

Chapter 1

Introduction

Introduction

The task of introducing a book such as this is not inconsiderable, especially as it has been co-authored by scholars who place themselves very differently within, and in some cases without, the field of health geography. We should be clear about this latter point right from the outset. This text is a critical introduction to health geographies – deliberately presented in the plural rather than the singular form – and it is written by scholars with different and sometimes quite jarring epistemological perspectives and ontological positions. Like many of our contemporaries, we do not see health geography as a single field of study and how we each approach the question of health differs considerably. Moreover, some of us are less concerned with health as an object of investigation than we are with subjects that appear to fit a little more comfortably under the rubric of medical, or perhaps more appropriately biomedical, geography. For example, there is as much focus on disease and biomedicine in this textbook as there is on questions of health and health care. In practice, then, this book works across disciplinary and sub-disciplinary boundaries that have been established by those writing within the field (e.g. Kearns 1993; Mayer and Meade 1994; Kearns and Moon 2002; Rosenberg 2016) but perhaps tend to overlook what is going on outside of it (e.g. Parr 2004; Philo 2000, 2007; Dorn et al. 2010).

As a second point of introduction we should also say a little about why we targeted our ideas for this book at the Wiley-Blackwell *Critical Introductions to Geography* series. You will be aware that there are numerous textbooks covering the field of health geography, from Kelvyn Jones' and Graham Moon's (1987) classic *Health, Disease and Society: An Introduction to Medical Geography* to more recent, and sometimes a little more specialist, texts such as Robin Kearns' and Wilbert Gesler's (2002) *Culture, Place and Health*, Sarah Curtis' (2004) *Health and Inequality*, Anthony Gatrell's and Susan Elliott's (2009) *Geographies of Health: An Introduction* and Peter Anthamatten's and Helen Hazen's (2011) *An Introduction*

to the *Geography of Health*. To these texts on health geography, we might also add Melinda Meade's various editions of *Medical Geography* (e.g. Meade and Emch 2010). Each of these books offers their readership invaluable insights into the field, however we were struck by the idea that the Wiley-Blackwell series is committed to providing 'broad and introductory' textbooks with a 'critical edge'. It was the emphasis placed upon criticality that was especially important to us and we believe should be important to you as readers. Here, it is not only a matter of how criticality is defined by us but how this commitment to criticality should shape the ways in which you approach this text. We will deal with the former of these points in the section that follows, but as readers we encourage you to examine the evidence that we present and consider the theoretical influences upon it. Be sure to interrogate the interpretations that we offer and to reflect on possible alternatives to them; think, for example, about what is present and what is absent in our readings of the field. Ask yourselves how persuaded you are by the arguments and opinions that we present and the conclusions that we draw. In sum, you should be aware that we have made decisions in our research and writing and we encourage you as readers and potential future authors to enter into academic debate with us.

A Critical Introduction to Health Geography?

If we take a fairly straightforward view of what health geography is concerned with, we might suggest that it questions how the interaction of humans, materials and the environment shapes and constrains health, wellbeing, survival and flourishing. At the heart of this interaction are complex social, economic and political issues which can complicate and extend conventional debates about health. An examination of these issues and how they affect people around the world, often very differently, can unearth a myriad of health costs and benefits. For example, rising conflict in the Middle East has been quickly followed by outbreaks of polio, which has re-emerged because efforts to immunise children are being hampered (Blua 2013). Meanwhile, more than 5 billion people worldwide now have a cell phone, leading to a number of efforts to use mobile technology to revolutionise the way medical care and health information are delivered, particularly in the rich countries of the Global North (Hampton 2012). In each case, health is entangled with complex ethical, social and political concerns over the autonomy, control and care of humans. These are concerns that demand critical health geographers engage with ideas, debates and perspectives from outside of their direct fields of interest. Equally our response to them ensures that we contribute to knowledge and understanding of a multitude of health and biomedical issues that is interdisciplinary in nature.

So health geography is a broad field of enquiry, as this book amply demonstrates. Yet, we agree with Robin Kearns and Damian Collins (2010) when they state that at the core of the sub-discipline lies, or at least should lie, a concern for social justice. This is as good a place to start as any when considering the question of what a critical introduction to health geography might entail. This concept evolved from foundational principles associated with the 'social contract' (for a full history of this concept, see Rawls 1971). The social contract is the recognition that individuals have rights such as dignity and autonomy with which the state cannot unduly interfere. Individuals allow the state to rule only through laws which, at least in theory, pursue the principles of freedom and equality. This 'pact' allows society to function as a whole and gives legitimacy to the authority of the state over the individual. Of course, since these early foundational principles, different interpretative theories of social

justice have developed which sit on top of the foundational principles. Governments have tended to have either a 'right' (liberal) or 'left' (social democratic) political understanding of the social contract. On the right, governments tend to interpret the social contract to mean the minimum possible role of the state: individuals should be completely untethered to pursue their own ends. The state is despised as a wasteful villain that obstructs the self-equilibrating market system. The corollary is that the state provides minimum protections to those who 'fall between the cracks'. On the left, governments tend to interpret the social contract to mean the state should provide a more supportive role and protect against the more self-destructive forces of the capitalist system.

When considering this question, critical health geographers must therefore be cognisant of the underlying political philosophies of the state as they can have significant effects on the health of individuals. A value judgement can be made about the social justice element of particular policies and their impacts on certain individuals, groups or even the population as a whole. For example, Danny Dorling's (2014) geographic work in the United Kingdom has mapped the health and distribution of wealth of its citizens and argues that as a result of the British state's commitment to neoliberal policy, including the more recent politics of 'austerity', the mere accident of being born outside the nation's wealthiest 1 per cent will have a dramatic impact on the rest of your life: it will reduce your life expectancy, as well as educational and work prospects, and affect your mental health. To Dorling's voice we can add that of Clare Bamba who, in her work with Ted Shrecker, recently argued that there are clear parallels between the health effects of neoliberalism and the 'unfettered liberal capitalism of the 19th century' (Shrecker and Bamba 2015, p. 17). Specifically, they argue that now as then the conditions in which people live, work and play are vital in determining how long and in what state of health people live.

