THE POLITICS OF HEALTH AND CITIZENSHIP: FROM POSSESSIVE INDIVIDUALISM TO NEOLIBERALISM

My lecture is about the theme of a conference which I organized together with Frank Huisman more than ten years ago, and which in 2014 resulted in an edited volume. The invitation to contribute to this conference triggered me to reconsider its general introduction. I would like to thank the European Association for the History of Medicine and Health for the opportunity to present an updated outline of my argument about the history of the relation between citizenship and physical and mental health and illness.

➔ Current issues and debates

As we all know, historiography often is not only about the past, but also about the present. My interest in the health and citizenship nexus was inspired by developments in health care in Western democracies since the collapse of communism in the East and the retreat of Social-Democracy in the West. Let me briefly indicate some trends. First and foremost, escalating costs of health care as a consequence of: ageing populations; more and longer surviving chronic patients; and the very success of curative medicine, in particular the advance of ever more sophisticated and expensive treatment options and medical technologies. This has fueled warnings that broad access to collectively funded health care as a basic civil right is jeopardized, unless citizens take more responsibility for their health. Such alerts are related to the partial retreat of the welfare state and introduction of market mechanisms in health care. Also, a more general concern about citizenship is at stake: the feeling that entitlements and boundless claiming have superseded civic virtues and obligations; and that there is a need to boost individual self-reliance as well as social adjustment of deprived groups (the unemployed, the uneducated, ethnic and religious minorities) which seem to lack the sociocultural capacities which are required in times of globalization and neoliberalism.

➔ Citizenship: a historically layered and essentially contested concept

Let me briefly explain how I view citizenship. It is, like health, a complex, historically layered and contested concept with a wide variety of meanings and dimensions, used in a descriptive as well as in a normative sense. Citizenship is generally about what draws individuals together into a political community, in the modern world in particular the nation, and what keeps that allegiance enduring and meaningful to its participants. In contrast to traditional sociopolitical relations of subordination and dependence, democratic citizenship presupposes some sort of balance between public commitment and individual self-determination. Defined and secured in the legal and political framework of the state, citizenship is also inevitably entangled in a dynamics of inclusion and exclusion.

➔ The political-legal dimension

Citizenship has a formal political-legal and an informal sociocultural dimension. The first is about reciprocal legal, political and social rights and entitlements,

granted and guaranteed by the state, as well as responsibilities and duties towards the state and civil society. Roughly, legal, political and social citizenship has been realized between the late 18th and mid-20th century in three stages together with the formation of the liberal-constitutional state, parliamentary democracy based on voting-rights, and the welfare state. At least, this is the North-West European pattern, but the timing, sequence and particular realization of the stages was different elsewhere. In the United States, for example, social citizenship has hardly been attained (which explains the continuing controversy about public health insurance), whereas in Germany and later, in Eastern Europe under communism, the emergence of social citizenship preceded rather than followed the full implementation of political citizenship.

➔ **The sociocultural dimension**

The second, more practical, everyday dimension of citizenship, implying certain attitudes and behaviors acquired through socialization and a sense of belonging, is about how people are supposed to act as involved and competent members of a community; how they adopt and give actual meaning to rights, duties and contributions and meet requirements for adequate functioning in society, for example with regard to obeying the law, paying taxes, voting, work and productivity, responsible public behavior, raising children, education, and also health.

➔ **Health as a human right?**

The relationship between health and citizenship, which is relevant for all modern political regimes, whether they are liberal-democratic or more authoritarian or even totalitarian, raises some pertinent, politically loaded questions. Can health or the prevention of illness be considered as a civil right or even as a human right, as it has indeed been proclaimed by the World Health Organisation in 1945, and by the United Nations in the *Universal Declaration of Human Rights* in 1948?

➔ **Health as a civil right?**

But what does such a right exactly imply? It is easily stated in the abstract, but its practical implementation is fraught with difficulties. Unlike other civil rights such as freedom of speech or religion, universal suffrage or fair trial, health in itself can hardly be guaranteed by laws or policies. Illness is largely a matter of nature and fate, of inevitable biological distinctions between individuals. Equal access to health care may be feasible, but there are no objective criteria for its range and quality, and the fair allocation of scarce resources. Which treatments of which patients should be covered by collective funds and on what conditions? How much of our income and tax-money can and do we want to spend on health care? What is the price we are willing to pay for saving and extending lives?

