The Politics of Health and Citizenship: Historical and Contemporary Perspectives

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At the end of the Second World War, health was defined as a universal human right. The Preamble to the Constitution of the World Health Organisation, drafted in 1945, states that '[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.'[1] And article 25 of the *Universal Declaration of Human Rights*, proclaimed by the United Nations in 1948, reads: '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'.[2] In the course of the twentieth century health and disease became a matter for the state in most Western countries as well as in the former communist world. The provision of medical care is considered not just as a favour or a commodity, but as a civil right - no matter whether such rights are explicitly laid down in constitutions, in social security laws, or in the administrative regulations of the welfare state.

The notion of health care as a civil right can historically be traced back to the enlightened human rights discourse based on natural law, the principles of the American *Declaration of Independence* (1776) and the *Déclaration des droits de l'homme et du citoyen*, issued by the revolutionary French National Assembly in 1789. In the past two centuries this ideal gradually materialised: more and more medicine and politics became mutually entwined. Next to poverty, ill health was the first social issue targeted by the emerging intervention-state in the nineteenth century. Following the principle of a fair allocation of resources to meet basic needs, many countries introduced collective funding of health care in the course of the twentieth century in order to share costs equitably. Apart from inevitable biological distinctions between individuals, equal access to health care is an aspect of democratic citizenship.

All of this may be understood as the logical outcome of growing humanitarianism and democratisation in combination with scientific and technological progress. However, collective health care arrangements were also supported by authoritarian and totalitarian regimes. Also, there have always been counter movements that seriously doubted the idea of scientific progress in medicine. The relation between health and citizenship is far from self-evident and uncontested; it is fraught with complications and ambiguities. The idea that health care is a civil right is easily formulated in the abstract, but practical implementation is another matter. Unlike freedom of speech or religion, universal suffrage or fair trial, health cannot be construed as an absolute, legally enforceable right. Not only are individual health and illness to a large extent still a matter of nature and fate, but the realisation of health as a civil right also requires resources (money, medical expertise, and an adequate health care infrastructure), political consensus with regard to the relation between individual and social responsibilities, and a long-term perspective. Collective health care inherently nurtures conflicts over the range of state-intervention, costs and priorities, and political control over medical professionals and services.

Against the background of the crisis of the welfare state since the 1980s, the foundations of collective health care provisions were and are called into question, in

particular because of the rising costs. Costs have continuously gone up due to improved technological treatment possibilities, increasing numbers of surviving and chronic patients, and the ageing of the population. Ironically, to a large extent advances in medicine undermined the affordability of socialised health care and the political consensus on which they were based. The very success of curative medicine, the growing impact of preventive health care and the promises of biomedical technology provoked rising expectations and growing demands among the public.[3] Health became a central issue in a whole array of institutions, agencies, services, commodities and policies addressing insurance, risk prevention, life style, living conditions, environment and well-being. The substantive content of health tends to expand continuously and the right to medical care appears to be infinite. This reflects a more general development in modern societies: people's increasing reliance on scientific and technological control has made it more and more difficult for them to accept the contingencies of human life, including disease and death. Although since the 1960s medicine has frequently been criticised by social scientists and patient's organisations, at the same time most people cherish a faith in medical progress and its promise of prolonging life, minimising pain, and securing a gentle death. At the same time, tensions between regular and alternative medicine as well as the ascent of new biomedical technologies have given rise to ethical and political controversies.

From the 1990s on we have seen heated public and political debates about the organisation and financing of collective health care as well as medical ethics. One of the key questions was to what extent the state can be held responsible for the health of citizens and the practice of medicine. Critics of the welfare state argued that it had led to passive and dependent individuals relying on care from the cradle to the grave and to an overloaded bureaucratic system that was no longer affordable in a competitive global economy. Praising the benefits of market dynamics, neo-liberals created a strong feeling that the state should withdraw from the social domain. In many countries collective arrangements were being critically reconsidered, reformed or transferred to 'the market'. Rationalisation and commercialisation brought in managers taking over control from professionals, creating new bureaucracies that to a large extent withdrew from democratic supervision.

Neo-liberalism not only affected the financing and organisation of health care, but had other political implications as well. With respect to citizenship, it shifted the emphasis from collective solidarity to individual responsibility, from rights to obligations, and from passive entitlement to active involvement. The redefined concept of citizenship, stressing individual autonomy and rational self-interest, suggests that health should be within the control of the individual. The state will be unable to guarantee adequate health care, the neo-liberal argument runs, if citizens do not act responsibly with respect to their own health and that of others. Attempts to curtail direct state intervention in the organisation and funding of collective health care, however, have not diminished political interference with public health. The last decades have witnessed 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, overeating, unhealthy foods, lack of exercise, polluted environments, sun-bathing, stress, and international migration and tourism. People are being warned of unhealthy lifestyles and admonished

to change them. They are urged to have themselves vaccinated for contagious diseases and periodically screened for cancer and other ailments. Public health not only engages the interests of individuals and the state, but also the responsibility of citizens towards each other with regard to the possible unhealthy and polluting effects of their behaviour and consumption. For this reason, for example, smoking has been banned from many public places. One may wonder whether citizens have the democratic right to lead unhealthy lives, and the question has been raised whether they are still entitled to the benefits of collective health insurance if they do so.

Recent developments make clear that 'health' and 'citizenship' are elusive categories that are time and again redefined, negotiated and disputed. We believe that they also should be historically analysed, as this volume attempts to do. Current debates about health care as well as about citizenship can be understood against the background of a process that originated in the late eighteenth century, when the contours of modern liberal democracy as well as of scientific medicine emerged. Since then, certain questions about the connection between health and citizenship have surfaced time and again and they are still relevant.

Can health be considered as a civil right and what does such a right mean? The right to remain free from state intervention or the right to collective arrangements in the field of health care? Where lies the boundary between medical treatments that should be covered by them and those to be excluded? Given the fact that democratic citizenship not only involves entitlements, but also responsibilities and obligations, can health or the prevention of illness and a healthy lifestyle be imposed on citizens as a civic duty? To what extent is the state allowed to interfere with the (private) lives of its citizens? How should the responsibilities of state, civil society, the medical professions and individual citizens be delineated? How do collective health care arrangements, professionalism and democracy relate to each other? Is health a precondition for the realisation of citizenship and to what extent is citizenship a precondition for health? Should the state deal with morally controversial biotechnological developments and related medical treatments? These are the leading questions in this volume.

Our call for a reflection on the changing relationship between health and citizenship does not imply the claim that knowledge of the past leads to clear-cut answers for the present. This volume does not intend to 'solve' current socio-political problems - as products of their age such solutions are always provisional and politically disputed - but rather to analyse the connection between health and citizenship historically and thus put contemporary debates into perspective.[4] We also suggest that health care is entwined with national traditions of state craft and citizenship. With this volume we want to develop not only a historical but also a comparative perspective. By soliciting chapters about five different countries (Great Britain, The Netherlands, Germany, Belgium and France), we hope to throw light on the way in which their health care cultures and systems were influenced by national models of citizenship.

This introduction offers a general outline of the relationship between models of citizenship on the one hand, and the definition of health and illness and the practice of health care on the other. We will first explain why the linking of health and citizenship is relevant for medical historiography and might offer a new perspective on familiar subjects. Secondly, we will elaborate on the concepts of health and citizenship and demonstrate that they are essentially contested and historically layered concepts. Thirdly,

we will offer an historical overview of the changing relation between (public) health and citizenship from the late eighteenth century until the present. Fourthly, we will conclude by returning to recent developments and problems in public health and medical ethics.

Health and citizenship in medical historiography

Whereas studies by historians and political scientists on citizenship are manifold, the concept has hardly been applied explicitly in medical history. Medical historians who have worked on the development of public health and health policies, have not systematically explored the relation between health and citizenship. When they did examine it (usually implicitly), their narratives tend to be one-dimensional as well as teleological. Older, presentist historiography of public medicine suggests 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.[5]

More recent work in the field is influenced by a Foucaultian perspective, according to which the interlocking of (scientific) knowledge and (professional) power resulted in the disciplining of bodies and minds. Michel Foucault and his followers argue that the modern idea of health was historically constituted when medicine and the human sciences delimited the normal and the abnormal. The medicalisation of social relations turned what was considered as deviance into pathology. As exponents of an anonymous 'biopower' and 'governmentality', physicians played a key role in imposing social order and conformity.[6] From a similar angle sociologists such as Eliot Freidson and I. Zola have focused on the strategies of physicians to expand their field of action by 'medicalising' individual as well as social problems. Doctors were enabled to dominate the health care system because the state had granted them a large degree of professional autonomy in matters of (public) health.[7]

To a lesser extent, the history of public health has been inspired by Norbert Elias' theory of the civilising process. The essence of this process is the shifting balance from external social constraint towards internalised self-control and it is brought about by functional specialisation, social differentiation, lengthening chains of interdependence between more and more people and changing balances of power between social groups. In this view, the growing preoccupation with health and the introduction of collective arrangements are explained in terms of civilised manners, which the middle class supposedly imposed on the labour class and which were gradually also adopted by the lower orders. While the Foucaultian and professionalisation perspective stress the disciplinary power of the medical profession, the Elisian view emphasises that the spreading and internalisation of health norms was a consequence of changing social relations in society as a whole.[8]

Despite their differences these approaches all focus on the interplay of social coercion and rational (self-)control as the fundamental characteristic of modern liberal-democratic society. Without rejecting this viewpoint altogether, we feel that it is one-sided and incomplete. Medicine indeed became increasingly involved in social issues, but its impact on society was differentiated and diffuse. By including the development of citizenship, we would like to draw attention to the complications and ambiguities in the changing interaction between medicine, professionalism, state-intervention and politics.

The expansion and socialisation of medicine in the course of the last two centuries should not be interpreted as an inevitable and one-linear development. Neither was medicine a uniform and overpowering social force that imposed its definitions and practices on society. The health policies of voluntary organisations and the state did not always accord with each other, and they might conflict with the ambitions and interests of the medical profession and other social groups.