Collectively, this work serves as a useful example of how to be 'critical'. The value judgements presented by all of these scholars are drawn from thoroughly-researched, empirical findings. Based upon their generally realist epistemological positions, Dorling and Bamba recognise *what* evidence is essential to validate their argument as well as *how much* evidence is needed to support their conclusions. However, an important caveat here is that to be critical, one should remain equally alert to the nature of evidence itself. For example, the idea of evidence-based health care (EBHC) has quickly become a global priority. Yet, the wide-ranging critique of EBHC highlights that, although it is appropriate that the best health care is provided in the best known ways, EBHC goes far beyond this objective, becoming a powerful movement in itself that espouses a dominant scientific worldview that selectively legitimises and includes certain forms of knowledge but degrades and excludes other forms, such as qualitative ones. Critical health researchers argue that, in response, a critique is necessary for deconstructing this mode of thinking, and that resistance is ethically necessary given the powerful forces in play (Holmes et al. 2007).

Another way of thinking about the criticality of this work is to focus on the philosophical and social theoretical perspectives that it draws upon. As Hester Parr (2004) argued some time ago now, critical geography is, among other of its key aspects, broadly defined as research work that is relevant, interdisciplinary, cutting edge and theoretically sophisticated. While Dorling's and Bamba's work does not necessarily pay too much attention to some of the other characteristics of critical geography that Parr outlined (notably those that relate to the 'theoretical gymnastics' that we might associate with the 'cultural turn'), it can be argued to mirror these other elements. For example, Dorling implicitly draws on the Marxist philosophy of unequal ownership of wealth to help make sense of his empirical observations and provide new ways of understanding the complex matters of health, wealth

and illness. Similarly, Shrecker and Bamba offer an account of contemporary health and health care that demands we pay close attention to the neoliberal political philosophy that underpins many of the policy decisions that are made around the world today. Being able to theoretically (re)interpret research is an important way of making sense of empirical observations, as it allows us to disentangle and articulate some of the underlying meanings and processes involved. We may not all agree with the particular theoretical and for that matter political perspectives that we encounter but it is important to recognise that academics use theory to frame how they see the world and as critical health geographers we need to question this as well as consider theoretical possibilities other than those presented to us.

Of course, to be critical does not limit us as health geographers to only addressing those topics that are most closely aligned with questions of social justice. As Lynn Staeheli and Don Mitchell (2005) note in their analysis of the politics of relevance, what counts and does not count as relevant, and by extension critical, research is defined in many ways. For example, for some of the geographers that they interviewed in their research, relevance was linked to the kinds of political commitment and wider social impact demonstrated by Dorling and Bamba in the above discussion. Outside of this, relevance can also be defined in terms of the pertinence of research – the timeliness of an issue with regard to a particular time and place, as well as in relation to questions of the applicability of research – the ability of research to be applied or to result in some kind of action. Although these two values may appear to be constraining, especially on research that is more theoretically oriented, Staeheli and Mitchell reveal that this does not necessarily have to be the case. Referring to interviews that they conducted with Michael Dear and Jennifer Wolch, whose research we refer to later on in the book (see Chapter 6 and Chapter 7), Staeheli and Mitchell note that theoretical work is not only necessary to the development of research and to its communication but also to ‘bringing to light issues and ways of thinking that might change how people understand problems or evaluate what is important’ (2005, p. 370). Though questions of social justice are relevant here, so too are many other social issues and the various possible responses to them of interest to health geographers.

Critical research demands that we do not simply accept the world as it is presented to us in political announcements, policy briefings or in empirically-oriented, atheoretical research. Instead, critical researchers are encouraged to familiarise themselves with relevant literature, theories and research methods, as well as be cognisant of their own values, assumptions and epistemological and ontological positions. In so doing, researchers place themselves in a position to be able to challenge social and institutional norms, models of thinking and hegemonic power relationships. With this goal in mind, critical health geographers often pay close attention to people and issues that are neglected or marginalised in mainstream society. It is observed that certain people – often deemed the most vulnerable – ‘fall off the map’ of policy, practice and research. We might think here of those least able to care for themselves, for example the young and the elderly, the mentally ill or physically incapacitated, or populations who are placed on society’s margin because of their sexuality, race or ethnicity, class position or housing status. However we define vulnerability, and it is a complex question that deserves careful consideration, it is up to critical researchers to challenge neglect and expose the lived experience of people in their everyday encounters with social relations of power. As Blomley (2006) suggests, as critical geographers we should promote solidarity with people, particularly those who are the oppressed and victimised, and this book is certainly attuned to this ideal.

To extend this perspective on criticality a little further, another important facet of being a critical health geographer is exploring and questioning everyday practices and their complex

inter-relationship with the spaces and places which we co-inhabit with other human and non-human entities. Health geographers are interested in the everyday in many different ways, for example, in terms of the decisions that people make or the routines and practices in which they partake (e.g. whether to eat '5 a day', consume alcohol or smoke tobacco products or take part in risky sexual practices) and the socio-environmental conditions under which people live and work and the differential effects of these on their ability to access health care services and health-related resources. We might also focus in on the experiences of individual citizens – often, but not only, when they are reconstituted as patients, risk groups or as healthy or diseased subjects, as well as on the significant role of health professionals, health care commissioners and policy makers and increasingly bioscientists and pharmaceutical companies in helping to shape these experiences. Crucial to our understanding of the everyday is not only that we account for those processes that (materially) structure people's experiences, but that we also recognise that these experiences are contingent upon the spaces and times within which people live. Here, it is vital that we acknowledge that the identities people assume and those that are socially ascribed to them – whether based on race/ethnicity, class status, sex and/or sexuality, ability/disability and so on – will be important in differentiating these health-related experiences and their consequences for people's health and wellbeing. Moreover, we argue throughout this book for a concern with the modes of governance – often referred to under the Foucauldian concept of biopolitics – that help to shape and reconfigure the kinds of behaviours and practices discussed, as well as our understanding of the bodies who willingly or otherwise perform them.

