# Globalisation, Healthism and Harm Reduction

## Responsibility, Blame and Cultures of Care

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**Dr. Max Hopwood**

## Introduction

***In its current manifestation, however, medical harm reduction offers little real solution to the growing difficulty posed to societies through illicit drug use.***

**In recent decades, there have been moves toward emphasising the role of individual responsibility in the maintenance of health, as well as a tendency to stigmatise and blame some individuals and social groups for their ill-health. This brief article explores notions of health responsibility and blame through the lens of major economic and cultural phenomena which have occurred over the past thirty-five years: namely, globalisation, healthism and harm reduction. In this article I draw on the work of contemporary sociologists and historians to examine the interrelationship of these phenomena. In line with a growing number of commentators, I urge a direct political analysis of the social and legal systems that create harm for people who inject illicit drugs. This is important because harm reduction as it is currently constituted within public health individualises health related responsibility while masking the structural determinants of risk behaviour and ill-health, to the detriment of the people the paradigm purports to protect.**

## Globalisation

Beginning in the early 1970s, well documented changes have occurred in relation to the functioning of capitalism. Globalisation, or the growing integration of economies and societies around the world, has resulted in rapid economic growth for some countries. A factor which is driving globalisation is neo-liberalism, an economic, social and moral philosophy which embraces small government and flee-market privatisation over state intervention in the affairs of citizens. Under this market based philosophical system, nation-states willingly divest power and control over the economic affairs of their citizens to the private sector and its accompanying culture ideology of consumerism. The general neo-liberal vision is that every individual citizen is an entrepreneur managing his or her own life, and should behave in ways consistent with prevailing conventions of economic and social responsibility. The State, paradoxically, plays an increasingly regulatory role on behalf of private capitalist concerns (Robertson, 1992).

## Healthism

Such far-reaching economic reforms create equally significant cultural shifts and the changes which flow from globalisation are important for understanding cultural developments in notions of responsibility and blame, and cultures of care. On the heel of these changes emerged a new consumer movement and health consciousness which sociologist Robert Crawford (1980) refers to as 'healthism'. Crawford defines healthism as:

> **... a pre-occupation with, personal health as ... the primary focus for the definition and achievement of wellbeing; a goal which is to be attained primarily through the modification of lifestyles, with or without therapeutic help. (Crawford, 1980)**

Consistent with the neo-liberal focus on individualism, healthism construes individual behaviour, attitudes and emotions as the factors which need attention for the realisation of health, and solutions to preventing illness are seen to lie in the realm of individual choice. For proponents of this new health consciousness, the path to good health is via an individual's determination to resist the temptations of culture, overcome institutional and environmental constraints, resist disease agents and refuse to succumb to lazy or poor personal habits. Individuals are implored to be personally responsible for their health and are encouraged to engage in a variety of health maximising practices like exercise, attending to diet, reducing alcohol consumption and ceasing smoking (Crawford, 1980). Much of the cultural shift toward personalising health responsibility, as articulated by the tenets of healthism, is explained in terms of an ideology of consumerism that is functional for the new globa1ised regime of capitalism. The main beneficiaries of these changes are the private sector, the new middle class and the power elites of the state (Scambler, 2006). Indeed, it is not uncommon to hear politicians make rather simplistic claims regarding the significance of personal or individual responsibility for health, or to attribute blame for viral

epidemics to individual behaviour, such as:

> **... [A] lot of [viral epidemics] are a function of personal behaviour ... so I think we can get a message out there: personal behaviour does matter ... Original sin is a serious problem in our make-up. But the fact is we can't give up on the message that people need to take responsibility and that personal choice counts. (Tony Abbott, 2003)**

But personal responsibility risks the myopia of classical individualism where individual responsibility is seen to be all that anyone ever needs. Healthism does not acknowledge the social and cultural constraints which large swathes of health consumers experience against 'choosing' healthy practices and lifestyles. It follows, as many commentators have remarked, that the notion of individual responsibility promotes an assumption of individual blame for ill-health. Under a regime of healthism, people experience intense social pressures to act in ways to minimise the likelihood that their behaviours, motivations and emotions will result in costly ill-health; failing to act preventively becomes a sign of social, not just individual, irresponsibility. In this way, our globalised economy has determined that individual responsibility for health is more important than individual freedom. Behaviours, attitudes, and emotions that are deemed to put individuals at risk of disease are medicalised and people become morally obliged to correct unhealthy habits. Illness and any practice that can potentially lead to illness, becomes an individual moral failing caused by personal deficits.

Through this process, victim-blaming ideology gains strong roots in popular culture. The phenomenon of victim blaming is familiar to those working with marginalised populations like people with H.I.V. and hepatitis C infection.

The upshot of the interrelationship between economic and cultural changes brought about by globalisation and healthism over past decades is that blame is attached to the shame which defines health-related stigma. Individuals or groups of people whose lifestyle practices are deemed to constitute a personal or community health risk are understood to be a drain on resources and a threat to civilisation, and often both (Jones et al. 1984). As Crawford argues, individualism and the ideology of healthism foster an insidious de-politicisation which undermines the social effort to improve health and wellbeing. While it serves a benefit for many middle-class people who can afford to adopt a health promoting lifestyle, healthism can reinforce an illusion that we as individuals always improve health will somehow satisfy the longing for a much more varied complex of needs (Crawford, 1980, page 368).

