Introduction

> The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services. (Mental Health Taskforce, 2016, p. 4)
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> To be successful, a comprehensive long-term strategy to tackle obesity must act in two complementary ways to achieve and maintain a healthy population weight distribution. First, an environment that supports and facilitates healthy choices must be actively established and maintained. Second, individuals need to be encouraged to desire, seek and make different choices, recognizing that they make decisions as part of families or groups and that individual behaviour is 'cued' by the behaviours of others, including organisational behaviours and other wider influences. (Butland et al., 2007, p. 122)

The inhabitants of most OECD countries tend to regard state intervention in the everyday lives of individual citizens and in society at large with a certain scepticism. At the very least governments and public authorities in so-called liberal democracies are expected to come up with quite convincing moral arguments to justify interventions that go beyond protecting basic civil and political rights. One does not have to be a libertarian to acknowledge that state power may have quite far-reaching implications for our everyday life and that the orchestration and mobilization of such powers calls for critical attention. Notwithstanding liberal concerns over state power (and the many inbuilt mechanisms in liberal democracies to account for and regulate its use), there is an area in which most liberal democracies seem to be very tolerant in the use of direct state power: the governing of public health and the vigour and quality of the lives of individuals and populations seem to constitute a case in which liberal concerns over state interventions at times seem less adamant.

For more than a century, industrially developed states have contributed to the establishment of comprehensive and widely available health

services, such as hospitals, clinics, general practitioners, home nurses, and community health centres (Starr, 1982; Blank and Burau, 2014). We have also seen the development of large-scale physical infrastructure interventions to ensure sewage treatment, clean water, and waste management (Corbin, 1986). While our growing cities may seem chaotic, the design of housing, streets, and squares has been strictly regulated since the end of the nineteenth century to ensure hygiene, clean water, and reasonably clean air with a view towards ensuring public health (Latour, 1988). The state then has intervened extensively in society in the name of public health since the nineteenth century.

Michel Foucault used the term biopower to designate the modern state's responsibility for ensuring the vigour and quality of the population inhabiting its (the state's) territory (Foucault, 1978, pp. 139–141). Sovereign, state power would now be used not so much to take life but to invest in life and its quality. Moreover, during the nineteenth and twentieth centuries a series of regulatory interventions, relying less on sovereign power of commands and interdictions but more on indirect forms of power, were launched to promote personal conduct and physical spaces more conducive to public health. Yet these regulatory interventions targeting both individuals and the population have generally been limited by liberal concerns over excessive state interventions (Osborne, 1997). The aspirations of the programmes seeking to cure and prevent illness have usually been tamed by institutionalized norms of civil and political rights protecting individuals and society at large from instances of state power and other powers not grounded in constitutional or legal regulations. Thus, both curative and preventive strategies have usually targeted the health of individuals and populations in a voluntary and/or indirect way. The curative services offered by hospitals, general practitioners, and others are just that: offers. Unless you have a highly contagious and dangerous disease, no one will force you to see a doctor. The preventive strategies seeking to promote hygiene by constructing sewage systems, securing clean drinking water, organizing waste management systems, and regulating housing design and construction all work indirectly. They modify the physical environment of citizens to make this more hygienic and healthy. These changes to the physical environment may alter the everyday conduct of citizens quite significantly, but this happens indirectly.

Of course, Western societies – corresponding roughly to the existing OECD countries – have seen the use of direct and even coercive forms of preventive interventions in the name of the population's vigour and quality. All over these societies, the emergence of the eugenic movement in the interwar period resulted in various public interventions seeking to protect the quality of the stock by trying to reduce the reproduction of the physically and mentally unfit, culminating with the Nazi

extermination programme to ensure the purity of the Aryan race. The eugenic movement – at least in its negative form – has so far served as a political warning of just how wrong things can go when sovereign state power is mobilized in the name of the population's vigour and quality. Thus, Western societies have been reluctant to use coercive means and to use interventions directly targeting and modifying behaviour or conduct. This may be about to change.

