

4 The making of health

The *Oxford English Dictionary* defines health as the ‘general condition of the body with respect to the efficient or inefficient discharge of functions’. Disease is understood as a ‘morbid physical condition’ of the body, ‘or of some part or organ of the body, in which its functions are disturbed and deranged’.¹ According to this understanding, health and disease are essentially bodily states or conditions. Is it possible to interpret in a political way a phenomenon that is so powerfully linked to bodily experience? Part I of this book suggested that a good way to begin to unravel the political dimensions of a phenomenon is to ask questions about its constitution as something ‘real’. This will be the starting-point of this book’s discussion of health.

Colin McInnes and Kelley Lee (2012) have provided an important contribution to a political reading of health by emphasizing the role of ‘frames’. Each of the frames they identify – evidence-based medicine, human rights, economism, security, and development – is ‘based on a set of norms, privileges certain ideas, interests and institutions’ and as a result ‘has particular answers to questions of who and what is important in global health, and why’ (McInnes and Lee, 2012: 18). McInnes and Lee suggest that these frames do not merely reflect ‘real world’ developments; rather, they effectively contribute to shaping them. The reality of health should be seen as socially constructed, with ideas shaping the perceptions of actors and influencing their choices and practices.

Some limitations can be identified in McInnes and Lee’s discussion. They tend to treat the different frames of global health as self-contained and already determined. Even though McInnes and Lee (2012: 18) recognize that frames ‘may spill over one into another’, the interactions between frames are not sufficiently considered. Moreover, the two authors do not sufficiently engage with the ways in which the meanings within a frame originate and evolve; and also with the possibility of transforming these meanings. Their analysis does not take further the insight that frames are ‘internally contested, with competing theories, methodologies and approaches’ (McInnes and Lee, 2012: 18). This situation is particularly visible in the treatment of the security frame, which is said to have an ‘underlying logic’ based on ‘threat and defence’ (McInnes and Lee, 2012: 19).

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McInnes and Lee are right to argue that global health has multiple meanings. Nonetheless, the argument presented in this chapter starts from the linkages between frames, and particularly from the influence that one of the frames – security – has had over others. Instead of being characterized by the simultaneity of discrete frames, global health is here seen as underpinned by a broader imaginary: a fluid register of meaning that has resulted in the dominance of particular ideas of security and threat, as well as of a politics based on fear.

The argument lays out the main features of this security/fear imaginary and investigates some of the assumptions and practices that lead to the reality of health being constituted in this way. Of particular importance here will be the connotations attached to ideas of infection, contagion and pollution; and their results in fostering a sense of dread and ontological uncertainty. Adopting the standpoint of the interaction between meanings – instead of assuming the presence of a particular frame – allows one to capture the complex constitution of the reality of health.

The imaginary of health

McInnes and Lee (2012) argue that the reality of health should be seen as socially constructed. But, what is the nature of this construct? How exactly is health made? The starting-point of this chapter is that security – and, correspondingly, insecurity and threat – spill over the boundaries of a ‘frame’ and play an important role in shaping the meaning of health in the international sphere. This does not mean that other visions of health are not present. However, the security meanings attached to health can be seen as transversal insofar as they affect the way in which these visions are deployed.

The transversal role that security plays in the making of health can be understood by drawing on the notion of the ‘imaginary’. Charles Taylor (2004: 23) has defined a social imaginary as incorporating:

the ways people imagine their social existence, how they fit together with others, how things go on between them and their fellows, the expectations that are normally met, and the deeper normative notions and images that underlie these expectations.

For Taylor, an imaginary is something broader and deeper than the theoretical frames people mobilize to think about social reality. It has a number of distinguishing features: on the one hand, an imaginary consists of the ways in which people imagine their surroundings, often by use of images, stories and myths; on the other hand, unlike a theoretical frame, an imaginary is normally shared by a broader society. As a result, the imaginary assumes the shape of a ‘common understanding that makes possible common practices and a widely shared sense of legitimacy’ (Taylor, 2004: 23).

Following Taylor, the imaginary can thus be conceived as a shared set of meanings, expectations and assumptions regarding what is natural, necessary

and legitimate in a society. Although they do not need to be translated into written norms, these meanings help to define the boundaries of political imagination – the conditions of possibility of thought and action in a given context. As Taylor (2004: 24) recognized, an imaginary is at once ‘factual’, in that it structures experience and tells us how things are, and ‘normative’, in that it prescribes how things ought to be.

What does this mean for the analysis of the reality of health? Conceiving health as ruled by an imaginary allows for a deeper exploration of the rise of health as a site of societal concern and a domain of intervention for policy-makers. It entails studying the cultural meanings that are attached to health and disease; their origins and historical development; how these meanings are reproduced and transformed through practice; and their broad social impact. The particular framings of health problems, as well as the measures that are deemed necessary as a result of these problem-definitions, can thus be placed in a context, and their interlocking meanings can be understood better.

Studying the imaginary of health must be underpinned by an awareness of the historical development of notions of health and disease, and the correlate development of practices of healing.² The disciplines of sociology and anthropology are crucial for understanding the specific manifestations of these notions.³ In addition to ‘visible’ manifestations, the imaginary includes an attention towards the symbolic dimension of health. This dimension, which can be gleaned in rituals and metaphors, provides an entry-point into the social role of health. Arthur M. Kleinman (2010 [1973]) addressed this implicit, yet socially and culturally powerful, dimension of health by enquiring into the ‘symbolic reality’ of medicine. For Kleinman, medical systems have a symbolic reality not only because they are manifestations of wider cultural beliefs but also because they perform a social function. The practice of healing has an important role in cementing social bonds and values. Kleinman (2010 [1973]: 87) writes:

[t]he healing dialectic has been considered effective when the bonds between the sick individual and group, weakened by disease, are strengthened, social values reaffirmed, and the notion of social order is no longer threatened by illness and death; or when the individual experience of illness has been made meaningful, personal suffering shared, and the individual leaves the marginal situation of sickness and has been reincorporated in health or even death back into the social body.

