicament* [Paris: Presses de Sciences Po, 2006] and in the context of AIDS research (Sébastien Dalgalarrondo, *Sida: la course aux molécules* [Paris: Editions de l'EHESS, 2004]).

[19] Didier Fassin, "Politique des corps et gouvernement des villes: La production locale de la santé publique," in *Les figures urbaines de la santé publique: Enquête sur des expériences locales*, ed. Didier Fassin (Paris: La Découverte, "Recherches" series, 1998): 7-46 and *Faire de la santé publique* (Rennes: Editions de l'EHESP, 2008). On policies for combating drug addiction and alcoholism, see, among others, Henri Bergeron, *L'Etat et la toxicomanie: Histoire d'une singularité française* (Paris: Presses Universitaires de France, 1999) and on AIDS, Claude Thiaudière, *Sociologie du sida* (Paris: La Découverte, "Repères" series, 2002).

[20] It would not make sense to present an exhaustive list of these studies here. For a presentation and discussion of related research, see Didier Fassin and Boris Hauray, eds., *Santé publique: l'Etat des savoirs* (Paris: La Découverte, 2010); Henri Bergeron, "Politiques de santé publique," in *Politiques publiques 2, Changer la société*, ed. Olivier Borraz and Virginie Guiraudon (Paris: Presses de Sciences Po, "Gouvernances" series, 2010): 79-111; Claude Gilbert and Emmanuel Henry, eds., *Comment se contruisent les problèmes de santé publique* (Paris: La Découverte, " Territoires du politique" series, 2009). On the European Union, see Sébastien Guigner, L'institutionnalisation d'un espace européen de la sante: Entre intégration et européanisation, doctoral thesis in political sciences, Rennes, Université de Rennes I, 2008.

growing role of market-sector actors in the actual production of public health has not been at the centre of political science or sociology analyses.

Local policies for combating overweight and obesity: privatization or hybridization?

Recent major changes in the way public health policy is done[21] should nonetheless move us to pay more systematic attention to this research problem—specifically, changes in policy related to the now national and international public health "cause" of preventing obesity and overweight. Among the wide range of preventive and curative actions that have been developed to combat overweight and obesity, providing information and education on individuals'—and particularly children's—health is now thought of as essential. In France, health education campaigns are run by all sorts of national and local prevention actors: the Institut National de Prévention et d'Education pour la Santé (hereafter INPES), *départément*-level health promotion organizations, specialized, private–status not-for-profit associations as defined by France's Law of 1901, *département*-level services for the protection of pregnant women, new mothers and children, Ministry of Education services, municipal health and hygiene services, national public health insurance services, complementary health insurance organizations, etc. But one particular prevention program caught and held our interest: "Ensemble Prévenons l'Obésité des Enfants" [Together let's prevent obesity in children], hereafter noted EPODE. Designed and run by professionals in the fields of nutrition, management and marketing who work through a private social marketing agency, and funded by contributions from towns and cities enrolled in the program as well as subsidies from partner companies, some of which belong to the food and mass marketing industries, EPODE has managed to acquire a key position in shaping and developing arrangements for detecting and preventing child obesity. It is now operating in over 200 French cities and towns, including major cities such as Lille and Paris, and is perceived as a crucial player in public health policy around this problem. As such it has been presented by the Ministry of Health as particularly innovative, to the point where, in the eyes of the public

[21] See Bergeron, "Politiques de santé publique."

authorities, it incarnates the most successful instance of public-private partnership (PPP).

We studied the genesis and implementation of this program in four municipalities and at the national level, using the methodology specified below. We obviously make no claim to have exhausted or revealed all changes in state action in connection with public health policy through this study of a single program, or even to have synthetically identified the particular type of governance or dominant type of regulation operative—and prospering—in the anti-obesity and overweight policy sub-sector. Our three aims are more modest.

First, studying the genesis and operation of this program and the relations obtaining between the private-status actors and organizations that run it and the many other actors involved is a particularly effective means of observing implementation of a policy for "governing citizens' bodies,"[22] as well as the (difficult or non-existent) combining of state action and local action, the latter primarily municipal.

Second, this case is useful for apprehending the mechanisms that govern the rise to legitimacy of a private actor in the public policy area of public health. Like security policy in France (see Sébastien Roché), public health policy is understood to belong *categorically* to the French state's sovereign competence and scope of activities,[23] and the involvement of private business enterprises has elicited much resistance, since public health is generally not to be considered a "commodity." We try to shed light on some of the processes and mechanisms through which such a program has managed to become institutionalized in what is still a "recalcitrant"

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[22] Fassin and Memmi, eds., *Le gouvernement des corps*.

[23] The principle of the state's *categorical* responsibility for public health was inscribed in law as early as the public health law of 1902, though in a relatively subterranean manner. A vast amount of jurisprudence in France's "administrative courts" [handling disputes in which the state is either plaintiff or defendant] then confirmed and crystallized that responsiblity (Didier Tabuteau, "La sécurité sanitaire, réforme institutionnelle ou résurgence des politiques de santé publique," *Sève* 3, no. 16 (2007): 87-103. In recent years, state responsibility for public health has been more conspicuously affirmed, namely in the law on patients' rights of 2002. Legislative assertion reached its apogee in 2004 with the law "relative to public health." Drafted by a small circle of experts and senior civil servants at the Direction Générale de la Santé (DGS; department in the Ministry of Health), most of whom had trained in public health and epidemiology at the best British and American universities (cf. Henri Bergeron and Constance Nathanson, "Construction of a Policy Arena: the Case of Public Health in France," *Journal of Health Politics, Policy and Law* 37, no. 1, forthcoming in 2011), this law asserts in no uncertain terms that public health is part of the state's jurisdiction and competence and provides for regionalizing public health policy, a move which, as Bernard Goudet has remarked, should be interpreted not as deconcentration but as a "decentralizing transfer" (Bernard Goudet, "La loi de santé publique du 9 août 2004: une analyse sociologique," *Santé Publique* 4, no. 44 [2004]: 601).

policy area.[24] Specifically, we show how EPODE is a quite particular example of the private public-policy actor. EPODE actors do not belong to the category qualified by Pierre Lascoumes and Dominique Lorrain as "black holes of power" because they do not act *in an absolutely* "discreet"[25] manner or operate like a "back-office" for "the public authorities" in accordance with an "unwritten division of labour" principle; nor do they have any legislative, executive or conflict-regulating powers.[26] And they do not really correspond either to the "moral entrepreneur," a figure whose importance has often been stressed in literature on public policy following the seminal works of Howard Becker.[27] Though the program came into existence and began developing before the obesity problem got put on the public policy agenda, it was not at all involved in the initial moves to frame "bad eating," overweight and obesity as social problems (though today it is increasingly likely to assume this role);[28] it neither helped "sound the alarm"[29] nor proposed or defended the guidelines along which "solutions" to the problem were to be found. In fact, the actors running the EPODE program correspond most closely to the figure of the private entrepreneur[30] as depicted in recent years in economic sociology studies.[31] They seem to have managed to assume a stable position, to act and settle in as actors, on the boundary between two heterogeneous and in many respects antagonistic worlds: public health and the market.

Third, studying how this actor established itself as a legitimate "operator" of public policy to combat obesity and overweight, and how it helps

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[24] The meaning we attribute to the concepts of institutionalization and institution is explained in greater detail below.

[25] Though as we shall see there is a certain "vagueness" regarding the effective legal status of a number of the local actors.

[26] Pierre Lascoumes and Dominique Lorrain, "Les trous noirs du pouvoir: Les intermédiaires de l'action publique," *Sociologie du Travail* 49, no. 1 (2007): 5.

[27] Howard Becker, *Outsiders: Etudes sociologiques de la déviance* (Paris: Métaillié, 1985); originally published as *Outsiders: Studies in the Sociology of Deviance* (New York: The Free Press, 1963).

[28] Cf. the latest report by the Office Parlementaire d'Evaluation des Choix Scientifiques et Technologiques, headed by Senators Jean-Claude Étienne and Birgitte Bout, "Prévention et traitement de l'obésité: l'état de la recherche," report on the public hearing of March 4, 2009.

[29] Francis Chateauraynaud and Didier Torny, *Les sombres précurseurs: une sociologie pragmatique de l'alerte et du risque* (Paris: Editions de l'EHESS, 1999).

[30] Though in order to get established in the field they did have to symbolically efface—in part and only in part—the primarily private nature of their initiative; this they did by obtaining the support and commitment of public authorities and institutions, as we shall see.

[31] David Stark, *The Sense of Dissonance: Accounts of Worth in Economic Life* (Princeton and Oxford: Princeton University Press, 2009); Pierre-Paul Zallio, "Sociologie économique des entrepreneurs," in *Traité de Sociologie économique*, ed. Philippe Steiner and François Vatin (Paris: Presses Universitaires de France, 2009): 573-607.

perform missions in the general interest, is first and foremost an occasion to identify original ways of "privatizing" public action.

1) We show how this actor goes beyond the tasks of diagnosing the problem, identifying targets for local public action, designing action tools and even assessing the action (all these activities signalling varieties of privatization have already been identified in the literature), playing an active as well in the essential, properly political task of coordinating the activity of public actors and local organizations. We discover a partially "reversed" version of privatization, in which private actors help coordinate the action of public actors (i.e., belonging to some level of government) and association actors.

2) While some features of a movement to privatize public action may be discerned in this policy sub-sector, it is crucial to see that there is also a reciprocal phenomenon of "publicizing" private action. We show that the nature of the institutional setup now governing implementation of the EPODE program is fundamentally hybrid—so much so that the very notion of "privatization" is no longer accurate to define the way public action is being reconfigured in this sub-field.

