5 Health and the making of politics

It is undeniable that health issues have political repercussions. Disease outbreaks call for the implementation of policies of response and the allocation of resources. Sometimes, health problems are of such magnitude that they force states to alter their political priorities. In order to make decision-making easier and swifter, many states have established institutional and bureaucratic apparatuses – health authorities – that take up substantial responsibilities in health policy-making. In sum, health is an important component of the day-to-day of politics. This 'unidirectional' view of the relationship between health and politics takes the former as a given, a set of material events that confront decision-makers. But, what if health problems are seen as more than simple microbial or physical occurrences? Can the political impact of health, as well as the relationship between health and politics, be understood differently?

The present chapter pursues the analysis of the politics of health by exploring what the latter 'does' in the political sense. Rather than circumscribing its scope to the immediate effects of health issues upon policy priorities, resource allocation or institutional arrangements, the argument takes a simultaneously broader and deeper view of the political work of health. It explores the constitutive effects of health upon the political realm – that is, the ways in which politics is made through health understandings and practices. Health is not simply a set of technical or managerial problems and solutions that are extraneous to an already-defined political sphere. Instead, and drawing on the conclusions of the previous chapter, the argument starts with health as an assemblage of perceptions and processes, an imaginary in which security – and in particular an anxiety over the integrity of the self – plays a prominent role.

On the basis of this, the argument approaches health as an experience that is profoundly implicated in the constitution of the political. Specifically, it unpacks the role of health considerations upon the mechanisms of power; it traces the impact of ideas and practices of health upon social relations, upon understandings of the subject and upon the meaning of political categories such as citizenship. Using the example of colonial relations, it illustrates how health has provided the occasion for the deployment of power in the

international realm, and shows that health is an important site for the negotiation of the 'inside' and 'outside' of political community.

Health as political experience

Charles E. Rosenberg (1992) has used insights from his studies on the history of medicine to argue that disease is a social phenomenon, not just because it is perceived and acted upon within a particular context, but also because it performs certain social functions. Specifically, Rosenberg sees disease as a form of social diagnosis, insofar as it helps to frame debates about society and policy-making. The occurrence of disease has historically provided the opportunity for patterns of normality to be set and for current political arrangements to be judged on the basis of their perceived failings. As Rosenberg (1992: 317) has argued, since at least the mid eighteenth century diseases have become 'an occasion and agenda for an ongoing discourse concerning the relationship between state policy, medical responsibility, and individual culpability'. Put differently, health issues have become an important component in the determination of the remit of state intervention, as well as in the definition of the relationship between state action and individual responsibility.

It is in this context that one can begin to unravel the deep political impact of health. The work of Michel Foucault offers important clues in this regard, by effectively conceiving health as a 'chalkboard for the articulation of various visions for creating and maintaining political communities' (Aaltola, 2012: 52). Foucault mobilized and contrasted models of medical organization in order to chart a transformation of the nature of power in Western societies during the eighteenth and nineteenth centuries. These models are, for Foucault, more than technical solutions to medical problems; they are also political experiences in that they presuppose different 'ways of exercising power over men, of controlling their relations, of separating out their dangerous mixtures' (Foucault, 1977: 198). The first model analysed by Foucault is the 'exile of the leper'. Leprosy provided the opportunity for the definition of a political problematic predicated upon exclusion and upon the possibility of excising diseased elements from the healthy social body, or the pure community: '[l]epers were immediately expelled from the shared space of the community, for the purification of the urban environment' (Elden, 2003: 242). Even though some historians (Watts, 1997; Edmond, 2006) have put into question the historical accuracy of this 'Great Exile' of lepers, the basic political problem posed by leprosy remains important. Lepers represent a threat to the purity of the social body; the aim of protecting the integrity of the latter calls for the mobilization of power that seeks to establish borders and distinctions, upholding the boundaries of political community and preventing the diseased from spreading pollution. Leprosy is thus treated as a political problematic.[1]

A second medical model analysed by Foucault clarifies this view of disease as political problematic. Importantly, it does so by showing once again how

the reality of disease is constituted against the background of a security imaginary as outlined in the previous chapter – that is, one characterized by an anxiety in relation to the purity and integrity of the self. This second model deals with the plague, a disease of a completely different nature that requires a distinct form of political problematization. As Alan McKinlay (2009: 168) has noted, leprosy could be easily identified and contained: given that 'the disease was rare, developed very slowly, was difficult to catch and struck isolated individuals', it was possible to contain the disease by separating and seeking to exile the sick. Plague, on the other hand, struck entire populations very quickly and the exclusion of affected individuals did not stop the spread of the disease. For Foucault, the challenge provided by the plague thus calls for a reconfiguration of the nature of power. He wrote:

> [w]hile leprosy calls for distance, the plague implies an always finer approximation of power to individuals, an ever more constant and insistent observation … an attempt to maximize the health, life, longevity, and strength of individuals. Essentially, it is a question of producing a healthy population rather than of purifying those living in the community, as in the case of leprosy.
>
> (Foucault, 2003a [1999]: 46)

Two things are noteworthy in this plague model. To begin with, the victim of disease is not simply excluded from society as a dangerous and polluting element. Instead of becoming an outcast, an outsider to the domain of political intervention, victims of plague needed to be 'placed at the centre of an administrative system to control and render calculable the scale of the disease' (McKinlay, 2009: 168). This represents a shift in the nature and, particularly, in the purpose of political power, which assumes the responsibility of care for the sick and for the management of disease among a given population.

