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# The judicialization of biopolitics:

## Claiming the right to pharmaceuticals in Brazilian courts

### ABSTRACT

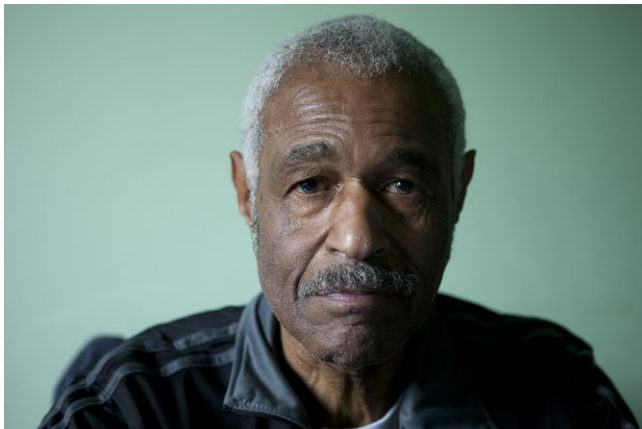
In Brazil, low- and middle-income patients are not waiting for new medical technologies to trickle down. They are using free legal assistance and a responsive judiciary to access health care, now understood as access to pharmaceuticals. The pharmaceuticalization and judicialization of health reveal an experiential-political-economic field beyond the biopolitics of populations. At stake in this field are the ways in which government (qua drug regulator, purchaser, and distributor) facilitates a more direct relationship, in the form of technology access, between atomized and ambiguous political subjects of rights and the biomedical market. Not fully governed by either state or market, these subjects negotiate the constraints and possibilities of a technological society using jurisprudence. They work through available legal mechanisms and instantiate new social fields to engage and adjudicate their demands, concretizing abstract human rights. In the process, the judiciary is consolidated as a critical site of politics—and of political economy. [*right-to-health litigation, pharmaceuticalization, judicialization of politics, Brazil, para-infrastructures, patient-citizen-consumers, biopolitical theory, anthropology of law and medicine*]

**A** retired bus driver, Edgar Lemos lives in a lower-middle-class neighborhood of Porto Alegre, the capital of the southern Brazilian state of Rio Grande do Sul. Dealing with significant motor difficulties, Edgar had to wait for more than a year for a specialized neurological appointment at a nearby public hospital. He was finally diagnosed with hereditary cerebral ataxia in November of 2008. The neurologist prescribed the drug Somazina, which is not included on any governmental drug formulary.

Coming from a destitute family, Edgar had worked since the age of eight. He was proud of the gated brick and mortar house he had built himself on the top of a hill. Edgar's ataxia affected not only his mobility but also his sense of dignity and worth, as it made him dependent on the care of his wife and two adult daughters. Religion had become an important source of emotional sustenance and a complement to his pharmaceutical treatment. While Edgar felt that Somazina was helping to halt the degeneration of his motor abilities, he was also taking a variety of other drugs, from statins to antihypertensives and antianxiolytics, to soothe additional symptoms.

During a conversation I had with him over his dining-room table in August 2011, Edgar opened a box containing the five medicines that make up his regimen. As he held each one in turn, he said, "This one I don't judicialize, this one I don't judicialize . . . I only judicialize this medicine because I went into debt paying for it." A monthly supply of Somazina costs about \$200.

After paying for the drug out of pocket for several months, Edgar had to take out a bank loan. Unable to keep up with house expenses and his loan interest, he had "no other alternative but to judicialize." He learned about the Public Defender's Office (Defensoria Pública) from other patients also waiting for specialists' referrals at the public health post, and filed a lawsuit to compel the state to pay for his medication. The Porto Alegre district judge issued a court injunction on his behalf, and Edgar received the medicine for several months, but then "the delivery stopped." He filed a new claim and won another injunction for three additional months of treatment. As state attorneys were appealing the judge's decision, Edgar nervously anticipated having to renew the lawsuit again.



**Figure 1.** Pensioner Edgar Lemos spoke to Biehl, August 2011, about his efforts to access treatment through the court in Porto Alegre. Photo by Torben Eskerod.



**Figure 2.** In conversation with Biehl over his dining-room table, Edgar Lemos opened a box containing the drugs that made up his treatment regimen, Porto Alegre, August 2011. Photo by Torben Eskerod.