By focussing on the role of citizenship with respect to health (care), we attempt to shift attention from the social control perspective to an outlook that acknowledges human agency, and that redresses the balance between repressive and empowering effects. The development of modern medicine and public health was intertwined with the rise and expansion of democratic citizenship and civic participation. Their relation was one of conflict and restraint as well as mutual facilitation. 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 relieve social tensions and protect and advance individual rights. Medical knowledge, which has increasingly multiplied in a large diversity of scientific and popular viewpoints on health and illness, was not only deployed to further the power of the medical profession, insurance companies, pharmaceutical industries, state agencies and welfare bureaucracies. Information about health and illness has also increasingly been used by voluntary associations, social interest groups, patient organisations, and individual citizens for their own purposes. As citizens, individuals should not be considered as passive victims of a monolithic and controlling medical juggernaut, with no other choice than to conform to its dictates. Citizens may play an active role in defining health and illness and in utilising regular or alternative health care services.[9]

Health and citizenship as contingent and contested concepts

Health and citizenship are ambiguous and multiple-layered concepts. Both are open to a variety of definitions and interpretations. Their meaning as well as the connection between them are historically contingent and embedded in changing socio-political frames of thought, debate and practice, which not only reflect, but also shape their social realities. The contemporary debate about citizenship as well as about health care, for example, is closely linked with neo-liberal and neo-conservative criticism of the welfare state and of the controversial socio-political legacy of the 1960s and 1970s. Health and citizenship are essentially contested concepts: their definition and application are not self-evident, but always open for debate, negotiation and strife. Only a historical survey of the changing connotations of health and citizenship can shed light on their diverse meanings and shifting mutual relationship. Together, they relate to key-issues like life and death, collective and individual well-being, independence and dependence, coercion and liberty, social solidarity and individual responsibility, public and private, professionalism and self-help, and humanitarianism and technocracy.

It is difficult to give an unambiguous definition of health, not only because it involves an array of aspects that no single description can fully cover, but also because the term can be used in both a descriptive sense and a normative one. As a concept, health may refer to a particular state of affairs as well as to specific ideals to be pursued. The simplest definitions describe health as the absence of disease or as the unimpeded

physiological functioning of a body, enabling life's basic biological functions such as survival and reproduction. Such definitions, however, have been criticised as too limited and biologically reductionist. They have been replaced by broader descriptions that incorporate values concerning people's social functioning, reflecting a shift from preserving towards optimising health in the sense of, as the World Health Organisation has defined it, 'a state of complete physical, mental and social wellbeing.'[10] As such health not only refers to the ability to cope with everyday life without being hindered by some physical or mental malfunctioning, but it may also apply to the individual capacity to carry on in society and realise specific goals in life.

From the eighteenth century onwards, the elastic meaning of health has been expressed in the tendency to interpret more and more aspects of life - such as education, reproduction and sexuality, mental and behavioural disorders, addiction, criminality, labour relations, lifestyle, diet, and family life - in medical terms. In the process, health came to be associated with the bourgeois catalogue of virtues, in which such notions as individual independence, self-sufficiency, self-control, responsibility, soberness and moderation, regularity and order, willpower, industriousness, achievement, utility, thrift, investment, cleanliness and moral purity occupied a prominent place. These qualities were geared to a controlled and progress-oriented life. As an essential precondition for optimal productivity, health in particular represented economic value. Partly as replacement of the Christian ideal of salvation, the idea gained currency that health was a good that could be actively pursued, not just by the individual but by society as a whole. Enlightenment thought assumed that advancing scientific knowledge of disease would automatically lead to the control of the human body and behaviour in such degree that overall health would improve. The pursuit of medical knowledge was considered to be an ethical and also political imperative grounded in the rational explanation of nature.

From the eighteenth century onwards, health and hygiene were essential ingredients of the bourgeois ethos and identity. They embodied key values with which the rising middle class distinguished itself from aristocratic idleness, frivolity and decadence, as well as from lower class' disorderly conduct and debauchery. Health was associated with cleanliness and moral purity, whereas sickness was linked to dirtiness and depravity. As such, health represented the opposite of the way of life and attitudes of the poor and working class, whose irrational, impulsive, undisciplined, and intemperate behaviour could only lead to endemic diseases. Whereas the aristocracy had asserted the exclusive character of its blood and the antiquity of its ancestry in order to maintain its status, members of the bourgeoisie stressed the health and vigour of their body and progeny.[11]

The political-philosophical roots of the middle-class health ideology can be traced back to the ideas of Thomas Hobbes (1588-1679) and John Locke (1632-1704).[12] Hobbes distinguished two bodies: the natural body of the individual and the man-made body politic, the state. By nature a human being, according to Hobbes, is driven by a restless pursuit of lust and the avoidance of discomfort, giving rise to a continuous urge for power and, given the scarcity of means, a struggle of all against all. This 'natural state' was ended because in the interest of their own safety people of their own free will surrendered the right to use violence to a sovereign, thus eliminating the war of all against all. Thus Hobbes formulated the liberal notion of the social contract and of fundamental civil rights. As he argues, the body is owned by the individual self, who possesses the

inalienable right to protect it from pain and death, to sustain it and keep it in optimal condition.

Hobbes' notion of possessive individualism has been elaborated by Locke. He conceptualised not only possession of one's body, but also that of material goods as an inalienable individual right. This right to material possession followed from the right to possession of one's own body: what the body produces by means of labour, Locke argued, is the rightful property of the person who owns that body. In his view, individuals not only own their body and the products of their labour, but their thoughts, feelings, acts and experiences as well. Locke was one of the first to formulate the idea of a self-contained and continuous self as the essence of the individual. His *Essay Concerning Human Understanding* (1694) marks the conceptual transition from the Christian soul that is part of a supernatural order to the secular self as a self-reflective monitoring agent who considers his own inner life and outward behaviour.[13] Locke's view of the autonomous and self-responsible person is closely linked to his political doctrines, which hold that society is an aggregate of separate individuals rather than a collective entity. The state, founded on a rational and voluntary contract, is to protect the fundamental property rights of (male) individuals and not interfere in their private lives. Individual autonomy and freedom should be guaranteed, so that citizens can freely develop themselves. Possessive individualism was the core liberal value driving people to improve themselves and fulfil their potential, bringing about social progress in the process. As such, it was the basic principle underpinning liberal thought on citizenship as well as health.

The meanings of citizenship are at least as diverse as those of health and even more contested. Since the 1980s, citizenship has become a fashionable concept all over the political spectrum through which dissatisfaction with specific developments in present society are articulated and certain solutions are put forward. Several social and political issues have been formulated in terms of citizenship: the crisis of the welfare state, ongoing individualisation and the presumed loss of social cohesion, growing ethnic and cultural diversity, the declining trust in parliamentary democracy, and globalisation. Discussions focus on the supposedly disturbed balance between rights and duties. All suggested solutions tend to take the direction of a revitalising of civic virtues, which are defined in terms of individual autonomy and self-reliance as well as of active involvement and social obligations.

In general citizenship is about what draws individuals together into a political community and what keeps that allegiance stable and meaningful to its participants. The sociologist Bryan Turner has broadly defined citizenship as 'a set of practices which constitute individuals as competent members of a community' and which 'over time become institutionalised as normative social arrangements'.[14] This overall definition can be specified by pointing to three basic constituents of citizenship, the liberal-democratic ideal in particular. First, citizenship has to do with rights and entitlements granted and guaranteed by the state on the one hand and with responsibilities and obligations towards the state on the other. Second, citizenship is about political and civil participation on the basis of a combined sense of individual autonomy and public commitment: it presupposes a capability of self-direction that is irreconcilable with subordination and dependence. Third, citizenship refers to the more or less enduring allegiance between the individual

and civil society, the social space of free association that is separate from the state, the market and the private sphere.[15]

The best way to clarify the notion of citizenship is by outlining its various historical forms in the Western world since the Renaissance. Overall, citizenship is a result of a modernising process that replaced local, fixed and hierarchical patterns of membership in family, feudal and corporate networks with more abstract, flexible and egalitarian conditions of social belonging on a larger scale. The first forms of self-government emerged in autonomous towns, in which the public space of the Greek *polis* as an arena of debate for independent men served as a venerable model. The rise of modern liberal citizenship, which was inspired by the Enlightenment idea of the 'natural rights' of man, was a consequence of the centralisation of states and their expanding influence on society. These provoked a growing sense of solidarity among their subjects and the assertion of their common rights vis-à-vis the government. Centralisation and democratisation went hand in hand: the revolutionary conflicts from the late seventeenth century on gradually transferred sovereignty from the body of the monarch (based on divine right and tradition) to the body politic of his subjects (based on a social contract), transforming dynastic states into nation states. The liberties granted by the state and the consensual means of governance following in their wake had to be actively secured by citizens. The implementation and expansion of rights - with respect to the number and range of legal, political and later also social rights as well as to the number and range of people who were entitled to them - was realised through political activism and struggle. The reverse implication of this democratisation of citizenship was the growing interference of the state in society.

Ideal-types of citizenship

The contours of citizenship took shape in the field of tension between freedom and equality, rights and duties, individual autonomy and the common good, uniformity and diversity, state and society, state administration and self-government, inclusion and exclusion, and active (civic) and passive (civil) involvement. Passing over different national traditions, roughly five ideal types of citizenship, partly successive, partly overlapping, can be distinguished in Western history since the Middle Ages: (1) classical republican citizenship, defined by self-government and civic virtues; (2) classical liberal citizenship, stressing civil rights against intrusion by the state; (3) liberal-democratic citizenship, centring on political rights, in particular suffrage and political representation; (4) social-liberal and social-democratic citizenship, through which welfare entitlements are granted; and (5) neo-republican citizenship, that emphasises civic responsibilities and obligations.

Classical republican citizenship, the early-modern interpretation of the Greek ideal of the *polis*, implied that citizens are both governors and governed and it stressed civic virtue, the obligation to serve the state. Republican citizenship was not only defined by administrative and military duties, it presumed undivided loyalty and total patriotic commitment. The republican ideal conflated state and citizenship and it subordinated personal life and economic endeavours to the public cause. It was not a democratic right, but an exclusive, honourable status. Only independent, propertied and reasonable men qualified as full citizens. To the extent that this ideal was realised, the location was the small-scale city-state, in which only privileged males could dedicate themselves to

politics. Only during the Jacobin phase of the French Revolution did the republican ideal serve as a model for citizenship on a national scale. Jacobinism prescribed citizenship as the patriotic identity of every adult Frenchman as opposed to alternative identities connected to one's family, estate, region or religion. Efforts to realise this ideal, however, involved coercion, civil war, and terror.

Classical liberal citizenship, entailing civil rights on a national scale, emerged in the late eighteenth century as a product of the Enlightenment ideal of natural, inalienable human rights, as proclaimed in the American *Declaration of Independence* (1776) and the French *Déclaration des droits de l'homme et du citoyen* (1789). They established the basic civil rights of individual freedom against unlawful intrusion by the state, such as the integrity of the person, the private sphere, and property, equality before the law, and freedom of religion, thought, speech, press and assembly. Liberal citizenship is based on the Lockean notion of the free and independent human being, who should be able to create his - not yet her - own destiny. Although it also refers to membership of a particular state, it is first and foremost about individual freedom and equality of opportunity. Liberalism stresses the importance of 'negative freedom': the right of citizens to be protected against improper interference by the state or third parties. Neither the state nor any other institution should be able to impose any particular vision of the good life or collective purpose. As long as individuals did not intrude upon the rights and liberties of other citizens, they should be free to determine their own ends. Whereas republican citizenship was exclusive and stressed active duties, liberal citizenship was inclusive and largely relied on the passive enjoyment of rights. Another difference is that the latter is only a partial state: whereas republican citizenship had absorbed the person in its totality, liberal citizenship only conferred legal status. In liberalism, the state and politics are not goals in and for themselves, but rather the instruments that should safeguard the individual's autonomy and self-development in private life, civil society and on the market.

