Health Politics in an Interconnected World

Background Paper

Thirteenth Berlin Roundtables on Transnationality

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Maintaining and improving the health of the world's population is one of today's key challenges. Scientific, administrative and political changes in the last century have improved the quality and duration of life for people in many parts of the world. Yet, health levels have stagnated and even worsened in many developing countries, and the health of marginalized populations in developed countries resembles that of much poorer countries (Birn, Pillay, and Holtz, 2009). At the same time, aging populations in rich as well as industrializing countries threaten to destabilize health care and pension systems, and health care costs continue to increase exponentially (Gruber and Wise, 1999). Furthermore, medicine and health are implicated in the processes and structures of global and transnational organizations in multiple ways. As a result, it is necessary to explore the theoretical and methodological challenges—which also comprise moments of inter- and trans-disciplinary collaboration—associated with the study of health and medicine in an interconnected world (Dilger and Hadolt, 2010). Addressing these issues requires research and dialogue among scholars, practitioners, and policymakers from all backgrounds and areas of the world.

Health-related connections intertwine global, national, and local social and political life. At the global level, the multifaceted ties between nations and individuals along with enduring inequalities make possible the spread of new diseases, including SARS, influenza, and HIV/AIDS, as well as the recrudescence of ailments such as tuberculosis and malaria (Garrett, 1994). These ties, which are simultaneously transnational, national, and local, also shape responses to health issues. In particular, a web of government offices, development agencies, non-governmental organizations, community-based groups, and individuals struggle to both prevent further new infections and to care for those who are afflicted (Lock and Nichter, 2002).

At the national level, interest groups with varying degrees of power quarrel over the allocation of resources to the health field, and also over the distribution of those resources *within* the field (Powers and Faden, 2000). Countries vary greatly in terms of the emphasis placed on curative versus preventative strategies, and in terms of the degree to which health care and other social support is provided to those with lower incomes. At the local level, health care and prevention efforts are implemented and experienced by individuals, with differing impacts based on social, political, and cultural context.

Yet, despite national and local particularities, it is clear that epidemiologic, regulatory, and business patterns are often repeated in different parts of the world. The outbreak of "swine" flu (H1N1) is a dramatic case in point, as is the fact that fertility rates and levels of type 2 diabetes

in certain areas of low-income countries now match those of more developed countries. In addition, health insurance and old age pension plans are connected across geographic boundaries via the participation of investors and financial intermediaries in worldwide capital markets. Finally, the focus on local responses to health-related challenges highlights the need to recognize and acknowledge the potentials and resources that are mobilized by individuals and communities in relation to health and medicine, and that also have an impact on the effectiveness of national and global health programs and initiatives. Therefore, while health is experienced at individual and local levels, there are wider transnational forces and power structures that connect and determine our experiences, and that must not escape our attention. These forces render any clear-cut distinction between "developed" and "developing" worlds obsolete, and will affect the health of people throughout the twenty-first century.

The extent to which similar processes have an impact on the health of different individuals and communities is the unifying thread for this piece of the 2010 Berlin Roundtables on Transnationality. These roundtables will consist of three workshops, each with its own theme as described below. It is hoped that this call for papers will attract people from a variety of disciplines—including all of the social sciences, public health, and medicine—as well as from different backgrounds, including scholars, practitioners, and activists. It is also hoped that papers will address both developed and developing countries, as well as make comparisons across geographic, social, and political space. Finally, we expect that paper submissions adopt a methodological-analytical perspective that takes seriously the multiple challenges and opportunities that are implicated in the study of medicine and health in an interconnected world.

Workshop 1. The Production of Evidence

Chairs:
Stefan Ecks (Medical Anthropology, Edinburgh); Hansjoerg Dilger (Social Anthropology, FU Berlin)

Implementing health care interventions requires evidence, but evidence is not a straightforward good. Its collection and interpretation require human intervention, which takes place in specific socio-economic and cultural contexts. The Tuskegee syphilis experiment, in which hundreds of poor Afro-American men in the U.S. were used to study the advance of the untreated disease between the 1930s and the 1970s, provides an example of how obtaining evidence can contribute to strife and lasting memories of injustice (Reverby, 2000). Similarly, contests have emerged over the evidence that HIV causes AIDS, and also over the evidence that leads to the withholding of experimental AIDS drugs (Epstein, 1996). This conflict has pitted scientists and community activists against each other, and even involved South African President Thabo Mbeki (Fassin, 2007). The controversy highlights how the production of evidence can be linked to rash, misguided, or under-informed actions that have grave consequence for individuals and groups, and even cause friction at the international level.

What, then, ought to count as evidence? What kind of methodological instruments do different disciplines provide in order to study and account for evidence? Do anthropologists, for example, provide "evidence" with a single case, or should we strive to meet the benchmark standard of

biomedical science, the randomized controlled trial? Similarly, choosing the best possible course of action when faced with a health crisis is not a straightforward matter. What kinds of bureaucratic regimes and procedures evolve in relation to specific health problems, and what effect do systems of neoliberal accountability and efficiency have on the institutional settings of governmental, non-governmental and/or religious and community-based organizations? How do certain individuals and agencies acquire the competence and authority to decide what counts as evidence? Who decides whether to focus on the prevention or cure of disease, and which disease should be the focus of resources?

