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Critical Approaches to Global Health

Alan Ingram

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Abstract and Keywords

This chapter places the critical analysis of global health in wider intellectual and political perspective, situating critical thinking in relation to the philosophical idea of Enlightenment and ensuing debates about the nature of power, knowledge, and freedom. After a brief genealogy of critical thought, the chapter considers some of the main sources of critical thinking in global health and provides a brief survey of critical takes on health in the era of globalisation. It then considers three influential varieties of critique—of political economy, of representation, and of biopower—while touching on other critical perspectives, including feminism and anticolonial thought. As a way of prompting further reflection, the concluding section of the chapter considers recent debates about the problems of the critical enterprise itself.

Keywords: critique, Enlightenment, political economy, biopower, representation

Introduction

What does it mean to approach global health critically? To address this question, this chapter situates the critical analysis of global health in a broader intellectual and political context. Its premise is that while some conception of critical thinking is inherent to the creation of any systematic knowledge about the world, thinking critically also means taking power and politics into account; to approach global health critically is to appreciate that any analysis of global health takes place in the midst of power relations, power struggles, and political events. This is not to say that the world and knowledge about it are entirely determined by the distribution and deployment of power, or that everything can be reduced to politics. A belief that ‘everything is political’ does not entail the idea that ‘politics is everything’. The point is rather that any attempt to understand

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the world (or more specifically, global health) without some awareness of how this enterprise is enabled, constrained, and oriented by power relations, power struggles, and political events will in some sense be uncritical and therefore lacking.

The chapter is itself critical in that it adopts a questioning approach towards the problem at hand and recognises that the question of what counts as a 'critical' approach to global health is contested and contestable. While recognising that some approaches have been influential and indeed formative for critical thinking on global health, it aims to prompt reflection about the meaning of criticality (or critique), as well as the possible stakes and pitfalls of being critical in particular ways. In pursuit of this goal, the chapter is organised in four main sections. The first section offers a brief genealogy of critical thinking in global health in relation to the European Enlightenment and critiques of it. The second section identifies three sources of critical thinking in global health. The third then considers in more detail some of the more influential critical approaches to global health, covering critiques of political economy, representation, and biopower. The fourth, concluding section offers some challenges for critical thinking in global health by considering debates on the fate of the critical enterprise itself.

A Brief Genealogy of Critical Thinking

The global health field as it exists today can be thought of as having emerged in the wake of the Enlightenment, the intellectual movement that developed in Europe in the seventeenth and eighteenth centuries. In broad terms, this movement sought the progressive elimination of suffering, want, and oppression and the enhancement of freedom via the application of reason and rationality to human affairs. Global health can therefore be understood as a critical project to the extent that it embodies these ideals. However, while it might appear to be self-evidently progressive, the Enlightenment project has itself come to be viewed much more critically in light of its apparent implication in the horrors of colonialism, two world wars, and the Cold War. As many thinkers have observed, the pursuit of progress through reason is tangled up with the exercise of power, and, as discussed in this chapter, the ostensibly progressive intentions characteristic of the global health field have themselves been subject to critical appraisal.

The work of Immanuel Kant is fundamental to the Enlightenment understanding of critical thinking. As Kant wrote in a footnote in the preface to the first edition of the *Critique of Pure Reason* ([1781] 1933, 9, note a): 'Our age is, in especial degree, the age of criticism, and to criticism everything must submit. Religion through its sanctity, and law-giving through its majesty, may seek to exempt themselves from it. But then they awaken just suspicion, and cannot claim the sincere respect which reason accords only to that which has been able to sustain the test of free and open examination'.

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For Kant, criticism meant subjecting matters to systematic questioning and reasoning in an open and public way; any authority that claims exemption from such scrutiny is thereby not worthy of 'sincere respect'. Critical thinking can thus be thought of as being fundamental to both modern scientific activity and modern ideas of rights, democracy, freedom, and the public sphere. In the essay *What Is Enlightenment*, Kant ([1784] 2009, 1) urged, '*Sapere aude!*': dare to know! Enlightenment is the emergence from dependence on authority, achieved through the exercise of systematic, rigorous, and reflective thought and inquiry.

