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Society, Differentiation and Globalisation

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Introduction

Sociology was born of modernity and the conception of ‘society’ as a sovereign unit of analysis. Since the turn of the present century this has been subject to considerable critical analysis as it has been argued, with increasing force, that the discipline has entered a ‘post-societal phase’ as a consequence of globalisation, challenging as a consequence sociology’s basic units of analysis, namely, the nation-state (Burawoy 2005). Urry characterises this as ‘a theoretical and empirical whirlpool where most of the tentative certainties that sociology has endeavoured to erect are being washed away’ (2000: 17). The effects are several, including the search for new theoretical frameworks and associated conceptual tools which turn from the traditional emphasis on stasis, structure and social order in favour of mobility, contingency and complexity (see e.g. Castells 2010; Walby 2009, 2015). Concurrently, theorists have re-examined the assumptions of modernity, or what it means to be modern, that shaped

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the discipline. As Connell (2007: 14) expands, ‘sociology developed in a specific location: among men of the metropolitan liberal bourgeoisie’. The so-called founding fathers of the nineteenth century, such as Durkheim, Marx and Weber, were concerned principally with the social changes taking place as European societies modernised, processes such as socio-economic restructuring, loss of social cohesion and new forms of social inequality. Consequently, the very meaning of modernity itself was Eurocentric since the social was conceived as ‘an internally coherent, bounded phenomenon that could be understood without any reference to external relations such as the colonial or imperial misadventures that were being undertaken at the time’ (Bhambra 2007: 49). For example, Durkheim’s (1964[1893]) analysis of the division of labour in society, especially his disquiet about excessive individualism and lack of social cohesion under organic solidarity, was approached overwhelmingly by reference to processes internal to a society.

Sociologists have questioned the constraints that this presents for an adequate understanding of social life in both the global north and the global south. But as Bhambra (2007: 6) argues, while sociologists are now far more inclined to discuss modernities in the plural, these often refer back to European analysis such that ‘the West is understood as the major clearing house of modernity’ to the rest of the world, meaning that non-Western peoples must now begin to engage their traditions with modernity in different forms of hybrid “modernities”. As she continues, with globalisation these multiple modernities still tend to be seen as becoming global as they incorporate features of the West to local circumstances. Thus, as she puts it, while there is recognition of difference, that difference does not necessarily *make a difference* to sociological ways of thinking. Bhambra (2007) exemplifies this through the analogy of the spokes of a wheel where European modernity of the centre diffuses along the spokes of other parts of the world or countries in relation to their encounters with the West, with very little consideration given to how the spokes may relate to each other. Perforce there is a tenacious northernness to sociological theory which can result in the erasure of the experience of peoples outside of the metropole—the majority of the people of world—from the foundations of social thought (Connell 2007).

This has sizeable implications for the analysis of *society, differentiation and globalisation* and health. The connections between ‘global’ and ‘health’ are very far from given, rather, as this chapter seeks to show, global health problems and responses are ‘enabled, imagined, and performed via particular knowledges, rationalities, technologies, affects, and practices across a variety of sites, spaces, and relations’ (Brown et al. 2012: 1183). This means it is important not only to consider globalisation’s processes and effects but also how they are theorised and the consequences that this might have for our understanding of health and healthcare in different parts of the world.

This chapter is organised as follows. Part 1 addresses theories of globalisation and their implications for the analysis of health issues. In particular I emphasise that globalisation is embodied, something often overlooked by sociologists working outside of the field of health (Turner 2004). Emphasis is given to the health vulnerabilities that arise from the heightened mobility, and connectivities that characterise globalisation, taking migration and health as an illustration. In Part 2, I turn to consider differentiation by highlighting disparities in health vulnerability and the capacity of social groups to protect their health. This is illustrated first by reference to the securitisation of health and (Elbe 2010a). A focus on the mental and physical health consequences of violent conflict then draws out the special vulnerabilities of children and of women. Finally, in Part 3, I reflect on neoliberalism as the dominant politico-economic policy framework driving health system change and on the increasing interconnectedness of various national health systems, and their implications for the delivery of effective healthcare.

Part 1—Conceptualising Societies, Globalisation and Health

As Turner emphasised over a decade ago, ‘we can no longer study the treatment of disease in an exclusively national framework because the character of disease and its treatment are global’ (2004: 230). The sociology of health needs to be global in scope and, crucially, the globalisation of health risks and of medical institutions should be added to globalisation

theory as ‘the first steps toward a globalisation of the body’ (Turner 2004: 236). While Turner underlines that the spread of global health risks and global health institutions can be thought of as a new phase of globalisation, attention in these terms is wanting in most globalisation theories. Even so, they can provide a useful lens into the analysis of health in the global context.