The second important element in the plague model is that this power is not only directed at the people suffering from plague. In fact, the power that the plague model calls for is not one that merely heals the sick; it is one that actively produces health. Producing a healthy population requires an all-encompassing power, one that is able to reach the minutiae of bodily life. The smallest details of everyday life must be observed and regulated; patterns must be identified and trends calculated; dynamics must be steered towards desirable ends. As Foucault (2007 [2004]: 10) puts it:

> [t]hese plague regulations involve literally imposing a partitioning grid on the regions and town struck by plague, with regulations indicating when people can go out, how, at what times, what they must do at home, what type of food they must have, prohibiting certain kinds of contact, requiring them to present themselves to inspectors, and to open their homes to inspectors.

According to this political imagination, the plague-stricken town would be 'traversed throughout with hierarchy, surveillance, observation, writing [and] immobilized by the functioning of an extensive power that bears in a distinct way over all individual bodies' (Foucault, 1977: 198). The plague represents the utopia of a perfectly governed town: the ordering of space by opening up new streets and waterways, the partitioning of the population, the control of movements and contacts by imposing quarantines and curfews, the standardization of bodily circulation according to a desirable norm.

Thus, for Foucault, more than a concrete reality – an actual epidemic affecting a given city – the plague constituted a horizon of possibility and the motivation for rulers and political theorists to envision an exhaustive kind of power. The plague is a political experience, the background against which a set of political discourses and practices are mobilized. The experience of the plague symbolizes the moment in which the dream of a pure community (as in the leprosy model) was replaced by the idea of a perfectly disciplined society.

Foucault examines yet another disease that marks an important departure in terms of how power and the political sphere were conceived. In the case of smallpox in eighteenth-century Western societies, the problem is not so much the working of disciplinary power through bodies, even though disciplinary procedures are still important. Rather, the question posed by smallpox is one of calculation and statistical knowledge: dealing with it requires knowing:

> how many people are infected with smallpox, at what age, with what effects, with what mortality rate, lesions or after-effects, the risks of inoculation, the probability of an individual dying or being infected by smallpox despite inoculation, and the statistical effects on the population in general.
>
> (Foucault, 2007 [2004]: 10)

The case of smallpox shows that dealing with phenomena that are epidemic or endemic requires a new form of power that goes beyond the partitioning of space and the management of bodies. Smallpox inoculation campaigns were framed in terms of a calculus of probabilities, including not only the (disciplinary) supervision of the inoculated and non-inoculated populations, but also a 'set of calculations made in the attempt to determine whether or not it really is worth inoculating people, whether one risks dying from the inoculation, or dying from the smallpox itself' (Foucault, 2007 [2004]: 60). The result of this quantitative analysis is that smallpox appears as a distribution of cases in a population. As such, it called for the mobilization of a power that is both individualizing, in the sense that each case is individual, and totalizing, in the sense that individual phenomena are embedded in a collective field by quantification and calculation.

The experience of smallpox thus called for further reconfigurations of the political sphere. As with the case of the plague, what is at stake is not only the

definition of a technical solution to a medical problem, but rather the interpretation of health issues as political problems and their mobilization in the context of broader shifts in political practice. The diseases discussed by Foucault should be seen as political experiences that, to some extent, are interconnected and overlapping; they emerge as nodal points in a long-term transformation of the means and purposes of political power. Diseases are moments of crisis in which traditional ideas about political organization are thrown into question, in which different political practices are deployed and in which the political realm itself is reconstituted. Specifically, the response to disease was at the core of an expansion of the reach of state power in its relations with individuals and populations. As McKinlay (2009: 181) has put it: '[t]he experience of the extraordinary – the epidemic – established the methods, the administrative systems and the political rationale for the state to assume responsibility for the ordinary'.

In sum, Foucault's analysis of leprosy, plague and smallpox as political experiences offers a useful entry-point into the political work of health. Diseases call for interventions that should not be seen merely as medical or therapeutic, insofar as they are also concerned with the organization of the political sphere. The argument will now scrutinize more closely the impact of health upon the constitution of the political, by focusing on some of its more important manifestations.

Medicine and government

The preceding discussion highlighted that health issues pose problems to the configuration of the political sphere, calling for the redeployment of power within a given polity. However, health can also be seen as a political activity in its own right – a form of power that directly regulates the political sphere. This can be ascertained by looking more specifically at the development of medicine and the medical profession, which by now can already be considered as involving more than the provision of medical care and the allocation of resources.