3) We also work to show that substituting a private service-provider for a public service-provider for certain tasks (particularly diagnosis, target definition, tool development and policy assessment) is not a perfectly neutral operation: it has significant impact on what it means to "do public health."

After briefly retracing the genesis of this "moral service implementer" we turn to how it has tried to legitimate its intervention in the area of child obesity prevention and managed to accommodate critiques of its private-sector origins and its business-oriented aims.

Methodology

One theoretical source for our study is the sociology of organizations developed by Michel Crozier and Erhard Friedberg and other

researchers at the Centre de Sociologie des Organisations.[32] Since our purpose was to understand the mechanisms through which this private operator assumed importance and influence in the public health arena, it was important to collect and understand actors' individual, subjective perceptions of the program and its ways of proceeding, and to discover the structure of those actors' informal relations. This is why, in addition to examining materials developed and disseminated by the program, types of actions carried out, and official documents and reports, we chose to conduct a number of in-depth semi-directive interviews. Systematic, reiterated comparison of actors' viewpoints, duly related to the more factual data we have also analyzed, enable us to identify and circumscribe the regularity of certain action dynamics and approaches and so to go beyond a mere accumulation of idiosyncratic opinions.

Given the program structure, we chose to focus the investigation on two interdependent levels: national and local.

At the national level, the point was both to understand the strategy[33] of program promoters and their interrelations as well as their relations with their main partners and other institutions in the field. We therefore questioned managers in charge of the not-for-profit association and the private business running the program, some of the scientists that those managers work with in the framework of the program, industry representatives involved in funding the program, and actors involved in the Plan National Nutrition Santé (PNNS) at the DGS and INPES.

At the local level, we chose only cities that had been enrolled in the program for at least a year so that we could observe how the program was being implemented. We selected four towns that were different enough to make it reasonable to hope that comparison would be productive: three towns with high rates of child overweight and obesity and one with low rates. The idea here was to study whether local dynamics for implementing the program differed by degree of significance the problem seemed to have. Furthermore, two of the towns

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[32] Michel Crozier and Erhard Friedberg, *L'acteur et le système* (Paris: Seuil, 1977); in English, *Actors and Systems: the Politics of Collective Action*, trans. Arthur Goldhammer (Chicago: University of Chicago Press, 1980); Erhard Friedberg, *Le pouvoir et la règle* (Paris: Seuil, 1993); Christine Musselin, "Sociologie de l'action organisée et analyse des politiques publiques: deux approches pour un même objet?" *Revue Française de Science Politique* 55, no. 1 (Feb. 2005): 51-71.

[33] In the broad sense that Crozier and Friedberg give to the term (*L'acteur et le système*); i.e., reconstructed by the researcher and not necessarily implying actor awareness.

with high levels of overweight and obesity are small towns, the other is medium-sized, the point being to measure whether amount of municipal resources influenced the nature of program implementation.

The four towns studied may be described as follows: Town A, the administrative "capital" of a *département* to the north of Paris, is medium-sized, 40 000 inhabitants, a fairly young population (one-fourth under 20). It has been in the program since 2004 and was thus one of the ten experimental cities. Of those cities, it had the highest proportion of overweight and obese children: more than 20% of the child population (5 to 12 years of age), according to 2007 Body Mass Index (BMI) measurements. Town B is a small town in Bretagne, 15 000 inhabitants, with a higher proportion of young people than Town A (one-third of the population is under 20). It enrolled in the program in 2003 so as to qualify as an experimental city. However, of the 10 experimental cities, Town B had the lowest BMI rating in 2007: approximately 10% of the population aged 5 to 12 was overweight or obese. Area C encompassed two small towns of respectively 11 000 and 7000 inhabitants, both part of a conurbation in the north of France, a region particularly affected by obesity. The conurbation as a whole had joined the program in 2006.

A preliminary study in one of the towns enabled us to identify the types of actors to be interviewed in all. For each town studied, we questioned many of the actors directly or indirectly involved in the program, both those participating in program enactment and those who did not wish to participate in it despite program members' uniform desire to have them do so. We tried to reconstitute the system of informal relations obtaining between these local-level actors as well as relations between local officials and national program coordinators. In each of these three locales (comprising our four towns), we interviewed elected town officials and town administrative workers, doctors and nurses, community organization actors, actors permanently employed by the Ministry of Education [these are civil servants in France], and representatives of the state's "external services" [state services operating at the regional level under the prefect's authority, the prefect being the representative of the central state at the level of the *région* or *département*] as well as representatives of regional health and social affairs bureaus (DRASS) and regional public health authorities (GRSP). In each of the three locales

(Town A, Town B, Area C), between 30 and 50 interviews were conducted, for a total of 123.

Brief history of a "moral service implementer"

Several studies in recent years have worked to identify the socio-political processes at work in the construction of obesity as both an epidemic disease and a public health problem.[34] The central role played by the Body Mass Index or BMI, which became the "obviously" relevant means of indicating corpulence, has received particular emphasis.[35] World Health Organization action also seems to have been decisive for the emergence of overweight and obesity as a political and policy issue, though the specific mechanisms explaining how the organization's famous 2000 report[36] qualifying obesity as the first non-viral epidemic could have such an impact on so many countries' policy agendas have yet to be identified. Above all, the speed with which obesity got put on the policy agenda[37] is a genuine enigma that many current studies are seeking to solve. France is a striking example of the speed of public response: the first anti-obesity measures were in place barely one year after the Haut Comité de Santé Publique submitted its 2000 report listing factors implicated in the development of obesity,[38] and only a few years after the first national study of obesity levels, the ObEpi survey, done for the first time in 1997.

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[34] Abigail C. Saguy and Rene Almeling, "Fat in the Fire? Science, the News Media and the 'Obesity Epidemic,'" *Sociological Forum* 23, no. 1 (2008): 53-83; Abigail C. Saguy and Kevin W. Riley, "Weighing Both Sides: Morality, Mortality and Framing Contests over Obesity," *Journal of Health Politics, Policy and Law* 30, no. 5 (2005): 869-921; Annemarie Jutel, "The Emergence of Overweight as a Disease Entity: Measuring up Normality," *Social Science & Medicine* 63, no. 9 (2006): 2268-2276; Thibault Bossy, Poids de l'enjeu, enjeu de poids: La mise sur agenda de l'obésité en Angleterre et en France, doctoral thesis in political science, Institut d'Etudes Politiques de Paris, 2010; Eric J. Oliver, "The Politics of Pathology: How Obesity Became an Epidemic Disease," *Perspectives in Biology and Medicine* 49, no. 4 (2006): 611-627; Faustine Régnier, Didier Torny, "Une épidémie kaléidoscopique: les constructions savantes de l'obésité dans le contexte français," 2008 convention of the **Association Internationale de Sociologie,** Montreal; Jean-Pierre Poulain, *Sociologie de l'obésité* (Paris: Presses Universitaires de France, 2009).

[35] For a critical account of the history of this indicator, see Ian Hacking, "Façonner les gens," courses at the Collège de France, Lesson 3: "Normalisation: l"épidémie' d'obésité," 2005; Thibault de Saint-Pol, "Comment mesurer la corpulence et le poids 'idéal'? Histoire, intérêts et limites de l'indice de masse corporelle," *Notes & Documents* 2007-01, Observatoire Sociologique du Changement, 2007.

[36] WHO, "Obesity: Preventing and Managing the Global Epidemic, Report on a WHO Consultation," *Technical Report Series* no. 894 (2000).

[37] It was not until the mid-1990s that research began to mention an obesity "epidemic" (Saguy and Riley, "Weighing Both Sides").

[38] Haut Comité de Santé Publique, *Pour une politique nutritionnelle de santé: Enjeux et propositions* (Rennes: Editions de l'ENSP, 2000).

Thibault Bossy has identified three major sources for France's anti-obesity policy.[39] The first of these is the Plan National Nutrition Santé (PNNS), in operation since 2001, a national program that arranges for publication of nutrition guides aimed at influencing consumer food and diet choices; the launching of INPES-designed health education campaigns in the media; and negotiations with the food industry to establish "voluntary commitment" charters where food companies agree to modify the composition of their products. The PNNS is steered by the Ministry of Health via the Direction Générale de la Santé, which has a bureau that deals exclusively with that issue. The second source is a 2001 Ministry of Education internal circular on the "composition of school cafeteria meals and food safety."[40] The third source is the 2004 public health law, one article of which regulates food product advertising[41] while another prohibits beverage and snack-food vending machines in schools.

As explained, the community organization that started the EPODE program did not really play a part in getting obesity on the policy agenda nor did it advocated any particular axiological, cognitive or instrument options, though its first actions in this area did take place before obesity was recognized as a public health issue. Instead it took advantage of what was a favourable context to offer local community structures a set of public policy standards and instruments. What was at issue for this "moral service implementer" was to institutionalize its "solution" to a problem that had already been recognized as such and thus been legitimized.

An in-depth history of the genesis and development of the EPODE program and its institutional trajectory, and an analysis of the decisions and factors that shaped that trajectory, have yet to be done.[42] However, the material we have already been able to assemble, namely our

[39] Bossy, "Quand le poids devient un problème public: la mise sur agenda de l'obésité en France et en Angleterre," paper for the Pôle Action Publique graduate seminar at the CEVIPOF (Centres de Recherches Politiques), Sciences Po, Paris, 2008.

[40] Circular no. 2001-118, June 25, 2001.

