

Article

'Abnormal' Bodies on the Borders of Inclusion:Biopolitics and the paradox of Disability Surveillance

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Abstract

When conducted according to the biomedical definition of disability, disability surveillance involves monitoring bodies against normative ontological standards, classifying 'abnormality' and problematizing 'abnormal bodies' as risky. While disability surveillance that operates within a biomedical perspective of disability contributes to the exclusion of people with impairments, disability surveillance that recognizes the social construction of disability promotes the inclusion of people with impairments. In examining this paradox, this paper looks at the inconsistent and problematic ways in which the Canadian government defines and measures 'disability', the implication of discriminatory immigration policies and ableist biometric technologies, and the ways in which the collection of statistical data on people with impairments are used. Drawing from the work of Foucault on normality/abnormality and subsequent literature on biopolitics, a theoretical framework with which to resolve this paradox is proposed.

Introduction

Surveillance Studies has made significant contributions to discussions on human rights by documenting practices of discrimination based on characteristics such as race (Poudrier 2003; Glover 2008, 2009; Browne 2012), gender (Monahan 2009; Koskela 2012), and class (Gilliom 2001; Maki 2011). Yet surveillance practices associated with the embodiment of impairment and the experience of disability have been largely ignored. This omission is perplexing given the emphasis that Surveillance Studies places on the normalizing technologies of power used to monitor, control and regulate behaviours and mobilities of certain bodies. The absence of a discussion on impairment and disability in Surveillance Studies is also curious given the prominence accorded to the monitoring and regulation of the body in relation to social norms in the work of Michel Foucault. While Foucault has examined the biopolitical arrangements through which health and welfare of the population is advanced, there is a dearth of literature that examines the connection between impairment, disability, surveillance and biopolitics. To date, the research agenda of leading disability scholars have explored the myriad ways people with impairments are subjected to social exclusion, inequality and oppression and how these practices are framed within biomedical perspectives of disability (see, for example, Oliver 1990a, 1990b; Rioux and Valentine 2006; Barnes and Mercer 2010; Oliver and Barnes 2012). Few have ventured toward an analysis of how the biomedical perspective of disability is used to rationalize biopolitics and to sustain a surveillance regime that excludes people with impairments.¹

¹ The intersecting themes of normalization, biopolitics and disability have been explored by Waldschmidt (2006) and Tremain (2008). Other Foucauldian themes weave through the work of a number of disability scholars and can be found in the collection edited by Tremain (2005) and also Reeve (2002).

This paper seeks to address this gap by introducing the concept of 'disability surveillance'. Building from a widely accepted definition of surveillance proposed by Lyon (2007), I define disability surveillance as the practice of collecting, documenting, monitoring and classifying personal data that pertains to the embodied characteristics and attributes of impairment. In order to avoid conceptualizing disability surveillance in purely disempowering terms, my aim is to highlight the ways in which surveillant practices oscillate between biopolitical practices of social control that exclude people with impairments in order to prevent perceived economic 'risk' and practices of counting and classifying people with impairments in order to promote rights. I argue that this paradox stems from contradictory and inconsistent definitions of disability used by various sectors of the Canadian government.

When disability surveillance is carried out in ways that pathologize and exclude people with impairments in order to limit access to resources and/or citizenship, disability tends to be defined in terms of a functional limitation and people with impairments are seen as those with non-normative bodies that pose a 'risk'. Disability surveillance that operates on perceived notions of risk are carried out under biopolitical rationalizations that aim to promote the health and prosperity of the population through social sorting processes that involve identifying and categorizing 'abnormality' through the collection of medical data. In identifying the operation of biopolitics in Canadian immigration policy, I look specifically at s. 38(c) of the *Immigration and Refugee Protection Act*, commonly referred to as the 'excessive demand clause', as an exclusionary mechanism of power that denies immigration applicants with certain health conditions and impairment on the presumption that they would impose undue costs on health and social services. I also look at the ways in which biometric technology at the border contributes to the experience of disability by assigning the identity of 'abnormal' to people with impairments who do not conform to the system's ableist design.

However, in order to improve accessibility, remove disabling barriers and develop adequate programs, services, and accommodation it is necessary to measure and count the prevalence and impact of impairment. When conducted for this purpose, disability surveillance operates according to the principles and goals of the disability rights movement and is conducted according to a definition of disability that does not reduce disability to the body, but instead recognizes the ways in which social constructions and processes contribute to disability. This presents a paradox whereby the techniques of disability surveillance become a venue for both exclusion and empowerment. Disability surveillance reinforces ableist norms, but also provides the tools to change them. This paper problematizes normalization and definitions of disability grounded in medical discourse for its legitimization of the perception of abnormal that is used to rationalize exclusionary biopolitical agendas. I conclude with a theoretical argument that aims to resolve the paradox of preventing 'risk' and promoting rights by applying Ojakangas' (2005) notion of an affirmative biopolitics of care.

Defining Disability

The first task in providing a discussion of disability surveillance is to provide a definition of disability. In recognizing that disability has contested and nuanced meanings (c.f. Finkelstein 1980, Oliver 1990a, 1990b; Shakespeare and Watson 2001; Tregaskis 2002; Thomas 2002, 2004; Reeve 2002; Galis 2011), I offer a definition of disability that takes multiple perspectives into account and propose that disability is an experience that emerges from the intersection of physical, sensory, and/or cognitive difference or impairment with social interaction and processes that result in exclusion, discrimination, disadvantage, marginalization, segregation, or oppression. As a relational experience, disability is ontologically, spatially, temporally, materially, discursively, culturally, socially, politically and economically contingent (c.f. Kitchin 1998: 343 and Thomas 2002: 47). It is prudent to mention that while my understanding of disability does not deny the embodied experience of difference and impairment or the role the body plays in the experience of disability I do not define disability in terms of a functional limitation. This is important to note given that disability scholars continue to disagree on the extent to which the body and

impairment should be considered in defining disability. For the scope of this paper, my intention is not to provide an overview of these competing views, but rather illustrate how 'disability' came to be understood within a normative paradigm as an 'abnormality' and the implications this has for people with impairments.

