The politics of health and citizenship: historical and contemporary perspectives

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Introduction

The broad subject of my talk, the connection between health and citizenship, concerns an issue with which I have been dealing for some years now. In 2005, together with my Maastricht colleague Frank Huisman, I organised a conference on this topic, in which British, German, Belgian and Dutch medical historians participated. Together with Frank and Anne Hardy of the Wellcome Institute in London, I'm editing a volume on the subject, including a selection of the papers presented on the conference. The objective of this volume is to analyse historically the relationship between health and citizenship against the background of different national traditions: British, German, Dutch, and Belgian. My talk is based on the provisional introduction that I wrote for the volume in order to explain why it makes sense to connect health and health care with citizenship, and also to offer an outline of the historical as well as contemporary background of their relation.

This lecture has four parts.
First, I will explain why linking health and citizenship is relevant for current debates on health care and public health.
Secondly, I will explain why linking health and citizenship is relevant for medical history.
Thirdly, I will elaborate on the concepts of health and citizenship and argue that they are essentially contested and historically layered concepts.
Fouthly, I will offer an historical outline of the relation between health and citizenship and conclude by returning to some of the current debates on public health.

When we prepared the conference, Frank and I naïvely assumed that linking together health and citizenship was more or less self-evident and did not need much explanation. We were wrong. Some participants were uncertain how to deal with this subject and some of the German members in particular argued that connecting health and citizenship did not make sense, let alone that it was a relevant theme for medical history. One of them asserted that citizenship belongs to the domain of politics, and health and illness to the private sphere as well as to the market, the demand and supply of health services.

Now this criticism and the misunderstandings between some German participants in the conference on the one hand and most of the British and Dutch

members on the other, probably throw light on fundamental national differences in the way citizenship, and the relationship between health and politics are framed and understood - which might be interesting in itself for an internationally comparative perspective. However, until now I have not been able to find out what exactly these differences are. But there might be an explanation for the ardour with which some of our German friends criticised the subject of the conference and accused us of unjustly politicising health and disease. Actually I was rather surprised that they did, because if there is any country where health and disease have been politicised, of course it is Germany during the first half of the twentieth century. After all the Nazi regime can be characterised as a 'biocracy': several social and political issues like the so-called Jewish 'question', ethnicity, gender, crime, 'asocial' behaviour and sexual deviance, were transformed into and reduced to biomedical problems. In the biomedical worldview of the Nazi's, the German people suffered from or was threatened by deadly diseases. The Nazis employed a rhetoric of medical emergency and presented their policies as applied biology. Their 'cure' was racial purification that would progress from coercive sterilisation and segregation to direct medical killing and genocide. Thus, in the German context of racism and eugenics, the relationship between politics and the domain of health and disease is emotionally charged. This might be the reason why, in the view of the German medical historians who criticised the topic of our conference, democracy should implicate some sort of seperation between politics on the hand and health and illness on the other.

1. The relevance of the link between health and citizenship for current debates on health care and public health

However, so I would respond to this viewpoint, one can hardly deny that in the last two centuries, and certainly in the last one, health and illness and politics became mutually entwined more and more, in liberal democracies as well as in authoritarian and totalitarian regimes. This entwinement originated in the late eighteenth century when the contours of the politics of modernity[1] as well as modern medicine emerged. Together with poverty, (ill) health was among the first social domains in which state intervention took shape. Such intervention might affect the personal lives of people who, since the American and French Revolutions were more and more transformed from subjects into citizens. It

[1] *Politics of modernity*: (1) Ideal of ‘makability’: politics as instrument to (re)shape society based on a particular ideal image; notion that society as a whole can be organised anew. (2) Ideological contradictions: politics implies ongoing discussion and struggle on the basis of divergent ideas on how society should be organised. (3) Mass politics: the people as political force. Political power depends on support of the people, especially if the people have the right to vote. The people are involved in the state through taxes, conscription and the concept of citizenship. (4) Scaling-up: centralization and national unification. The national unified state takes over the role of the state that is based on estates, with a large degree of regional autonomy and local self-government.

therefore entailed **some basic questions concerning the relationship between state and the individual and the role of professional medicine in the politics of modernity**.

- Firstly, questions about **the role of the state** in (public and individual) health care. Was the state allowed to interfere with the lives of its citizens? If so, to what extent was it responsible for their health? How far did individual responsibility of citizens for their own health and that of other citizens go?
- Secondly, questions about **the meaning of civil rights** in this context. Do they refer to the right to stay free from state intervention or the right to collective arrangements in the field of health care? Can health or the prevention of illness be considered as a civil right at all, and can it also be imposed on citizens as an obligation? Is health a precondition for the realisation of citizenship and to what extent is citizenship a precondition for health?
- Thirdly, questions about the relationship between **the conceptualisation and the shaping of (democratic) citizenship** on the one hand and **the definition of health and illness and the practice of health care**, either regular and professional or alternative healing practices and countercultures of health, on the other.

Such questions are relevant for past and present. However, as far as I know, medical historians have hardly explored the relation between health and citizenship. Whereas on the one hand recent studies by historians and social and political scientists on citizenship are manifold and on the other health policies and public health are well-covered subjects in medical history, the concept of citizenship has hardly been applied by medical historians explicitly and systematically.

