Medicalization, pharmaceuticalization, and health imperialism

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The starting point of the discussion proposed here is consideration of factors that lead to seeking healthcare services. Seeking healthcare initially results from the interaction between the subjective feeling that something is going wrong and cultural patterns in the expression of health problems and the services' availability. In contemporary industrial societies, this interaction results in seeking a hospital or clinic where one expects some disease to be diagnosed, for which a treatment will be proposed.

The concept of medicalization was formulated in the study of the historically contingent process of structuring this response. An initial problem is that there are different concepts of medicalization, not always mutually compatible, since they are linked to different ways of understanding the complex relations between health and society. According to Zola [1], for example, medicalization is a way of controlling society; for Foucault [2], it is the inevitable consequence of the social transformations that both create modern medicine and submit to it; finally, Conrad [3] adopts an operational definition of the concept that is highly useful for empirical studies. According to the latter author, medicalization is the process of transforming problems not previously considered "medical" (or "health-related", we might add) into medical ones, usually in the form of disorders or diseases.

Explicitly absent from this definition is the tone of moral condemnation found in the more radical theses on medicalization. This is one of the important differences in the various narratives grouped under the word "medicalization", a spectrum, which, on one end, contends that there is no legitimate place for medicine in caring for people (for example, Illich [4]) and on the other end recognizes the possibility of ethically justifiable contributions from this same medical knowledge-practice-institution.

Over time, this conceptual variability has been diluted into scarce on rigour appropriations that have turned medicalization into a sort of universal explanatory principle, a quasi-conspiratorial theory with widespread applicability, emptying the concept of its meaning and power.

The rest of this discussion adopts Conrad's definition, which we consider the most precise and easily usable in an empirical context. Meanwhile, we raise the challenge of considering under which circumstances medicalization might or might not be justifiable. Although an in-depth exploration of the latter issue is beyond the scope of the current discussion, some examples may clarify this point.

Before 1981, AIDS and HIV did not exist on the horizon of medical knowledge. The report of two clusters of previously unidentified diseases in similar groups (young, homosexual, previous-

ly healthy males) triggered a wave of investigation which, in a relatively short period of time, forged and stabilized a new diagnostic category, produced an explanatory mechanism, identified an infectious agent to which the origin of the disease was attributed, and led to the development of tests, finally followed by medication capable of considerably prolonging the life of affected individuals. According to Conrad's definition [3], this was clearly a process of medicalization, but with a positive ethical connotation. The other end of the spectrum would include, for example, attempts to create a purported "female sexual dysfunction", heavily influenced by commercial interests linked to the pharmaceutical industry [5].

The concept of medicalization as proposed by Conrad [3] thus raises this initial challenge: to examine (in real-life cases) how the (re)construction or expansion of diagnostic categories unfolds, bringing to the forefront the underlying processes and exposing the role of interests that are disconnected from or even contrary to the well-being of populations.

However, similar phenomena also require attention, especially in relation to the latter issue, the extension of possibilities for intervention at the service of economic interests uncommitted to the ethical purposes associated with the logic of health care.

Williams et al. [6] defend the idea that there are processes of this order that escape the strict conceptualization of medicalization as approached previously. According to these authors, it is also necessary to consider "pharmaceuticalization", which they define as the translation or transformation of human conditions, capacities, and potentialities into opportunities for pharmacological interventions. Although pharmaceuticalization overlaps extensively with medicalization, it differs from the latter because it is not necessarily linked to some kind of medical diagnosis, as shown by the growing phenomenon of medication use without a therapeutic indication, rather aimed at a "super normalcy" through pharmacological "enhancement". These authors further define pharmaceuticalization as a complex social and technical process that interacts with the processes of medicalization. Pharmaceuticalization creates identities around the use of certain drugs, in addition to reinforcing the idea of "a pill for every ill", thereby expanding the pharmaceutical market beyond traditional areas, including use by healthy individuals, undermining the medical profession's predominance by creating direct relations between industry and "consumers" and colonizing human life with pharmaceutical products.

Finally, a third process usually included in the discussion of medicalization still lacks an adequate term. In a previous attempt [7] we proposed the word sanitarization, while Conrad has suggested "healthicization". Regardless of the term, the idea is to identify what could be called the tyranny of "health", encompassing a set of components embedded in the idea of a "positive concept of health" [8], namely:

- an undefined and potentially infinite expansion of the health concept, to the point of encompassing all of human experience;
- a paradoxical narrowing of the ethical and aesthetic ideals of a "good life", reduced to living long years with a minimum of diseases, with no consideration for pleasure or aspirations beyond the individual level, a "fearful and restrictive" health as described by Sayd [9]; and
- the expansion of a consumer market for "health" products, with functional foods, exercise gyms, and home use devices.

In our view, this process, in particular, extends the panoptic potential of the "health" dispositive, since human life ends up being viewed exclusively through this prism. One no longer eats or drinks for pleasure, but because given foods and beverages protect against given diseases, meanwhile refraining from drinking or eating to avoid the risks associated with other foods and beverages. Physical exercise is no longer undertaken for bodily pleasure, but to "take care of one's self".

This logic has received an important contribution from an erroneous conceptualization of so-called risk factor epidemiology [10], blaming individuals for their illness, leaving them more willing to assume the role of consumers in the grand health supermarket, while sidestepping (even if unintentionally) the social determination of illness.

In conclusion, we highlight that despite the overwhelming nature of these processes, resistance is possible, and this is the main reason for proposing a public debate on the conceptual tools discussed here. For example, Conrad [3] refers to de-medicalization processes, citing the example of the successful action by the gay movement to exclude homosexuality as a psychiatric diagnostic category. Tiefer [5] reports the relatively successful resistance by feminists and health professionals against the creation of "female sexual dysfunction". We hope that by shedding light on these processes, future studies will allow the development of effective healthcare practices that are not simply the extension of a captive consumer market.

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