Finally, as critical health geographers it is important to remain alert to the differential effects of mobility and scale on health as well as on their relevance to our understanding of disease and biomedicine. Geographers sitting outside of the sub-discipline of health geography, as well as other social scientists, have been particularly attuned to these questions. The case of severe acute respiratory syndrome (SARS), which we explore in Chapter 11, is an especially good illustration of this. In their edited volume covering the epidemic, *Networked Disease: Emerging Infections in the Global City*, Harris Ali and Roger Keil draw on a quote from the former Director-General of the World Health Organization (WHO), Gro-Harlem Brundtland, which is especially helpful in highlighting the importance of scale: 'Today public health challenges are no longer local, national or regional. They are *global*' (Brundtland 2005. Cited in Ali and Keil 2009, p. xix. Emphasis added). The point being made here is one that geographers are, of course, fully alert to and that is the idea that local situations and events are increasingly closely related to global scale processes. SARS was an especially powerful illustration of this because of the rapidity with which a relatively localised epidemic – one whose origins lay in the economic and cultural practices associated with the production and consumption of civet cats in the Guangdong province of China – was transformed into the first major pandemic of the twenty first century in part because of the global cities network through which it was primarily transmitted.

The chapters in this edited volume not only offer accounts of the transmission process, they also provide important insight into wider sets of questions relating to the processes of globalisation and the hypermobility of pathogens such as the coronavirus that caused SARS, for example the interplay between human and non-human agents, the challenges that such hypermobility places upon public health strategies of containment and control, as well as the pathologisation of highly mobile human bodies and the closely related problem of their subsequent stigmatisation. Of course, it is not only infectious diseases and the pathogens that cause them that are mobile and multi-scalar in their effects and as such the target of critical health scholarship. Similarly to SARS and other emerging and re-emerging infectious

diseases, it is also increasingly recognised that the so-called 'global obesity epidemic' is caused by processes – namely risk factors associated with diet and physical inactivity – that were once believed to be confined to affluent nations in the Global North but are now global in their reach. As Tim Brown and Morag Bell (2008) have commented, non-communicable diseases are considered to be transmissible across borders due to their being linked to risk behaviours, which, according to a joint report by the WHO and the Food and Agriculture Organization, 'travel across countries and are transferable from one population to another like an infectious disease' (WHO/FAO 2003, pp. 4–5. Cited in Brown and Bell 2008, p. 1575).

Applying a Critical Perspective to Our World

Drawing on this loose typology of critical research above, and the inherent lessons for how such an approach can be used, our book seeks to develop understanding by focusing on the main debates and thematic areas that we argue define critical scholarship in health geography research. From our work in the field of health geography, which for us also includes topics that might otherwise be covered under the rubric of medical and biomedical geographies, we distil five key cross-cutting critical themes that extend across all the chapters of this book. Some are more obviously relevant to, or explicit in, some chapters than in others and we do not claim that this list is exhaustive. Nonetheless, given that each contributor to this book is firmly committed to advancing critical health geography debates, we argue that the five themes serve as important rallying calls to begin to explore the myriad and diverse issues and trends with which the book engages, therefore allowing you as a reader to punctuate such debates. While the themes are not necessarily 'new', we argue first that they have entered new stages in their depth and breadth of reach, and second that they have become increasingly entangled and intersected with each other, thus creating new forms and new spaces entirely. Taken together, they therefore have a cumulative effect on the health of people around the world and, we argue, can either exacerbate or ameliorate many of the challenges people face in their everyday lives.

Neoliberalism

Whilst being an ideology rooted in earlier liberal philosophy and a blueprint for the 1970s Thatcher–Reagan government projects in Anglo-America, neoliberalism has arguably entered a new phase in terms of its breadth and reach. In the wake of the financial crisis of 2007–2008 and its prolonged aftermath, governments in many countries, particularly in the Global North, have resorted to policy measures that seek to reduce the role of government – although as argued later, it has hardly reduced bureaucratic control in many areas involving welfare and support – as well as implemented deregulation, privatisation, outsourcing and competition in public services. Governments have imposed strict fiscal discipline and cut public spending in the hope of restoring budgetary integrity and securing the confidence of investors. These measures are argued to be essential in order to pave the way to renewed economic growth.

Interestingly, this has largely been done without neoliberalism being mentioned by the political parties that drive it. Its anonymity, according to George Monbiot (2016), is both a symptom and cause of its power: 'So pervasive has neoliberalism become that we seldom even recognise it as an ideology' (Monbiot 2016). Its creeds have become internalised and reproduced with little thought. According to Monbiot's argument, the result of this

internalisation has been that the rich (can) persuade themselves that they acquired their wealth through merit, ignoring the personal advantages – such as education, inheritance and class – that may have helped to secure it. Meanwhile, the poor begin to blame themselves for their failures, even when they can do little to change their circumstances. While neoliberalism has gone incognito in a very short space of time, the political dogma of ‘austerity’ has become the catchword for the renewed attempts to cope with ‘post-crisis’ uncertainties at different spatial scales (Blyth 2013, p. 2; Peck 2012, p. 626). With neoliberalism firmly positioned as the dominant economic policy script, the tension between the right and left politics mentioned above has come to be increasingly resolved in favour of right-wing austerity. David Featherstone and colleagues talk about ‘austerity localism’ whereby ‘localism is being mobilised as part of an “anti state”, “anti public” discourse to build support for an aggressive round of “roll back” neoliberalism’ (Featherstone et al. 2012, p. 177).