However, classical liberal citizenship still resembled its republican predecessor to the extent that political rights and participation were still exclusive and elitist. For the better part of the nineteenth century suffrage and eligibility were restricted to the minority of the male population that met certain requirements of property, independence, and education. The granting of political rights was geared to the liberal values of possessive individualism and independent contractual exchange. Women were excluded from political citizenship (and to some extent even from full civil citizenship), and the same was true for lower middle-class and working-class males – to say nothing about the poor, colonised peoples or, in the United States, black slaves. 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. Universal suffrage and eligibility established the right of all adult citizens to have access to the parliamentary process and be represented in government. This was the outcome of the struggles of the labour and feminist movements, of the introduction of a comprehensive national system of education, of mass-mobilisation during the First World War and - last but not least - of the response of the governing élites to the threat of revolution. They tried to counter massive upheaval by granting political and also, to an increasing extent, social rights, in return for co-operation and national integration.

Social-liberal and social-democratic citizenship originated in the late nineteenth century and, through the workings of the welfare state, matured in the second half of the twentieth century. This form of citizenship involves entitlements (and obligations) that concern economic and social security, including income, education, health, and welfare. Such entitlements, in particular income-guarantees in case of sickness, disability, unemployment or retirement, provided formal rights with a material foundation. Social citizenship was the answer to the contradiction between liberal ideals (individual autonomy and opportunities) on the one hand and capitalist realities (social and economic inequality) on the other. The argument underpinning social citizenship is that civil and political rights can only materialise when there are no social and economic impediments to their exercise. Social security, welfare assistance, state-funded education and collective health care arrangements are put in place in order to mitigate socio-economic inequalities induced by the free market. The main goal of the various emancipation movements emerging from the late nineteenth century onwards was to remove obstacles blocking the realisation of citizenship for disadvantaged groups: first the working class and women, and later, from the 1960s on, also youths, ethnic minorities, homosexuals, the handicapped and patients. The 1960s protest movement and other emancipation movements of the 1960s and 1970s can be seen as a continuation of the development of liberal-democratic citizenship, embracing now an array of social institutions and also what until then had been considered as the private sphere. Unequal relations of power in society as a whole were questioned and politicised. There was a strong belief that the welfare state would fully realise the egalitarian and integrative potential of democratic citizenship and thus enable all people to participate in civil society and politics.

The most recent model of citizenship, the neo-republican one, evolved from mounting neo-liberal and neo-conservative criticism of social citizenship. In the 1980s and 1990s, debates on citizenship centred on the presumed decline of civic virtues in Western democracies and they marked the end of the tacit post-war consensus, which had been articulated most clearly by the British sociologist T.H. Marshall in his *Citizenship and Social Class*.[16] Defining equality as the core value of democratic citizenship and considering liberalism as its starting-point, Marshall distinguished three historical phases in its development: civil, political, and social citizenship - as discussed above - which were institutionalised in constitutions and law courts, in parliaments, and in welfare arrangements respectively. According to Marshall the history of modern citizenship is basically a progressive extension of rights. After the gaining of civil liberties and universal suffrage, the realisation of social rights constituted the pinnacle of democratic citizenship. The welfare state would guarantee the well-being and full participation of all citizens in society. Social security, universal education and comprehensive health care would eventually remove all inequalities that hampered individual emancipation and civil participation.[17] Marshall postulated a fundamental antagonism between citizenship and capitalism. Although capitalism had generated individual freedom and high standards of living, full citizenship in the sense of equal opportunity for all could only be realised through the domestication of the market-economy by the state.

Marshall's social-democratic model, which formed an influential paradigm for the post-war welfare state in Western Europe, came under pressure from the early 1980s on. Critics, ranging from neo-liberals and neo-conservatives to feminists, communitarians and political theorists, argued that his model was inadequate, both for understanding the

historical development of citizenship in different countries and for meeting the challenges contemporary Western democracies were facing. Marshall's account of the development of citizenship in terms of succeeding phases and linear progression seems to be modelled on the British example and hold true for countries like France, the Netherlands, and Belgium as well, but it does not apply to countries like Germany and the former communist world.

In Germany the absence of a successful bourgeois revolution and the incorporation of the middle class and the working class in the nation from above by an authoritarian government, resulted in a superficial realisation of political citizenship and a significant implementation of social citizenship. Neither Nazi Germany nor the Soviet Union and other communist countries provided substantive civil and political rights, but social citizenship was developed to a large extent. This suggests that the establishment of social citizenship before the full realisation of civil and political rights may obstruct the development of civil society and democracy. Neither does Marshall's model reflect the development of citizenship in the United States. American citizenship, rooted in the classical liberal notion of possessive individualism with its connotations of independence, self-interest, and contractual exchange, continued to be centred on civil and political rights and duties. As far as an American conception of social citizenship exists at all, it focuses on obligations to the community rather than welfare entitlements. Welfare and social work are associated, not with civil rights, but with voluntary and private charity implying altruism, unilateral gift-giving and getting something for nothing.[18]

Marshall's story is basically about liberation from oppression and deprivation, and the political struggles to obtain, extend and give substance to formal rights. However, as his critics point out, these rights have largely been articulated as passive entitlements while the other side of democratic citizenship, participation in public life and taking on social obligations, has been neglected. Marshall did not address questions about the relation between rights and duties and about the intrinsic quality of citizenship in terms of competence and responsibility.

The crisis of the welfare state prompted the neo-liberal attack on social citizenship, first in United Kingdom under Margaret Thatcher and in the United States under Ronald Reagan, and later in other Western European countries. The economic crisis of the 1970s and early 1980s and the growing volume of beneficiaries undermined the solvency of the welfare state. In the decades that followed it became the object of recurrent political controversy. Critics asserted that the welfare state was dysfunctional, both in its economic and in its welfare effects. It was trapped in a cycle of rising expenditures, taxes and wage costs, an overloaded public sector, decreasing entrepreneurial incentives and economic investments, and an increasing exit rate from the labour force because of unemployment, early retirement and the massive distribution of employment disability allowances. Welfare provisions were not liberating, they added, but rather kept beneficiaries tied in dependence and strangled individual initiative. Also, more and more citizens – calculatedly or not – were abusing the welfare system. The sense of civic responsibility necessary to sustain the welfare state appeared to be crumbling. At the same time the welfare state had not removed poverty and social marginalisation, but contributed to the rise of a dependent underclass and social disorganisation. Such, in neo-liberal eyes, were the perverse effects of the rights-based, 'duty-free' practice of social citizenship that the welfare state had engendered.

The legitimacy of state-guaranteed social rights was also challenged on the basis of classical liberal principles. State intervention in social-economic life, which entailed that governments embraced certain values regarding how people should conduct their lives, was considered to be fundamentally at odds with the formal task of the state as a neutral arbitrator, which should restrict itself to upholding the law and securing civil and political rights. By blurring the boundaries between state, society, and the private sphere, the welfare state became an overloaded apparatus for satisfying an endless array of personal demands and transformed responsible citizens into demanding welfare clients. Moreover, welfare from the cradle to the grave involved a state with paternalistic dimensions. Increasing bureaucratic regulation and tutelage by the helping professions threatened basic civil liberties and resulted in dependency and demoralisation.

Neo-conservatives and communitarians backed up the neo-liberal rejection of social citizenship. In their view, the extension of welfare benefits in combination with the 1960s liberation movement had bred selfish, irresponsible and consumerist individualism. The result was an erosion of social cohesion, public morality, and civil manners, while citizenship had degenerated into passivity: between elections, citizens had become spectators of rather than active participants in the democratic process. Moreover, democracy was undermined by declining political participation, growing voter-apathy, decreasing membership of political parties and social organisations, and growing ethnic and religious diversity. Similar concerns, which were increasingly shared by representatives of the political left and advocates of participatory and deliberative democracy, became even more pressing in connection with concern about the continued existence of a marginal 'underclass' which had grown and diversified as a result of mass immigration from the underdeveloped countries. Even in the welfare state many people were suffering from poverty, unemployment, bad health, and educational deprivation. Lacking autonomy, self-reliance and the social skills required for full participation in modern society, they could hardly be considered as full citizens. In addition feminists suggested that Marshall's concept of social citizenship still presumed a definition of politics as distinct from the private sphere of the family and a patriarchal approach to women. To a large extent, they argued, social security arrangements were geared to the traditional family: women, in their unpaid caring role of housewife and mother, depended on male wage-earners (or welfare recipients) and were thus designated a position as second-class citizens.

Criticism of Marshall's model was boosted by socio-economic and cultural changes in the Western world from the 1970s. The growing complexity, fragmentation and variability of the social fabric as a consequence of economic liberalisation and globalisation, the pluralisation of individual life-styles, and cultural and ethnic diversity, affected the transparency of society and the belief in social engineering, on which the welfare state was based. The post-war welfare state was built on a more or less socially integrated and culturally homogeneous nation state, which had a large degree of control over a largely nationally organised and industry-based economy. Further, the gender-division of labour between male breadwinners and female caretakers in the family was taken for granted. Economically, the emphasis shifted from the manufacturing industry to high technology, information, and services. Socially, alongside the traditional family, a plurality of alternative living arrangements evolved, which together with the ongoing process of individualisation and emancipation of women, resulted in stronger claims for

economic independence of individuals. Globalisation and European integration as well mass immigration and increased ethnic and cultural pluralism affected the autonomy of and the loyalty to the nation and also the homogeneity of its culture. Cultural and religious heterogeneity have shaken the experience of shared citizenship.

In the 1980s and 1990s, a new ideal of citizenship was articulated in public debates by politicians as well as political and social scientists. This neo-republican model came down to a revitalisation of liberal-democratic citizenship by infusing it with elements of the older republican ideal of active citizenship. It implies that the resilience of modern democracy depends on the attitudes of citizens, the mutual engagement of the state and its population, and the vigour of civil society. Shifting the emphasis from social rights and benefits to duties and responsibilities, the new ideal focuses on the intrinsic quality of the practice of citizenship. Under the banner of 'civic-mindedness' it refers to an ensemble of social abilities and public virtues: independence, self-control, reasonableness, open-mindedness, the capacity to discern and respect the rights and opinions of others, tolerance without being indifferent, social and political participation, and 'civil' behaviour in the public sphere.

