Critical Interventions in Global Health: Governmentality, Risk, and Assemblage

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The rise of the term global health reflects a concern with rethinking the meaning of health in the context of globalization. As a field of practice, however, global health renders problems, populations, and spaces visible and amenable to intervention in differentiated ways. Whereas some problems are considered to be global, others are not. Some are considered to be matters of global security, whereas others lack this designation and remain in the realm of health or development. Attention is drawn to individual global health problems, even as their broader structural dimensions are often obscured. We suggest that a critical geographical approach to global health therefore entails reflexivity about the processes by which problems are constituted and addressed as issues of global health and identify three analytical approaches that offer complementary insights into them: governmentality, risk, and assemblage. We conclude by outlining some further issues for critically reflexive geographies of global health.

Key Words: assemblage, globalization, governmentality, health, risk.

El surgimiento de la expresión salud global refleja una preocupación por repensar el significado de la salud en el contexto de la globalización. Como campo de práctica, sin embargo, la salud global rinde problemas, poblaciones y espacios visibles y susceptibles de intervención de maneras diferentes. Si bien algunos problemas se aprecian como globales, otros no. Algunos son considerados materia de seguridad global, en tanto otros carecen de esta designación y permanecen dentro del mundo de la salud o del desarrollo. Se llama la atención sobre problemas globales de salud individuales, incluso si sus dimensiones estructurales más amplias a menudo son oscuras. Sugiero que un enfoque geográfico crítico de la salud global requiere consecuentemente una reflexión acerca de los procesos con los que se constituyen los problemas y son abocados como asuntos de salud global, e identificamos tres enfoques analíticos que ofrecen comprensión complementaria para los mismos: gobernabilidad, riesgo y ensamblaje. Concluimos esquematizando algunas cuestiones adicionales para geografías críticamente reflexivas de la salud global. Palabras clave: ensamblaje, globalización, gobernabilidad, salud, riesgo.

“Health is global,” or so we are encouraged to think.¹ The rise in prominence of the term global health has gone hand in hand with a multitude of academic analyses, think tank papers, policy initiatives, media reports, institutional innovations, and political controversies over the course of the last twenty years. The global health field has seen an influx of new actors, including activist networks, high-profile philanthropies, and new kinds of public-private partnerships, giving rise to a plethora of global health initiatives. All of this has coincided with a doubling of donor aid for health over the course of the last decade. This has triggered a rapid growth in academic global health centers and programs, many of which recognize that global health now goes beyond biomedicine, epidemiology, public health, and development to embrace matters of law, politics, history, economics, trade, diplomacy, and security.
Although geographers have long contributed to the understanding of health worldwide via medical geography, epidemiology, public health, and development studies, they are increasingly turning a critical eye toward its political, economic, cultural, and ethical dimensions, helping to shape a broader interdisciplinary field of critical global health studies. An important part of this agenda is a critical rethinking of how the global health field itself shapes the way global health is imagined, understood, and thus addressed. A key concern here is the differentiated manner in which particular problems, populations, and spaces are rendered visible and amenable to intervention. Although some problems (like emerging infectious diseases or tobacco-related disease) are considered to be global, others are not. Some (like influenza, HIV/AIDS, or biological weapons) are designated as matters of global security, whereas others (e.g., maternal health, diarrheal, and other so-called neglected diseases) remain in the realm of health or development. Attention is often drawn to individual problems (like epidemics or other crises) or solutions (e.g., vaccination or antiretroviral therapy for HIV and AIDS), whereas the broader structural dimensions and determinants of ill health, diminished life chances, and shortened lives (which derive from long-term and wide-scale political and economic processes) are often obscured (cf. Brown and Moon 2012).

We suggest that a critical geographical approach can contribute further to the process of revisioning global health by opening the processes whereby health is rendered global to reflexive scrutiny. Building on recent interventions by geographers and others (Braun 2007; Ali and Keil 2008; Hinchliffe and Bingham 2008; Lakoff and Collier 2008; Kears and Reid-Henry 2009; Sparke 2009), we outline three analytical approaches that offer complementary insights into these processes: governmentality, risk, and assemblage. Each is relevant, because it draws attention to how global health problems and responses are not given but enabled, imagined, and performed via particular knowledges, rationalities, technologies, affects, and practices across a variety of sites, spaces, and relations.