As already noted, since globalisation is envisaged as a new social order, a substantially new theoretical framework is necessary to analyse what is envisaged as a ‘new unbounded social system’ (Connell 2007: 53). While popular thinking tends to equate globalisation with linear diffusion of Western values and ideas to the rest of the world and construe arrested globalisation as resistance to such a trend—such as in the interpretation of the rise of Islamic fundamentalism as a direct response to the spread of western political and cultural values into the Middle East—most social scientists maintain that globalisation has no one single logic. Instead of moving in one direction, they stress that it is multi-dimensional and multi-causal. Bauman (1998: 60) describes globalisation as uncontrolled, operating in what he depicts as a ‘vast – foggy and slushy, impassable and untameable – “no man’s land”’. Similarly for Beck (2000), there is no over-riding logic or driver, such as the economic; rather globalisation is multi-causal and multi-dimensional. Consequently it presents as a new form of radically uncertain modernity. According to Walby, globalisation is best identified as ‘a process of increased density and frequency of international interactions relative to local or national ones’ (2009: 36). She argues that this can be grasped most effectively through the lens of complexity theory. This entails a reworking of the concept and theory of society to bring system to the fore but in a substantively different way to erstwhile approaches such as that of Parsons (1951), where social systems were construed as entities made up of parts. By contrast, Walby (2015) proposes that sociology should be the study not of parts but of all of society as a set of relations. From this position, she maintains it is possible to ‘address multiple regimes of inequality existing within the same territory without assuming that they must neatly map onto each other or be confined to the same borders’ (Walby 2015: 166). This offers a new vocabulary with which to understand social change; that of co-emergence, non-linear processes and heterogeneity (Walby 2009),

which draws attention to features of globalisation such as heightened mobility and new forms of connectivity between people, all of which have health implications.

In his theory of the networked society, Castells (2010) advances that social structure is always in the making, connecting the local and the global. While mobility is crucial, of equal importance for Castells is perpetual connectivity. Mobility stratifies through movement and through the lack of it. For some, ‘space has lost its constraining quality and is easily traversed in both its “real” and “virtual” renditions’ (Bauman 1998: 88), increasingly making it possible to move around the world for employment, in search of personal health and well-being and, as discussed in Part 3 of the chapter, for healthcare. Conversely, there are people, such as refugees, who, for reasons such as civil war and persecution, have no choice but to move and to keep on moving. Globalisation also makes visible the world of the ‘locally tied’ and globally many people are tied to risky communities that are damaging to their physical and mental health. (See Chap. 4.) In *Collateral Damage*, Bauman argues that ‘the inflammable mixture of growing social inequality and the rising volume of human suffering marginalised as “collateral” is one of the most cataclysmic problems of our time’ (2011). ‘Collateral damage’ is military in origin and refers to the unplanned effects of armed intrusions. Applying it to global societies, Bauman conveys how the poor become collateral damage in a profit-driven, consumer-oriented society. Although he does not address health and illness, it may be instructive to conceptualise those increasingly vulnerable to health inequity as a form of collateral damage. We turn to look at this now through the example of recent migration and health.

Migration and Health

The term migrant encompasses multiple forms of mobility. In broad usage, it is often taken to refer to people who move ‘voluntarily’ to live in another country for a year or more, such as ‘economic migrants’ and also ‘irregular migrants’ (those entering a country without required documents). By turn, ‘forced migrants’ comprises refugees, defined under the United Nations (UN) Refugee Convention of 1951 as those forced to

flee to save their life or preserve their freedom; asylum seekers, or people seeking international protection, awaiting a decision on whether they have refugee status; and internally displaced persons (IDPs) forced to leave their homes to avoid armed conflict, natural or human-made disasters, or violations of human rights, but who have not crossed an international border. The UN Convention protects refugees, but asylum seekers and IDPs have few rights and hence limited protection.

The relationship between migration and health is complex for the reason that migrants are a heterogeneous group. Nonetheless, it can be useful to draw a general distinction between ‘voluntary’ and ‘forced’ migrants. Although we need to be wary of overgeneralising, where ‘voluntary’ movement is concerned, research points to health selection since migrants often are healthier compared to people in their country of origin, yet it is important to recognise that migration itself can carry risks such as those of transit and adjusting to life in a new country. From his in-depth consideration, Gatrell (2011) concludes that although migrants tend to be in better health than those left behind as well as than those in the new host population, these relative health advantages attenuate as immigrants adapt their behaviours, particularly their dietary and exercise behaviour, to the norms of the new community. This is borne out by Huijts and Kraaykamp’s (2012) large-scale analysis of immigrant health in Europe. Based on European Social Survey data for 2002–2008, they analysed the health of over 19,000 immigrants from 123 different countries who had moved to 31 different European countries. Basing self-assessed health on a five point scale (i.e. very bad, bad, fair, good, very good), they analysed foreign born and second generation migrants in Europe with a focus on ‘origin’ and ‘destination’ effects on health. Characteristics of origin were found to have a lasting influence. For example, high levels of political oppression were associated with poorer health in both first and second generation migrants. Religion was found also to be influential. Notably, first generation immigrants from Islamic countries reported better health than those from countries where other religions predominate (all other factors being equal). The authors relate this to socialisation into positive health behaviours such as refraining from alcohol consumption and smoking, although, this did not apply to the second generation, something which they put down to the influence of culture in the destina-

