Embodied expectations: the somatic subject and the changing political economy of life and health

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In a recent contribution, historian William H. Sewell, Jr has offered a careful assessment of how the new "architecture of world capitalism" associated with the shift from "a state-centric to a neoliberal paradigm of capitalist political economy" (Sewell, 2009: 254) may be related to the state of and trends in population health. According to Sewell (2009: 255), "[t]he political economy of capitalism should be linked to population health through four distinct pathways (…)." These pathways include:

1. "Levels of economic prosperity and rates of economic growth";
2. "public provision of goods relevant to health", including "water supply, sanitation, medical care, housing, education, alleviation of poverty, or control of environmental pollution";
3. "the nature and extent of material inequalities";
4. "insecurity" and "general stress levels of population", associated with decreases in regulation of public goods such as health care (Sewell, 2009: 255).

Sewell's account does identify a number of key processes related to population health and how they have changed throughout the "shift" he describes. He points the way to a careful inquiry into these processes, their outcomes, and the variety of historical experiences and trajectories through which they take shape. As he states,

> "the world of capitalism is hardly flat. Within world capitalism, the economic developments, regulatory policies, and economic ideologies of the wealthiest nation states are vastly more influential than those of the poor and 'underdeveloped' countries (…). [T]he controlling structures of world capitalist development in the years since World War II have disproportionately embodied the interests and the socio-political outlooks of the wealthiest states and of their political and economic elites" (Sewell, 2009: 256).

Sewell,s text is the final chapter of a collective volume on “how institutions and culture affect health” (Hall and Lamont, 2009). In fact, political economy figures prominently in most contributions to the volume, and there is a concern, by contributors, to avoid the Euro-Noth-American bias in the treatment of global health and its determinants. But the volume seems to address only part of the story of how a new political economy of health is emerging. Another part is being told in recent accounts of what has been variously described as the biomedicalization of health (Clarke et al, 2003), the politics of life itself (Rose, 2007), the rise of biocapital (Sunder Rajan, 2006) and of new forms of biopower (Rabinow and Rose, 2003) and biosociality (Rabinow, 1996; Gibbon and Novas, 2008). And another part of the story, still, is being told by work in medical anthropology, but also by the emergence of “other” accounts of health and healing, of life, death and the body, and of how they contribute to the shaping of a more complex political economy of life and health.

The focus of this paper is on these two types of accounts - which should be read as complementary to, but also in tension with, those included in the volume edited by Hall and Lamont – and their implications for re-thinking the political economy of life and health in a post-neoliberal mood. It aims at contributing to a research agenda which would allow a convergence and dialogue among the different abovementioned approaches or accounts.

The biomedicalization of health and the politics of life itself

Over the last three decades, the capacity to manipulate life and to intervene in vital processes has grown in tandem with the incorporation of “life itself” into the overall dynamics of capitalism. Biological entities, such as cell lines, genes, human tissues, organs or genetically modified organisms – which are themselves the outcome of technological innovations - have become subject to private appropriation and to intellectual property rights and turned into new sources of capital accumulation, or “biocapital” (Sunder Rajan, 2006; Waldby,). The promissory notes as well as the actual achievements of biomedical research drawing on these innovations have become, in turn, building blocks of a new political economy of health, thriving on expectations and hopes of eradicating disease, but also of preventing it through the early detection of os susceptibility to specific disorders through the capacity to identify individual genetic profiles, or of delivering personalized care based on those profiles. Pharmacogenomics

has become one of the main expressions of this individualized conception of health care, through the design of drugs (and of their mode of delivery) according to the genetic profile of the individual patient. But promissory notes go one step further, as they include the prospect of enhancing human life and human capacities through biological manipulation.

This emerging political economy of life and health has profit as its prime mover and driving force, with the consequence that research in the life and biomedical sciences and the delivery of health care and health care tend to become increasingly subordinated to private interest (Krimsky, 2004). The privatization of research and of its outcomes takes shape through a variety of new organizational arrangements, legal frameworks and modes of funding. New regimes of knowledge production have emerged, based on private-public partnerships or on the privatization of research – be it through the private funding of research carried out at both public and private facilities, or through the expansion of intellectual property. Start-ups companies have become a key locus for cutting-edge research. New markets and new (private) forms of organization of the delivery of health services have turned health care into a highly profitable business, and pressures towards the privatization or private management of public health services are a topic familiar to citizens of countries (in Europe, in particular) where public, national health services and access of all citizens to these services had been regarded, for decades, as constitutive of democracy and of democratic citizenship. The development, production and consumption of drugs has expanded considerably, with pharmaceutical companies seeking new markets as well as new fields for clinical trials of drugs, especially in countries displaying "treatment naiveté" – i.e., countries, where populations exhibit epidemiological profiles close to those of the so-called rich countries of the Northern Hemisphere, but where access to medical treatment and to drugs is limited, thus avoiding the problem of having to deal with "confounding" effects associated with the consumption of drugs. These populations, like those in some Eastern European and Latin American countries, thus provide a large pool of "experimental subjects" which, in turn, has given rise to a new political economy of clinical trials, involving not only pharmaceutical companies and trial subjects, but also contract research organizations (CROs), local facilities for trials, ethical committees and boards and regulatory initiatives and entities (Petryna, 2008). And, finally, these processes are inseparable from new forms of biopower (Foucault, 1976; Rabinow and Rose, 2003) and of biosociality (Rabinow, 1996; Gibbons and Nova, 2008),