Global Health Governmentality

A full account of today’s global health field would need to explore multiple temporalities and spatialities, including imperial and colonial historical geographies, the formation of the world economy and patterns of state formation in terms of their mutual constitution with ecological and epidemiological processes, post-colonial problematizations of the Third World as requiring developmental intervention, the wreckage of postcommunist transitions, and the emergence of disputes over neoliberal globalization. It would also include a series of specific developments during the 1990s: the formation of the concept of emerging infectious diseases; alarm at epidemics spreading within and beyond the global south; efforts of policy entrepreneurs and activists on health, human rights, development, and peace issues; concern about bioweapons stocks, infrastructures, and expertise; and shifting concepts and practices of security. It would trace, too, the emergence of an ecosystem of global health governance, constituted by dozens of organizations and institutions concerned in some way about global health issues. With the term governmentality we signal additionally, first, the reflexive implication of particular knowledges, rationalities, and technologies in the constitution of global health (Larrinaga and Doucet 2010; Ingram 2010). We wish to signal three further aspects of global health governmentality in particular.

The first is the manner in which the global health field deals with problems of space. Foucault’s (2007) discussion of how the management of population and circulation comes to form the preeminent object and logic of modern government is particularly suggestive when it comes to global health. As Braun (2007) argued, in the case of biosecurity, what is apparent is an aspiration to govern the global biological that is enabled by a variety of surveillance and monitoring technologies and institutional arrangements. Furthermore, as Braun (2007), Ali and Keil (2008), and Hinchliffe and Bingham (2008) argued, the Euclidean geography of the nation-state system, on which global health governance had been based, is ill suited to the complex topologies of emerging infections, where one thing can morph into another and distinctions between the inside and the outside are blurred (see also Sarasin 2008). Efforts to secure the globe from emerging infections thus link cutting-edge surveillance, post-Westphalian sovereignty, and emergency alert and response (Fidler 2004; Elbe 2009).

Global health governmentality thus intersects with geopolitics in complex ways. Global health security systems, which are largely grounded in and funded from within the global north, reflect global north priorities, and render sovereignty provisional, start to look like a form of empire (see also King 2002; Weir and Mykhalovskiy 2006). Things might be changing, however. Controversies over global health security (Aldis
Global Health, Global Risk

As noted, to understand global health, and to critically intervene in it, we need to ask questions about the kinds of knowledges, technologies, and tactics that are used to render it visible or to make it doable (Kickbusch, Silberschmidt, and Buss 2007). One possibility here would be to focus on specific devices—such as the disability adjusted life year—and on the ways in which they are used to fix the geographical contours of global health and around which specific assemblages are formed. A more extensive technology associated with global health discourse, however, is what Dean (1999) referred to as “epidemiological risk”; it is on this concept, which we suggest is an example of what Foucault referred to as a dispositif (see Foucault 1980, 194–95), that we focus here. Before doing so, we briefly discuss Beck’s (1992) original articulation of the risk society thesis in which risk is defined as a “systematic way of dealing with the hazards and insecurities” that are the somewhat paradoxical result of scientific and technological advances associated with late modernity (21).

Beck’s formulation contributed to the development of a new research paradigm in which risk was elevated to the status of a key analytical rubric. This is apparent in analyses of the heightened threats to health (and life) associated with globalization. As Brundtland (2001) commented, there are “two critically important forces shaping the world we live in: the revolution that is taking place in information and biotechnology, and the growing momentum of globalization. Both of these forces carry with them immense potential for good. But, as we are all aware, they carry risks.” Brundtland went on to highlight the nature of these risks, noting that “[w]ith globalization, a single microbial sea washes all of humankind” and that there are “no health sanctuaries.” She also pointed to the growing recognition that it is not only infectious diseases that are spread with
globalization but heightened risks of heart disease, diabetes, and cancer.

Brundtland’s general statements on the consequences of globalization can be associated with the emergence of particular interventions; for example, the antitobacco campaign mentioned earlier or others such as the global strategy against noncommunicable diseases and the Global Fund to Fight HIV/AIDS, Malaria, and tuberculosis. It is, then, important that we acknowledge the centrality of risk to current understandings of global health because ideas about its current and predicted future contours are in part shaped by this particular analytical frame (Brown and Bell 2008). We would argue, however, that it is equally important that we recognize that this conceptualization, which, as Dean (1999) suggested, assumes that “real riskiness has increased” (182, italics added), is not the only approach that we might take. Beck (2009) himself acknowledged this in his recent reworking of the risk society thesis. As he noted, “[r]isks are social constructions and definitions based on corresponding relations of definition,” and, as such, are open to dramatization, transformation, and even denial (30).

