A genealogy of "healthism":

Healthy subjectivities between individual autonomy and disciplinary control

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Abstract

Healthism is a sociological concept that has circulated widely outside of academia, while is it rather neglected by social sciences. This article intends to propose its genealogy in order to revitalize this term and to propose it as an analytical framework able to grasp some of contemporary tendencies marked by the centrality of individuals. After an historical excursus of healthism, which began as a spin-off of the well-known term "medicalization", the article proceeds by exploring the legacy of this notion for contemporary analysis of the expanding sector of illness prevention and prediction as well as health/wellness promotion and optimization. In particular, it focuses on the establishment of lifestyles and risk factors as the vector of medical devices, practices, and concepts in society. Instead of looking at these changes in spatial terms, as either an expansion or a shrinking of medical discourse, healthism provides an analytical framework attentive to the relationship with medical power, technologies and data inherent in emerging medical subjectivities.

Keywords

Healthism, medicalization, lifestyles, risk, subjectivity.

Une généalogie du « santéisme » : Subjectivités et santé entre autonomie individuelle et contrôle disciplinaire

Résumé

Concept sociologique qui circule largement en dehors du milieu universitaire, le « santéisme » est pourtant plutôt négligé par le débat contemporain au sein des sciences sociales. Cet article vise à proposer sa généalogie afin de revitaliser ce concept et de le relancer en tant que cadre analytique capable

de saisir certaines des tendances contemporaines de prévention des maladies aussi que de promotion et optimisation de la santé et du bien-être. Historiquement dérivé du terme beaucoup plus connu de « médicalisation », le santéisme gagne bien tôt sa propre autonomie conceptuelle, en introduisant certains thèmes centraux pour l'analyse des transformations contemporaines de la santé liées à la centralité du patient. En particulier, il met l'accent sur la mise en place de modes de vie et des facteurs de risque comme vecteurs des dispositifs, des pratiques et des concepts médicaux dans la société. Au lieu de regarder ces changements en termes spatiaux, soit comme une expansion ou une contraction du discours médical, le « santéisme » fournit un cadre analytique attentif à la relation avec le pouvoir médical, les technologies et les données inhérentes aux subjectivités médicales émergentes.

Mots-clés

Healthism, médicalisation, styles de vie, risque, subjectivités.

Una genealogía del "salutismo": Subjetividades saludables entre la autonomía individual y el control disciplinario

Resumen

El salutismo es un concepto sociológico que ha circulado ampliamente fuera de la academia, pero que ha sido más bien descuidado por las ciencias sociales. Este artículo intenta proponer su genealogía para revitalizar este término y proponerlo como un marco analítico capaz de captar algunas de las tendencias contemporáneas marcadas por la centralidad de los individuos. Después de un excursus histórico de salutismo, que comenzó como un derivado de la conocida expresión "medicalización", el artículo procede a explorar el legado de esta noción para el análisis contemporáneo del sector de prevención y predicción de enfermedades, así como la promoción y optimización de la salud y el bienestar. En particular, se centra en la creación de estilos de vida y factores de riesgo como el vector de dispositivos médicos, prácticas y conceptos en la sociedad. En lugar de ver estos cambios en términos espaciales, ya sea como una expansión o una contracción del discurso médico, el salutismo ofrece un marco analítico atento a la relación con el poder médico, tecnologías y datos inherentes a las emergentes subjetividades médicas.

Palabras clave

Salutismo, medicalización, estilos de vida, riesgo, subjetividad.

1. Why healthism

Presenter (Jenny Brockie): Julius, you are a fitness trainer. What do you think of Jenny and Dorothy *(two overweight women)* being happy with their bodies?

Julius (personal trainer): I think that's fantastic. Are you healthy? Have you been to the doctor and they've been told that you are healthy?

Jenny: I think that's quite a loaded question, because I don't think that anyone here who's thin is going to be asked that.