➔ **Health as civic duty?**

To what extent are health and illness private or public issues? Should the state be accountable for the health of its citizens and if so, how far can its interventions and enforcements go? Should it directly or indirectly, for instance through

insurance companies, health services or professional authority, impose health standards on citizens for their own benefit and/or for the common good? How far does individual responsibility of citizens for their health go? Do they have the right of *not* giving priority to their health or even leading unhealthy lives? Who should pay for the consequences: careless citizens themselves or taxpayers and subscribers to insurance schemes?

➔ The twofold historical relation of health and citizenship

The premises of such questions are not new. From the start of liberal thinking in the late 17th century, and the gradual realization, from the late 18th century on, of more or less democratic political regimes, health and citizenship have become entangled in a twofold, mirroring way. On the one hand, intact health, an able body and a sound mind, was framed as a requirement for full citizenship. On the other hand, citizenship became the precondition for the right to health, for access to the means for maintaining and restoring it. Both connections involved a continuously shifting balance between rights and duties as well as inclusion and exclusion of either good and full citizens or troublesome, second-rate, impossible and non-citizens. All of this entailed a tension between on the one hand agency, self-determination, consent, liberation and empowerment, and on the other hand regulation, control, and coercion.

➔ Hobbes and Locke: possessive individualism

The political relevance of *mens sana in corpore sano* can be traced back to classical antiquity. The founding moment of the modern interlinking of health and citizenship, however, can be found in the liberal-capitalist notion of possessive individualism, introduced by Thomas Hobbes in his *Leviathan* (1651) and elaborated by John Locke in his *Two Treatises of Government* (1690). Hobbes' materialist and Locke's empirical conceptualization of man as a being that is fundamentally driven by 'natural' feelings of pleasure and pain, grounded morality and the justification of sociopolitical order in concrete physical and mental sensations instead of supernatural, religious values. Their axiom that life in itself is good and the taking of life is bad implies that physical security is the most basic need. The foundational claim of their theory of the social contract is that individuals, as prime owners of their bodies, possess an inherent natural right to oppose pain and death and preserve their lives.

➔ Locke: the person as a self-reflective, accountable and self-reliant agent

Locke's argument about the centrality of individual self-determination and the constitutional state protecting vital rights depended on his understanding of possessive individualism. In his view not only the possession of one's body, but also of cultivated soil and material goods is such a right, because what the body develops and produces by means of labor is the rightful property of the person who owns that body. Likewise, according to Locke, individuals are the rightful owners of their thoughts, memories, feelings, acts, experiences, talents and capacities. This leads him to the assumption of the continuity of personal

consciousness enabling the individual to experience himself as the same being in different places, social settings and times – in other words, to have a personal identity apart from one's social position and the moral destiny of one's soul. And identity, which is essential for recognizing all one's thoughts and actions over time as one's own, and for reflecting and judging on them, enables taking personal responsibility for them. In this way Locke articulated the modern secularized notion of the person as a self-reflective, accountable and self-reliant agent. Such self-owning individuals should be free to decide for themselves what they do with what is naturally theirs, without owing society anything – at least as far as they do not impede others from exercising the same freedom. Apart from upholding the natural law principle that 'no one ought to harm another in his life, health, liberty or possessions', the state should not interfere with one's undertakings and self-development.

➔ **Stratified citizenship on the basis of naturalist criteria**

For us many of Locke's points may be self-evident, but in traditional, authoritarian and totalitarian settings they were and are not. This is not to imply that Locke favored democratic egalitarianism. In the Lockean and classical liberal perception not all individuals can constitute themselves as self-owning and rights-bearing persons and therefore as full citizens. Self-conscious autonomy and self-reliance essentially require freedom from dependence on the wills of others. Such independence is understood as a function of ownership and appropriation. It is striking that the precondition for citizenship was defined in these terms and that these assets are related to the requirement of an intact body and sound mind. Full citizenship on the basis of a capable body and mind was associated with the capacity to supersede irrationality, to exercise will and control over one's own potentially disruptive drives and passions as well as over dependent others. Until into the twentieth century full citizenship was only granted to independent adult male property-owners and denied to other groups, apart from social class, largely on the basis of naturalist criteria: sex, ethnicity or 'race', age, and mental coherence. Women, non-natives, wage laborers, the poor, minors, convicted delinquents, and those diagnosed as insane, feeble-minded, and disabled were excluded because their bodies, in particular their nervous systems and brains, were supposedly inadequate. Their incapacity or unwillingness of an independent and rationally organized life, and therefore of acquiring and managing property, was situated in an inevitable natural inequality which overrode the formal liberal ideal of equality of opportunity. Classical liberalism took for granted the uneven distribution of property in capitalism as well as the subordination of women on the basis of the belief in the existence of unequal biomedical categories of people.