Though such ideas might seem to be self-evidently progressive, the scope and implications of the Enlightenment have always been contested. While the import of Enlightenment ideals is ostensibly universal, many European thinkers held that freedom and equality could only be extended to sufficiently capable and responsible subjects, who were invariably understood to be property-owning men of Western European heritage. Liberal thinkers often thought that 'civilised' and 'uncivilised' populations would have to be governed in fundamentally different ways: while the civilised could exercise reason, freedom, and equality in a responsible way, paternalistic or harsh measures would always be required for others, whose best interests would be decided for them (Duffield 2007).

To what extent are the critical ideals of the Enlightenment universal, or universalisable, then? This is a significant question for a field that calls itself *global* health. For many anticolonial thinkers, the Enlightenment is fundamentally compromised by its historical association with European domination. For Frantz Fanon ([1963] 1991), a trained psychiatrist and theorist of anticolonial revolution, rationality was always on the side of the colonisers; by comparison the colonised would always be seen as fundamentally different and inferior. Feminist thinkers since Mary Wollstonecraft ([1792] 1992) have questioned the masculine bias of European critical thought, while socialist thinkers before Karl Marx and since have questioned whether true knowledge or freedom is possible within a capitalist system. At the same time, such critiques have often themselves been advanced via rational argument and debate and in the name of universal ideals (Israel 2001).

While framed by Enlightenment ideals, the global health field can be thought of more specifically as having inherited what anthropologist Tanya Murray Li (2007) has called the 'will to improve'. As Li argues, 'improvement' has frequently, if not invariably, meant actions taken by some people to ameliorate the lot of others, a process that involves values (which may not be shared) and which is necessarily relational (because it implies distinct roles of knowers and known, improvers and improved). Improvement is thus fraught with issues of control: Who sets the agenda and who is in charge of implementation? The relational dynamic between improvers and those-to-be-improved, Li suggests, began in the colonial era but endures in contemporary development and humanitarianism and is liable to affect any project, regardless of the intentions of the improvers. No matter how benevolent these might be, Li argues, problems arise when improvement is led by outsiders. The idea that such problems can be avoided via

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participation and partnership has itself been subject to critical appraisal: How meaningful can such processes be across huge gaps in wealth, knowledge and power (Cooke and Kothari 2001)?

If today's ideas of improvement are descended from the colonial period, they were reshaped during the Cold War and decolonisation. While the Western and Soviet blocs advanced distinct models of health and development based on their respective systems and ideologies, the non-aligned movement tried to develop alternative paths. Ensuing struggles affected the workings of the World Health Organization (WHO) and other United Nations (UN) bodies and pervaded health policy debates, for example that surrounding the primary healthcare movement that was launched at a meeting in Alma-Ata in the Soviet republic of Kazakhstan in 1977 (Lee 2009). Consider also the efforts by the post-revolutionary Cuban state to project its influence by exporting doctors and nurses as well as soldiers across the 'Third World' (Kirk 2015). Western states likewise often saw the provision of healthcare as a way of projecting influence and developing political relationships in an ostensibly non-political way.

The project of improvement also flourished within individual nation-states, especially in the political context of decolonisation following the end of World War II. Competing national projects across 'first', 'second', and 'third' worlds sought to link health programmes with competing ideas of identity, progress, and modernity, which were sometimes also associated with regional identities like pan-Africanism, pan-Arabism, and pan-Americanism. Ideas of national and regional identity combined with distinct ideas of gender and household structure: to be a healthy citizen of a nation invariably meant contributing to its growth, development, and flourishing in particular ways, for example by giving birth to a certain number of children and raising them in line with ideas of the public good. Ideas about health were therefore fundamental to ideologies of development, and the extent of a country's success in, for example, vaccination programmes, extending public infrastructure, or improving nutrition and education came to be seen as indicators of political success.