To these virtues neo-liberal and communitarian merits were added. In the neo-liberal perspective, dominated by economic considerations and a strong belief in the benefits of a free market, citizens should be self-supportive and self-reliant, while the state should limit itself to facilitating private initiative, enterprise, labour force participation, and education. Communitarians deny that these neo-liberal tenets are sufficient for realising good citizenship. Rejecting naked self-interest and fearing social atomisation, they hold that individuals are dependent on communities sharing a common basis of togetherness and accountability. Apart from conservative norms and values such as law and order and the work and family ethic, they stress the significance of community-spirit and mutual assistance and care as civic virtues. Communitarianism is guided by the idea that the democratic public spirit can only be realised by active participation in civil society. While the role of the state is minimal in neo-liberal ideology, it is quite significant in the neo-republican and communitarian approach, making it acceptable to social democrats as well. The state should not just constrain the market and set the basic rules for civil society in order to prevent disproportional inequality and dependency. It should also create the preconditions for the development of active and competent citizenship, for example through teaching civic virtues and democratic values in schools, mandatory national service for youths, projects aimed at the cultural integration of ethnic minorities, and the advancement of responsible and healthy lifestyles. At the same time welfare benefits have been trimmed and continue to be trimmed down, and social rights are balanced by more duties and obligations than before. The welfare state has embarked on a new course by replacing 'passive' social security rights with more participatory structures. Absorption into employment, the work ethic, flexibility and mobility in the labour market, continuing education, and the incentive to develop one's talents and abilities as well as one's health to their fullest extent, are key elements in new welfare regimes and the neo-republican ideal of citizenship. These policies have been accentuated as a consequence of the financial and economic crisis since 2008, which has put the tenability of the welfare state to the test.

In the next four sections, we will discuss the implications of shifting models of citizenship (respectively the classical liberal, liberal-democratic, the social-liberal or

social democratic, and the neo-republican ideal type) for health and illness from the late eighteenth century to the present.

The birth of liberal citizenship and public health

Although the body politic and the natural body had been metaphorically associated with each other since Antiquity[19], traditionally medicine was mainly individual and private rather than collective and public as well as curative rather than preventive. There had been some state supervision and intervention in the sphere of medicine since the Middle Ages. In response to recurrent plague epidemics and in order to cope with the sick poor, (city-)governments had taken a variety of incidental measures, such as quarantine and *cordons sanitaires*. Medical practice was often regulated in state-licensed corporate organisations and physicians and surgeons were called upon in times of emergency such as war or, as forensic experts, in the administration of criminal justice. However, for the most part medical practitioners were self-employed and patient-doctor relations generally involved a personal contract or charity on an individual basis.

The private character of medicine continued to a large extent in the nineteenth and twentieth centuries, but from the end of the eighteenth century onwards, health care was also explicitly defined as a public issue and as a part of state policy. The political dimension of health and disease took shape against the background of the growing role of the state in the pursuit of a rational and efficient organisation of society, an aspiration that was intensified by the secular optimism of the Enlightenment and the French Revolution. Foucault has characterised this new policy in terms of 'governmentality' and 'biopolitics'.[20] While traditional political regimes legitimised themselves through legal and religious arguments for sovereignty and the aim of rulers was to keep or augment their personal power, modern government consisted of the rational control and calculated management of a country's natural resources, population, and economy. In traditional regimes the exercise of power was 'negative' with rulers affirming their sovereignty by taking the possessions and lives of rebellious subjects. The modern employment of power, on the other hand, was 'positive': it set out to control and regulate human life in order to improve the quality of the population in general and the labour force in particular. This implied that the advancement of the health of both individuals and the population as a whole was considered as a precondition for increasing the strength and productivity of a country.

The concept of 'medical police', introduced in some absolutist central-European states and adopted by Russia, Austria, Hungary, Denmark, and Italy in the late eighteenth century, represented the first governmental attempt to establish a permanent public health policy. The classic formulation was the six-volume *System einer vollständigen medicinischen Polizey* (1779-1819), published by the physician Johann Peter Frank. He proposed that medical councils made up of civil servants and physicians be charged with the supervision of the health of the population and the prevention of contagious diseases. All this was part of the enlightened despotic project known as cameralism, which aimed at the centralisation and rationalisation of administration. By surveying all relevant physical and social living-conditions as well as individual habits with the help of systematic registration (statistics), an orderly and healthy society would be promoted in the interest of the state. Since in practice the means for implementation - financial and

otherwise - were lacking, medical police was to remain a blueprint rather than a reality. Moreover, the project was conceived as part of a benevolent yet paternalistic instrument in the hands of autocratic rulers without engaging their subjects as active citizens and therefore it lacked backing by relevant groups within society itself.[21]

More long-lasting was the impact of the Enlightened philosophy of natural rights and popular sovereignty as well as the liberal-capitalist doctrine of possessive individualism, stressing self-help and civic improvement. The Enlightenment belief that science and technology, through the rational control of nature and society, would bring about a better future implied optimism about progress in medicine and health care. The Enlightenment *philosophes* located morality within nature rather than in a Christian spiritual realm. Some compared themselves to physicians: as anatomists and radical diagnosticians of state and society, they would be able to analyse social and political pathologies and indicate a cure. Many were convinced that unspoilt human nature offered the foundation both for moral behaviour of the individual and for harmonious relations between the individual and society. In the context of the emergence of a science of man, physicians began to consider health and disease in terms of the interconnectedness between the individual, his living environment and society as a whole. Such ideas brought a closer rapport between health politics and the emergent bourgeois civil society. In France, Great-Britain and the United States, the concern for public health was advanced by democratic impulses as well as by the economic rationality of possessive individualism and utilitarianism.[22]

During the French Revolution health care was discussed as a political issue. The Constituent Assembly committees on poverty and public assistance targeted illness as one major cause of poverty and proclaimed 'that society owes the ailing poor assistance that is "prompt, free, assured, and complete."'[23] Rejecting traditional Christian charity and advocating scientific efficiency in the service of patients, in 1791 medical reformers proposed public health programs and a national network of medical practitioners. Medical benefits would not only entail rights for citizens, but obligations as well: participating in medical interviews and physical examinations; fulfilling doctor's orders; following a healthy regimen and hygiene; undergoing preventive measures such as vaccination; and allowing autopsy of dead bodies in the interest of medical science. The basic idea was that the health of the nation ultimately depended on the responsibility and compliance of 'citizen-patients'. Motivating them to keep and restore their health was part of a wider advocacy of revolutionary civic virtues like self-respect, public commitment, respect for other citizens and national solidarity.[24]

The far-reaching revolutionary plans for public health care, however, came to nothing because of lack of money and expertise, political strife, the exigencies of war, and - perhaps surprisingly - because of opposition by physicians. Fearing to become (underpaid) civil servants, they insisted on the individual relationship between doctor and patient. They prioritised reform of medical education and the organisation of their profession over the creation of a public health system, creating what has come to be known as 'the Paris school of medicine'. The revolutionary achievements in medicine included the replacement of traditional corporate rights, privileges, and monopolies by licensing based on meritocratic principles; the innovation of medical education along clinical lines; and the organisation of a new type of hospital in order to advance medical teaching and research along the lines of bed-side observation, systematic scientific

analysis, pathological anatomy, and the use of new diagnostic techniques. The French Revolution also entailed major reforms in the care for the insane. Replacing the fatalism of moral and religious views of insanity with an ameliorative medical approach, Philippe Pinel was one of the founders of modern psychiatry that sought to cure and rehabilitate the insane in the context of the new therapeutic facility set up to that end, the mental asylum.[25]

Even though the revolutionary ideal of the 'citizen-patient' was not realised, the link that was established between health and citizenship was to become a reference point during the nineteenth century. Reform plans were to a large extent inspired by the so-called *Idéologues*, a group of physicians and philosophers who believed in the possibility to transform both citizens and society through medical knowledge and social hygiene.[26] Assuming that the physical, the mental and 'the moral' were interconnected, they demanded a central role for vitalist physiology and medicine in the development of a comprehensive science of man. The study of man in its totality, synthesising physiological and medical knowledge of the human body, passions, mind, and moral attitudes, should be grounded in the empirical methods of observation and inductive reasoning. The intellectual source of *Idéologie*, which was expressed most systematically in the works of the philosopher Antoine-Louis-Claude Destutt de Tracy (*Eléments d'Idéologie*, 1804) and the physician Pierre Jean Georges Cabanis (*Rapports du physique et du moral de l'homme*, 1815), was sensationalism. This radical form of empiricism held that sensations are the primary sources of human perception, knowledge, understanding, judgement, and behaviour.

Starting from the sensualist premise that the body and mind are both an integral part of nature, the *Idéologues* focused on the way human thinking and behaviour were determined by man's inborn dispositions, needs and capabilities as well as by his variable physical and social environment. Similarly, health and well-being were thought to depend on the interplay between individual nature, habit and living-conditions. Therefore, they claimed authority for physicians in many dimensions of human life. The organisation of society should be based on knowledge of how individuals, as interrelated physical, mental and social beings, functioned. Scientific information about bodily and mental operations would enable people to gear their behaviour to rational principles and improve their lives. Thus the science of man would replace tradition and religion as a moral standard and serve as a guide for good citizenship and the reform of society.

Believing in the perfectibility of man and society, the *Idéologues* embraced the revolutionary principles of individual liberty and equality of rights. They also supported the new republican order because its anti-clericalism encouraged free and unbiased scientific inquiry into the nature of man and society. Many of them were involved in revolutionary politics, but at the same time they feared the dangers of anarchy, ideological discord, uncontrolled collective violence and state terror, which were also part of the French Revolution. In their view the science of man was an important neutral instrument to establish and preserve social stability. The *Idéologues* shared the concern of the succeeding republican governments to foster fitness for good citizenship. Their common aim was the moulding of self-conscious and loyal citizens who would adopt the general will as their own and who would subscribe to the rational foundations of social harmony. The ideal citizen was the healthy, balanced and well-tempered individual, who,

through responsible and well-adjusted behaviour, contributed to the harmony and the progress of society as a whole.

The ideas of Cabanis and Destutt de Tracy about health as an issue of public policy inspired one of the founding fathers of the United States, Thomas Jefferson, and some political thinkers associated with him. They also came to believe that biological, social, and mental dimensions of man were interlocked, and that their development depended on social, economic and political conditions. The enjoyment of health was considered as a precondition for the complete enjoyment of civil liberty, which required a responsible and democratic government. According to Jefferson, despotic regimes bred ill health while democratic government was beneficial for health.[27]

Idéologie, which foreshadowed positivism, was not the only movement to construe a socio-political role for medicine. Inspired by French enlightened thought and against the background of the Industrial Revolution in his home country, the influential English philosopher of utilitarianism Jeremy Bentham also nourished far-reaching ideas about social reform in general and a politics of health in particular.[28] Like the *Idéologues*, Bentham was opposed to tradition and religion and he strongly believed in empiricism and the malleability of man and society. Bentham assumed that the principal human drive was hedonistic and egoistic: the avoidance of pain and discomfort and the striving after pleasure and happiness. A rational ordering of society should be based on scientific knowledge of human nature and of the practical ways to regulate behaviour in order to lead it in a social and moral direction. According to Bentham's hedonistic calculus the greatest happiness of the greatest number could be realised by making utility, a rational measure for right and wrong, into the dominant ethical principle and by introducing social engineering along the lines of secular and economic efficiency.