➔ **Health as an essential ingredient of the bourgeois ethos**

The possession and management of a sound body and mind was crucial for the self-definition of the rising bourgeoisie, its secularized and naturalized moral order, and its progress-oriented attitude towards life. Health and hygiene embodied its self-affirmation against both the frivolous and squandering aristocracy and the irrational and irresponsible lower classes, living without

foresight, ‘from hand to mouth’ as Locke had already stated, and not being able to raise their awareness above that subsistence level. They were neither capable nor willing to invest in a healthy body and mind. The broad meaning of health, as it took shape in enlightened thinking, was entwined with core middle-class merits: independence and self-reliance, self-control and responsibility, soberness and moderation, cleanliness and moral purity, regularity and order, willpower and foresight, utility and achievement, and thrift and investment. Since the eighteenth century more and more aspects of life have been evaluated in terms of health, such as reproduction and sexuality, family life and educational issues, housing conditions, mental and behavioral disorders, addictions, crime, economic productivity and labor relations, lifestyle, habits and diet. As such, health and illness would gradually and increasingly become an object of modern politics.

➔ **Health and illness as an object for state-intervention**

As a reaction to the regular return of the plague and the burden of the diseased without means, from the late Middle Ages on, town-governments had taken ad hoc quarantine and surveillance as well as charitable measures. But it was in the late 18th and early 19th century, under the influence of enlightened optimism about the progress of science and technology, that health and illness were explicitly conceptualized as a public issue and target of state policy. The so-called medical police, established under some 18th-century enlightened despotic regimes, was a rudimentary instrument to conduct a politics of health through preventing contagious diseases and promoting hygiene. This was part of the emergent role of the state in the pursuit of a rational and efficient organization of society.

➔ **Health and illness as an object for democratic politics**

The democratic revolutions between the 1770s and 1848, more and more transforming passive subjects under authoritarian rulers into citizens with rights and duties, stirred the democratic vision of health and illness in the sense that an inclusionary and equalizing promise was added to the exclusionary leanings of classical liberalism. In fact, Locke had already raised that hope when he mentioned health among the basic natural rights and thus implicitly incorporated it in citizenship. Now it was also articulated by French and American revolutionaries and influential sociopolitical thinkers such as the French Ideologues and Jeremy Bentham. The public programs for health care and disease prevention that were debated during the French Revolution mentioned rights and obligations for citizens. The basic idea was that the nation’s health ultimately depended on the state’s ability to protect citizens against infections and unhealthy circumstances as well as their responsible and motivated attitudes, such as participation in physical examinations; fulfilling doctor’s orders; the practice of temperance and hygiene; undergoing preventive measures such as vaccination; and frugal use of public resources. Also, politicians such as Thomas Jefferson and Thomas Paine believed that the realization of civil liberties required good health, which should be advanced not only through charity and philanthropy, but rather through constitutional and democratic government – a

view that Bentham shared. In his utilitarian argument he compared the purpose of curative and preventive medicine with that of legislation and the administration of justice, healing the harmony of the social body and countering crime. Both had essentially the same purpose: fighting grief and promoting the greatest happiness of the greatest number. For Bentham a politics of health, implying social reform, was not only indispensable for socioeconomic efficiency and progress, but it was also a democratic achievement in the sense of advancing the equality of opportunity. Such thinking marked a significant reference point for the link between health and democratic citizenship, which would eventually be realized in the course of the 19th and 20th centuries.

➔ Sanitary reform and public hygiene

A significant step was taken in the mid-19th century when sanitary reform movements began to address the disruptive effects of industrialization and urbanization on the health of the working class and poor. Governments faced a growing pressure, not only from the rising medical profession, but also from other experts such as engineers, lawyers, and civil servants, as well as public-spirited citizens, to combat endemic and contagious diseases, and to improve the environmental conditions of health. Several measures were introduced with respect to urban cleansing and infrastructural and sanitary provisions. This was more than a medical project targeting unhealthy living conditions. It was also a melioristic project in an emerging mass society: it articulated what was normal and virtuous, and it referred to social order and the public good. Crossing the boundaries between the private and the public and wavering between the voluntary and the coercive, sanitary reform included the broader zeal to civilize and integrate the lower orders in society, and thus, at the same time, to make life for the middle classes less risky.