Other authors have considered the symbolic role of health-related ideas and practices. One example is Sarah Nettleton (1995: 26), who has argued that it is not enough to see health as a social construction. In fact, she argues:

[t]he relationship between social relations and disease works in two ways: social relations contribute to the creation of diseases, and the language of

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disease, which is presumed to be ‘natural’, serves to conceal the nature of social relations – a process of reification.

As a result, seeing health as enveloped within a particular imaginary means not only contextualizing health-related meanings but also investigating how these meanings are implicated in the reproduction of social processes.

This discussion of the scope of the imaginary of health points to the crucial importance of questioning taken-for-granted knowledge about the nature of health and disease. For many years, sociologists have focused their attentions on the ‘medical model’ (Barry and Yuill, 2012: 23–24) of the explanation of health. This model is centred on the body as a biological entity abstracted from context. The body is a machine with its own biological and scientific laws; in turn, explanations of disease tend to focus on dysfunctions in the physical workings of the body, to the detriment of broader social, cultural and economic issues. Rather than a reflection of the true nature of disease, the sociological challenge sees the medical model as a historically and geographically located experience. Modern medicine has its roots in the Enlightenment belief in the potential of science, rationality and secularisation. The medical model thus reflects Western values and contributes to reproducing certain social arrangements, by prescribing desirable behaviours and empowering specific actors.

Seeing health not only as a biological phenomenon – the regular functioning of the individual body – but also as a social experience is crucial for grasping the workings of the imaginary of health. In this context, it is useful to take into account Allan Young’s (1982) distinction between the terms ‘disease’, ‘illness’ and ‘sickness’. According to Young, the physical dimension of the phenomenon can be described by using the first term. The medical model normally deals with diseases as ‘pathological states’ and ‘abnormalities in the structure and/or function of organs and organ systems’ (Young, 1982: 264). In contrast, ‘illness’ refers to the subjective dimension of disease, to a person’s perceptions and experiences. Young (1982: 270) also differentiates ‘sickness’, a broader term that denotes:

the process through which worrisome behavioral and biological signs, particularly ones originating in disease, are given socially recognizable meanings, i.e. they are made into symptoms and socially significant outcomes ... Sickness is, then, a process for socializing disease and illness.

This layered understanding of the meaning of health – as a physical phenomenon, a subjective experience and a social reality – connects with a similarly layered understanding of the body and its relation to disease. As was already mentioned in Chapter 1, the body of medical knowledge cannot be seen simply as a given biological entity, waiting to be revealed by science. Instead, the body was effectively constituted as a tangible object of knowledge via the interconnection of norms, practices, intellectual and technological

developments (Foucault, 2003 [1963]). Put differently, the body as we know it results from social processes. This has been an important theme in the anthropology and sociology of health (Helman, 2007: 19–52; Barry and Yuill, 2012: 182–205; Bradby, 2012: 95–118). Part of this work conceives health as a form of biopolitics, that is, a power over life that is visible in the practices through which bodies are shaped and disciplined (Turner, 1987; Jones and Porter, 1994; Rose, 2007). The notion of embodiment – that is, the becoming of bodies and their investment with meaning – and the idea that the body should be seen as a political practice are paramount when tracing the development of understandings of health and the social construction of disease categories. The imaginary of health is always reflected in conceptions of the ‘healthy body’ and the ‘diseased body’.

A good way to trace these ideas is to take the perspective of social interactions. An analysis of the imaginary of health must include a mapping of the health field: the practices of actors, their experiences and the repertoires they use to justify what they do; their relations and struggles, and how these sediment into social structures and connect to institutional settings; and the imbalances and inequalities that are produced as a result of these interactions. Health professionals play a fundamental role here; however, they are far from being the only relevant actors in the health field, and recent years have witnessed the rise of health-related social movements, and patients’ and carers’ associations.

As the remainder of this book will show, by allowing one to focus on these social interactions, the imaginary allows one to shed light on the political dimensions of health and disease. The production of the meanings of health through discourse and practice reflects particular interests and entails silences. Because they depend upon ideas about desirable subjectivity, these meanings often lead to exclusionary and stigmatizing practices. Also political is the fact that the social field of health is an arena where, very often, inequality and disadvantage are produced. More broadly, health issues connect with broader political issues by reflecting and mobilizing concerns and debates about citizenship, community, borders, or sovereignty. Because they are so intrinsically connected with the constitution and reproduction of the political realm, health-related struggles can also be an entry-point into broader political change.

In sum, seeing health as ruled by an imaginary allows for a thorough understanding of the processes through which the reality of health is (re)produced. It provides an entry-point to the critique of established knowledge about health. Furthermore, sociological and anthropological tools enable an enquiry into specific practices and interactions. Finally, the imaginary is a window into the politics of health.

Infection, pollution and the self

Having made the case for approaching the reality of health through the notion of the imaginary, and having identified the latter’s scope and main

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themes, what can be said about the role of security in this imaginary? This chapter suggests that security is an important organizing principle in the imaginary of health. Security entails a series of assumptions, concerns and prescriptions of political action that traverse different framings of health problems and impact upon domains that are normally seen as separate.

It is important to stress that seeing health as a field that is strongly shaped by security is not the same as claiming that political actors are explicitly identifying health issues as threats. This chapter is interested, not in charting actual instances of securitization of health, but rather in exploring the conditions that allow for health to emerge as a security concern, as well as the assumptions and processes that enable the securitization of some issues. This is where the notion of the imaginary becomes useful: one of its benefits in relation to the notion of frame is that it allows one to recognize the presence of meanings that are not explicitly articulated.