Now, this gap in medical history is not the only reason why Frank and I raised the issue of health and citizenship. It did not come out of the blue as a value-free topic for scholarly debate. Our interest bears the stamp of **recent developments** in the Netherlands, which are shared in one way or another by other Western countries. The last two decades or so have witnessed a radical change - I would say a hardening and polarisation - of the social and political climate in the Netherlands. Next to the decline and criticism of the welfare state, the growing impact of neo-liberalism, and the rejection of the leftist legacy of the 1960s and 1970s including what is now considered as inappropriate political correctness, there were growing concerns about the presumed loss of social cohesion, public morality, and national identity as well as a critical re-evaluation if not rejection of ethnic diversity and multiculturalism. Against this background there is a growing body of public opinion advocating **a revitalisation of citizenship**. There is a widespread feeling that especially civic virtues and duties have been neglected since the 1960s and that there is a need to restore social responsibility, adjustment, and integration as well as to promote some sort of moral regeneration. In this way, that is in a highly politicised manner, citizenship has been raised as an important public issue - I will come back to this later.

Next to the transformation of the sociopolitical climate, there have been **changes in the field of health care and health policies** as well. One of the basic achievements of the welfare state is that it guarantees medical care for individuals - at least for its residents - according to their needs because they are citizens with equal rights. Access to health care is an aspect of democratic citizenship: it is considered, not just as a favour or a commodity, but as a civil right. In fact health has also internationally been defined as a basic human right, as these quotes illustrate.

> '[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.' (Preamble to the *Constitution of the World Health Organisation*, 1945)
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> 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including […] medical care.' (Article 25 of the *Universal Declaration of Human Rights*, proclaimed by the United Nations, 1948)

As part of the discourse of human rights in liberal-democratic political thought, the notion of health as a right can be traced back to natural law in Enlightenment philosophy and the principles of the American and French revolutions. Following the principle of a fair allocation of scarce resources to meet basic social-economic needs, in the course of the twentieth century many countries have introduced collective funding of health care in order to provide the conditions that put individuals on a more or less equal footing with regard to health care.

However, in the last decades it has become clear that the relation between health and civil rights is fraught with **complications**. Health is not only still largely a matter of nature and fate, of inevitable biological distinctions between individuals, it is also a condition that cannot be determined absolutely and definitely. Health cannot be construed as an absolute, legally enforceable right, like freedom of speech or religion, universal suffrage or fair trial. The idea that medical care is a basic human right is easily formulated in the abstract, but it runs into difficulties as soon as practical implementation is at stake.

Bringing good health care within the reach of all citizens requires ample financial resources and entails continuously **rising costs** that are difficult to check. Costs have continuously gone up due to improved technological - and more and more expensive - treatment possibilities, increasing numbers of chronic patients, and the ageing of the population. Moreover, **since the substantive content of health is not fixed and tends to expand continuously, the right to medical care appears to be infinite.** The very success of curative medicine, the growing impact of preventive health care, and the promises of biomedical technology, not

only to cure illnesses but also to improve health, have provoked rising expectations and growing demands. The ever-widening areas of medical and social intervention aimed at improving health, entails a whole array of policies, agencies, services and commodities addressing insurance, risk prevention, life style, health advancement, and environmental topics. A host of social issues, for example, abuse of women and children within the nuclear family, traumas and victimhood, sexuality, addiction, disability and work-related problems, and sports, have partly been put under a medical regime.

The pursuit of health seems to be boundless, whereas the financial resources are finite. Therefore, collective health care inherently nurtures conflicts over economic costs, income distribution, access and priorities, and political control over medical professionals and services. Against this background, the expansion of collectively funded health care has been called into question. Moreover, the continuing and even growing popularity of alternative medicine and the ascent of new biomedical technologies, especially in the area of genetics and reproduction, have given rise to political and ethical controversies. As a result, the last decade has witnessed **heated public and political debates with regard to the financing and organisation of national health care systems as well as to medical ethics**. One of the questions is to what extent governments are and can be responsible for the health and well-being of citizens and the contents and quality of health care. Neo-liberalism has advanced a strong feeling that the state should withdraw from the social domain. The welfare state and its overloaded bureaucratic system supposedly have led to a passive, consumerist and dependant population, relying on care from the cradle to the grave. Collective arrangements are being critically reconsidered and consequently, reformed and transferred to the 'the market'. With respect to citizenship, the emphasis has shifted from collective solidarity to individual responsibility, from rights to obligations, and from passive entitlements to active involvement. Against this background citizens are challenged to think afresh about their health. The redefined concept of citizenship stressing individual autonomy, 'empowerment', and rational self-interest, suggests that health is or should be more within the control of the individual. The state will be unable to provide adequate health care, thus the argument runs, if citizens do not act responsibly with respect to their own health and that of others.

Ironically, the partial withdrawal of the state in the organisation and funding of collective health care **has not diminished its concern with public health and health education in particular**. Whereas collective financial arrangements in the field of health care have been put up for debate and there is a shift to private arrangements, there is apparently no right to stay free from state interference. On the contrary, the last decades have seen a **growing involvement of governments in a public health discourse** that stresses the danger of health risks and the need to take precautionary measures. There is a broad concern about the health risks of tobacco, alcohol, drugs, 'unsafe' sexual behaviour, stress, overeating, unhealthy foods, lack of exercise, polluted environments, sun-

bathing, and international migration and tourism. People are being warned for unhealthy lifestyles and admonished to change them, and they are urged to have themselves periodically screened for cancer and other diseases. One may wonder whether citizens have the democratic right not to give priority to their health and to lead unhealthy lives, and the question has been raised whether, if they do so, they are still entitled to the benefits of collective health insurance. So, where lies the boundary between the idea of health being a right of citizenship to that of health being a duty?