Disability Language and Terms

Debates surrounding definitions of disability have raised questions as to appropriate language and terms. The term 'people with disabilities' is considered 'people first language' and is widely used in an effort to emphasize the individual rather than the 'disability'. However, some disability scholars reject this term. Barnes and Mercer (2010) prefer to use 'disabled people' to distinguish "impairment", as a medically classified biophysiological condition, from "disability", which denotes the social disadvantage experienced by people with accredited impairment' (11). Yet, for some, this term is also problematic. To identify as a 'disabled person' is to identify as a member of an oppressed group (Lawson 2001). Shakespeare and Watson point out that some people with impairments do not identify

[A]s disabled, either in terms of the medical model or social model. They downplay the significance of their impairments, and seek access to a mainstream identity. They do not have a political identity because they do not see themselves as part of the disability movement either.

(2001:20)

In an effort to avoid conflating 'disability' with 'impairment' and in recognizing the complexity surrounding identity politics, I use the term 'people with impairments' to refer to individuals with body difference or body variation that result in functional limitations or are perceived by others to result in functional limitations. Although I define disability as a relational experience to describe the intersection of the body with the social, and not to refer to functional limitation, I use the term 'disability surveillance', rather than 'impairment surveillance', to emphasize the paradoxical outcomes and purposes wherein some surveillant practices directed toward people with impairments produce the experience of disability while other surveillant practices are carried out in an attempt to prevent the experience of disability.

Genesis of Normal

The emergence of a positivist understanding of ontological normality can be traced back to the nineteenth century and attributed to the work of two key statisticians.² In the 1830s, Adolphe Quetelet extended the *law of error* principle to the body by proposing the concept of the 'average man'. The implication of Quetelet's work was profound in that it provided the discursive and statistical backdrop from which the concept of the 'norm' emerged. The statistical process of relating individuals to others can perhaps best be illustrated through the principle of the *normal distribution*. According to the *normal distribution* principle, the majority of the population should fall below 'the arch of the standard bell-shaped curve' (Davis 2006: 6). Individuals with attributes that diverge from the arch are therefore considered 'abnormal'. However, in recognizing that not all traits that deviate from the arch are undesirable and that some are actually preferable, Sir Francis Galton modified the bell curve in such a way that it would reflect a ranking of desirability (Davis 2006). Following the work produced by Quetelet and Galton, the idea of the body as that which can be compared, measured and improved spurred the widely held notion that there is a 'normal' way of being.

² In this paragraph, I draw from the work of Davis (2006) and provide a very succinct overview of the genesis of 'normal'. For a comprehensive and detailed account of the emergence of 'normal' see Davis (2006). For an overview of the role that statistical concepts play in Foucault's articulation of the norm and biopower see Mader (2007).

The genesis of normal was further reinforced by the rise of capitalism marked by industrialization and urbanization and a shifting mode of production. In an economy organized around factory work that required able bodies, disability came to be understood as a functional limitation defined in terms of a deficit or defect and understood through comparative measures as an abnormality that presents a burden to society (Finkelstein 1980; Thomas 2002; Oliver and Barnes 2012). The social response was that of segregation through institutional arrangements and medicalization geared toward treatment and rehabilitation (Finkelstein 1980; Thomas 2002; Oliver and Barnes 2012). In his critique of the medicalization of disability, Oliver (1990a) argues that '[t]he whole medical and rehabilitation enterprise is founded upon an ideology of normality and this has far reaching implications for treatment. Its aim is to restore the disabled person to normality, whatever that may mean' (under 'The Medicalisation of Disability'). By the twentieth century, the biomedical perspective of disability gained widespread acceptance and while it has since garnered notoriety by disability rights advocates and proponents of the social model, it continues to be the dominant approach with which disability is defined and understood by various branches of government and institutions.

Recognizing the exclusionary impact of understanding disability through medical discourse, the disability rights movement has made challenging the biomedical response to disability (referred to in disability studies literature as the 'medical model' or the 'individual model') a priority by adopting the social model view and reframing 'disability' as a social construct (Oliver 1990a, 1996). The social model rejects the idea that disability emerges from functional limitations/impairment and argues instead that disability emerges through social practices that fail to account for the needs of people with impairments (Oliver 1990a, 1996). In essence, it is attitudes and perceptions of what constitutes ontological norms that result in disability. The social model takes issue with the medical model for understanding disability within a health context. The problem with this approach is that it elicits a medical response to disability as a condition that occurs within the individual and should therefore be treated and cured (Oliver 1990a, 1996: 35-36).³

The social model's argument against the medicalization of disability resonates with what Williams and Calnan (1996) refer to as the 'medicalization thesis' (1996: 1609), in which conditions that were not initially considered medical issues have become situated within the field of medicine. They note that the preoccupation and emphasis on 'locating the genetic precursors of illness, diseases, disabilities and behaviours, means that the knowledge base of scientific medicine has encroached still further into defining the limits of "normality" and proper functioning, deportment and control of the human body [8]' (1996: 1609). The genesis of normal has altered how the ontology of the body is experienced and perceived. Consequently, the 'abnormal' body has become objectified by medical discourse and its techniques of intervention. Hughes (2002) argues that 'the production of medical knowledge about disabled people has itself been disabling' (59). He explains:

The definition of disability as a corporeal problem has meant that, for the most part, throughout modernity, disabled people have come under the jurisdiction, control and surveillance of (bio)medicine. This process of locating disability within the disciplinary scope of medicine has influenced profoundly the state of knowledge about it. Disability has been understood as sickness, and disabled people have been understood as invalid.

(Hughes 2002: 58)

In *The Birth of the Clinic*, Foucault (1973) articulates how the body becomes separated from the individual to become the focus of the 'medical gaze'. The medical model invariably locates disability in

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³ The same argument can also be applied to the concept of 'impairment'. Physical, sensory or cognitive difference cannot be used as an index to measure health. Variations in auditory and visual perception, for example, do not directly cause illness and have no bearing on whether an individual is considered healthy or not.

the body as a 'body problem', placing people with impairments under the scrutiny of the medical gaze and thereby absolving society from the responsibility of removing disabling social barriers (Oliver 1990a; Rioux and Valentine 2006). By distinguishing between disability and impairment, the social model is able to put forth a political agenda that advocates for social change.