In terms of breadth, neoliberal policy has expanded across Europe, North America, Latin America and Africa, although of course it remains always incomplete and existing in myriad different forms. In Asian nations, for example, ‘coordinated market capitalism’ exists whereby institutions coordinate many of the most important economic decisions and functions (e.g. wage setting, bargaining, business/labour management of social programmes) (McGregor 2001). Nonetheless, despite its hybridity, through the IMF, the World Bank, the Maastricht Treaty and the World Trade Organization, neoliberal policies have been imposed – often without democratic consent – on much of the world (see Chapters 11 and 14). In terms of its depth of reach, it has also become more firmly embedded in political and economic contexts and in terms of the level of impacts on the ground. One of the most pressing concerns relating to neoliberalism in health geography is the withdrawal of the state from health and social care. Freedom from collective bargaining and trade unions has meant the freedom to suppress wages. Freedom from tax has meant a freedom from the distribution of wealth that lifts people out of poverty and poor health. The post-war consensus that the state is best placed to provide comprehensive health care no longer has widespread credence. In the UK for example, the Institute for Fiscal Studies (2015) drew the conclusion that the Conservative manifesto of public sector cuts would reduce state and social spending to *pre-(World War II) welfare state* levels.

Under neoliberalism, state health care is seen as inefficient and private markets are seen as more cost-effective and consumer-friendly. The neoliberal agenda of health care reform includes cost cutting for efficiency, decentralising to the local or regional levels rather than the national levels and setting up health care as a private good for sale rather than a public good paid for with tax revenue (McGregor 2001). Austerity budgets have led to reductions in community services, such as the closure of day centres (Hall 2014). Meanwhile, in the Global South, some of the initiatives led by international organisations under the flag of development were counter-productive in many contexts, such as the Poverty Reduction Strategy Papers introduced by the World Bank and the International Monetary Fund in 1999, which ultimately reduced health service expenditure in several African countries (Navarro 2007, p. 354; see also discussion of SAPs in Chapter 14). Alongside the decline in state health care provision, epidemics of self-harm, eating disorders, depression, loneliness, performance anxiety and social phobia are being increasingly documented (Verhaeghe 2014). Social care users risk ‘moving from a position of enforced collectivism to an enforced individualism characteristic of neoliberal constructions of economic life’ (Roulstone and Morgan 2009, p. 333). Readers of this book should therefore remain alert to the idea of the political shaping of health and the politics of vulnerability. Those at the front line in health care provision often have little time to engage critically with such debates, and yet they must deal with the pragmatic challenges of reduced budgets.

Inequality

Disadvantage is patterned across a range of spatial scales from the local to the global, and within and between populations of interest. The existence of inequality relies on the social, economic, political and cultural ordering of people and place and is thus not a naturally occurring property of society but a product of the way we live now and the ways we have lived. As a cross-cutting theme in this book, inequality is both the precondition and outcome of the other themes we identify, acting reciprocally to either deepen or ameliorate experiences of disadvantage according to individual circumstance.

As indicated in the earlier discussion, Dorling's (2014) work illustrates the growth of inequality within the British context. But Britain typifies a growing trend in both Global North and South countries towards an unequal accumulation and distribution of wealth. In Stiglitz's (2015) *The Great Divide*, he traces the massive growth of deregulation, tax cuts, and tax breaks for the 1 per cent in the United States and argues that many are falling further and further behind. In a global comparison, according to the World Bank Gini coefficient (2015),¹ many of the wealthiest nations in the world such as the United States (calculated at 0.41 out of 1) and the United Kingdom (0.38) are in a race to the bottom of the global league tables of wealth inequality. Those deemed as the most unequal include nations such as Brazil (0.53), Haiti (0.59) and Colombia (0.54). According to the Organisation for Economic Co-operation and Development (OECD), Britain serves as a pertinent example, as it was once deemed one of the most equal countries in the post-war period of the 1950s.

What has driven these increases in inequalities? While there is no consensus, it is argued that one key reason has been the rise of globalisation and skill-biased (task-biased) technological change and institutional change. However, critical researchers also argue that social policy, particularly tax and benefit policy, no doubt also plays a key role in modifying these external pressures. Indeed, David Harvey's (2000) central thesis argues that inequality stems from a class-based political project rooted in the global neoliberal philosophy, thus creating new means of capital accumulation. Inequality is often employed as a proxy for social justice, discussed earlier as a key motivator for health geographic research, particularly as an indicator of 'distributional fairness' or 'distributive justice'. These terms capture how resources are differently allocated in a society and owe their prominence to early work such as Harvey's *Social Justice and the City* (1973) and David M. Smith's *Human Geography: A Welfare Approach* (1977). A range of terms have been used in the literature to describe situations of (in)equality, most notably including (dis)parity, (in)justice and (in)equity. As Paula Braveman (2006) elucidates in an annual review, there is little consensus about the practical differences between these terms but they nonetheless remain important concepts nationally and internationally to governance and policy. The enduring value of inequalities work is evidenced by the range of recent publications that describe the disadvantage of some within a society compared to others as inherently detrimental to its functioning: Richard Wilkinson and Kate Pickett's (2009) *The Spirit Level*, Danny Dorling's (2010) *Injustice* and Thomas Piketty's (2014) *Capital in the Twenty-First Century*.