[41] State framing of food advertising, a highly conflictual matter in France because of the problem it raises of relations between the state and the food industries (represented by the Association Nationale des Industries Agroalimentaires or ANIA), recently came to the fore once again in parliamentary debate on the "Hôpital, patients, santé et territoires" bill.

[42] A study funded by the Agence Nationale de la Recherche and focused on the genesis of the EPODE program is currently under way.

interviews with actors who played crucial roles in the program's development and success, is substantial enough to enable us to provide a broad outline of that history and thereby grasp how the program gradually became inscribed in a moral and political context not of its own making. We first present the initiative that preceded and gave rise to EPODE; then analyze program creation and development more closely.

From an epidemiological survey focused on schools to a program for local action focused on towns and cities (1993-2004)

What gave rise to the EPODE program was an initiative taken in 1992—that is, before obesity and overweight were granted the controversial status of "public health problem"—by a not-for-profit organization named Fleurbaix Laventie Ville Santé or FLVS. Fleurbaix and Laventie are the names of two small towns in the north of France, the project's first two experimental towns. The prevention activities initially contemplated by this new association structure did not target obesity but rather cardiovascular disease, highly likely to be caused by obesity and overweight. A physician and endocrinologist named Jean-Marc Horet working at the teaching hospital of Lille, with the support of his nutritionist colleague there, launched a nutrition education plan for the schools of Fleurbaix and Laventie. Dr. Horet's plan was modelled on an experiment under way in a small town near San Francisco that had set up a community health program to reduce inhabitants' cholesterol levels. It thus partook of the characteristic French tropism consisting in "transferring" policies and preventive interventions developed in Anglo-Saxon countries to France.[43] Dr. Horet's undertaking may be described as environmental. His objectives were 1) to modify the "environment" of children's nutritional choices by circulating information on what they were eating and what they should eat, in the hope of 2) getting them to transmit this information to their parents. A variety of actors—dieticians, teachers, physicians, teacher-training professionals—were called upon to write up information and prevention sheets and have them distributed in schools to children in the two towns initially involved. The preventive aspect of the project drew greatly on the frequent exchanges and strong ties between health and education professionals. In this first period, the

[43] For an analysis of similar phenomena in connection with France's drug addiction policies, see Bergeron, *L'Etat et la toxicomanie*.

issue was for program promoters to scientifically demonstrate the effectiveness of this environmental method of preventing cardiovascular disease. A team of researchers from the Institut National de Santé et de Recherche Médicale (INSERM) took on the tasks of drafting the protocol for an epidemiological study, data collection and analysis. They were scientifically interested not just in obesity but also chronic disorders such as diabetes and cardiovascular disease.[44]

Starting in 1997 (that is, 4 years before the first PNNS plan was launched), the study underwent two significant changes: the focus shifted to preventing obesity, specifically in children, and the frame of action for the program was enlarged from schools to the towns themselves, as their involvement in it had been growing. This shift went together with changes in organization. Initially, Dr Horet had created a nutrition consulting agency, the aim being to collect funds for implementing the project and following up on the epidemiological study. The project's first funding came from a few major pharmaceutical companies[45] and a large food industry company. In 1998 and 2001, the nutrition agency merged successively with a public relations agency specialized in food and health and founded by a former food-industry business manager, and a "social marketing" agency specialized in setting up educational projects on nutrition. These two mergers and the "patent" success of the original experiment were incentives for its promoters to turn the initial epidemiological study into a program of action targeting a large number of cities and towns.

Institutionalizing and extending the action program (2004-2009)

In 2004 the EPODE program was created and put in place as an experiment to be conducted in ten cities or towns. Perfectly in line with the policy orientations for combating obesity and overweight that had been initiated by the PNNS in 2001, the program aimed to "gradually modify social norms and reduce inequalities in access to prevention [of overweight and obesity] by promoting a varied, balanced, manageable and pleasant diet and providing incentives to children and their families

[44] Some INSERM researchers thus acquired the status of experts on obesity and launched other scientific programs on the issue.

[45] One project director from a pharmaceutical industry project partner ended up quitting her job there to join the nutrition agency; she eventually came to head the partnership between EPODE and member cities.

to increase their daily physical activity level."[46] To attain these multiple demands, the program promoters set out to increase the number and variety of partners, establishing relations with scientists, health professionals, local communities, administrations and industrial companies. One original aspect of the program was that the municipality was thought of as a relevant local echelon for actions to promote prevention. Above all, the program proposed an "original method" for acting on and realizing health promotion ideas, the overall aim being to make it easier to reach the objectives set by the national authorities.

The formal channels and nature of this case of interorganization cooperation, the complexity of which we explain below, are the following: a town or city government signs a contract with the FLVS association to get the EPODE program set up there; the cities in question first sign an agreement called a "commitment charter"; they then have to hire an "EPODE project head" (or call upon a municipal employee to spend a [variable] amount of his or her time coordinating the program at the local level). They also pledge to set up a "steering committee," to be composed of at least one representative of the medical corps, teachers or other permanent Ministry of Education employees (e.g., school nurses), and elected officials. Meanwhile the FLVS hires the social marketing agency to "design the program and engineer the project as well as coordinate the set of actions recommended to cities to make the program operational, coordination to be overseen by the Expert Committee" (excerpt from the "Charte d'engagement des partenaires locaux" [local partners' agreement]). It is the agency's (remunerated) task to train local actors (particularly EPODE project heads; see below), disseminate healthy nutrition practice guides, propose obesity prevention activity ideas, centralize height/weight data collection done in the framework of the program on children from kindergarten through the last year of elementary school [age 11-12],[47] and develop teaching tools—nutrition information sheets and, more recently, "action sheets," designed as aids to launching actions that take into account the particular activities of the types of actors they are addressed to (elementary school teachers, physical education teachers, etc.), this last point constituting the core of EPODE technical expertise.

[46] Excerpt from an institutional presentation of the program, entitled "[EPODE:] a method for preventing obesity."
[47] This data has been collected annually since 2005 in the ten experimental cities; in the future it will be collected in all cities every two years.

But the program goes beyond providing expertise on how to promote health and design prevention instruments. It also provides a social engineering methodology and actively helps to coordinate local actors. The methodology makes it possible to guide or orient an entire set of actors who, however active they may be, are in any case quite scattered, and to activate state (i.e. public) and community organization resources, even private-sector funding, to enable those actors to operate within a collective action framework stamped "EPODE." The action is supposed to take the form of an integrated network: creation of a town management centre in turn centred around the project director and steering committee who work in close collaboration with the national directorate of the EPODE program; regularly scheduled meetings with involved and potentially involved local actors; the development of a shared public relations strategy around local prevention actions (diffusion of the EPODE logo, posters, creation of EPODE events, etc.); regular dissemination of information about the activities of the various actors[48] and the accomplishments of the national network; bi-annual national meetings of all municipal project heads, etc. Every year, priority issues are identified by the EPODE national coordination committee, and member cities are invited to find ways of working on them locally using instruments and action tools developed by the agency. The national program also sends out calls for proposals to network-member cities; winning proposals are then funded by partner industries or state offices. The EPODE program thus performs the properly political work of running activities and coordinating local actors around a local policy perceived to be in the general interest.

The success of the program can be summed up in a few figures. From 2004 to 2009, the number of French cities enrolled rose from 10 to 226, including Paris and Lille. The experiment has also been taken up by several other countries and regions of the world (Australia, Mexico, Belgium, Spain and Greece), enabling program promoters to claim that no less than four million people are concerned. Moreover, the European Commission—specifically, the Directorate General for Health and

[48] The program's internet site lists a series of examples of healthy practices implemented by EPODE cities, together with a description of the actions and the identities of the persons in charge. Operative here is the desire to have EPODE cities participate in a network and feel they belong to a "community" guided and coordinated by national EPODE headquarters.

Consumer Affairs or DG SanCo—was quickly won over by the experiment[49] and has hired EPODE to develop a healthy practices guide to be used in local obesity prevention policy throughout the EU, the idea being for it to serve as a cognitive and normative basis for implementing similar policies in all European Union cities. Dr Horet is now considered a national expert, and there is hardly a scientific or institutional conference, televised debate, press article or radio program on the subject in which he is not included as a guest speaker.

The success story just presented, a collective reference in program members' discourse, is remarkable in many respects. How, in the space of ten years, did a modest epidemiological study carried out in two cities by a private actor manage to metamorphose into a method for action recognized by the European Union and operating in more than 200 French cities and towns and five countries? To answer that question, we need to analyze in greater detail the strategies that enabled program promoters to legitimate their intervention.

A public policy entrepreneur in search of institutional recognition

EPODE actors heavily stress the support their program has received from institutions as diverse as city and town governments (via city enrolment in the program, with those cities then immediately joining the "EPODE cities club"), mayors (the "EPODE mayors club," via the Association des Maires de France), the European Union (via the DG-SanCo), the French state (via the Ministry of Health and Sport, the Ministry of Education, the Ministry of Food, Agriculture and Fishing, the state ministry for Urban Affairs and Renovation, and the PNNS), and "science" (via EPODE's links to scientists working in the common research framework it has developed, as well as its ties to the Académie Nationale de Médecine, the Société Française de Pédiatrie, the Association Française de Pédiatrie Ambulatoire, and scientific papers published in those organizations' medical journals).[50] It is methodologically difficult to demonstrate that the development of this institutional support network was the fruit of a deliberate strategy drawn

[49] The DG SanCo puts great store by partnerships between public and private actors and often justifies its action in public health matters in terms of potential positive effect on the economy (S. Guigner, L'institutionnalisation d'un espace européen de la santé).