While the social model has been credited for advancing rights based disability discourse, it has also been criticized for removing the body and impairment from this discourse, thereby denying the relevance of individual experiences of impairment and disability. By understanding impairment as a functional limitation, a number of scholars have argued that the social model neglects to recognize that impairment can also be socially constructed (Hughes and Paterson 1997; Shakespeare and Watson 2001; Tremain 2008). Taking the social model into account, while being mindful of its limitations, is helpful for understanding the political response toward people with impairments. It also provides a useful means with which to recognize how the biomedical objectification of people with impairments can be linked to Foucault's notion of biopolitics as a means of regulating populations and 'defending society from the abnormal' (Stone 2004: 77).⁴

Abnormal

In its most basic conceptualization, abnormality can be thought of as that which deviates from the norm. However, the concept of abnormal extends beyond its binary relation to normal. Even before Quetelet and Galton established the normal or average human form, there were notions of otherness and difference associated with varied physiological characteristics. In his lectures at the Collège de France 1974-75, Foucault (2003a) locates the abnormal individual in three figures: 'the human monster, the individual to be corrected and the onanist' (XVII). In describing monstrosity from the Middle Ages to the eighteenth century he states:

[T]he monster is essentially a mixture. It is the mixture of two realms, the animal and the human: the man with the head of an ox, the man with a bird's feet—monsters. It is the blending, the mixture of two species: the pig with a sheep's head is a monster. It is the mixture of two individuals: the person who has two heads and one body or two bodies and one head is a monster. It is the mixture of two sexes: the person who is both male and female is a monster. It is a mixture of life and death: the fetus born with a morphology that means it will not be able to live but that nonetheless survives for some minutes or days is a monster. Finally, it is a mixture of forms: the person who has neither arms nor legs, like a snake, is a monster. Consequently, the monster is the transgression of natural limits...

(2003a: 63)

This description of monstrosity evokes the idea of abnormality as physiological incompleteness. The blending of two species and the mixture of two individuals or sexes is by virtue of its amalgamation incomplete. The body that lacks unification and completion and therefore 'compensates' by mixing or conjoining human or animal forms or presenting ambiguous (combined) sex organs creates an unnatural hybrid—a 'monster' and therefore an 'abnormal' individual. However, for Foucault, this 'transgression of natural limits' (2003a: 63) alone does not constitute monstrosity. His interest in the abnormal individual lies not in the body constructed as a deviant body, but in the body that performs deviant acts. For Foucault, monstrosity shifts from being understood as a physical abhorrence or oddity to crimes of a

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⁴ In his article, 'Defending Society from the Abnormal: The Archaeology of Bio-Power', Stone (2004) examines two of Foucault's lectures at the Collège de France (*Abnormal* and *Society Must be Defended*). The title of his article reflects the titles of both of these lectures. I use Stone's phrase and apply it to my analysis of disability surveillance suggesting that the rationalization or aim of biopolitics is that of 'defending society from the abnormal' (2004: 77).

gruesome nature that are attributed to psychological disturbances and irregularities that 'calls law into question and disables it' (2003a: 64).

In describing the historical view of the monster as a figure of abnormality, Foucault (2003a) mentions disability, not to suggest that people with impairments were a less insidious variation of monstrosity, but to separate disability from the notion of monstrosity entirely. It follows logically that if Foucault considers the abnormal individual to be located in the human monster and if people with impairments are not monsters then people with impairments are not abnormal. However, this logic is not upheld in that Foucault himself states that '[d]isability may well be something that upsets the natural order, but disability is not monstrosity because it has a place in civil or canon law. The disabled person may not conform to nature, but the law in some way provides for him' (64). In disassociating disability from monstrosity, Foucault substantiates the notion that disability is 'unnatural' and 'non-conforming', which seems to only reinforce the idea of disability as that which is 'abnormal'.

For disability studies scholars, understanding disability in terms of non-conformity to bodily norms is what renders it an 'abnormality' and people with impairments as 'abnormal'. In his essay on the medicalization of disability and independent living, Brisenden describes how disability is underpinned by conceptions of normality and abnormality:

The word 'disabled' is used as a blanket term to cover a large number of people, who have nothing in common with each other, except that they do not function in exactly the same way as those people who are called 'normal'. Consequently, this large number of people are considered 'abnormal'. We are seen as abnormal because we are different; we are problem people, lacking the equipment for social integration.

(1998: 22-23)

Brisenden contends that the real difference between people with impairments and those without is not the embodied attributes of impairment itself, but that people with impairments are looked at through a lens that only focuses on their limitations and as such are considered "non-people" with "non-abilities" that are helpless and dependent (1998: 23). Brisenden attributes the oppression and marginalization that people with impairments routinely experience to a society that demands conformity to idealized physiological norms. Similarly, Loja et al. (2013) trace the notion of abnormality to the medicalization of disability that defines disability within the context of non-conformity to prescribed bodily norms. They contend that the medical view of disability reduces and invalidates impaired bodies by regarding them 'as abnormal, deviant, inferior and even sub-human' (Campbell 2008, cited in Loja et al. 2013: 191).

At the outset of his lectures at the Collège de France 1974-75, Foucault (2003a) explains that his objective is to examine the 'emergence of the power of normalization...and the way in which it has extended its sovereignty in our society' (2003a: 26). Though not examined in great depth, his subsequent writings on biopower and biopolitics provide a tenuous link to 'abnormality'—not as the human monster, the incorrigible figure or the onanist, but in those that do not conform to bodily norms and are therefore considered a threat to the welfare and progress of the population. In the remainder of this paper, I aim to show how assumptions made about the 'risks' associated with those deemed abnormal are used to rationalize biopolitical strategies, which is especially relevant to understanding the management of people with impairments.

Biopolitics

Ongoing debates about the relationship between bodies (biological life) and the state (politics) have prompted scholars to revisit Foucault's writings and lectures on biopolitics. Among the competing articulations, Lazzarato provides a useful contextualization of the parameters of biopolitics noting that it

can be 'understood as a government-population-political economy relationship [that] refers to a dynamic of forces that establishes a new relationship between ontology and politics' (2002: 102). Scholars who have examined Foucault's lectures have traced biopolitical themes in his genealogy of race (Su Rasmussen 2011) showing how otherness emerges as a result of the construction of inferior races (Fassin 2001). A parallel can be drawn between the otherness of racialization and the 'abnormality' of impairment in that both are the consequences of a biopolitical regime underpinned by normalization.

A common theme that weaves through diverging views of biopolitics is an emphasis on the dyadic relationship between life and politics. What has been largely overlooked is the notion that biopolitics is an active and reactive process that politicizes life by locating it within the polarizing paradigm of normality and abnormality and thus categorizing life as either productive or unproductive and therefore worthy or risky. In this way, biopolitics operates on its own paradoxical axis in that its strategic aims and methods are carried out through a range of practices that, according to Esposito, can on one hand be 'affirmative and productive and on the other hand negative and lethal' (2008: 46). To illustrate the underlying rationalization of biopolitics it is fruitful to return to Foucault and his conception of biopower and biopolitics in the context of the 'normalizing society'.