While coercion is hardly on the contemporary public health agendas of these countries, they have witnessed the emergence of an approach that urges state power to be both intensified in order to reach ever deeper into the personal dispositions of individuals and to be extended to reach into ever more parts of the social environment shaping the choice and conduct of citizens. Thus, under the broad heading of health promotion, we have seen the unfolding of a wide range of new ideas, strategies, programmes, and techniques that are trying not to cure illness but to promote health (World Health Organization, 1986, 1998). The WHO's Health for All strategy adopted in the mid-1980s seems to have contributed significantly to the framing of health promotion ideas and strategies in many OECD countries. To get the gist of the new approach, it may be worth quoting the WHO's Ottawa Charter at some length:

> [H]ealth promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organizations, by industry and by the media … Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health … Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors and ways of removing them. The aim must be to make the healthy choice the easier choice for policymakers as well. (World Health Organization, 1986, p. 2)

In the following years, most countries in Europe, North America, and the Antipodes, and several countries in Asia, have designed strategies and launched programmes that seek to promote health and to prevent, rather than cure, illness (Blank and Burau, 2014, pp. 208–213). The distinction between health promotion and curing of illness may seem an insignificant one, but the political implications of the two conceptions and the strategies they imply are substantial. The cure of illness is a relatively narrow and well-defined political enterprise; health promotion is not. To cure illness is limited to specific target groups (those deemed ill); health promotion targets each and every citizen. A cure has a start and an end; health promotion is a never-ending process in as much as it is always possible for everyone – even the most apparently healthy person – to further improve her healthiness or vigour. Health promotion then is really not

about curing diseases or even about preventing diseases. While the promotion of health should, according to its own success criteria, be able to reduce the likelihood that a person falls ill and thereby be preventive, its ambition goes further than the prevention of illness. As hammered out over and again by the WHO, national health authorities, and a number of health professionals, the ambition of health promotion is not only to reduce the risk of falling ill but also to augment the health and vigour of a person and of the population at large. This implies that each and every one starts reflecting on their own health, their habits of dieting and physical exercise, and further, as we shall see in the following chapters, that our social environments and relations are shaped in ways that are conducive to the choice of a healthy lifestyle. In this sense, health promotion goes much farther than any hitherto existing preventive strategy, including the infamous eugenic movement.

In the somatic area, obesity has become a phenomenon of acute political concern. Until recently, obesity was not regarded as an illness. The populations of many OECD countries are living an increasingly sedentary life and consuming increasing amounts of high-fat and high-sugar food products. Accordingly, the prevalence of overweight and obese people has increased more or less steadily. Today, medical experts are debating whether obesity should be considered a disease. However, they agree that obesity significantly enhances the risk of contracting so-called lifestyle diseases, such as diabetes, a wide range of cardiovascular diseases, orthopaedic diseases, and certain forms of cancer (World Health Organization, 2016). This has caused some US medical experts to regard obesity as a threat to national economic sustainability (Olshansky, Passaro, Hershow, Layden, and Carnes, 2005). They expect that obesity among American children and youth will dramatically increase health costs and erode the tax base, as the capacity of the obese to remain in employment will drop.

Partly informed by this medical knowledge, we have seen the emergence of a wide array of health promotion interventions that work neither by curing diseases nor even by modifying the physical environment – though we find both these types of interventions too. These new interventions are targeting the individual and the social environment in order to make people adopt a healthier lifestyle. The individualizing interventions include fitness courses, therapeutic procedures, cookery programmes, obesity camps, self-esteem techniques, and workplace gymnastics (Ayo, 2012). In a few instances, such as in Singapore, these interventions include mandatory physical training programmes for obese children (Foo, Vijaya, Sloan, and Ling, 2013). We have also seen the emergence of interventions targeting the social environment of the obese and the general population. This includes the forging of networks or joined-up government between schools, workplaces, sports clubs, community centres, and various voluntary organizations on the one hand,

and hospitals, clinicians, general practitioners, and municipal health services on the other (Blank and Burau, 2014, pp. 217–221). Network or joined-up governance is invoked here to make it easier for individuals, families, and groups to choose and actually live a healthier life (Vucina, 2014, pp. 164–189). The WHO has encouraged such comprehensive strategies based on extensive cooperation between public agencies, and between such agencies and all parts of civil society in order to reach not only the obese, but also those who at a later stage in their life may gain excessive weight, in particular children and young people (WHO Regional Office for Europe, 2006).