It is at this juncture that we turn to readings that have been informed by Foucault’s work on governmentality (e.g., Castel 1991; Dean 1999). When thought of in these terms, risk, and specifically here epidemiological risk, emerges not so much as an objective reality of late modernity but as a dispositif. In making this connection, our goal is not to undervalue the material realities that shape people’s lives and render them more or less exposed to health-related hazards. Rather, it is to acknowledge that the ways in which these realities are rendered visible, the ways in which they come to be known both now and in the future, is to a great extent shaped by the heterogeneous ensemble of elements that Foucault identified as being a part of the apparatus of a dispositif (Foucault 1977; see also Agamben 2009).

Clearly, then, we are referring here to a very different type of analytical frame than that elaborated by Beck in his initial conceptualization of the risk society thesis, and it is one that demands a focus on the constitution of things as risks and on the material consequences of this rendering within particular assemblages and in the context of particular forms of rule. As Dean (1999) argued, it is possible, when using governmentality as the lens through which to analyze risk, to “demonstrate that risk rationalities are not only multiple but heterogeneous and that practices for the government of risk are assembled from diverse elements and put together in different ways” (182). Two points are crucial here. First, we recognize that epidemiological risk is central to current conceptualizations of global health and that it represents the calculative basis on which the health status of a population is determined or rendered visible (Brown and Bell 2008). Further, it is increasingly on the basis of these factors of risk, what Osborne (1997) referred to as “surrogate values” (186), that public health interventions are put into place.

This leads us to our second point. There is an acknowledgment in some critical accounts of global health discourse that the risks to health and well-being around which global health assemblages cohere reflect the priorities of the global north rather than those of the global south. Elbe provided an illustration of why this is important, when he noted that interventions to secure populations against HIV/AIDS were justified when they appeared to serve the national interests of those seeking security (those in the global north) rather than those being secured against (those in the global south; Elbe 2005, 2006). It is, however, not simply in relation to the risk posed by epidemics of infectious diseases that this question arises. As several commentators have acknowledged, despite recognizing the threat posed by the globalizing of lifestyle diseases and especially the double burden of disease that it poses to the world’s most vulnerable populations, questions have been raised about the global commitment to tackle their causes (Beaglehole and Yach 2003; Yach et al. 2004; Marmot 2008).

Clearly, this suggests that we cannot interpret risk in terms of simple dichotomies; there is more than one at-risk population in operation here and they are affected by risk in different ways. This is an important point to acknowledge because risk is not a technology that remains static. It is adapted to or, in Foucault’s terms, fabricates, organizes, and plans the milieu within which it is operationalized and the specific problematic on which it is brought to bear. A second question is that although epidemiological risk renders visible a particular present and future problematic (O’Malley 1996), there is a material as well as subjective facet to this rendering process. Put differently, not only are some individuals more prone to particular diseases or states of being but the subjects of risk discourses stake claims of identity, entitlement (biological citizenship), and voice on the basis of their status (Rose and Novas 2005; Rose 2007).

Assembling Global Health

The discussion so far leaves open the question of the epistemologies through which we might reflexively
investigate, for example, the articulation between the constitution of risk and the global political economy (Farmer 2005; Global Health Watch 2005; Sparke 2009). Our use of the concept of assemblages is helpful here in highlighting the various actors and forces coming together within the milieu of late twentieth- and early twenty-first-century global capitalism and shaping the regulatory structures, social practices, and knowledge formations constituting global health. Our take on assemblage is purposefully syncretic, as we draw from a number of scholars who employ the concept (explicitly or not) to elicit the ethical complexities of new technologies and the “regimes of living” they help determine (Collier and Lakoff 2005; Ong and Collier 2005); highlight the productive frictions possible within the convergence of transnational, grassroots, and institutional forces (Tsing 2005); or track the unpredictable movements within networks (Latour 2005). To varying degrees for these scholars, tracing the interactions of highly diverse actors better elucidates the logic, contradictions, and negotiations within global processes; it also brings visibility to the role of nonhuman actors in changing the course of global practices. With few exceptions, however (cf. Nichter 2008), assemblages as a theoretical framework have been applied to examinations of environment, biosecurity, or technological deployment rather than in the investigation of global health. Often, attention to how complex networks interact also comes at the expense of retaining analytical sight of uneven power relations, making most global processes highly inequitable. We argue for a deployment of assemblages that addresses these gaps.

Returning to the differential actions of technologies of risk, although the milieu of global health is the globe itself, the spatial and political tensions between conditions of vulnerability (to infectious disease, obesity, smoking, cancer, etc.) and the rendering of securitization and governability take place within particular transnational circuits and regional locations. One practice helping to obscure these relations is the way the universal, as noted by Tsing (2005), has typically been produced within hegemonic regimes valorizing Western ideals and economies; it is a technique of obfuscation, as it works to suggest a commonality. Such hegemonic understandings of the universal or global commonly underlie high-level policy reports on globalization and health, placing in tension assumptions of universal practices of globalization with ascriptions of risk to particular populations. This tension then leads to what Lakoff and Collier (2008) called the “emergency modality of intervention” (17); that is, quick fixes aimed at shoring up, rather than extinguishing, risk.