In his lectures at the Collège de France in 1975-1976, Foucault (2003b) distinguishes between these two concepts noting that biopower is a disciplinary technology of power aimed at the individualized body while biopolitics is a regulatory technology of power aimed at the population. Foucault clarifies that while both are 'technologies of the body' (2003b: 249), the trajectory of power differs for each. Biopower is exercised through knowledge and power structures embedded within institutional arrangements that 'discipline' and condition the individualized body through processes of surveillance and training while biopolitics is concerned with the population as a biological and political problem and operates through administrative and strategic arrangements of the state through 'forecasts, statistical estimates, and overall measures' and intervenes in 'the birth rate, the mortality rate, various biological disabilities, and the effects of the environment' (2003b: 245-246).

According to Foucault (2003b), the concept that underpins biopower and biopolitics is 'the norm' (253). It is the application of the norm to the body and population that establishes the 'normalizing society' (2003b: 253). Foucault defines the normalizing society as 'a society in which the norm of disciplines [biopower] and the norm of regulation [biopolitics] intersect...' (2003b: 253). It is a society in which power dominates the 'organic and the biological' through control over the life of both the body and the population (Foucault 2003b: 253). Foucault (2003a) suggests that the 'norm' is a political concept wherein processes of power emerge and are legitimized. He claims that the underlying principles of the norm are that of 'qualification and correction' (2003a: 50). Mader observes that processes of 'qualification and correction' are contingent on comparing and measuring bodies against 'quantifiable qualities' (2007: 6). Only when bodies are inscribed with measurable attributes can they be 'controlled and managed' (2007: 6). Although Foucault recognizes the repressive outcomes of political power exercised through processes of normalization, he is averse to conceptualizing political power in strictly repressive terms and suggests that repression is a 'secondary effect' (2003a: 52) and that the function of power that emerges in accordance with the norm is not to 'exclude and reject', but is 'a positive technique of intervention and transformation, to a sort of normative project' (2003a: 50). Foucault's association of the normative project with positive intervention might seem curious given the underlying themes of power and its relation to social control that underlie much of his work. Yet, he contends that disciplines of normalization that emerged in the eighteenth century produced a productive form of power aimed toward 'transformation and innovation' (2003a: 52).

For Foucault (1978), biopower was the driving force of capitalism, which relied on able bodies to produce thereby shifting the 'phenomena of population to economic processes' (1978: 141). Foucault contends that within 'the sphere of economic processes' (1978: 141), powerful institutions emerged as instruments of

the state to exert control over the body and increase productivity (2003b). This occurred toward the end of the seventeenth century and during the first half of the eighteenth century. By the end of the eighteenth century, illness, which was deemed a threat or risk to economic processes, became the target of political power. As a result, biopolitical initiatives aimed at medically normalizing society became more widespread (Foucault 2003b).

In examining biopolitics in the context of disability, Tremain (2008) echoes Mader (2007) in remarking that 'biopower normalises people in order to make them governable' (2008: 102). She states that:

[D]ifferences amongst populations have been materialised and made perceptible as pathology, while the subjects who come to bear them are rendered as defective, are disabled, and signified as less than fully human. In short, they are the embodiment of a 'problem' which must be resolved or eliminated.

(2008:102)

For Rose, the connection between risk and biopolitics is inextricably linked, but he claims that contemporary biopolitics is concerned with resolving rather than eliminating 'abnormal bodies':

[Biopolitics] is no longer a question of seeking to classify, identify and eliminate or constrain those individuals bearing a defective constitution ... Rather, it consists in a variety of strategies that try to identify, treat, manage or administer those individuals, groups or localities where risk is seen to be high. The binary distinction of normal and pathological, which were central to earlier biopolitical analyses, are now organized within these strategies for the government of risk.

(2001:7)

Rose (2001) explains that the strategies for addressing risk are carried out in a multitude of ways within various levels of intervention and management. In the following section, I illustrate how abnormality is translated as 'risky' by the state and how biopolitical strategies that involve classifying, identifying, eliminating or constraining still occur and are rationalized as a means of 'defending society from the abnormal' (Stone 2004: 77). In particular, I focus on immigration practices in Canada and the application of the excessive demand clause.

Defending Society from the Abnormal: Exclusionary Immigration Practices in Canada

While Foucault (2003a) centres his discussion of abnormality on psychiatry and criminal justice, his analysis offers two important points which are particularly relevant for understanding the treatment of people with impairments in modern Western society. The first is the idea of 'abnormal' understood as a transgression of nature and characterized as a physiological lacking, a subject without a unified body, which is ultimately seen as incapable, unable and therefore 'disabled' to perform in accordance with the demands of modernity. The second point that Foucault addresses is the political response and the exclusionary impact of abnormality. He recounts the segregation of lepers during the Middle Ages, noting that their exclusion was a social practice that involved a process of division. It involved casting individuals beyond the periphery of the towns and outside the margins of society (Foucault 2003a: 43). Foucault explains that the act of exclusion implied both 'juridical and political' disqualification (2003a: 43). Those that were disqualified ceased to exist as political subjects. Foucault considers these exclusionary tactics as mechanisms of power. Ultimately, those considered contagious were perceived as dangerous and seen as a threat to society.

Toward the end of the eighteenth century, illness was considered a threat because it reduced productivity and demanded economic compensation (Foucault 2003b: 244). Accordingly, illness was seen to have a

detrimental impact on the population and on social and economic progress. Medicine therefore emerged as a mechanism of institutional power to instil public hygiene and to establish a dominant 'normalized' discourse of the body (Foucault 2003b: 244). Implicit in Foucault's (2003b) articulation of biopolitics is the underlying purpose of preventing and protecting the population from 'internal dangers' or risk (2003b: 249). However, the benefit of protection is contingent on individuals being healthy and normal. Those that become ill, impaired or otherwise 'abnormal' are excluded from being protected as they become the very 'threat' or 'risk' that the population must be protected from.

In the eighteenth century, another mechanism of power emerged that involved the quarantining of plague victims. Unlike the practices of exclusion that occurred in the Middle Ages, quarantining involved spatial partitioning (Foucault 2003a). Foucault describes with some detail the process of monitoring that occurred within these quarantined spaces and the registries that all citizens were required to sign as a means of population management. He points out that the model of control that emerged in the eighteenth century was not carried out by driving out individuals, but by including them by 'establishing and fixing them' and defining 'subdivided presence' (Foucault 2003a: 46).