The history of medicine and public health has long recognized that medical practice is concerned not just with individual bodies, but also with the health of the social body more generally.[2] Foucault was particularly incisive in this regard when he considered the development of modern medicine in the context of the emergence of governmental power. The process of governmentalization, which began in the fifteenth and sixteenth centuries, corresponds to the transition of the state from an instrument of sovereign power to a large-scale system of administration. This transition resulted from the weakening of feudal ties and the waning of the unitary spiritual power of the Church. The question of individual conduct could no longer be seen as regulated by the traditional networks of personal dependence and reciprocal obligation, and thus emerged as a matter of concern for the state.[3]

As mentioned in Chapter 3 of this book, the governmentalization of the state can be described as a shift in the means and aims of power. In what

concerns the former, government signals a transition from sovereign coercion towards the management of conduct. Rather than being personalized in the figure of the sovereign and having the localized extraction of life and wealth (in the form of executions and taxes) as its privileged *modus operandi*, power became a network of relations between multiple actors and nodes, which interact in the management of actions and dispositions. In what concerns the aims of power, government signals a shift from the exclusive concern with the protection and enrichment of the sovereign towards the optimization of the natural features and capacities of individuals and populations. Going back to the passage by Nikolas Rose (1999: 6):

> authorities came to understand the task of ruling politically as requiring them to act upon the details of the conduct of the individuals and populations who were their subjects, individually and collectively, in order to increase their good order, their security, their tranquillity, their prosperity, health and happiness.

According to the political rationality underlying governmental power, this concern with welfare sought to foster the natural capacities and dynamics of individuals and populations. Governmental power aims at providing the conditions in which natural regulations can unfold – the ultimate objective being an efficient economic and political organization.

Considering governmentalization in conjunction with the development of medicine is fruitful for two main reasons. First, it allows for the nature and scope of medical practice to be understood in a different way – that is, beyond medical practice as a mere relationship between health professionals and patients. Indeed, a closer look at the nature and logic of medical practice reveals dimensions that are intrinsically political. Rose (1994) has observed, for instance, that medicine encompasses processes of demarcation and categorization, with their attendant practices of subject-constitution: examples are the distinction between sickness and health, between illness and crime or between madness and sanity. Just like law, religion or education systems, medicine contributes to creating its own objects and domains of intervention. Rose also argues that the remit of health goes well beyond the hospital: health 'happens' in many other places – cities, factories, homes or classrooms – because its injunctions traverse social settings and shape thought and action. Medical practice thus serves as a site in which a variety of spaces, people and procedures interact; it becomes:

> a medico-administrative apparatus for regulating social space, incorporating within itself a range of activities from the directly political to those involving architecture and urban planning; the transformation of the home and the family into a hygienic machine; [or] the medical staffing of the population in the form of general practitioners and innumerable other medical agents.
>
> (Rose, 1994: 51)

The other reason why it is important to consider health and medical practice in the context of a broader reflection about government is the fact that medicine is a crucial component in the process of governmentalization of the state, as the monitoring and management of disease became acute problems for state authority. Rose (1994: 54) has argued that it is important to pay attention to the interconnection between 'medical reason' and 'political reason'. Thus, on the one hand, the problem of how to deal with disease is always a problem of government – what the state should be doing, or how well it is living up to its ascribed role. On the other hand, political reason has an important medical dimension, inasmuch as the success of governmental practices relies upon knowledge and procedures that are connected with health: the well-being of the population, its levels of mortality, life expectancy, sexuality, fertility rates, or the strength and capacity of individuals to work and perform their social roles. An increasing medical intervention coincided with the expansion of state responsibility in the management of the population, as medical vocabularies and rationales permeated governmental practices. Medicine provided a template within which governmental power conceived population as its object; it allowed for individuals to be approached in novel ways, and for state power to acquire new domains of intervention. For example, phenomena like 'delinquency, criminality, indigence, inebriety were construed as sicknesses afflicting the social body, they were rendered thinkable in medical terms' (Rose, 1994: 56). This led to a reconceptualization of the role of the state in relation to these matters. Medicine provided the knowledge, the tools and the occasion for the expansion and reconfiguration of state intervention in bodily and daily life.[4]

This process was visible from the seventeenth and eighteenth centuries, where one can witness the emergence of a social medicine concerned with public health, with health education and with the prevention of disease – alongside already existing private practitioners who focused mainly on the cure of individual illnesses. In Germany, state medicine drew on the development of a *Staatwissenschaft*, a 'science of the state' that conceived the latter as a multifaceted system of administration, collecting knowledge in order to adequately manage populations. State medicine was, in turn, connected to the deployment of a medical police. Foucault has argued that the policing of health consisted of a number of elements: the systematic observation of healthy and unhealthy populations; the establishment of uniform parameters of medical practice and knowledge; an administrative organization for overseeing medical practice; and the creation of the figure of the 'medical officer', appointed by the government, who took responsibility for a particular region.[5] The German model of state medicine was at the basis of later efforts of institutionalization of public health systems.

Accompanying the growth of the public health apparatus was a growing concern with the salubriousness of urban environments and, more broadly, with the management of life in the city. Medical practice was not simply preoccupied with observing and managing the dynamics of individuals and

populations; rather, it assumed the task of managing 'the living conditions of the existential milieu' (Foucault, 2000c [1977]: 150). There were different factors leading to this. To begin with, prevailing assumptions about the causes and conditions for the spread of disease emphasized the dangerous effects of enclosed spaces, narrow streets in which the air could not circulate (thus leading to the presence of miasmas), buildings without running water, the inexistence or inefficiency of sewage and waste disposal mechanisms. This preoccupation with public hygiene and sanitation was coupled with an anxiety about increasing urbanization. In Foucault's (2000c [1977]: 144) words, these urban fears included:

> a fear of the workshops and factories being constructed, the crowding together of population, the excessive height of the buildings, the urban epidemics, the rumors that invaded the city; a fear of the sinks and pits on which were constructed houses that threatened to collapse at any moment.[6]