[50] The full set of logos for these support sources is displayed on the EPODE internet site and official EPODE brochures.

up *ex ante* by the entrepreneurs who constitute EPODE's driving force—i.e., the Association Fleurbaix Laventie Ville Santé and the social marketing agency, Agence Protéines—but we do think that network goes a long way to explaining the success of the program. Indeed, EPODE is embedded in a vast network of other institutions, all of which are perceived to be in solidarity with and indissociably linked to its own activity. The effect of this is to legitimate that activity.

The proper name EPODE has thus become a "label" in Pierre François' sense[51]: an "empirical proposition" becomes a label—or an institution—when actors regularly turn to and use it as a pre-existing framework of experience that orients their judgment and action, particularly when they need to make choices in situations of uncertainty. The EPODE label has an obvious normative dimension, as it prescribes what various actors (mayors, local actors, EU actors, etc.) should decide and do in a highly varied set of situations (transposability) and is regularly used by those actors as a means of recognizing and gaining recognition for the seriousness and professionalism of the actions carried out in its framework.

We are now ready to analyze how the "virtuous circle" of legitimation that allowed for institutionalizing the program. There are three main sources of legitimacy: science, integration in local action, and integration in national and EU institutions.

Legitimation by science

Clearly, the quest for scientific legitimacy began very early in the experiment: Dr Horet brought in a Paris team of INSERM-associated epidemiologists almost immediately. At last count, 23 articles on the FLVS/EPODE experiment had been published in medical journals. Dr Horet is systematically indicated as co-author, while the FLVS association president (who is also a member of the expert committee) appears in 11 of the articles and the program's national coordinator in six. More interesting yet, five articles are signed "FLVS Study Group." This procedure, widespread in medicine, is aimed at giving visibility to a cooperative group that has developed into a collective entity—above and

[51] Pierre François, "Puissance et genèse des institutions: un cadre analytique," in Pierre François, ed., *Vie et mort des institutions marchandes* (Paris: Presses de Sciences Po, 2011).

beyond individually cited authors. The fact that the name of this group is identical to the name of the association manifests a desire to identify the experiment as a patented scientific activity. Furthermore, in 11 of the articles, the name of the experiment, which once again corresponds exactly to the name of the association, appears in the title, while in five other articles it is cited in the abstract. Altogether, only two articles—nonetheless co-signed by program members—make no explicit mention of the program. Though only one article actually assesses experiment impact,[52] this hefty set of references, all published in top journals, most of them international, works to accredit the actors' claim that the EPODE program as a whole has a scientific foundation. Moreover, the publications have made it possible to "enrol" INSERM epidemiologists in the program, in the sense the term is used in sociology of science[53]—epidemiologists who in fact are more interested in the data collected for the experiment than in program evaluation.

The experiment was "evaluated" for the first time in 1997. Changes in the two towns' overweight and obesity rates were compared with the situation in control cities in the same region. The results were inconclusive. Indeed, the height and weight data collected reveal increased rates of obesity and overweight for the two cities up until 2000: 18.2% of boys and 10.2% of girls were overweight (obesity included) that year, whereas in 1992 the figures had been 14.1% and 9%. Undiscouraged, Dr Horet claimed the experiment could only produce the desired results over the long term and requested that the epidemiologists continue collecting the information. In 2004 the figures showed a sharp "improvement" for the program: 10.4% of boys and 7.4% of girls in the towns of Fleurbaix and Laventie were overweight, as opposed to 19.4% and 16% in the "control cities," and obesity prevalence for lower-income families in the two towns was 15.2%, versus 26.9% in the control cities. The article presenting these results was accepted for publication in an international though not top-ranking journal, *Public Health Nutrition*, despite the obvious difficulty of imputing

[52] The others are on methodological questions (e.g., Can self-reported weight, physical activity and food habits be accepted as accurate?) or else they provide epidemiological data on obesity trends using the towns of Fleurbaix and Laventie as references (e.g., comparing adiposity in children and parents of the two cities, comparing height and weight trends, etc.), work to establish a link between metabolic factors and adiposity, or test the effects of diet or sports on overweight or obesity. There are also two reviews of the literature.

[53] Michel Callon, "On Interests and their Transformation: Enrolment and Counter-Enrolment," *Social Studies of Sciences* 12, no. 4 (1982): 615-625; Madeleine Akrich, Michel Callon, Bruno Latour, eds. *Sociologie de la traduction: textes fondateurs* (Paris: Presses de l'Ecole des Mines, 2006).

the results with any certainty to the policy measures implemented. (Even if we assume that imputation was valid, it remains to be specified which measures produced the results.)

But EPODE actors wished to go beyond medical and epidemiological evaluation and evaluation by their own expert committee. They moved to set up partnerships with other scientists, thereby consolidating their image of a program with academic ambitions. No fewer than four European universities volunteered to be key partners in the framework of the European Union project EPODE was steering (analyzed below). Universities were mobilized for actions judged crucial by program designers. Here again, in documents presenting the program, interviews with the press, and matters of symbolic resources, this partnership with researchers presents all the external, *discursive* signs of scientific respectability, and it does so in two distinct ways: 1) such partnerships are reputed to produce knowledge that may eventually fuel program actors' thinking and their attempts to improve the technologies they use; 2) they help legitimate all program actions, in that directly involved actors now have firmer grounds for claiming that the program they were developing belongs to the closed circle of "evidence-based practices."[54]

Legitimation through local action

EPODE's success is due in large part to the move to shift program focus from schools to mayors. The mayors quickly grasped why it was in their interest to sign up for the program: it would enable them to display concern for the health of their citizens at a relatively low cost, in connection with a public health problem considered politically profitable because associated with both children and social inequality. Moreover, EPODE's perimeter of intervention is theoretically very wide. Its purpose is to "combat sedentariness by promoting physical activity of all sorts and to initiate children in a balanced diet, diversity, and the pleasure of being at table" (excerpt from the local partners' "*Charte d'Engagement*" [commitment charter] agreement). Meanwhile, the list of actions carried out in the field under the EPODE label reaches out in all directions: "taste week," all-you-can-eat fruit and vegetable "salad bars" in the school cafeteria, "sports fortnights," cooking classes ("eat better without spending more"), closing a street to traffic so that children can walk to

[54] This analysis also applies to the study that EPODE actors have asked us to do.

school more easily; setting up a "pedibus" (i.e., laying out a footpath for taking children to and from school); "solidarity gardens" (growing vegetables in the town's public garden space and cooking them), reducing breakfast size, setting up a "baby gym," scheduling hikes, re-arranging the school courtyard to make physical activities easier, etc.

Not only are all these operations ideologically unobjectionable, but the EPODE program refrains from calling into question any initiatives that may already exist in the given city. Indeed, for the people in charge of implementing the program, any existing local initiatives are to be seen as acceptable and "good" if aimed at preventing obesity.[55] So when a municipal government signs a contract with the FLVS association, the project promoters do not do any attentive, potentially critical inventory of existing practices, nor do they select "[existing] operations to be continued" in their own program on a cognitive and normative basis of previously identified "good practices" (identified, that is, either through past experience or international literature on the relative effectiveness of various preventive actions). This "ecumenical" approach to obesity prevention is ultimately not only consistent with other messages, reports and public projects in this area,[56] but also offers mayors the significant advantage of enabling them to bring together *all* local initiatives in a global municipal action policy.

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[55] A parallel can be drawn here between the measures proposed by partisans of the battle against obesity, particularly those acting under the EPODE label, and nineteenth-century hygienists attacking those presumed evils from all sides without identifying priorities and so leaving an impression of disorder. This similarity is perhaps due to the absence in both cases of any stable etiological or pathogenic theories (genetic, behavioural, psychological). As Bruno Latour has noted, "Disease as defined by hygienists could be caused *a little bit by anything*" (Latour, *Pasteur: Guerre et paix des microbes* [Paris: La Découverte, 2001]: 38). Another aspect of the parallel is that both hygienists and actors combating obesity may be said to have (had) the intention of modifying the "environment" of the populations in question. However, the two are quite different on at least one point: obesity fighters aim above all to modify the environment from a cognitive perspective (by acting on the information provided on product packaging, for example) and a normative one (stigmatizing certain behaviours, encouraging others). Nonetheless, some of their "weapons" are similar to the hygienists': the point in making bicycle paths, athletic fields and (trying to) change the composition of industrially produced food is to modify individuals' environment, to make it "healthy," in a sense similar to the hygienists' when they set about getting sewers dug, demanding water, light, and the like. See Latour's quotation of William Coleman: "'Hygienists took care of the essential conditions of existence—food, supplying pure water, … the conditions of physical and mental activity'" (Latour, *Pasteur: Guerre et paix*, p. 43).

[56] One of the latest examples is a communiqué sent out by 20 medical associations to the future "Commission on obesity" on October 5, 2009: among the "17 high-priority worksites" (sic) identified are developing "standards for the composition of meals served in school cafeterias," requiring schools to install water fountains, the creation of informative courses on diet and foods at the equivalent of sixth and seventh-grade levels, providing free public service message space to INPES, "promoting maternal breastfeeding," setting up regional overweight and obesity treatment networks, "increasing physical activity at school," etc. (for the complete set of propositions, see <http://www.sfsp.fr/activites/file/CPcommissionobesite.pdf>).

The program's power also derives from its label, which has become a kind of flag for community organizations to rally round. While many EPODE activities are modelled on interventions and events that already existed at the national level, such as "taste week," and though program promoters seek to develop their own new actions (above all supervised activities, interventions in the classroom), many obesity prevention activities have been organized by not-for-profit associations, Ministry of Education employees (nurses, teachers, school cafeteria directors in particular) and child day-care centres. These activities may well have already been in place before the municipality contracted with FLVS. In fact, these groups and organizations agree to use the EPODE label primarily because they hope it will help them catch the attention of the local press and so win greater recognition for their own actions and receive more support from the other institutions in exchange.

