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Reading 1

The Political Economy of Health and Healthcare

Ellen Annandale

By outlining some of the earliest sociological explanations of health and illness, and sociological critiques of healthcare, Ellen Annandale's discussion demonstrates sociology's concern to move beyond individual explanations, towards a social analysis of health, illness and healthcare. Taken from one chapter in a whole book concerned with the sociology of health and illness, in this reading Annandale considers the origins and current relevance of the political economy perspective as relevant to health, illness and healthcare systems. The roots of this approach lie generally in Marxist thinking, and specifically, in Friedrich Engels' *The Condition of the Working Class in England*, which was first published in 1845. Engels argued that health and healthcare could be understood only in relation to the political and economic framework. Illness, then, is socially produced under capitalism and the healthcare service itself becomes part of the capitalist system. Having outlined the main argument of the political economy approach, Annandale goes on to consider two ways in which capitalism operates in the search for profit in the field of health and healthcare today. Her first example is the manufacture of the silicone breast implant, which she provides as an example of body modification. For her second example she considers how the focus on lifestyle, in a time that some have called late capitalism, leads to a stress on individual responsibility for health. Through these two examples Annandale introduces some of the criticisms of the political economy approach. She also briefly considers the argument suggested by some contemporary theorists that it is through an analysis of 'risk' and not class (and other differences such as gender and 'race') that we can best understand individual experiences of health and healthcare.

Although this is only a short reading, many of the issues that Annandale explores are considered by other authors in this reader. For example see

Section III for several articles on inequalities and diversity in health and healthcare and see Section IV (especially Reading 18) for some further examples of body commodification/modification.

THE POLITICAL ECONOMY PERSPECTIVE

By the 1970s a clear agenda had been set for medical sociology: to liberate contemporary understandings of health and medicine from the political straitjacket of the biomedical model. The roots of the political economy approach lie in Engels' *The Condition of the Working Class in England* (1993 [1845]). Engels analysed the aetiology and distribution of typhoid, tuberculosis, scrofula and rickets in the population and concluded that, since they had a direct association with the relations of production under capitalism, medical intervention alone was insufficient for the eradication of disease. Out of these beginnings, the political economy approach has built a profound criticism of the social production of ill health under capitalism. The central tenet is that there is a contradiction between the pursuit of health and the pursuit of profit (Doyal, 1979). Medicine is enmeshed in the constant search for profit by finance and industrial capitalists, itself both contributing to and bolstered by the capitalist system and girded by the activities of the state. Crucially, this tripartite relationship operates in the interests of capitalism (largely) in the interests of medicine, but definitely not in the interests of the health of the population.

It should be apparent that from this perspective there is little to be gained by attempting to understand health and healthcare by reference to the activities of individuals or to the institution of medicine; they must be placed within a broader political and economic framework. McKinlay sets this framework up nicely through the analogy of the game. He argues that

one can conceive of medical care-related activities as the game among a group of highly trained players, carefully selected for the affinity of their interests with the requirements of capitalist institutions, which is watched by a vast number of spectators (involving all of the people some of the time and, increasingly, some of the people all the time). And surrounding this game itself, with its interested public, is the capitalistic state (setting the rules by which the game ought to be played before the public), the presence of which ensures the legitimacy of the game and guarantees, through resources derived from spectators, that the prerogatives and interests of the park (finance and industrial capital) are always protected and advanced. (1977: 464–5)

Capital invades all areas of life (home, work, leisure time) creating health-related problems such as unemployment, pollution and stress in the unmitigated search for profits. Social services grow to meet this demand and medicine takes on the impossible task of solving problems that are outside its control (Navarro, 1986).

So, although the profession of medicine is a target of criticism from the political economy perspective, since historically it can be seen to have actively sought a position of dominance, it is not the ultimate culprit since its power is delegated by capital. Capital operates in the field of health in the same way that it does in all other areas of society: ‘invading, exploiting, and ultimately despoiling any field of endeavour – with no necessary humane commitment to it – in order to seize and carry away an acceptable level of profit’ (McKinlay, 1977: 461). McKinlay (1984) refers to a logic of capital accumulation in healthcare which operates in cycles as follows: (1) competition forces capitalists to expand their output and sales (irrespective of the use-values of the commodities that are produced); (2) this generates profit, which (3) needs to be reinvested (in new ventures and in research); (4) profit must be realized on these new ventures; (5) there is a search for new buyers and new markets, often using deceptive advertising and the creation of a commodity-fetishist culture; (6) foreign markets are also captured; (7) profits are reinvested, returning us to the beginning of the cycle. These forces underpin the operation of formal and informal healthcare, and also circumscribe our definitions of health and illness.