Julius: Hmm.

Jenny: So I guess that I would say to that to answer that we have to look as well at the assumptions that are made. And I would say that you can't actually tell someone's lifestyle or health by looking at them. I think there's such a health focus in our country that I call it healthism – a kind of moral obligation for people to be healthy and I think we have to watch that too.

(This passage is taken from an episode of the Austalian SBS talk show *Insights* tellingly entitled "Fat Fighers", aired on the 28th of May 2013).

In the TV studio they are discussing being overweight and obesity. A guest, Jennifer Lee, who represents the group scrutinized in this occasion, "oversize" people, replies to the pretty critical remarks of the "fat fighter", Julius, a perfectly in shape blond-haired fitness trainer, by referring to the notion of healthism. Her very sharp reply went viral on the Internet, particularly on the websites, blogs, and social networks of "fat acceptance movement" activists. In these spaces, healthism is used as a critical tool with which to frame the obsessive desire for thinness as a new form of puritanism[1], an upper classes privilege[2], or a bias[3].

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[1] Jha, S. (2013). "Healthism : The new puritanism", *The Health Care Blog*. Retrieved on September 30 from thehealthcareblog.com/blog/2013/12/04/healthism-the-new-puritanism.

[2] Andersen, J. and Simon, A. (2015). "I am free to have a body that is unique to me", *Health at Every Size Blog*. Retrieved on September 30 from healthateverysizeblog.org/2013/11/19/the-haes-files-speculations-on-healthism-privilege.

[3] See, e.g., sleepydumpling (2013). Fat Stigma, healthism and eating disorders, *Fat Heffalump*. Retrieved on September 30 from fatheffalump.wordpress.com/2013/05/23/fat-stigma-healthism-and-eating-disorders; lexiedi (2013). "Just wait: Fat discrimination and healthism", *Fierce Freethinking Fatties*. Retrieved on September 30 from fiercefatties.com/2013/07/18/just-wait-fat-discrimination-and-healthism; Tiffany (2013). "Activism, Healthism, and Fat Athletes", *More Cabaret*. Retrieved on September 30 from morecabaret.com/2013/04/15/activism-healthism-and-fat-athletes. See also all the posts of a blog by

Far from being limited to this type of debate, healthism is one of the successful instances in which a sociological term (of its numerous –isms) has gained wide public currency, and become a common everyday word, even triggering heated reactions. The notion of healthism has widely circulated in the media, Internet, and medical publications. It has also been translated in many languages, such as the French *santéisme*, Italian *salutismo*, Spanish *salutismo*, and so forth. Travelling beyond the narrow space of academic debates, the public use of the word has isolated and/or shifted certain facets of the sociological analysis, and in some cases has even reversed part of the original meaning. Several webzines draw on this concept by comparing it either to a form of discrimination like racism and sexism[4], or to an expression of neoliberalism[5]. In the opposite direction, certain websites that promote healthy lifestyles[6], or individual testimonial health blogs, use the term healthism with a positive connotation, in order to motivate others to be "healthier" like them[7].

Paradoxically, while the term healthism has circulated widely outside of academia, even with opposite meanings, the social sciences have rather abandoned this term. On the contrary, this special issue intends to revitalize this concept and to extend its use for the analysis of contemporary innovations and trends in the fields of disease prevention, and wellness and health promotion. In this regard, it is remarkable a less widespread connotation of healthism, which regards the wide set of devices, knowledge, and data now used to monitor and explore manifest health behaviour as well as the silent biological processes of our body, with the goal of preserving and optimizing the organism. Although less common, this meaning can be found in everyday use too. For example, an innovative start-up that develops mobile applications for personalized and evidence-based preventive health has chosen "Healthism" as its brand name while developing a blog on technological innovation in the field of biomedicine[8].