2. The relevance of the link between health and citizenship for medical history

Now, our call for historical reflection on citizenship and health (care) does not imply that we claim that knowledge of the past leads to clear-cut answers to current problems and questions. Our claim is rather that the focus on citizenship may contribute to **a new perspective on the history of health politics and public health** in general, which may help to understand current issues in a broader context. Considering the standing historiography we see that **older Whiggish and presentist histories**[2] of public medicine have suggested that the growing rapport between medicine and the state was both desirable and more or less foreordained, the ultimate outcome being socialised health care in the democratic welfare state. Many recent works in this field, on the other hand, are more or less dominated by **the Foucaultian perspective**, according to which the interlocking of (professional) power and (scientific) knowledge resulted in the disciplining of bodies and minds. From a similar angle professionalisation theories have focused on the strategies of physicians to expand their field of action by 'medicalising' individual as well as social problems. To a lesser extent the history of public health, at least in the Netherlands, has been inspired by **Nortbert Elias's theory** of the civilising process, and has been elaborated on by the Dutch sociologists Joop Goudsblom and Abram de Swaan (*In Care of the State*) and the German medical historian Alfons Labisch on *homo hygienicus*. In their view, the growing preoccupation with health is explained as a form of civilised self-control, which has supposedly been imposed by the middle class upon the lower orders. Both the Foucaultian and the Eliasian approach focus on **the interplay of social coercion and self-control** as a fundamental characteristic of modern liberal-democratic society, be it that the first stresses the disciplining of the abnormal or the Other by professional (medical) power, while the second emphasises growing self-restraint as a consequence of shifting and equalising balances of power among various social groups in society as a whole.

Without rejecting these perspectives completely, we feel that stressing the disciplining effects of medicine in particular is **one-sided and deterministic**. By

[2] The fallacy of presentism or Whig-history: understanding and judging the past on the basis of present-day standards and norms and values and not for its own sake, as if there is a necessary and logical development, often interpreted as inevitable progress, leading from the past tot the present.

including the development of citizenship, we would like to draw attention to the ambiguities in the complicated and changing relationships between medicine, state-intervention, and individuals, whether they are patients or not. The expansion and socialisation of medicine in de course of the nineteenth and twentieth century should not only be interpreted as an inevitable, coherent, and overpowering medical emperialism that imposes its definitions, methods and techniques on society, thus controlling and disciplining people. Entangled in various social and political interactions and conflicts, the weight of medical knowledge and practices in society was differentiated and diffuse. The health policies of voluntary organisations and the state did not always accord with each other, and they might conflict with the social ambitions of the medical profession as well as with the interests of individual citizens and various social groups. The power of medicine should not be overemphasised. Individuals were not passive victims of the controlling rationality of a monolithic medical juggernaut, with no other choice than to conform to its dictates.

By focussing on the role of citizenship with respect to health we would like to shift the focus from the social control perspective to **a viewpoint that acknowledges human agency and self-determination and that redresses the balance between repressive and empowering effects**. The development of modern medicine and public health care was intertwined with the rise and expansion of democratic citizenship, and their relation was one of mutual facilitation as well as conflict and restraint. The medicalisation of social issues can involve serious infringements on civil rights and the subjection of individual interests to those of the collective or the state, but it can also function as a neutralising and pacifying strategy to solve social problems and protect individual rights. Medical knowledge, which has increasingly multiplied in a large diversity of scientific and popular viewpoints on health and illness, is not only deployed for the purpose of the vested interests of the medical profession, health care institutions, insurance companies, pharmaceutical industries, state agencies and welfare bureaucracies. More and more medical knowledge is also put in service by voluntary organisations, social interest groups, patient's organisations, and individual citizens asserting their interests and rights. Just consider the impact of internet on the democratisation of medical knowledge.

3. Health and citizenship: essentially contested and historically layered concepts

Before presenting an outline of the historical relationship between health and citizenship, first some explanation on how we employ both concepts as **essentially contested and historically layered concepts**. Such concepts are open for a variety of historically contingent definitions and interpretations, and they are used in an empirical-descriptive as well as in an evaluative-normative sense. The contemporary debates about citizenship are a case in point. Since the 1980s, citizenship has become a fashionable concept all over the political spectrum to articulate dissatisfaction with specific developments in present

society as well as to put forward solutions. **Several social and political issues have thus been formulated in terms of citizenship**: the crisis of the welfare state; the consequences of individualisation and economic liberalisation; the presumed lack of social cohesion and public morality; mass immigration and growing cultural and ethnic diversity; the changing relation between the state and individual citizens; increasing voter apathy and the declining trust in parliamentary democracy; and European unification and globalisation. Discussion focuses on the supposedly disturbed balance between rights and duties as well as the presumed threat of social and national disintegration.