In health geography, early work on inequality sought to characterise disadvantage, particularly economic disadvantage, as leading to the development and widening of a number

¹ The Gini coefficient is a number between 0 and 1, where 0 corresponds with perfect equality (where everyone has the same income) and 1 corresponds with perfect inequality (where one person has all the income – and everyone else has zero income). Income distribution can vary greatly from wealth distribution in a country.

of health ‘gaps’ between the various occupational social classes. This was the approach adopted by the UK Government in the influential *Black Report* (DHSS 1980) in which an expert committee led by Sir Douglas Black demonstrated the existence of widespread inequalities in population health (see Chapter 10). The report showed that at the time of its publication, people belonging to the lowest occupational social group, ‘unskilled workers’, had a death rate twice that of the highest occupational social group, ‘professional workers’. The objective of public health policy at the time became the narrowing of the gaps between social classes in light of evidence that suggested that these gaps were widening. The narrative of health inequalities has continued ever since in public health policy in the United Kingdom and globally; however, we now no longer think of health inequality as being the presence of ‘gaps’ between the richest and poorest, rather we talk in terms of a ‘social gradient’ of inequality in health.

The expression of health inequalities from gap to gradient owes much to the work of Sir Michael Marmot, who chaired the *Marmot Review* (see Marmot et al. 2010), and his team who evidenced that rather than a gap there was a continuous gradient in life expectancy in the continuum from most to least deprived. Academic and policy-based characterisations of inequality have been complemented by more populist accounts, such as Danny Dorling’s (2013) *The 32 Stops*, which narrates inequality along the London Underground’s Central Line. This project reflects work by the London Health Observatory whose diagram (see Figure 1.1) shows the inequality in male life expectancy along the London Underground’s Jubilee Line. James Cheshire (2012) subsequently produced a web map called ‘Lives on the Line’ (see <http://life.mappinglondon.co.uk/>, visited on 21 April 2016) which maps life expectancy at birth and child poverty, as well as other social determinants of health, according

The Jubilee Line of Health Inequality

Travelling east from Westminster, each tube stop represents up to one year of male life expectancy lost at birth (2002–06)

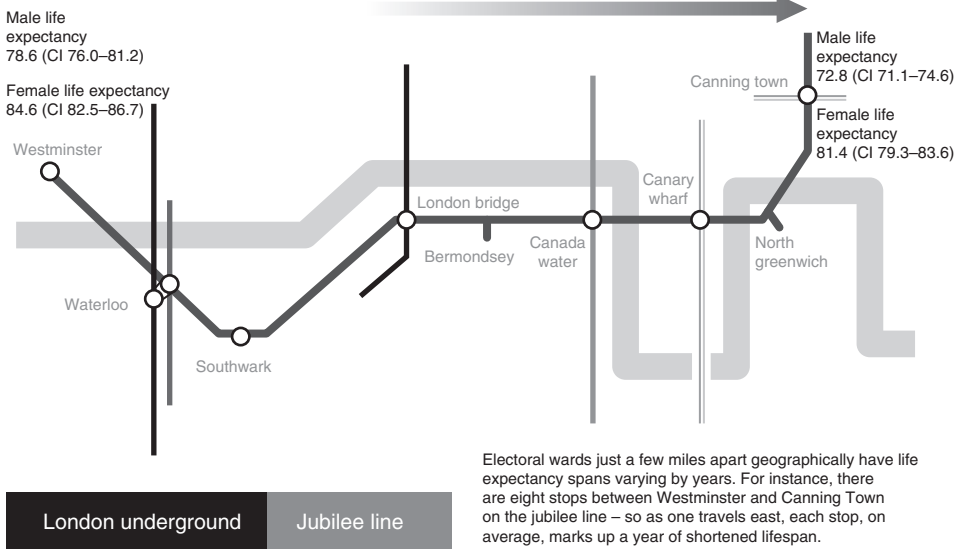


Figure 1.1 Male life expectancy on the Jubilee Line, London. Source: London Health Observatory, 2012. Contains public sector information licensed under the Open Government Licence v3.0.

to the London Underground network for the entirety of Greater London. Similar maps have been produced for other major British cities, and revealing the extent to which public health professionals and academic researchers have highlighted an issue that a Conservative government under the leadership of Margaret Thatcher sought to conceal with the shelving of the *Black Report* (Schrecker and Bamba 2015).

Globalisation/urbanisation

The notion that inequality solely captures differences in the allocation or distribution of resources has been useful for health geographers, wherein access to material resources can be readily quantified and compared for different groups of people and used to inform arguments about what is 'fair' or 'just'. However, a critical insight suggests that inequality should extend also to capturing less immediately tangible concerns. Doreen Massey, for instance, developed 'power geometry' (1993) as a way of connecting notions of power to the global flow of people and the differential effects of globalisation. David Harvey, again, demonstrates the relational nature of space, place and time to social and environmental justice in *Justice, Nature and the Geography of Difference* (1996). This leads us to our third cross-cutting theme, which is globalisation and, closely associated with it, urbanisation.

The growth in specialisation, information and communication technologies and mobilisation of people has become a key characteristic of the early twenty first century. In parallel with these human endeavours, global climate change continues to loom as a growing risk to the Earth's environment and to the health and wellbeing of us all. This is clearly evident from the rhetoric of international health organisations such as the WHO, whose current Director-General, Dr Margaret Chan, stated that:

Population growth, incursion into previously uninhabited areas, rapid urbanization, intensive farming practices, environmental degradation, and the misuse of antimicrobials have disrupted the equilibrium of the microbial world. New diseases are emerging at the historically unprecedented rate of one per year. Airlines now carry more than 2 billion passengers annually, vastly increasing opportunities for the rapid international spread of infectious agents and their vectors. ... These [and other] threats have become a much larger menace in a world characterized by high mobility, economic interdependence and electronic interconnectedness. Traditional defences at national borders cannot protect against the invasion of a disease or vector. Real time news allows panic to spread with equal ease. Shocks to health reverberate as shocks to economies and business continuity in areas well beyond the affected site. *Vulnerability is universal.* (WHO 2007, p. iv. Emphasis added)