Today's global health field has emerged in large part out of the crisis of these models of health, development, and progress, and amidst the growing influence of 'neo-liberal' ideas and policies, according to which state and society ought to be re-engineered in terms of private economic interests (Harvey 2005). Emerging during the 1970s, these ideas have increasingly affected health and health policy around the world. In 1982 interest rate increases by banks based in the global North triggered debt crises across many countries that had borrowed to finance development in the 1960s and 1970s. In return for bailing them out, the International Monetary Fund (IMF) and World Bank, backed by governments in the global North, sought to shrink the public sector and expand the private.

Public health services were defunded; across much of sub-Saharan Africa, Latin America, and South Asia, and with increasing speed across post-communist countries after 1989, many standard indicators of health and development went into reverse. 'Old' diseases like

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cholera, malaria, and tuberculosis made a comeback, and 'new' diseases, most notably HIV, emerged, in a world that was becoming ever more connected. The models credited with producing health and wealth for some seemed to entail the opposite for others.

In this context, the idea that health had to be understood in 'global' rather than 'international' terms began to gain ground among policy communities as well as academics (Brown, Cueto, and Fee 2006). Influential here was the work of journalist Laurie Garrett (1995, 2000), who diagnosed the global health problems of the 1990s primarily in terms of a lack of political awareness and responsibility. Focusing on the problem of emerging infectious diseases, she argued that governments and political leaders had largely failed to give health issues adequate priority and had failed in their duty to ensure the provision of adequate health infrastructures and services. In light of globalisation, policymakers had to give new priority to health and ought to consider it a security issue alongside defence and strategic policy. Though telling, Garrett's account remained rather circumscribed in terms of its analysis of power and politics. A contrast can be drawn with the work of anthropologist and physician Paul Farmer (1999, 2003), which illustrates more fully what critical thinking in global health has come to mean. For Farmer, the policy shifts of the 1980s and 1990s emerged from, and served to exacerbate, long-term, deep-seated patterns of racial oppression, political disempowerment, and economic disenfranchisement. Here Farmer's work is exemplary in challenging narrow framings of global health problems and advancing fundamental criticism of the social, economic, cultural, and political relationships in the midst of which they emerge.

Critical Thinking in Global Health

Where does the impetus for critical thinking in global health come from? On one level we can again refer to Enlightenment ideals of improvement, freedom, and justice. But we can also think a bit more deeply about how critical thought emerges out of epidemiological events and the expertise they engender, out of distinct epistemic or research communities, and out of social and political struggles.

First, critical thinking is occasioned by the attempt to make sense of disruptive epidemiological events. Historians and philosophers (e.g., Latour 1988; Foucault 2007) have considered the processes whereby, in the modern period, epidemics have driven innovation and experimentation in economic and political thought as well as medicine and public health. An important example of this in recent history is the way in which HIV epidemics around the world gave rise to new fields of scientific inquiry and debate, beginning with the race to characterise HIV and to develop new treatments and interventions, a process that has carried with it profound social, cultural, and political implications and ramifications (Piot 2015). Research into pandemic influenza has similarly given rise to wide-ranging and hotly contested debates about appropriate surveillance and response mechanisms and over vaccines and antiviral medications should be developed and distributed (Fidler 2010). As these examples indicate, the social, cultural, and political reception of an epidemiological event as an event is shaped by contending forms of expert knowledge, which can transform the ways in which something is understood as being a health problem and an epidemic in need of response. A particularly clear example of this is the way in which tobacco came to be framed as a public health issue, a process that involved a wholesale redefinition of smoking as a problem and tobacco companies and governments as responsible actors (Collin, Lee, and Bissell 2002). Events are thus not entirely straightforward: our sense of events as events depends to some extent on the forms of knowledge and expertise that frame them.

Second, critical approaches to global health have emerged in particular epistemic communities—that is, within specific networks of research, critique, and debate that have tended to construct knowledge in particular ways. The disciplinary tradition of anthropology, for example, tends to emphasise the importance of everyday, non-elite knowledge, whereas the field of international relations has traditionally focused on how actions and agendas on a global scale are shaped by states and other institutions. Much knowledge is generated within, or in close proximity to, policymaking bodies, such as research by the World Bank that helped to redefine tobacco as an economic as well as health problem (World Bank 1999; Shibuya et al. 2003), but sometimes thinking is more closely connected with social movements, such as the access to medicines (ATM) movement (Smith and Siplon 2006). Some strands of research are more heuristic and others more theoretical; some are more applied and others more reflective. The body of critical thinking on global health also to some extent reflects the geography of knowledge production more generally, in often being centred around global North languages,

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theories, and institutions. However, none of these communities is entirely hermetic, and the formation of coalitions across epistemic communities, as in the case of the anti-tobacco movement and AIDS activism, can itself be understood as a source of new critical perspectives that can influence global health thinking, policy, and practice.