The development of health promotion interventions emphasizing lifestyle changes may be seen as the obvious or natural response to the growing prevalence of obesity and the diseases it may induce. However, on closer inspection this response is not so obvious. Firstly, there is strong medical evidence suggesting that the risks from being overweight or slightly obese are negligible and in some cases it may even be beneficial (Flegal, Kit, Orpana, and Graubard, 2013). Secondly, health promotion interventions are extremely costly. In fact, it has been estimated that the costs of obesity control outweigh the benefits (van Baal et al., 2008). Thirdly, and most importantly from the point of view of this book, health promotion interventions interfere very directly in the everyday life of people, something that usually arouses suspicion and resistance. While we often accept the right of public authorities to step in and regulate everyday behaviour in cases of contagious diseases, in the case of most other diseases liberal rationalities tend to prevail, in the sense that people are given a choice of whether they want to receive treatment or not. In the case of obesity, which many medical experts do not even regard as a disease, there seems to be an increasing consensus on the need for extensive interventions. This acceptance of public intervention to control obesity seems even more curious if we consider that most interventions target not only the obese but all those at risk at becoming overweight or obese (i.e. everyone).

Within mental health we have seen the emergence of so-called community psychiatry or community mental health and outpatient treatment. This reflects the de-institutionalization of the treatment of people suffering from a wide range of mental illnesses. During the 1970s and 1980s, many patients were moved from the ambit of the asylums and mental hospitals to more or less well-integrated networks of psychiatric programmes, general practitioners, municipal services, and specialized housing projects that seek to create a life close to 'normal' (Castel, Castel, and Lovell, 1982, pp. 162–169; Grob, 1991). Apart from saving money on running costly mental hospitals, the proponents of community health services argue that many patients are cured more effectively outside of hospitals and that even those who are never fully cured may experience a richer and

fuller life outside the confines of the mental institutions (World Health Organization, 2001, 2007). Thus, the basic rationale of community mental health interventions is really to empower the mentally ill via the enabling institutions and services offered by the community.

The biomedical approach to a number of mental diseases, including schizophrenia, changed quite significantly during this period of de-institutionalization. In particular, the emergence of recovery as a strategy emphasizing the enhanced ability of the patient to cope with her symptoms, rather than eradicating these, stands out. Recovery is the label for a wide range of relatively recent schemes, programmes, procedures, and therapeutic techniques employed neither to cure the mentally ill nor to prevent mental illness but to enable or empower patients to live a better life with their disease (Roberts, Davenport, Holloway, and Tattan, 2006a). Recovery constitutes a major break with previous forms of mental treatment. First of all, it is entirely voluntary. We may recall that the history of psychiatry is notorious for the use of forced incarceration in dungeons or at mental asylums with a view to curing the patient of his madness (Foucault, 1967). We may also recall that preventive strategies targeting the mentally ill became particularly brutal during the twentieth century, when several countries saw the use of state power to control the procreation of the feebleminded and other mentally inferior groups to protect the health and vigour of the wider population (Dikötter, 1998). Secondly, recovery relies less on strictly biomedical medicine and therapies and more on various psychosocial empowerment techniques. To recover is to enhance the quality of life not in biomedical terms but in psychosocial and economic terms, i.e. to raise the self-esteem of citizens and improve their capacity to have a reasonably normal life with a family, an education, and perhaps even a job. Our motivation for focusing on recovery as the second case of health promotion is precisely because recovery does not really seek to cure illness. It seems to us that if health promotion and its strategy of empowerment can find its way into the treatment of incurable diseases, then this kind of intervention could probably find its way into any phenomena related to the improvement of human life.