These historical mechanisms of power and their underlying rationalization of eliminating the threat of 'abnormality' continue to be exercised by the Canadian government. Section 38 (c), more commonly referred to as the 'excessive demand clause' of the *Immigration and Refugee Protection Act*, articulates both mechanisms of power. In accordance with s 38(c), immigration officials look at whether potential immigrants have a medical condition that would endanger public health and safety, and whether their condition would place excessive demand on health or social services (*Immigration and Refugee Protection Act*). In order to determine if applicants pose a danger to the public or would impose excessive demand, those hoping to immigrate to Canada must pass a medical examination conducted by an 'authorized' physician (Citizenship and Immigration Canada 2012a).

In addition to its inherent discriminatory nature, what is troubling about the medical requirement is that medical reports and data collected during the medical examination 'become the property of Citizenship and Immigration Canada medical authorities' and are not returned to applicants (Citizenship and Immigration Canada 2012a). Furthermore, doctors do not inform applicants of the results unless they have a 'health-related problem' (Citizenship and Immigration Canada 2012a). What the doctor and Citizenship and Immigration Canada consider a 'health-related problem' is not clear as specific details and examples are not provided. What is perhaps most troubling is that Citizenship and Immigration Canada does not provide information on how long the medical data is stored and whether and how it may be used in the future. The possibility that this data will be kept in a database of 'undesirable applicants' raises doubts as to whether rejected applicants could have a successful application in the future.

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⁵ Excessive demand is defined in subsection 1(1) of the Immigration and Refugee Protection Regulations as follows:

⁽a) a demand on health services or social services for which the anticipated costs would likely exceed average Canadian per capita health services and social services costs over a period of five consecutive years immediately following the most recent medical examination required by these Regulations, unless there is evidence that significant costs are likely to be incurred beyond that period, in which case the period is no more than 10 consecutive years; or

⁽b) a demand on health services or social services that would add to existing waiting lists and would increase the rate of mortality and morbidity in Canada as a result of an inability to provide timely services to Canadian citizens or permanent residents (Immigration and Refugee Protection Regulations 2002).

⁶ Citizenship and Immigration Canada provides a generic application wherein potential immigrants specify on the application the immigration category under which they are applying. The fine print at the bottom of the application does not mention anything about the storage of medical data that is collected during the medical examination. However, it does state that information provided on the application will be stored in 'Personal Information Banks (PPU 042 entitled immigrant case file...)' and may be shared with several governmental and law enforcement agencies and departments in Canada and abroad pursuant to subsection 8(2) of the Privacy Act.

In denying individuals permanent residency on the grounds of perceived excessive demand on health and social services based on a medical diagnosis, the Canadian government is carrying out what Foucault describes as an exclusionary mechanism of power. In her critique of the excessive demand clause, Wiebe points out that applicants with certain illnesses, such as 'HIV/AIDS, inactive TB (those who have active TB are rejected) and treated or positive syphilis' (2008: 337) may be granted permanent residency (included), but on the condition that they consent to being surveilled—a sort of subdivided presence. Here we can begin to see the underlying rationalization of biopolitics first through the conception of 'normal' as an imperative of modernity and second through the conception of 'abnormal' as posing a danger, threat and risk to the health of the population and to economic stability and progress.

The underlying rationalization to defend society from the abnormal is deeply ingrained in Canadian immigration policy dating back to the time of confederation. In chronicling the history of exclusion of disabled people, and particularly those deemed 'mentally defective' in Canadian immigration law, Chadha (2008) explains that the Immigration Act of 1886 imposed monetary penalties:

[F]or '...any lunatic, idiotic, deaf and dumb, blind or infirm person not belonging to any immigrant family.' If the Medical Superintendent believed any disabled passenger could become a permanent 'public charge,' the Medical Superintendent was required to immediately report that information to the port's Immigration collector of customs. The vessel's Master was required to post a \$300 bond for every such disabled passenger so as to indemnify the government and charitable institutions for potential expenses incurred within three years for the passenger's maintenance and support.

(Chadha, under 'The Immigration Act of 1886')

Despite numerous revisions, Canadian immigration policy continues to assess immigration applicants against corporeal norms and potential expenses thereby perpetuating the idea that inclusion of 'abnormal' bodies is detrimental to a healthy and productive citizenry. It is in large part for this reason that the Council of Canadians with Disabilities (CCD), a national organization that advocates for inclusion and accessibility for people with impairments, takes issue with the excessive demand clause claiming that it 'devalues Canadians with disabilities and does nothing to recognize the contribution persons with disabilities and their families can and do make to Canadian society' (CCD 2013a).

Writing in the context of racism and sexual oppression, McWhorter (2009) hones in on the concept of 'abnormality' and provides a compelling appropriation of Foucault. In explaining how psychiatry became 'a technology of abnormality' (Foucault 2003, quoted in McWhorter 2009: 30), she writes:

[I]t identified persons who it supposed could not be assimilated into the life of the community, and then it went to work to capture those individuals, discipline them, and thereby defend society from the threat they posed. In the process, the public became sensitized to newly recognized dangers:...eccentrics, and nonconformists of all kinds. Such people—abnormal people—were not only problems for those whose intimate lives they shared but were threats to the general public and rightfully subject to surveillance and constraints imposed through psychiatry and other means by or on behalf of society as a whole.

(McWhorter 2009: 30-31)

In the same way that psychiatry became 'a technology of abnormality' (Foucault 2003a: 163), so too did the biomedical definition of disability in that it identified and categorized people with impairments as unhealthy, defective and incapable, rendering them social burdens and therefore a threat to the normalizing society. For people with impairments, the path to a normalizing society is one marked by a sequence of 'dividing practices' (Foucault 1982: 777) that begins by classifying abnormal bodies through

the implementation of ableist policies and practices and the demarcation of spaces as those designated for 'normal' (able) and 'abnormal' (impaired) bodies (Hansen and Philo 2009). Kitchin (1998) recognizes the ways in which disability is spatially produced through power relations that work to organize people with impairments. He claims that the social relations that emerge through socio-spatial processes serve to 'isolate and marginalize' people with impairments (1998: 343). In the context of the excessive demand clause, the political tactic of managing bodies through the use of medical data to categorize desirable immigrants from undesirable immigrants in accordance with perceived excessive demand on health and social services illustrates the operation of biopolitics (Wiebe 2008, 2009). The use of this data to determine who will be granted permanent residency also illustrates how socio-spatial processes work through power relations to exclude people with impairments.