tion countries. Overall then the health of immigrants shows a strong resemblance to the health of native inhabitants of the country of destination, but there are some lasting effects of origin countries (Huijts and Kraaykamp 2012).

The deregulation of wars is one of globalisation's most ominous effects. As discussed further below, most present-day war-like actions are carried out by non-state entities and consequently associated with the erosion of state sovereignty and the burgeoning frontier-land conditions of 'supra-state global space' (Bauman 2007: 37). Populations who flee conflict in their homelands often find themselves as outcasts in camps where they are neither 'settled nor are they on the move; they are neither sedentary nor nomadic', becoming 'undecidables' made flesh (Bauman 2007: 51). When analysing forced migration we need to think less in terms of individuals moving in a linear fashion from point A to point B and more of constructed group movement, where the journey from A to B is often protracted and involves periods of stasis in 'transit' locations such as IDP and refugee camps, as well as interception stages, such as border controls. Such journeys are risk-laden (Zwi and Alvarez-Castillo 2003). As Gostin and Roberts (2015: 2125) relate, 'each stage of the forced migration journey...poses health risks. Individuals face armed conflict, famine, or both in their home countries causing physical illness, severe mental distress, and lifelong trauma'. The body of a 3-year old Syrian refugee, Aylan Al-Kurdi, lying on a Turkish beach in September 2015 is an enduring image of the present European 'migrant crisis'. In 2016 alone, 5096 people were reported dead or missing in the Mediterranean Sea as they sought to escape conflict in countries such as Syria and Afghanistan (UNHCR 2017). Other health risks include injury and disability in transit and infectious diseases, such as measles, polio, cholera, tuberculosis, dysentery, and typhoid which can be rife in camps and exacerbated by food insecurity and lack of clean water. A report from UNHCR (Hassan et al. 2015) on the mental health and psychosocial well-being of Syrians affected by armed conflict draws attention to experiences of violence, exploitation, isolation and losses such as grief for loved ones, homes and possessions. This manifests in helplessness, loss of control and anxiety as well as social withdrawal (especially amongst women and young people), fatigue, sleep problems, loss of appetite, and unexplained physical symp-

toms. The authors detail that often suffering is understood as a normal part of life, not in need of medical attention. Most Arabic and Syrian idioms of distress do not separate physical experience and mental symptoms since body and soul are linked in explanations of illness. For example, ‘*habat qalb* or *houbout el qalb*, literally “falling or crumbling of the heart”, corresponds to the somatic reaction of sudden fear’, and ‘*kamatni kalbi* “my heart is squeezing” ...generally refers to anticipated anxiety and worry’ (Hassan et al. 2015: 23).

The health consequences of forced migration are a powerful illustration of the ‘social suffering [that] results from what political, economic, and institutional power does to people, and reciprocally, from how these forms of power themselves influence responses to social problems’ (Kleinman et al. 1997: ix). Bauman (2016) argues that, from the stance of the more secure in the world, migrants embody ambient fears of precarity and of people whose lives are defined by precariousness and anxiety. The insecure are less able to evade their own vulnerabilities, including fears of loss such as of work, homes and loved ones, that are intensified by their scattered and unpinpointable nature (Bauman 2016). Grove and Zwi (2006) draw on ‘othering theory’ to account for the responses of people in destination countries of the global north to forced migrants. The process of othering marks migrants out as different to ‘us’ and in the process shores up feelings of normalcy. Concurrently migrants are constructed as risky to ‘us’, as distant and strange others, as needy, as charity cases and as health services queue jumpers who create welfare overload. As Grove and Zwi (2006) discuss, the language used is that of burden to the neglect of the agency, resilience and skill of many migrants.

Part 2—Differentiation: Securitisation of Health and the Health Effects of Violent Conflict

The Securitisation of Health

The health of forced migrants is but one example of the negative health consequences of globalisation. It highlights differential health vulnerabilities and the (in)capacity of groups of people to protect their health, the

focus of this section of the chapter. The concept of the ‘other’, referred to earlier, is a useful frame within which to approach the effects of the securitisation of health in global context.