A former union organizer, Edgar had a sense that aspects of racism and socioeconomic inequality were improving with the rise to power of the Workers' Party (Partido dos Trabalhadores, or PT) and new social-protection measures (Anderson 2011). As for why he was not judicializing the other drugs he was taking, Edgar reasoned, "I know that the state cannot give everything to everyone. I have to do my part and pay for whatever I can."

Across Brazil, patients like Edgar are seeking, and sometimes realizing, access to health care through the courts, a phenomenon that has been termed the "judicialization of health" (Biehl et al. 2009; Ferraz 2009). Though patients are suing the government to provide everything from baby formula to complex surgeries, a large number of lawsuits are for access to prescribed drugs (Scheffer et al. 2005).

In this article, I explore how right-to-health litigation has become (in the wake of a successful universal AIDS

treatment policy) an alternative for many Brazilians seeking to access health care, now understood as access to pharmaceuticals that are either on governmental drug formularies or are only available through the market. Throughout, I show how the relations between individual bodies, political subjectivities, medical technologies, and state institutions are compellingly rearranged along this judicialized front. The article's ethnographic vignettes pave a path toward a relatively unexplored frontier of medical, legal, and political anthropology: that zone where medicine and law intersect in unexpected and deeply personal ways, and where our notions of how medicalization and biopolitics operate from the bottom up must be rethought.

### **From the right to health to the right to pharmaceuticals**

The 1988 Brazilian Constitution declared health a "right of all persons and the duty of the State," and the creation of the country's Unified Health System (SUS) extended health coverage to all citizens (Paim et al. 2011). Judicialization stems from an expansive definition of the meaning of the right to health and also, in part, from the passage of a landmark law in 1996 establishing free universal access to antiretroviral (ARV) therapies for HIV-infected individuals (Berkman et al. 2005; Biehl 2007b; Galvão 2002). Ministry of Health policies and a 2000 ruling by the Federal Supreme Court further advanced the right to medicines as part of the constitutional right to health (Supremo Tribunal Federal 2000).

SUS provides health services and medicines free of cost (Porto et al. 2011). As part of a broader process of decentralization and in an effort to improve the administration of SUS, the Ministry of Health divided responsibilities for pharmaceutical distribution among three levels of government (Ministério da Saúde 2010). While the federal government retained some of its central role in financing public health, state and municipal health secretariats had to develop new structures to assess health needs and to administer federal and local funds for care delivery.

Today, federal, state, and municipal tiers of government are responsible for purchasing and distributing medicines according to specific drug formularies. The federal health ministry continues to finance high-cost medicines called "specialized medicines" that are distributed by state health secretariats. Municipal governments are responsible for purchasing low-cost "essential medicines," which are dispensed at local public pharmacies (Souza 2002). State governments finance and distribute "special medicines" that their state residents require but that do not appear on either of the other two formularies (Ministério da Saúde 2001). In addition, the federal health ministry funds strategic programs for the control of certain infectious diseases such as HIV/AIDS, tuberculosis, and leprosy as well as rare disorders such as Gaucher's disease (Ministério da Saúde n.d.).

Despite these laws, policies, and judicial rulings, the experience of patients in realizing access to medicines has been uneven. Today, about 200 thousand Brazilians take ARV drugs paid for by the government. At the same time, many citizens go to local public pharmacies only to find that basic medicines are out of stock and that the newer medicines they seek are not included in official formularies (Mendis et al. 2007). Decentralization delegated responsibility but did not ensure sustainable funding and technical capacity at local levels. Many municipalities remain ill equipped administratively and financially to provide the essential medicines for which they have been made responsible. The same can be said for states and their mandate to provide high-cost specialized medicines. Governments at every level have not been able to adequately administer the growing complexity of needs within an already complex health system.

With a population of about 200 million people and an economy on the rise, Brazil has one of the fastest-growing pharmaceutical markets in the world (with an estimated total value of more than \$25 billion in 2012, according to the Sindicato da Indústria de Produtos Farmacêuticos no Estado de São Paulo [SINDUSFARMA]). Public and private doctors increasingly prescribe and patients demand new medicines, some of uncertain benefit. Newer medicines, however, are often only available through private purchase. Unable to pay out of pocket (as in Edgar's case) or to find low-cost generics at public pharmacies, patients are increasingly suing the government to obtain what they need. People often use the expression *entrar na justiça*, "to enter the judiciary" or, literally, "to enter justice," to refer to their lawsuits.