Urban medicine arose out of challenges posed by diseases and by the environment in which these were allowed to spread. This was not merely a matter of responding to a medical problem with a set of 'technical' instruments. It is true that the 'solutions' put forward by urban planners and medical authorities were, at first glance, very technical – they included partitioning different areas of the city, opening wide streets and boulevards in which the air could be renovated, demolishing old buildings deemed insalubrious, constructing underground networks of sewers through which residual waters could be drained. Nonetheless, it is important to note that the rise, within the urban space, of health as a domain of intervention corresponded to the reinforcement of a wider political concern with problems of circulation – specifically, the proper circulation of people and goods so that capacities could reach an optimum level and risks could be minimized (Foucault, 2007 [2004]: 18). The connection between medicine and urban planning constituted another instance of the governmentalization of understandings and practices of power. More than being simply the object of reordering, the city became 'a laboratory in which power and knowledge were not simply exercised but rethought, applied and re-evaluated' (McKinlay, 2009: 181). The city became, in itself, a multifaceted mechanism for the management of life via the management of health.

It is important to highlight that the rise of governmental power in tandem with medical reason links with security in important ways – demonstrating once again that the political dimensions of health are inextricably linked to security. To begin with, the development of medicine owes much to the emergence of health issues as sites of dread, fear and – particularly in the case of urban settings – even panic. Rather than it being simply the case of a pre-existing fear of disease leading to the deployment of novel medical practices, it was also the very framing of health as a problem of government that

provided the occasion for health to trigger anxiety and to become a focus of other social anxieties. On another level, the development of medicine as part of a broader governmental apparatus has obvious links with state security – of special importance in this regard is the health of the army and the maximization of its capacities, which required the development of a military strand of medicine with its correlate apparatus of knowledge.

There are other, more profound linkages with security, insofar as the latter is at the heart of the broader governmental rationality that accompanies the development of modern ideas and practices of health. Given that the aim of governmental power is no longer the extraction of life or the containment of life forces, but rather the promotion of the capacities and dynamics of populations, it becomes necessary to ensure 'the security of the natural phenomena of economic processes or processes intrinsic to the population' (Foucault, 2007 [2004]: 353). Since government is concerned with managing the behaviour of free individuals, power assumes the role of securing the basic conditions of freedom.

Thus, within the context of government, security is much more than a question of framing and responding to threats; rather, it becomes involved the constitution and 'governability of the social' (Gordon, 1991: 34). Security assumes the form of a mechanism of power, aimed at the creation and safeguarding of the conditions under which the capacities of individuals can flourish and the dynamics of the population can be directed towards useful ends. Mitchell Dean (1999: 116) gives the example of the mechanisms of social security, which were designed to ensure the regular and 'natural' functioning of the market. He writes:

> assistance to the indigent can be considered a mechanism of security that must be provided in such a way as to ensure the participation of labourers in the labour market and not to interfere with the 'natural' responsibility of male heads of households for the subsistence of their wives and children.

Ideas and practices of health should be seen as one of these mechanisms of security through which the political and social sphere are rendered as problems and managed accordingly. In this context, the case of social relations provides another perspective into the political impact of health.

The society of health

It has been argued that ideas and practices of health are an intrinsic part of governmental power and that health is a mechanism of security and a form of power in its own right. This power has a social impact that goes well beyond immediate behavioural shifts. Rather, health plays an important role in the very constitution of the social, by helping to shape individual subjectivity in the field of social relations.

The idea that ideas and practices of health produce subjects stems from the constitutive notion of power, discussed in Chapter 3. According to this view, more than assuming that power is an external imposition and a force of constraint, prohibition or repression, one should investigate how it works 'as the regulatory and normative means by which subjects are formed' (Butler, 1993: 22). Power not only acts upon subjects, it effectively constitutes them as such. In addition to being the condition of possibility of subjects, power is also productive by foreclosing effects and by delimiting the sphere of the possible and desirable. In this sense, power also produces its own 'domain of unlivability and unintelligibility' (Butler, 1993: 22), which circumscribes what the subject is not or must not be.

Using this notion of productive power, Deborah Lupton (1995) has discussed how health can be seen as a political mechanism for the construction of subjectivities. For her (1995: 11), public health is a form of power not by constraining or determining the actions of individuals, but rather in the ways in which its discourses and practices 'invite individuals voluntarily to conform to their objectives, to discipline themselves, to turn the gaze upon themselves in the interests of their health'. The injunctions of public health inform the policies of a wide range of organizations and institutions and seep deeply into the consumer culture, the mass media, the family and the education system. Public health – as an ideal and a set of injunctions, in addition to the concrete policies of medical authorities – aims at 'constructing and normalizing a certain kind of subject; a subject who is autonomous, directed at self-improvement, self-regulated, desirous of self-knowledge, a subject who is seeking happiness and healthiness' (Lupton, 1995: 11).