This attention towards long-term, implicit and surreptitious dimensions is particularly important when studying an imaginary ruled by security. In fact, the securitization literature shows that security assumptions and rationales can be present even when the language of threat is not used, so that one can speak of security issues that have not been the object of securitizing moves. Securitization can emerge via the constitution of a sense of unease and anxiety about a particular issue, or via the definition of risky situations – through the juxtaposition of meanings and the linkage of social interactions, bureaucratic processes and institutional dynamics (Bigo, 2002; Abrahamsen, 2005; Huysmans and Buonfino, 2008). Here, the process through which an issue becomes securitized is more akin to a continuum, not always directly attributable to a securitizing intention or actor. The idea of an imaginary also dovetails with the recognition of ‘macrosecuritizations’, broad securitizing processes that ‘structure and organize relations and identities around the most powerful call of a given time’ (Buzan and Wæver, 2009: 259). Macro-securitization highlights the role of wider registers of meaning, ‘symbolic short hands that trigger vivid imagery and built-in narratives that do not have to be unfolded’ (Buzan and Wæver, 2009: 267).

A good way to begin to disentangle the assumptions and narratives that constitute the imaginary, as well as the imagery and emotions it evokes, is to take a fundamental aspect of contemporary perceptions of health: the focus on infectious diseases. As has been noted (McInnes and Lee, 2006; Labonté and Gagnon, 2010; Rushton, 2011), infectious diseases occupy a central place in the global health agenda – a place that is often unrelated to their actual burden to society. Infectious diseases normally become priorities for policy-making, garnering substantial resources, and attract great media and public attention. Lorna Weir and Eric Mykhalovskiy (2010) have traced the development of an ‘emerging infectious disease’ (EID) concept in public health knowledge from the end of the 1980s onwards. This concept was originally put forward in US public health circles as a challenge to diminished funding for infectious disease control, before being internationalized and taken up by

the World Health Organization. The infectious disease paradigm mobilizes quantitative data and expert knowledge to emphasize the catastrophic dangers of ‘new’ or ‘emerging’ viruses that threaten to turn into devastating pandemics and disrupt human society as we know it.⁴ This discourse has become more pressing in recent years, with the intensification of flows of people, information and goods, which not only allows for constant updates on outbreaks in other parts of the world but also threatens to bring these diseases very close to home in only a few hours. The infectious disease paradigm has indeed seeped into public consciousness: it has become a permanent feature of media coverage of disease outbreaks and is also very popular in entertainment.⁵

Weir and Mykhalovskiy show how the EID concept captured the attention of public health officials and came to structure their perceptions and preferred strategies of response. It ended up having ‘a pervasive presence’ in international public health, by ‘rema[king] international communicable disease control [and] operating as the discursive target for a new way of knowing and acting on communicable disease outbreaks’ (Weir and Mykhalovskiy, 2010: 13). Several reasons could be advanced for the privileging of these issues to the detriment of others that are arguably more pressing for societies. It has rightly been observed that there is an ethnocentric bias in the global health agenda insofar as the issues that are given more importance are often those that speak to the concerns and self-perceptions of Western and developed countries. Nonetheless, although immediate interests – national, or even corporate (King, 2002) – are undoubtedly crucial for understanding the growth of this paradigm, they do not by themselves explain its considerable traction.

Understanding the deep social and cultural resonance of this paradigm entails going beyond the discourses of policy-makers and media. Why are these understandings and images presented in such a way? Why are they regarded as natural and almost intuitive? Why is global health so often equated with epidemic and pandemic scares? In order to tackle these questions, working at the level of the imaginary becomes important because it allows one to investigate the assumptions, regarding the nature and the potential impacts of disease, that underpin these representations and perceptions.

Moreover, when taking the standpoint of the imaginary of health, security becomes a very a useful register for two main reasons. First and foremost, disease is very often conceived as a question of the integrity of the self – what may be termed ontological security. Ontological security has been conceptualized by, among others, Jennifer Mitzen (2006), for whom the need to be ontologically secure should be seen as being as basic as the desire for physical security.⁶ Ontological security refers to the security ‘of the self, the subjective sense of who one is, which enables and motivates action and choice’ (Mitzen, 2006: 344). Mitzen (2006: 345) specifies this notion further by arguing that the condition of being ontologically secure means that an individual holds ‘confident expectations, even if probabilistic, about the means–ends relationships that govern her social life’. These expectations

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allow for stability and control over an individual's self-perceptions, which in turn enable action. In a similar vein, for Stuart Croft (2012) ontological security consists of a condition in which an individual is not overwhelmed by anxieties and dread (which he differentiates from the actual fear of being attacked by a concrete entity). Croft distinguishes different dimensions in ontological security: first, a degree of biographical continuity, which allows for self-monitoring and provides the conditions of agency;⁷ second, the presence of a web of relations of trust; and, third, a sense of self-integrity and reflexive control over one's own actions and surroundings. Croft also observes that the inherent fragility and precariousness of ontological security should be considered one of its defining features; put differently, ontological security is never fixed and needs to be constantly performed and assured. This latter point is particularly important, insofar as it shows that there is no fundamental essence to ontological security – the latter is ultimately about the (contextualized and constantly reiterated) self-perceptions of specific actors.

The notion of ontological security – and its crucial importance for individual and societal life – goes some way to explaining the social and cultural susceptibility to the infectious disease paradigm. Looking more closely at the notions of 'infection' and 'contagion' provides further clues. Medical texts are crucial sources for tracing the historical development of ideas of infection and contagion (Nutton, 1983); however, it is also important to note that these concepts are not purely medical. This was noted by Margaret Pelling (2001: 17), for whom the idea of contagion cannot be separated from 'notions of individual morality, social responsibility, and collective action'. More than the transmission of a disease or the actions of a disease carrier, contagion should be seen as 'reflecting the relationship between things in the world, as well as the influence upon the human being of factors in close and remote spheres of his/her environment' (Pelling, 2001: 17).