Although there is a strong historical connection between health and the security of nations, such as in times of war, the notion of ‘health security’ is quite recent. The catalyst was the events of 9/11 in the year 2001. This occasioned the setting up of the Global Health Security Initiative, an international partnership between several countries, including Canada, France, Germany, Italy, Japan, Mexico, the UK and the US, intended to supplement and strengthen their preparedness to respond to threats to global health, not only in regard to terrorism, but also pandemic infection and bio-chemical warfare. By 2007, ‘health security’ was high on the global agenda, as reflected in the World Health Organisation’s annual report, *A Safer Future* (WHO 2007). The Report defines health security as ‘the activities required, both proactive and reactive, to minimise vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries’ (WHO 2007: ix). This signifies a two-way relationship between health and security. First, the health of populations is seen increasingly in security terms; that is, there is a felt need to secure population health against threats. Concomitantly, the security of nations is viewed in medical terms. In *Security and Global Health*, Elbe (2010a) proposes that the medicalisation of security has three dimensions. The first is that national security moves from being only about military capabilities and the hostile intentions of other states to the proliferation of lethal medical problems in the bodies of citizens. An instructive way to consider this, and also to track changes in ways of thinking over recent time, is to consider responses to infectious diseases such as HIV/AIDS and SARS (severe acute respiratory syndrome). The AIDS epidemic (see also the discussions on AIDS in Chaps. 3 and 4), which began over 30 years ago in the 1980s, was perhaps the first time that governments, notably the US as a superpower, began to link pandemics to national security and to worry about the possible effects of illness on US interests abroad (McInnes and Ruston 2013). Several years on in 2001, then US President Clinton declared AIDS a national security threat to the country. First, and perhaps foremost, there was concern with high HIV prevalence in

the armed forces in times of war and hence the capacity to protect the nation (Elbe 2010a). With the SARS epidemic of 2002, security concerns shifted from armed conflict and the stability of national states to mortality burdens and economic repercussions (Elbe 2010a). SARS was traced to Guangdong province in China, and thereafter it spread to Hong Kong, Singapore and Toronto. By 2003, the WHO was warning against all but essential travel to these countries. In Hong Kong, over 1200 people were subject to isolation orders. When SARS spread to the middle-class private housing complex of Amoy Gardens in Kowloon, the Department of Health quarantined 264 apartments (although by the time the police arrived most people had already fled). A headline in the Singapore *Straits Times* of May that year emblazoned that 'SARS is like Singapore's 9/11'. The security threat attended very much to the economic repercussions. With SARS respiratory droplets are produced when an infected person coughs or sneezes; this is largely invisible and unpredictable and hence hard to avoid. During the outbreak people began to keep away from public spaces, to minimise time spent outside home, and to wear face masks. The economic effects were predictable; with the avoidance of travel, retail sales declined and there were less business exhibitions and meetings. It was estimated that the Asian region as a whole lost the equivalent of 25–30 million US dollars. The Canadian government evaluated that three million dollars were lost to the country's economy in the first two weeks alone of the outbreak in Toronto (Elbe 2010a). This prompted wider concern that any epidemic outbreak could wreak havoc on the world economy, further boosting the medicalisation of security.

The second dimension of the medicalisation of security addressed by Elbe (2010a) is the expansion of medical power and accompanying influence. At the most general level this is evident in increased involvement of medically trained persons in national security circles, most notably in the US. A key turning point was when then President Clinton brought physicians into politics in relation to AIDS with the objective of using them in helping to defend the US population from disease. Of significance here is the shift in emphasis from physicians as not only treating disease in individuals but defending against disease in populations. Presently, the US Homeland Security hosts an Office of Health Affairs which has a division of Health Threats Resilience. The third and final dimension

of the medicalisation of security brought to the fore by Elbe (2010a) is measures to secure, or attempt to secure, population health. The main strategy of governments to protect citizens has been the stockpiling of medical countermeasures to major illness as a readiness or preparedness against future uncertainty highlighted by Bauman (2016) as referred to earlier. This is exemplified by the stockpiling by several governments of the global north of the anti-viral Tamiflu during the ‘Swine flu’ (H1N1) outbreak of 2009. The differential consequences for populations of containment efforts can be illustrated by the race to secure antiviral medications and vaccines in the wake of the possible H5NI (Avian flu) pandemic in the mid-2000s. As recounted by Elbe (2010b), the majority of cases and of deaths at the time were in Indonesia (see also Chap. 7 regarding how rural poor women in Indonesia are at great risk for maternal mortality, morbidity and infant death). In 2006, the country’s government stopped sharing its virus samples to WHO under the Global Influenza Surveillance Network because it discovered that they were being given to Western pharmaceutical companies and novel vaccines offered back at unaffordable commercial rates.