Health and citizenship cannnot be defined in a neutral way, without taking into account the historical context in which these concepts are used. In other words: **only a historical survey of the changing definitions and meanings of health and citizenship can throw light on their contents** and the same holds good for the relations between them. They are embedded in changing socio-political frames of thought and debate, **which do not merely reflect, but also constitute the social realities of health and citizenship, and the political interests related to them.**

As far as the concept of **health** is concerned, the most simple and minimalist definitions describe health as absence of disease or infirmity, in medical-analytical terms: the (statistically) 'normal' and unimpeded physiological functioning of a body that makes possible life's basic biological functions in order to survive. However, in history we see a variety of other, broader descriptions incorporating normative and social-cultural values. In the second half of the twentieth century, for example, there was a shift from preserving toward optimizing health, in the sense of, as the all-inclusive definition of the World Health Organization has it, to 'a state of complete physical, mental and social well-being.'

In fact, already since the eighteenth century **broadening meanings of health** have been expressed. More and more aspects of life began to be considered in medical terms, such as sexuality, mental and behavioral disorders, addictions, criminal behavior, the raising of children, lifestyle and habits, living conditions, labour relations and urban infrastructures. The meaning of health was entwined especially with **bourgeois or middle-class virtues** such as individual independence, self-sufficiency, self-control, responsibility, voluntarism, soberness and moderation, regularity and order, willpower, achievement and thrift, investment and utility, cleanliness and moral purity. Many of these values, as has been pointed out by Foucault, were geared to a progress-oriented life whereby health represented economic value, as a useful investment and an essential condition for industriousness and optimal productivity. From the eighteenth century, health and hygiene embodied the new bourgeois order. Giving health priority determined the self-image and self-affirmation of the rising middle class against both aristocratic idleness, frivolity and decadence and the dirtiness, disorderly conduct and depravity of the lower orders.

The political-philosophical roots of the middle-class health ideology may be traced back to the work of the founders of liberal thought, Thomas Hobbes and John Locke in the seventeenth century, in particular their notion of **possessive individualism**. As Hobbes argues, the individual, both in his natural state and in the body politic, possesses the inalienable right to protect his own body from pain and death, and even has the 'natural duty' to sustain that body and keep it in optimal condition. This notion of possessive individualism has been elaborated by Locke. In his argument the fundamental individual right to material possession followed naturally from the right to possession of one's own body: what the body produces by means of labour is the rightful property of the person who owns that body. Possessive individualism was the core liberal value that was driving people to fulfil their potential, to improve themselves and to bring about social progress. As such it was the basic principle underpinning liberal thought on health as well as citizenship.

Partly as replacement of the Christian ideal of salvation, the idea gained currency that **health was a good in itself** and that it did not only depend on the whims of nature or God's will, but that it could be actively pursued. Enlightenment thought assumed that advancing scientific knowledge of disease would automatically have to lead to the control of the human body and behavior in such degree that diseases would be countered and overall health promoted.

The meanings of citizenship are even more diverse and contested than those of health. Citizenship is generally about what draws individuals together into a political community or civil society on the basis of rights and entitlements on the one hand and with responsibilities and obligations on the other. The domain of citizenship can be delineated from the private sphere of intimacy as well as from the market swayed by economic interests. Citizenship is about participation on the basis of both a sense of individual autonomy and a sense of public commitment. It presupposes the capability of self-direction and can hardly be reconciled with subordination and dependence. As such citizenship is an essential component of social and political modernisation that replaced fixed and hierarchical patterns of social membership, which bound individuals to local networks of kinship and corporate bodies, with achievement criteria, growing individual independence, and more egalitarian conditions of social belonging on a national scale. Centralisation and democratisation went hand in hand. The actual enjoyment as well as the expansion of civil rights - with respect to their number and range as well as the number and range of people who were entitled to them - was realised through political activism and struggle. The reverse of this continuing democratic politics of citizenship was the growing interference of the state in society. In this historical process, the contours of democratic citizenship took shape in the area of tension between freedom and equality, rights and duties, individual autonomy and the common good, uniformity and diversity, state and (civil) society, and inclusion and exclusion.

I cannot elaborate on the complicated history of citizenship in the Western world and its different national traditions, but basically five, successive but also overlapping and cumulative models of citizenship might be distinguished since the Renaissance: classical republican, classical liberal, liberal-democratic, social-liberal or social-democratic, and neo-republican citizenship. I will not go into details and the characteristics of the five models - I assume that this historical outline is more or less familiar to you. It is partly based on the work of the sociologist T.H. Marshall on *Citizenship and Social Class* and also on a critical, largely neo-republican re-evaluation of it. I would like to continue with an historical outline of the link between health and these models of citizenship.