To sum up, liberal democracies have seen the emergence of a new politics of health that seeks to promote the health and vigour of individuals and populations by directly targeting their conduct. While health promotion is clearly not based on coercion, it is a form of power orchestrated and often, albeit not always, implemented by state authorities that have few if any inbuilt political limitations. It is these limitless features of health promotion that call for critical scrutiny. In order to do so, we focus on two general strategies found in many health promotion interventions, namely the individualizing technologies seeking to empower citizens with a view to enable them to live a healthier life and the environmental

or socializing technologies seeking to shape the social environment, networks, and relations of citizens, again, with a view towards enabling these to adopt a healthier lifestyle.

Aims and arguments

The overall aim of this book is to provide a critical understanding of current health promotion ideas and practices unfolding in liberal democracies. By 'critical' we refer to an understanding of the ways in which various power relations, expert knowledge, and social norms structure the freedom of those subjected to health promotion interventions. Of course, many existing studies critically address the shortcomings of health promotion programmes, i.e. their frequent inability to really make people healthier. However, as we will show in the following chapter, very few studies question the moral endeavour and the political strategy of health promotion, i.e. that we should constantly try to improve the health of individuals and populations and that public authorities can do only too little in securing this.

Our critical ambition is fleshed out in three more concrete aims of an empirical, conceptual, and critical character. Firstly, we seek to expose the various relations and techniques of power, expert knowledge, and social norms that constitute contemporary health promotion. This entails specifying the uniqueness of health promotion as compared to other public health strategies. Secondly, we aim to expand and qualify the conceptual debate on and understanding of contemporary tendencies in the politics of health. This implies discussing and elaborating Michel Foucault's notion of governmentality and its link to biopower (Foucault, 1978, pp. 135–159; 2007). Finally, we aim to discuss and problematize the desirability and political-ethical implications of health promotion, i.e. the promises and the limitations or costs to the freedom of citizens, patients, communities, and other subjects invoked by health promotion.

The general argument of this book is that contemporary health promotion interventions are structuring our freedom in ways that both enable new forms of freedom and limit the space of possible freedom. The empowering ambitions and techniques of health promotion work through the freedom or self-steering capacities of individuals and communities (N. Rose, 1999). In doing so, health promotion simultaneously contributes to the development of new freedoms but also imposes a number of rather strict limitations on the kinds of freedom it regards as desirable. More precisely, we argue that health promotion is a genuinely new public health strategy. It differs fundamentally from curative strategies. It also differs from earlier forms of health prevention in that it employs forms of power that directly target the conduct of citizens.

Moreover, we argue that Foucault's concepts of biopower and governmentality are both still highly useful for understanding contemporary health promotion interventions in liberal democracies. The term biopower may assist us in grasping the way in which health promotion innovates but ultimately retains the state's concern with the biological quality of the population inhabiting its territory. While the exercise of biopower in both England and Denmark has undergone tremendous changes since its emergence in the nineteenth century, notably by its increasing dependence on the self-steering capacities of individuals and communities, the term biopower is still useful in creating a space for critically analysing the ways in which state power in liberal democracies is concerned, perhaps more than ever, with the vigour of populations. The notion of governmentality allows us to address the various political rationalities at play and, at times, in conflict over health promotion. In particular, classical liberal concerns over excessive state intervention seem to be steadily losing terrain in favour of *constructivist neoliberalism* concerned with the mobilization of the self-steering capacities of individuals and communities (Triantafillou, 2017). If the term governmentality is problematic, it is because it is often used as an explanatory term, rather than a descriptive one. To be clear, we use the general term governmentality and the (more) specific term constructivist neoliberalism not to explain the emergence and functioning of health promotion but as analytical concepts that may enable us to render visible and hopefully better understand the political rationalities informing the quest for health promotion pursued not only by the state but also by a wide range of private institutions, public health experts, and other groups.