While all of the contributions in this volume are devoted to exploring this concept through specific case studies, this article intends to map a brief genealogy of the concept of healthism. After an historical excursus of healthism, which began as a by-product of the well-

(anonymous) "scientists about the anti-science of healthism" and tellingly entitled *Fuck no healthism! An anti-healthist blog by scientists, for everyone*. Retrieved on September 30 from http://fucknohealthism.tumblr.com

[4] Brown, E. N. (2013). "You've heard of racism and sexism – But what about healthism?", *Bustle*. Retrieved on September 30 from www.bustle.com/articles/9205-youve-heard-of-racism-and-sexism-but-what-about-healthism

[5] Michel, F. (2012). "Healthism: A neoliberal version of wellness", Solidarity. Retrieved on September 30 from solidarity-us.org/node/3757

[6] See, e.g., commercial websites which republish on-line articles about fitness and diets, such like *Healthism: A way to become healthy* – healthism.blogspot.fr – or, in Italian, *Salutismo* (*Healthsim*) – www.salutismo.it

[7] See for example the personal blog of Cassidy aimed at motivating others to keep in shape and being healthy: *Health is my Happy* – healthismyhappy.tumblr.com.

[8] For more information visit the website of the company Healthism Labs – www.healthism.com

known term "medicalization", and immediately gained its own autonomy, it proceeds by exploring the legacy of this notion for contemporary analysis of the expanding sector of illness prevention and prediction, and health/wellness promotion and optimization. In particular, it focuses on the establishment of tools based on managements of health rather than illness, such as lifestyles and risk factors, between contestation and extension of medical institutions, knowledge and profession. Instead of looking at these changes in spatial terms, as either an expansion or a shrinking of medical discourse, healthism provides an analytical framework attentive to the relationship with medical power, technologies and data inherent in emerging medical subjectivities.

2. Healthism and medicalization

It is not possible to introduce the concept of healthism without referring to the "medicalization" paradigm. As is well known, in the 1970s, this dynamic and critical perspective on medicine challenged the structural functionalist approach formulated by Talcott Parsons (see, in particular, Parsons, 1951), which previously dominated the 1950s and 1960s. According to the latter, medicine is an institution charged with managing illness, which is deemed, from a social perspective, as a legitimate and temporary deviant condition. Medicalization swept away this framework, by shedding light on the expansion of medical jurisdiction, authority and practices into numerous aspects of social life, often focusing on deviant *behaviours*, which were not previously deemed *medical* issues. As it is well known, this standpoint overtly criticises the power and influence of medicine as "an institution of social control" (Zola, 1972), as well as medicine's alleged lack of effectiveness, and/or iatrogenic, collateral effects (see, in particular Illich, 1975). In a similar manner, the analytical framework of healthism is also committed to unveiling hidden political implications behind the apparent neutrality, objectivity and scientific status of the medical approach towards social issues as if they were individual problems to be fixed through technical solutions. Not by accident, these two notions share the same founding father, Irving Zola.

In 1972 Zola published the first article on medicalization, and five years later introduced the term healthism as a sort of *conceptual spin-off* in an article tellingly entitled *Healthism and Disabling Medicalization* (Zola, 1977). According to Zola, medicine increasingly addresses a number of social functions due to a favourable, complex cultural climate that tends to fix issues by relying on technical expertise. By drawing on Eliot Freidson's influential criticism of the medical profession (Freidson, 1972), Zola describes the medical institution as a Church without

religion, taking on the social role of regulation that was initially religion's, and later, juridical. More specifically, he insists on two aspects of medicalization: the jurisdiction and legitimized competences of medical profession; and the extension of the range of social phenomena considered illness. Although this movement of medicine presents itself as a neutral and technical strategy to cope with deviant phenomena, it actually functions as a strategy to de-politicize societies, by understanding individual deviance as an issue to fix through technical means. He introduces "healthism" to refer to the cultural implications of the propagation of medical values and practices.