According to Wiebe (2008), biopolitical agendas that regulate health in order to optimize economic prosperity inevitably construct a narrow conception of citizenship extended only to those deemed healthy and productive. Wiebe adds that 'surveillance derives from a fear of the unknown, which translates into the state's ambition to conduct risk management practices' (2008: 337). Writing on the theme of surveillance as biopower, Ceyhan (2012) echoes Wiebe's sentiment, remarking that surveillance operates as a technology of 'biopoliticalized security' (2012: 39) as a means of mitigating uncertainty. Indeed, it is the Canadian state's assumptions about impairment and its inclination toward managing economic 'risk' and uncertainty that the purpose of conducting disability surveillance at the border becomes evident.

Biopolitics at the Border: Social Sorting and Ableist Biometric Technologies

The pervasiveness of surveillance and its inherent discriminatory characteristic of identifying and classifying certain individuals and groups as 'risky' have given rise to the notion of 'surveillance as social sorting'. According to Lyon, surveillance as social sorting centres 'on the social and economic categories and the computer codes by which personal data is organized with a view to influencing and managing people and populations' (2003: 2). It is the process of predicting and preventing risk by classifying subgroups of society deemed to pose a threat (Lyon 2003). Lyon attributes social sorting and 'digital discrimination' to the prevalent use of networked technology (2003: 8) and the 'rising attention paid to the body itself as a source of surveillance data' (2007: 55).

The concept of social sorting and the emphasis on the body as a source of data is especially relevant in the context of disability surveillance in that the collection and documentation of information about the body reduces people with impairments to 'impaired bodies' and further still to 'impaired data'. The data double therefore can become 'disabled' in much the same way as the individual insofar as it is not perceived, viewed, monitored and treated equally as 'non-impaired' data doubles. The data double itself may include biometric details or other forms and fragments of information that allude to or signify the embodiment of impairment. The implication of this is that the 'abnormality' of the body is extended to the digital and what serves to mark, label and stigmatize the body in the physical environment now has the ability to mark, label and stigmatize the body digitally.

Referring to electronic patient records (EPR) as an example of the digitalization of the body, van der Ploeg considers the data they contain to be 'extended forms of "unique identifiers" due to the personal information they contain, including biometric data' (2003: 62). The increased use of biometric identifiers in EPRs (as well as in other contexts such as immigration) are superimposing traditional forms of identifiers such as name and birth date as they are considered a more reliable representation of identity (van der Ploeg 2003). In challenging the gendered neutrality of surveillance, Monahan argues that representations of data render 'a disembodied and highly abstract depiction of the world' by removing social context (2009: 286). Monahan contends that surveillance systems 'artificially abstract bodies, identities and interactions from social contexts in ways that both obscure and aggravate gender and other social inequalities' (2009: 286). He considers the embodied consequences that arise from surveillance

practices that operate on a 'level of abstraction' (2009: 286). Building from Monahan's argument on the socially de-contextualized collection of data and applying it to disability surveillance provides a useful means with which to contextualize the consequences of conducting disability surveillance within a biomedical perspective.

A useful starting point is to consider the ways in which certain surveillance strategies such as biometric technologies separate the social from the body. Biometric technologies operate by capturing physiological markers of bodies including fingerprints, face or voice recognition, iris and handwriting authentication. The data produced by the body is then used to verify identity (Maddern and Stewart 2010). However, biometric systems do not only verify identity, but they also play a significant role in assigning identities. This is worth considering in light of the government's reliance on biometric data, which stems from the belief that biometric technology is infallible (Maddern and Stewart 2010).

The use of biometric technology at the Canadian border is being touted by Citizenship and Immigration Canada (2012b) as a 'highly reliable way to reduce identity fraud'. In a public notice released online announcing the scheduled implementation of biometric technologies in 2013, Citizenship and Immigration Canada (2012b) states that 'biometrics would strengthen the integrity of Canada's immigration program by helping prevent known criminals, failed refugee claimants, and those previously deported from using a different identity to obtain a visa...' and that 'biometrics will strengthen and modernize Canada's immigration processes'. In lauding the collection of biometric data as part of the immigration process, the Canadian government neglects to consider how the technology might have a discriminatory impact for certain groups.

Pugliese (2010) questions the infallibility of technologies that filter bodies through a racialized lens. He looks in particular at the ways in which biometric technologies fail to accurately capture the data and images of bodies that do not conform to the features of whiteness, which biometric technologies were designed to accommodate. Similarly, by virtue of their ableist design, biometric technologies also filter bodies through a normalized lens. Trials have shown that biometric systems are not designed to conform to disabled people, but that disabled people are expected to be able to conform to the system's design (Maddern and Stewart 2010). The ableist way in which they collect physiological data inherently carries out the function of social sorting by classifying and categorizing those who are not able to pass easily through the system. The passage below illustrates this point:

For someone in a wheelchair if you can't perfectly adapt your position it could be difficult. For blind people it certainly can be difficult because they can't see...You don't actually have to focus, but you do have to keep a constant relationship with the camera...that's why we couldn't get acceptable enrolment (in a recent trial) for a quite a large selection of people with disabilities.

(respondent and biometric technology user quoted in Maddern and Stewart 2010: 247)

This quote reveals the challenges that biometric technologies present for some people with impairments. The inability to navigate through biometric systems not only impedes mobility, but reduces people with impairments to 'deviant bodies' that do not conform to preconceived standards of ontological normality.

According to Haggerty and Ericson,

The observed body is of a distinctively hybrid composition. First it is broken down by being abstracted from its territorial setting. It is then reassembled in different settings

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⁷ Pugliese notes, for example, that biometric templates are created from trials that recruit white participants and that when the system encounters features that do not correspond there are higher FTE (failure to enrol) cases.

through a series of data flows. The result is a decorporealized body, a 'data double' of pure virtuality.

(2000:611)

For some people with impairments, their bodies are in a sense already decorporealized before they are even reassembled, due to the biometric systems' inability to accept and process their varied physiological traits. Similarly, Garfinkel suggests that biometric technologies are problematic in that they 'do not identify *people*, they identify *bodies*' (2000: 65 emphasis in original). Here we can begin to see that the surveillance gaze is similar to that of the medical gaze in that it calls 'abnormal' bodies into question.

