Introduction to "Health Panic and Women's Health"

Geneviève Rail and Natalie Beausoleil

Between a national conference on women's physical activity and sport, and the funeral of a dear and too young friend who died of breast cancer; in cyber space somewhere between Québec City, Ottawa, Montreal, Toronto and St. John's, where we live and work and find the comfort of our parents and friends; this is when and where we wrote the introduction to this special issue. The social, geographical and cultural contradictions of our locations and experiences were no less important than the paradoxes associated with our attempt to shed a deconstructive light on the current "health panic" while at the same time appropriating dominant discursive resources in our personal efforts to make sense of our (un)timely encounters with health and death.

We would like to dedicate this special issue to Suzanne Rajotte (1957-2002), a friend and colleague who relentlessly worked for the vitality of the francophone community in Newfoundland and Labrador, and who also initiated the first creative arts workshop for adults with cancer at the Dr. H. Bliss Murphy Cancer Centre in St. John's. Her life was full and vibrant. Her passing is a tragedy although it does unmask the illusion that we live forever and challenges the idea of the "material effectivity" (Balsamo 2000, 189) of the deployment of scientific knowledge and technology within our healthist culture. These are important issues on which we would like to elaborate next, as a way to better contextualize the articles we have selected for the issue.

THE CORPORATE COLONIZATION OF HEALTH

In the last twenty years in Canada, a consensus has developed between economic and political elites and the lines between corporate governance and national governance have become blurred. Thanks to approximately 450 lobbying firms present in Ottawa, large corporations have strengthened their political platform and their role in the radical "adjustment" of the Canadian state. The type of state that is currently being developed in Canada successfully serves large corporations and its premier objective is to establish favorable conditions for multinational corporations' investment and competitiveness. This process is supported by the current federal government, although it started much earlier and became evident in 1986, under the leadership of Brian Mulroney, with the publication of Minister Nielsen's report - a report that critically reviewed all government programming in market-driven terms. In the period of time since, the broad sectors of the Canadian economy and society have been scrutinized, cut or re-organized. Abandoning the goal of social security, it is the investor's security which is now favored. Consequently, the state endeavors to maintain a climate of stability, security and confidence necessary for the maximization of competitiveness and profits. The state apparatus has been redesigned to better assume its new roles. The public sector must function as a corporation: ministries must learn to do more with less and all must repeat the mantra of economic priority and market federalism.

Habermas (1987) has argued that major corporations have come to replace religious, familial, educational, and community institutions in the production of meaning, personal identity, values and knowledge. Such a powerful influence on society by corporate ideologies and practices is what Habermas has called the "colonization of the life world." In Canada, corporate colonization has resulted in the presence of a corporate agenda in Ottawa, as well as its impacts on civil society. For instance, workers' unions have seen their power diminish as governments no longer respect collective agreements and corporations sully their reputations. Women's organizations have been among the first victims of government's budget cuts despite the feminization of poverty and the widespread problem of violence against women. Similarly weakened have been environmental groups and, more generally, citizens' groups. The latter are often considered "special interest" groups and are thus denied a voice, as has been the case during meetings related to the Multilateral Agreement on Investment (Montreal), the World Trade Organization (Seattle), the World Economic Forum (Davos), and the Summit of the Americas (Quebec City). The influence of civil society has therefore decreased at the same time as representatives of large corporations have been invited to play a predominant role on government consultative groups and panels.

To summarize the current social-political

context, we could say that it is characterized by a domination of large corporations, a restructuring of the Canadian state, a reduction of social spending and transfer payments to the provinces, an increase in corporate welfare, and a globalization of markets. What we are suggesting here is that it is in this very context that we must consider the emergence of a business model of health and of a "health panic."