Lupton highlights the constitution of the healthy ideal as one of the levels of the constitution of subjectivities through health. Here, the politics of health is visible in the way in which it constructs a figure of the desirable healthy subject and calls on individuals to voluntarily adjust their behaviours, habits and lifestyles in order to achieve that ideal – by following an exercise regime, by eating certain foods, by buying certain products.[7] There are, however, other aspects to the subjectifying work of health. In addition to defining the ideal healthy type, health practices also contribute to the constitution of the diagnosed subject – the one suffering and/or recovering from a disease. For Rosenberg, certain diagnoses of disease become social frames in their own right by helping to constitute the medical category and the reality they purport to describe. 'Once diagnosed as epileptic', Rosenberg (1992: 313) argues, 'an individual becomes in part that diagnosis.' The same could be said of cancer, schizophrenia or heart disease: in all of these examples, disease becomes:

> an important aspect of an individual's life, to be integrated in ways appropriate to personality and social circumstance. Diet and exercise, anxiety, denial and avoidance, or depression can all constitute aspects of that integration.
>
> (Rosenberg, 1992: 313)[8]

Individuals are not only diagnosed, they are constituted through their diagnosis. They assume certain thought processes and patterns of action in order to adjust to expectations and roles, be they suggested or self-prescribed. Didier Fassin and Richard Rechtman (2009) have provided an illuminating example of this process by studying the emergence of the category of trauma in the medical and public discourse. They noted that trauma developed from a suspect condition, with its sufferers being considered weak or dishonest, to a legitimate status inspiring sympathy. Trauma – and, in particular, the diagnostic category of post-traumatic stress disorder – was:

> produced through mobilizations of mental health professionals and defenders of victims' rights, and more broadly by a restructuring of the cognitive and moral foundations of our societies that define our relationship to misfortune, memory, and subjectivity.
>
> (Fassin and Rechtman, 2009: 7)

The medical discourse on trauma effectively constituted the traumatized as a morally legitimate category, one deserving social recognition and requiring the attention of authorities. Medical ideas and practices altered perceptions and self-understandings, thereby enabling a different standing of the victims of trauma in their relations with other people and institutions. The traumatized were no longer considered cowards or sycophants, but rather people who had been harmed in some way. By constituting the subjectivity of the traumatized along these lines, ideas and practices of health shaped the social field and opened the door for a policy shift in relation to this issue.[9]

This dynamics of subject-constitution can also be observed at the international level. Some authors have noted the rise of a 'therapeutic' approach to governance, resting upon the portrayal of populations and societies as helpless, traumatized and in need of outside guidance. Vanessa Pupavac (2004) has used the case of international intervention in Bosnia to analyse the development of an international therapeutic paradigm, which seeks to resolve political problems by addressing the psycho-social issues faced by traumatized populations. The result is a pathologization of war-affected populations that often overlooks underlying material and structural problems affecting war-torn societies, while legitimizing particular forms of intervention. This process disempowers these populations: it reinforces relationships of dependency and perpetuates external interference by reproducing the very conditions that made it necessary in the first place.[10]

This connects with another aspect of the subjectifying work of health: the production of stigma. After all, as Butler remarked, power produces subjects but also their outside; it subjectifies by including and excluding. Accordingly, health may entail the differentiated production of subjects, as diseases are accompanied by stigmatizing practices. The cases of leprosy and HIV/AIDS are two paradigmatic examples of how disease – with its accompanying fears of pollution and moral decay – has resulted in affected individuals being

singled out, excluded or subjected to measures that impinge on their rights. As will be argued later in this chapter by looking at the case of colonialism, stigmatization is often linked to broader dynamics of inequality, exclusion and marginalization.

In addition to playing a role in the constitution of subjectivities, health also has a social-political impact by helping to shape social relations. Its impact on family relations is an example. As Foucault noted, one of the consequences of the development of social medicine concerned with matters of public health was the transformation of the family into a medical entity, a site for the mobilization of health concerns and the implementation of medical ideas and practices. The family assumed the responsibility of being proactive in matters of health, by adopting certain practices (such as hygiene) that were aimed at warding off the multiple health risks that emerged with industrialization and urbanization. This had an impact upon traditional relationships between parents and children. In Foucault's (2000a: 96) words:

> [t]he family is no longer to be just a system of relations inscribed in a social status, a kinship system, a mechanism for the transmission of property; it is to become a dense, saturated, permanent, continuous physical environment that envelops, maintains, and develops the child's body.

The family became an important nodal point in what could be termed the socialization of individuals through health. It was accorded a significant responsibility in shaping individuals' behaviour in line with the injunctions of a healthy life, and as a result became politicized. The family was assigned 'a linking role between general objectives regarding the good health of the social body and individuals' desire or need for care' (Foucault, 2000a: 98). It provided the necessary transmission belt for the political work of health to reach the lives of individuals and mark their socialization processes.

Sarah Nettleton (1992) provides an illustration of the impact of medicine upon social and family relations. She discusses the evolution of the discipline and practice of dentistry and argues that this evolution corresponded to the constitution of a social space via the mobilization of power. She writes:

> dentistry did not merely involve the treatment of diseased mouths, but rather it was a system that monitored mouths, bodies, people and social relationships. Education was part of a process which enabled the dental regime to become continuous and integrated by ensuring that everyone oversees their own mouths.
>
> (Nettleton, 1992: 55)

An important feature of this process was the reconceptualization of the domestic space and of family relations. Nettleton argues, for example, that the concern with dental disease and a new awareness of the necessity of regular dental hygiene – as a necessary step to the health and well-being of the

body – placed a new emphasis on domestic diligence, and particularly on the figure of the 'caring mother'.[11]