> I'm telling you, we didn't have to wait for EPODE to do EPODE ourselves. What's good is that it gave *us* some resonance. In the end we realized that [what we were doing] was really part of the program: athletic games, getting the children to move. … What was new was that we got recognition for what we were doing. We're better known. It's easier to get material when you're better known. We've got a reading workshop. We were able to get money for books on diet, DVDs. It's easier
> (Activity leader of a noontime children's play centre).

> I'm going to run EPODE activities to get [our] association better known and show what we know how to do. Because there's a big [negative] story about this neighbourhood. It's to show another image of the neighbourhood, to give it value
> (Leader of a children's play activity association).

Getting included and integrated into the program thus constitutes a strategic resource similar to the one provided to companies by norms and standards: actors can promote actions they consider important more effectively if they refer to the EPODE program than if they mention only their own competence and skills.[57] In this way, the EPODE label

[57] On the usefulness of norms and standards for legitimating an action, see in particular Nils Brunsson, Bengt Jacobsson, eds., *A World of Standards* (Oxford: Oxford University Press, 2000).

actually works to desingularize the EPODE project, situating it within a vaster—and more legitimate—collective.

> It helps strengthen *us*—we were already doing things at the school—[it helps us] get recognition. It enables us to justify our actions to parents by saying to parents, it's not just us. Because at first the parents thought we were forcing their children to eat because we were bad and we wanted to make them cry! So in fact it [the program] brought recognition and gratitude, because we could say: 'You see! It's EPODE, it's the town hall, it's a program, it's important, it's national'
> (Teacher).

Because EPODE is able to bring together local initiatives and get them working around its own label, it represents an important resource for mayors who want to show how committed they are to serving their fellow citizens. In exchange, those mayors have played (and continue to play) a fundamental role in institutionalizing and diffusing the program. Mayors and local elected officials (in some towns deputy mayors are more directly involved in the program than mayors), together with local project directors (once again, member towns and cities either hire a director or assign a municipal worker to perform the director's tasks) become the national team's primary interlocutors. Dr Horet claims that mayors are responsible for the quicker-than-expected expansion of the program. The following excerpt from an interview with him makes it quite clear how important mayors have been in legitimating the program, especially when the mayor in question is also a national political figure.

> And then we were outdone by the Association des Maires, namely because [a former government minister] was in it—fairly emblematic people. They said: 'We want to do promo for EPODE. In terms of social cohesion and a change in our city hall work methods, this is good for us, it creates a positive dynamic, we want to develop it.' So now we've got 200 EPODE cities—it all happened more quickly than expected
> (Interview with Dr Horet).

An "EPODE mayors club" was created that brings together the mayors of all member cities. The club is both a political resource network to be mobilized to defend the project and an agent that promotes the "adventure" to mayors still hesitant about whether to take the plunge. Mayors who have signed an EPODE contract are uncommonly persuasive when it comes to touting the merits of the experiment and "selling" it to their peers. Moreover, the individuals in charge of developing EPODE internationally organize trips to member cities for foreign delegations. We have here a fairly classic illustration of the neo-institutionalist claim that institutional entrepreneurs need dense networks of united actors in order to be successful.[58] The point would have to be further substantiated, but we can already hypothesize, given the critical mass of the program now and the "institutional power" of the many labels that now "support and are ready to answer for" its actions, that the enrolment of new cities reflects what Paul DiMaggio and Walter W. Powell called "mimetic isomorphism."[59] Beginning with the support of a few nationally renowned mayors, the program has thus been able to spread with remarkable speed across French national territory—somewhat like the epidemic it intends to combat.[60]

Legitimation through recognition from national and European Union institutions

The program has thus acquired legitimacy through its ability to bring together and aggregate a network of actions and local initiatives around its label. But in order for that label to be judged effective and useful by local actors and for EPODE to continue to grow, it seemed necessary to its promoters to link the program to national and European Union institutions.

EPODE's initial strategy was to align itself with PNNS guidelines. The idea was to transpose PNNS messages onto local operations targeting the population's everyday life. EPODE thus linked itself indissociably with a national program that other actors had developed, and it is PNNS

[58] "Institutional entrepreneurs" in that the program initiators were trying to turn the "EPODE solution" itself into an institution.

[59] Paul DiMaggio and Walter W. Powell, "The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields," *American Sociological Review* 48, no. 2 (1983): 147-160.

[60] The program's internet site includes a map of France studded with as many EPODE logos as there are cities participating in the program, a "geographical" representation that corresponds closely to classic epidemiological imagery and dynamics.

officials who validate EPODE action tools, though the contact between the two entities remains minimal. This "symbolic embedding" operation has been so successful that many of the local actors we met with thought that EPODE and the PNNS belonged to the same world. Indeed, many of the persons we interviewed thought of EPODE as an "emanation of the ministry" and a "public entity" itself in a field where, as we have mentioned, private initiatives (that is, initiatives not originating with Law of 1901 not-for-profit associations) are likely to elicit distrust and resistance.[61]

Connections between the social marketing agency and central state government offices have also taken a variety of forms. When the PNNS was created in 2001, the private agency designed its logo. It was also performing other services in state- and agency-run national information and education campaigns. But the Ministry of Health is not the only national actor to have approved and underwritten the program. Other ministries, such as Food, Agriculture and Fishing, Education, and Youth and Sport have publicly declared their support, either financial or institutional. EPODE program promoters constantly cite that support in the program's public relations documents, material that itself displays those public-entity logos. The EPODE internet home page sports an impressive list of supporting public institutions.

> So the public partners—either the Ministry of Youth and Sport, the Ministry of Health, the Ministry of Education, the Ministry for Small and Medium-size Businesses, Agriculture … for us it's recognition. Some bring in funds, like the Ministry of Sport; then there's research via the PNNS, also the Ministry of Health. … So first there are ministries, and we submit a file that is analyzed by a committee that thinks about our file and gives its opinion, and then the minister sends us a note to tell us they agree to support us. We've been very well received. All we ask is recognition, and that gets us support from the public authorities.
> (Dr. Horet).

[61] We were told by the program's head of international development that in countries like Greece that did not (yet) have a national public policy for combating obesity, development was harder to organize at the local level.

While it is doubtful that the founders of EPODE imagined from the outset being able to give their program a European Union dimension,[62] it is not at all hard to imagine that doing so immediately appeared as if it would be very useful for 1) developing EPODE into an international program—one strategic priority—and 2) strengthening the program's legitimacy at the national level. In fact, "international guidelines"—i.e., the "good practices" already being used in local battles against obesity—were already being developed within a setup involving four European universities. Some of the meetings held in connection with the international program were an opportunity for program promoters to demonstrate to potential partners the extensive know-how of the EPODE program. They also represented an opportunity to "sell" the experiment to foreign guests who were themselves local elected officials.

It would be risky to postulate that operations for obtaining and assembling numerous labels sufficed,[63] by mere mechanical transitivity, to institutionalize an initiative like EPODE. More must be done to turn an initiative or program into an institution than to piece it together from other institutions, however legitimate those institutions may be in the field in question. The conceptual framework put forward by Pierre François[64] in what is in part a rereading of Wittgenstein's and Weber's works seems to us of great relevance here: 1) an initiative or "empirical proposition"—label—can only become an institution if the actors using it grant it the role of an institution in their decisions and practices; 2) those practices have to be *regular*, and actors have to note that regularity and internalize the practices as "normal"; 3) the practices have to be adapted to the environment they are situated in. These three conditions seem to have been met in the case we are studying. It is reasonable to affirm that the EPODE label now regularly functions in many social arenas (though not all) as a normative and cognitive reference or touchstone, eliciting trust and commitment from a variety of actors, despite the fact that the institutionalization process is far from complete

[62] We were not able to collect all the material required for fully apprehending how EPODE actors obtained funding from the European Commission to design a good practices handbook for local obesity prevention policies because our survey gave priority to analyzing the conditions and limitations of the program's current legitimacy within the field. However, we can hypothesize that the program's national visibility, as well as the alignment of the program's main goals (modifying individuals' "environment," setting up public-private partnerships, and creating an actor network) with the strategy of a 2007 EU White Paper entitled "A Strategy for Europe on Nutrition, Overweight and Obesity-related Health Issues" are among the explanatory factors.

[63] Use of the verb "sufficed" should not lead us to neglect the intensity and difficulty of this "institutional work."

[64] François, "Puissance et genèse des institutions."

and is even regularly threatened. In a word, EPODE *makes sense*, in several ways, to the actors who use or refer to it. We have also stressed the importance in the institutionalization process of winning the solidarity of other labels and the support of united actors. Here again, EPODE seems to have been able to develop and combine the benefits of what Lucien Karpik defined as "impersonal judgment arrangements" (i.e., other labels) and "personalized trust arrangements" (here in the form of the mayors' network).[65] The decisive contribution made to the institutionalization process by the institutional *ties* these entrepreneurs were able to develop patiently over time is clear: EPODE quickly found itself embedded in a vast fabric of institutions and supports, which its promoters were then able to closely identify with their own activity; institutions and supports that in turn furthered institutionalization of the EPODE program.[66] This strategy has recently succeeded anew, and that success is highly significant: on May 27, 2010, then health minister Roselyne Bachelot deemed it proper that all "EPODE cities" should be *automatically* stamped "PNNS cities."[67] The EPODE label is therefore no longer sheltering behind those that manifest the legitimacy of the central public authority; it has become the equivalent of those labels.[68]

But while this policy makes it possible to bring together a great number of actors in a collective project, to unite them behind a common banner, therefore helping to ensure the visibility of each and all, it cannot conceal the conflicts that have arisen regarding the very nature of the program: Can public health be promoted by private for-profit enterprises?