Owsei Temkin's (1977) study of the etymology of infection offers important insights in this regard. Temkin observed that *infectio* and *inficere*, roots of the term 'infection', denote the act of staining or dyeing something. Infection was, since Antiquity, understood as defacement or, more profoundly, pollution. This notion of infection as pollution is also connected with ancient understandings of disease as involving some kind of moral blemish or predicament.⁸ Diseases were often judged to be punishments for a crime or a moral fault – the breaking of a social taboo – and this explains the stigma that surrounded them.

Thus, in its original sense, the term 'infection' referred to more than just a physical ailment: it tied in with a more general weakness or failure of personhood, a fundamental lack of the self. More than just a dysfunction of the body or of its components, infection represented a disruption of the relation between the individual, the social environment and the metaphysical realm. Becoming infected was therefore a social and moral matter. This notion has persisted throughout history: Temkin (1977: 459), for example, noted the obstinacy of ideas of 'the plague as God's wrath at a sinful people, leprosy

and venereal disease as filthy, mental disease as a disgrace'. While the modern medical model of explanation seemed to take away this moral dimension, by attributing infection to observable physical causes or to the action of micro-organisms, the case of HIV/AIDS shows that morally imbued notions of disease and infection are still very much present today (Sontag, 2002 [1991]). In fact, as Allan M. Brandt (1997) has suggested, discussions about the causation of, and responsibility for, disease can still be seen as reflecting the moral beliefs of a society.

Considering the origins of the concept of infection and its long-standing relation with moral 'staining' and pollution, one begins to see how health and disease were tied in powerful ways to the integrity of the self in its relations with the wider context. The maintenance of integrity (that is, the avoidance of infection) resulted not only from morally sound behaviour but also from the safeguarding of a separation between the individual and the outside, in the form of external agents that might lead to deviations in behaviour or that might literally invade the self and disrupt its normal balance. Pelling (2001: 21) has noted that pollution is very much about the negotiation of a boundary between the self and the outside; in her words, 'with the individual's sense of separateness from his or her environment and how this separateness is to be maintained or regulated'. It is in this context that *infectio* becomes enmeshed with 'contagion'. The latter term derives from *tangere* – to touch – and denotes the transmission of a disease through direct or close contact.

It is also in this context that the discourse on health and disease – facilitated by the intertwining of *infectio* and *tangere* – assumes the contours of a moral concern with purity; more precisely, with the preservation of pure individuals in pure communities, or with their purification if need be. Because disease was connected with defilement and the breaking of taboos, communities saw it necessary to resort to strategies of demarcation or separation from diseased elements or from entities that could cause disease – lest the presence of uncontrolled disease throw social order into disarray. These strategies have included measures of containment: one historical example is the institution of quarantine and isolation in fourteenth- and fifteenth-century Italian cities as a response to plague outbreaks; another example is the range of reactions to leprosy (Pullan, 1992; Harrison, 2004; Edmond, 2006).

However, separation was hardly a sweeping programme of exclusion and confinement; it worked, and still works, in more minute ways. Indeed, there was no generalized confinement of lepers (Watts, 1997: 40–83); moreover, as Michel Foucault (1977: 195–200) observed, the strategy for dealing with plague was more sophisticated than simple isolation. In addition to 'macro' strategies of separation – which are seldom all-encompassing and totally effective – the maintenance of individual and communal purity also manifested itself in the performance, throughout history, of specific rituals of purification. Anthropologist Mary Douglas (1996 [1966]) has argued that rituals to stave off pollution combine religious beliefs and communal anxieties, and reflect a desire to safeguard both bodily and social margins. For Douglas,

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margins are essential to preserve order. Contagion results from disorder; it is, in fact, a disorder in itself, a state in which something is out of its natural place, in which boundaries have been breached.

The importance of preserving external boundaries helps to explain how disease assumed, within the imaginary of health, the form of an acute pre-occupation with the integrity and ontological security of the self. The question of preserving boundaries is present, for example, in modern notions of hygiene and cleanliness. According to Temkin (1977: 468), by the eighteenth century hygiene had become powerfully imbued with religious and moral considerations as a response to infection. Diseases were seen as either emanating from foul and filthy environments, as held by miasmatic theories of disease (Halliday, 2001; Johnson, 2006), or were considered filthy in themselves – a good example being syphilis, which was historically associated with sexual practices deemed shameful. Originally regarded as cosmetic matters, cleanliness and hygiene were incorporated into the sphere of health and surrounded by moral imperatives regarding proper behaviour.⁹

The concern with boundaries also influenced notions of immunity that are still relevant today. Looking at twentieth-century representations of immunity in the United States, Emily Martin (1994) identified the persistence of a war imagery, which revealed itself in the notion of the individual body as a fortress or an embattled ground, and of the outside world as inimical. As Martin (1994: 53) put it: '[t]he notion that the immune system maintains a clear boundary between self and nonself is often accompanied by a conception of the nonself world as foreign and hostile'. These images were particularly vivid up until the 1950s, when anxieties regarding hostile agents within the body began to increase. In an earlier work, Martin (1990) drew a parallel between the individual and the social-political body, with bodies being conceived as nation states. Undoubtedly, a two-way relation between individual and social body is present, insofar as the shift in focus from external to internal enemies could be seen as echoing post-war anxieties in the United States about internal subversion. Whether one is speaking of the invasion of a foreign agent or of infiltrated 'cells', the basic rationale underlying ideas of immunity remains the same: it is a matter of preserving the integrity of a previously defined self, by identifying enemies and by ordering the world with categories that are inherently moral and political.