However, sanitary reform was entrapped in the dilemma of individual freedom against collective protection. The question whether the common interest of public hygiene justified state-intervention in civil society and the free-market economy challenged the liberal model of citizenship and the associated civil liberties and sanctity of private property and enterprise. Only when in the late nineteenth century, liberal elites, responding to the extension of suffrage, began to recognize that the state should shoulder greater social responsibilities, more and more sanitary goals were completed. On the other hand, compulsory health measures with regard to vaccination, alcoholism, venereal diseases, tuberculosis, child-raising, domestic hygiene, and also healing practices now labeled as quackery, might provoke popular resistance, which was difficult to ignore by rulers facing the broadening of the electorate.

➔ Professional and technocratic public health regimes

The liberal framing of health policies tended to avoid direct state interference and to rely on what Michel Foucault has coined as ‘governmentality’. Interventionist strategies were depoliticized through delegating their implementation to professional regimes, which applied rational solutions on the basis of scientific

knowledge and technocratic expertise. In the mid-19th century the sanitary project had started as a broad movement, including professionals as well as voluntary social reformers, and adopting an environmental approach. In the second half of the 19th century, however, *biomedical* approaches began to dominate public health. This shift manifested itself not only in the rise of bacteriology and epidemiology, but also in the growing impact of degeneration theory, Social-Darwinism, racial hygiene, eugenics, and the social claims of psychiatry and criminal anthropology. The associated biological reductionism, together with the expanding medical domain, entailed a tendency to stretch the definition of pathology and mental disorder, and to diagnose a range of sociopolitical issues as medical problems, such as alcoholism, crime, sexual perversion, educational deprivations, and a variety of attitudes and behaviors considered as deranged, abnormal or anti-social.

➔ **Undemocratic and totalitarian health policies**

All of this reflected growing anxieties among bourgeois elites about the leveling effects of mass-democracy, socialism and feminism. The scientifically backed response was the emphasis on innate inequalities between races, bloodlines, sexes, classes, the normal and abnormal, and the healthy and the ill. The assumption of inadequate biological categories together with organic social thinking thwarted the formal liberal priority of the individual and the endorsement of equality of human worth and opportunity. The physical and mental capacity for citizenship of particular groups was questioned, now more explicitly than before. Differentiations between various grades of social adaptability in modern mass-society could serve as selective standards for inclusion and exclusion. The consequential top-down, coercive health policies focused on the quality of the population *en masse* for the sake of national vitality and survival. In such settings medical professionalism, based on exclusive expert knowledge and authority, was at odds with democratic citizenship, not only because silent compliance of lay people was assumed, but even more because biomedical regimes tended to violate the formal liberal threshold of individual rights and liberties. Such a trend, supplanting liberal possessive individualism by exclusionary possessive *étatisme*, occurred in several countries. Several American states and Scandinavian countries, for example, enacted eugenic laws enforcing mandatory sterilization, institutional segregation, and other measures. The active role of physicians in large-scale eugenic and euthanasia programs as well as medical experiments in Nazi Germany is the most extreme example of the affinity of biomedical expertise with the 'biocratic' aim to purge society of all those considered as defective, unfit, dangerous or a public burden.

➔ **The socialization of health care**

On the other hand, from around the First World War also a more democratic connection between health care and the state was realized in two ways.

First, particular public health interventions in the domains of family-life, child-raising, schools, and the workplace, became entangled with the interests and

aspirations of the targeted lower echelons themselves. Such interventions increasingly relied on their agreement or even co-operation in order to enhance their living conditions. Although several degrees of coercion and tutelage were applied, more and more health workers, in their effort to stimulate those who seemed to impede their own self-interest and progress, relied on education, advice, counselling, and social and material support – all of this in order to encourage people's responsibility and self-regulation, and to instill habits and attitudes that were not only conductive to cleanliness and fitness, but also to social adaptation and integration. Whereas in the late 19th and early 20th century, biomedical reductionism involved drastic infringements on civil rights and exclusion, this form of medicalization rather dovetailed with a pacifying and inclusionary extension of rights that would frame social citizenship.

Second, as a consequence of the introduction of universal suffrage, the political emancipation of the working class, and the sacrifices of millions of soldiers in two world wars, in most Western countries the state would increasingly assume responsibility for the general accessibility of health care provisions. Older practices of charitable poor relief were more and more replaced by social insurance schemes and state guaranteed entitlements covering sickness, disability, and old-age. Collective health care benefits, realized by governments of different political colours and either through direct government funding or combinations of private, corporatist and socialized arrangements, were an essential ingredient of social citizenship in the post-war welfare state. Equal access to basic health care was now understood in terms of civil rights.