We use the term *optimistic vitalism* to characterize the particular merger between contemporary biopower and constructivist neoliberalism. We argue that contemporary health promotion is essentially a quest to improve the vigour, quality, and even happiness of the lives of individuals and populations. Contemporary health promotion interventions are widely seen as justified regardless of whether the person is seen as perfectly healthy or is diagnosed as suffering from an incurable disease. Apparently, there is always room for improving the vigour of your life. In particular, there is always room for you to reflect on yourself, on your choices around diet and physical exercise, on your coping with eventual bodily or mental maladies, and not least on how you engage with the social relations that may affect your self-esteem and choice of lifestyle. All this may sound a bit conspiratorial, as if some external machine is secretly forcing people to think in particular ways about their health. This is definitely not our understanding of optimistic vitalism, which hinges on citizens' reflecting on themselves and choosing a particular mode of conduct in order to pursue what they find is the

best way to lead a vigorous and happy life. Our point is that today these reflections and choices of conduct are restricted by social norms and political programmes that urge individuals and groups to constantly think about how they can live a more vigorous and happier life in more or less particular ways.

Throughout the twentieth century, the term vitalism has served a variety of epistemological and normative purposes. The reflections of French philosopher Henri Bergson on evolution and vitalism (Bergson, 1911) inspired some to argue for a new vitalist theory or epistemological approach to biology in order to address the complexities of organic life (Hoyningen-Huene and Wuketits, 1989), while others have proposed a vitalist-materialist ethos of life celebrating becoming and transgression of boundaries (Deleuze, 1988; Braidotti, 2002). Moreover, inspired by the biological and biomedical writings of French medical doctor and philosopher Georges Canguilhem in the 1950s and 1960s (Canguilhem, 1991, 1994), we find more cautious discussions on the ability of vitalism to prepare the way for a new ethos of life (Greco, 2008), a *pathos* of life (Osborne, 2016), and to function as a principle for criticizing the normalization of life (Sholl and De Block, 2015). All these reflections are highly interesting in that they suggest that it is possible to think about and act upon life in ways that go beyond scientific biomedicine and the norms it espouses. However, they do not shed much light on the actual political exploits of vitalism today. It has been suggested that the absence of analysis of the link between vitalism and state power may be linked to a certain a priori conception of vitalism as something that transgresses state power (Villadsen and Dean, 2012). Whatever the reason, with some notable exceptions (Mills, 2013; Villadsen and Wahlberg, 2015; Wahlberg, 2016), very little has been done to critically analyse how vitalist aspirations have informed contemporary public health interventions exercised by, or at least relayed through, the state. In sum, there is a need to grasp how vitalist thinking and norms inform the exercise of biopower today. We think that obesity control and mental recovery constitute exemplary cases of health promotion, the analysis of which will allow us to better understand the particular kind of optimistic vitalism that feeds into the political ambitions of public health authorities through their attempt to govern our lives today.

Like the proponents of vitalism, this book is driven by a certain normativity. However, our concern here is not with finding a new ethos of life but with the kinds of power exercised through health promotion and the optimistic vitalism informing it. We find health promotion to be problematic because of its grand and seemingly unlimited ambitions of promoting the health of each and all by way of mobilizing society at large. If taken to its logical conclusion, health promotion may substantially reduce the space of possible freedom for the ways in which we think about and act upon ourselves in terms of health. On the one hand, we

should be careful not to exaggerate the influence of health promotion vis-à-vis other health strategies. And we should be particularly careful not to overlook the fact that health promotion does allow and even stimulates new forms of freedom, whereby patients, citizens, communities, and other subjects can govern their health in novel ways that they find desirable. On the other hand, health promotion not only generates new forms of freedom, but it also actively discourages other forms, namely any form of conduct that is regarded as risky or unhealthy. Even on its own terms, health promotion is questionable as it tends to focus rather narrowly on charging individuals and communities with the responsibility of changing lifestyle choices rather than addressing wider inequalities in education and income levels. Perhaps what is particularly disconcerting is that public authorities, medical experts, and various empowerment engineers have so few qualms about intervening so extensively and quite directly into the lives of citizens and their surroundings.