This (necessarily brief) discussion of the synergies between concepts of ontological security, infection, contagion, pollution, (im)purity and immunity allows one to begin to tease out the ways in which security can be seen as a determining element in the imaginary of health. The concern with infectious diseases encapsulates the security imaginary that conditions and shapes the current health agenda. 'Infectious disease' is much more than a technical term or a physical reality; it should be seen as a powerful assemblage of meanings, one that is deeply ingrained in culture and that is traversed with moral and political concerns. By invoking widespread ontological and social anxieties, infectious disease becomes much more than an ailment that is transmitted

through contact. As Alison Bashford and Claire Hooker (2001: 5) put it in their study of the notion of contagion, the latter has the capacity to function as a ‘deeply resonant metaphor for the circulation of social, moral or political dangers through a population’.

The dread of disease

This discussion has so far made the case for the centrality of security in the imaginary of health, on the basis of a concern with the preservation of the stability of the self in the face of infection/contagion – the latter implying ‘absorption, invasion, vulnerability, the breaking of a boundary imagined as secure, in which the other becomes part of the self’ (Bashford and Hooker, 2001: 4). This is, however, just one side of the question. In order to fully understand how the reality of health has been constituted within the realm of security, it is also important to consider how disease has been intertwined with insecurity. Or, to put it differently, how is it that disease commands so much dread and anxiety?

The transformation of an issue into a security threat is said to occur when that issue is presented and accepted as a challenge to the very existence of a certain entity. A threat entails the prospect of an imminent dissolution of the referent; it must be dealt with before the referent is destroyed or transformed in such a way that its nature changes fundamentally. Health issues are sites where the prospect of the dissolution of the referent is presented with special acuteness. This is because they are seldom experienced as simple physical ailments, but rather as symptoms and manifestations of a deeper social malaise – a society on the brink of a radical shift.

Perceptions and representations of health problems are often intertwined with narratives of social crisis. This is particularly true of infectious disease outbreaks, but can also be observed in contemporary responses to issues such as obesity, autism, addiction or deficit attention disorder. As Philip Alcabes (2009) has argued, the fears that surround health issues do not just relate to their specific physical dimensions; rather, the dread of disease functions as a catalyst of other fears, a narrative that weaves together other insecurities and anxieties in society – the fear of strangers, of technological development, of racial difference and so on. The anxiety over health mobilizes other anxieties lurking in society and interacts with them. As a result, the dread of disease is never just about a specific disease; it is also about the political fate of a society. Health issues raise so much anxiety because they probe the limits of what we know and fear: they evoke what has happened in the past; they function as a reminder of the precarious balance upon which society rests; and they provide the occasion for forecasts to be made about what will happen if things are allowed to go unchecked.

This is not a new phenomenon. Since Antiquity, diseases have been seen through the lenses of the broader social and political context of the day. In

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recent years, however, the interconnection between disease outbreaks and social crisis has achieved renewed power with the growth of the ‘infectious disease paradigm’ outlined above. Disease outbreaks are accompanied by the global escalation of concerns, which in turn is supported by pessimistic projections and catastrophic scenarios put forward by policy-makers, experts and the media. These scenarios, which draw upon images and narratives that have been popularized in entertainment, simultaneously capture and amplify the dread of disease by highlighting the sense of urgency and reiterating the seriousness of each outbreak. Weir and Mykhalovskiy (2010) have noted that global public health is currently dominated by the idea of ‘emergency vigilance’, that is, by the constant watchfulness towards not only actual diseases but any other events that create the potential for disease. In their view, there is a shift in public health from the focus on known diseases to a broader, precautionary engagement with a ‘microbial world full of potential and surprise’ (Weir and Mykhalovskiy, 2010: 62), which requires the constant monitoring of phenomena that may trigger catastrophic events.

The resonance of these concerns, and the power of the scenarios they invoke, can be explained in part by their support in ‘expert knowledge’ and by the immediacy of information about outbreaks that is able to circulate quickly around the globe. There are, however, other narrative elements that help to explain the traction of these scenarios, and that support and heighten the contemporary dread of disease. The first of these elements is the existence of historical cases that can be invoked as precedents and mobilized as ‘ready-made’ repertoires of meaning. In order to make sense of novel and unpredictable situations, humans often resort to drawing parallels with familiar cases. This is done not only to make predictions and to draw lessons on what to do and what to avoid. By enveloping unfamiliar situations in familiar clothing, humans are also seeking reassurance, or at least a more precise image of what they already fear. In the case of health, two historical cases are frequently used to illustrate the dangers of uncontrolled outbreaks. One of them is the fourteenth-century outbreak of bubonic plague in Europe – the ‘Black Death’. This plague has penetrated the imaginary of Western societies, to the extent that it can be considered a ‘model epidemic’ (Alcabes, 2009). With its estimated 25 million victims and a surrounding imagery of death and terror – visible in paintings by Hieronymus Bosch and Pieter Brueghel – the Black Death had a cultural impact that has lasted to the present day (Cooke, 2009). Its role as a reference point for making sense of new outbreaks is confirmed, for example, when Laurie Garrett (1995) wonders where ‘the coming plague’ will come from, or when SARS is dubbed the ‘twenty-first century plague’ (Abraham, 2005). Another relevant historical illustration is the 1918 influenza outbreak. This historical episode has gained notoriety with the ‘swine flu’ and ‘avian flu’ outbreaks, to the point of being termed ‘the mother of all pandemics’ (Taubenberger and Morens, 2006). As with the plague, contemporary events are read through the lens of historical experience: the anxiety over a possible repetition of the past conditions reactions to new

phenomena, determining the way in which problems are defined and legitimizing certain responses.