> (M)edical science began to define progress as well as the meaning of life in new terms. Health itself became not merely the means to some larger end but the end in itself, no longer one of the essential pillars of the good life but the very definition of what is the good life (Zola, 1977, p. 51).

Medicalizing society has a strong impact on culture in as much as it concerns our basic concepts of human control over life (such as birth and death) and natural phenomena (like ageing). As a result, what emerges is a new form of social Darwinism that legitimizes inequalities, no longer on the basis of racial superiority, but on biological and supposed health differences. In addition, framing issues as health issues to be solved technically rather than politically or socially ends up emphasizing individual responsibility, which in turn can strengthen the stigmatisation of the less healthy.

This same topic, individual responsibility, is the core of a paper by Robert Crawford (1977), who focuses on its potential economic and social impact on public health. Three years later, Crawford elaborates on the same notion though a broad reflection on a new pervasive health consciousness. Like Zola, he considers healthism "a form of medicalization" (Crawford, 1980, p. 381), and refers, in particular, to the spread of medicine as a depoliticization strategy. More specifically, he defines healthism as:

> ... the preoccupation with health as a primary – often *the* primary – focus for the definition and the achievement of well-being; a goals which is to be attained primarily though the modification of life styles, with or without therapeutic help (Crawford, 1980, p. 368. Italics in original).

Yet, Crawford articulates this notion by taking completely different phenomena into consideration. For Zola, medicine replaces the Church as the archetypical regulating institution

of modern societies. Accordingly, he points to the metabolization of technoscientific innovations as one of medicine's distinguished features. Cutting-edge innovations of that period, such as clinical genetics, prenatal diagnosis, organ transplants, sex reassignment surgery, or new psychological diagnoses for emotions, self-control etc., represent the increased power of medicine to define and control life and death, normalcy and pathology, the natural and the artificial. Crawford instead focuses on holistic medicine and self-care as examples of patients' claims to a more active role in the healthcare process. These movements challenge modern medical detachment and the objectification of the patient, by proposing new models of healthcare based on patients' experience and expertise. Paradoxically, the attempt to attribute a more active role to the patient turns out to strengthen the disciplinary power of medicine implicit in its epistemology and, in particular, in the "clinical gaze" (Foucault, 1973). According to Foucault, the modern, clinical discourse is based on the localization of the pathological event within the boundaries of the individual body. For Crawford, the movements of contestation of medicine would spread the same individualistic approach well beyond the medical profession, into society at large. Historically, this contradiction would be the result of the disillusionment that followed the failure of the occupational and environmental medicine movement, which in the 1960s attempted to reform medicine from within. Their ambition was to re-integrate illness into the social context, assume a social approach to disease and attribute a more active role to the patient. While fostering a similar criticism towards medical reductionism, the new healthist movements studied by Crawford take on a completely different significance, and contradictorily strengthen the influence of medicine itself.

At this point healthism becomes an autonomous concept, which is developed in at least four directions. First, healthism does *not* address the expansion of the jurisdiction of medical professionals or institutions, as in the medicalization thesis, but rather "the dissemination of medical perception and ideology" (Crawford 1980, p. 370) among non-experts, who usually contest physicians prerogative and claim a more active role in the healthcare process. Second, as a corollary, healthism does not necessarily address medical practices and treatments, but rather focuses on lifestyles, i.e. attitudes, behaviours, and emotions regarding diseases prevention, health maintenance, and wellness promotion. Third, the individual not only becomes the privileged terrain of medical explanation and intervention, but also the subject of responsibility for their own health – again different from the medicalization thesis which, especially in its early formulations, gives all agency to the medical profession (Conrad, 1975). Fourth, the individual responsibility entails a process of blaming which generates a new form "moralism", according to which "healthy behaviour (becomes) the paradigm of the good living" (Crawford 1980, p. 380). In brief, healthism grasps the expansion of medicine *beyond* and, in some cases, *against* medical professions and institutions. A sort of *medicalization without doctors*, healthism may be defined as the analysis of a set of attitudes, behaviours, and

emotions that result from the elevation of health to a pan-value and committed to a more active engagement of patients in the process of healthcare. What started as a companion notion to medicalization, became very quickly an independent and, in some cases, alternative category.

