Taking back control (of our health): The responsibilised UK citizen and post-Brexit health governance

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Slide 1

Introduction to the HGAB project.

Slide 2

The idea for this paper came from our 'street ethnography' (Author ????). We have spoken to more than 400 people in five locations across Northern England and Northern Ireland (Sheffield, Rochdale, Rotherham, Newry and Derry). Describe what this ethnography means and entails: showing people this photo and starting a conversation with them. One of the key questions has been around responsibility: who is responsible for health; and who is responsible for this photo featuring a promise that cannot be kept; as well as containing the NHS logo. The photo sparks a lot of discussion on Brexit, politicians and the NHS, but this paper is focusing on one of the unexpected outcomes. What we did expect were narratives involving the government being held responsible for health; or health professionals within the broader context for the NHS; even if imaginations about responsibility and accountability would differ. But what we did not necessarily expect, yet observed and recorded, was a lot of people thinking of themselves, as in the individuals, being responsible for health. We have observed narratives about personal responsibility for personal health, as well as personal responsibility for the 'health' of the health system itself. People saw themselves as the primary holder of responsibility not just for their own health, but also for not misusing the NHS by relying on it too much, or using it inappropriately, as well as personally responsible for preventing others from misusing the NHS, in most cases meaning migrants, invoking health tourism. In other words, we are responsible for being the ideal patients, as well as the ideal citizens. Responsible, vigilant, cooperative and not too reliant on the system, be it the health system or the social welfare system. We will argue later on that there is a clear connection between the two in relation to responsibility. That prompted us to look into the familiar concepts of self-responsiblisation and ethopolitics and to apply them to our Brexit and health research to explore what are we currently not saying about health governance after Brexit, and even about Brexit itself.

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Explaining the structure of the paper. Context, theoretical framework and research questions. Followed by conclusions at the end.

Slide 4

Before we proceed further in the paper, we want to show you a few examples of the narratives on responsibility for health that we have recorded in our ethnography so far. We would like all of us to make sense of them in the particular context of Brexit and apply the critical lenses of choice to understand them as something different from their initial reading. These notes are our raw data, or our immediate recordings of the conversation, including our personal reflections and thoughts.

2A (Sheffield): People should be responsible for their own health and make healthier lifestyle choices. 'The community is fucked, regardless of Brexit'. She argued that euthanasia should be allowed. ***People should invest in their health. The responsibility for health lies with the individual.***

27A (Newry): She would prefer to get healthy local food, I presumed that she meant instead of EU food, although she did not specifically explain that. She would eat fresh food, instead of having to go to the NHS for health-related procedures. She struck me with the argument that ***we are responsible for our health as much as the government*** *is.*

78A (Rochdale): She focused on the importance of additional services which can reach vulnerable people and thought health is also a ***personal responsibility***. She identified instances in which professionals like her can fill in gaps in the NHS, but she didn't see them as gaps, but as ***an opportunity to expand the functions of the health system*** and help more people

We can read these narratives as examples of logical, or prudential thinking about health and the NHS. It is perfectly understandable than when asked about responsibility for health people would see themselves as the primary means of ensuring they are well, either by eating well, or by exercising, or being conscious about their mental health. There is a whole wellness and well-being industry that caters to us indulging in healthy behaviour and healthy life choices and taking advantage of a personalised and holistic approach to health. But if we take a critical approach, as we have, we can begin understanding these narratives as internalising a particular way of governing health, as well as a particular way of governing subjects, thus marrying governance with a political economy (Howell 2015) (a focus on prudentialism and a neoliberal strategy for governing the NHS). Critical scholars like Howell have developed a critical approach to responsiblisation that accounts for the ways in which subjects are engaged in 'multiple contestations, shaping, or even taking pleasure in governance)'. It is this realisation that the people we have spoken to are subjects of a particular way of governance that has prompted us into looking at the work of Nikolas Rose to use as a critical tool in analysing the data we have gathered.

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We have chosen to use two very familiar concepts emerging from the work of Rose: self-responsiblisation and ethopolitics. These concepts are by no means new, and they would be extremely familiar to the CLC audience. What is novel, however, is using them in the context

of Brexit, not so much to analyse Brexit itself as a socio-political phenomenon, but to try and make early predictions about what our post-Brexit reality might look like from the perspective of health. Our critical approach is also novel in the context of a legal project that was primarily going to rely on doctrinal legal research, comparative legal research and legal ethnography.