Third, some of the main critical approaches that have been brought to bear on global health have been forged in the context of broader social and political struggles, while struggles over global health have themselves also engendered new thinking. As we have seen, the critical philosophy of the Enlightenment emerged in part as a struggle against religious and monarchical authority; similarly, critical theories of economics were shaped by the struggles of working people, feminist theories emerged from struggles against patriarchy, and critical theories of race came from anti-racist struggles. One locus of particular importance for the social sciences and humanities in the global North has been the intense intellectual, social, cultural, and political ferment of the late 1960s and early 1970s, which saw the emergence of 'new' social movements associated with identity, gender, sexuality, human rights, and the environment, as well as the rethinking of 'old' movements centred on critiques of capitalism, colonialism, and militarism. This period also saw significant shifts in the theory and practice of development and humanitarianism, while the debt and financial crises of the 1980s and 1990s and struggles over the AIDS crisis each produced distinct episodes of concentrated critical thought. Critical approaches to global health are not purely theoretical exercises, then, but emerge out of messy collisions among epidemiological events, scientific debates, and broader social and political struggles, which their proponents are in turn often attempting to influence.

Varieties of Critique

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It is further possible to disentangle different varieties of critique in global health. At one level we can identify critique as an inherent facet of intellectual inquiry, in that it means subjecting any account of the world to systematic questioning and scrutiny. Many studies use analytical tools to scrutinise how power, politics, and policy affect both health outcomes worldwide and the institutional field of global health governance. One influential reference point has been the 'health policy triangle' advanced by Gill Walt and Lucy Gilson (1994), which enables analysts to unpack instances of health policymaking in terms of the contexts, actors, and processes at work, then to identify different kinds of power that may be in play in a given situation (Gilson et al. 2008). Such heuristic (or descriptive-interpretive) approaches are useful in that they can quickly enable people to begin thinking about power and influence in global health, while indicating where further investigation might be useful.

A further example of systematic, questioning analysis is the work of David Fidler (e.g., 2008, 2010) on the politics of epidemics, global health diplomacy, and global health security. Fidler's work shows how, despite attempts to build global health surveillance and response systems to deal with emerging infectious diseases since the 1990s, the politics of epidemic response has still been strongly driven by how the more powerful states in the global North define and pursue their national security interests. In the midst of the H1N1 pandemic of 2009, the richer and more powerful states, prioritising the protection of their own populations, were able to effectively monopolise the antiviral drug and vaccine supply until concerns about the event had abated (Fidler 2010). By putting together a timeline of the event, Fidler questions and qualifies statements by states to the effect that they were committed to global cooperation and sharing of resources, in effect holding them to public account. In conceptual terms this work implicitly brings a 'realist' approach to bear on the international politics of health, whereby the workings of global health are shown to be primarily still driven at the state level, by material interests and by concerns about exercising sovereignty, or ultimate decision-making, in a given situation. This analysis suggests that revision is needed of earlier views of global health as having made the transition to a new, more enlightened form of governance appropriate to the global era. Fidler's work thus points to the limits of progress and to how deeply rooted political factors continue to influence what is possible in global health.