If historical examples of death and turmoil caused by disease function as repositories of meaning for interpreting present outbreaks, the anxiety over health issues is further reinforced by the establishment of parallels between disease and narratives of moral degeneracy and political decay. Charles E. Rosenberg (1989: 12) has commented on the role of diseases as frames for undertaking broader social commentary; in his words, ‘the incidence of disease has served as index and monitory comment on society’. There are numerous illustrations of this: James Longrigg (1992), for instance, has observed that Thucydides’ account of the great plague of Athens is, more than anything else, an account of the disintegration of Greek society. Roger Brock’s (2000: 24) study of the medical imagery in the Greek polis also confirms this, by arguing that discourses of bodily and political sickness interacted as Greek cities were not only beset by physical events but also by ‘a range of symbolic and metaphorical diseases, amongst them the equation of disorder in the state with a sickness of the body politic’. Throughout the medieval period – and again the example of the Black Death is an illuminating one – there were numerous instances in which disease acquired eschatological contours, as societies were considered to bring upon them the wrath of God because of degenerate behaviour. One only needs to look at the reactions of some religious fundamentalist groups to HIV/AIDS to recognize the persistence of these rationales in the twenty-first century. In sum, the occurrence of disease has historically fed into perceptions of societal decline, and this interaction may be said to shape the contemporary understanding of disease (Aaltola, 2012). An epidemic occurrence is seen as a signal that a given society is declining, or at least resting upon shaky foundations. Disease assumes the role of a warning sign, a metaphor, a symptom of broader processes of disintegration and a contributing factor for further decay.

This leads to another element of the contemporary dread of disease: the sense that even though disease may be introduced by external elements, debilitating conditions already present in society facilitate its spread. Societies are here seen as predisposed to disease, as internal weakening or subversion turn them into breeding grounds for outbreaks. Two aspects of this narrative element can be distinguished. The first, present in the ‘new and emerging viruses’ discourse, emphasizes how danger lurks inside the systems that societies develop in order to protect themselves or to provide the means of a more comfortable life: examples are the dangers of mutating viruses stemming from genetic manipulation or from the incorrect use of antibiotics, or of deadly pathogens living in air-conditioning ducts (Alcabes, 2009). Here, the occurrence of disease outbreaks is a side effect or an unintended consequence of a society’s own development. The second aspect is more broadly moral and political: the notion that disease is already inside society functions as a cautionary note against complacency and leniency with regard to threats from within. The spread of a disease comes to signify both ‘the dangers circulating

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in social bodies and in populations – actual viruses and bacteria, “contagious” morals and ideas, social dangers re-thought as bodily infectiveness’ (Bashford and Hooker, 2001: 10). Anxiety over disease reveals itself in a requirement for permanent and encompassing vigilance, entailing composure and self-scrutiny; preparedness against all possible threats; and focusing attention on things and people that seem unusual and different.

Another element of the dread of disease emerges from this discussion: disease scares are fertile grounds for finger-pointing, which in turn entails damaging effects for social stability and for the lives of those directly involved. When an outbreak occurs, the immediate reaction is to search for origins and causes, circumscribing the source of the problem in order to make it more manageable. These control attempts often involve the ascription of responsibility and blame – be it to individuals, groups or even states. For centuries, disease outbreaks have been connected with undesirable – or simply different – ‘others’. The Black Death provided the opportunity for the recrudescence of anti-semitic feelings; in the seventeenth century, syphilis was dubbed a ‘French disease’ in Great Britain; the homosexual community was held responsible during the early years of the AIDS pandemic. Sometimes the process of blaming becomes individualized, as with Gaëtan Dugas, for many years the suspected ‘Patient Zero’ for AIDS; or Mary Mallon (‘Typhoid Mary’), who is believed to have infected around 50 people with typhoid fever in the New York area in the beginning of the twentieth century. Importantly, however, Dugas and Mallon still functioned as social types. In the imaginary of disease, flight attendant Dugas is the globe-trotting homosexual with a voracious sexual appetite; while Mallon is the reckless Irish cook who works for well-to-do families before returning to her squalid dwellings at the end of the day (Kraut, 1994). The paradox of seeking to gain reassurance by tracing the origins of an outbreak is that this process reinforces anxiety by identifying disease with certain agents or carriers – thus constituting an image of danger that is always present, a shortcut to the imaginary of disease that can be easily mobilized and applied to new cases.

In sum, the reality of health is strongly shaped by security, not only because it is closely connected to the preservation of the integrity of the self, but also because it is sustained by multiple sources of anxiety. The remainder of this chapter explores the case of immigration, an example of the ways in which health is constituted simultaneously as a question of ontological security and a source of dread.

Immigration, disease and the politics of fear

The linkage between disease and the immigration has been a problem for medical thought since the days of Hippocrates, when it was assumed that individuals and communities were naturally suited to their locations (Marks and Worboys, 1997: 7). According to this view, disease was the result of a disruption of a natural harmony between body and environment, either by

environmental changes or by human movements. This environmentalist approach interacted throughout history with an emphasis on the body as a source and spreader of disease. This latter focus on the body has become predominant with scientific developments from the nineteenth century onwards, particularly in the field of bacteriology. With these developments, a number of diseases came to be explained by the presence of micro-organisms that infect the body and that can be transmitted from one body to another.

The decline of the environmentalist approach entailed a shift, not only in attitudes towards migration, but also in responses to the perceived 'problem' of immigrants. To begin with (following the argument presented by Marks and Worboys), the question is no longer one of 'acclimatising' individuals to new environments, but rather of identifying and isolating *foci* of infection, in addition to addressing the circumstances that allow for infection to occur (such as housing conditions and hygiene habits). Disease came to be conceived, not as the disruption of a balance, but rather as something external that is brought about by population movements. The result is an anxiety with regard to foreign bodies that threaten to bring infection. Immigrants, as both individuals and groups, are identified as risky. At the same time, the identification of micro-organisms as the causes of disease opened the door for the development of a broad range of strategies for protection against infection. Indeed, the language of medicine and public health increasingly came to permeate discourses and policies towards immigration. The idea that diseases could be traced back to a specific cause 'galvanized existing public health programs and encouraged medical authorities to believe that germs could be contained and controlled through direct intervention' (Markel and Stern, 2002: 761).