### Para-infrastructures and political experimentation

For the past four years, I have been coordinating a multi-sited ethnographic study of right-to-health litigation in the southern Brazilian state of Rio Grande do Sul, which has the highest number of such lawsuits in the country.<sup>1</sup> Implementing collaborative evidence-making practices, our research team moved across domestic, clinical, judicial, and administrative domains to track the interconnection of sites and the interplay of scales that the judicialization of health calls on and calls into question. Some of the core queries that guided our investigation included the following: Is the judicial system an effective venue for implementing socio-economic rights? Which social fields and practices of citizenship and governance are crystallized in the struggles over pharmaceutical access and administrative accountability? How is it possible to gauge the market's influence on the medical demands and practices as well as on the public institutions of the world's sixth largest economy?

While examining the tense negotiations of the constitutional right to health in daily life, I often had a sense of social roles and political positions out of place: of the judiciary as a sort of pharmacy, the public defender as a physician, the physician as an activist, the patient association as legal counsel, and the patient citizen becoming the consumer, among other translocations and displacements. I found Michel Foucault's (2008) tentative reflections on biopolitics and neoliberalism helpful as I tried to understand the form and reach of these novel medico-socio-legal realities, in particular his observations on the frugality of government in contexts where market exchange determines value. But these realities also contravened Foucault's reflections, as they underscored the importance of the juridical subject to late-liberal political economies.

In his 1978–79 lectures at the Collège de France, Foucault argued that we can adequately analyze biopolitics only when we understand the economic reason within governmental reason, suggesting that the market shapes and even determines governmental logics. In Foucault's words, "The market constitutes a site of veridiction-falsification for governmental practice. Consequently, the market determines that good government is no longer simply government that functions according to justice" (2008:32).

The ways and means of right-to-health litigation in Brazil reveal an intense experiential–political–economic field. Here the penetration of market principles in health care delivery is unexpectedly aligned with the juridical subject of rights. The rational choice-making economic subject (necessarily a consumer of technoscience) is also the subject of legal rights. The right to life is claimed in between the clinic, the court, and the marketplace. What do these processes of judicialization mean for how anthropologists approach the study of politics and engage with ongoing debates, inside and outside the academy, about the relationship of health to human rights and social justice? How are the interpenetrating domains of health, therapeutic markets, and the law emerging as implicit and explicit sites for claiming political rights and confronting political failures?

Jonathan Spencer has written about anthropology's difficulties in "drawing bounds round 'the political'" (2007:29; see Biehl and McKay 2012). While classic political anthropology limited politics to formal and functional analyses (a "politics without values"), the anthropology of politics that emerged in the 1980s and 1990s as a necessary and invigorating corrective (as exemplified by subaltern studies) "deliberately exclud[ed] the state from the domain of authentic politics" (Spencer 2007:23). In the intervening decades, the anthropology of politics has moved to include a consideration of the state and development (Ferguson 1994; Sharma and Gupta 2006), of transnational politics and neoliberalism (Comaroff and Comaroff 2011; Englund 2006; Ong 2006; Petryna 2002), and of the affective domains and subjective experiences of political life (Biehl et al. 2007; Povinelli 2011).

And while much recent anthropology has productively applied Foucault's concept of "biopolitics" to a variety of contexts (Fassin 2007; Nguyen 2010; Ong and Collier 2005; Rabinow and Rose 2006; Rajan 2006), we are only beginning to capture the fluidity and fragility of biopolitical processes and their entanglement with the market as a testing ground for techniques of governance and self-fashioning (Edmonds 2010; Franklin 2011; Roberts 2012).