We can also identify more self-consciously critical varieties of thought, such as 'Critical Theory'. This term properly refers to a specific form of analysis developed by the influential post-war 'Frankfurt School' of social analysis but is also often employed (without the capital letters) to include theories claiming allegiance with social movements seeking emancipation or freedom from domination. The Frankfurt School developed a form of Marxist analysis that was critical of capitalism but also of the state communism maintained by the Soviet Union and its allies, and further embodied a critical stance towards the Enlightenment itself. Its leading theorists, Theodor Adorno and Max Horkheimer ([1947] 1997), argued that the Enlightenment had to be rethought in quite fundamental ways after World War II and the Holocaust, but also in light of what they saw as the banality of Western culture and institutional life. As they saw it, the progressive rationalisation of human affairs according to science and reason necessarily resulted in

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disenchantment and barbarism. These downsides were not external to Enlightenment rationality but were produced by it, as they thought, 'dialectically'. Ideas and ideologies of freedom, progress, and improvement could not therefore be taken at face value and had to be subject to continual critical scrutiny. Critical theory has played a significant role in global health debates since the 1990s, and in the following I trace its influence as well as ensuing debates and developments in three stages.

The Critique of Political Economy

During the 1980s and 1990s neo-liberal theorists tended to promise and predict that their version of globalisation would spread prosperity, reduce conflict, and enhance health, while any downsides would be due to faulty or partial implementation rather than the theories themselves (for an expression of this see Feachem 2001). By contrast, more critical analyses insisted that these downsides were indeed inherent to 'neo-liberalisation' (Navarro 2007). A central task of critical analysis here has been to expose what is held to be the ideological (i.e., false and biased) nature of dominant ideas.

The thought of the Italian communist Antonio Gramsci has been influential in this regard. Gramsci (1971) analysed the political situation of early twentieth-century Italy and came to the conclusion that part of the reason that communist revolutions had not been successful was that certain sectors of society that might have been expected to rally to the communist cause had embraced ideas that ultimately served the capitalist class. Dominant sectors of society had insulated themselves politically by propagating capital-friendly ideas throughout society, in culture as well as in politics and economics, endowing an unequal society with undeserved legitimacy. The continuation of capitalism was thus secured not just by coercion but also by the production of consent. This could be achieved by establishing certain patterns of thought as unquestionable 'common sense'. The struggle for a better society would accordingly include the attempt to shift common sense to a position friendly towards what was held to be genuine social progress. The battle of ideas was as important as practical organisation, and if revolution was not possible, it was still important to fight to establish an understanding of the situation that was correct from a critical point of view. This would enhance the prospects for revolutionary change should the political situation shift.

This background enables us to understand why many critical theorists considered neo-liberal ideas of globalisation to have become 'hegemonic'—that is, to have achieved the status of 'common sense', from which all (or most) would benefit and only the deluded or deficient would dissent. A large part of critical global health analysis during the 1990s and since (e.g., Thomas and Weber 2004; Navarro 2007) has accordingly been concerned to expose and challenge these ideas by showing how neo-liberal policies have been implicated in health crises and how this has stemmed from the dominant role played by the IMF, World Bank, and World Trade Organization (WTO) in global health policy. Much critical global health analysis has therefore been engaged in what Marx (1859) called the 'critique of political economy', of dominant ideas of politics and economics. Some analysts

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have further linked this critique with others, for example, linking feminist and political-economic critiques of international responses to HIV/AIDS (O'Manique 2005) or interpreting new epidemic alert and response systems as in some sense neocolonial, to the extent that they involve the projection of ideas and technologies developed in the global North into other areas of the world (Weir and Mykhalovskiy 2007). Such critiques promote ideas of emancipation from domination and typically call for more democratic structures and processes within global politics.

If Critical Theory approaches to global health gained ground amidst the struggles of the 1990s, the theoretical landscape has to some extent shifted since then in tandem with changes in the global health field. Around the year 2000, a combination of social movement mobilisations, critical academic analysis, and scientific and political alarm contributed to major shifts in global health governance. Donor states began to pledge increasing amounts of overseas development aid (ODA) for health (albeit targeted towards a highly selective range of problems). After having been largely sidelined in the 1980s, WHO assumed a more active and political role in global health policy debates under Gro Harlem Brundtland. A broader range of corporate and civil society actors began to get involved in global health, often but not exclusively around the response to HIV/AIDS. And new institutional forms, such as the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (the Global Fund), were created. Such 'global health partnerships' typically assembled some mix of government, corporate, civil society, and academic actors to work together in new ways to find solutions to global health problems. Global health problems were being addressed, or 'governed', in apparently novel ways.