3. Lifestyles and risk factors

In hindsight, the clairvoyance the healthism analysis had in pointing out the incipient role of lifestyles and their connection to stigmatisation is quite impressive. Moving beyond even the concepts of health and fitness, *lifestyle* becomes a key notion for describing people's behavioural tendencies, consumption patterns, leisure activities, clothing, bodily dispositions, and so forth. The shift of its meaning is emblematic of the transformations of contemporary consumption societies, and attributes a critical place in cultural transformation processes to the health domain. If previously lifestyles referred to the distinctive style of life of a specific group, since the 1980s the term starts to connote individuality, self-expression and a stylistic self-consciousness (Featherstone, 1987). In the context of wellness promotion and illness prevention, choices regarding smoking, drinking, fitness, as well as kinds of diets, physical exercise programmes and healing methods become increasingly relevant (see, e.g., Blaxter, 1990; Hansen & Easthope, 2007; O'Brien, 1995).

In this context, healthism comes also to be used as a category that includes services that respond to a specific health issue, even if medical professionals do not treat them. At the beginning of the nineties, Peter Conrad, one of the most influential mentors of the medicalization thesis, suggests drawing a clear line between medicalization and healthism, which he re-baptises for this reason "healthicization".

> With medicalization, medical definitions and treatments are offered for previous social problems or natural events; with healthicization, behavioral and social definitions are advanced for previously biomedically defined events (e.g. heart disease). Medicalization proposes biomedical causes and interventions; healthicization proposes lifestyle and behavioural causes and interventions. One turns the moral into the medical, the other turns health into the moral (Conrad, 1992, p. 223).

According to Conrad, the proliferation of health concerns assumes two opposed directions, whose difference depends in the end, on the presence or absence of medical mediation. From his perspective, which is grounded in the medical profession, the healthism sphere appears as an unrelated phenomenon to be treated as completely extraneous to medicine. An article devoted to the increased attention to sleep disruption embraces this conceptual distinction empirically, by classifying medical interventions, such as sleeping pills, as medicalization, and instead the services suggested by the popular media or pharmaceutical and complementary companies, that include lifestyles, over-the-counter drugs and other remedies, as healthism/healthicization (Hislop & Arber, 2003). According to this perspective, healthism would uniquely refer to the wide set of behaviours and services related to health prevention or optimization that are not prescribed or provided by doctors. Yet, the conclusions of the article seem to undermine these premises. Patients dealing with sleep conditions are *bricoleurs* who combine, adapt and mix all the available means, and do not pay too much attention to distinguishing between strictly medical and non-medical therapies.

If it is true that healthism has contributed to bringing the relationship between health and lifestyle to the fore, it is limited and to some extent inaccurate to say that healthism only regards health and wellness promotion practices that are not mediated by health professionals. In the Nineties, many authors indicate the resurgence of public health programmes which draw on the notion of "healthy lifestyle" as part of a socio-political change towards control and management of health resources (Massé, 1999; Petersen & Lupton, 1996; O'Brien, 1995). The same scholars point out the contradiction between the "new morality" of illness prevention and health optimization, and the liberal model of health based on free choice. Lifestyle, as constructed in terms of risk factors associated with the ever-expanding notions of health, is integrated into the traditional model of medical service provision that becomes an important vector of this new ideology of health. General practitioners are the pastors of this new form of hygienism, which takes place not in society, but in the individual space of the doctor-patient encounter, by deploying a number of new bio-entities (triglycerides, blood hypertension, advanced maternal age, etc.) and tools, such as screening tests, check-ups, risk thresholds, which travel beyond the clinic and become part and parcel of popular culture, as far as they enter and are re-appropriated by laypeople's experience (Turrini, 2014).