Health also shapes the content of the social sphere by regulating class relations – and, in particular, by helping to determine the social location of poorer classes. The connection between poverty and disease is long-standing throughout history; in fact, as Brian Pullan (1992) has shown in the context of the outbreaks of disease in the Italian cities from the fifteenth century onwards, in situations of epidemic the poor were often considered a health hazard to wealthier classes, and thus regarded with a mixture of fear and pity. With the development of social medicine, these perceptions were mobilized in a reconfiguration of the social location of the poorer sections of the population. The definition of poor people and workers as objects of medical practices was aimed at safeguarding the strength and vitality of the labour force, but also stemmed from a growing concern with the 'dangers' posed by poor people. According to Foucault (2000c [1977]: 153), the institution of a state-funded welfare medicine, through which the poor were given the possibility of receiving free or low-cost medical care, was part of a broader move towards the creation of 'an officially sanctioned sanitary cordon between the rich and the poor', which included, for example, the parallel expansion of private medicine for those who could afford it. Ideas and practices of health thus functioned as instruments of social differentiation.

In sum, by impacting so profoundly upon the constitution of subjectivities and upon social relations, health can be conceived as a social actor in its own right, 'a structuring factor in social situations' (Rosenberg, 1992: 312). Health and disease are social, not just because they are contextual and subjected to social influences but also because they are intrinsically connected with the ways in which 'the very idea of *society* has been brought into existence and acquired a density and a form' (Rose, 1994: 54, emphasis in the original). The social work of health is, in turn, of a political nature, inasmuch as it deploys power and advances the interests of certain groups. Health shapes subjectivities differently and can help to reinforce existing hierarchies and inequalities. The remainder of this chapter will draw together the political implications of health by discussing the case of medicine in the colonial context.

Health and colonialism

The case of immigration, analysed in the previous chapter, highlighted the extent to which the health challenges stemming from the encounter of peoples bring forth important political challenges. The discussion of immigration focused on the processes through which migrants are perceived and constituted as health risks, and began to show the extent to which this enables a fear-based politics. The present chapter also looks at a health encounter and its resulting political dilemmas. The case of medicine in the context of colonialism raises, however, other dimensions, which allow for the focus to be placed on the political impact of health understandings and practices.

The impact of disease on colonial agents (soldiers, merchants, officials and missionaries) since the beginning of the European expansion in the fifteenth century led to the gradual development of a body of medical expertise and its attendant medical practice. In the early days of colonial contact, medical practice in the colonies aimed primarily at obviating the hazards of geographical displacement. From the outset, the colonies were seen as an inherently inhospitable environment for Western bodies – a 'white man's grave'. Medical doctors were tasked with addressing the imbalance between bodies and environment – caused by climate, bad water or diet, the foul emanations from the rivers, swamps and jungles – thus enabling acclimatization. Medical practice, conceived thus, was essentially a relationship between doctor and patient.

With the advent of germ theory and contagionist views of disease, the role of medical doctors became more complex. It soon became apparent that ensuring the health of European colonizers required attacking disease at its source. The fear of contagion shaped not only medical practice but also the colonial encounter as a whole. Attention was drawn to the contact between the colonizers and the colonized, as medicine began to look beyond what happened inside Western bodies. The discovery that germs could spread by human contact and cause illness meant that the development of tropical medicine was spurred by the fear of the 'pathological consequences of contact with native races' (Anderson, 2006: 2). Ideas about health in the colony were thus enveloped by a racialized form of anxiety (Marks, 1997). This anxiety mobilized some of the themes analysed in Chapter 4 – such as pollution and immunity (Anderson, 1996) – and impacted profoundly upon intercultural relations and colonial politics as a whole.

It is in this context that one can conceive tropical medicine, not merely as a medical apparatus or a clinical relationship but also as a political practice in its own right. Tropical medicine evolved as a response to the political problematic stemming from the increased contact between Westerners and non-Westerners in colonial settings – which posed broader challenges in what concerned the relation between the colony and the metropole. In this context, medicine assumed the role of a boundary-drawing and boundary-maintaining device, 'a fence around Europe and around the European in the tropics' (Edmond, 2006: 141). More than merely re-inscribing the difference between colonizers and colonized, tropical medicine shaped it in important ways. As Rod Edmond (2006: 141) has put it:

> [h]ealth and disease were an important element in this refashioned grammar of difference, and tropical medicine played a significant role in naturalising the basis upon which difference was constructed.

Health and disease constituted the backdrop for a reconfiguration of the social and political space of the colony. The distinction between civilized and uncivilized, clean and unclean, rational and irrational, developed and

backward was imbued with medical vocabularies and rationales. Medicine provided legitimacy and conceptual support for a process in which social differentiation served as a means of political control.

The first element in the politics of colonial medicine is, therefore, its origins as a form of knowledge with a purpose that is not only medical but also distinctively political. As a system of knowledge, medicine provided the lens through which Western nations made sense of the colonial space. Colonial society was constructed as an object of knowledge with the help of ideas and practices of health. By the end of the nineteenth century, this medical framing of the colony conjoined scientific, racial and moral notions. In the words of David Arnold (1988: 7):

> Europeans began to pride themselves on their scientific understanding of disease causation and mocked what they saw as the fatalism, superstition and barbarity of indigenous responses … [Medicine] gave scientific credence to the idea of a tropical world as a primitive and dangerous environment in contradisctinction to an increasingly safe and sanitised temperate world … Disease became part of the wider condemnation of African and Asian 'backwardness'.[12]

As Arnold has observed, the experience of diseases like smallpox, plague, cholera and malaria, and their association with the indigenous population fed into pre-existing suspicions and prejudices. At the same time, the observation of ill-health among the colonized 'fostered Europeans' growing sense of their innate racial and physical superiority' (Arnold, 1988: 8).