The implications of these developments have been the subject of extensive critical debate. On the one hand, for example, new philanthropic initiatives seemed to offset the case made during the 1990s that the rich and powerful had abandoned responsibility for those less fortunate. But while some new money has been allocated to global health and development, and a degree of progress has been achieved in certain areas such as the responses to HIV and malaria, the kinds of global health interventions that have emerged since 2000 carry ambiguous implications. In terms of critical theory, the key question is whether these new developments represent a radical transformation of global health or incremental (or even possibly counterproductive) reform.

Debating Product (RED)

Many of the issues surrounding the new global health initiatives that emerged during the 2000s were crystallised in a debate concerning the implications of the (RED) project, an initiative led by celebrities and large corporations to generate revenue for the Global Fund, a new but controversial funding mechanism created in 2001. (RED) has contributed hundreds of millions of dollars to the Global Fund, but this is only a small percentage of its multi-billion-dollar programme, which is largely funded by governments, and which is in turn only a percentage of what is needed to address HIV in full.

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What, then, is the significance of (RED)? In a critical analysis, Colleen O'Manique and Ron Labonte (2005) effectively argued that its real significance was ideological, in that it seemed to demonstrate that corporations and consumerism could help to solve global health problems. They suggested that large corporations, many of which had been criticised for unethical and exploitative practices during the 1990s, were effectively using the initiative to project an image that was contrary to reality: rather than being part of the solution, such corporations were drivers of a form of neo-liberal globalisation that was in fact inimical to global health. The real effect of (RED) was thus to perpetuate an existing state of affairs and block the formation of critical awareness. Responding to this critique, Jeremy Youde (2009) argued that rather than preventing people from forming an appropriate critical understanding of the role of corporations in global health, (RED) might actually form an entry point for greater awareness and participation, while generating additional resources that global health activists could ill afford to disdain.

This exchange can be placed more broadly in the context of critical takes on 'philanthrocapitalism', 'charitainment', and 'celebrity colonialism' (see the chapter in this volume by Youde), each of which, critics have argued, is a shallow, ideologically laden, and limited response to profound structural problems in the way the world works. If critical theories tell us that capitalism and colonialism continue to influence the world in deep, consequential, and harmful ways, so the critical reasoning goes, only deep and radical change will suffice to address the problem; furthermore, this cannot be delivered by entities that have a vested interest in maintaining the existing state of affairs. While philanthropic ventures have dramatically altered the global health landscape in the last couple of decades, a critical theory take might suggest that this has come about by focusing on technical interventions rather than on political or structural change; by substituting private, discretionary decision-making for public, democratic accountability; and by validating corporate domination of the global economy so long as the wealth it generates is later given away. While noting the real benefits to people of philanthropic giving, from a critical theory perspective this would nevertheless amount to an adjustment or even entrenchment of a global order that is still fundamentally unjust.

The Critique of Representation

While such debates have been taking place, research has also explored how global health politics is shaped by what has been called the politics of representation. The argument is that how people represent the world to themselves and each other has important consequences for what happens in the world. A central point here is that prejudicial stereotypes about other people and places help to make and sustain unequal power relationships; our ideas and images of the world do not simply reflect a pre-existing, material reality, but help to bring that reality about. This line of thinking also implies a potential remedy: perhaps we can change the world by representing it differently. A clear example of this is work towards the destigmatisation of people living with HIV, to which the effort to shift language and imagery has been central.

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This line of thinking has been particularly influential in international relations (IR) work on global health, which has examined what IR theorists call 'securitisation' (Buzan et al 1998; Balzacq 2011). The underlying thrust of securitisation theory is that saying something is 'a security issue' is more than a description; it also sounds the alarm and calls for action. Because governments consider security their overriding priority, so the reasoning goes, getting a problem recognised as a 'security issue' can lead to its increased prioritisation. The clearest example of this seeming to work is in relation to HIV/AIDS, which the US government and the United Nations accepted as a security issue around the year 2000, thereby adding force to international responses (Elbe 2006, 2010; McInnes and Rushton 2010). Securitisation theory counts as a critical theory in three ways. First, it helps us to think about power and politics: for a securitising speech act to be successful, it must be made by a figure with authority; that is, the security 'speech act' requires some form of political power in order to be successful. Second, it encourages reflection on the potential downsides of political 'success': securitisation theorists highlight that there are many dangers to invoking 'security', especially where this leads to normal political processes being suspended or bypassed (theorists have also debated how far the theory applies in situations where exceptional powers are the norm). Third, securitisation theory reminds us that just changing our representations is not enough on its own; we need to think about how language connects to other forms of power.