The transformations in the political economy of life and health summarized above are all part of the shift, discussed by Sewell, towards the “neoliberal paradigm”. But that transformation goes well beyond changes in the organization, funding, regulation and property frameworks. They also entail the constitution of a new kind of subjectivity.

The somatic individual or subject (Novas and Rose, 2000) appears, in this story, as an instantiation of the (neo)liberal subject, endowed with all the attributes of autonomy, responsibility and capacity for choice. These attributes, though, are themselves constituted through specific arrangements of devices and dispositions. The somatic subject arises within a dense web of attachments to health care delivery systems, to medical professionals, to counsellors, to insurance companies, to drugs and health clubs. His/her life as a responsible citizen, steward of his or her own health, is shaped by what Andrew Szasz (2008) appropriately described as “inverted quarantines” ensuring self–protection against a hostile and threatening environment, but also the awareness that, as new resources become available for screening for genetic predispositions or for early detection of disease, every responsible citizen should regard him/herself as a prospective patient, as a “healthy ill” or pre- or asymptomatic person. The grip of biomedicine over personal life is thus a key feature of the many-stranded changes in what Nikolas Rose (2007) christened “the politics of life itself”. Considerations of cost-benefit, which would be promoted through the privatization of health care and health maintenance, allegedly allowing customers/uses to exercise their right to choose the best offers in the market thus go hand in hand with the ongoing reduction of public health institutions and systems. Assessment of the state of health is now enacted through systems of accounting, auditing and accountability procedures inspired by private management and by its offspring, new public management.

This approach to health and life goes hand in hand, however, with a growing awareness of its costs in terms of selective access to its alleged – and real – benefits and of the neglect of the major health problems affecting the majority of the world population, namely in the Global South. The current definition of priorities and distribution of resources for biomedical research, drug development and health care delivery is a brutal reminder of the inequalities generated and reproduced by the current regime of the “politics of life itself” (Farmer, 2005).

Responses to this process have emerged in both North and South, “interrupting” the dynamics of privatization and commodification of health. Among these is the

emergence of patients and other affected groups as collective actors, organized in associations or movements, promoting new ways of defining health and its political economy, and of designing and organizing biomedical research (Akrich et al, 2008; Brown, 2007). These organizations or movements take different shapes and engage in different kinds of actions in a variety of settings. The concept of "biosociality" (Rabinow, 1996; Gibbons and Novas, 2008) has been proposed by some to account for these new forms of collective. It is not clear yet to what extent these new collectives will be able to induce or promote sustainable changes in the current regimes of knowledge production, innovation and health care, and of the values and notions of objectivity associated with them. Some of them may even contribute to a reconfiguration of those regimes without challenging their logic and workings. But many of them are playing a crucial role in, first, publicly demonstrating the existence of inequalities, neglects and exclusions associated with the current forms of biocapital and the associated regimes of knowledge production, and, secondly, contributing to both the debate over and the promotion of a new political economy of life and health, resting upon the promotion of sanitary, environmental and social justice as guiding values and of associated forms of knowledge production, and giving shape to a further shift, this time away from the neoliberal architecture.

Reframing life and health

The approach summarized in the previous section offers important insights and contributions towards the elucidation of the emerging political economy of life and health. But, as mentioned before, there is a third "family" of approaches or accounts of health and life which provide important inroads into key issues topics which are either absent or secondary in both the "institutional/cultural" and the "biomedicalization/politics of life itself" approaches. These issues can only be sketched out here, and each of them would require detailed inquiry:

- Both supporters and many critics of the current regimes of health care and of heakth-related research tend to share the same conception of health as a discrete set of goods and services which can be delivered through a range of processes, including the market, redistribution through public institutions, charities or, more generally, NGOs, or through communities and a variety of channels of reciprocity and social solidarity. This is precisely what allows life and health to be unproblematically described as "goods" or services, even if the nature of those goods (public, private, for instance) is contested.