A distinction between healthism and medicalization is also problematic because the topic at its core, lifestyle, pervades both leisure activities and clinical practices. To treat them as different processes may lead us to miss what they have in common. Rather, the concept of lifestyle in healthism fits the paradigm of "surveillance medicine" that David Armstrong (1995) elaborated in the same period. According to this approach, as the distinction between the normal and the pathological blurs, medicine remaps the architectural, epistemological and

interventional space of pathology. Medicine propagates well beyond the walls of the clinics as the location of disease causation divides into a multiple set of risk factors that identify the precursors of future illness. Lifestyle in healthism does not mean addressing only emerging phenomena, but also formulating an original perspective on the influence of health concerns on medicine itself, as well as on culture and society at large, especially in the processes of the construction of the self (see, e.g., Lupton, 1994). In this regard, healthism paradigm participates, along with other traditions in medical sociology, sociology of health and illness, medical anthropology and cultural studies, in examining the hybrid formations which, in name of health and wellness, cut across the boundaries between medicine and popular culture, private, ordinary life, public spaces and clinics, medical professionals, patients and other health professionals.

4. Healthy subjectivities

By looking at those practices and devices that establish bridges between traditionally distinguished domains, healthism conceives the power as a dispersed and complex phenomenon that targets and reveals itself through the construction of healthy subjects. This marks a radical difference from medicalization, which, in its crudest version, "gave all agency to the medical profession… (*while*) the subject of the social definition of behaviours falling within the domain of medicine were perceived as lacking agency and hence viewed as victims" (Riska, 2010, p. 151). While in medicalization individual autonomy is constrained by members of an authoritative institution that is allowed to dictate how they should behave, in healthism autonomy becomes the principal issue at stake. As a moral discourse based on individual responsibility about one's own psychophysical condition, healthism poses the question of why individuals choose, embrace, or refuse these values. Once again, this debate anticipates the massive use of Foucault in the social sciences of medicine during the Nineties (see, e.g., Lupton 1997), in particular the construction of subjectivities as a by-products of both the disciplining of a population and "technologies of the self".

The relationship between emerging subjectivities and the power of medicine takes on a dual significance. On one hand, individuals are the target of a State-centred strategy to generate inequalities (see Zola, 1977), or limit their liberty (see Skrabanek, 1994), while, on the other, Foucault-inspired scholars such as Robert Crawford, Deborah Lupton, Alan Petersen, adopt a more dispersed and pervasive conception of power and focus not on its institutions, but its effects on subjectivities.

Petr Skrabanek is the influential mentor of a libertarian interpretation of healthism based on a stern opposition between the State and the individual. His sarcastic criticism targets public health initiatives committed to *Health for all*, which are increasingly incorporated in new medical initiatives – from screening tests to preventive treatments, from medical recommendations to awareness campaigns, including medical practices. According to Skrabanek the paradigm of "anticipatory" medicine, which increasingly relies on a statistical assessment of risk factors, degenerates and de-humanizes the clinical tradition that, in his view, was originally based on the encounter between physicians and patients. In addition, this social approach to the medical clinic provides an efficient and poisonous means to the State, which could purposefully use it to limit individual freedom and increase stigmatization.

> (T)he State… uses propaganda and various forms of coercion to establish norms of a "healthy lifestyles" for all. Human activities are divided into approved and disapproved, healthy and unhealthy, prescribed and proscribed, responsible and irresponsible (Skrabanek, 1994).

The State mission to protect and promote the health, wellness and happiness of any single individual, what he calls "coercive healthism", revitalises and adapts old ideologies that legitimized racism, racial segregation, and eugenic control. The public moral of healthism is an incipient form of future totalitarism that leverages the collaborative efforts of each single citizen to build its power.