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[65] Lucien Karpik, "Dispositifs de confiance et engagements crédibles," *Sociologie de Travail* 38, no. 4 (1996): 527-550.

[66] At a general level, one is struck by the intensive recourse to labels in the public health field. France's Ministry of Health and INPES directly promote the "WHO (World Health Organization) City" label (INPES) and the "PNNS city" label (Direction Générale de la Santé or DGS). And the European Union grants certain actors what it considers the privilege of using its name. The PNNS, a French government policy in the same area, has itself become a label, used to endorse what it considers "good actions." We see that public relations and prevention operations designed to induce consumers to turn toward trusted (label-bearing) products need to be "labelized" *themselves*. This way of saturating the field with labels is perhaps an indicator that a major reshuffling is under way—an indicator, then, of intense uncertainty about the quality of the (new) actors investing the field and the (new) services and products circulating in it.

[67] Opening remarks at the annual EPODE convention, May 27, 2010.

[68] It should be noted that the effect of equating the two labels is quite ambiguous given that the conditions for obtaining them are not the same or even similar: to be stamped a "PNNS city," it suffices to have implemented a program for preventing obesity, whereas, according to the promoters, the EPODE program is more demanding. The danger for EPODE actors is that equating the labels will work in favor of the less demanding of the two and lead in the medium term to turning local communities away from the program. If this scenario were to become reality, it would provide us an opportunity to measure the relevance of George Akerlof's used car market argument (Akerlof, "The Market for Lemons: Quality Uncertainty and the Market Mechanism," *Quarterly Journal of Economics* 84, no. 3 [1970]: 488-500).

A private entrepreneur in the service of public health?

In the last twenty years or so we have been witnessing a renewal in economic sociology research around the figure of the entrepreneur.[69] The studies stress entrepreneurs' ability to operate on the boundaries of heterogeneous worlds, taking advantage of discontinuities in the circulation of information,[70] commodities,[71] or values[72] within those worlds. EPODE is an interesting example in this connection because this program, whose mission is to bring together what are for the most part public actors and resources in the framework of a public policy initiated by the state and managed by cities, had its origins in the private sector in two respects: first, the program was initiated and is steered by a private enterprise; second, it is funded in part by private firms, most of which belong to the food industry. While the program often ostentatiously displays the public-private partnership as one of its primary strengths, that kind of tie is nonetheless perceived by some public health actors as fundamentally unnatural. Is there not an obvious conflict of interest in having food industry groups play a role in preventing an epidemic that they themselves are thought of, rightly or wrongly, as primarily responsible for (along with others)? Does not such a partnership instantly discredit the entire undertaking? The "public-private" partnership thus appears as much the Achilles' heel as the Herculean strength of the program, as it makes program profitability possible while threatening program institutionalization. However, what is clear from our survey is that the extremely complex organization of the EPODE program is a direct response to the conflicts caused by the very existence of this partnership, conflicts that that type of organization seeks to neutralize.

After briefly presenting the fierce debates sparked in France around the idea of private actors intervening in public policy, we will examine more directly how organization works to neutralize these value-centred conflicts.

Tensions between public and private: a conflictual partnership

[69] Zallio, "Sociologie économique des entrepreneurs."
[70] Ronald Burt, "Le capital social, les trous structuraux et l'entrepreneur," *Revue Française de Sociologie* 36, no. 4 (1995): 599-628.
[71] Alain Tarrius, *La mondialisation par le bas: les nouveaux nomades de l'économie souterraine* (Paris: Balland, 2002).
[72] Stark, *The Sense of Dissonance*.

The EPODE program is the result of two types of public-private partnership. First, as pointed out, the program involves mobilizing and coordinating the actions of public actors (teachers, public hospital nurses, youth counsellors, etc.), community organizations and associations (athletic associations, parent-teacher associations) and in some cases private ones (school cafeteria suppliers, supermarkets, etc.). A private, for-profit agency—Agence Protéines—is active in performing this task. But the public-private partnership goes beyond a private actor's involvement in coordinating public, associative, and private actors; it is also manifest in the way the entire operation is funded. Of the 12 000€ that the Agence Protéines annually bills the FLVS/EPODE association for setting up and coordinating the program in a single city, only 6000€ are actually paid (as contributions) by the city or town government. The remaining 6000€ euros (which covers the as yet unpaid services that Protéines bills the FLVS/EPODE association) comes out of funds collected by the association from a club of industrial partners made up primarily of food firms; their annual contribution has been set at 100 000€.[73]

As becomes clear from a cursory visit to the program's internet site, where food company logos rub up against those of state ministries, this "public-private partnership" is considered by the promoters to be one of the four "pillars" of the program. In fact, having access to private industry manna is what makes it possible to lower the cost of the service for local governments and bring in greater resources than those that might be collected from public actors alone. Private-sector funding, then, may be one explanation of the program's extremely quick progress throughout France. It would also explain the European Union's interest in the program. The 2007 EU White Paper, *A Strategy for Europe on Nutrition, Overweight and Obesity-related Health Issues*, suggested modifying the "environment" that "shapes" "an individual's knowledge, preferences and behaviours … related to lifestyle and eating habits"—the lead-in to the presentation of a program that member states but also "the food industry and civil society," together with "actors at the local level such as

[73] At the local level, arrangements for certain preventive actions sometimes require actors, including the project head, to find additional funding. In 2010 a new procedure was put in place that once again combines public and private, blurring the boundaries between them. As explained, the EPODE program sends out a call for proposals to enable it to fund local initiatives; that funding is to come *either* from a ministry or one of the program's private-sector partners.

schools and community organizations," should participate in; a program aiming to better inform people in matters of diet—including through product labelling and advertising, to improve accessibility of a healthy diet, and to encourage physical activity.[74] EPODE promoters' emphasis on the virtues of public-private partnership was without a doubt highly influential in winning European Commission recognition for the program.

Meanwhile, that partnership has been at the root of most criticism of the program in France. During our interviews with representatives of national and regional public health departments, who at times see themselves as competing with EPODE in obesity prevention, the participation of private companies in a public health program was often presented as reason enough to denigrate the initiative.[75] And those representatives are particularly critical of the fact that the vast majority of preferred program partners are food industry or mass marketing corporations, the very actors assumed responsible (at least in part) for the increasing prevalence of overweight and obesity in the French population (in that they diffuse products of "aberrant" nutritional quality, put pressure on supermarket prices and thus move industrial food producers to skimp on ingredient quality, etc.). For this varied set of actors, the EPODE enterprise is "necessarily" questionable because it obeys specific economic imperatives and thus cannot disinterestedly defend the common good—in this case, public health. Some INPES and DGS officials criticize the program for operating as a moral front for food industry participants, thus limiting these respondents' own abilities to negotiate with such companies to change their product composition (a reference to the negotiations around "voluntary commitment charters" mentioned above).[76]

> I'm extremely reserved [about the EPODE program]. We've been following the tobacco industry for a long time. It's had a certain strategy for avoiding regulation and taxes by showing it's doing

[74] In addition, DG SanCo has created a "platform" bringing together industrial companies, representatives of "civil society" and health professionals, to get the food companies to commit to changing their offer (in terms of both product labeling and ingredients) voluntarily.

[75] By contrast, the set of actors we spoke with who are locally implicated in the program (with the exception of elected officials and project leaders) simply did not know that EPODE is steered and run by a private company.

[76] Corporation partners have the option (which they often take) of mentioning their support for the program on their internet sites, a guarantee of their "responsible" commitment. On the other hand, they are not authorized to use the EPODE label to promote a given brand.

> prevention. … But in terms of image, that strategy is not well regarded. Well, we know full well that the next wave in all of this is the food industry: tobacco and food are closely linked. We know that the food industry is trying to keep from being the next one on the individual's list to have to pay out millions in compensation. Among the things they've done, there's 1) setting up lobbies at the European Commission level to avoid regulation and taxes, 2) being on national committees, and 3) showing they're doing prevention ...: 'look, we've got to show we're doing prevention to get a good image and avoid paying taxes.' And the main strategy is to favour public-private alliances. That enables them to steer clear of constraint measures. … If only EPODE had public interests it would be all right. Do you think that [name of a firm and program partner that produces chocolate] is there to get away from obesity? Oh no! They're showing they're good pupils
> (leading member of INPES).

This critique of public-private partnerships is to be found not only among EPODE "competitors" but also in the social and political spheres in which the program is trying, unsuccessfully for the moment, to put down roots.

> For the French, public is wonderful, private's the devil. When I presented EPODE at the city hall of [name of a city in the north of France], [the town's Socialist mayor] was in power. Well I've got a lot of measures going in the framework of a network for fighting severe obesity. We've got a lot of actions going on treating obesity in underprivileged districts. We organize actions in social centres [in that city]. So in the year and a half leading up to the municipal elections, [the mayor] was looking for ideas that she could put in her platform. So we're sitting around the table, and I say, 'On child obesity, in fact, the role of the city is really to try to promote activity, to arrange things so people can move around more, to include that aspect of things.' And I describe a little the role of the city in EPODE. She says to me, 'Oh, what you're proposing is good! It's an excellent idea.' So I say, 'Right, it's the EPODE concept.' She was sitting next to a city councillor and I see him whispering something

in her ear and then, just like that, she moves on to something else. (Laughter)
-- What do you think he whispered to her?
-- 'EPODE equals private, the [political] right, capital.' (Laughter) Key words like that.
(President of the FLVS association).