THE BUSINESS MODEL OF HEALTH

We agree with Pat Armstrong when she argues that the business model of health is based on a belief in market strategies and for-profit managerial techniques. Speaking of the last few decades, she comments on the appearance and consequence of such a model in the following terms:

> The welfare state and public sector workers came to be defined as part of the problem. Solutions were sought in market mechanisms and for-profit management techniques. Increasingly, health care was defined as a consumer commodity and as a business that could be a source of profit. In the name of cost control, efficiency, effectiveness, accountability, integration, continuity and choice, governments began to intervene more in the organization of health care. Somewhat paradoxically, privatization has often been the strategy or the result. (2001, 49)

Although there is no evidence to show that market approaches would improve the overall quality or performance of health care, governments are considering them because they are promoted by small but influential groups: for-profit providers, insurers, and the wealthy. Translated in gendered terms, this means that, *grosso modo*, a small minority of men benefit from such approaches, while women - particularly as care providers and care recipients - carry the burden (Armstrong 2001). Ever-expanding health industries are driving the global health privatization push and there are good reasons for this. The American focus on high-tech care has resulted in skyrocketing health costs in that country and this has meant massive increases in profits for drug, hospital and insurance corporations. Giant health corporations are amongst the fiercest opponents of so-called "trade barriers" to protect public health care in Canada and other countries. Many of these barriers have already fallen and more will fall according to the corporations, whose voice can be heard loud and clear.

The prevalence of the corporate voice is such that, at the time of writing these lines, the *Final Report of the Commission on the Future of Health Care in Canada* authored by Roy Romanow (2002) had just been released and we already sense the counterattack from the usual suspects. Romanow's report demonstrates the sustainability of Medicare and shows no enthusiasm for the injection of free-market principles or more private-sector responsibilities into the system. Reaction was swift and in the day following the release of the report, national newspapers featured articles with titles such as: "Is This Man Public Enemy No. 1?"; "Let's Get a Second Opinion from Senator Kirby"; "Oops! Your Hypocrisy Is Hanging Out"; "A Provincial Chorus of Complaints"; "Show Us the Money, Roy"; "Reform Illusory When the Market Is Ignored"; and "Private Health-care Providers Protest" *(The Globe and Mail)*. *The National Post* presented: "A Noble Principle or Just More Red Tape?"; "Clinics Shoot Back: Private Is Cheaper"; "An Unconscionable $27b Health Bill"; "Ideology Blinds Romanow Study"; "Romanow's Failure"; and "Straight Out of Central Planning."

We have argued that attacks on efforts to sustain publicly-funded health systems may be better understood in the context of the corporate colonization of health and health care, as well as the emergence of a business model of health. We would like to argue next that such reactions are part of, and derive their meanings from, a range of discourses that (wittingly or unwittingly) result in a "health panic."

HEALTH PANIC

By "health panic," we mean a psychosis of national proportions about "health risks," the identification of "bad" genes, the "impending epidemics" of illnesses and diseases, the lack of access to public health care, and the decreasing quality of public health care. We do not mean to say that health risks, pathological genes, illnesses, diseases, and low-quality or low-accessibility health care do not constitute important problems since they do, especially for women and other marginalized individuals. Rather, we are suggesting that a number of dominant discourses are structured in such a way as to feed unhealthy obsessions with health, obscure or mystify patriarchal, socio-cultural and political explanations for health problems, and focus undue attention on pharmacological, individualised or privatised solutions. On this, we agree with Ray Moynihan and his colleagues when they suggest that, at least in the case of under-treated and under-diagnosed problems, "Pharmaceutical companies are actively involved in sponsoring the definition of diseases and promoting them to both prescribers and consumers. The social construction of illness is being replaced by the corporate construction of disease" (2002, 886). The manufacturing of fear and the "selling of sickness," to use Moynihan's expression, carries the danger of unnecessary medicalisation, poor treatment decision, iatrogenic illness, economic waste, diversion of funds away from the prevention and treatment

of more serious diseases, and threat to the viability of publicly-funded health systems that are so crucial for the large majority of women and other marginalised individuals who could not afford private care and services.