In addition to the development of theories of disease causation, the perception of immigrants as risks to health was facilitated by the conjunction of other ideas and processes. The definition of immigrants as risky draws on, and mobilizes, other anxieties in society. While studying the association between immigration and disease in the United States of America, Howard Markel (1997) argued that ideas about the health risks of immigration cannot be separated from other concerns, namely economic ones – the fear that immigrants will take up existing jobs, drive down wages and constitute a burden for the public welfare system. Equally important are anxieties about the integrity of the political system. In the United States, prejudice against foreigners was often intertwined with suspicions regarding their 'untoward political (e.g., anarchist, socialist, or communist) beliefs and the fear of the immigrants' collective potential somehow to taint the American political process' (Markel, 1997: 9).

In connection with these political fears, one can also detect others related to the moral and social degeneracy that supposedly would be introduced by immigrants. In addition to the immediate risk of transmission and spread of disease and alien ideas, anxieties about the long-term impact for American society of admitting immigrants were closely intertwined with perceptions of

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the relative (in-)‘salubriousness’ of immigrants. As Markel and Stern (2002: 766) have put it, ‘[l]ong after the admission to American ports and borders of the “neurasthenic” Jew, the “criminally minded” Italian, the grimy Mexican, or the parasite-ridden Asian, their defective genes would multiply and defile the national body’. One thus sees how the connection between immigration and disease mobilized security-related ideas about the integrity of the American self. Indeed, in a time of Cold War ideological confrontation, immigrants were identified as subversive elements that endangered the national security of the United States – security being understood not only as strategic advantage *vis à vis* the Soviet Union, but also in terms of the self-understanding of the United States as a society and political system.

The link between health and security in the case of immigration was visible, for example, in the US Immigration and Nationality Act of 1952, which established a number of categories of ineligible aliens including:

the feeble-minded; the insane; people with epilepsy or other mental defects; drug addicts and alcoholics; those with leprosy or contagious diseases; aliens found to have a physical defect, disease, or disability that would restrict their ability to earn a living; the impoverished; criminals; polygamists; prostitutes; homosexuals; contract laborers; and Communists, anarchists, or those subscribing to totalitarian political ideologies.

(Markel and Stern, 2002: 773)

By tying together these categories without providing any explanation of the actual threat that each constituted, this Act effectively established a continuum between disease, criminal behaviour, immorality and political subversion. More than just risks to health, immigrants were perceived as threats to the American way of life, to societal stability and to national security.

Understanding how immigrants came to be associated with disease and how immigration was thus surrounded by discourses of emergency and danger requires that one looks, not only at discourses and explicitly stated ideas, but also at underlying feelings, emotions and suspicions in society. Desmond Manderson’s (1997) study of Australian reactions to Chinese immigrants in the nineteenth century provides an illuminating account of this dimension. For Manderson (1997: 24), feelings of hostility towards immigrants include an important ‘aesthetic’ element, inasmuch as ‘the different look and sound of newcomers seems to offend accepted parameters of beauty’. The process by which health problems were defined included ideas of purity and cleanliness in Australian society – and, conversely, the latter’s dread of dirt and pollution. Manderson shows how existing xenophobic sentiment was heightened by the fact that the Chinese way of life was considered ‘dirty’ and ‘immoral’, and thus elicited feelings of disgust and revulsion. The Chinese community came to signify, not only a health risk, but, more importantly, a ‘metaphorical or symbolic disturbance’ (Manderson, 1997: 29). Disease was connected with filth and depravity and this process

was given particular immediacy and legitimacy with the use of scientific knowledge.

Alan M. Kraut has shown how the linkage between immigrants' health and security was reflected in a politics of fear. Kraut (1994: 256) argues that, throughout American history, one can observe a 'double helix of health and fear of the foreign-born' that feeds on a cocktail of ideas about national security, race and nationality. This connection draws on the establishment of synergies between medical knowledge and nativist ideas, that is, ideas that express the fear of, and opposition to, foreigners. Attitudes towards immigration were underpinned by the 'medicalization of preexisting nativist prejudices' (Kraut, 1994: 2), as medical knowledge and rationales were mobilized to justify the exclusion or stigmatization of foreign-born individuals and groups. By the beginning of the twentieth century, nativist groups (generally white, Anglo-Saxon and Protestant) were overtly using scientific medicine as a weapon against immigrants, and these pressures impacted upon policy-making in profound ways.

The case of Chinese immigration provides numerous examples of these policies based on prejudice and fear.¹⁰ Paradigmatic among these is the case of the 1900 bubonic plague scare in San Francisco. The plague outbreak initially occurred in Chinatown and as a result it ended up reinforcing existing Sinophobic sentiment. Sensationalist press reports at the time used historical descriptions and imagery of the 1665 London plague to dispel any doubts about the veracity and danger of the outbreak (Risse, 1995). In this context of fear, San Francisco health authorities mobilized an array of strategies, including a full quarantine of Chinatown (reversed after social unrest); the mass inoculation of Chinese (and Japanese) residents with a vaccine that often had fatal side-effects; inspections and the threat of resettlement – amid discussions in the press of simply burning Chinatown to the ground (Kraut, 1994; Markel, 2004: 49–77). More than simply reflecting the origin of the outbreak, these draconian measures against the Chinese community were connected with broader discourses of Chinese deviance and danger. In fact, Nayan Shah (2010) argues that these measures were part of a wider effort towards the production and reinforcement of Chinese difference in relation to dominant (white) norms. More broadly, they reflected a desire to uphold an ideal American identity in opposition to undesirable 'others'. As Shah (2001: 12) has put it:

[a]t the turn of the [twentieth] century, 'health' and 'cleanliness' were embraced as integral aspects of American identity; and those who were perceived to be 'unhealthy,' such as Chinese men and women, were considered dangerous and inadmissible to the American nation.