It is therefore important to underscore that the securitisation of health is practised through, and acts on, the bodies of populations; it is a fundamentally embodied phenomenon involving the surveillance and control of populations, their bodies and their health (see also Chap. 3 for a detailed discussion on embodiment). This is now pervasive for the reason that many of the health threats referred to are unpredictable—no one predicted the outbreaks of SARS in 2002 and Ebola Virus in 2014–2015, for example, and it is hard to know where future threats may come from and what they will mean. Future health pandemics have rogue status, as depicted in the metaphor of the black swan. Initially the notion of black swan was used to refer to unexpected events in financial markets, and then expanded to refer to any surprise event of major proportions. It has been evoked by the US National Intelligence Council (2012: 16), which advises that ‘no one can predict which pathogen will be the next to start spreading to humans, or when or where such a development will occur. An easily transmissible novel respiratory pathogen that kills or incapacitates more than one percent of its victims is amongst the most disruptive events possible. Such an outbreak could result in millions of people

suffering or dying in every corner of the world'. Uncertainty is associated with both vulnerability and the escalation of agencies of health security. While the securitisation of health might seem to the good for all individuals and all populations, it can also be divisive, highlighting our concern with differentiation. Among the questions to be posed are: To what extent is the concern with 'national security' and to what extent with 'human security'? (DeLaet 2015) Are differential health interests being served? It has been argued (Davis 2008) that the securitisation of infectious disease prioritises the health concerns of Western states. In this regard agencies such as WHO are not neutral actors; diseases come to be identified as a threat when Western states feel threatened; after the threats wane so does the support (Davis 2008). Securitisation is then state-centric and shaped by the interests of privileged populations. Disease that is seen as containable within national boundaries, such as diarrheal disease and the more hidden burdens such as maternal mortality, infant mortality, hunger and traffic deaths, fails to reach the level of concern that securitised infectious diseases evoke. Resources are directed away from public health actors and poverty-related health challenges in ways that do not accurately reflect the global burden of disease (DeLaet 2015).

Differential Health Vulnerabilities in Violent Conflicts

Based on data reported at the end of 2016, there were 43 extremely violent conflicts going on in the world in 2015 (OCHA 2016). As well as deaths, injuries and all the other effects of collective violence, there were 65.3 million forcibly displaced persons, including 21.3 million refugees, 3.2 million asylum seekers and 40.8 million IDPs (OCHA 2016). Most contemporary or 'new wars' involve a range of not only state but also non-state combatants who use violence to pursue exclusionary goals, such as religious, ethnic and economic interests, as exemplified by the civil war in Syria. Frequently in such contexts, civilian casualty is not a side effect but an aim in itself. To give an illustration, UNICEF (2016) reports that two million children are living in areas largely cut off from any humanitarian assistance; 2015 saw over 1500 cases of killing and maiming of children, as well as attacks on schools and hospitals and denial of humanitarian

aid to children. When considering the health effects of armed conflict analysts can be inclined to focus on fatalities from direct combat or death from fatal injuries sustained in combat, including the deliberate use of starvation as a direct weapon of war. But, there are other direct effects such as significant physical and mental health problems amongst both the armed forces and targeted and untargeted civilians—such as illness resulting from disabilities (e.g. loss of limbs) and from atrocities of war, such as rape and torture, and sexually transmitted infections. There are also indirect effects of conflict. For example, health facilities, which may not have been of the highest standard even before the onset of conflict, can be destroyed, cutting off access to essential care. Moreover, disease spreads in insanitary conditions such as overcrowded refugee camps, and persons living in war-torn environments invariably suffer fear, insecurity and mental trauma (Levy and Sidel 2008).

The differentiation of peoples is fundamental here. In *Frames of War*, Butler (2010) counsels that wars seek to manage populations by distinguishing lives to be preserved from those that are dispensable. Some lives become grievable and others not, since to be grievable a life has to matter rather than to be seen as imminently destructible. Violent conflict is then one of the most radical inequalities imaginable as *some* deaths of *some* populations or groups are seen as necessary to protect the living of others. As will be discussed later, women and girls, and children in general are often differentially vulnerable. We will now take this further through two case illustrations: the health of former child soldiers and rape of women in war.