(1) **Classical republican citizenship** that developed in city-states and that is defined by self-government and civic virtue, above all patriotic commitment to the public cause. This was an exclusive, patrician form of citizenship: only men who were qualified, that is independent because of their property and capable because of their reasonable judgement, were recognised as full citizens.
(2) **Classical liberal citizenship** that stresses basic civil rights against unlawful intrusion by the state. It emerged in the late eighteenth century as a product of the Enlightenment ideal of fundamental, inalienable, 'natural' human rights, as they were proclaimed in the American and French revolutions. Whereas republican citizenship, implying that citizens are both governors and governed, is exclusive and stresses active duties, liberal citizenship largely relied on the passive enjoyment of legal rights and it was inclusive - at least in theory, but not in practice during the larger part of the nineteenth century, when suffrage was in fact limited to the propertied classes.
(3) **Liberal-democratic citizenship** that centres on political rights, in particular suffrage and political representation. Through the gradual extension of suffrage in the late nineteenth and early twentieth century, liberal citizenship was democratised: more and more people acquired full political membership of the national community.
(4) **Social-liberal and social-democratic citizenship** that grants welfare entitlements. It originated in the late nineteenth century and was fully developed in the second half of the twentieth century through the welfare state. This form of citizenship refers to those entitlements that concern economic and social security and that provided civil and political rights with a material foundation. The argument underpinning social citizenship is that civil and political rights can only have substance for all citizens if there are no social and economic impediments for reasons outside their control that prevent them from exercising these rights.
(5) **Neo-republican citizenship** that is a mixture of neo-liberal, neo-conservative and communitarian values and that has evolved in the 1980s and 1990s from mounting criticism of the wellfare state, and later on, also of cultural and ethnic diversity, considered as social fragmentation. The argument is that social citizenship has largely been articulated in terms of passive entitlements while the other side of democratic citizenship has been neglected: the

capacity and willingness to actively participate in public life and take on social responsibilities and obligations. In this view welfare is identified with an all-powerful bureaucratic intervention state that strangled individual autonomy, responsibility and initiative, and threatened basic civil liberties. The ideal of neo-republican citizenship was also a reaction to the fear of an erosion of social cohesion and public morality, which would endanger constitutional democracy, the more so because of declining political participation, growing voter-apathy, decreasing membership of political parties, and growing extremist movements. The neo-republican ideal presupposes that the resilience of modern democracy depends on the attitudes of its citizens and the vigour of civil society. It focuses on an ensemble of social abilities and public virtues: independence, self-control, sound judgement, reasonableness, open-mindedness, the capacity to discern and respect the rights and opinions of others, tolerance without being indifferent, the willingness to engage in public debate, and 'civil' behaviour in the public sphere. To these republican civic virtues were added neo-liberal and communitarian merits: in the neo-liberal view individuals should be self-supportive and self-reliant, adapt themslves to economic and technological change, whereas communitarianism stresses the significance of mutual assistance, social solidarity as civic virtues, and being active in civil society.

Historical outline of the link between health and citizenship

Where can we trace **the historical origins and development of the relationship between health and citizenship**? I already referred to the liberal ideology of **possessive individualism**. As far as state interference with public health is concerned one could point to a variety of ad hoc measures that early modern (city-)governments took as a reaction to the regular return of plague epidemics and in order to cope with the nuisance of the sick poor, such as **quarantine, *cordon sanitaires*, and surveillance**. In the course of the eighteenth century, we see the emergence of the idea of the so-called **medical police**, established in some enlightened-despotic central-European states as part of the pursuit of a rational and efficient organisation of society. The notion of medical police, although hardly implemented, explicitly defined health as a public issue and as a structural part of state policy. More significant and long-lasting than such a top-down approach, however, was the impact of the Enlightenment philosophy of **natural rights and popular sovereignty** as well as the gradual emergence of a **civil society**. Also, the Enlightenment belief that reason, the advancement of science and technology, would create a better future included optimism about the progress of medicine.

As Dora Weiner has shown in het book on *The Citizen-Patient* in revolutionary France, during the **French Revolution** political and medical reformers raised health and health care - albeit in theory rather than practice - to the rank of a constitutional right. Rejecting traditional Christian charity and advocating secular efficiency, they proposed public programs for health care and disease prevention

on a national scale. Medical benefits would not only entail rights but also obligations for citizens: participation in medical examinations; fulfilling doctor's orders; the practice of temperance, a healthy regimen and hygiene; and undergoing preventive measures such as vaccination. The basic idea was that the health of the nation ultimately depended on the judgement and decisions of **'citizen-patients'** and they should become active participants in its advancement. Patients should behave as responsible citizens who were motivated to restore and keep their health. Such an attitude was part of a wider complex of revolutionary civic virtues like self-determination and public commitment. The far-reaching revolutionary plans for public health care and the project of the 'citizen-patient' were not realised, but the revolutionary link between health and democratic citizenship remained a significant reference point for the future.

Similar ideas about the need for public health care were formulated by one of the founding fathers of the United States, Thomas Jefferson, and some political thinkers associated with him, and in Britain, of course, by **Jeremy Bentham,** the philosopher of utilitarianism, in particular. Medicine and a politics of health played a prominent role in his utilitarian reform projects. To a large extent Bentham's reputation has been coloured by Foucault's depiction of him as the originator of the panopticism, all kinds of surveillance techniques to control and discipline individuals. However, Bentham's work was also inspired by democratic aspirations. The government's task was not only to keep law and order, but also to guarantee a decent subsistence level and equality of opportunity. A politics of health, which implied intervention by the state in society, was an indispensable element in the advancement of social harmony and justice. More and more Bentham came to believe that only representative democracy, a considerable extension of suffrage, freedom of information, and free debate would refrain the government from oppressing the people and from blocking progress. The utilitarian goal of the greatest happiness of the greatest number could only be realised in a democracy, in which citizens were actively engaged in politics and they controlled, and, if considered necessary, changed the government. For Bentham good health for the greatest number not only was an economic requirement, a sound investment, but also a democratic achievement.