Clearly, anthropologists have stayed attuned to politics—even as the substance of what is considered "political" has varied with disciplinary conversations—whether as activists concerned with the inequalities of the field or in their theoretical concerns with such issues as postcolonial disorders, structural violence, social suffering, and biopolitics (Chatterjee 2004; Comaroff and Comaroff 2011; Das 2007; Farmer 2003; Good et al. 2008; Hansen and Stepputat 2001; Holston 2009; Merry 2006; Riles 2000; Schepher-Hughes 1992; Tate 2007). Most compellingly, anthropologists have begun to examine the politics involved in the formation of "para-infrastructure" such as humanitarian interventions and therapeutic policies (Biehl and McKay 2012:1210; see also Biehl 2007a; Fassin and Pandolfi 2010; McKay 2012; Ticktin 2011).

While Stephen Collier (2011) has explored how Soviet urban infrastructures reveal political and economic rationalities and negotiations over the form of the (post)social state, other anthropologists such as Nikhil Anand (2012) and Hannah Appel (2012) have shown how infrastructures (such as water networks and oil enclaves) form critical sites of engagement and negotiation for corporations and states and their subjects (or citizens) in everyday life. However, with the term *para-infrastructure*, I mean to call attention to, and account for, the interstitial domain of political experimentation that becomes visible in people's case-by-case attempts to "enter justice" in Brazil. There is no predetermined strategy of control in the judicial para-infrastructure. Norms are constantly in flux, and numerous parties—state and market institutions as well as experts, legal representatives, and citizens—can manipulate levers of access. While laying claims to life, or facing off over and disputing responsibility, evidence, and costs—benefits, these various parties bide their time and become at once empirically present and permeable.

Although precarious, para-infrastructure such as the judicialization of health significantly inform the ways of living that people take up in the context of ailing or inadequate public institutions as well as the scope and reach of governance in real time. Attention to such "intermediary power formations," as I considered them elsewhere (Biehl 2007a:94), and to the growing "judicialization of politics" (Comaroff and Comaroff 2006) presents new ethnographic quandaries. They compel us to engage and think through the ambiguous political subjectivities and social formations that crystallize amidst the blurring of distinctions between

populations, market segments, political movements and constituencies, and collective objects of intervention or disregard (Biehl and Petryna 2011; Schuch 2012).

Moving across various scales of anthropological analysis, this article brings into view lives and living forged across exceedingly complex and often contradictory institutions. The experiences of and vignettes from lawyers, patients and families, doctors, advocates, policy makers, and judges presented here do not and cannot perfectly cohere. I try to describe the entanglements of the judicialization of health without claiming that it is seamless. Instead, I urge us to consider how this new political phenomenon compels sick persons, laws, experts, officials, and commodities to shuttle between the home, the hospital, public offices, and the courtroom, remaking those spaces and themselves. As ethnographic descriptions and people's stories move in and out of this larger narrative of the pharmaceuticalization and judicialization of health, I mean to leave the reader with a sense of how present-day institutions and social fields dance, and how ethnographic writing situated at their intersections must also keep in step.<sup>2</sup>

Ethnographic realities can help us to refine, complicate, and even dislodge totalizing assumptions about neoliberal structural adjustments and market-driven societies. In the Brazilian judicialization of health, we do not see a top-down biopolitical model of governance in which population well-being is the object of knowledge and control but, rather, a struggle over the utility and purpose of government by multiple private and public stakeholders. At stake here are the ways in which government (qua drug regulator, purchaser, and distributor) facilitates a more direct relationship, in the form of technology access, between atomized and ambiguous political subjects of rights and interests and the biomedical market.

Surprisingly, the decentralization of state authority has created the space for a return of the juridical subject but in an altered form. Neither entirely controlled by nor fully accountable to the state or the market, those who inhabit this new political subject position negotiate the constraints and possibilities of a technological society using jurisprudence. They work through available legal mechanisms and instantiate new sociopolitical domains to engage and adjudicate their demands, making abstract human rights concrete. These various developments, in turn, end up consolidating the judiciary as a critical site of politics—and of political economy.

### **The diseased citizen and justice in the absence of adequate public policy**

"Welcome to the juridical hospital," said Paula Pinto de Souza, the lawyer in charge of right-to-health litigation at the Public Defender's Office in Porto Alegre, during our first encounter in August 2009. Her office is where the poor get



**Figure 3.** Attorney Paula Pinto de Souza at the Public Defender's Office in Porto Alegre, August 2011. The majority of the lawsuits requesting medicines from the state originate in the Defensoria Pública. Photo by Torben Eskerod.

free legal assistance and where the majority of the lawsuits requesting medicines from the state originate. Souza did not mince words in describing what she thought the state's biopolitics had become: "When there are no defined public policies, or when they exist but are not executed, or when policies are not in touch with new maladies and medical advancements ... what do we have? We have a diseased citizen."