The book analyses obesity control and mental recovery in England and Denmark from the 1980s until around 2015. Why these two countries? Health promotion in England and Denmark represents diversity within sameness. On the one hand, they display some fundamental similarities. Both England and Denmark have advanced relatively far in developing new ways of governing citizens, public health services, and the institutional environment supporting health interventions. They also both face relatively large problems – compared to other European OECD countries – with so-called lifestyle diseases, such as obesity, diabetes, cardiovascular diseases, and certain forms of cancer. On the other hand, the two countries differ on some important points. England is characterized by a liberal welfare regime with a strong tradition of private measures in public health and an acute sense of the problems of excessive state intervention. Although the English health services to a great extent are state-financed, as in Denmark, they nevertheless reflect strong political concerns over excessive intervention in people's lives. Denmark, on the other hand, is widely recognized for having an advanced and more or less universal welfare regime, which is supported by a widespread domestic consensus on the desirability of comprehensive state intervention to ensure the health of the population. This diversity or difference between England and Denmark is used to show that the politics of health promotion do not imply a uniform policy package but may inform quite diverse forms of political interventions.

Overview of chapters

Chapter 1 identifies and discusses the merits and the limitations of the most influential political science and sociological analyses seeking to

critically address contemporary politics of health. Firstly, it focuses on studies dealing more or less directly with health promotion, i.e. the kinds of health policies that seek to improve the health of citizens through a range of empowerment strategies and programmes. Secondly, the chapter zooms in on Foucault's analytics of power and government. We account for the critical potential and limitations of Foucault's analytics and explain how they can be used to analyse power–knowledge relations and unquestioned norms in contemporary politics of health. Finally, we account for our method in terms of the cases and data selected to study the politics of health promotion in liberal democracies.

Chapter 2 seeks to provide a solid understanding of the wider political context of health promotion in England and Denmark. The chapter first delineates the emergence of biopower in the two countries during the nineteenth century. This includes accounting for the basic rationalities, interventions, and organizational structures of the public health systems. Secondly, it accounts for the major public health reforms taking place in the two countries since the 1980s with a particular focus on the health promotion strategies and programmes employed. Finally, we show how the community (or the wider institutional environment) became a site of interventions seeking to mobilize the capacity of citizens to choose and pursue healthy lifestyles.

Chapters 3 and 4 examine obesity control in England and Denmark respectively. Both chapters first briefly delineate the historical antecedents to obesity control. We then examine how political rationalities and expert knowledge mutated in both countries from around the late 1980s to render obesity an epidemiological problem requiring systematic government intervention. This was linked to political rationalities emphasizing the potential of governing through the freedom of individuals and their environments. We then move on to account for political reforms, programmes, and technologies employed to fight obesity and promote healthy lifestyles. We examine both the individualizing interventions and techniques and the programmes seeking to mobilize communities and the institutional environment in general to make it easier for citizens to eat healthily and engage in regular physical activity.

Chapter 5 and 6 analyse how and why psychiatric patients – particularly those with chronic mental illness – in England and Denmark are urged to take charge of their mental illness with reference to the notion of rehabilitation. They shed light on techniques of psychological counselling and social assistance with particular attention given to so-called Crisis Resolution and Home Treatment. As an alternative to hospital admission, these novel techniques for engaging the patients as well as the family and community expanded rapidly in England in the early 2000s. Both chapters analyse key shifts in predominant forms of political rationalities and expert knowledge on

how best to treat psychiatric patients. This includes examining how the experts involved in treating the chronically mentally ill – doctors, psychiatrists, psychologists, social workers, and nurses – depend on the problematization of the targeted patients. Finally, the chapters examine how expert knowledge and political rationalities informed political interventions (policies, programmes, and technologies) in an attempt to promote rehabilitation along with increased implementation of community-based treatment.

In the conclusion we summarize and discuss the analytical findings regarding the governing of citizens through lifestyle and rehabilitation respectively. The chapter also highlights the conceptual and critical contributions to our way of understanding, debating and governing health today. Finally, it points to the needs for further research on the politics of health promotion.