Bentham attributed a prominent role to medicine - in his view the first human science that had successfully adopted the empirical method of natural science - in his utilitarian reform projects. Considering a politics of health as an indispensable element in the advancement of social progress and harmony, he compared medicine to legislation and the administration of justice. Just as the doctor cured the individual body using a scientifically based treatment, which was attuned to the type and seriousness of the disease, the judge healed the social body by his balanced verdict, which should be proportional to the character and seriousness of a conflict or a crime. Both had essentially the same purpose: fighting grief and promoting the greatest happiness for the greatest number. Further, medicine and criminal justice resembled each other because of their potential preventive effects. Impressed by Edward Jenner's claim in 1796 that smallpox could be prevented by vaccination with cowpox, Bentham advocated various public health measures like fighting filth and poverty, providing clean air and water, and improving labour conditions. In this context Bentham also pointed to the need of statistical registration of the population: creating transparency in society was a precondition for efficient surveillance and state intervention. As such, it was in line with his design of the *Panopticon*, the architectural structure he advocated as a model for prisons, poor houses, work houses, factories, mental asylums, hospitals and schools.

Bentham's historical reputation has been coloured to a large extent by Foucault's depiction of him as the architect of the surveillance society. The *Panopticon* has become infamous as the quintessential machinery for the connection of knowledge to power, resulting in the disciplining of bodies and minds and a chilling economic efficiency.[29]

However, selectively focusing on the repressive effects of the *Panopticon* does not do justice to Bentham's work, which was largely inspired by democratic aspirations. Initially, he had assumed that social reform could be brought about by appealing to the reasonableness and benevolence of established authorities. However, when they disappointed him he grew convinced that the interests of traditional rulers and their subjects were in opposition to each other. Although Bentham was not in favour of revolution and championed gradual change, he opposed the monarchy, the House of Lords, and the Anglican Church. He came to believe that freedom of information and debate, a considerable extension of suffrage, representative democracy, and active citizenship would pave the way for the greatest happiness for the greatest number. The state should not limit itself to keeping law and order, but should also guarantee a decent subsistence level and equality of opportunity. To Bentham, good health for the greatest number was not just an economic desideratum, but also a democratic achievement. In the mid-nineteenth century his approach made itself felt in the British sanitary movement and it would be echoed in appeals for medical reform on the European Continent. The socio-political involvement of medicine would affect and complicate the relations between health and liberal-democratic citizenship.

The sanitary movement and liberal-democratic citizenship

The Industrial Revolution and the emergence of a self-critical bourgeois civil society advanced social concern for the environmental causes of disease. The rise of the sanitary reform movement, first in Britain and France in the 1830s and 1840s, and later, from around 1850, in Germany, the Netherlands, and Belgium, was prompted by a combination of demographic, epidemiological, socio-economic, and political factors. The disruptive effects of a fast growing population, industrialisation and urbanisation entailed massive poverty, unsanitary living conditions, nutritional deficiencies, and new health hazards. Many people suffered from endemic diseases like smallpox, measles, rickets, tuberculosis, malaria, diphtheria, scarlet fever, typhoid, typhus, and infantile diarrhoea while cholera struck Europe in four lethal waves in the 1830s, 1850s, 1860s, and the 1890s. The growing fear of social disorder sparked off public and political responses. Governments were facing a growing pressure, not only from physicians, but also from other professional and interest groups (like engineers, lawyers, civil servants and statisticians) and public-minded citizens (philanthropists, moral entrepreneurs, evangelicals and feminists) to take responsibility for health matters. Together, they put public hygiene on the agenda as an urgent problem calling for collective action and state intervention. In the course of the second half of the nineteenth century several infrastructural measures were taken with respect to urban cleansing such as sewerage, drainage, water supply, and garbage collection. Public health laws were enacted, establishing national and local medical inspection boards and health councils, and introducing (compulsory) vaccination and inspection of dangerous trades, food supplies, public buildings, and private dwellings.[30]

Since the French Revolution, France had been the leading nation with respect to public health schemes. During the 1830s and 1840s however, Great Britain, the first industrial nation, set the tone in sanitary reform. Between the 1830s and the 1870s, a set of public health laws was enacted that was more comprehensive than legislation in any

other European country and any American state. This is remarkable, given the fact that the liberal philosophy of *laissez-faire* was strongest in the Anglo-Saxon world. In Britain, central government was relatively weak, while individualism and civil society were strong. Sanitary reform was initiated by voluntary private initiative springing from philanthropic impulses and utilitarian considerations about social efficiency and national improvement. The undisputed leader of the British sanitary movement in the 1830s and 1840s was Edwin Chadwick, a lawyer and former secretary to Bentham. Chadwick devised the new Poor Law that was enacted in 1834. Following utilitarian principles, it differentiated between the deserving and undeserving poor, between those being unable and those being able to work. Since deserving poverty appeared to be caused by ill health to a considerable degree, Poor Law medicine expanded in order to increase the numbers of the poor being able to work. A survey of the health of the working classes in England and Wales, published by Chadwick in 1842, suggested that the diseases of the poor were caused by environmental filth that generated putrid vapours, the so-called *miasmata*. Whereas traditionally, poverty and ill health were explained in terms of moral failings, Chadwick shifted the emphasis to the environment and the living conditions of the poor. His preventive solution, for which the operative slogan was cleanliness, was not so much medical as social and above all technical. In his view engineering was crucial for sanitary reform: the provision of clean drinking water, effective sewerage and drainage, paving, removal of garbage and filth from the streets, control of industrial effluents and offensive trades, the supervision of dwellings, and the establishment of standards of environmental and personal hygiene.

Chadwick's analysis was underpinned by statistical research mapping the distribution of disease and death, and correlating such biomedical data with various parameters like geography, class, income, age, sex, and occupation. The statistical 'biometer' – developed by the leading French sanitary reformer Louis René Villermé – came to serve as a standard for comparing health situations in various places. In the 1820s and 1830s Villermé had pioneered this scientific method by producing numerous socio-medical studies. Although his work also indicated that poverty and illness frequently went together, Villermé's solution differed from Chadwick's. It boiled down to the moral regeneration of the lower classes, civilising and disciplining them out of poverty through philanthropic benevolence and paternalism. Such an approach hardly lent itself for purposive state action. After the bourgeois July Revolution of 1830 leading sanitary reformers embarked on a new course by embracing liberal policies and positivistic social science.[31] Economic modernisation, industrialisation in particular, and administrative reform were considered important for the advancement of public health. During the revolution of 1848 physicians, who were partly inspired by Saint-Simonianism, were involved in attempts at political and social reform, but these were not lasting. French sanitary legislation was far from compelling and the state was slow to translate it into practical policies, despite the French centralist and *étatist* tradition.

In Germany, appeals for sanitary reform were also triggered by social and political tensions. Just before the outbreak of the revolution of 1848, the Berlin physician Rudolf Virchow had been commissioned by the Prussian government to carry out an investigation on a serious typhus epidemic in Upper Silesia. In his report Virchow explained its outbreak in the context of the geography, economy, social relations and culture of the region. His conclusion was that the spread of typhus had been caused

largely by poverty, ignorance, backwardness, conservatism, political and religious repression as well as the Prussian government's reluctance to improve the living conditions of the Polish population in Silesia. Only through removing the obstacles posed by traditional culture, socio-economic modernisation, and especially, as Virchow wrote, 'full and unlimited democracy', and 'education with its children freedom and well-being', was a structural improvement of the people's health condition feasible.[32] For Virchow, who was supported by other liberal physicians and sanitary reformers, there was no difference between public medicine, science and politics. Medical students should be trained in natural science and physicians should serve as attorneys of the poor. As one of the most outspoken liberal leaders of the democratic left in Berlin he applauded the revolution of 1848. In the journal *Die medicinische Reform* (Medical Reform), which he co-edited in 1848 and 1849 and which advocated 'the great struggle of criticism opposing authority, natural science opposing dogmatism', Virchow argued that endemic diseases and recurrent epidemics were symptoms of social malaise.[33] Only thorough socio-political reform would offer an effective and humane prescription.

As a medical researcher Virchow was associated with an ambitious group of Berlin scientists. They attempted to link physiology and medicine to chemistry and physics, and reorganise science radically on a materialist and experimental basis. Their scientific program was in strong opposition to the Romantic *Naturphilosophie*, and implicitly also to autocratic political regimes and dogmatic religion. In their explanation of biological phenomena they rejected the vitalist understanding of life as a hierarchically organised whole and at the same time propagated liberal-individualistic values.[34] Significantly, Virchow, who became famous because of his path-breaking research into cellular pathology, metaphorically associated the cells of the body as the autonomous units of life with the individual citizens in a republic. Cells lived in what Virchow called a 'cellular democracy', while the body could be viewed as a 'republic of the cells'.[35] In the 1860s and 1870s Virchow was one of the leaders of the Progressive Party (*Fortschrittspartei*) and as a long-time member of the liberal opposition in the Prussian Chamber of Deputies he criticised Bismarck's authoritarian government in the Prussian *Obrigkeitsstaat*. He also devoted his energies to the reorganisation of Berlin's sanitary and public health facilities. Virchow and his associates clearly claimed that medicine involved politics and that a healthful existence should be a constitutional right of citizenship.