When people finally access public institutions, all their vulnerabilities are exposed and they have become quite sick. Souza continued, "We are beyond preventive medicine here and the concept of health as physical, mental, and social well-being is no more. When this infirm person comes to me, the cure is most likely no longer possible. Her right to health has been profoundly injured by public power."

While previous laws had exempted the poor from legal fees, the 1988 Constitution emphasized the autonomy of the judiciary from government and stipulated that "the State shall provide integral and free juridical assistance to those who prove to lack resources" (Constituição Federal do Brasil 1988). In its normative dispositions, the constitution also stipulated the creation of public defender's offices to help poor people access to the judiciary.

The Public Defender's Office in Rio Grande do Sul was established in 1991. Yet, throughout the 1990s, because of political maneuvers and lack of human and material resources, the office had limited outreach and impact (Souza 2011). In the 2000s, however, with growing financial and administrative independence, the office thrived and consolidated itself as a political institution to be reckoned with. There are now some four hundred attorneys offering services throughout the state, and in 2010, the Public Defender's Office attended to about 450 thousand cases, a considerable growth from the 225,000 cases it handled in 2006.

Souza speaks of her work in the office as an attempt to ameliorate human suffering and to restore rights to the sufferer. For the public defender, this means indicting local politics: "The constitution guarantees access to the judiciary and we bring concrete cases of injury to the judge. The person comes here sick and wronged by the failure of public policies. This is the medicine that I practice here: to help people survive with dignity. Even if the medication might not bring them life, the claim is also for their dignity."

The judiciary, in her view, can acknowledge the person's medical emergency and call on "the state writ large (federal, regional, municipal) to take on its responsibility to provide the prescribed treatment." Souza is adamant that "it is not the role of the judiciary to make public policies." Yet without judicialization, she reasons, state politics would remain populist and only electorally focused, failing to uphold constitutionally mandated responsibilities: "The government lacks political will to make public policies work. There is no concern with the human being, but a lot of concern with publicity. Forget about infrastructure. When it is election time, *then* medicines get disbursed, drug formularies updated."

In the past five years, right-to-health litigation, particularly over access to medicines, has become a subject of contentious debate throughout Brazil and has attracted international attention (Azevedo 2007; *Economist* 2011). In a 2008 conference on "Accessing Medicines via Courts," Dr. Osmar Terra, then Rio Grande do Sul's health secretary, affirmed the state's commitment to addressing the issue of pharmaceutical dispensation by SUS "in a manner that is more comprehensive, more just, and that benefits a growing number of people." But instead of speaking of specific policies the government might champion, Terra highlighted the secretariat's "partnership" with the General Attorney's Office in addressing "frontier issues in knowledge and technology" that are increasingly "at the center of public services."

In his comments, Terra reduced the complex reality of right-to-health litigation to instances of demand for select and largely ineffective medical technologies recently brought to the market. "We try to guarantee the availability of medicines. But it is extraordinarily perverse that we have to guarantee the most expensive medicines, which have no effect whatsoever. The laboratories use patients to increase profits."

The health secretary mentioned the lack of convincing data on the efficacy and safety of drugs and asked whether "a medical professional has the right to prescribe whatever he wants, independent of protocols and scientific proof." Several times, he emphasized "public disinformation," "the draining of public health funds," and the "inequality" that the demand for new medical technologies by a selective population has inaugurated. "We are talking about public money here."

In this official's rendering, there seems to be a clear line between good and bad science, need and interest, unconscionable for-profit medicine and responsible public health officials. And while medical professionals provide market-driven means of checking unwarranted patient claims to treatment, Terra proudly announced that the state's Attorney General's Office had created its own taskforce of medical consultants to verify or disqualify claims for treatment access and efficacy.

With the judicialization of the right to health, courts have become battlefields of veridication–falsification and a politics of one-case-at-a-time medical rescues. But at a deeper level, I suggest, this process also makes the judiciary a site in which the state's biopolitical disregard (i.e., its willingness “to ‘let’ die”<sup>3</sup>)—in collusion with the market—is exposed for public critique.