The term ‘former child soldier’ refers to children abducted into armies and rebel forces and then returned home. There are an estimated 300,000 child soldiers in the world today, of whom, over 40 percent are girls. The participation of children under the age of 18 years in armed conflict is generally prohibited under international law, and the recruitment of children under 15 into conflict is a war crime (Amnesty International 2017). Coerced, enticed or abducted, children serve as combatants, porters, spies, human mine detectors and sex slaves. Their health and lives are endangered. Many are forced to commit atrocities such as killing or maiming a family member in order to break ties with their community and to make it harder for them to return home. A high rate of mental health problems amongst returnees is inevitable, not the least because when they return home they

can experience stigma due to perceptions that they are immoral or dangerous. It is unsurprising, therefore, that former child soldiers have high incidences of post-traumatic stress disorder (PTSD), which is associated not only with their experience during war, but its aftermath. Betancourt et al. (2010) researched children in Sierra Leone who were recruited into the national army and civilian defence during the civil war of 1991, most notably the Revolutionary United Front (RUF), which was responsible for brutal atrocities against civilian populations, including amputations to suppress resistance, and large-scale abduction of children. The RUF forced children to commit atrocities including the murder of loved ones. Many were subject to repeated rape and forced to take drugs to reduce inhibition against committing violent acts.

After the war ended, programs were set up to reintegrate children into their former communities, yet this was very difficult as most faced fear and distrust and girls were seen as sexually promiscuous or defiled. Betancourt et al. (2010) studied the role of stigma in mediating children's exposure to war-related events and mental health outcomes. A total of 152 former RUF child soldiers aged between 10 and 18 years were interviewed at the end of the war in 2002 and again in 2004 with a focus on family and community acceptance and psychological adjustment, especially levels of depression, anxiety and hostility. The researchers found that the large majority of the respondents were involved with the rebels by force with an average age at abduction of 11 years. In all, 44 percent of the girls and 7 percent of the boys reported being a victim of rape; 31 percent of girls and 35 percent of boys had wounded or killed either a loved one or a stranger. Levels of depression were high and 79 percent felt local people acted afraid of them, and 82 percent that the local people felt threatened by them. As one child said, 'initially when I arrived [back home], people feared me. Some said I was a killer. There were times when I wanted to touch or play with other kids, but their parents will shout at me. I felt bad during those early days' (quoted in Betancourt et al. 2010: 24).

In conflict zones around the world, military forces use gender-based sexual violence (GBSV) to terrorise, humiliate and demoralise whole communities, including by the spread of a disease such as HIV and of sexually transmitted diseases—a clear illustration of illness as a tactic of war. Here the association between the individual and the collective

becomes paramount. There has been a tendency to explain rape and sexual violence as random and opportunistic acts of war, that is, outside of the wider structural context of the society concerned. Yet gendered structural conditions are crucial. Indeed, it is arguably because of the normalisation of women's inequality in a society where GBSV appears logical and instrumental (Davis and True 2015). Though violent conflict and health is not their focus, Scheper-Hughes and Lock's (1987) theorisation of the 'mindful body' is a valuable lens through which to evaluate GBSV. (See Chap. 3 for a discussion of 'the mindful body' in the context of embodiment theory.) They draw attention to the *individually experienced* body-self, and also to the *social body* and its symbolic and representational uses, and to the *body politic*, or the regulation and control of bodies, for example in families and in medical systems. Research examples illustrate how the individual body, social body and body politics come together to help explain rape and sexual violence in war. In their research on GBSV in South Kivu, Democratic Republic of the Congo, Kelly and colleagues (2012) found that, absolutely vital though this is, rape goes far beyond individual physical and psychological trauma and becomes a societal phenomenon where isolation and shame often become as important as the attack itself. Analysis of focus group data revealed that many interpreted rape as a form of destruction to the community, associated with the spread of disease, the devaluation of women and the breakdown of families. As one respondent put it, 'if you are a girl [who has been raped], your parents will start mistreating you, they can't understand that you have been forced and that it was not your fault. You will never get married. They will throw you away because you are not worth anything; you will lose all value because nobody will marry you' (quoted in Kelly et al. 2012: 290). Husbands may view their wives as 'contaminated', such as by sexually transmitted infections, and also as morally contaminating since the rape of a wife can result in loss of pride and a feeling of impotence in being unable to provide support (Kelly et al. 2012). A second illustration of the power of collective structural context on individual experience comes from the Serbian occupation of Croatia in the early 1990s. Olujic (1998) argues that to understand what happens in war we must take account of the pre-war gendered context, especially meanings of female sexuality and the codes of honour and virtue that women represent in the

