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# Modernisation, smoking and chronic disease: Of temporality and spatiality in global health

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## ABSTRACT

This article explores the spatio-temporal logics at work in global health. Influenced by ideas of time-space compression, the global health literature argues that the world is characterised by a convergence of disease patterns and biomedical knowledge. While not denying the influence of these temporalities and spatialities of globalisation within the global health and chronic disease field, the article argues that they sit alongside other, often-conflicting notions of time and space. To do so, it explores the spatio-temporal logics that underpin a highly influential epidemiological model of the smoking epidemic. Unlike the temporalities and spatialities of sameness described in much of the global health literature, the article shows that this model is articulated around temporalities and spatialities of difference. This is not the difference celebrated by postmoderns, but the difference of modernisation theorists built around nations, sequential stages and progress. Indeed, the model, in stark contrast to the 'one world, one time, one health' globalisation mantra, divides the world into nation-states and orders them along epidemiological, geographical and development lines.

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## 1. Introduction

Influenced by the theories on globalisation that became so pervasive after the end of the Cold War, many of those who have written on global health assume that the last decades of the twentieth century have been marked by an accelerated compression of time and space (e.g. Beaglehole and McMichael, 1999; Walt, 2000). For them, the world has become a global village characterised by political, economic, and social integration as well as temporal simultaneity. This, they contend, is the consequence of trade liberalisation policies and technological innovations like air travel and the Internet, which have brought about growing flows of people, knowledge, capital and goods around the world. Applying these ideas to public health and biomedicine, these commentators explain that the world we now live in is characterised by a convergence of disease patterns, biomedical knowledge and public health strategies. Often these arguments have been made in relation to infectious diseases, as with the idea that air travel has allowed for the rapid spread of microbes around the globe (e.g. Garrett, 1995; Youde, 2012). More importantly for us, similar ideas have also been articulated about non-communicable diseases (NCDs) and their risk factors and, specifically, the smoking

epidemic and the chronic diseases it contributes to (e.g. Yach and Bettcher, 1999; Lee, 2003). So, for example, many commentators have argued that smoking and lung cancer are a global epidemic caused by trade liberalisation and multinational tobacco companies. Likewise, others have argued that 'global advocacy' in the field of tobacco control was made possible by the Internet, which allowed activists from around the world to 'interact simultaneously' (e.g. Yach and Bettcher, 2000; Lee and Collin, 2005).

There is little doubt that these temporalities and spaces of globalisation shape many theories, practices and materialities in today's global health and chronic disease complex (McGoey et al., 2011). But, as an emerging body of research suggests, there are other, often-conflicting spatio-temporal logics at work within this complex (e.g. Tousignant, 2013; Beisel, 2014; cf. also Lakoff and Collier, 2008; Fassin, 2012; Anderson, 2014). This article contributes to this research by arguing that there exists, within the contemporary field of global tobacco control, what I term temporalities and spaces of modernisation that have been extremely influential and stand in stark contrast to the spatial and temporal logics of globalisation. To do so, I examine a statistical model of the global smoking epidemic that has shaped the way tobacco control advocates have thought for the last twenty years and which was elaborated by epidemiologist Alan Lopez and his

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colleagues at the World Health Organisation (WHO) in the early 1990s. Specifically, drawing on extensive archival and ethnographic research on the international tobacco control movement,<sup>1</sup> I unpack how this model links the different temporal phases of the epidemic with particular disease patterns, public health policies, geographical regions and levels of development. I also show how many of its assumptions can be traced back to postwar modernisation and development theories. I conclude by exploring what this might mean for our understanding of global health. But, before doing so, I examine the temporalities and spaces of globalisation that can be found in much of the literature on global health.

## 2. Temporalities and spatialities of globalisation

In *The Condition of Postmodernity*, geographer David Harvey argued that the world was experiencing a 'time-space compression':

As space appears to shrink to a 'global village' of telecommunications ... and as time horizons shorten to the point where the present is all there is ... so we have to learn to cope with an overwhelming sense of *compression* of our spatial and temporal worlds (Harvey, 1989, p. 240).

He further observed that this time-space compression, which had been on-going since at least the mid-nineteenth century, had recently accelerated because of radical changes in the nature of capitalism and revolutions in transport and communication technologies. While particularly influential, Harvey was certainly not alone in articulating these ideas. Indeed, the last decades of the twentieth century saw a growing number of publications and debates on this topic, so much so that ideas about time-space compression and globalisation more generally had gained widespread acceptance by the late 1990s (May and Thrift, 2001; Scholte, 2005).