The conduct of, or failure to conduct, health interventions inevitably leads to conflict. Some of these conflicts result from the classification of certain social groups as "at risk," due to traits that include their place of residence, their age, their behaviors, and their sex (Petersen and Lupton, 1996). How are risk groups determined, and how are priorities set for addressing their needs and desires (Booth, 2004)? How do social and cultural prejudices affect decisions in this respect? In a related vein, what evidence, if any, justifies the criminalization of a disease, and how can information and knowledge be used to reduce stigma? What, in short, are the macro- and micro-politics of evidence in relation to specific health settings? What lessons have we learned to improve the delivery of health care services, politically, technically, and organizationally? Can these lessons be shared across national borders?

Workshop 2. Negotiating Access

Chairs:
Anita Hardon, Social and Behavioral Sciences, Amsterdam School for Social Science Research, The Netherlands; Marian Burchardt (Sociology, Bayreuth)

Access to resources is one of the primary ways in which individuals are linked to communities, and communities to states, and states, communities, and individuals to the broader social fabric. As human needs such as health are increasingly interpreted as social rights and enshrined in national and supranational legislations, access to healthcare is also normatively postulated as an ideal (Toebes, 1999). Emphasis on health as a right raises questions as to the how, by whom and for whom this ideal is being realized. Access to healthcare, drugs and health-related knowledge, as well as to different types of treatment and healing practices, is often shaped by membership in groups and their specific economic, cultural and political resources (Farmer, 2003). What are the processes whereby access to healthcare is granted or withheld, and whereby membership turns into a privilege or a barrier? How does political activism, as well as various forms of biological citizenship, challenge prevailing structures of access (Rose and Novas, 2005)? Central issues include undocumented immigrants' access to emergency room care, of HIV+ individuals' access to antiretroviral therapy, and 'ordinary' men's and women's access to insurance (Ticktin, 2007).

In a globalized world dominated by biomedicine, access to healthcare is also an outcome of states' agency and power in interactions with international organizations and pharmaceuticals (Hayden, 2007). Which factors influence the degree to which states safeguard health-maintaining resources for their populations? How do legal structures, ranging from TRIPS to patent law, influence access to lifesaving drugs? How does the crisscrossing of national

boundaries by health-seekers, intermediaries, insurance companies, and pharmaceuticals re-shape the health field?

The politics of access also influence the ability of another party to gain access to and have rights over an individual and the environment. For example, who is allowed to draw blood, who is allowed to determine which people become subjects in a drug trial, and how do we ensure that vulnerable populations are treated ethically (Shapiro and Meslin, 2001)? As insurance companies increasingly dominate medical decision-making, who is best qualified to make decisions about the end of life, and what role do religious convictions play in this matter (Light, 1992)? Finally, whose responsibility is it to preserve and protect health within and across countries, who should set health priorities, and how should these entities be held accountable?

Workshop 3. The Politics of Locality

Chairs:
Lisa Ann Richey, Associate Professor, Dept. of Society and Globalization (Roskilde University, Denmark); Rachel Sullivan Robinson (Sociology, School of International Service, American University Washington DC); Raul Necochea (Medical History, McGill University Montreal)

The local and the global are linked in myriad ways, sometimes causing conflict, and other times working together in harmony (Meyer et al., 1997). What are the effects of global standardization of health programs (related to everything from smoking to HIV to obesity) on local practices and attitudes, and how do local realities influence global discourses, technologies, and regulatory approaches? Given that western public health, as a field of expertise, has a long history of subordinating, co-opting, and ignoring alternative forms of knowledge regarding health and the body, how do power differentials shape the effectiveness of health interventions? In a related vein, is bioprospecting simply a novel way to do what Western public health experts have done for over a century, and how does it impact the health of local communities (Merson, 2000)?

As developing countries create durable health institutions, their ability to help one another increases (Muntaner et al., 2006). How does South-South collaboration in the health field differ from the traditional model of a developed country providing aid to a developing one? At the same time, the circulation of individuals across the globe is not only responsible for the spread of epidemics, but also for the diffusion of expertise, and consumption patterns from one locale to another (Krause, 2008)? How can people participate in the solution to global health problems without having to travel abroad? On the other hand, how can brain drain be mitigated? What are the ramifications of medical tourism (Kangas, 2007)?

As the focus on, and the impact of, the global has risen, the local has simultaneously taken on new dimensions, particularly in regards to health and so-called "traditional" medicine (Bodeker, 2001). How has traditional or indigenous medicine become "local" and then eventually been incorporated into global health regimes, and what are the specific politics, interests and power relations that have constituted a medicine as "traditional" or "local" (Adams, 2002)? At times adherence to medical traditions has been construed as an expression of cultural sovereignty and cultural rights, lending the local a new global visibility. At other times, the traditional is

identified as the source of negative health outcomes (Vázquez, Mosquera, and Kroeger, 2002). Which contradictions may emerge when non-biomedical pathologies and therapeutic cultures meet with bureaucratic logics of accountability and corresponding notions of evidence?

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