We see that, far from being consensual, public-private partnerships are a source of axiological conflict that is constantly threatening the durability and spread of the program. EPODE program heads like to defend the presumed benefits of public-private partnerships in the field of public health as a kind of normative proposition. They regularly shake their heads at how people in France are "incapable" of thinking that private enterprise could make positive contributions to realizing a common good like public health. And they actively militate to end demonization of such partnerships. However, their position-taking and activism have not sufficed to dissipate all criticism or neutralize occasional attacks against the program. To protect themselves and circumvent potential and real resistances, program promoters have engaged, as we have seen, in major "institutional work"[77], work made up above all of obtaining legitimate labels and personalized support from mayors. But it is important to see how these efforts are further facilitated by a highly original type of organization, which we shall now describe.

Two-headed organization and a moral filter

The organizational setup at the base of the EPODE program is extremely complex. The program is organized around three main entities:[78]

- The FLVS association, a not-for-profit organization founded at the same time the original experiment in the two northern French cities got under way; the FLVS is the legal entity that sets up contracts with cities that decide to enrol in the EPODE program; it is in charge of collecting money from municipal authorities and private enterprise foundations;

[77] Tom B. Lawrence, Roy Suddaby, "Institutions and Institutional Work," in *Handbook of Organization Studies*, ed. Stewart Clegg, Cynthia Hardy, Tom B. Lawrence, Walter R. Nord (London: Sage, 2006): 215-254.
[78] It should be noted that the "partners' club" subsidizes but does not intervene in program design and content.

- The private social marketing agency, produced by the merging of three agencies (see above); it designs the social engineering necessary for getting the local cooperation dynamic going as well as "technical" tools for implementing prevention policies;
- The "expert committee," made up of five scientists—a sports medicine physician, an epidemiologist, a nutritionist, a psychologist, a pediatrician—and Dr Horet.

If we leave aside the "expert committee," whose purpose is to provide scientific legitimacy by proposing and/or validating the themes to be developed in the program framework and by "regularly evaluating" the program, practical program organization is based on two entities of quite different statuses: a not-for-profit association that enters into contracts with local actors, particularly public-sector ones, and a private company that invents and develops the services and coordination tool supply that the (generally) public actors have formally ordered and agreed to pay for. Remarkably, this two-headed organization extends to internal distribution of the respective prerogatives of the two key figures that conducted the program until 2010, Dr. Horet and S. Distin. The formal "external" separation between the association and the private company thus seems to have been reproduced in an arrangement whereby a physician with an intense interest in public health issues acts in certain arenas (the media, scientific and institutional lectures and conferences, etc.) and a head-of-business and marketing specialist positions herself in others, especially relations with other potential private-sector partners.

> It does have to be said that without Dr Horet and S. Distin, EPODE would not exist. It's really the fusion of two personalities. S. Distin brought her experience as a head of business and her experience of social marketing, and J.-M. Horet his experience as a physician—that's why it works. They telescoped. You can have a fine research project, but if you don't have marketing and public relations, it doesn't work. It's a tandem pure and simple, and it's what makes it possible to move forward and be a leader, to have clever things that really work
> (EPODE national coordinator).

That this complex two-headed organizational system, quite opaque to the uninitiated, managed to develop and to maintain and refine itself over time is to be explained by its fulfilling a fundamental role in the relations that program promoters entertain with relevant segments of the environment they operate in. We hypothesize that the formal organization of the program operates like a "moral filter" that mitigates the tensions provoked by the private-public partnership. The arrangement stipulates that the FLVS association, not the Protéines private company, will sign contracts with mayors and collect industry "donations." It is only later that it turns to the Protéines company, which then bills the association for its services. Not only does this type of organization formally separate local communities and other local actors from the Protéines private company and food industry actors, rendering the two sets of actors more or less impermeable to each other,[79] but it also symbolically effaces, more or less successfully, the business and market character of the program itself. Lastly, it makes it possible to obtain funds from foundations and private companies, which thus partake, though indirectly (since the food and mass marketing industries are directly subsidizing only the FLVS association, not, of course, the Agence Protéines), in the activities and success of another private, for-profit company.

> People see Protéines as something like the devil. It's the agency that does public relations for [name of a fast food company]. It's a bit like the devil, whereas the association, if you will, is the showcase of respectability. My main role, if you will, is to provide respectability. But the role I would like to play is that it wouldn't be just a showcase anymore
> (President of the FLVS association).

The way the EPODE program is organized thus constitutes a moral filter in the sense that it is a necessary intersection point[80] for exchanges of financial and symbolic resources between the two network poles, public and private. Without the mediation provided by the EPODE program, those exchanges could not take place.

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[79] It should be specified that the mayors and elected officials of EPODE cities are perfectly aware of the private sector's participation in the program and express no reservations about it.

[80] Michel Callon, "Eléments pour une sociologie de la traduction: La domestication des coquilles Saint-Jacques et des marins-pêcheurs dans la baie de Saint-Brieuc," *L'Année sociologique* 36 (1986): 169-208.

> But [our company] does it a lot [i.e., gets involved in actions to promote sale of healthy food in stores]. Ok, so nutrition is not done exclusively by [EPODE]. Nutrition is not done only by EPODE. *It is in fact a marketing agency that does it. … So it's complicated to handle—I say that in all honesty*. [Our company] has its own public relations teams and already plenty of tools—I see them, there really are a lot of things. How to consume inexpensively but well-balanced; recipe cards to make people want to prepare balanced meals—it's a reality. But in spite of everything, [our company] does business. We can't always link [our company] to [EPODE]. … Because [our company] can't … On the leaflets that [EPODE] writes, there can't be one of [our company's] products because it's still [EPODE]. So in fact, we're advertising for [EPODE]. We can't put [our company name], or if we do, we put our little partner logo—that's how it is
> (Person in charge of the partnership at an EPODE "partners' club" food company foundation; our italics).

In the end, the move to acquire "public-sector" labels (the European Commission, enrolling public-sector researchers, ministries, local communities) and the quite unique organizational setup these entrepreneurs have developed may be interpreted as different yet convergent strategies for effacing the doubly private-sector origin of the initiative. We would suggest that the mayors' network is also part of this filtering arrangement, in that it constitutes an efficient committee for defending the program against critics. When loud, heavily publicized, discordant voices relay the criticism that "an increasing number of food industry companies [are] sponsoring the program," as in French MP Valérie Boyer's 2008 report,[81] these local elected officials speak up in unison on the national stage to try to dispel any suspicions that might be cast on the program.

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[81] Valérie Boyer, *Rapport d'information à l'Assemblée nationale sur la prévention de l'obésité*, Commission des Affaires Culturelles, Familiales et Sociales, no. 1131, 2008, p. 142.

Examining how France's obesity prevention policy is being implemented through the prism of the action of a now central actor has brought to light some singular features.

Alongside INPES national-level prevention messages and policy actions specific to the Direction Générale de la Santé at the national and regional levels, the city and town echelon now appears heavily implicated in obesity prevention policy. This observation contrasts with the conclusions of many analyses emphasizing the state's and its regional representatives' (possible) (re)investment of policies for monitoring and controlling the biological bodies of citizens. Cities and towns—municipalities—have only seldom been at the centre of analyses of public health policies in France,[82] though, paradoxically, they did play a crucial role in the management of epidemics up until the mid-twentieth century and it is the municipality echelon that has been the most likely to innovate organizationally and institutionally in social and health policy,[83] including during the recent period.[84] Legislatively, the only official duties granted to cities and towns have been 1) to function as a kind of public health police, administratively and technically overseeing application of hygiene, safety and environmental protection regulations, and 2) (optionally) to administer social aid. The example of the combat against obesity shows that just when the state is ostentatiously reaffirming its central role and competence in public health policy, in *practice* the tasks involved in implementing public policy are being performed in many regions of France by the municipalities, which benefit in this from substantial support from a private actor that is both policy tool designer and co-coordinator of local public action. Stuck between a European Union echelon that wants to diffuse the same public policy model throughout its jurisdictional territory and a network of mayors ready to defend the legitimacy of their local initiatives, state services at the regional level seem to have quite limited ability to act in places where the EPODE program has been able to establish itself. Clearly if we want to grasp the meaning of transformations of state action in the area of public health it is not enough to examine formal changes in institutional and legal arrangements. It would be advisable instead to increase the number

[82] A significant exception being Didier Fassin, ed., *Les figures urbaines;* and *Les enjeux politiques de la santé: Etudes sénégalaises, équatoriennes et françaises* (Paris: Karthala, 2000): 175-188.
[83] Patrice Bourdelais, *Les épidémies terrassées: Une histoire des pays riches* (Paris: La Martinière, 2003).
[84] Bergeron, *L'Etat et la toxicomanie*.

of case studies, a synthesis of which would then enable us to make more fully substantiated general observations. Only by doing so can we hope to fuel sounder thinking on the supposed "tutelary role" played by the state in the design and implementation of new "biopolicies"—a role whose existence has been proclaimed perhaps a bit too prematurely in some Anglo-Saxon literature, as Luc Berlivet has suggested[85].

Another interesting point in this case lies in the original way that tasks are distributed between public and private actors in the framework of public health policy.