Thus, medicine framed the ways in which the 'natives' were seen, but also helped to define the self-understandings of colonizers *vis à vis* the colonized and the territory. It informed their relative positions, the nature of their interactions and the space in which these interactions occurred. As Warwick Anderson (1992: 526) argued in relation to North American colonialism in the Philippines, the colonized 'were construed as a collection of hygienically degenerate types, requiring constant surveillance, instruction, and sometimes isolation'. Medicine spoke to the anxiety regarding the protection of the Western self in a 'hostile' environment, with the colonized being portrayed as the major threat for the health of colonizers. More importantly, their position as potential foci of contamination, combined with their habits and hygiene, were seen as threats to the colonial project. A security imaginary was clearly in place as the backdrop of tropical medicine.

This provided the incentive, and the legitimization, for a transformation in the ways in which life in the colony was managed. Here, it is useful to conceive colonial medicine not only as a form of knowledge but also as a (correlated) mobilization of power. By providing the occasion for power to manifest itself, and by emerging themselves as a form of power, ideas and practices of health became an intrinsic part of empire, one that contributed decisively to the expansion and consolidation of colonial rule.

The mobilization of power in the colony accompanied the vicissitudes of disease aetiology, prevalent assumptions and prejudices, but also the political instruments at the disposal of the colonizers. Anderson (1992) argued that the transition from environmentalist to contagionist ideas of disease causation was translated into a more interventionist approach – also due to the persistence of notions of racial propensity, according to which non-whites were more susceptible to being carriers of disease. In this context, health promotion required an extensive surveillance and management of colonized populations. This assumed, in the first instance, the form of a disciplinary apparatus of containment and control. Curtin (1985) has discussed the implications of colonial medicine on urban planning, showing how the concern with diseases such as malaria led to calls for 'sanitary segregation'. This was visible, for example, in the British colonies of Northern and Southern Nigeria at the beginning of the twentieth century, when colonizers sought to establish a *cordon sanitaire* by partitioning the urban area into sections, thus creating a 'hygienic village' for Europeans, and by forcibly moving non-whites. As Curtin notes, these ideas and tendencies were also present in the German colony of Cameroon and in French-colonized Dakar.[13]

The politics of medicine went, however, beyond the reordering of urban space and of the social relations within the city. Anderson (2006: 2) notes that in the Philippines the construction of hygienic enclaves for whites was not always a practical solution; it was necessary, instead, to make the Philippine *barrio* 'resemble a well-ordered American army camp'. This meant the deployment of a military logic, as North American colonizers took up the task of managing the Filipino social body. In order to do so, they claimed authority over personal and domestic life. Anderson (1996: 114) writes:

> colonial authorities targeted toilet practices, food handling, dietary customs, housing design; they rebuilt the markets, using the more hygienic concrete, and suppressed the unsanitary fiestas; they assumed the power to examine Filipinos at random, and to disinfect, fumigate, and medicate at will.

The management of daily activity was, in turn, enabled by the emergence of the body as a focal point (Arnold, 1993). The colonized body – its strength, ability to work, propensity to fall ill, its movements, functions and excretions – became the centre of a medical system of knowledge-production and intervention. At the same time – and in connection with the mobilization of medical knowledge – the body emerged as an object of political concern, a malleable surface to be shaped by power.

The medical-political apparatus in the colony should be seen as more than simply repressive; instead, it was part of a broader process of governmentalization of life in the colony. Undoubtedly, medical interventions in the colony included a substantial degree of coercion. Discussing French responses to bubonic plague in colonial Senegal, Myron Echenberg (2002) highlights

the use of forcible control measures such as compulsory vaccination, travel restrictions and undignified burials. Another example is provided by Edmond (2006), who noted a punitive pattern of segregation in relation to leprosy. Nonetheless, it is also important to highlight the extent to which the colonizers were able, not only to occasionally secure the consent of African elites to some of their interventions, but also to utilize medical power as a 'conduct of conduct' in the ways described by the governmentality literature. Medical power in the colony may indeed have been 'top-down', coercive and repressive, but it was also geared towards the management of circulation – promoting the 'good' circulation of people and goods and restricting the 'bad' circulation of microbes and disease-carriers. It was a form of power that worked through the action of a number of agents – including the military, missionaries and teachers – and that sought to foster the dynamics of life in the colony, in the name of economic utility.

Recognizing the status of colonial medicine as a form of governmental power should not, however, lead to its domineering aspects being overlooked. As medical practice served ends that were more than medical, ideas and practices of health became an important mechanism through which the colonizers sought to dominate the colonized. Tropical medicine served the interests of dominant groups (whites and non-white elites), often to the detriment of the majority of the population. Indeed, the health needs of the majority were very often neglected (Lasker, 1977). Importantly, the racialization of health in the colony – supported by ideas of racial propensity or susceptibility to disease – meant that crucial aspects were sidelined. Thus, Roy MacLeod (1988) has argued that the ideological foundations and the tools at the disposal of tropical medicine meant that the connection between disease and social structure was obscured. Along the same lines, Shula Marks (1997: 215) noted that tropical medicine had very little interest in the political economy of disease, that is, the set of social, economic and political institutions that 'shaped the disease environment and controlled the availability of health services and therapeutic choice'. She argues that, in addition to race, class and gender must be central in the analysis of the political work of health in the colonial context.