Far from such a simplistic dichotomy between State and individual, Foucauldian approaches focus instead on a disseminated notion of power and its influence on subjectivity formation processes. A Foucaultian analysis might see power as dispersed into a complex network of heterogeneous entities, including institutions, political bodies, architectures, knowledge, methods, perceptions and concepts. Although pervasive and potentially totalizing, the influence of medicine is not aimed at strengthening an all-powerful State (as in the sovereignty theory), but rather the "science of the individual" that fashions the "modern individual" (Foucault, 1973). The locus of power is not restricted to the State here (as in Skrabanek) or the medical profession (as in medicalization), but is rather "a complex and expanding apparatus of control, discipline and regulation that involves micropolitical processes whereby the individuals were encouraged to conform to the morals of society" (Petersen & Lupton, 1996, p. 14).

The main issue at stake, therefore, is not the process of domination of individuals, but rather how they internalize, reproduce and intensify health awareness spontaneously and

without any external coercive force. Nonetheless, what can be deemed as an exercise of choice and free will aimed at optimizing health, lays the foundation for sustaining a very strict normativity and homologation, which is inescapable due to the dissemination of health concerns into everyday life. A genealogical analysis of health concerns is very clear on this point. Dating back to the end of the 19th century, the role health plays in the construction of subjectivities is double, as it involves discipline and mobilization[9] of the social and individual body (Crawford, 2006). For Crawford, nowadays, the healthist construction of an "healthy self", as separated from the "unhealthy other", is spontaneously adopted by the middle-class, who develop an ethic based on autonomous individualism, self-control, self-determination, and self-responsibility to face the rise of inequalities in the neoliberal economy (Crawford, 1994). Health has become a vector for the production of the self and the formation of neoliberal subjectivities that introduces the faculty of choice and free will into the everyday management of our body through risk assessment. Though based on individual independence, the health awareness discourse conveys a strong normativity. Monica Greco finds the roots of the healthist moralism in an alternative epistemology that has coexisted alongside the medical perspective since the beginning of the 20th century: psycho-somatology. The effort of new prevention and health management strategies intends to render the unconscious, motivational component of disease studied by psycho-somatology visible, conscious, and therefore amenable to some kind of rational decision.

In so far as the psychosomatic subject constitutes both the locus and the ultimate responsible agency of preventive intervention, the event of disease has become a moment of verification of the moral aptitude of individuals to form part of the society within which they live (Greco, 1993, p. 357).

Health cannot be imposed, because only complete compliance with this morality serves as a visible sign of the initiative, adaptability, endurance and strength of will that healthism requires. This fits well with a version of normativity which interpellates not only ill people, but anybody who is presently *a-symptomatic*, i.e. potential patients. The right to health and the duty of the patient to see a doctor is here translated in to the very general and omnipresent concept of the *duty to stay well*. The construction of subjects who are autonomous, responsible and active participants in their own health assumes a universal significance and becomes the political project of building up a "healthy citizenship" (Sharon, 2014). The tension between autonomy and discipline, contestation and homologation, expressivity and normativity, pervades many facets of the self-construction of the body. The body, on one hand, takes a

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[9] Interestingly enough, health awareness is genealogically associated with the end of the 19th century, a period marked by both the first public policies of hygiene campaigns, as well as a turn towards a "physical culture" aimed at bodily vigour and revitalization, well represented by the new interests in sport activities.

central position in a wide set of care practices, and, on the other, tends to be homologated to ideals of wellness and beauty, which come to be one of the most notable signs of psychological self-acceptance and wellness (Rysst, 2010).