In the Netherlands and Belgium, hygienics, which evolved from the 1840s, was also rooted in liberal political ideology. Using statistical evidence, some leading physicians established that there was a causal relationship between the spread of epidemic diseases on the one hand and living conditions and social and political influences on the other. Hygienists argued that science-based and state-supported preventive public health care could provide a major contribution to social progress, national regeneration, economic prosperity and social harmony. People should not resign themselves to disease or premature death, but should take destiny into their own hands: active intervention in social conditions was urgently called for. The Dutch and Belgian hygienists were guided by the liberal ideal of citizenship, pertaining to free individual development and productive virtue. At the same time they viewed society as an organism, arguing that the whole was more than the sum of its parts and that harmonious collaboration constituted the foundation of social order and the improvement of the

quality of life. Citizens owed it to themselves as well as to their community to lead industrious and virtuous lives, but many people fell ill through no fault of their own. Since all citizens should have the right to keep and improve their health, government should take the appropriate preventive measures with the help of the medical profession.[36]

In many countries ambitious plans for sanitary reform were proposed, but their implementation was controversial: they were entangled with delicate issues like individual versus collective rights and responsibilities, the legitimate sphere of influence of central government, and the sanctity of local autonomy, private property and enterprise. Public health schemes were often inspired by liberal-democratic impulses, but at the same time staunch defenders of liberal principles opposed them. One of the legacies of the French Revolution with respect to democratic citizenship was the dilemma of civil liberties and individual freedom against solidarity and the common good. Conceptualising politics as distinct from the private as well as the economic sphere, classical liberalism emphasised the principle of minimising state interference in society. The program of sanitary reform, on the other hand, was based on the recognition that some sort of intervention was necessary to secure a more or less harmonious functioning of society in accordance with public interest. Liberalism vacillated between *laissez-faire*, allowing individuals to pursue their own interests, and utilitarianism, seeking the greatest good for the greatest number.

Many liberals - and conservatives tended to support them - rejected public health measures and legislation because they believed that such compulsion would undermine personal freedom, the operation of the free market and local autonomy. Since civil rights and liberties were highly cherished and a sense of urgency for sanitary reform often seemed to be lacking, its implementation frequently met with opposition or indifference. Compulsory health regulations might provoke popular resistance, which was difficult to ignore for political leaders who, with the extension of suffrage in the last decades of the nineteenth century, had to take the expanding electorate into consideration. Controversies about compulsory smallpox vaccination, the compulsory treatment of tuberculosis by isolating patients, and the medical regulation of prostitution in order to combat sexually transmitted diseases were cases in point. In Britain for example, the country that was at the forefront of sanitary reform, the laws and regulations concerned were repealed or watered down.[37]

Implementation of public health measures was also hampered by the ambiguous attitude of the medical profession. There was no monolithic block of physicians pressing forcefully for the incorporation of medicine within the state administration. Apart from social reformers, like Bentham and Chadwick, and members of the urban medical elite, the majority of physicians did not take much interest in public health schemes. While the elite committed itself to science and social progress, the rank and file of the profession was pursuing narrower professional interests relating to income, working conditions, and social position. For most of the nineteenth century, the large majority of physicians worked in private practice and constituted a group of minor entrepreneurs of rather low prestige. The public image of doctors was one of intra-professional squabbling and weakness. They were dependent on the approval, trust and fee-for-service payment of their (upper and middle class) patients, and competition between practitioners, including non-licensed healers, could be fierce. Traditional patronage and corporate organisation

had been replaced by meritocratic ideals. Physicians operated largely on the free market, which might be lucrative, but which for many of them was also insecure. [38]

Although employment in public health positions represented professional opportunities for physicians, as a group they remained rather ambiguous and divided about the role of the state in health care. Apart from national differences between the Anglo-Saxon world, where physicians generally operated on the market as a free profession, and continental countries like Germany and France, where the medical profession was more closely associated with the state, in general the professionalisation of medicine was double-edged. On the one hand physicians were striving for autonomy and self-organisation in order to be able to shape the conditions of their occupation themselves. Large segments of the medical profession, which were attached to economic liberalism and the concomitant bourgeois values of individual initiative and independence, feared being subordinated by the state. On the other hand, they were keen on safeguarding some degree of state regulation to protect their professional status and licensing procedures, and to reinforce their control of the medical market. As soon as such occupational objectives had been realised more or less, professional medical organisations tended to retreat into defending their privileged interests. Cherished professional values, such as exclusive scientific knowledge, expert authority and compliance of the patient were largely at odds with public health schemes, in particular if these implied a more democratic and egalitarian vision of medicine. At the same time, physicians who were involved in sanitary reform and public health, tended to shift their focus from a liberal-democratic programme of social progress to a more narrow scientific and technocratic approach.[39]

When, in the last decades of the nineteenth century, liberals were confronted with the advent of mass democracy and the social question, they began to recognise that they had to abandon the principle of *laissez-faire* in its pure form. In order to cater to the needs of an expanded electorate, the state had to shoulder greater social responsibilities. In order to create more equal social and economic preconditions for materialising the ideal of democratic citizenship, social liberalism paved the way for increasing state intervention in society. As a consequence, more and more sanitary goals were realised. At the same time the character of public health changed. In the 1830s and 1840s the sanitary project had started as a broad movement aiming at social reform. Connecting disease to poverty and the detrimental effects of urban, industrial society, and tending to consider health as a right of citizenship, a broad coalition of public-spirited social reformers, advocated public health aims on socio-economic, humanitarian, and political grounds. The miasmatic theory of disease, offering an atmospheric explanation of disease causation, underpinned an environmentalist programme of disease control. In the last decades of the nineteenth century, however, medical expertise increased its hold on public health, replacing the idealistic involvement of voluntary groups. From the 1880s and 1890s onwards, bacteriology and epidemiology toned down the relevance of the larger social environment while reinforcing a biomedical and technocratic approach. Whereas bacteriology was looking for disease-causing organisms in the laboratory, epidemiology set out to understand the spread of diseases through statistics and identify individuals and social groups who harboured injurious germs. Both were geared to the contagion theory of disease and implied that public health was to be based on specialist

scientific knowledge and expert authority and that the role of lay social reformers should be limited.[40]

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 and disturbances in a democratising 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 the government should respect and guarantee civil liberties, the liberal art of social policy was often not based on direct state interference. It rather took the form of 'governing at a distance' or indirectly with the help of professional expertise outside the state apparatus. By delegating the execution of social policies to more or less independent, state-regulated - but not state-controlled - helping professions and their administrative networks, such interventionist strategies were removed from the disputed terrain of democratic politics and ideological controversy. Professionals applied putatively neutral scientific knowledge about what is normal, virtuous, healthy and efficient. By using various methods - education, persuasion, disciplining, inducement, management, incitement, motivation and encouragement - socio-political concerns about poverty, social unrest and disorder, criminality, depravity, abnormality, and disease could be translated into expert language and dealt with by technical means. The lack of democracy associated with professionalism was compensated by the professional ethos, which presupposed personal integrity, scientific competence, technocratic efficiency, and disinterested dedication to the public good.[41]

Professionalism became a crucial feature of the liberal-democratic order, but at the same time they were at odds with each other. Next to the positive or inclusive link between professionalism and democratic citizenship, which we will discuss in the next section in the context of social citizenship, there were also negative, exclusive ones. The first relates to the development and growing popularity, from the late nineteenth century onwards, of alternative forms of healing, such as homeopathy, and counter-cultures of health, like in the German *Lebensreform* movement. These movements doubted the liberal belief in progress through science and technology, and they also resisted state-supported professionalism. Alternative and 'natural' healing practices involved disputes about the exclusive right of professional physicians to medical treatment and the legitimisation of such a monopoly by the state versus the right of citizens to decide for themselves and to withdraw from professional regimes.

Another negative relation concerns the fundamental ambiguity of the liberal order. While in principle committed to equal rights and opportunities, in practice it often subordinating democratic values to what was considered as the collective good, the national interest, and economic efficiency. Under the cloak of professional regimes, the liberal threshold of individual rights and liberties might be crossed or even violated. A case in point is the turning away from environmental and social reform approaches to biological ones in public health, social hygiene and psychiatry. This shift manifested itself not only in the rise of bacteriology, but also in the growing impact of degeneration theory, Social-Darwinism, criminal anthropology, and eugenics in the late nineteenth and early twentieth century.

Two years before Charles Darwin published his *Origin of Species*, the French psychiatrist Benedict Augustin Morel, in his *Traité des dégénérescences physiques, intellectuelles et morales de l'espèce humaine* (1857), had devised a theory of retrograde

evolution. According to Morel, pathological phenomena were caused by the combined effect of environmental and hereditary influences. Adapting the Lamarckian idea of the inheritance of acquired characteristics, Morel explained how a pathogenic environment and the extraordinary demands of modern civilisation affected the behaviour and constitution of individuals, who consequently passed on the damage to their offspring. Following their inevitable biological course, inherited physical and mental disorders deteriorated over the generations and would ultimately result in racial decline. The spectre of degeneration presented a dismal counter-current to the predominantly optimistic outlook that the Darwinian emphasis on natural selection seemed to propagate.

In the second half of the nineteenth century the theory of degeneration found widespread acceptance, especially in France, Belgium, and Germany.[42] Projecting the stigmata of deviance onto the lower stages in the evolution of mankind, the idea of degeneracy suggested a causal relationship between normality and progress, and between abnormality and decay. Physical disorders, mental retardation, insanity, nervous disorders, sexual perversion, alcoholism, prostitution, suicide, crime, the declining birth rate and sometimes even political agitation and women's emancipation were all treated as the effects of widespread biological decline. Concern about degeneration signalled a crisis in the optimism that had characterised both liberalism and positivist science. The broad social acceptance of hereditary thinking signified a turn away from environmentalism and optimistic notions of social reform. It undermined Enlightenment faith in benevolent nature and the hope that through the scientific discovery of its rational laws, individual and social diseases could be cured. Degeneration theory was grounded in determinism: forces outside of and predating the lives of individuals were believed to shape them in ways beyond their control. Thus, disease and other abnormalities were considered to be the result of natural destiny.

The theory of hereditary degeneracy as well as Social Darwinism interpreted social and political issues in biomedical terms. The Enlightenment concept of human nature, stressing the fundamental similarities shared by all men and forming the basic assumption of democratic equality, was superseded by an increasing emphasis on inborn differences and 'natural' inequalities between (groups of) men: those of race, gender, and class as well as of the contrast between rationality and insanity. Society was no longer viewed as the sum of its individual citizens freely interacting and associating, but rather as an organism in which the hierarchical interdependence between its parts was a guarantee for its stability and harmony. Society was compared with a living body that could suffer from illness, and its supposed decay was discussed as a natural fact. Thus, the concept of degeneration and other biological theories not only naturalised existing social and political relationships, but also provided a rationale for medicalising a wide variety of social problems. This biomedical perspective reflected deeply felt conservative and liberal fears of the 'dangerous' classes in cities and other social groups regarded as public nuisances, of recurring revolution and class struggle, and of mass democracy, socialism, and the emancipation of women. An increasing amount of 'non-social' and 'unreasonable' behaviour in mass society as well as growing demands for further democratisation were believed to undermine the bourgeois ideal of controlled freedom. Discussion of the danger of degeneration expressed a more general fear among the middle classes of 'the primitive', which was supposed to be embodied in the residuum among the poor, the insane, criminals, alcoholics, prostitutes, and sexual perverts.