We have so far identified "classic" modes of privatizing public action—classic in that they have already been observed in and formulated for other fields or sectors,[86] specifically in research that makes the point that diagnosis is now being done, policy targets identified, strategies devised, instruments designed and policies evaluated by private actors using knowledge and technology initially designed in the framework of market activities. But the present study reveals the existence of other types of privatization, which to our knowledge are quite unprecedented. First, France's public authorities cannot be said to have delegated the task of implementing specific actions and interventions here to private actors who are then, according to Patrick Hassenteufel, [87] regulated and supervised more or less closely by that same state, its departments or some of its "second-rank" institutions, as in the case of health agencies.[88] In the policy we have described, a different, *partially*[89] reversed variety of privatization may be observed, in which a private actor contributes decisively to the fundamental work of coordinating public-sector and community organization actors. Indeed, the "moral service implementers" that are part of the EPODE program are helping fulfil the properly political functions of bringing actors together, getting them

[85] Berlivet, "Une biopolitique de l'éducation pour la santé."

[86] See some of the references in the introduction. Let us specify once again that some case studies in the public health field, done from theoretical perspectives different from our own and centred around investigations that differ from ours**,** have shed light on some of these processes. The CFES [*Comité Français d'Education pour la Santé]* study (see Berlivet, "Uneasy Prevention" and "Une biopolitique de l'éducation pour la santé") has already brought to light a tendency to turn to public relations skills and tools in designing prevention messages; see also the case of AIDS (Marcel Calvez, *La prévention du Sida: Les sciences sociales et la définition des risques* [Rennes: Presses Universitaires de Rennes, 2004)]).

[87] Hassenteufel, "L'Etat mis à nu par les politiques publiques?"

[88] Benamouzig, Besançon, "Administrer un monde incertain."

[89] We use this adverb to prevent the effacing of the role played by mayors and project directors. Trained by EPODE and in constant contact with the program's national headquarters, project directors are also involved in coordinating and implementing the program.

to work together and initiating, running, and publicizing (cf. "labelization" and public relations strategies) actions that are ultimately carried out by public agents and community association partners.

However, as we see it this case involves not really privatization but a kind of hybridization of public and private actors. This hybridization is to be discerned first in the formal and informal organization of the program, which brings together in reticular fashion[90] a private public relations agency, a community association,[91] and local, national, and European Union authorities. Hybridization may also be discerned in the structure for funding the program: funding is ensured at once by cities, food industry companies and now by national government departments.[92] Hybridization can also be detected in the private operator's moves to "publicize" itself, symmetrical to the move to "privatize" public policy described above. Moves to win all sorts of public labels to the cause, the solemnly announced inclusion of state representatives (PNNS, Ministry of Health, Ministry of Food, Agriculture and Fishing) on two EPODE program committees,[93] and the move to equate a private label ("EPODE city") with a public label ("PNNS city") are all operations that work powerfully to blur the market and business nature of the initiative. Lastly, hybridization is observable in the nature of approaches to program implementation. The partially reversed privatization mentioned above may also be thought of as producing a coordination mode itself hybrid: while some operations (diagnosis, policy target identification, strategy development, policy instrument design, policy action assessment, etc.) are carried out almost exclusively by the private actor, coordination and the actual running of the public policy are carried out collectively. The institutional arrangement governing program implementation therefore cannot be described as a system that allows for cooperation/coordination between private structures and public institutions; rather, it is the result of a combined historical privatization-publicization process. It is therefore fundamentally hybrid. And that hybridization can ultimately be thought

[90] Certain segments of the network are linked by contract-like commitments and objective ties of both an institutional and organizational nature; others are embedded in strong, lasting, albeit informal, relations of interdependence.

[91] *Several* associations if we add the EPODE mayors association.

[92] On calls for proposals, see above.

[93] The committees in question are the scientific committee and the future ethics committee for the public-private partnership. The latter came to seem necessary and was created in 2010.

of as the product of a gradual, not fully teleological[94] strategy implemented by private entrepreneurs seeking to establish themselves and to act and continue acting at the junction between two heterogeneous worlds long disconnected from each other: public health and the market.[95]

We wish to conclude by stressing that the operation that consists in entrusting to private companies the work of establishing a diagnosis, devising a purposeful strategy and developing public policy instruments is not without effect on what it means to do public health. As Elke Krahmann has shown,[96] delegating the performance of certain operations and activities to market actors amounts to more than a mere transfer or change of suppliers that has no effect on the substance of the good to be realized. We can therefore claim that the EPODE program exhibits some of the new forms of governmentality that other analyses, inspired by Michel Foucault's work, have brought to light in the field of public health.[97] Prospering in a neoliberal context from which the welfare state would seem to be withdrawing, a context in which individual liberties and responsibilities (in that order) have been granted immense value, the fight against obesity, similar in this to other public health policies, aims primarily to change individual behaviours. Such public policies set out to help individuals—conceived as autonomous, capable of acting rationally (or becoming rational)—to become responsible, the understanding being that if only they are given the right information and references, they will, of their own volition, make choices that will be good for their health.[98] In so doing, this new type of public health policy fuels the development of what may be thought of as an

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[94] "Not fully teleological" in that our empirical material cannot clearly establish that it was thought out and designed reflexively from the start by EPODE actors. It is nonetheless a "robust action" in John F. Padget and Christopher K. Ansell's sense of the term ("Robust Action and the Rise of the Medici, 1400-1434," *American Journal of Sociology* 98, no. 6 [1993]: 1259-1319).

[95] Stark, *The Sense of Dissonance*; Zallio, "Sociologie économique des entrepreneurs."

[96] Krahmann, "Security: Collective Good or Commodity?"

[97] Robin Bunton, Sarah Nettleton, Roger Burrows, eds., *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk* (London: Routledge, 1995); David Armstrong, "The Rise of Surveillance Medicine," *Sociology of Health and Illness* 17, no. 3 (1995): 393-404; Sylvia N. Tesh, *Hidden Arguments: Political Ideology and Disease Prevention Policy* (New Brunswick, N.J.: Rutgers University Press, 1988); Alan Petersen, Robin Bunton, eds., *Foucault, Health and Medicine* (London: Routledge, 1997); Torkild Thanem, "There is no Limit to How Much you Can Consume: The New Public Health and the Struggle to Manage Healthy Bodies," *Culture and Organization* 15, no. 1 (2009): 59-74.

[98] This also applies to environmental policies; see Yannick Rumpala, "La 'consommation durable' comme nouvelle phase d'une gouvernementalisation de la consommation," *Revue Française de Science Politique* 59, no. 5 (Oct. 2009): 967-996.

"atomist political fiction,"[99] that of apprehending individuals, their lifestyles and social action *outside* of the socio-economic factors and collective interdependencies that shape and determine them. Our study helps refine these conclusions. Turning to a marketing company (one now doing "social marketing") that is also a public relations company, a company that develops technologies of the self based on knowledge generated in the market sphere, not only helps reproduce public health policies that aim to act primarily on individual behaviours, but also helps diffuse a market-type anthropological conception of the "psychological" dynamics fueling those same individual behaviours. The targets of public policy have come to be thought of as *consumers* with lifestyles that have pernicious effects on their health (smoking, alcohol consumption, lack of physical exercise, poor diet, "anomie," etc.) and that can be acted on, depending on lifestyle component, by acting on prices, quality, information technologies and public relations.[100] The figure of the individual that suffuses the policy studied here is quite consistent with this understanding. That figure is not *homo economicus*, who acts entirely on the basis of rational calculation[101] and reacts "mechanically" to market signals. It is instead the *consumer* as shaped by "marketing,"[102] an individual who has to be convinced and won over by playing on such experiences as pleasure, desire, and self-esteem.[103] Thinking of public health policy targets as consumers to be seduced or won over—this is the remarkable consequence of certain moves to privatize public action[104] in a policy area—public health—that involves a good of which we nonetheless stubbornly declare that it is not a "commodity."[105]

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[99] Bergeron, "Politiques de santé publique."

[100] Bergeron, "Politiques de santé publique."

[101] On types of marketing knowledge and marketing action modes, see Franck Cochoy, *Une histoire du marketing: Discipliner l'économie de marché* (Paris: La Decouverte, 1999) and "A Brief Theory of the 'Captation' of Publics: Understanding the Market with Little Red Riding Hood," *Theory, Culture & Society* 24, nos. 7-8 (2004-7): 213-233.

[102] developed out of Marketing and public relations studies often makes use of knowledge developed in psychology and social psychology (Peter Miller, Nikolas Rose, *Governing the Present* [Cambridge: Polity Press, 2008]).

[103] Other studies have identified these types of wellsprings in public health policies; see Berlivet, "Une biopolitique de l'éducation pour la santé," and Thanem, "There is no Limit to how Much you Can Consume."

[104] As explained, while the term privatization does not adequately account for the set of dynamics studied here—we prefer hybridization—*some* of the activities and operations here analyzed do correspond to and represent a continuatoin of "classic" privatization.

[105] In addition to EPODE members and members of public institutions (Ministry of Health, PNNS, INPES, INSERM) who agreed to meet with us, we wish to thank the company and association that made this study possible and that were ever willing to play the scientific research game: not only did they help ensure that the field study was carried out as it should be, but they never interfered in our scientific strategy design or the content of our interpretations, which, needless to say, we alone are responsible for. We would also like the thank the graduate students in the "Sociology of public action" master's program at the Institut d'Etudes Politiques de Paris, who carried out the field survey, as well as the researchers who supervised them, Hugo Bertillot and Fabien Foureault, with special thanks to Elsa Gisquet, who coordinated a part of the fieldwork and was primarily responsible for the research report; we have reproduced some of her observations here. It should also be specified that this study is part

Henri Bergeron, Patrick Castel and Étienne Nouguez
Amy Jacob (English Translation)

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