In examining biometrics through a governmentality perspective, Epstein observes that biometric databases operationalize two types of risky bodies: "guilty" bodies' understood as 'transgressors of the law' and 'immigration violators' understood as 'destructive bodies' (Epstein 2007: 160). For people with impairments, biometric technologies seem to operationalize a third type of risky body understood as 'non-normative bodies'. By failing to process the data from bodies that do not conform to the system's ableist design, biometric technologies also function as 'a technology of abnormality' (Foucault 2003a: 163). In reinforcing corporeal norms, biometric technologies operate as part of a broader biopolitical project aimed at eliminating 'abnormality'. Biometric technologies, especially when used in combination with provisions that emphasize ontological normality such as the excessive demand clause, do not account for the social construct of disability. Consequently, it is not ableist and discriminatory social structures, systems and attitudes that are deemed flawed, but the body. The 'flawed body' is then evaluated against normative corporeal standards used to determine citizenship often resulting in an undignified, if not outright exclusionary, immigration process.

The focus so far has centred on the negative impact of disability surveillance. However, classifying impairment and quantifying its prevalence is important in order to address and remove the social barriers that contribute to the experience of disability. The following discussion highlights some of the ways in which impairment and disability related statistics are used by the government and non-governmental organizations (NGOs) and how the collection of data on people with impairments establishes the paradox of disability surveillance.

Promoting Rights and Preventing 'Risk'

The concept of abnormality and its association with economic risk operates as a decisive factor in determining citizenship. Combined with ableist biometric technologies, the focus of disability surveillance is largely centred on the body. Yet not all surveillant practices reduce disability to the body. Statistical data on people with impairments, for example, can be used to challenge discriminatory practices and mobilize the disability rights movement. When conducted on a national level, disability surveillance is typically carried out through the collection of statistical data through 'censuses, household surveys, and administrative registries' (Fujiura and Rutkowski-Kmitta 2001: 74) and relies on the self-reporting by citizens. In a national census, disability surveillance is conducted by counting the population and in doing so counting how many people report living with impairment. In Canada, statistical figures are compiled to reveal the percentage of the population that report experiencing particular impairments. What census data does not highlight is the way in which social factors impact people with impairments and the level of restriction and exclusion that is encountered. Household surveys, such as the Participation and Activity Limitation Survey (PALS) conducted by Statistics Canada are designed to address the limitations of a population census by gathering additional data on impairment and the impact that impairment and other factors present with regards to level of participation and activity in daily life.

PALS is intended specifically to identify the experience of disability as it relates to barriers, discrimination, types of assistance needed and the cost of obtaining aids and devices (Statistics Canada

2006). According to Statistics Canada, the purpose of generating 'a comprehensive database' on people with impairments is to support disability related research and to assist in the development of social policy at both the provincial and federal levels. Provincial administrative registries such as the Ontario Disability Support Program (ODSP) collect impairment related data as they correspond to benefit applications. Those who apply for and receive benefits will be included in the registry. This is a less accurate way to measure impairment as not all people with impairments will qualify or seek benefits through government assistance programs. Impairment statistics are also collected on an international scale and documented in global statistical reports, such as The World Report on Disability, prepared by the World Health Organization (WHO). The WHO collects impairment related information in order to identify strategies to improve accessibility and equality and promote participation and inclusion. The WHO (2011) claims that this data is collected and published to enable policy-makers to assess existing programs in areas such as health, education, employment, transportation and information.

Fujiura and Rutkowski-Kmitta (2001) suggest that it is in the interest of nation states to measure the demographic patterns of the population for planning and policy purposes. In addition to benefiting policy makers, the information obtained through census data used to compile national and international reports on disability is used to further the agenda of the disability movement. For example, the Council of Canadians with Disabilities (CCD) uses statistical information collected from the 2006 Canadian census and PALS to identify human rights issues that impact Canadians with impairments. The CCD advocacy priorities include: alleviating poverty, increasing opportunities for employment, ensuring that all public transportation is accessible, and advocating for technology that adheres to universal principles of design. CCD works toward achieving these priorities by challenging discriminatory statutes, litigation, educating the public and promoting awareness and by engaging with political actors (CCD 2013b). Without the use of statistics, it would be difficult for CCD and other disability organizations to know how many people with impairment experience exclusion that stem from social barriers and what their concerns and needs are. Without the knowledge of the prevalence and impact of the experience of disability, advocating for national and provincial services and programs would be difficult, if not impossible.

When used to promote awareness about the prevalence of impairment and disabling barriers and to promote equality and inclusion, disability surveillance can be an effective means of highlighting the needs of people with impairments in order to promote and enable full societal participation. Counting and classifying impairment and the experience of disability can therefore aid policy makers in designing programs that make social, political and economic opportunities equally available to people with impairments. However, disability surveillance becomes highly problematic when it utilizes the biomedical definition and fails to consider disability within a social context.

While PALS uses a definition of disability that incorporates the social model by recognizing the role of environmental and social factors (Statistics Canada 2006), other branches and departments of the Canadian government adopt a very narrow definition rooted in the biomedical perspective. For instance, in order to be eligible for Canada Pension Plan (CPP) disability benefits, applicants must have a severe and prolonged 'disability'. 'Severe', according to the federal government 'means that a person is incapable of regularly pursuing any substantially gainful occupation. "Prolonged" means that the disability will prevent the individual from going back to work in the next 12 months, or is likely to result in death' (Service Canada 2012). In order to be eligible for disability income support in the province of Ontario, disability is defined under the Ontario Disability Support Program Act as 'continuous or recurrent; expected to last for a year or more; significantly limits the applicant's ability to work, look after themselves, or get out in the community; and has been verified by an approved health professional' (Ontario Ministry of Community and Social Services 2012). Both of these definitions use the term 'disability' to mean functional limitation or restriction of activity. The narrow and inconsistent definitions of disability rooted in the biomedical perspective utilized by federal and provincial government to determine eligibility for benefits serves to objectify the body by decontextualizing disability from the social and locating it within the individual. By

framing 'disability' as a functional limitation or restriction of activity in the context of severe and prolonged, the government is able to limit access to economic resources. This can have a direct and detrimental impact on the life chances of people with impairments.