Thus, to global inequalities in wealth and the associated challenge of 'Closing the Gap' highlighted by WHO's Commission on the Social Determinants of Health, under the chairmanship of Sir Michael Marmot (Marmot 2008; see Brown and Moon 2012), we can add health problems linked to the economic, social and political consequences of an ever greater concentration of the world's population in urban centres. As the Population Division of the UN's Department of Economic and Social Affairs reported, over half of the world's population now live in urban areas and by 2050 this figure is projected to reach 66 per cent (United Nations 2015, p. 1). More significantly, some 90 per cent of this growth is estimated to occur in Asia and Africa. As Clare Herrick (2014, p. 557) states, the conditions under which many people live in the megacities that are emerging from this process of urbanisation, especially, though not only, those in the Global South, threaten to 'unravel the "urban advantage" received by urban dwellers who are believed to benefit from better education, higher

incomes and improved access to employment opportunities, health care services and so on. As she notes, the question is not so much of an 'urban advantage' but of an 'urban penalty', which returns us to debates about the health consequences of rapid urbanisation experienced in the nineteenth century (see Kearns 1991).

How we approach these questions as critical geographers will vary. Undoubtedly there are many health geographers whose focus will remain on questions of social justice and the closely aligned issue of (global) health inequalities. Others may concentrate on the discursive construction of spatially distant, hypermobile populations as the 'Other', especially when they become associated with the movement of infectious diseases such as AIDS/HIV, SARS and Ebola from 'there' to 'here' or, put differently, from 'the rest to the West' (Hall 1992). However, Herrick's call for a much greater focus on the urban in these questions of globalisation and global health is a timely and important one. This is so not only because urbanisation is helping to intensify processes that are responsible for many of the health problems that the world now faces, as exemplified in the quote from Chan. It is also because the urban has often been overlooked in the responses of what Herrick refers to as the 'Global Health' enterprise; as she argues, the urban question is an 'implicit rather than explicit area of activity, investment and activism' when it comes to addressing global health issues (2014, p. 561). Although this book does not respond to Herrick's call as effectively as it might have, we certainly recognise the importance of the issues that she raises to critical health scholarship in the future.

Biopolitics

A concept generally ascribed to the French philosopher, Michel Foucault, biopolitics describes the political governance and control of the 'bio' of people (their bodies and minds). Biopolitics has arguably become more relevant as the modes and techniques of controlling, tweaking and 'nudging' people's bodies have grown more elaborate and fine-tuned in the political orchestration of health and social care policy (see Chapter 2). Whilst biopolitics has been around for a long time – indeed since the original 'social contract' emerged – its growth in scientific, technological, bureaucratic terms has arguably surpassed previous eras in the extent and degree of subtlety to which the state can manage the everyday lives of individuals.

Nikolas Rose and Carlos Novas (2004, p. 440) suggest we might think of the ways in which biopolitics has effectively remade citizens into 'biological citizens'. They define biological citizenship as 'all those citizenship projects that have linked their conceptions of citizens to beliefs about the biological existence of human beings, as individuals, as families and lineages, as communities, as population and races, and as a species'. In this way biology is used to determine what constitutes normal, healthy bodies or citizens and those bodies seen as being unhealthy or deviant. The crafting of biological citizenship can be seen in the formation of state policies and interventions that target the population as biological beings. For example, in welfare policy, psychology now plays a central and formative role in stigmatising the existence and behaviour of various categories of poor citizens and in legitimising the measures taken to transform and activate them. Rather than blame structural causes of unemployment, these strategies can perpetuate notions of psychological failure and shift attention away from wider social and economic trends, including market failure, precarity and the scale of income inequalities, towards individual weakness. In Britain for example, recent workfare assessments have led to severe sanctioning of those who are judged to be not complying with an increasingly elaborate set of demands. Inherent in these policies is

a summoning of various citizen-subjects such as the responsible citizen, the active citizen, the democratic citizen, the citizen worker and so on (Newman 2013).

Another example of biopolitics in health and social care is seen in the implementation of personalisation policy. While originating as a response to inflexible group disability services, personalisation shifts the emphasis of what *service* people want towards what kind of *life* a person wants. Inherent in this approach is the choice afforded to individuals. While this goal is of course laudable and has been shown to have positive outcomes for disabled people, its implementation during a time of austerity has led to the wholesale shift in responsibility to the individual (Power 2014). Those eligible for social care are in effect having to become managers and 'sole-traders' of their own care. This means disabled people have to now manage insurance and employment related tasks associated with arranging support as well as their own personal lives.

This individualisation mirrors other neoliberal state strategies to 'responsibilise' citizens. One of the ways in which the state can manage people is to give them more individual responsibility. Individualisation has become a key driver of health and welfare policy. People therefore become culpable for their own health, or as Foucault (see Box 11.2) might put it, the care of the self is placed in the hands of the self. However, such responsibilisation can cut both ways. Adriana Petryna (2002) explores how, following the nuclear explosion in Chernobyl in 1986, citizens drew on biological understandings of themselves as bodies affected by radiation to create a new collective identity as *poterpili* or sufferers. This new biosocial collective then used their shared status as biological citizens to make demands upon the state for compensation and health and welfare provision. In this way biological citizenship 'can thus embody a demand for particular protections, for the enactment or cessation or particular policies or actions, or, as in this case, access to special resources' (Rose and Novas 2004, p. 441). This leads us towards a final theme, resistance.