➔ The pitfalls of socialized health care

In the post-war period all over the Western world expenditure on health care and welfare benefits for physical and mental inabilities has gone up continuously, outstripping actual economic growth. Apart from the direct causes mentioned earlier, rising and eventually unaffordable costs were also propelled by some inherent dynamics of welfare regimes. They tend to depoliticize potentially controversial social areas and issues such as child-raising and education, reproduction and sexuality, a host of mental and behavioral difficulties, work-related disabilities, and victimhood and traumas, by redefining them as medical and psychological problems and referring them to the subsidized domain of the helping professions. Although collective solidarity assumes mutual obligations and social responsibility, it rather fostered in citizens a sense of rights and entitlements, and also triggered rising expectations and mounting tensions over the range and priorities of provisions.

All of this becomes even more challenging when the substantive meaning of health expands through the growing impact of preventive and predictive medicine and 'healthism'. 'Healthism' refers to the pursuit of improved and optimal health through the shaping of lifestyles, as part of what some sociologists characterize as 'life politics', involving a whole array of policies, agencies, services and commodities. Health has become the crucial benchmark for the quality of life – as

exemplified in the broad definition of the World Health Organization of health as ‘a state of complete physical, mental and social wellbeing’. Expectations and claims appear to be endless, whereas the collective and private means are finite, in particular in times of austerity policies and a retreating welfare state. As a result, the last decades have witnessed worries and controversies about the endurance and organization of national health care systems. As a consequence, the health and citizenship nexus has been reevaluated.

➔ The new public health

Since the upsurge of neoliberalism in 1980s and 1990s, the collective arrangements of the supposedly overregulated welfare state, have been critically reconsidered and partly subjected to market mechanisms. However, this has not lessened political and management control over medical provisions. Overall, the health care market is not a free one, but to a large extent still (directly or indirectly) state-regulated in order to guarantee some degree of equal accessibility and budget control. Neither has public and political concern about health diminished. On the contrary, it has rather broadened and intensified, while at the same time the responsibility for health tends to be individualized. The predictive and preventive approach of the so-called ‘new public health’, for example, focuses on the detection and mapping of health risks and the prognosis of possible illnesses among the general population. People are warned for the health risks of tobacco, alcohol, drugs, ‘unsafe’ sex, stress, unhealthy diets, lack of exercise, and polluted environments. They are urged to be aware of and monitor their health condition, to know about and manage risks, to change unhealthy lifestyles, to have themselves vaccinated and screened, and to act as conscious ‘health consumers’. The implicit suggestion is that reflexive, motivated and competent individuals can, to a considerable extent, have control over health and illness as part of the continuous effort to boost the quality of their lives. The principles of individual autonomy and self-determination are also central in contemporary medical ethics stressing patient’s rights and integrity, free choice and informed consent. Current medical practice indeed shows a more active stance of patients and health consumers, who educate themselves on the basis of the wide availability of scientific and popular information about health and illness, in particular online; who adopt professional language, understand themselves in terms of biomedical knowledge and psychological discourse, and use it for their own purposes; who assess scientific information and dispute expert authority; who organize themselves in interest and support groups, who assert their rights, and, as medical consumers, shop on the medical market of professional as well as semi-professional and alternative healers.

➔ The comeback of possessive individualism

The requirement of a responsible, self-monitoring and self-empowering attitude, the crux of contemporary health policies and life politics, dovetails with the neoliberal framing of citizenship in terms of a largely de-socialized and self-interested individualism. It marks a revival and expansion of possessive individualism as the norm, not, as in the past, for a restricted group of middle-

class male property-owners, but now for all citizens. The assumption that individuals are self-sufficient and self-interested agents - 'without owing society anything' to quote Locke once more - implies the suggestion that they have by definition free choice and can optimally shape their lives through an enterprising, calculating and self-motivating manner. Citizens are expected to act according to 'their own best will', exploit their inner resourcefulness and 'get the best out of themselves'. Such an imperative implies particular psychological and social abilities such as proper initiative, decisiveness, continuous self-examination, self-management and self-promotion, but also a flexible, communicative and cooperative attitude.