Deconstructing the Paradox

Given the varied use of disability surveillance, how can we resolve the paradox of promoting rights and preventing 'risk'? In attempting to answer this question, I suggest not a departure from biopolitics itself, but a departure from the underpinning rationalization of eliminating abnormality and a return to 'the hidden foundation of biopolitics', which Ojakangas describes as 'love (agape) and care (cura), "care for individual life"' (2005: 5). In distinguishing between Agamben's (1998) conception of biopower as 'bare life' and Foucault's conception of biopower as 'optimizing life', Ojakangas argues that the aim of biopower is not to reduce life, but 'to invest life through and through' (Foucault 1978: 139 quoted in Ojakangas 2005: 14). He identifies the hidden foundation of care and love as the origin of biopower noting that, historically, biopolitical processes were embedded in the state's inclination toward power, but were nonetheless carried out with the aim of promoting the welfare, prosperity, health and happiness of the population. He recounts the origin of biopower, pointing out that it emerged not only in the modern state, but in Western religious ideology, namely 'Judeo-Christian tradition[s] of pastoral power' described in the metaphor of the shepherd watching over and protecting his flock (2005: 19).

In his examination of biopower in the context of left politics, Hannah takes up Ojakangas' notion of 'biopolitics of care' remarking that 'an affirmative biopower has at its core a biophilia, a love for living beings, that can be mobilized as a form of solidarity to help combat injustice and inequality, and to make the world a better place' (2011: 1050 emphasis in original). However, Hannah recognizes that there are challenges in mobilizing and implementing an affirmative biopolitics. He refers to the dilemma that Esposito raises, noting that the protection of life is often carried out through authoritative processes that at times produce 'negative effects' (2011: 1048). For Hannah, these negative effects can be attributed to a futurist biopower. As he describes it, a biopower oriented toward the future is similar to biopolitics aimed at preventing risk in that it seeks to ensure 'the survival of the Same in the future, at the expense of an Other' (2011: 1048). According to Hannah, biopolitics came to be viewed in a negative light due to historical events marked by racist practices, eugenics and Nazi ideology, which were carried out and rationalized under the purview of 'futurist investment' (2011: 1048). However, as Hannah acknowledges, biopolitics does not necessarily need to abandon concern for the future. Rather, what it must abandon is the tendency to determine political qualification by measuring the value of life according to ontological norms.

The notion that ontological 'abnormality' poses a threat to the welfare, prosperity, health and happiness of the population and therefore must be eliminated is contingent on the conception of ontogenetic norms and its association with productivity and progress (Finkelstein 1980; Oliver 1996; Davis 2006; Oliver and Barnes 2012). The emphasis on bodily norms is what drives biopolitical agendas and is what results in discrimination and exclusion of those deemed abnormal. For Ewald (1990), there is no innate relationship between normal and abnormal. He maintains that the establishment of norms is a relational process that often has little to do with biological variations and more to do with how difference is perceived in society and constructed and experienced as a 'handicap' (1990: 157). Ewald points out that '[i]f environmental requirements change, performance does too, and along with them the location of the boundary between normal and abnormal' (1990: 157).

⁸ Hannah refers specifically to Barkan's (2006) analysis of business corporations as an example of futurist biopower where the survival of the 'same' is used to refer to the survival of corporations at the expense of humanity and non-human life (the other). However, this analogy is particularly relevant in the context of biological life in that 'the survival of the Same at the expense of the Other' can be used to describe the aim to protect the welfare of bodies (life) considered 'normal' (the Same) at the expense of bodies (life) deemed 'abnormal' (the Other).

Shifting the boundary between normal and abnormal and uncovering the hidden foundation of an affirmative biopolitics requires rethinking the body according to normative standards within a biomedical and pathological context to thinking about the body 'as a situation' 'lived' and 'changeable' (Peuravaara 2013). In theorizing the body according to conceptions of disability and normality, Peuravaara (2013) contends that bodies are always situated and that situations are constantly changing, which invariably shapes the 'lived body'. Peuravaara follows Moi (2005) in asserting that the 'lived body is part of society without being a mere product of society' (2013: 414). Removing the experience of disability in the context of the lived body involves adopting a 'politics of difference' that rejects dominant practices of ableism and values ontological diversity (Loja et al. 2013: 191). It also requires rethinking spaces and the spatialization of difference (Kitchin 1998; Hansen and Philo 2009). If underpinned by the hidden foundation of care and love, biopolitical strategies can be used to promote rights whereby disability surveillance, such as classifying and counting people with impairments, is not conducted as a means of exclusion, but to achieve inclusion and to improve the welfare of both individual and collective life.

Conclusion

The paradox of disability surveillance hinges on its purpose and outcome of promoting rights and preventing 'risk' and can be understood as a consequence of utilizing one definition of disability over another and adopting ontogenetic norms as a condition for political qualification. I have used the term 'disability surveillance' to refer to several practices including counting, classifying and categorizing people with impairments and have suggested that disability surveillance operates as a form of social sorting. Framing disability surveillance as a means of social sorting is useful for recognizing the body objectifying aspects of surveillance that remove the social thereby decontextualizing people with impairments by reducing them to 'unproductive' and 'risky' bodies. To date, disability studies has been largely absent from Surveillance Studies literature. There is a case to be made that disability studies is worth considering in the broader context of Surveillance Studies not least for its contribution toward expanding discussions on human rights issues and highlighting the exclusionary impact of social sorting, but also to remind us that surveillance can produce positive outcomes and can be used as a tool to promote inclusion.

The examples of disability surveillance discussed in this paper reveal that dominant notions of risk are not intrinsic, but constructed. In tracing the emergence of the genesis of normal, this paper examined how surveillance practices operate according to biopolitical rationalizations of eliminating abnormality in an effort to prevent economic 'risk'. By collecting medical information, the government controls the number of citizens who will have access to benefits and services. In Canada, these controls are carried out by adopting a pathological definition of disability, thereby limiting the number of eligible applicants for benefits, and by implementing immigration policies that serve to categorize applicants on the basis of impairment and health and from this determine (dis)citizenship. However, when social factors are taken into account, disability surveillance helps advance and promote rights for people with impairments by providing policy makers and NGOs with necessary data that highlights the prevalence of impairment as well as the concerns, needs, and experience of people with impairments to develop effective programs and services and remove disabling barriers. The paradox therefore lies not in the act of conducting surveillance that target people with impairments, but in using a biomedical definition of disability as part of a broader biopolitical strategy to minimize 'risk'. Resolving this paradox is contingent on understanding the social and political dimensions of disability and a revival of an affirmative biopolitics of care that promotes the welfare of an inclusive, collective and diverse society.

Acknowledgements

I am very grateful to Jeffrey Monaghan, Martin Hand, David Lyon, Annette Burfoot and two anonymous reviewers for their insightful and constructive comments on earlier versions of this paper.

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