Self-responsiblisation has been defined as 'ways of thinking that invoke self-responsiblisation as solution to certain problems', a form of governance of subjects that operates through 'diverse strategies, techniques and tactics by which various authorities seek to inculcate', or create, an 'an ethic- a set of self-government' that links the 'self-mastery of the individual' with the 'imperatives of good government'. (Rose & Lentzos 2016).

Ethopolitics is understood as that ethic of self-government that 'concerns itself with the self-techniques by which human beings should judge and act upon themselves to make themselves better than they are' (Rose and Lentzos 2016).

It is this aspect of the techniques of self-responsiblisation operating in the field of ethopolitics that we are concerned with. We want to use these concepts to critically analyse our data and come to a different conclusion about the prudentialism and the heightened feeling of person-centrism that we are observing. To us these narratives emerge from the bigger picture of responsiblisation within health, or the focus on individual behaviour for the realisation of a health governance strategy that leads towards minimal state involvement in health and lends itself to the creation of the ideal neoliberal subjects and in our case patients. From this perspective the ground for responsiblisation of health post-Brexit has already been laid and could have been predicted. Post-Brexit health governance will be completely compatible with already existing mechanisms for responsiblisation and subject crafting at both UK and EU governance levels.

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Here we want to briefly develop the idea that what proceeded Brexit and what will happen post-Brexit in relation to health governance is the continuation of a governmentality logic that focuses on responsible behaviour for the achievement of effective and prudential neoliberal governance. From all the examples we could give we want to focus on three: the welfare reform policies in the UK; the hostile environment towards 'non-ideal' citizens at both UK and EU levels; and the constructing of the responsible EU citizen. To us this provides important context for how to understand the data we have collected, as well as a convenient platform to make early predictions about post-Brexit health governance.

Since at least 2010 UK subjects have been subjected to austerity-driven welfare reform policies that aim to lower public expenditure for welfare and dramatically interrupt the perceived over-reliance on the welfare state. There is a lot of important research on the disproportionate, disciplinary and harmful effects of these policies, but we are most interested into interpretations of the welfare reform as a form of social control and management of deviant populations (Sokhi-Bulley and Antova 2019). Through policies like the benefits cap, benefit sanctions and work capability assessments, the right way of being a citizen has been codified as being responsible, independent and a productive member of society. The policies operating as tactics of governmentality have both constructed and

managed deviants (the poor, the disabled, migrants) as a burden that can be eradicated if the correct form of government of subjects and their behaviours is applied. The five locations of our fieldwork are all places in the UK where working class communities have been battered by the welfare reform and have been expected to justify their existence through increasingly hostile and invasive tactics of scrutiny, monitoring and discipline. We should not be surprised that parts of that governmentality have been internalised: the social control of subjects happens with the individual at the centre.

The hostile environment towards that consecutive Tory governments have pursued operates much in the same way. Individual behaviour is in the centre of the hostility: we are expected to be migrants of the correct and useful, legal type; as much as we are expected to report any non-ideal migrants that can and should be removed. The hostile environment operates through personal responsibility for one's own legal status, as well as through one's personal responsibility for monitoring and cleansing the shared space from illegal deviants.

We have also been inspired by research focusing on the creation of the responsible EU subject. This research comes from various related fields. One example, in relation to disability, which was one of the categories of deviance most impacted by the welfare governmentality, described EU policies as 'often well-meaning, but somewhat paternalistic' (Baar & Trigt 2019). Paternalism here refers to the restriction of freedoms of subjects and instead installing in them responsibilities and values that are seen to be in their best interest, as well as in the best interest of the government ethics that is pursued, that of self-responsibility. Research examining recent cases concerning EU citizenship argues that the abstract concept of responsibility is 'translated into very concrete sets of obligations, thus generating' certain normative expectations and building a normative dimension to Union citizenship: 'The Union citizen is law-abiding, economically productive member of the host-society' (Coutss 2018).

We wanted to provide this context, so we can situate Brexit and the post-Brexit health governance within a broader pattern of responsiblisation of subjects that has been happening for a long time. The people we have spoken to share only a snippet of their overall thinking; and the street ethnography collects momentary emotions, thoughts, reflections and ideas. But what we want to argue is that the responsibilised UK subject already exists and is opening herself to further tactics of responsiblisation within the health system, which is our focus.