Political economists have explored the range of ways in which capital operates in the search for profit in the field of health and healthcare, supported by the state and mediated by medicine. Here we will look at just two broad areas for illustration. First of all, we will consider the commodification of the body, taking the manufacture of silicone breast implants as our example. The second illustration will be the way in which the lifestyle politics of ‘late capitalism’ foster an ideology of health which stresses individual responsibility.

CAPITAL AND THE COMMODIFICATION OF THE BODY

The process of industrialization, from the early development of manufacturing capital through to the high-technology industries of the late twentieth century, carries risks to health of various kinds from exposure to chemical toxins, to the E. coli outbreak and BSE crisis, to dangers in the construction trade, and the stresses and strains experienced by chief executive and shop-floor worker alike. For some commentators (e.g. Hart, 1982) it is this wider process of industrialization, rather than in capitalist variant, which is at fault. Yet political economists insist that there is an inevitable contradiction between safety and the pursuit of profit. Women’s current struggle for compensation for the side-effects of silicone breast implants provides a good illustration of this. In 1963 Dow Corning (a subsidiary of Dow Chemical Company) began manufacturing a breast implant consisting of a semi-permeable envelope of silicone elastomer filled with silicone gel. The silicone gel was deemed to be inert, so if a rupture occurred the gel would not migrate or be harmful to body tissue. However, since the 1970s a minority of surgeons became concerned with the transgression of silicone across the envelope of the implant (often called gel-bleed) and began to

press manufacturers and the US Federal Drugs Agency (FDA) for a moratorium on production. According to Jenny (1994) and others, this pressure went unheeded for far too long as plastic surgeons and manufacturers convinced the FDA that silicone implants were safe.

Approximately one million women had implants for cosmetic reasons and for reconstruction after surgery for breast cancer and other conditions during the 1980s and early 1990s. Levy (1994) estimates that this includes between 30,000 and 50,000 women in the United Kingdom (about 60 per cent of these implants were done after surgery for breast cancer). By 1994, 36,000 women had reported injuries (such as implant ruptures) and were seeking damages (Tran, 1995). Two major risks to health have now been identified. First of all, silicone gel bleeds into the body from the envelope and has been linked to serious diseases such as systemic sclerosis, lupus and other auto-immune and neurological conditions (many of these conditions may have a latency period of thirty years). The second problem is encapsulation, which occurs as the body reacts to the presence of silicone by developing a hard encircling capsule of fibrous tissue around the implant. In addition to these two problems, since silicone gel is radio-opaque, radiographers can have difficulty visualizing breast tissue behind the implant, which hampers the early detection of breast cancers. Several women have died as a result of the side-effects of silicone implants and a great many more live with chronic illnesses which seriously impair their lives. In August 1997 a state jury in Louisiana found that the Dow Chemical Company had knowingly deceived women by hiding information about silicone and health risks. In 1992 the FDA had banned all but their limited use in the US (in the UK the Department of Health has taken the stance that more evidence is needed before it can be concluded that they are unsafe, although at the time of writing in the summer of 1997 a new review looks imminent). Dow Corning and other manufacturers have stopped manufacturing implants, but still insist that they are safe.

During the 1980s Dow Corning (the major manufacturer) settled a number of US lawsuits out of court with confidentiality clauses attached and court protection of all findings and medical records. In 1988 Mariann Hopkins filed a lawsuit and resolved not to settle despite an offer of \$1.8 million to do so. The jury ruled in her favour to the tune of \$7.3 million and Dow Corning was found guilty of fraud and malice. The case opened up the floodgates to litigation, prompting Dow Corning to settle \$4.225 billion in 1993 on a class action suit. In such a suit the claims and rights of many people (currently estimated at approximately 400,000 women world-wide) are decided in a single court proceeding on a 'no win no fee' basis. There are a number of benefits of opting into a class action suit, not the least being that there is no need to prove that current illness postdates the claimant's first implant. On the down side, it is rumoured that the very large number of women in the class action means that payouts may be considerably smaller than those that could be achieved in a successful individual lawsuit. Moreover, while in the class action Dow Corning and other manufactures can continue to deny liability (it is a 'business decision' to settle cases), in separate lawsuits they can be held accountable. However, in an individual case in the US a

woman would need to prove cause, and such suits have had a chequered success rate to date. Tran (1995) reports that 1,500 women have opted out of the class settlement to date to pursue separate actions. According to a spokesperson for Dow Corning ‘we have consistently said that we cannot both fund the global settlement [class action] and afford large numbers of law suits outside the settlement’ (quoted in Tran, 1995: 3). In May 1995 Dow Corning filed for bankruptcy protection.