The Enlightened, revolutionary and utilitarian vision of medicine as part of ameliorative politics and social engineering foreshadowed the development of **sanitary reform** projects in the course of the nineteenth century. The late eighteenth and early nineteenth century saw the emergence of a self-critical bourgeois **civil society** as appears from an increasing concern among intellectuals, professionals, philantropists and moral entrepreneurs about the environmental causes of disease. Facing the disruptive effects of industrialisation and massive urbanisation, they put public health on the agenda as an urgent socio-political problem that called for collective action and legislation by local and central governments. The sanitary movement was much more than a medical project targeting disease and unhealthy living conditions. It also addressed

questions of social order and integration in an industrialising and urbanising mass society. Public health was one of the first social projects in which professional groups used their expertise to make themselves advocates of the public interest and civil virtues. People should not resign themselves to disease or premature death, but ought to take their destiny into their own hands: active intervention in social conditions was urgently called for.

Many sanitary reformers were guided by the liberal ideal of citizenship, pertaining to free individual development and productive virtuousness. At the same time they viewed society as an organism: the whole was more than the sum of its parts; harmonious collaboration constituted the foundation of social order and improving the quality of life. Citizens owed it to their community to lead industrious and virtuous lives, but the problem was that many fell ill through no fault of their own. In order to guarantee the civil right of health or at least the prevention of disease, in their view the government should take the appropriate measures needed, with the help of the medical profession. Sanitary reforms included the missionary zeal to **civilise the lower strata of society and educate them into middle class values**, and thus, at the same time, make life for the middle classes less dangerous and more pleasant. The miserable health conmditions of the lower orders, especially the possible spreading of cantagious diseaese like cholera, also endangered the health of the middle classes. Abram de Swaan in his book on the historical development of the welfare state has pointed out how the fear and the enlightened self-interest of the middle class resulted in their willingness to to pay for collective and infrastructural arrangements in the field of public health, such as garbage collection, sewage drainage and clean water supply. Although it implied disciplinary strategies, at the same time sanitary reform, through articulating what was healthy and clean as well as normal and virtuous, was also geared to making self-governing and responsible citizens out of the lower strata of society.

However, all of this was not without complications. More often than not sanitary reform programs ran against indifference and inertia and gave cause to opposition. Plans were ambitious, but several **obstacles and controversies** hampered their implementation. One of the causes was that the sanitary movement was at odds with a crucial element of liberalism: **the principle of non-interference by the state in citizen's private lives and the economic sphere**. Public health reforms were impeded by the contradiction between the need for state intervention and the civil liberties of individuals as well as the operation of the free market. Thus efforts by public authorities to control the spread of contagious diseases gave rise to the dilemma of individual freedom and the sanctity of private property and enterprise against collective responsibility and protection, of the voluntary against the coercive. Public health schemes were often inspired by liberal impulses, but at the same time staunch defenders of liberalism also opposed them. Only in the late nineteenth century more and more liberals began to recognise that the state should shoulder greater social responsibilities, in part to placate an expanding democratic electorate, more and

more sanitary goals were realised. On the other hand, **medicalising objectives might be unpopular among the people** and compulsory health regulations provoked popular resistance, a fact that was difficult to ignore by political leaders who had an eye to the ratings. Controversies about compulsory smallpox vaccination and the medical regulation of prostitution and prevention of sexually transmitted diseases were cases in point.

Moreover, there was a **tension between on the one hand a democratic and egalitarian vision of citizenship and on the other medical professionalism and a technocratic approach of public health**, which superseded social reformism in the second half of the nineteenth century. Despite the radical democratic rhetoric of for instance Rudolf Virchow and his sympathisers in Germany around 1848, the overwhelming majority of the medical profession, belonging to the middle class, shyed away from a radical social reform. The bacteriological and epidemiological approach toned down the relevance of the larger social environment and shifted the emphasis to a technocratic approach based on expert authority.

The growing role of **medical professionalism** in public health can be explained against the background of the tension between the increasingly felt need to respond to social problems in modern mass society on the one hand, and the liberal reluctance to state intervention on the other. Since liberal democracy was based on the principle that civil liberties should be respected, the liberal art of social policy was often not based on direct state interference, but rather took the form of **'governing at a distance' or indirectly** with the help of professional expertise outside the state apparatus. The execution of social policies was delegated to the helping professions and their state-regulated, but not state-controlled administrative networks. These applied putatively neutral scientific knowledge about what is normal, virtuous, healthy and efficient. The lack of democracy connected to professionalism was compensated by the professional ethos, which presupposed scientific competence, technocratic efficiency, and disinterested dedication to the public good. In this way interventionist strategies were removed from political controversy and professional regimes became a crucial element of the liberal-democratic order. They did not only put constraints upon people or discipline them, but they also operated by co-opting them and by encouraging and guiding their self-control, self-direction and self-advancement. Targeting individuals and groups who supposedly did not behave in their own self-interest or who seemed to be indifferent to their own advancement, professionals like physicians became engaged in 'making up' responsible citizens, who would be capable of regulating themselves and bearing a kind of controlled freedom. That was the positive or inclusive link between professionalism and democratic citizenship, but there were also **negative, exlusive ones**.