Colonial medicine provides a powerful illustration of how ideas and practices of health have profound political effects in the configuration of the social sphere and in the nature and purposes of political power. Importantly, the legacy of colonial medicine runs deep and still shapes the political work of health. The colonial medical experience is relevant to the analysis of contemporary global power structures, as well as the study of exclusion and harm in the international sphere. Anderson (2006) has noted the diffusion of ideas and practices, making the case for the continuity between the intervention models of colonial medicine and the international health regulations, especially after the Second World War.[14] Indeed, the colonial mentality – which saw non-white populations as an undifferentiated mass to be utilized for the advancement of the interests of colonizers – is still present in some

international health interventions. As the 'therapeutic governance' literature suggests, and as was shown, for example, in the case of the 1940s Guatemala syphilis trial – in which Guatemalan prison inmates and mental patients were deliberately infected with syphilis as part of a scientific experiment (Selyukh, 2011) – the colonial medical model is still influential in the relations between North and South.

Conclusion

Politics as we know it is, in part, the outcome of ideas and practices of health. This chapter argued that, more than being made in certain ways, health is also political inasmuch as it does things. Throughout history, diseases have confronted humans as political experiences: they pose challenges and dilemmas to the way society and the political sphere are organized, and they often lead to their reconfiguration. Importantly, security – in the form of an anxiety over the definition and safeguarding of the self – plays a central role in the justification and operationalization of the political work of health.

The argument highlighted the extent to which health concerns have framed the transformation of the state into an extensive administrative and bureaucratic system. Health is present in the way cities are planned, in the way the social space is defined, and also in the interactions between individuals and groups within that space. Health produces subjects: be it pathological states of being or healthy ideals to be achieved (or purchased, or consumed). Health provides a vocabulary and a frame of reference for legitimizing decisions and actions; it is part of the political imagination in which decisions and actions occur. As the case of tropical medicine shows, the political impact of health goes well beyond short-term policy-making; it should be seen as part of long-term dynamics in the mobilization of power and in the reproduction and reconfiguration of the political realm. In this context, this chapter demonstrated the usefulness of working with a notion of power comprising government (a multifaceted power over life), and domination, that is, an identification of inequalities, systematic disadvantages and outright harm.

The political work of health is long-standing, and its future is as yet uncertain. In his reflection about some recent technological developments in the field of biomedicine, Rose (2007) raises important questions about the future impact of ideas and practices of health. What will be the social and political consequences of recent technologies that allow for the human body to be known in new ways, and that provide the opportunity for the physiology and functions of body parts and organs to be recast? How will these technologies be framed by new ideas about the meaning of being human and the meaning of being in society? And what health challenges does the future reserve? The political work of health will continue to evolve through the interaction between challenges, ideas and technical instruments.

This points to another crucial dimension of the politics of health: the fact that health is also political in the sense that it is not fixed and determined. If

health is made in certain ways, it can be 'unmade' and 'remade'. As the next chapter shows, health can be the site where alternative ideas and transformative efforts are deployed. Given that it plays such a crucial role in the making of politics, health may also be the focal point for a new politics to be imagined.

Notes

1 This argument thus takes inspiration from Foucault's history of problematizations – the questions and political problems his work poses, rather than the substantive answers it provides. See in this respect Castel (1994) and Foucault (2000b [1984]).
2 See for example Harrison (2004) and Baldwin (2005). On the history of public health, see Rosen (1993 [1958]) and Lupton (1995: 16–47).
3 Colin Gordon (1991) also highlights the importance of the wars of religion, which disrupted existing distinctions between public and private and resulted in an increasing preponderance, within state practice, of the management of individual conduct.
4 See in this context Nadesan (2008: 93–137).
5 See the discussion in Foucault (2000c [1977]: 140–41). See also Rosen (1957) and Carroll (2002).
6 On public sanitation and its connection with the rise of the preventive approach to medicine, see Hardy (1993). Johnson (2006) discusses this issue against the background of the 1854 outbreak of cholera in London.
7 For other discussions of how the promotion of health produces subjectivities, see for example Gastaldo (1997), Nettleton (1997) and Davies (1998).
8 Lively and Smith (2011) provide a discussion of the linkages between identity and illness as a lived experience.
9 Another example is the production of 'hyperactive children'. Matthew Smith (2011) locates this production in the context of Cold War politics.
10 See also Pupavac (2002) and Hughes and Pupavac (2005).
11 For a detailed account, see Nettleton (1992: 56–63). William Arney (1982) has argued that the development of obstetrics also shaped the relationship between mother and child.
12 In a similar vein, Philip D. Curtin (1985: 613) highlights the political nature of tropical medicine by describing it as science interlayered with 'racial prejudice, political convenience, and economic advantage'.
13 Edmond (2006: 178–219) discusses different forms of enclosure and segregation in relation to leprosy in colonial settings.
14 On the historical development of international health regulations, see also Fidler (2001, 2005).