An antidote to these problematic renderings is to look at the specificity of connections, as these reveal various interactions of multiple forces, technologies, agencies, actors, and power dynamics. As Ong and Collier (2005) suggested, assemblages are never “reducible to a single logic,” and they do not “always involve new forms, but forms that are shifting, in formation, or at stake” (12). Every situation brings with it its own different set of connections that are unpredictable in both their constitution as well as their outcome (Tsing 2005), yet not every component of an assemblage plays an equally important role. Latour’s (2005) notion of the intermediary versus the mediator is helpful here: The intermediary is “what transports meaning or force without transformation,” whereas “mediators transform, translate, distort, and modify” (39).

Influenza vaccines are a good illustration of how a focus on assemblage elucidates aspects of global health. During the H1N1 pandemic, egg shortages thwarted rapid development of vaccine serum, forcing questions concerning why laboratories were still dependent on outdated technologies when new genetically based methods are known to be quicker. The answer in part lay in high liability risks and low profits, generating little incentive for pharmaceutical companies to develop new technologies. The areas of the world most at risk of inadequate vaccine supplies, however, are those that lack legal capacity to negotiate contracts with, or afford sizable fees to, the few pharmaceutical companies producing flu vaccines—fees governed in large part by global regulatory mechanisms such as the World Trade Organization’s Trade Related Aspects of Intellectual Property (TRIPS). Within the context of regulatory regimes, legal negotiations, scientific parameters, pathogenic vicissitudes, and national financial capabilities, influenza vaccines become mediators changing the biopolitical terrain of influenza prevention and—in the event of a more virulent outbreak—survival (Craddock and Giles-Vernick 2010). As many have noted (cf. especially Hinchliffe and Bingham 2008), techniques of security actually end up rendering some populations more vulnerable, thereby ironically diminishing the efficacy of those techniques, no matter how robust. Yet these formations are in constant tension as well as emergence, as countries contest the terms of TRIPS, new organizations arise to respond to inequitable distribution, and philanthropic agencies underwrite the costs of better vaccine technologies.
Thus, embedded within the narratives as well as practices of intervention and security, yet belied in the declarations of universal vulnerability, is the fact that some people are profoundly more likely to be at risk of disease than others (Brown 2011). In other words, it is important to look not only at the ways in which practices of governability and security shape understandings of risk and their spatial contours: Equally trenchant is the recognition that these practices are a part of the broader network of global economic practices actually creating patterns of risk and disease burden.

Conclusion

The field of global health has emerged in large part as a response to the increased mobilities of populations, commodities, and pathogens associated with late twentieth- and early twenty-first-century globalization, yet the particular financial, regulatory, economic, and political structures determining these movements and the risks that result often remain in the margins of dominant global health imaginaries. A focus on mobilities but not the interrelations of their determinants consequently produces a turn toward securing countries and populations against a constant state of risk “emergence” (Cooper 2006). Whereas Cooper focused on the biological, we extend the analysis to include such risks as the global spread of obesity, cancer, or deaths from road accidents, as well as on the techniques utilized to secure against them. Too often, though, the technologies mobilized by governments, or even pharmaceutical companies, contain risk by “conducting conduct.” Containment is simultaneously about making particular risks visible through increasingly robust technologies of surveillance, which in turn produce definitions of vulnerable populations and their socio-geographic loci of intervention. What these techniques are, how they operate, and the geopolitical terrain informing them constitute a field of inquiry requiring more attention from geographers.

Furthermore, these same technologies obfuscate as much as they elucidate. Although health risks are made visible through ever more sophisticated scientific, communications, and biotechnological capabilities, these cannot be construed as neutral. Not only are some issues made visible through practices of security and medical discourse (AIDS, SARS, H1N1) whereas others are not (vitamin deficiency, domestic violence), vulnerable populations are themselves redefined in sometimes problematic ways through the production of statistics or the mapping of epidemiology onto geopolitical and historical understandings of behavior. Further, at-risk populations are themselves not entirely absent from this rendering process. As Rose (2007) has indicated, human beings are increasingly coming to understand themselves in somatic terms and as such play a crucial role in the framing both of themselves and the issues that affect them as global health concerns. Going beyond such fixes requires critical contextualization of the kind that we have begun to outline here.

Note

1. Here we borrow the title of a recent UK government report (HM Government 2008).

References


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