To some extent, healthism has anticipated a poststructuralist approach to medicalization recently introduced by Adele Clarke and colleagues (2003; 2010) characterised by addressing specific health tendencies: the widespread of health issues within and beyond the clinics marked by the centrality of individuals. The reconfiguration of the care-spaces, for example, is significant both for telemedical systems, which follow patients directly in their homes through their own input or constantly through revelation technologies, as well as self-tracking devices and do-it-yourself services that give laypeople the possibility to mimic the same control practices of one's own organism through the production of bio-data. While users are actively involved in these practices, and in some cases actively contesting medical authority, these devices may serve as tools of control that impose new burdens and responsibilities. This perspective does not regard only technoscientific innovations, but also practices and devices that propose a model of healthcare alternative to biomedicine, as it was in the first conceptions. Biomedical innovations of the period served as the starting point of Zola reflection on healthism, while Crawford chose the blossoming movements against the introduction of technoscientific innovations in medicine. Likewise, healthist tendencies combine devices and practices of apparently opposite nature. Nowadays, this connection is particularly inspiring to map the increasing area of convergence between the use of self-tracking devices and data an approaches to medicine based on lifestyles, food behaviour and fitness. If healthism can provide a very interesting framework to map all these new phenomena, what is probably missing is to put in question the boundaries of health. The appropriation of medical discourse of health (and not only disease) cannot be understood simply in terms of an expansion, but rather in terms of a transformation. The hybridization of health issues into everyday life shows us a use of health-related practices, devices, and data for aims that do not have a strictly clinical utility.

5. Conclusions

Healthism is a widespread term used commonly even in everyday language to refer to the role played by health promotion as a moral imperative. Initially conceived as the ideology of the broader process of medicalization, healthism since the beginning gains its autonomy by shedding light on the expansion of medical discourse beyond medical institutions and

professions. This notion is the result of a reflection on either technological innovations aimed at disease prevention and health/wellness promotion and optimization or new practices of self-care challenging the centrality of medical authority. Healthism has thus the merit of grasping the common thread which these heterogeneous phenomena, although their differences, share. In particular, lifestyles and risk factors are the vectors of an innovative, hybridized medical discourse, which tend to blur the boundaries between the clinics and society at large, between physicians, patients and laypeople (deemed as asymptomatic patients), between properly medical interventions and other healing procedures.

The appropriation of medical concepts, practices, devices, attitudes and gazes is framed by healthism not much in spatial terms, as an expansion of medical authority, but rather as an incipient political phenomenon. The rise of a post-disciplinary model of medicine is here framed though the dichotomies of freedom and coercion, stigmatisation and individualization, medical paternalism and patient empowerment. These conceptual coordinates may be very useful to analyse a wide set of innovative, hybridized practices in the field of self- and health-care based on the centrality of individuals. For all these reasons, healthism should not leave to the common sense, and on the contrary should be fostered in the analysis of a wide of biomedical innovations, including do-it-yourself diagnostic tests, quantified-self, telemedicine, and its associations with other forms of alternative or non-Western medicine.

In order to revitalize healthism as a category, we would also like to point out to some of its major pitfalls. First, healthism should avoid to assume a stern conception of medical discourse. The difficulty to border medicine, which is particularly clear in the case of healthism, could be approached through an approach based on practice where what is medical is not an assumption of the research, but, if anything, the result of a set of practices. Second, the political approach proposed tends to end up to a prescriptive approach. As noted by Foucault (2004, p. 18) in referring to medicalization, "the present situation must not be considered in terms of medicine or antimedicine, or whether or not medicine should be paid for, or whether we should return to a type of natural hygiene or paramedical bucolicism".

Rather than thinking nostalgically about returning to a non-medicalized past through de-medicalization, the analysis should focus on the processes of subjectification. There is no *uncorrupted* individual outside the overwhelming power of medicine, as the individuality itself is a by-product of it. The production of large amounts of data regarding biological processes and/or the behaviour of our psycho-physical organic self, combined with the practices needed to make these devices work, indicates the increasing importance of health and similar domains of prevention, promotion, optimization and fitness, in the construction of new subjectivities. In other words, practices around health devices and data go beyond medical discourse and, so, need to be analysed beyond merely health issues and concerns.

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