The first is the development and growing popularity, from the late nineteenth century on, of **alternative forms of healing and counter-cultures of health**,

like in the German *Lebensreform* movement. This involved disputes about the exclusive right of professional physicians to medical treatment and the role of the state vis-à-vis professional claims and the right of citizens to decide for themselves as far medical treatment is concerned and withdraw from professiol regimes. The second negative relation concerns the fundamental ambiguity the liberal order in the sense that, while committed in principle to equal rights and opportunities, it more often than not remained in practice **selective in the granting of rights and opportunities**. Under the cloak of professional regimes the liberal threshold of individual rights and liberties might be crossed or even violated, thus subordinating democratic values to what was viewed as the collective good and national interest.

A case in point is **the turning away from environmental en social reformist to biological approaches** in public health and social hygiene in the late nineteenth and early twentieth century. This manifested itself not only in the rise of bacteriology, but also in **the growing impact of social hygiene programmes, degeneration theory, Social-Darwinism, criminal anthropology, and eugenics**. They provided a biomedical language for naturalising social and political relations and pathologising a wide variety of social problems. In the course of the nineteenth century the enlightened liberal idea of a uniform, rational, and malleable human nature, which formed the basic assumption of democratic equality, was superseded by an emphasis on biologically rooted differences and inequalities between human beings: those of race, gender, and class as well as of the contrast between rationality and stretched definitions of mental disorder. Stressing the naturally determined inequality between individuals and social groups, biomedical theories like that of social Darwinism and degeneration made it possible to distinguish various grades of social integration and adaptability within modern society, which could be used as **a selective standard for citizenship in order to exclude several social groups** from the liberal political order. Biomedical metaphors, which equated society with a living organism, suggested that social politics might essentially be medical treatment. Embracing a social-hygienic role, physicians expanded their domain by claiming expertise in formerly non-medical fields like alcoholism, crime, sexual perversion, a variety of serious and minor mental derangements, educational deprivations, and other problems viewed as social pathologies. Such trends occurred in many countries, albeit in different degrees en with more or less serious consequences as far as civil rights were concerned. The Nazist biocracy, building on a strong affinity of German medicine with authoritarian politics, is the most extreme twentieth-entury example of the undemocratic, coercive and unaccountable structures of (medical) professionalism.

At the same time, it was also the twentieth century that saw the most profound and lasting 'positive' liaisons between health care, the state, and democratic citizenship. Shifting the balance from liberal to more **collectivist arrangements** of medicine, the emerging **welfare state** would increasingly assume responsibility for the accessibility of health care provisions for all of its citizens.

Older practices of subsidised health care as an aspect of charity and poor relief, were more and more replaced by collective insurance schemes and state guaranteed entitlements covering sickness and disability. All of these, of course, reflected the growing political emancipation of the working class. It was no coïncidence that in many countries the provision of collective health insurance became a major issue after the First World War - at the same time when **universal suffrage** was introduced all over the Western world - and was realised around the Second World War. **War**, which took a heavy toll of the life and health of so many citizens, was the final confirmation that health should be a national concern and belonged to the responsibilities of government.

Health care benefits were an important ingredient of social-liberal and social-democratic citizenship. Social security arrangements offered itself as an exemplary solution to the social question reconciling labour and capital in the interests of social stability and turning potential revolutionaries into loyal citizens, who were expected to internalise middle class values. Collective insurance would foster self-control, social responsibility, a rational, methodical conduct of life, and foresight, and would bind these new citizens into a system of solidarity and mutual obligations. **Social citizenship**, forged by the welfare state, involved several degrees of coercion and discipline, but it also became to be considered in terms of **rights and enlightened self-interest**. They fostered in the lower classes a sense of entitlement that might further politicise them, the more so because tensions arose over provision and payments of benefits. Also public health activities depended on the more or less active co-operation of the targeted populations, which they might be willing to give if such interventions accorded with their well-understood self-interest and enhanced their living conditions.

Regardless of the way health care was socialised - whether in the form of nationalisation and government-funding (like in Britain) or a combination of private insurance and socialised sickness funds (like in many other European countries) - since the 1960s or 1970s or so, as a result of broad coverage and open-ended fee-for-service, in many countries costs have tended to climb much higher than expected. Earlier on I already referred to developments that enhance this trend. Against this background the **growing impact of neo-liberalism** since the 1980s, emphasising the benefits of the market, has entailed major shifts in thinking about and practices of health care. Because of continuously rising costs of socialised health insurance schemes and the devaluation of state regulated welfare services, economic and efficiency considerations have won ground in the organisation and delivery of health care. At the same time medicine has broadened its scope to the protection of the still healthy from sickness by means of the detection and prognosis of possible illnesses in the more or less distant future. The predictive and preventive approach, fostered by the growth of epidemiological surveys and new techniques of medical screening and monitoring, is based on a view of health and illness as a continuum, a statistical style of reasoning, and above all **the notion of risk**. Considering everybody as a

potential patient, predictive and preventive medicine focuses on the detection, calculation, and management of health risks.