Resistance/resilience/care

While the four earlier concepts each signal different challenges and risks facing people's health, it is also worth being equally aware of the ever-present, ever-changing nature of resistance and resilience as antidotes, coping strategies and modes of counterattack to these challenges. Critical health geographers must always remain attuned to the possibilities of action and change. People do oppose, defy, repel and endure. In *Landscapes of Antagonism*, Newman (2013) reminds us that while the current climate of neoliberal cuts, austerity and state retrenchment is presented as a meta-narrative, there is also space for politics and agency – and care. She urges us to think about the co-existence of diverse governmental, economic and political projects. As Power (2014) found, the realm of social care policy for example is a lot more heterogeneous and fluid than commonly presented. Indeed, Needham (2011) argues that the design of much health and social care policy rests on 'stories'. Using the example of personalisation discussed above, Needham argues that the stories driving personalisation have evolved and mutated from often mundane sources including conversations between individuals, third-party reports, and individual accounts of innovation. Similarly, Power (2013) found that in the design and provision of support to disabled people, real-life individual 'stories' of change are often used by service managers and policy design consultants as important markers of organisational learning, and a currency with which to trade ideas with other providers, individuals and families.

Thinking about health and social care policy design and implementation in this way can open up our understanding of the multiple spaces for change and support that exist. Geoff

DeVerteuil (2014) argues that these supportive approaches are arguably downplayed by many mainstream (primarily US) accounts of urban injustice by geographers who have become largely fixated on the punitive accounts of injustice in the city – particularly within the context of the residual neoliberal welfare state. Indeed, DeVerteuil argues injustice must *co-exist with* and *depend upon* more supportive currents within urban space. These undercurrents can evolve as direct forms of resistance to the thematic trends discussed above. Harvey's (2012) work on *Rebel Cities* traces the growth in urban protest movements from Johannesburg to Mumbai, and from New York to Sao Paulo. These movements reveal deep currents of resistance to the growing inequalities of capital accumulation and control of urban 'public' space.

Equally, DeVerteuil (2015) reminds us of the daily examples of *resilience* which exist alongside more overt and direct struggles against global, national and local challenges. Inherent in this work is an appreciation of the role of the community and voluntary sector in ameliorating the external challenges experienced by different groups deemed vulnerable. People also seek to be resilient in their everyday individual lives. Health geographers have traced the 'health enabling landscapes' (Foley and Kistemann 2014) used and developed by people, including spas, yoga centres, stillness and alternative therapies retreats to achieve more positive physical and mental health. This personal attention to human flourishing is also evident in the growing demand for healthy foods and diet supplementation. These personal practices have no doubt contributed to the growing life expectancy of people in western countries, although such a trend also undoubtedly relates to the broader influence of the global pharmaceutical industry and neoliberal economic wealth accumulation in the Global North mentioned above.

Putting this last point aside, underlying all of these personal and political 'tactics' to boost health and social wellbeing, and resist the previous four trends is an ethic of care. Drawing on feminist geographers such as Victoria Lawson (2007; 2009) and Linda McDowell (2004), the ethical responsibilities to care are paramount in the face of poverty and the pervading individualistic ethos in the labour market and the welfare state. This ethic ultimately guides how individuals support each other, and contributes towards greater wellbeing and human thriving. This ethic of care therefore speaks to broader issues of social justice in the way we value and encourage human lives and human flourishing.

A 'Road Map' to Health Geographies: A Critical Introduction

It should, we hope, be clear that the primary aim of this book is to help you to develop your credentials as a critical health geographer or, more broadly than this, as a critical health scholar. To help you with that process we have organised the remainder of this book into four substantive parts: (1) *Body, Health and Disease*; (2) *Changing Spaces of (Health) Care*; (3) *Producing Health*; and, (4) *Emerging Geographies of Health and Biomedicine*. Each of these parts and the various chapters contained within them are designed to prompt particular sets of questions as well as to promote understanding of what we think are the main contours of past, present and potential future discussion within the sub-discipline. Each chapter has identified further reading and we set out a series of questions that we hope will encourage you to think further about the topics that we outline. Of course, we recognise that these topics are not exhaustive and that their highlighting by us is based upon our own highly partial readings of the sub-discipline and of related fields of enquiry. In the spirit with which this book has been co-authored we encourage you to identify what is absent and to critically engage with that which is present, though ultimately we take full responsibility for both!

To help you organise your reading, we have described in a little more detail the chapters that are contained in each of the parts. The first part, *Body, Health and Disease*, seeks to cover territory that is already well explored in the kinds of introductory texts that we mention above. In Chapter 2, the body is identified as a key locus of health and medical concern and it is rightly the main starting point for this text. In articulating the break with medical geography, health geographers stated quite clearly that the focus should be on exploring the body in its social and environmental context. Here, consideration is given to the multiple ways in which geographers and other social scientists have approached this question, from studies that illustrate how different types of bodies (aged, gendered, raced, sexed) experience health and health care differently, to the ways in which health is embodied and to debates relating to the geographies of exclusion and ideas about what constitutes the normal/abnormal, healthy/diseased body, and we briefly touch upon more-than-human geographies towards the end of this chapter.

Alongside the body, place was also identified as being crucial to reformulating the so-called 'post-medical geography of health'. This topic is covered in Chapter 3 which focuses explicitly on the importance of place to health geography scholarship. It locates this understanding within an historical overview that identifies geographers' earlier engagement with place through reference to the disease ecology perspective of medical geography. It then explores the significance of, and shifts associated with, the turn to place that was encouraged by health geographers writing in the early 1990s. While the emphasis is placed on ideas that illuminate the power of place to promote and enhance health, the chapter also covers much more recent scholarship on non-representational theory and considers the relevance and value of this to critical health scholars. This focus on the close inter-relationship between health and place is further explored in Chapter 4 which covers the therapeutic landscape concept that has emerged as a key thematic area of interest ever since its introduction to the sub-discipline by Wilbert Gesler in the early 1990s. While it might be regarded as a central feature of the turn to place, we argue that its impact on the wider discipline and indeed beyond this is such that it warrants a separate chapter. A further ambition of this chapter is to engage with the widely used but perhaps a little more elusive concept of wellbeing.