family, alongside the role of men in protecting this honour. As she puts it, 'women's honour reflects that of men's, which, in turn, reflects that of the nation' (Olujic 1998: 38). Rape can then represent men's inability to protect women, an attack on their honour and a cause of their shame. Thereby the individual bodies of women become metaphoric representations of the social body and the injury to their bodies maims the family and the community. Based on fieldwork in hospitals in 'post-conflict' Erbil, Kurdistan, Keller (2012) explored women's expression of illness through presenting symptoms such as limb paralysis, convulsions and muteness. In women's own accounts, symptoms such as these were linked to home life, to experiences that were too much to bear and to lack of support. Keeler (2012) associated this with the imposition of global neoliberal agendas in the individual and social body: women's trauma narratives become (re)inscribed by their physicians as anti-modern, positioned as belonging to a 'bygone age'. Thus 'hysterical women' become a counter-narrative to the global prosperity trope and are medically silenced by the 'body politic' to 'expunge non-normative expressions of trauma' (Keeler 2012: 140) in post-conflict modernity. This occurs by such procedures as 'pain stimulation', including saline injections, the bending back of fingers and the threat of sexual trauma as 'medical treatment'.

This illustration directs our attention to the alliances between health-care and political agendas. In the final part of the chapter, I reflect on the interconnections of healthcare systems and neoliberal political agendas.

Part 3—Globalisation and Health System Change

Health systems can be defined as the assemblage of public and private sector institutions and actors concerned with the support of health and the amelioration of illness. Even though globally many countries are grappling with common problems, such as increased health needs and demands for healthcare, alongside the rising costs of providing it, there is not one, simple international line of convergence towards a common form of health system. The reason is that health systems are shaped significantly by their centuries-old economic and political regimes. In addi-

tion, they take their form from ‘national logics’, that is, how a society defines and deals with issues of health and illness. Equally, cultural factors influence how populations respond to proposed changes to their health system as well as how those external to a country relate to it. Even so, without undue risk of overgeneralisation, we can point towards a worldwide drive towards the commercialisation of health systems and, where public provision exists, such as in our case example of the UK, to the roll-back of state or public provision in favour of the free market principles. Thus, most health systems around the world have or are moving towards a mix of public/private provision. With this point in mind, it has been argued that health services are now as much about investor potential as access to care for patients. Tritter and colleagues maintain that

Health systems are no longer important primarily because they ensure that people gain access to health services when in need and irrespective of their ability to pay, that epidemics are prevented or controlled[...]or that the social determinants of health are addressed as part of public policies. In the emerging context of the reform policies, health systems are important not only as providers of products and services for which people are willing to pay, but also as an investment opportunity within global financial markets. (Tritter et al. 2010: 36)

Although they manifest in different ways across health systems, we can point to a set of three shared global influences: neoliberalism (see also the discussions on neoliberalism in Chaps. 4 and 6) as the dominant politico-economic policy framework driving system change; macroeconomic policies and structural adjustment programmes (SAPs); and international trade agreements.

As addressed elsewhere in this book, neoliberalism can be defined as a project of economic and social change based on the transfer of economic power and control from governments to private markets and the injection of market competition into areas such as education, housing and healthcare which, in many western countries at least, were once part of the welfare state (Scott-Samuel et al. 2014). As discussed in Chap. 4, neoliberalism is usually interpreted as a response to the period of structural crisis of the 1970s when, from mid-decade, countries such as the US and UK witnessed lower rates of financial accumulation and growth,

rises in unemployment and rising inflation. Neoliberal economic policies encourage financial deregulation and the opening up of trade and investment by resource-rich countries in regions where social conditions afford high returns. Up to the late 1970s, the predominant approach to health improvement globally was to strengthen public health systems, especially access to primary health care. This was the position established by the WHO's influential Alma-Ata Declaration of 1978 which brought about access to healthcare as a human right. The World Bank (WB), the International Monetary Fund (IMF), the World Trade Organisation (WTO) and other agencies rebuffed this position in the 1980s as they established monetarist policies prioritising the achievement of macroeconomic stability by putting constraints on the growth of money supply and public spending. Supranational agencies, such as the IMF, WTO and the WB, have been key players in the spread of global neoliberalism in the health field. Their influence is often indirect comprising the development of trade and investment agreements negotiated at bilateral and multilateral levels and the promotion of market-friendly structures and regulatory reforms.

One of the most controversial of WB policies has been the pressure upon countries of the global south to adopt SAPs. As a condition of receipt of foreign aid and loans, structural adjustments comprise lowering trade barriers, the selling off of state-owned assets and cutting public sector budgets and public sector workforces (Rowden 2009). The stance of the WB is that structural adjustment stabilises economies, promotes investment and generates long-term economic growth. But it has been argued to the contrary that this leads directly to chronic underfunding of local public sector services, collapsing domestic industries in the face of cheaper imports, rural-urban migration, reduced health budgets (and less money for health workers) and the reduction of access to services by local communities. For example, it might be argued that the unpreparedness of Liberia, Sierra Leone and Guinea to deal with the Ebola Virus outbreak of 2014–2016 in West Africa was associated with a short-term focus on economic objectives and on profitable sectors, such as minerals (iron ore, gold, bauxite and rubber) at the expense of the public sector. Stubbs et al. (2017) explored the effects of IMF aid conditionalities on the provision of healthcare in 16 West African countries including the