Particular technologies are, then, implicated in health risks, but these risks are exacerbated by the search for profit, with medicine operating as a lucrative site for capital. In brief, capitalism despoils both health and healthcare.

The political economy perspective has been subject to strong criticism on a number of counts. For example, several commentators (Hart, 1982, 1985; Reidy, 1984) argue that it fails to recognize health gains – such as the increases in living standards and in longevity – that have accompanied capitalist development. In response political economists – Navarro (1985a, 1985b) in particular – have pointed to the contradictions of capitalism and the possibility for (short-term) working-class gains. In addition, many sociologists within this tradition are themselves actively engaged in activities to effect reform from *within* the capitalist system. (For example, Navarro (1994) was centrally involved in defining health policy for Jesse Jackson’s Rainbow Coalition in the late 1980s and was a member of Hillary Clinton’s National Healthcare Reform Task Force.) To argue that improvements in mortality undermine the political economy position in particular seems to miss the mark since the concern is with *relative* differentials in morbidity and mortality between social classes.... Concerns about the ability of individuals and social groups to effect social change within the Marxist political economy perspective, however, carry more weight. While Navarro has consistently emphasized the role of working-class praxis in the struggle for health and healthcare under capitalism, this has often been framed at a fairly high level of generality drawing upon limited examples, leaving the complex relationship between structure and agency largely unarticulated. Gerhardt (1989: 331) raises the question of whether ‘individuals are seen as anything but docile members of a pervasive social order’. Even Waitzkin’s (1991) work on the micro-politics of healthcare, which explores the ways in which apparently humanistic and unproblematic encounters between doctors and patients mask assumptions which encourage conformity with the dominant expectations of capitalism (such as the work ethic), leaving the structural problems which foster ill health unchallenged, seems to overstate the influence of medical ideology on patients, or at least fails to explore the possibility that patients do not accept the doctors’ view of their problem uncritically.

DISORGANIZED CAPITALISM: A NEW POLITICAL ECONOMY OF HEALTH?

Although the criticisms that have been raised deserve ongoing consideration, their immediacy as *particular* issues for debate is tempered by the weightier general

question of the current status of Marxist social theory itself. Bluntly put, if Marxism is dead, what implications does this have for the political economy of health? For many, events of the early 1990s in the former Soviet Union and eastern Europe signal not only the end of communism, but also a death blow to Marxism, which is seen to have come to an 'end' itself (Makdissi et al., 1996: ix). For example, Lash and Urry (1994: 1) begin their exploration of the nature of late capitalism in a deliberately provocative tone, by asking: is 'any writer more dated, more of a "dinosaur", than Marx?' Certainly, the industrial capitalism that Marx described no longer exists, as the extraction of surplus for profit has shifted from the production of commodities with a relatively stable use-value to satisfy fairly easily defined needs, to a phase of what Lash and Urry call 'disorganized capitalism' where use-values are destabilized as capitalism becomes at once increasingly fragmented, flexible and international in form. In concrete terms, we have seen a radical shift from an economy in which people transform raw material into mass-market goods, to a flexible economy based on the production of knowledge and information. The old order where the 'capitalist core was characterised by a set of producer networks clustered around a heavy-industrial hub of the motor, chemicals, electrical and steel industries' and where 'finance, services and distribution functions were either subordinate to, or driven by, industrial production' has given way to a new cluster of information, communication and other industries (Lash and Urry, 1994: 17).

While – as has been the case for Marxism ever since the nineteenth century – conflicting interpretations abound, for many commentators what we are witnessing rather than the *end* of capitalism, is its *revitalization* as new arenas of exploitation open up quite unlike any that have gone before. As Landry and MacLean (1993: xii) put it, now 'the market is "in" everything and nothing is incapable of being commodified'. Modernity, therefore, has not been superseded, but, in the words of Lash and Urry, radically exaggerated. Individuals live in a world that has a runaway character, subject to a veritable barrage of information and new goods, many of which are more important for the status that they confer than for their use-value – status symbols, such as designer labels, for example, having more importance than the basic use of the product. Lash and Urry (1994: 3) argue that the flows and accumulations of images and symbols of disorganized capitalism do not 'just lead to increasing meaninglessness', rather, they encourage the development of a new *critical reflexivity*, or sense of freedom to act, on the part of individuals, which is itself a *precondition* of capital accumulation through consumption. For a large part of society – the professional–managerial classes and the skilled working class – this means a new empowerment, as traditional structures like social class and the family recede to be replaced by a new ability to make consumer choices; for others there is spiralling downward mobility into the de-industrialized spaces of the impacted ghetto (in the shift of manufacturing from the cities to the suburban and ex-urban locations).