This **new public health** is all about providing individuals with information about their health status and possible risks, so that they can act to reduce those risks and preserve or even improve their health. At the same time the risk discourse does not provide certainty, but, on the contrary, generates its own discord about what constitutes a risk, its implication, and how to respond. Conflicting and changing knowledge about sources and levels of risk, brought on by the ever-expanding range of information, services, and products, has moved public health policy and expert systems towards identifying the individual as ultimately responsible for the assessment and avoidance of risk. Patients a well as healthy individuals are framed as active and conscious 'health consumers', who are or should be well-informed about their health-status and who supposedly can take responsibility for it.

The rise of **'healthism'**, which implies that people are expected to be active in keeping and optimising their health by adapting a healthy lifestyle, fits in with the neo-republican ideal of citizenship stressing a reflexive, competent, and entrepreneurial self. Healthism requires the replacement of passive 'welfare dependency' by active citizenship, which is not only defined in terms of rights, but also of duties. Individuals whose behaviour is deemed contrary to the pursuit of curbing risk and advancing health, are likely to be considered as lacking self-control, rationality and responsibility. As such they appear not to be fulfilling their duties as citizens and the question has already been raised whether they still should be entitled to collectively funded health care.

Both the neo-liberal emphasis on the free market and the thinking about health in terms of risk management assume individual responsibility, independence, free choice, knowledge, competence and motivation. **Autonomy** is the key concept, not only in neo-republican citizenship, but also in medical ethics. According to this principle, adults have the right – and to a large extent also the duty – to self-determination and self-organization of their lives. However, regardless of whether the high-flown neo-republican ideals are achievable for everyone at all, the principle of autonomy seems to be especially inadequate to answer the **ethical problems and political controversies** that arise in the context of the practices of predictive medicine and also of biotechnology. Furthermore, both entail dangers as far as **human and civil rights** are concerned.

Let me conclude by pointing to **five sets of questions and problems as far as the present relationship between health and citizenship is concerned**.
First, the neo-republican principle of **autonomy,** which has also been embraced by the patient movement since the 1970s, gives rise to difficulties in medical practice, because being ill, implicating suffering, pain, dependency, anxiety and confusion, is often accompanied by an infringement on or a lack of self-determination. Patients do not always have the proper information at their

disposal to be *able* to choose, and it is questionable whether they always *want* to have a choice. The conditions in which patients typically find themselves differ from those of citizens and consumers on the free market. Despite commercialization and privatization, the largely monopolistic offerings of collectively funded health care and the conditions posed by health insurers impose limitations on patients' freedom of choice. Also, the neo-liberal objective of the patient as freely selecting citizen and consumer is at odds with the increasing standardization of care and empasis on efficiency and medical specialising, the growing influence of medical technology, cost benefit rationalities and administrative and managerial factors.

Second, the suggestion that health and illness depend on individual choice and responsibility not only plays down differences between individual biological constitutions, but also underestimates the extent to which ill health is still being **determined by social-economic and cultural factors,** such as deprivation, lack of education, unemployment and ethnicity. There is the danger that the new preventive interventions will benefit the already healthier population groups instead of those with few opportunities.

Third, predictive and preventive medicine might give rise to **a permanent dynamic of health standards being forced up**, which may cause those who cannot meet them – the chronically ill, the physically and mentally disabled, and psychiatric patients – to become marginalized and downgraded, despite their formal rights, to second-class citizens. Also the **open future**, which the principle of autonomy presupposes, is called into question by predictive medicine, because it provides knowledge about the chance of becoming ill at some point in the future. Such predictions not only have a medical significance and generate feelings of uncertainty, but may also entail an accumulation of other negative effects such as being refused by insurance companies, mortgage lenders, or employers. Thus predictive medicine may entail discrimination and social exclusion of individuals whose health prognosis is considered as risky. In this way predictive medicine may undermine the democratic principles of freedom, equality and solidarity. This raises the question whether governments have a task to take measures in order to safeguard civil rights vis-à-vis the practices and consequences of predictive medicine. As the amount of information of individual health profiles and risks in data banks increases, the accessibility and the control of such information touches on the civil right of privacy and the inviolability of the body.

The fourth problem concerns **the professional power of medicine to define what constitutes a health risk, who are at risk, and what the consequences of such risks are**. Informed consent, which nowadays is an important principle in medical ethics and which has made the patient into a citizen-patient, is difficult to realise in predictive medicine. For a variety of reasons lay people are often not in a position to resist and refuse the services of predictive medicine. Lay people may lack contra-expertise vis-à-vis its specialist and sophisticated knowledge

claims and may not being able to assess the practical consequences of predictions. They also may participate in predictive health practices out of fear because they are afraid in advance that they will regret non-participation in the near or distant future or that non-participation will harm the health of next-of-kin. All of this raises the question whether people should follow the professional definitions of health and health risks or whether they should be enabled to form their own opinions about the results of predictive medicine and its possible social consequences. Perhaps governments have a task to initiate political debates and public discussions about predictive medicine and also the possibilities of medical technology in order to advance active, well-informed citizenship in the domain of health and illness. Citizens should be able to discriminate between good and bad uses of predictive medicine and biotechnology on the basis of basic human and civil rights. However, if this would be realised there are still other problems. Democracy in the field of predictive medicine and biotechnology does not mean that the state the power to regulate all medical practices; not only because the retreat of the welfare state and neoliberal hostility to state intervention, but also because globalisation and international competition have put limits on the power of national states.