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Overview

Various movements are afoot in the field of global health: from the collective control of epidemics to the personalization of disease; from trial and error to the standardization of evidence and policy; from health as a public good to the pharmaceuticalization of health care; from governmental detachment to the industrialization of the nongovernmental sector and a privatized politics of survival. Alongside them, critical questions abound: Has the biopolitical morphed into a multilevel turf war of private versus public stakeholders battling over the utility of government? Where does this leave the majority and the “surplus” poor and diseased subjects who are not targets of specific interventions? Is their biomedical rehabilitation “futile” in a world where health policies are increasingly oriented by market principles? How does this underside of global health speak to the decline of civil society as a viable “transactional locus” for the guarantee of social justice?

The chapters by Ecks and Harper, Han, Whitmarsh, and Biehl and Petryna provide valuable examples of the ways in which the movement of global health toward ever-greater scientization and private-sector involvement can be creatively studied by anthropologists. Strategically located at the sites where pharmaceutical industries, public health care providers, and patient-citizen-consumers intersect, these case studies provide a fertile ground from which to rethink the role of science, the state, and the market in global health and to evaluate alternative configurations, protagonists, dynamics, and possibilities.

How are the interpenetrating domains of ill health, therapeutic markets, and the law emerging as implicit and explicit sites for claiming political rights and confronting political failures? Are the subjects of rights and economic subjects—once understood as distinct entities—now included or excluded through shared mechanisms shaped by the market of global medicine? Is the market, then, what is ultimately produced by government and by the people?

Case studies in this section show how health policy debates about risk and compliance, as well as patient struggles for access to pharmaceuticals, are part of a changed health care landscape that the concept of the medicalization of social problems cannot fully address (Conrad 2007; Lock 2003; Scheper-Hughes 1992). While the culture of biomedicine is undeniably powerful, it is also speculative and improvised, and patients do not simply become the diagnostic categories and treatments that are applied to them. People may inhabit them to greater or lesser degrees, but they are also able to refuse them, or to redefine and deploy them to unanticipated ends. Understanding today's capacious pharmaceuticalization of health care requires analytical tools and methods that can account for the entanglement of multiple social forces and markets in defining the politics of health, the unregulated circulation of pharmaceuticals and their chemical effects, and the role of patients in creating demand.

In their contribution, Stefan Ecks and Ian Harper offer a way to see how the landscape of tuberculosis treatment in India emerges at the intersection of global business and political schemes and the local constraints of providing care. They follow the pharmaceutical industry's efforts to shape the diagnosis and treatment of TB, homing in on interactions between medical representatives (MRs) and doctors, and showing how the very materiality of global health interventions (drugs, protocols, policies, recordkeeping) provides the context for the expansion of a private therapeutic market.

India has the world's largest number of people suffering from TB, and most patients receive their care from private practitioners. The sphere of these private caregivers has been for the most part unregulated, producing "therapeutic anarchy," a situation in which the standards of care set by the WHO are altered or ignored, and where determining the extent of such informal practices has become nearly impossible. The WHO, working together with the Indian government, has sought to tackle the TB emergency in the country by involving an array of voluntary, corporate, and private providers and by extending collaborations via "Public-Private Mixes" (PPMs). The WHO now relies on directly observed treatment, short-course (DOTS) as the standard of care. This mixed partnership has also allowed the Indian state, and by extension the WHO, to gain some control over the therapeutic practices of the private side of the system.

As the majority of TB sufferers continue to receive help through private practitioners, however, DOTS wilts by the wayside. The reasons for this are manifold, but in general they reflect the ineffective organization of the Indian health care system, doctors' reluctance to take on additional administrative recordkeeping chores, and the widely held perception among practitioners and patients (reinforced by the pharmaceutical industry through its medical representatives) that DOTS provides subpar treatment and is ill-equipped to handle multidrug-resistant TB. Here, as in the Ugandan account, the move toward public-private mixes and the standardization of evaluations of care offer the state a prop on which to hang its own legitimacy. The supposed retreat of the state that these partnerships signal is in fact a strategic renegotiation of the state's responsibilities and a bid to grab a hold on an otherwise unruly industry.

Ecks and Harper show that flexibility in tailoring treatment is available to different health practitioners in various degrees, and they show how this flexibility positions practitioners within the commodity chains of pharmaceuticals. While general practitioners are more likely to prescribe the cheaper, predetermined combinations, so-called top doctors use the wider selection of drugs and information provided by Lupin Ltd., India's leading producer of anti-TB drugs. They provide highly personalized care and are directly remunerated for their brand loyalty. Lupin, on the other hand, benefits by having a larger share of the market, which not only means more direct profit, but also invites further outside investment because it demonstrates a solid grasp of local markets, which is especially convenient when applying for contracts from the WHO. Moreover, feedback from health practitioners and patients makes its way back to the pharmaceutical industry. What might at first sight seem to be an entirely top-down industry thus emerges in this ethnographic account as a somewhat surprisingly responsive and well-connected model of knowledge production and service provision.