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Rose describes self-responsiblisation as a tactic of ethopolitics that takes the body as the key site for its work on marrying the political and personal aspirations for health (Rose 2001, Cardona 2008). We are using these recent NHS posters, as well as a photo of a NHS affiliated clinic in Rotherham market (one of our fieldwork sites) as visual props that depict the workings of self-responsiblisation.
As patients we are constantly reminded about our responsibility towards our oboes and the NHS, and this responsibility is dual in its ethical understanding. Brown, Malsen and Savulecsu (2019) the casual and the moral responsibility about health. Casual responsibility is when we play a key role in bringing about a particular consequence. If we don't exercise, if we smoke, if we don't lose weight, we are likely to be diabetics. Moral responsibility is then our role in bringing the particular consequence is worthy of a particular reaction. If we don't take our

diabetics pills, or take too many, we bring ye cost of the NHS up and contribute to its failing. This notion has been translated into the largest scale NHS strategies for the present and for the future. A 2016 NHS Manifesto that emerged under the pressure of Brexit talks about building a 'health creating society' where the NHS transitions towards a person-centred and health-based system and where all stakeholders, including citizens, must embrace responsibility for health and plan how to achieve a healthy community.

The people we have spoken to are the responsibilised subjects we recognise them as in internalising and presenting both the casual and the moral responsibility for their health in the stories they shared with us. Their narratives reveal how they willingly and unwillingly picki up on their role in ensuring that the healthy community will continue after Brexit as well. This self-responsiblisation, like preferring to eat healthy foods, or complaining about other people calling their GP for trifling reasons or accusing migrants of abusing the NHS system as irresponsible health tourists, are examples of self-responsiblisation that often accompany narratives on the problems with the NHS that self-responsiblisation can fix. The NHS is described as struggling, failing, in danger, forgotten, ineffective and costly. Brexit then presents an opportunity for the responsibilised subject to solve the implied failure of the NHS by opening themselves to the tactics of convincing them that it is indeed their responsibility to protect and improve health. By being responsible, compliant, and cost-effective patients, the responsibilised subjects both resist the danger to the healthy societies that Brexit creates and a rewarded with a collective experience of being in this together, together saving the NHS.

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The 'take back control' narrative of Brexit is an example of 'ethopolitics', of focusing on those attitudes, behaviours, tactics and techniques that encourage subjects to be self-responsible, to better themselves. Just like the UK will be better out of Europe, the UK subject will be better off taking responsibility for their own health and for the health of the NHS. The uncertainty of Brexit in terms of health governance results in subjects adapting to the uncertainty by opening themselves to ethopolitics. The 'Take Back Control' slogan through this perspective is an example of self-imposed resilience where subjects 'resist the damaging blows, bounce back from disaster, recover from our tribulations, adapt to our new situation, perhaps even stronger, fitter, more resourceful' (Rose & Lentzos 2015).

We understand that resilience and responsiblisation can be divorced, and resilience can emerge more organically than from a top-down relation, which is what Rose has argued in a paper called Making Us Resilient, but we do not necessarily share his optimism here. We ultimately see ethopolitics being played out in the Brexit slogans. Compare to Boris Johnson's attitude of condemning the "the doubters, the doomsters, the gloomsters". Brexit, as well as post-Brexit health governance, will be heavily dominated by narratives of self-responsiblisation, which will in turn legitimise the governance ethics of doing away with state responsibility for health and will allow for attempts to privatise health and responsibilise patients to thrive.

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Conclusions

Our street ethnography and the 400 and more conversations we have recorded has allowed us to find very interesting hidden information about how subjects think of post-Brexit health governance at this moment, in the eve of Brexit potentially happening. Many people speak about health being our responsibility. Not just health is for us to be responsible for, but also not abusing the NHS and making sure others don't abuse it.

This is happening whilst we are 'taking back control' over governance for health back from the EU. We will now be responsible for it. We will be better at looking after it than the EU. The NHS is 'the envy of the nations' and now we are taking back control over this institution and funding it with the money that would have gone to the EU.

We know that the battle bus was a lie. We as researchers know it, and the overwhelming majority of the people we have spoken to know it too. The most used phrases in relation to the bus and its promise that we have recorded have been 'bullshit', 'bollocks' and 'a pack of lies'. We know Johnson is not being held responsible for this lie.

But from an ethopolitics perspective the battle bus has been an incredibly successful tool for installing personal responsibility and a desire to resist a pending disaster by being the best citizen, the best patient that you can be.

The responsibilised subject has adopted the Take Back Control slogan as both the casual responsibility of being responsible for their own health and the moral responsibility of making the NHS that much better and health creating after Brexit.

Legitimate post-Brexit health governance will be all about ethopolitics and responsiblisation, making ourselves resilient. But not the optimistic resilience of Rose. The more cold-hearted neoliberal resilience where we resist ontological anxiety with focusing on what we can bring to the table.