Capitalism, then, is still with us and the issue that we must wrestle with is not its demise, but its revitalization in new forms. For some, Marx's social theory is still relevant to this task, while for others it has lost its usefulness and new

conceptualizations are needed. For example, Giddens (1994: 87) contends that Marxist politics provide no solution to new risks associated with ‘the driving expansionism of capitalistic enterprise’. To date, with just a few exceptions, sociologists of health and medicine have remained relatively quiet on these issues. However, it is possible for us to follow their implications through to a number of key areas of interest such as inequalities in health, the restructuring of healthcare provision, and the experience of illness.... Here we will briefly take up recent theoretical work on reflexivity, risk and health in late modernity.

REFLEXIVITY AND RISK, AND HEALTH IN LATE MODERNITY

Modern society, it has been argued, is a ‘risk society’ which puts the phenomenon of health centre-stage. Concern now is no longer simply that economic hazards undermine health, but that environmental risks to health threaten the very existence of society as ‘everywhere and eternally’ they ‘penetrate the economic and political system’ (Beck, 1992: 83). In this new social environment, risk is increasingly opened to the public gaze and new political forms emerge. Power is decentralized from the state into the specialized division of labour which Beck refers to as ‘techno-economic subpolitics’. Modes of living in risk society are very much tied to the sub-politics of medicine, that is, the broad arena of medical industries and health institutions. Medicine, defined in this way, employs a market strategy which profits from risk. Beck claims that

in more and more fields of action a **reality** defined and thoroughly structured by medicine is becoming the prerequisite of thought and action ... not only is the spiral of medical formation and decision-making twisted deeper and deeper into the ... reality of the risk society, but an **insatiable appetite for medicine** is produced, a permanently expanding market for the services of the medical profession whose ramifications echo into the distant depths. (1992: 211)

This means that risks to health *themselves* become an economic factor as new markets are generated for products such as filters for pollutants and vitamin complexes to enhance nutrition in an age of chemically infused fast foods. Science itself turns towards the definition and management of the very risks which it itself produces. The boom industry of cosmetic surgery, on which \$300 million and rising are spent every year in the USA (Davis, 1995), epitomizes Beck’s medical sub-politics. As we have seen in the discussion of silicone breast implants, the health risks that it generates can be enormous, yet the decision to undergo cosmetic surgery is itself part and parcel of the emergence of the self as a ‘reflexive project’. Giddens in particular stresses that under conditions of high modernity, the body is ‘reflectively mobilised’ becoming a ‘phenomenon of choices and options’ (1991: 8). As the ‘visible aspect of the self’, the body is not passive but needs to be monitored by individuals as they balance opportunities and risks, virtually forced to design their own bodies, and

to do so under conditions of considerable uncertainty. Anorexia, Giddens claims, is symptomatic of the negative effects of what he calls manufactured uncertainty on everyday life: 'deciding what to eat', he writes, 'is also deciding "how to be" in respect to the body – and for individuals subject to specific social tension, particularly young women, the iron self-discipline of anorexia results' (1994: 82). In wider terms, of course, the billion-dollar diet industry also epitomizes the new forms of capitalist enterprise that have emerged over recent decades.