From the thick description of these apparently out-of-the-way exchanges, we gain a more processual understanding of the entanglement of public and private health-related institutions and of the possibilities of action within and through them. By refusing outright condemnation of the market and its representatives, Ecks and Harper help us imagine different ways of negotiating the increasingly complex terrain of global health, of looking for possibilities where before we could only see limitations.

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Clara Han's chapter brings into focus informal economies of care and the ways in which domestic relations transform health interventions, while at the same time drawing our attention to the ways in which neoliberal state reforms create an environment of uncertainty and scarcity that can redraw the boundaries of mental illness and health. Drawing from her long-term fieldwork in Santiago, Chile, Han dislodges the primacy of the institutional in global mental health discourse by positioning herself within poor neighborhoods and in homes, alongside extended networks that, over time and to varying degrees, convert neighbors into kin. This ethnographic move steers the study of global health away from biomedical understandings and policy framings toward a view of health that emanates from the duress of the social.

The ethnographer here confronts an economy of missed connections, frustrated exchanges, and uncertain outcomes. The violence inherited from the Pinochet regime continues to limit the health horizons of Chile's poorest citizens. And the regime's neoliberal policies, hailed as miraculous innovations in their time, continue to produce a context in which unemployment and underemployment are endemic, and credit, while it can give people a chance to buy some time, can also become a noose on which the future hangs. Meanwhile, a brittle idea of community, refracted through the technical languages of the state and conforming to the requirements of cost-effectiveness, has come to dominate mental health care planning for the poor in decentralized and mixed public-private health.

We get at different understandings of disease and different conceptions of health based on where we start our studies. By beginning in domestic networks in La Pincoya and not with a mental illness diagnosis or treatment program, Han's case study allows us to see the interactions between those who are diagnosed and those who are not. From this perspective, diagnosis and treatment are not the exclusive purview of the biomedical, but are, like almost anything else, wielded and exchanged for different things. The depressed, be they diagnosed or not, have to deal with labor insecurity while experiencing all kinds of nonspecific aches and pains.

Yet material scarcity also opens the possibility for other kinds of generosity in which medicines, particularly antidepressants made available by mental health programs, can be offered as a salve that keeps other kinds of sociability alive. Han redirects the notion of community that is prevalent in discourses of global health (as in epistemic communities of disease, or targets of intervention, or populations at risk) back to that of kith and kin, to the networks both ephemeral and durable that are vital to the survival of the urban poor and that depend on affective engagements and transactions.

By looking at the ways in which community mental health interventions actually affect the lives of their targets and the networks through which they materialize and acquire alternative meanings, this ethnographic study makes a compelling case for the need to rethink the standards of evaluation employed. If antidepressants can be exchanged among family and friends to help with their pain, if in this act of kindness a debt is paid and relationships are healed and fed, and if this in turn also alleviates some of the person's own pain, what kind of success can this intervention be said to have? What would a people-centered reorientation of the intervention in such a local economy of survival look like?

A reorientation of global mental health programs toward "the weave of life" demands a transformed understanding of health care, one in which health is enmeshed in networks of sociality, and care continuously subverts "the norms that life must overcome."

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With rates of heart disease, diabetes, cancer, and asthma increasing worldwide, the treatment of chronic diseases has become a new frontier in global medicine and health policy. In his chapter, Ian Whitmarsh shows how this focus on chronic diseases is also transforming approaches in global health, marking a departure from the focus on urgent communicable conditions that have historically been the main objects of concern and intervention. He draws from multisited research conducted with medical scientists in the United States and health officials, doctors, and patients in Barbados and Trinidad and Tobago to problematize the constitution of population genetics as a powerful research and diagnostic tool and its deployment along the lines of race. A new figure of the patient is being fashioned in the twenty-first-century biomedical/market/policy focus on lifestyle diseases: “the locus of intervention shifts from attempts to remove structural barriers or expand access to medications, to getting individuals coming to see themselves as ill or potentially ill and acting accordingly.”

In contrast to infectious diseases such as HIV/AIDS, there is no a priori agreed-upon knowledge that can inform interventions to curtail chronic diseases. Interventions targeting them are future-oriented and, in a sense, always partial, as the search for genetic predispositions for common diseases continues to unfold. While attending to genetic propensities, these interventions concentrate on producing information about who the afflicted will be and managing a condition that, ultimately, turns into the management of everyday life. The integration of genomics in population health, particularly in the management of chronic diseases, spurs new databases, institutes diagnostic tools and treatment guidelines for a distinctive patient figure, and locates potential markets for preventative pharmaceuticals. In this framework, poor countries play a much more complex role than that of recipients of aid or laboratories of experimentation.

If questions of delivery plagued previous efforts to combat infectious diseases, patient compliance becomes the new locus of intervention when disease states are anticipated. No longer limited to the timely taking of drugs, compliance comes to demand changes in cultural, social, and psychological proclivities along new lines defined by biomedical knowledge. Noncompliance thus becomes the disease itself. Through the interchangeability of research and intervention, a dual patient subjectivity comes into view: the patient is part of a biological population at risk, and thus not responsible for acquiring the disease, but at the same time requires individualized interventions at the level of choice and disposition.