## Harm Reduction

As neo-liberal States during late modernity drew back from direct intervention in the lives of citizens and devolved many of their powers to a range of private interests and service providers, power became located more generally throughout society than in overtly governmental institutions (Foucault, 1991). Foucault's writing on governentality highlight how all institutions are governmental institutions and all citizens have a role to play in the governance of self and others (Foucault, 1991). Certain issues, such as H.I.V. and viral hepatitis epidemics, which are construed as requiring State action, are negotiated and mediated through consultations with stakeholders, some of whom were created by the State's need for bounded populations to act on, and sub-governmental bodies to act through. Such new regimes of government come about through what Mitchell Dean (1992) refers to as 'a new prudentialism' that is a reliance on a scientific calculation of risk based on large epidemiological data sets. 'Community' is created via statistical models of risk practice and risk groups with a purpose of developing harm reduction interventions that enculture self-regulation. An example is the 'injecting drug use community', a geographically and demographically unbounded collective constituted via a statistically determined common susceptibility, at least at a population level, to poor health outcomes. The importance of the modern harm reduction movement to public health is usually measured by its capacity to prevent transmission of blood-borne virus infections and avoid drug overdose by teaching drug users self-management interventions. Dean characterises harm reduction for injecting drug users as a technology of agency which:

> **... often comes into play when certain individuals, groups and communities become what I have called target populations, i.e. populations that manifest high risk or are composed of individuals deemed at risk ... the object being to transform their status, to make them active citizens capable, as individuals and communities, of managing their own risk." (Dean, 1992)**

Certainly, the emergence of the harm reduction movement is part of an overall shift away from social control through overt or coercive state power, to more productive techniques designed to elicit compliance through self-regulation (Roe, 2005). The harm reduction movement appears at a time in history when neo-liberal values of individualism and self-regulation are becoming increasingly common within the new public health discourse. The utopian ideal of globalization, healthism and prudentialism is a responsible, self-regulating harm reductionism. However, the way that harm reduction has evolved over the past decade has implications for 'self-regulation' among people from differing economic and social categories.

Historically, there has been much tension within the harm reduction movement as activists who comprise one of the two main pillars of the paradigm, criticise what they term 'medical' harm reduction - the other pillar - for its reluctance to criticise global drug prohibition and for its failure to highlight the structural determinants of problematic drug use such as poverty. Rather, according to harm reduction activists, medical harm reduction prefers to express opposition to social marginalization of illicit drug users by highlighting the poor medical outcomes they suffer, while continuing to work within existing institutions, policy and laws, "even though the health problems they address are substantially created by the ideology of systems in which they work" (Roe, 2005, page 245).

Observers of developments in harm reduction increasingly echo the words of Gordon Roe, who claims that medical harm reduction is:

**... characterised by a dangerous acceptance of the present situation of drug users, fatalism towards the prospect of larger change, failure to challenge the contradictions of licit and illicit drug use, and a continuation of the assumptions of addiction and morality that underlie abstinence and enforcement" (Roe, 2005).**

Indeed, many commentators have suggested that the tenets of medical harm reduction ensure continuation of the blaming and shaming which defines health-related stigma. When people who use illicit drugs are unable to effectively self-regulate, say, because of harassment by the police, because of constraints imposed on their drug use practice from living in poverty, because of expensive and contaminated drugs bought off the streets or because of other structural reasons that limit access to harm reduction information and services, blame is levelled at individuals, not the state.

It has to be similarly noted that medical harm reduction initiatives also reduce the social costs of law enforcement and insurance premiums for theft and damage (Roe, 2005), while leaving intact the broader prohibitionist regime which undermines marginalised individuals' efforts to self-regulate risk behaviours. In fact, as Peter Miller (2001) writing in the journal Critical Public Health argued, medical mainstream harm reduction represents a convergence of economic rationalism with social policy which actually enables the state to continue causing harm to people without accepting responsibility for or acknowledging the social, legal and economic source of those harms. By improving the immediate and worst short-term effects of illicit drug use, medical harm reduction circumvents the need for States to change drug laws or address other systemic impediments to health. Harm reduction as it is currently constituted relieves the institution of prohibition of its responsibility for exacerbating health issues such as viral epidemics and in so doing reduces the incentive to make fundamental changes to policy; harm reduction is non-judgemental of illicit drug users, yes, but equally non-judgemental of the system that creates them (Roe, 2005).

## Conclusion

It is important to note that medical harm reduction initiatives such as needle and syringe programmes and methadone maintenance treatment, medically stabilise and help prevent blood-borne viral infections and other negative health outcomes among people who inject. These initiatives of themselves are to be highly valued and supported because without them Australian health systems would undoubtedly have to cope with tens of thousands more H.I.V. and viral hepatitis infections than is currently the case, so I acknowledge absolutely the contributions made by medical harm reduction.

In its current manifestation, however, medical harm reduction offers little real solution to the growing difficulty posed to societies through illicit drug use.

Mainstream medical harm reduction facilitates the ongoing demonisation and blaming of people with H.I.V., viral hepatitis and injecting drug users for their failure to 'responsibly' manage the complex calculus of health needs associated with the practice of injecting. Without a reinvigoration of its political activist roots, modern harm reduction will remain a conservative medicalised movement, populated by middle class health professionals in denial of the movement's activist past, and providing no leadership toward a more just future.

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### Dr. Max Hopwood

**From the University of New South Wales website: Dr. Max Hopwood B.A. (Hons) PhD. is a Research Fellow at the National Centre in H.I.V. Social Research at the University of New South Wales. He is a social psychologist with an interest in hepatitis C, H.I.V., chronic illness, illicit drug use, harm reduction and international and national drug policy. His work includes mixed-method research designs which he has used to explore phenomena related to quality of life for people living with blood borne viral infections, including the impact of stigma and discrimination on health and identity.**



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