Labelling them as atavistic misfits in an evolving world, physicians and social theorists conferred the stigma of mental and social inferiority to such people. Stressing the naturally determined inequality between individuals and groups, degeneration theory and social Darwinism made it possible to distinguish between various levels of social integration within modern society. Thus, the biomedical sciences implicitly set a standard for citizenship and offered an instrument to legitimise the exclusion of several social groups from political rights.

The more liberalism allied itself with nationalism and its concomitant values of moral integration and national vitality, the more the right of the state and professional experts to set the standards for collective survival overrode the claims of private interests. Against this background, segments of the medical profession allied themselves to purity movements, stressing the need to promote morality and to outlaw obscenity, indecency, and depravation. They garnered much support in predominantly protestant countries like Great Britain, Germany and the Netherlands. By the late nineteenth century, the concern over depopulation and biological decline became something of an obsession affecting many nations, France in particular, but also Great Britain and Germany. National rivalries, for example between France and Germany, were framed in Darwinian terms of demographic battles for the survival of the fittest. In Great Britain the experiences of the Boer War in South Africa led to concerns about the physical deterioration of the nation as a whole and efforts to strengthen 'national efficiency'. The ability of the nation to defend its vitality against internal weak spots became the criterion for its external security. Embracing a social-hygienic role, physicians expanded their professional domain by claiming expertise in what they framed as social pathologies, such as alcoholism, crime, sexual perversion, mental disorders, and educational deprivation.[43]

Around the turn of the century, the precepts of eugenics seemed to promise a rational mastery of the laws of evolution. Such trends occurred in many countries, albeit in different degrees and with more or less serious consequences as far as civil rights were concerned. Several American states and Scandinavian countries, for example, enacted eugenic laws enforcing measures like institutional segregation and mandatory sterilisation of those regarded as 'unfit'.[44] In Germany in particular eugenics gained more and more of a following among the medical profession in the first decades of the twentieth century.[45] Under the Nazi regime, physicians endorsed nationalist and racist policies. In the Third Reich social issues like poverty, crime, 'asocial behaviour', sexual deviance, ethnicity, and the Jewish 'question' were largely defined and dealt with as biomedical problems. Employing the rhetoric of medical emergency, many leading Nazis considered their politics as applied biology. In their worldview, the German people suffered from deadly diseases. Their 'cure' was racial purification, moving from coercive sterilisation, euthanasia and segregation for 'hygienic reasons' to direct medical killing and genocide. Nazi racial hygiene dictated a 'total cure' of the nation through its purification from Jews, gypsies, ethnic minorities, psychiatric patients, mentally retarded and hereditary sick people, and homosexuals. Physicians played an active role in large-scale, mandatory sterilisation and euthanasia programmes as well as enforced medical experiments on humans in concentration camps. The Nazi regime did not corrupt a supposedly neutral biomedical science: its radical policies built on the strong affinity of the German medical profession with biomedical reductionism, its absolute trust in scientific expertise, and its lack of democratic values. In fact medicine had been

politicised early on, and, conversely, it lent Nazism a specifically scientific and technocratic character.[46]

Collective health care and social citizenship

The Nazi regime, which has been characterised as a 'biocracy', can be considered as an extreme example of the undemocratic, coercive, and excluding effects of medicine's linkage with state policies. However, beginning in the nineteenth century and intensifying in the twentieth century, more democratic and inclusive liaisons between medicine and the state developed and they were more enduring.

The sanitary movement of the nineteenth century, both in its earlier social-environmentalist and its professional biomedical form, was not just a medical project targeting disease and unhealthy living conditions. Sanitary reformers also addressed questions of social order and integration of the working class and poor into the industrialising, urbanising and democratising mass society. Public health was one of the first social projects in which professional groups - not only physicians, but engineers, lawyers and civil servants as well - used their expertise to make themselves advocates of the public interest and civil virtues. Crossing the boundaries between the private and the public, and wavering between the voluntary and the coercive, 'the social' emerged as a domain for professional intervention in the lives of the dispossessed.[47] Sanitary reforms included the missionary zeal to civilise the lower strata of society and educate them into middle class values, at the same time making life for the middle classes less dangerous and more pleasant. The miserable health conditions of the lower orders, especially the possible spreading of contagious diseases like cholera, also endangered the health of the middle class. Out of well-understood self-interest, it became prepared to pay for collective arrangements in the field of public health and to allow for a certain degree of state-regulated professional intervention.[48] Although it implied paternalism and disciplinary strategies, sanitary reform simultaneously, through articulating what was healthy and clean as well as normal and virtuous, was also geared to making responsible citizens out of the working class and the poor. Professional regimes did not only put constraints upon people: as democracy advanced they also operated by co-opting them and by encouraging and guiding their self-control, self-direction and self-development. 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 were involved in the constitution of citizens who would be capable of regulating themselves and bearing a kind of controlled freedom.

The late nineteenth and early twentieth century not only witnessed the realisation of various sanitary reform plans, but also the introduction of the first social insurance schemes for workers covering sickness and disability. The 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 increasingly replaced by collective insurance schemes and state guaranteed entitlements. All of these reflected the growing political emancipation and enfranchisement of the working class and the poor. Health care benefits - and obligations - were an important ingredient of social citizenship.

In several industrial nations the health risks of industrial workers - not only sickness, but also injuries caused by accidents on the work-floor - were taken into account as a result of the pressure of the socialist movement, trade unions, social reformers, enlightened capitalists and medical professionals. Sickness, disablement and life-insurance funds, developed by voluntary associations, mutual aid societies, trade unions, and political parties, contributed to the collective identity and political mobilisation of the working class. Sooner or later such endeavours were taken up and extended by the emerging welfare state, and they would also include unemployment, widowhood, and retirement. In Germany the first social insurance legislation laws for workers covering sickness, disability, and accidents, were introduced in 1884 by Bismarck's government. They were part of the strategy to counteract the spread of socialism and to bind the working class to the state. In other countries, like Great Britain, France, the Netherlands, and Belgium, social liberals, seeking to balance individual freedom and some basic social security through collective arrangements, laid the foundations of the welfare state. Both the authoritarian German government and the more liberal-democratic governments of other West European countries increasingly followed a middle way between liberal *laissez-faire* and socialist collectivisation. Social security arrangements offered themselves as exemplary solutions 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 a rational, methodical and responsible conduct of life and would bind claimants and beneficiaries into a system of solidarity and mutual obligations.[49]

When epidemic diseases had successfully been overcome, other public health issues began to assume prominence: poor nutrition, infant mortality, vaccination, child-raising, domestic hygiene, alcoholism, venereal diseases, tuberculosis and other endemic chronic illnesses. New forms of public health care and social hygiene, originating from voluntary associations as well as initiated by local and national governments, concentrated less on the social environment and more on individuals and their behaviour. New methods and institutions, such as health-education, social work, house visits, maternity allowances, material assistance, out-patient clinics, and social hygienic welfare centres, were based on a mixture of support, encouragement, regulation, surveillance and compulsion, and they especially addressed women. Specialised sanatoria, public and private, for tuberculosis and nervous and other disorders, involving segregation in rural areas, a medical regime, pedagogical instruction, and various degrees of coercion and discipline, multiplied rapidly in the late nineteenth and early twentieth century.

The new model of social citizenship that social insurance and collective health care arrangements forged, came to be considered in terms of rights instead of a mere favour. They fostered in the lower classes a sense of entitlement that might further politicise them, the more so because tensions arose over provision and payment of benefits as well as over the coercion that new public health policies entailed. On the other hand, many public health activities depended on the more or less active co-operation of the targeted populations, which they might be willing or not willing to give, depending on whether such interventions accorded with their self-interest and enhanced their living conditions.[50]

Although social and medical insurance and the expansion of public health activities entailed an extension of the professional domain of physicians, which they generally embraced, many of them were ambivalent about social medicine as far as its consequence might be a loss of professional autonomy. Their growing involvement as advisors and medical examiners in collective insurance schemes implied the control of medical practice by welfare bureaucracies and insurance companies. Social politics in the field of health care often provoked resentment and more or less successful resistance from the medical profession, distrustful as many physicians used to be of any threat to the liberal model of a 'free' profession and of any tendency to transform them into state functionaries.[51]

Despite objections by the medical profession, the provision of collective health insurance for all citizens in order to make medical services broadly accessible, became an issue after the First World War in many countries - at the same time as universal suffrage - at least for men - was introduced all over the Western world. The 'Great War', which took a heavy toll of the life and health of so many male citizens, was the final confirmation that health was a national concern and belonged to the responsibilities of government. After Germany had set the example for social legislation and the communist regime in the Soviet Union for socialised medicine, national health insurance schemes were discussed and partly implemented in Britain and France between the two world wars. The economic depression of the 1930s and the post Second World War reconstruction prompted states in the Western world to become far more active in social planning. In the Netherlands a national sickness fund for lower income groups was introduced by the German occupying force during the Second World War. After the war the United Kingdom, as part of the construction of the welfare state, took the lead with the introduction of a National Health Service for all citizens in 1948. Other countries, like New Zealand, Canada, and Sweden, also took the path of nationalised health care provision. In the Federal German Republic, the Netherlands, and Belgium, gearing their welfare systems to social market economies, a combination of private insurance and socialised sickness funds continued to prevail. The French state, relying on corporate planning, gradually realized a comprehensive national health insurance system for all citizens between 1945 and 2000.

The collectivisation of health care essentially occurred in one of two forms. Great Britain, some Scandinavian countries and the former communist countries, among others, opted for nationalised, publicly funded and government-organised health care, in which physicians lost much of their professional autonomy. Most other European countries opted for a budgetary funding system, with government, in consultation with the medical profession, setting the rules and conditions, and citizens having the obligation to purchase health insurance, either from a private insurance company or, for those in the lower income range, through public health funds. Although in these countries the organisation of health care was largely in the hands of social and (semi-)private organisations, it was monitored and supervised by the government, while the medical profession still managed to secure considerable autonomy. In the United States there was - and still is - strong resistance to any notion of socialised medicine. Here a stronger emphasis on the market as provider of medical services has prevailed, including the need to have private health insurance to pay for them. Medicaid and Medicare, introduced in the mid-1960s, were

essentially government-subsidised medical insurance for social security recipients and the elderly.[52]

As a result of broad coverage and open-ended fee-for-service, in many countries collective health insurance schemes and care systems have forced up costs much higher than expected.[53] In the welfare state the thing modern citizen-patients value most in life, is their health. The rising demand for health care follows from the increased treatment and prevention options, growing life expectancy and the increasing frequency of controllable chronic diseases, the higher expectations regarding health and the development of advanced medical technologies. Also, the domain of medicine expanded, moving from treatment and prevention of disease toward the preservation and improvement of health and well-being, including the realisation of personal wishes regarding, for example, appearance, parenthood and euthanasia. New biomedical technologies – such as in vitro fertilisation, surrogate motherhood, psychotropic (designer) drugs, embryonic stem cell research and genetic engineering – are (or will probably be) no longer used as a cure for ill-health only. The line between therapy for pathologies and the enhancement of body and mind tends to be blurred. Furthermore, a host of social issues, for example, abuse of women and children within the nuclear family, traumas and victimhood, sexuality, diet, addiction, disability and work-related problems and conflicts, sports and lifestyle, have partly been put under a medical regime. From the 1960s and 1970s onwards, the health care system in the welfare state more and more became a domain without limits. The boundaries of health and normalcy were stretched according to the expanding supply of health care services as well as the insatiable needs of the citizen-patient. The view of health as an inalienable right of social citizens entailed continuously rising costs. At the end of the twentieth century, this budgetary problem of the welfare state was crucial in bringing about a neo-liberal re-orientation with respect to health care as well as citizenship.