Whitmarsh’s ethnography and critique allows us to consider the ambivalences these subjects take on within a political, scientific, and cultural milieu populated by contradicting expectations and competing intentions. When global health efforts are increasingly framed in terms of experimentation, genomically racialized populations, and future diagnoses, the attentive eye of the ethnographer may help ferret out the technological and political-economic intermingling that ultimately shapes the possibilities of health care.

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As public health actors and institutions around the globe contend with limiting public health paradigms and limited delivery systems, they must also struggle with how to guarantee the human right to health and how to fulfill promises for increased access to medical technologies. João Biehl and Adriana Petryna's chapter explores the emergence of novel arenas of contestation in which the role of the state and socioeconomic and medical rights are being reimagined and reshaped.

In 1996, Brazil became the first developing country to adopt an official policy granting free access to antiretroviral drugs through its broad-reaching but ailing public health care system (SUS). In the years since the launch of this therapeutic policy, Brazil has asserted itself as an innovator and leader in efforts to universalize access to AIDS therapies in poor contexts (through generic drug production, price negotiations, drug distribution schemes, and South-South technology exchange programs).

As the government opened the country to international financial capital and championed populist and much-needed social policies, it also strategically withdrew from strict market regulation. Today Brazil is the eighth largest pharmaceutical market in the world (total market value amounted to twenty-five billion dollars in 2011). It is estimated that more than half of the adult population (about sixty million) consumes pharmaceuticals daily. Multiple public and private actors are invested in making medical technology (and not for infectious diseases only) broadly accessible.

In the wake of the country's highly publicized antiretroviral drug rollout, public health and care have become increasingly pharmaceuticalized and privatized (Biehl 2007), and the rights-based demand for drug access has migrated from AIDS to other diseases and patient groups. A growing number of citizens are acting within the state to guarantee their right to health, understood as access to medicines of all kinds, whether or not they are available in official drug formularies. Widespread and often desperate patient demand, informed by physicians' prescriptions and mediated by public defenders and private lawyers, drives this phenomenon known as "the judicialization of the right to health."

The contribution by Biehl and Petryna examines the political subjects that emerge from this complex law-state-market ecology and shows how in this new chapter in the history of the right to health, the judiciary has become a crucial arbiter and purveyor of care and technology access. They draw on their efforts to empirically map right-to-health litigation in the state of Rio Grande do Sul (which has the highest number of such lawsuits in the country) and explore the impact that judicialization is having on health systems and on practices of citizenship and care. People's life chances and health outcomes are, in such a context, determined by what kind of subjects they are able to become through appeals to the judiciary, government, and research and health industries, amid drives for profit and the construction of new therapeutic market segments. Subjects here are not entirely atomized, nor are they seen as belonging to preexisting populations, but they are rather members of temporary collectives meant to aid in the navigation of the judiciary system.

As in other cases studied in this book, conjunctions of private and public interests in the new world of global health have produced in Brazil a complex arena in which the role and limits of the state and the benefits and obligations of pharmaceutical industries are constantly negotiated in ways that undermine the easy categorizations of neoliberalism or market fundamentalism. By charting the therapeutic trajectories of patient litigants and their families, Biehl and Petryna show that such negotiations are also available to those deemed targets of interventions or subjects of future medical policies and protocols, and not just to planners and implementers.

Economists have wrestled with the question of what variables determine improvements in health and survival. Some argue that the introduction of new knowledge, science, and technology always increases inequalities in health outcomes, both within and between countries—"at least for a time" (Cutler et al. 2006:117). Cutler and colleagues suggest not only that "knowledge, science, and technology are the keys to any coherent explanation" of declines in mortality (116), but also that health gradients between and within countries will continue to increase along with the accelerating pace of new medical inventions. Notwithstanding these initial inequalities of access, the authors argue that "help is on the way, not only for those who receive it first, but eventually for everyone" (117).

Biehl and Petryna question the assumptions that underpin economic trickle-down theories—namely, of the self-regulating capacities of free markets and the march of ever-expanding access to new, life-saving technologies. What they instead show ethnographically is that poor patients are in growing numbers not waiting for new medical technologies to reach them, but are demanding access now, even if one-by-one, one disease and one court case at a time.

Dropping in new medical technologies and treatments without attention to local public health infrastructures and without broader institutional reforms, however, leaves everything to the vicissitudes of the market. This, in turn, leads to a kind of "open-source anarchy" (Fidler 2007) in which, as Biehl and Petryna suggest, new strategies, rules, distributive schemes, and practical ethics of health care must be improvised and assembled piecemeal by a wide array of deeply unequal stakeholders on the ground. The plights of patient-litigants raise crucial questions over what appropriate political and legal mechanisms should exist to foster "the help that is supposedly on its way" and to offset the losses of life that may plague those who do not receive the new technology first.

In addressing the joint phenomena of the pharmaceuticalization and judicialization of health care in Brazil, Biehl and Petryna's case study captures the fluidity and fragility of biopolitical processes and their entanglement with the market. Both the milieus that these phenomena help to produce and the contestations that they allow are testing grounds for present-day techniques of governance. Different forms of social being emerge within and through these milieus and contestations, and they are always in potential flux.

—João Biehl and Adriana Petryna