More generally, dominant health discourses have multiple "effects." As "regimes of truth" (Foucault 1973), they specify what can be said or done at particular times and places, they sustain specific relations of power, they favour particular practices, and they construct and maintain differences, particularly those embedded in modern binaries such as normal/pathological, man/woman, hetero/homosexual, White/Other, young/old, able bodied/disabled. These discourses (notably including medical science) are concerned with the maintenance, representation and regulation of an already gendered, racialised and sexualised body through highly codified and institutionalised forms of health practices. In that regard, Turner (1995 & 1996) has aptly demonstrated how the regulation of health is at the heart of the contemporary sexist, racist, heterosexist and ageist control of citizens, and how the latter is intertwined with a growing emphasis on personal responsibility for health. From the consumer standpoint, the self-management of health is envisaged as a defense against the epidemics of illness and disease. From a critical point of view, self-responsibility for health both fuels and appeases the current health panic: "health" becomes a market commodity, and "healthy" as much as "sick" individuals become potential consumers.

HEALTHISM AND INDIVIDUALISM

Dominant health discourses are often underpinned by the twin notions of healthism and individualism. Drawing from Crawford (1980) and Kirk and Colquhoun (1989), we see "healthism" as an ensemble of ideas and practices that constructs health as an unproblematic good, and "individualism" as a set of ideas and practices that assumes that individuals will always act in their own self-interest. Our point is that when these two notions are used in tandem, the achievement of health is represented as predominantly the responsibility of the individual. A healthist culture inevitably positions the body centrally in the creation of health, linking a range of bodily practices with the attainment of health. Present in this culture are the injunctions to life-long consumption of health practices, services and products, all being linked to shifting notions of health. We can draw from Foucault's (1979) analysis of the prison panopticon to theorise the current shift from externally applied and regulated punishment to a self-imposed internalised form of control or discipline. In using this analogy, we contend that the desire to achieve health has become a new form of corporeal (self) control and guilt has become intimately tied to an individual's failure to achieve it.

Desire and guilt are very strong emotions that are well understood and recuperated by the "health" industries. We only need to walk through city streets, watch television, surf the web or go through the pages of any newspaper or magazine to be bombarded by displays of miracle cures, ageless bodies, and products promising health, beauty and vigour. These displays fire the imagination of an audience eagerly consuming news of each medical triumph over the biological decay of the body. More generally, stories of medical cures, scientific discoveries, and illness and disease have taken on a powerful currency in popular culture. Through sitcoms or educational programs, television channels regularly tell us how to care for ourselves and for others. The media sell stories of DNA, cloning, AIDS, erectile dysfunction, obesity, osteoporosis, breast cancer, HRT, contraception, depression and the like. Medical dramas are popular around the world and self-help and lifestyle books sell in great numbers. According to Janine Marchessault and Kim Sawchuk (2000, 1), the incredible increase in health information is not a coincidence: "the explosion of health cultures in industrialised nations correlates directly with the erosion of health care systems - the less access people have to health care, the greater the consumption of health culture. Health cultures are placing health firmly in the sphere of consumerism." In their engagements with health, individuals (particularly women) are consumers of commercialised and commodified products of that culture. Since healthist culture provides discursive resources for making sense of health, women construct identities utilising these resources, sometimes in highly subversive, but often in reproductive and conformist ways.

According to Jeremy Howell and Alan Ingham, lifestyle and self-discipline have fused within dominant discourses on health and this fusion "became the affective and ideological resolution to the crisis of capital and the welfare state. Self-sufficiency, independence, self-improvement, voluntarism...would be used to blur the contradictions of capitalism" (2001, 331). These authors have argued that the newfound inwardness of health consumers produces conformity to corporatist ideology: "[the consumers'] political apathy is sublimated into their life management goal setting. While their goal setting serves their personal self-development, it also serves to enhance corporate profits in the exercise, health, and self-improvement industries, and to contribute to some ill-defined notion of national well-being" (345-346). One thing is sure, lifestyle has been envisioned as something everybody could do something about, which means that illness and health care have been redefined as private issues of character or as "a failure of individuals who refused to fight the good fight" (330).