It is therefore no surprise that these ideas have been so influential among many of those writing on global health over the last fifteen years (e.g. Walt, 2000; Lee and Collin, 2005).<sup>2</sup> Borrowing from the work of Marshall McLuhan, David Harvey, Anthony Giddens and others, these writers imagine that the post-Cold War period has been marked by 'a process of increasing economic, political and social interdependence and global integration' (Yach

and Bettcher, 1998, p. 735). 'Time and space', they feel, is 'collapsing' (Yach and Bettcher, 2000, p. 206). The world is becoming a 'global village' (Lee and Collin, 2005, p. 15) with 'a sense of transworld simultaneity and instantaneity' (Lee, 2003, p. 105) and a 'shared cosmopolitan culture' (Yach and Bettcher, 2000, p. 206). Following the literature on globalisation, these writers view this 'process of closer integration' as being the result of two key factors (Walt, 2000, p. 1). The first is 'neoliberalism' and, specifically, 'trade liberalisation' (Lee, 2003, p. 65; Harman, 2012, p. 5). The second is the 'revolution in communications and transportation technologies' from the Internet to the aeroplane (Daulaire, 1999, p. 22). These factors, they believe, enable the ever growing 'flows of information, goods, capital and people across political and geographical boundaries' that bring about a global convergence of social, political and economical life (Daulaire, 1999, p. 22).

What is innovative in these writings on global health is the way they conceive public health and biomedicine through the lense of globalisation and time-space compression (Brown et al., 2006; Fassin, 2012). Thus, for these writers, the world is 'a global health village' characterised by a convergence of disease patterns, biomedical expertise and public health interventions (Yach and Bettcher, 2000, p. 736). Often, these arguments are made in relation to infectious diseases (e.g. Garrett, 1995; Weinberg, 2005; Youde, 2012). Many of these writers argue, for example, that the development of air travel has led to 'the microbial unification of the world' by allowing for the rapid spread of pathogenic microorganisms (Berlinguer, 1999, p. 18). Another illustration is the way in which the development of new Internet-based, epidemiological surveillance systems allow public health authorities across the globe to know about and prepare against pandemics 'in real-time' as they unfold (e.g. Weir and Mykhalovskiy, 2010; Caduff, 2014).

Importantly for us, many commentators writing on global health have applied ideas about globalisation and time-space compression to their analysis of NCDs and their risk factors. Some of them have written on the relationship between trade liberalisation in the food industry and the rise of unhealthy diets and NCDs like diabetes (e.g. Smith, 2003; Chopra, 2005). Others have explored the impact of globalisation on the alcohol industry and the chronic disease burden (e.g. Gilmore, 2009; Collin et al., 2014). But, most of these commentators have focused on smoking (e.g. Yach and Bettcher, 1999; Lee, 2003; Collin, 2005). The reasons for this are mainly historical: smoking was the first NCD risk factor to be addressed in global health with the adoption of the *WHO Framework Convention on Tobacco Control (FCTC)* in the early 2000s and now serves as a model for tackling other key NCD risk factors (Yach et al., 2003; WHO, 2003; Casswell and Thamarangsi, 2009). For these commentators, smoking is conceived as a 'global epidemic' defined by worldwide mortality and morbidity figures. One author, for example, argues that 'the global tobacco epidemic' kills an 'estimated four million people' per year around the world (Collin, 2003). 'Transnational tobacco companies', they suggest, are the main driver of this epidemic (Collin, 2005, p. 114). Taking advantage of recent trade liberalisation efforts, these companies are expanding their markets around the globe through sophisticated advertising and marketing campaigns purporting to spread a 'shared [smoking] culture' articulated around 'global [cigarette] brands' and the notion of 'the global smoker' (Yach and Bettcher, 1999; Collin, 2003). These different commentators also draw on ideas about globalisation and time-space compression to rethink the public health strategies deployed to stop the smoking epidemic. To illustrate, some argue that in order to 'impact tobacco consumption throughout the world' one needs 'global norms and legal instruments' such as the *FCTC* (Yach and Bettcher, 1998, p. 740; Harman, 2012, p. 38). Similarly, others comment that new communication technologies like the Internet have 'profoundly improved' the 'prospects for global advocacy' by allowing experts

<sup>1</sup> This research was articulated around three, main data collection strategies: (1) articles were gathered from a literature search on global tobacco control in major online databases and the British Library catalogue; (2) documents were obtained from organisations active in global tobacco control such as the WHO and the Framework Convention Alliance; and (3) over 100 semi-structured interviews were conducted with tobacco control experts and advocates in accordance with standard ethical principles and procedures (cf. Latour, 1993; Prainsack and Wahlberg, 2013). This corpus of texts and interviews was examined to identify the notions of temporality and spatiality around which the advocates and experts that make up the global tobacco control movement conceptualise, narrate and experience the smoking epidemic. Although these advocates and experts often come from different socio-economic and geographical backgrounds, it is important to note that their styles of thinking and reasoning are remarkably similar and consistent over time (Fleck, 1979; Hass, 1992; Hacking, 2002).

<sup>2</sup> While the literature on globalisation and health has been very influential within the field of global health, it has existed alongside two other bodies of work. The first is the research on cost-effectiveness and the global burden of disease carried out by epidemiologists and economists like Dean Jamison, Christopher Murray and Alan Lopez. Concerned with health planning and financing in low- and middle-income countries, this work does not engage with theories of globalisation and is, like the Lopez model, markedly influenced by modernisation theories (e.g. Jamison et al., 1993; Murray and Lopez, 1996). The second is the anthropological and geographical research that is deeply sceptical of the global and celebrates the local, emphasising resistance to, mistranslation and re-appropriation of biomedical and public health discourses by community leaders, doctors and patients in particular places (e.g. Kelly and Beisel, 2011; Livingstone, 2012; Lawhon and Herrick, 2013).

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