Gambia, Liberia, Nigeria and Sierra Leone, between 1995 and 2014. The number of conditions put on aid over the period amounted in total to 8344 in the region. IMF targets, such as budget deficit reduction, were found to crowd out or to reduce the space for investment in the health sector and aid conditions which stipulated staff layoffs or caps on public sector wages limited much-needed staff expansion of doctors and nurses. In other words, conditionalities of aid negatively impacted the provision of healthcare in the countries concerned.

The third significant influence on global health systems is international trade agreements, specifically the General Agreement on Trade in Services (GATS) and the associated proliferation of bilateral agreements. GATS, which came into effect in 1995, was the first set of multilateral rules governing international trade in services, such as education and healthcare, with the object of removing trade barriers. Ultimately, since it aims to liberate all services, it is a potential challenge to the sovereignty of national governments over policy-making in relation to public health and the provision of health services. For example, at the time of writing in March 2017, it is not clear whether the Transatlantic Trade and Investment Partnership (T-TIP) between the EU and the USA, presently in an eighth round of discussions, will exclude the UK NHS (National Health Service). If it does not then it could give transnational corporations the right to enter the UK market and operate without limits on their activities.

For the reasons referred to earlier concerning the different histories and cultural contexts, the organisation of health systems varies considerably in different countries. The US, for example, has always been a privately reimbursed system where citizens pay for care by insurance through employment or out of pocket. By contrast, in the UK health system since the inception of the NHS in 1948 most aspects of care have been provided free of charge through taxation. The same broadly applies to the Nordic countries, as well as others such as Italy. In between this many countries, such as Germany, Japan, Taiwan and France, have social insurance models whereby patients and employers pay into sick funds which contract with a range of health providers. But, to varying degrees and in different ways, almost all are moving towards a blending of public/private elements.

The UK has in many ways been at the fore in this regard, beginning with reforms of the Thatcher government in the 1980s. But the approach has been espoused internationally by countries as varied as Italy, Singapore, India, Taiwan, Malaysia, the Philippines and Russia. Fundamentally, the intent has been to introduce market mechanisms to control costs. Globally, though to varying degrees, healthcare costs have been rising at significant rates. For example, healthcare expenditure as percentage of GDP rose from 4.0 percent in 1970/1 to 9.8 percent in 2014 in the UK and, for the equivalent period, from 6.4 to 16.9 percent in the US, and from 6.2 to 11.1 percent in Germany (World Bank 2017).

In the UK and most notably England, an internal market was introduced in the early 1990s as a number of GP practices became fundholders who purchased care from hospitals and other providers on behalf of their patients (DoH 1989). The intention was that this would make them more cost conscious since they would be paying; that is, they would be deterred from referring patients too readily for tests and treatments, and that they would hold care providers, principally hospitals, to account for spending and quality of care for patients (Hunter 2016). The New Labour government of 1997 broadly extended this policy, merging general practices into Primary Care Trusts which jointly commissioned services for patients. The late 1990s into the early 2000s saw the further introduction of private providers into the NHS, for example, to run day surgery, pathology and diagnostic services (DoH 1997). In 2010, the new Coalition government consolidated this by the setting up of Clinical Commissioning Groups (CCGs) which hold approximately two-thirds of the NHS budget. CCGs currently purchase care on behalf of GPs for their patients. Moreover, under the new 'any qualified provider' provision, care could be commissioned not only from NHS providers but also from the for-profit and the not-for-profit third sector (charities and social enterprises) (DoH 2010). This overall policy remains in place at the time of writing in 2017 with recent concern focusing less visibly on structural reform and more on incapacity to meet demand—for example, in January 2017 the British Red Cross said that the NHS was facing a humanitarian crisis in the face of escalating demand and rising waiting lists for treatment.

Conclusion

Health, Culture and Society endorses the enduring conceptual legacies that have shaped and continue to shape our thinking. It seeks to understand not only where we have come from but where we are going to. This has been the focus of the current chapter as we have explored sociology's disquiet with 'society', as its erstwhile unit of analysis. While theorists of globalisation have given relatively little direct attention to matters of health, it has been suggested that the attention to international connections, mobility and new emergent forms of differentiation and inequality can be a useful point of departure for the analysis of health and healthcare. In these terms we have addressed several critical health issues of our time, such as migration and health, the securitisation of health, the health devastation wrought on civilians caught up in violent conflicts around the world, and the commercialisation of health systems.

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