➔ **The neoliberal complications of health and citizenship**

The socialization of responsibilities in the field of health and illness, which started being realized in the 19th century with sanitary reform and climaxed in the 20th-century welfare state, had resulted in a balance between liberal possessive individualism and a more or less benign, inclusionary possessive *étatism*, or, in other words, between individual and collective self-determination. The neoliberal revival of naked possessive individualism, implying a particular framing of rights and duties, has upset this balance. There is nothing wrong with active, well-informed citizenship and to a large extent it has materialized. But the basic problem is that the one-sided emphasis on autonomous self-determination is far from resolving some fundamental ethical and political issues with regard to health and illness, especially in the age of predictive and preventive medicine, genetics and biotechnology.

➔ **Autonomy and self-determination adequate guidelines in the practical reality of illness?**

Firstly, to what extent can autonomy and self-determination be adequate guidelines in the practical reality of illness and health care? As long as we are in good health, we tend to believe that we *have* a body, but illness is the very experience that makes us painfully aware that we *are* our bloody body, that our ability to own and control it is limited, and that in the end it owns and controls us. Illness, implying suffering, pain, dependency, anxiety and confusion, basically involves a partial or complete lack or loss of the essential capacities of possessive individualism.

➔ **Autonomy and self-determination adequate guidelines in the practical reality of health care?**

Secondly, the reality of the neoliberal framing of the patient as a freely choosing consumer is questionable. Are patients always in the proper position to be *able* to choose, and do they always *want* to have a choice? Their situation is not like that of the citizen-consumer on the free market. Despite commercialization and privatization, the provisions of collectively funded health care are still largely monopolistic, standardized, budgeted and state-regulated, and thus restrict patients' freedom of choice. Moreover, because of the growing sophistication of

medical expertise and technology, lay people are not always able to assess health care practices.

➔ **Is the biomedical vision of the good life a threat to democratic values?**

Thirdly, is the ideal of autonomy and self-determination achievable in all circumstances and for everyone? In any case, on the personal level, the consideration of health and illness in terms of chance and probability does not provide certainty about what constitutes a risk, its implications, and how to deal with it. Knowledge about the sources and degrees of risk, provided by a range of scientific experts, health educators, policy-makers, advisory boards, insurance companies, and biotechnological and pharmaceutical companies, may be conflicting and changing, and cause doubt as well as hope. A related issue is the trust which citizens may or may not have in biomedical science and expertise. Controversies about the handling of new epidemic diseases, about a healthy diet, and vaccination programs, for example, suggest that public confidence in expert-based health policies as well as state-policies may be declining.

Furthermore, the consideration of health and illness in terms of individual choice and responsibility not only plays down differences between individual constitutions. It also underrates the extent to which ill health is still being determined by socioeconomic and cultural factors, such as poverty, lack of education, unemployment and ethnicity. The freedom and ability required for active engagement in 'life politics', are not granted to all. Quite the reverse, the preventive and enhancement approach in health policies may feed rising health standards, which may even widen the gap between the better-off and groups with fewer opportunities. The consequence is that those who cannot meet the forced up requirements – in particular the chronically ill, the disabled, and psychiatric patients – are or become marginalized as second-rate citizens.

Genetic screening, testing and counseling; bio- and neurotechnologies, and performance enhancing drugs may also bring about rising standards of physical and mental fitness. They may entail new social inequalities and exclusions on the basis of differences in biological make-up. For example, the evaluation of the economic costs and benefits of those with 'good' genes versus those with 'bad' ones can have consequences for insurance, mortgages and employability, and undermine social solidarity. If maximizing health and minimizing illness becomes not only desirable, but virtually mandatory, not being able or willing to partake in the healthist pursuit may be considered as failed citizenship. Those who lack the 'will to health' and are vulnerable to unhealthy conditions and lifestyles and behavioural problems, may be stigmatized and surveyed as high-risk groups. A biomedical vision of the good life could undermine democratic freedom when its criteria are imposed in more or less subtle ways, either by social pressure or insurance and state-agencies. Also, when biomedical information about citizens is registered in digital medical records and databanks, the accessibility and

control of such information and the possibility of surveillance, involves basic democratic values.

➔ Conclusion

I have tried to make clear that the development of modern health regimes was intertwined with the rise and expansion of citizenship. Their relation was one of mutual facilitation as well as of tension, involving a dynamics of inclusion versus exclusion, equality versus inequality, liberation versus suppression, and rights versus duties. The expansion and socialization of health care and the broadening domain of medicine during the past two centuries should not only be viewed as an inevitable and coherent medicalization, or imposition of 'biopower', to use Foucault's well-known term. The sociopolitical implications of health and illness and health care were entangled in various interactions and tensions between the state, medical professionals and either more active or more passive citizens – and they will continue to do so.