The Critique of Biopower

As the purchase of communist ideas on world politics was eroded during the 1990s and 2000s, the idea that a broadly Marxist account of the world could, more or less directly, inform the practice of socialist and revolutionary movements to create a better world was intensely questioned across the political and intellectual Right and Left. There are many strands to this debate, but two are particularly relevant here. One is that the major 'Critical' theories have had a narrow view of what counts as politics (social movements enacting revolutions or taking control of the state); the other is that such theories, in claiming privileged insight into how the world works and how it should change, have themselves become undemocratic, lapsing into a kind of policing exercise over what 'criticality' 'really' means. Conversely, theorists tagged as being 'post-critical' have been criticised for failing to confront domination in a direct enough way and have thereby been held to be complicit with it.

A central figure in these debates has been Michel Foucault, a French thinker who challenged disciplinary boundaries (he might be considered variously as a historian, a philosopher, an ethicist, or a political theorist) and who has become the most influential and most debated critical intellectual of the last forty years. He is important to consider here first because he saw himself as revisiting and critically extending Kant's idea of Enlightenment (Foucault 2000) and second because health and disease were central to his seminal idea of 'biopower' (Foucault 2007). Foucault argued that while Marxist thinkers had become overly preoccupied with the economic determinants of politics, political theory was fixated on the figure of the sovereign ruler who commanded the state. What they both missed, he suggested, was biopower: the means whereby the management of living things became the object of political strategy, or 'governmentality'. Foucault argued that power was exercised not only through sovereign power or by controlling the means of production, but also by myriad techniques for managing individuals, groups, and populations. Biopower was at work in the training of soldiers, the reform of prisoners, and the enhancement of worker productivity; in the management of food shortages, epidemics, and crime; and in architecture and urban design. While the centralised sovereign power of the state could be brought to bear in times of war or to colonise other people and places, biopower often appeared as a positive force, concerned with the enhancement of human potential and exercising control in subtle and indirect ways.

Foucault's thought has been politically controversial on the left because of his emphasis on the dispersed nature of power and hence the importance of local struggles, rather than centralised political movements aimed at taking control of the state or overthrowing capitalism. He also expressed a certain modesty about his work, encouraging others to view it as offering tools that they might or might not take up or adapt in their own struggles, rather than, as some Marxists claimed, a 'scientific' route map to universal human emancipation. Other controversial aspects of his work include his interpretation of truth as a political construct; while some people struggling for liberation and equality

have found such thinking enabling, others are concerned that if fundamental ethical and political ideas are seen as malleable, this leaves no solid ground upon which to stand and make claims. Foucault's influence on critical approaches to global health is evident in the widespread use of his concepts—including biopolitics, discipline, and governmentality—across disciplinary fields, including history (Bashford 2006), anthropology (Zigon 2010), international relations (Elbe 2005), sociology (Kenny 2015), and geography (Brown, Craddock, and Ingram 2012). Indeed, the emergence of the interdisciplinary field of critical global health studies is in significant measure attributable to the influence of his ideas.

The Stakes of Critique

This concluding section considers the relevance of ongoing debates on the wider stakes of critique for the field of global health, thereby offering reference points for further reflection. One criticism of critical theory is that it is always seeking to unveil, reveal, or expose something that we supposedly cannot otherwise perceive. A useful starting point here is the philosopher Paul Ricoeur's (1970, 33) description of Marx, Friedrich Nietzsche, and Sigmund Freud as 'masters of suspicion'. As Ricoeur observes, while they advanced very different ideas, each of these thinkers proposed to expose what he saw as the false nature of consciousness and to reveal how our sense of the world is actually determined by something else, whether this be (respectively) the mode of production, the will to power, or the unconscious. According to these theorists, our understanding of the world and ourselves is always false and needs to be exposed as such in order for real understanding and emancipation to become possible. A simplified parallel of this narrative in global health might be the (in critical terms, ideologically misled) consumer who buys a (RED) iPod, incorrectly believing themselves to be helping to end the AIDS epidemic. If consumers could only break the 'commodity fetish' and gain *critical* knowledge and awareness (e.g., that concerted governmental action is a primary solution and that corporations should be taxed and regulated rather than celebrated and empowered), they might then be in a position to transform themselves and the world.