Conclusion

The spectre of 'the next pandemic' looms large in contemporary visions of health. The reality of health has been profoundly shaped by the fear of

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rampant infectious disease and its potentially devastating impact upon social stability, political order and international relations. The infectious disease paradigm has become an almost commonsensical part of policy-making and the cultural landscape: if left unchecked, infectious diseases will spread and ultimately disrupt life as we know it.

This chapter unpacked the reality of health, scrutinizing the way health issues are defined as problems. It began to explore the political dimensions of health, showing how the latter has been made in certain ways, with certain purposes, and against a certain historical and cultural background. Notwithstanding the diversity of representations, one can understand the reality of health as shaped by an imaginary – an ensemble of deep-seated meanings, expectations and assumptions that delimit actors' self-understandings and their range of desirable and possible action. The imaginary of health is very often constituted under the sign of security – and its correlate meanings, insecurity, fear, anxiety or panic. Two dimensions of the security imaginary of health are particularly important: the concern with the integrity and ontological security of the self; and the dread of disease.

Health can be seen as profoundly political because it is constituted through interactions between actors and because it intersects with ideas about the preservation of the political body – ideas of national security, political cohesion and, in some cases, racial superiority. The making of health is a mechanism through which polities seek to define themselves in relation to elements deemed extraneous. Diseased or infected bodies are always political, not only because they are understood and addressed through political processes but also because they capture the political anxieties of the day.

The making of health cannot be separated from political interests. The predominance of the infectious disease paradigm speaks to the agenda and the concerns of Western, developed nations. At the domestic level, the health agenda also privileges the interests of dominant actors and has often provided the opportunity for these actors to reinforce their position. Nonetheless, there are tensions and silences in the making of health. The predominance of the current agenda entails the neglect of certain issues (like neglected tropical diseases, diarrhoea, or non-communicable diseases) that constitute a tremendous burden on less developed countries. Likewise, at the domestic level, the disadvantage of certain groups (such as ethnic minorities and immigrants) has been reproduced and reinforced via ideas and practices of health. In sum, the making of health very often reinstates hierarchical relations at both the international and domestic level, thus reproducing political inequalities and vulnerabilities – if not outright harm.

The fact that the reality of health is predicated upon normative visions and political agendas also means that it is fundamentally 'unfixed' and precarious. It can be challenged and eventually transformed through social contestation and struggle. Alternative views are possible and may, indeed, already be present, even if in a silenced and suppressed way. Before addressing (in Chapter 6) the possibility of alternative meanings and political change in relation to

health, it is worth exploring another dimension that has only remained implicit in this chapter. In addition to being made in a specific way, health is also something that does certain things or that provides the opportunity for certain things to be done. But how exactly does health impact upon the cultural, social and political landscape? The next chapter explores this dimension of the politics of health.

Notes

- 1 Entries 'health' and 'disease' in the *Oxford English Dictionary*, available online at <www.oed.com> (accessed 23 March 2012).
- 2 See, for example, Temkin (1973), Rosenberg (1992) and Porter (1999).
- 3 A number of edited volumes and readers provide overviews of the sociology (Petersen and Waddell, 1998; Nettleton and Gustafsson, 2002; Pescosolido *et al.*, 2011) and the anthropology of health (Inhorn and Brown, 1997; Good *et al.*, 2010).
- 4 Preston (1994), Garrett (1995) and Drexler (2002) offer iterations of this narrative. Its tropes and internal structure have been analysed by Ungar (1998) and Wald (2008). The cases of SARS, 'avian flu' and 'swine flu' are recent examples of the great political and public attention raised by infectious diseases. An account of the 2003 SARS outbreak is Abraham (2005). On influenza A/H5N1 ('avian flu'), see for example Davis (2005).
- 5 Examples from the media are numerous: see for instance Horton (2003), British Broadcasting Corporation (2005) and Syal (2009). Movies that reproduce the infectious disease paradigm are, for instance, *Outbreak* (2005) and *Contagion* (2011). A good example of a novel depicting a deadly outbreak is Michael Crichton's bestselling *The Andromeda Strain* (1995).
- 6 The concept has also been discussed by McSweeney (1999), Kinnvall (2004) and Steele (2005).
- 7 Continuity and stability are not the same as immutability. As Mitzen (2006: 344) has argued, '[n]eeding stability does not mean that self-understandings must be forever unchanging; indeed such changes are essential for learning and personal development. The idea is rather that individuals value their sense of personal continuity because it underwrites their capacity for agency.'
- 8 Pelling (2001: 20) also includes in this moral remit the idea of 'miasma', which derives from *miaino*, the Greek equivalent to *inficere*. Parker (1983) provides a detailed study of miasma and pollution in Ancient Greece.
- 9 They were also accompanied by the perception of poor classes as a health problem and a menace because of their hygiene standards (Hardy, 1993).
- 10 Reactions to Chinese immigration are but an indication of broader dynamics. Markel (1997), for example, has studied the case of East European Jewish immigrants, while in another work (Merkel, 2004) he looks at Haitian immigrants in the context of the HIV/AIDS pandemic (among other cases). Kraut (1997) has investigated southern Italian immigration, and Molina (2006) the policies put forward by Los Angeles public health authorities towards Mexican, Japanese and Chinese communities.