The new public health and neo-republican citizenship

The growing impact of neo-liberalism since the 1980s, emphasising the benefits of the market and a new, neo-republican ideal of citizenship in terms of freedom and autonomy, has entailed major shifts in health care. The endeavour to curb costs and to push back state regulated welfare schemes involved the introduction of economic considerations and market mechanisms in the organisation and delivery of care. A more or less free market of health products and services and the dynamics of competition were expected to bring about a balanced mediation of supply and demand as well as transparency to all parties involved. In reaction to the soaring costs of high-tech medicine and the rising demand it excited, managers were set to work alongside physicians to align medical expertise with budgetary discipline and economic efficiency. Thereby new forms of administrative and bureaucratic regulation emerged, which were withdrawn from democratic control.[54]

At the same time medicine continued to broaden 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 surveillance, screening and monitoring, is based on a view of health and illness as a continuum, a statistical style of reasoning, and the notion of risk. The so-called new public health is part of a wider

emphasis on anticipating and preventing dangers and undesirable events like illness, abnormality and deviant behaviour. Sociologists such as Ulrich Beck, Anthony Giddens, and Robert Castel have pointed to the rise of risk calculation and management as ways of dealing with growing uncertainties and contingencies in technologically advanced and deregulated liberal societies. Considering everybody at any moment as a potential patient, predictive and preventive medicine focuses on health risk profiles in relation to factors such as age, social class, occupation, gender, living-environment, lifestyle and consumption. Interventions take diverse forms such as genetic testing, periodic check-ups, screening and monitoring of groups at risk for specific illnesses, supervision over the health of children, public education about 'risky' lifestyles, products or environments, community and personal skills development, and health promotion.[55]

The new public health is all about providing individuals with information about their health status and possible health risks in the near or more distant future, so that they can act to reduce those risks and preserve or even improve their health. At the same time the risk discourse, although embracing the neo-liberal slogan of transparency, does not provide ultimate certainty, but, on the contrary, generates its own discord about what constitutes a risk, its implication, and how to respond. Scientific and expert knowledge on health risks is intrinsically provisional and time and again gives cause for disagreement, not only among experts, but also between expert and popular views. Medical information is increasingly located in the free market, where competition and various players with different interests are involved: physicians, medical researchers, public-health experts, epidemiologists, the manufacturers of foods and medical instruments, the pharmaceutical and fitness industries, health magazines, and patients and their support organisations.

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 and danger. Patients as well as healthy individuals are framed as active and self-conscious 'health consumers', who are or should be well-informed about their health-status and who supposedly can take responsibility for their own health and well-being. The rise of 'healthism' implies that people are expected to be active in keeping and optimising their health by adapting a healthy lifestyle including a balanced diet, regular exercise, stress-management, curbing smoking and drinking, and avoiding unsafe sex. Such demands fit in with the neo-republican ideal of citizenship stressing a reflexive, competent, and entrepreneurial self. Healthism requires the replacement of passive 'welfare dependency' rights by active citizenship, shifting the emphasis from entitlements to duties and responsibilities. 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 or to what extent they should still be entitled to collectively funded health care.

Both the neo-liberal emphasis on the free market and transparency and the consideration of health in terms of risk management assume individual autonomy, responsibility, free choice, knowledge, competence and motivation. This neo-republican ideal of citizenship has also put its stamp on debates about ethical issues that have resulted from the increasing medical possibilities to subject the beginning, course and end

of human life to manipulation and control. This broadening of medicine's role entails new relationships between doctor and (future) patient, and between medicine and other social institutions such as government and insurance companies. Autonomy is the key concept in medical ethics as well as contemporary notions of citizenship. According to this principle, which from the 1970s on also has been advocated by the patient movement, adults have the right – and to a large extent also the duty – to self-determination and self-organisation of their lives. In the Netherlands, for example, autonomy serves as the basic principle of patient's rights in medical practice. The Dutch Constitution of 1983 guarantees the right to the inviolability of the human body, while a law enacted in 1995 stipulates that medical treatment should be based on informed consent by the patient.

However, autonomy is not without problems. Not only is it far from self-evident that this high-flown ideal and the related neo-republican civic virtues are achievable for everyone, they are also contradictory to the experience of (chronic) illness and the practice of care. Being ill, implying suffering, pain, dependency, anxiety and confusion, often entails an infringement on or a lack of self-determination. In this sense illness is the opposite of the liberal-capitalist ideal of possessive individualism, on which the modern ideal of autonomy is based. Does not the experience of being ill and the certainty that we will all die make us aware that our ability to own and control our bodies is extremely limited and that in fact the body owns and controls us instead of the other way around? In addition, the emphasis on autonomy tends to privilege cure over care, and thus reflects the traditional gender division of labour in health care. In opposition to the intellectual, rational, scientific work of (predominantly male) doctors, aiming at cure and thus restoring autonomy, nursing, associated with menial tasks as well as emotional support and nurture, has been conceptualised as a natural female activity. Care, which presupposes dependency of patients, in particular those that suffer from chronic illnesses, was and is often considered of a lower status compared to the progress made by medical science in the field of curative treatment.[56]

Also the neo-liberal conceptualisation of the patient as a freely choosing consumer is problematic. Patients do not always have the proper information at their disposal to be *able* to choose - full transparency is more often a promise than a reality - and it is questionable whether they always *want* to have a choice. Moreover, the conditions in which patients typically find themselves differ from those of consumers on the free market. Despite commercialisation and privatisation, the largely monopolistic offerings of collectively funded health care and the conditions imposed by health insurers limit patients' freedom of choice. The neo-liberal promotion of customer-friendliness by gearing the supply of medical services to the demand of health consumers, is at odds with the increasing standardisation, scaling-up and bureaucratisation of health care and the growing influence of intricate and specialist scientific knowledge and medical technology.

The principle of autonomy also seems to be inadequate to solve the ethical problems and political controversies that arise in the context of the practices of predictive and preventive medicine as well of biotechnology. Apart from the question what might be the implications of biomedical technology for the definition of what will count as a human subject and citizen, human and civil rights are at stake.[57] Let us point to three sets

of questions and problems as far as the present relationship between health and democratic citizenship is concerned.

Firstly, the suggestion that health and illness depend on individual choice and responsibility not only plays down the differences between individual bodily constitutions, but also underestimates the extent to which ill health is still being determined by social-economic and cultural factors. There is a real danger that the new preventive interventions will benefit the healthier part of the population instead of those with fewer opportunities due to deprivation, lack of education, unemployment or ethnic and religious background. Predictive and preventive medicine may give rise to a dynamic of health standards being forced up. The consequence might be that those who cannot meet them – for example the chronically ill, the elderly, the physically and mentally disabled, and psychiatric patients – are downgraded and marginalised as second-class citizens, despite their formal rights.

Secondly, in some ways predictive and preventive medicine may even undermine the very principle of autonomy. By providing knowledge about the chance of becoming ill later in life, they call into question the open future, which the principle of autonomy presupposes. Such predictions not only have an impact on personal life and further feelings of uncertainty, but may also entail serious social consequences such as refusal by insurance companies, banks, mortgage lenders, or employers. Predicting health risks may result in discrimination and social exclusion and thus undermine the democratic principles of freedom, equality and solidarity, which are the foundation of civil and social rights. This raises the question whether governments have a task to safeguard civil rights vis-à-vis the practices and consequences of predictive medicine. As information on individual health profiles and risks is increasingly stored in data banks, the accessibility and the control of such information touches on the civil right of privacy and the inviolability of the body.

The third set of problems concerns the professional power of medicine to define what constitutes a health risk, who is at risk, what the consequences of such risks are and which measures should be taken. Informed consent, which is now an important principle in medical ethics and which has confirmed the patient as a citizen-patient, is difficult to realise in predictive medicine. For a variety of reasons, people may feel compelled to undergo its interventions: anticipation of regret about non-participation and feeling responsible for the health of next-of-kin, while at the same time not being able to assess either the value of its knowledge claims or the practical consequences of its predictions.

On the other hand there are indications that professional medical expertise, which legitimates itself by stressing scientific rationality and control, is more and more disputed by critical citizens. Whereas in the past the medical profession was often accused of being authoritarian and paternalistic, now trust in public health programmes seems to be declining because their rational and technocratic approach is far removed from the daily experiences and lay meanings of health and illness. Further, the increased possibilities to obtain and exchange a diversity of information and of popular opinions about health and illness have undermined the credibility of experts and government agencies responsible for the top-down implementation of health policies. In the Netherlands for example, large-scale vaccination programmes to prevent epidemics of Mexican flu and cervical cancer met with wide-spread distrust and even resistance, thus undermining the effectiveness of such measures. The same holds good for campaigns to prevent heart and

vascular diseases and other ailments though the promotion of healthy lifestyles. Health experts and government officials who urge citizens to be autonomous, expect them to take responsibility for their health according to rational insight. However, in practice autonomy may also imply that citizens choose not to be rational in this sense, that they have their own ideas about what is healthy or desirable and that they establish other priorities in their lives. Growing distrust among citizens seems also to be triggered by the fear of increasing government surveillance and control, which endanger the security of the private sphere. At the same time government is criticised for not adequately tackling public health problems. In the Netherlands the unhealthy consequences for human beings of environmental pollution and factory farming – such as antibiotics in meat-products and an outbreak of Q-fever - are cases in point.[58]

All of this raises the question whether people should follow professional and governmental definitions of health risks or whether the lay public should be democratically enabled to form and express their own opinions about the merits, results and consequences of preventive and predictive medicine and biotechnology as well as the ethical issues that are involved. Perhaps governments have the task to initiate public debates in order to advance active, well-informed citizenship in the domain of health and illness and thereby clear the way for a diversity of viewpoints, whether they are rational in the expert view or not. Also, more participatory structures of public health, in which citizens' own perspectives and experiences are taken into consideration, could be developed.[59] In this way citizens could be enabled to discriminate between good and bad uses of these medical practices on the basis of democratic empowerment and fundamental human and civil rights.

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