In the next part, *Changing Spaces of (Health) Care*, we engage with questions of health and care. In Chapter 5 we consider traditional approaches to questions of health care access and provision, which have been a core issue for health geographers for many decades. This chapter also explores how geographers have responded to the neoliberal reforms that helped to reshape the health care landscape in countries such as Canada, the United Kingdom and New Zealand and also the growth of what is commonly referred to as complementary and alternative medicine. Finally, it considers recent shifts to an evidence-based approach to health systems reform that is being articulated at the international level (e.g. through the WHO) and is being used to justify reform in health systems across the world. Chapter 6 is closely aligned with this, as it focuses on the interface between health and social care. This type of care is becoming more decentralised with a renewed focus on community living and an erosion of care centres and as a result is tending to take place in multiple settings involving a myriad of different actors and new technologies such as telecare and online marketplaces for purchasing care services. Consequently, there has been a re-sculpting of roles and relationships for those involved in care work, such as volunteering, the third sector, formal services or family care giving. The chapter pays keen attention to the gendered nature of this sector as well as to the impacts of neoliberalism upon it, especially in an age of 'austerity' politics.

The final chapter in Part 2, Chapter 7, focuses specifically on the geographies of mental health care, which has been a dominant strand of scholarship within health geography that has documented and critically explored the evolution of care during and since institutional settings. Its continued relevance as a field within health geography rests with the continuing legacies of institutional care on the lives of persons with mental health issues, in terms of the on-going forms of stigma, de-personalisation and marginalisation that still shape contemporary experiences and spaces of mental health care.

We shift tack slightly in Part 3, *Producing Health*. The chapters in this part of the book work together to explore on-going debates around how health geographers and health researchers more broadly defined account for the inequalities in health that are recognised to exist in many societies today. Here, it is recognised that there is considerable emphasis placed on the importance of place and space in geographers' accounts of health inequalities and this material is covered extensively in Chapter 8. The initial focus of Part 3 is the ecological turn in public health and especially the importance of context and composition in shaping understanding of health and health inequalities. We consider the role of epidemiology, sociology and geography in re-establishing interest in this area and question how researchers and policymakers have understood how space, place and the environment may contribute to disease risk. These are questions that are explored by geographers such as Danny Dorling and Clare Bambra; however, it will be apparent that the discussion of health inequalities in these chapters is less overtly politicised. The concern that some people fare worse than others when it comes to health remains the same, it is the way in which explanations for this important social phenomenon are interpreted that differs.

Chapters 9 and 10 add novel layers of understanding to what is a fairly routine account of the social determinants of health. In the first of these chapters, we explore the recent emergence of complex systems as a possible paradigm shift in ecological approaches in population health research. Taking a systems perspective, it can be argued, has resulted as a logical outgrowth of interest in group-level contextual phenomena in shaping health and health inequalities. In Chapter 10 we consider the kinds of area-based interventions that have become increasingly common as a result of a revitalisation of interest in understanding the social determinants of health. This suggests that modification of features of the local environment may have the potential to improve an individual's health and may also reduce social and environmental inequalities in health. This often makes contextual or area-based interventions inherently appealing as they fit well with the broader socio-ecological model of health discussed elsewhere in this book. The chapter investigates challenges in the rationale, design and evaluation of these interventions and critically assesses whether such interventions have the potential to be effective.

In the final part of the book, *Emerging Geographies of Health and Biomedicine*, we explore a series of topics that by and large sit at the margins of health geographers' interests. We include these topics not only because we believe they are important areas for geographers interested in health-related issues to consider, but also because they often draw on wider sets of literatures and debates. The first of these chapters, Chapter 11, explores different infectious agents and how their distinctive characteristics impact the probability that any particular disease outbreak will reach epidemic or pandemic proportions. Throughout the chapter we consider how the ways in which infectious diseases emerge, and the ways governments and international organisations respond, echoes many of the key themes of this volume. Specifically, we examine the impact of globalisation and inequality on disease ecology, the operation of biopolitics in tackling epidemics, the role of neoliberal policies in limiting access to vaccines and antivirals, and inequalities in who bears the greatest blame

for, and impact of, epidemic outbreaks. This chapter leads us quite neatly into Chapter 12 which focuses on the growing influence of the pharmaceutical industry in shaping global health outcomes. Nik Rose (2007) has suggested that the ways in which western societies approach the challenges of poor health and disease are becoming increasingly molecularised and pharmaceuticalised. As we discuss in some detail, this 'molecular gaze' has implications for how we treat disease, including placing a much greater emphasis on pharmaceutical fixes or drugs.

The final two chapters of the book explore closely inter-related topics. The first, Chapter 13, covers the question of medical tourism. Within the academic community the appropriateness of the term 'medical tourism' has proven a topic of considerable debate and disagreement. Despite the growing body of academic work exploring medical tourism, four basic issues remain: what medical tourism is, who medical tourists are, their numbers and their impact. In this chapter, we address each of these elements in turn, touching on many of the key themes of this volume including the impact of neoliberal policies and cuts to public health services, the globalisation of medical care and inequalities in access to medical tourism benefits. Finally, in Chapter 14, we focus on global health. There are two broad questions that shape this chapter: first, what are the circumstances in which a concern for global, rather than international, health arose? This is an important question and one that demands we consider the genealogy of global health. Here, we use the term 'genealogy' not simply with reference to its association with the tracing of a lineage or history. There is almost inevitably a suggestion of this when one mentions 'doing a genealogy'. In contrast, we aim to achieve two things: on the one hand, we examine global health's emergence as a specific field of enquiry, one that produces a particular form of knowledge about the present; on the other, we open up discussion about the further possibilities for geographical engagement in global health. This transformative element of genealogy relates to our second question: what might critical geographies of global health look like? This is as good a place to end as any.

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