HEALTHY WOMEN AS "GOOD CITIZENS"

The "health" industry is benefiting from media constructions of "healthy lifestyle" and "health consciousness" coated in an ideology of salvation through

consumption and self-discipline. White bourgeois visions of health and wellness are beamed into homes with increased marketing of fashion, equipment, products, programs, services and facilities. Appealing to discourses of economic rationalism, commercial health promoters have found new and creative ways to use medical statistics to convince politicians and the public at large of the contribution of their products to the national economy. Such products are said to constitute key strategies through which "good citizens" can be produced; citizens who can contribute to the national economy and not burden it by failing to take care of their health. Within these dominant discourses, women, as moral citizens, must take personal responsibility for, and actively manage, their own health. Unfortunately, this often leads to a convenient "blame-the-victim" approach to the health problems women inevitably come to confront.

Blaming the victim is associated with the sentiment of guilt which we have discussed above, but more significantly, it tends to elide the more important historical, social, environmental, and political factors that impact on women's health and health care. Indeed dominant discourses produce "truths" in ways that tend to legitimate the existing power relations in the health and health care industries. On this, we concur with Armstrong (2001, 22): "The risk is that, in the context of a dominant paradigm that promotes market methods and delivery with individual responsibility, it will not be women's understandings that prevail." A potent example of this is the fact that, in spite of Canadian women's victory in their quest to have "gender-based analysis" before the adoption of structural changes or new policies, the context for health care reform has been such that gender concerns have not been addressed. The freshly released Romanow report has been applauded by women's groups for confirming that a publicly funded system delivered through non-profit services is crucial for all women in Canada. However, groups like the National Coordinating Group on Women and Health Reform, and the Canadian Women's Health Network (2002 np) have also pointed to ways in which the report is not so promising:

> [L]ike other reports on health care reform in the last decade, this report fails to recognize the significant ways in which health care is an issue for women. Women are 80% of paid health care providers, a similar proportion of those providing unpaid personal care and a majority of those receiving care, especially among the elderly...Romanow ignores the skilled nature of women's paid work and their contributions to care. Moreover, he fails to make recommendations to address the deteriorating conditions women face in providing care...Romanow's report fails to adequately address the full range of home care women provide, especially long-term and chronic care... [A]lthough women constitute up to 3/4 of those in long-term care facilities, the report is virtually silent on these services.

Of course, the above critique could be complemented by the observation that the report has been successful in putting the issue of mainstream and institutionalized health care on the national agenda, as if any form of adjustment to the Canadian health care system could significantly affect the health of Canadian women. Dominant discourses on health have a way of silencing the voices and concerns of ordinary women and thus obfuscating the real determinants of health. "Good" and "bad" citizens are produced through such discourses and women (particularly those who are poor, obese, disabled, elderly, ill, etc.), despite their willingness to "fight the good fight," are often cast in a less than favorable role.

DE/RE/CONSTRUCTIVE STORIES OF HEALTH

We would like to view health in terms other than reforms, reports and policies. We believe that health constitutes a *social text*, something at least partly created by the densely interwoven network of experiences and interpretations we bring to it. In that regard, we believe in the importance of examining the social and political "constructions" of women's bodies and health and how they have led to important political struggles today. Recent interdisciplinary work in the field of health studies has foregrounded the need for researchers to look at health as an ensemble of ideas and practices that belong to culture. As feminists, we have a special interest in the way health discourses have come to make sense of women's bodies: the way "scientific" knowledge, popular conceptions, and the various media have impacted on gender, racial and class identities. Consequently, we think that feminist analyses of health must consider the multiple stories of health. We need to cast a deconstructive eye on the stories and discursive strategies that have been associated to credentialed knowledge, and we also need to hear the stories of a variety of women. We agree with contemporary Native author Leslie Marmon Silko, when she alludes to this in a poem contained in her novel *Ceremony* (1977, 2):

> I will tell you something about stories,
> they aren't just entertainment.
> Don't be fooled.
> They are all we have, you see,
> all we have to fight off
> illness and death.