In the opinion of both Giddens and Beck, the global conditions of late modernity invite us to reconsider the nature of individual experience which, it is argued, is no longer bound by class, gender and 'race', but exposed to new social parameters of risk and uncertainty which cross-cut traditional social divisions. To be sure, these divisions still have *relevance* for people, but they are no longer, in a straightforward way, the units from which experience derives. Risks to health of various kinds, ranging from nuclear catastrophe to mysterious viral infections, contaminated foods, and stresses from unemployment and unhappy marriages, must be dealt with reflexively as the individual increasingly stands alone, looking for security in the face of uncertainty and an implosion of knowledge-systems. While arguably reflexivity might increase 'health awareness' – indeed this is a plank of contemporary health promotion – being forced to make choices by accessing an array of expert information, under conditions of uncertainty, can create considerable anxiety. How does the individual cope?... at this point it may be useful to take one illustration, that of prenatal diagnosis. Katz Rothman's (1988) study of prenatal diagnosis vividly demonstrates the stresses that women experience in a social climate of risk that values knowledge and making informed choices. Women's reasons for refusing amniocentesis (taking amniotic fluid from the uterus to test for genetic abnormalities), which may centre around a commitment to the foetus/baby, feelings of safety (will the baby be 'normal?'), a sense of late, or the unacceptability of abortion, are difficult to justify in a world which values the information and 'choice' that an amniocentesis result ostensibly provides. Katz Rothman shows that, far from providing choice and control, amniocentesis creates a 'tentative pregnancy'; fearful of a 'bad result', women cannot embrace their pregnancy, maintaining an emotional distance from the baby/foetus and denying or not letting themselves really feel foetal movements until the test result is available.

As Crawford (1984) has discussed very well, capitalist ideology is refracted through health beliefs, be this through the promotion and consumption of new medical technologies such as amniocentesis or silicone breast implants, or through diet stuffs and exercise programmes. In many ways foreshadowing the work of Giddens, Beck and others, he points out that 'when macro-conditions that affect health appear out of control, self-control over the considerable range of personal behaviours that also affect health is an only remaining option' (1984: 74). The burden of responsibility is placed squarely upon the individual, breaking the connection between good health and the demand for public services in the process. Yet an economy built on 'responsibility' and *selfcontrol* alone – profitable though it may be (the diet industry, health clubs) – is ruinous to late capitalism. Consequently it exists alongside the economic mandate

to *consume* market-offered goods, as immediate gratification is portrayed as a source of stress reduction and emotional and physical well-being.

This introductory discussion of the political economy perspective has highlighted its status as a theory in transition. Buffeted by the significant challenges to its Marxist foundations and by the restructuring of capitalism ... within the field of the sociology of health and medicine it has yet to re-establish a truly firm theoretical foundation in an era of significant social change....

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Source: E. Annandale, *The Sociology of Health and Medicine: A Critical Introduction* (Cambridge: Polity Press, 1998).

Study Questions and Activities

1. From the perspective of the political economy approach, why is illness inevitable under capitalism? Consider the 'logic of capital accumulation' (McKinlay 1977 cited by Annandale) in relation to your own area of practice. Explain whether you agree or disagree with this theory.
2. Do the work of Giddens (1991) and Beck (1992) challenge or add to the political economy perspective?
3. In what ways is the self a 'reflexive project'?
4. Who do you think has benefited most from the manufacture of the silicone breast implant?

Further Reading

In addition to the book from which this reading is taken, Ellen Annandale has written several other books that you will find interesting and useful: *Gender Inequalities in Health* (edited with K. Hunt Buckingham: Open University Press, 2000); *The Sociology of Medical Knowledge, Medical Work and Healthcare* (edited with M. Elston and L. Prior, London: Blackwell, 2004) and *Feminist Theory and the Sociology of Health and Illness* (London: Routledge, 2002). There are lots of other books that provide overviews of the sociology of health. See, for example: M. Bury, *Health and Illness in a Changing Society* (London: Routledge, 1997); S. Nettleton, *Sociology of Health and Illness* (Cambridge: Polity Press, 1995) and M. Stacey, *The Sociology of Health and Healing* (London: Macmillan, 1988). If you would like to follow up some of the arguments that Annandale introduces, look for Freidrich Engels' *The Condition of the Working Class in England* (Oxford: Oxford University Press, 1999 [1845]); Ivan Illich's *Limits to Medicine: Medical Nemesis: The Expropriation of Health* (London: M. Boyars, 1995); Anthony Giddens' *Modernity and Self-Identity. Self and Society in the Late Modern Age* (Cambridge: Polity Press, 1991); Ulrich Beck's *Risk Society: Towards a New Modernity* (London: Sage, 1991); Barbara Adam, Ulrich Beck and Joost Van Loon's *The Risk Society and Beyond: Critical Issues for Social Theory* (London: Sage, 2000).

If you think you would like to read more about sociology and what sociologists are interested in, as well as about health and healthcare, try an introductory book. There are several of these – examples include: A. Giddens, *Sociology*, 5th edn (Cambridge: Polity Press, 2006); I. Marsh and M. Keating (eds) *Sociology: Making Sense of Society*, 3rd edn (Harlow: Pearson, 2006) and the text from which the next reading is taken.

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