“Expanded” conceptions of health as more than a set of conditions and interventions falling within the purview of biomedical and epidemiological knowledge have been a major challenge to what some have called the “biomedical model” or the “dominant epidemiological paradigm”. This is the case, for instance, of definitions like the well-known one championed by the WHO or those proposed and articulated by movements like Latin American critical epidemiology or Brazilian collective health (Campos et al, 2007). Scientific orientations such as ecosystem health or ecossocial approaches to health (Lewontin and Levins, 2007), in a move which is not entirely congruent but is largely consistent and convergent with the previously mentioned orientations, have sought to define health as an emerging property or effect of heterogeneous processes. Whereas some entities retain, within these approaches, their status of “goods” which may be conceived of as produced and delivered through different mechanisms, and some practices may still be described as services to be provided, health becomes tendentially coterminous with the protection, support and promotion of life.

- As recent work by Ed Cohen (2009) suggests, current conceptions of the somatic subject are inextricable form the notion that the body is a well-bounded entity which is to be defended from external assaults and aggressions, rather than an entity that connects. The centrality, since the late 19th Century, of the notion of immunity to describe the sought for relationship between the body and its environment thus overlaps with the notion of the self-centered subject, responsible for his or her own health, understood as the continuous and systematic detection of and struggle against potential threats. This conception stands in contrast with those which see the body as a permeable, complex entity, engaged in a myriad of ways with other organisms and entities, and dependent on these for its survival and development. It is now known that the majority of cells constitutive of a functioning human organism are not cells carrying the human genome: they are cells belonging to a range of other organisms. Recent work in ecological developmental biology (Gilbert and Epel, 2009), Developmental Systems Theory (Oyama, 2000a, b; Oyama et al, 2001) and intersecting, complex processes (Taylor, 2005; 2009) has substantiated and elaborated on this approach, through the engagement with the complex, multilevel make-up of bodies and organisms and the mutual constitution of organisms and their environments. What does this mean for our understanding of what a living organism is, and of what a healthy living organism is? Can we even speak of health when the latter is the outcome of the interference or intersection of heterogeneous processes and entities (Taylor, 2005), across permeable

bodies like the ones supposed to demarcate the body from its environment? An approach along these lines would take health or disease to be properties of eco-systems or, in another formulation, of eco-social systems which are not easily separable into organisms and their environments. Under these conditions, what Szasz calls "inverted quarantines" appear as a futile attempt at transferring the determination of health and disease to the terrain of personal responsibility and self-centered action.

- The very notion of health as a separate domain of human and natural activity should be put under scrutiny, since it is not clear that it is shared by each and every of the ontologies/epistemologies existing throughout the world. In fact, as Paula Meneses (2007) has reminded us, in certain languages and settings, words corresponding to "our" notions of health, illness and disease, pain or suffering may not exist. What we call health may be expressed as "good life", but it will not be thought of as a domain related to biology and subject to specialized human intervention which can be separated from other aspects of life. Pain and suffering ay themselves be expressed through different vocabularies of sensorial or embodied experience or, as pragmatist philosophers like Richard Shusterman (2008) have called somaesthesis. The diversity of "idioms of distress" (Nichter, 1981) and vocabularies and expressions of suffering thus becomes a key issue for a non-Eurocentric understanding of what counts as health, illness and disease.

Whither the political economy of life and health?

We are thus faced with two major challenges to the very notion of what a political economy of life and health and, more broadly, a politics of life stands for, and how it would look like if health were no longer "disassembled" into a range of well-defined and bounded goods and services which can be bought and sold in markets or, alternatively, produced and distributed though other arrangements, such as public health systems or what we could include into a broadly-defined community-based provision of health and health care. In fact, in most parts of the world, conceptions of disturbances affecting "good life" are described and understood using different vocabularies and as part of different cosmogonies. Healing as a response to disturbances is known in every society, but it is, generally, strongly connected to a range of forces, processes and entities which are not separable into organic, psychic or social, natural or human-made. The ways of describing and dividing the world may be quite different across societies, communities and collectives. The naturalistic worldview of modern, Western

biomedicine has been introduced into most societies through the same channels that brought colonialism. In many parts of the world, biomedicine and the conception of health as a separate domain of knowledges, practices and institutions was associated with tropical medicine. This is where "expanded" conceptions of health – such as Collective Health in Brazil (Campos et al, 2007) – and their tendential merger into a broader politics of life may find a productive space for dialogue with "other" approaches to the "good life".

At this point, the temptation is strong to wrap up by proposing something like a rough sketch of a blueprint for a "new" politics of life and a "new" political economy of life and health. I hesitate to take that step, not only because I believe it would be premature, but also because the making of a politics of life will have to be the outcome of a huge collective effort at the crossroads of research and collective action. But whatever its shape, I dare to suggest that it will have to build upon the intersection of a political ecology (Porto, 2007), a body politics and a geopolitics of life and health.

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