In this special issue, we are delighted to include feminist papers that both critically examine the dominant health discourses and reflect on alternative discourses and

practices emerging in the area of health. Denise Spitzer's piece examines the issue of hormonal replacement therapy, the dominant construction of the menopausal syndrome and the response of Somali, Chinese and Chilean Canadian women to this model of menopause. In poems focusing on one woman's overwhelming and devastating experience of surgical menopause, Cynthia Morawski brings to the fore the experience shared by millions of American and Canadian women after the removal of their ovaries. Audrey MacNevin analyses the linkages between holism and healthism in the narratives of women from two fitness clubs located in Nova Scotia. Through an analysis of three Ontario newspapers, Carmela Murdocca demonstrates the enactment of a racialised and gendered media spectacle in the making of the Ebola scare in Canada. Carolyn Carpan's study similarly focuses on the popular press in an exploration of how endometriosis is represented and constructed. The piece written by Lachlan Story examines the dissemination of discourses on "fetal stimulation" in pregnancy advice books, technologies and commercial products, and its role in medical studies of the fetus. The gender implications of the technology used to create the health information highway in Canada are discussed by Ellen Balka. Using personal narratives and a "Readers' Theatre" format, Lenora Wiebe, Elizabeth Quinlan and Beverley Dent bring to life and critique the academic literature relevant to women's caregiving. Finally, Natalie Beausoleil presents an interview with the two women behind the first production in St. John's of Eve Ensler's play, *The Vagina Monologues*, a work that is performed around the world as a benefit to raise money and awareness to stop violence against women and girls.

Health is a very personal issue but, as we have made abundantly clear in our introduction, it is also an extremely political one. We are thus enthusiastic about the idea of sharing the space of this special issue with an important thematic cluster of papers on women and political leadership. These interesting papers represent the proceedings of a recent workshop that was held at Mount Saint Vincent University in Halifax.

REFERENCES

Armstrong, P. "The Context for Health Care Reform in Canada," *Exposing Privatization: Women and Health Care Reform in Canada*, Armstrong, P., C. Amaratunga, J. Bernier, K. Grant, A. Pederson, and K. Wilson, eds. Aurora, Ontario: Garamond Press, 2001, pp. 14-56.

Balsamo, A. "Teaching in the Belly of the Beast: Feminism in the Best of All Places," *Wild Science: Reading Feminism, Medicine and the Media*, Marchessault, J. and K. Sawchuk, eds. New York: Routledge, 2000, pp. 185-214.

Crawford, R. "Healthism and the Medicalisation of Everyday Life," *International Journal of Health Services* 10 (1980): 365-88.

Foucault, M. *The Birth of the Clinic.* London: Tavistock, 1973.

_____. *Discipline and Punish: The Birth of the Prison.* New York: Vintage, 1979.

Habermas, J. *The Theory of Communicative Action, Volume II: Life World and System.* Boston: Beacon Press, 1987.

Howell, J. and A. Ingham. "From Social Problem to Personal Issue: the Language of Lifestyle," *Cultural Studies* 15.2 (2001): 326-51.

Kirk, D. and D. Colquhoun. "Healthism and Physical Education," *British Journal of Sociology of Education* 10.4 (1989): 417-34.

Marchessault, J. and K. Sawchuk. "Introduction," *Wild Science: Reading Feminism, Medicine and the Media*, Marchessault, J. and K. Sawchuk, eds. New York: Routledge, 2000, pp. 1-5.

Moynihan, R. I. Heath and D. Henry. "Selling Sickness: the Pharmaceutical Industry and Disease Mongering," *British Medical Journal* 324 (2002): 886-91.

National Coordinating Group on Women and Health Reform, and the Canadian Women's Health Network. "The Romanow Report: What Does it Mean for Women?" Press release, November 28, 2002.

Romanow, R. J. *Building on Values: the Future of Health Care in Canada. Ottawa: Final Report of the Commission on the Future of Health Care in Canada, 2002.* (Full report available at: http://www.commissionsoinsdesante.ca/pdf/HCC_Final_Report.pdf)

Silko, L. M. *Ceremony.* New York: Viking Penguin, 1977.

Turner, B. S. "Aging and Identity: Some Reflections on the Somatization of the Self," *Images of Aging: Cultural Representations of Later Life*, M. Featherstone and A. Wernick, eds. London: Routledge, 1995.

_____. *The Body and Society. 2nd edition.* London: Sage, 1996.