The literary theorist Rita Felski uses Ricoeur's idea of suspicion as a starting point for enumerating the main elements of critique as an academic activity. As she notes, 'critique is negative': 'To engage in critique is to grapple with the oversights, omissions, contradictions, insufficiencies or evasions in the object one is analysing' (Felski 2012). Critique is therefore secondary to the thing that is being critiqued; it is also a second order or meta-level activity and thus, it would seem, inherently 'intellectual'. A further aspect of critique is its relationship to politics: the academic critic may ally with social movements but typically maintains a certain distance from them and reserves the right to adopt a critical stance towards any particular political manifestation of the critical

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project. Critique is also inescapable in that within the critical universe there are no (desirable) alternatives to it; if one is not critical, one can only be uncritical (a bad thing).

For Kant, critique offered a means of creating knowledge independent of religious and governmental authorities and of submitting their claims to the test of reason. For the Frankfurt School, the critical attitude was a kind of least-worst option in a world where the promise of the Enlightenment had given rise to disenchantment and barbarism. And for many theorists, critical theory promises a way to diagnose the problems of the world but also a route map or toolkit for fixing them. However, some thinkers have in recent years suggested that the critical project has itself run into deep problems. The philosopher Jacques Rancière (2009), for example, has written about what he calls the 'misadventures of critical thought' with particular reference to the French intellectual and political scene. He has argued that ordinary people do not need 'critical' intellectuals to explain the nature of their domination to them. Critical understandings of the world are widely shared, and 'critique' has become a self-serving and self-referential genre, with hackneyed dramas of exposure, revelation, and enlightenment standing in for actual, progressive change. In a somewhat related vein, Bruno Latour (2004), another French intellectual, has suggested that critique has 'run out of steam'. Critical theory, Latour argues, has become a predictable schema that one can apply to any situation to produce reliable results, with the added bonus of placing the critic in the central, heroic role of 'unveiling' and 'challenging' oppression.

What particularly concerns Latour, however, is the way in which deconstructive approaches to science and truth of the kind he pioneered have apparently been turned against climate science by those hostile to its findings. If politicians and commentators have condemned critical academics for their relativistic approach to truth as in some sense fabricated, they have also realised that this schema can be applied to relativise the work of academics themselves: 'climate change' research could be portrayed as a self-interested industry; similarly, in global health 'anticolonial' politicians have dismissed antiretroviral therapies as a 'neocolonial' ruse. In the wake of critical theory, Latour suggests, the fostering of doubt, scepticism, and suspicion has become a political technique in the service of vested interests, with dangerous consequences.

Where does this leave us, if all knowledge can be dismissed as a product of bad faith and self-interest? Latour's answer is that academic communities need to realise that they are in a war over knowledge and to take on the challenge of demonstrating that some accounts of the world are indeed better than others. This idea will be far from surprising for many working in the global health field, who have first-hand insight into how to wage such wars (critical thinkers have debated whether the war metaphor is a good one; Bleakley 2017). Latour and Rancière have furthermore been criticised for what is seen as the superficiality of their analysis (Wark 2017; Foster 2012, respectively). The question of what makes an approach 'critical' therefore turns out to have profound implications for global health politics and research. What is at stake is, first, our understanding of the nature of reality (ontology); second, the means whereby we can generate effective knowledge of that reality (epistemology); and third, what we would do on the basis of that

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knowledge (practice, or, to use the critical philosophical term, praxis). To approach global health critically means taking on such issues in light of the developments, struggles, and debates considered here.

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Alan Ingram

Alan Ingram, University College London