### The pharmaceuticalization and judicialization of health care

While the justiciability of the right to health is of increasing interest internationally (Byrne 2009; Gauri and Brinks 2008; Hogerzeil et al. 2006; Yamin and Parra-Vera 2010), the volume of individual right-to-health lawsuits in Brazil stands out. In 2009, 5,536 cases appealing high court rulings related to the right to health reached the Superior Court of Justice, and about half of these cases ( $n = 2,583$ ) were for access to medicines. In the same year, the Federal Supreme Court heard 806 cases related to the right to health, 142 of which were for access to medicines (Sarlet 2010). Many of the nonpharmaceutical cases concerned access to things such as medical devices, prostheses, and special foods as well as the availability of hospital beds and specialized facilities for pediatric or drug dependence treatment.

In 2009, the federal health ministry spent \$47.8 million on court-attained drugs, a significant increase from the \$20.4 million spent in 2008 and \$4.2 million spent in 2007 and dwarfing the 2003 federal expenditure of \$58,800 (Collucci 2009). In the past decade, Brazilian states, particularly in the southeastern and the southern regions of the country, have also seen the numbers of lawsuits and costs for court-attained drugs rise dramatically (Biehl et al. 2012; Marques and Dallari 2007; Messeder et al. 2005). There are currently more than 240,000 health-related lawsuits under review in state and federal courts in Brazil. Almost half of all lawsuits (about 113 thousand) have been filed in the state of Rio Grande do Sul (*Zero Hora* 2012).

HIV/AIDS activists were among the first to successfully equate the constitutional right to health with access to medicines, and the rights-based demand for treatment has now “migrated” to other diseases and groups. As I documented in the book *Will to Live: AIDS Therapies and the Politics of Survival* (Biehl 2007b), an incremental change in the concept of public health has also been taking place. In

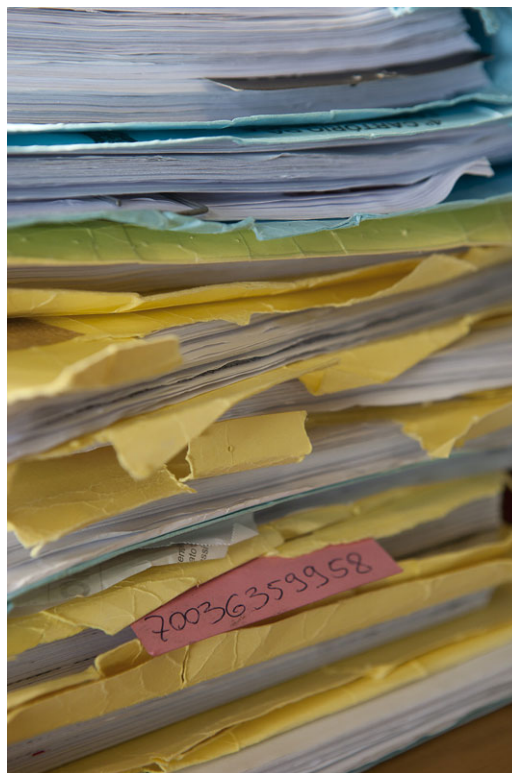


Figure 4. Stack of right-to-health lawsuits filed against the state of Rio Grande do Sul, August 2011. Photo by Torben Eskerod.

terms of both delivery and demand, public health is now understood less as prevention and primary care and more as access to medicines and community-outsourced care; that is, public health has become increasingly pharmaceuticalized and privatized.

Today, a variety of actors—industry advocates, public-health and private-practice physicians, medical researchers, and patient associations—have vested interests in making high-technology medicine accessible to all. In the process, the country is becoming a profitable platform of global medicine. It is estimated that almost 50 percent of the adult population (about 60 million people) uses pharmaceuticals on a daily basis. This is where the state comes into the picture: pharmaceutical access.

In 2008, during a conversation we had about unequal drug pricing worldwide, a pharmaceutical executive suggested that his company was adapting to the human rights and social justice frameworks that had successfully politicized access to treatments and health care in the recent past. Referring, for example, to the ongoing struggle over continued access to state-of-the-art ARV drugs in Brazil, he said rather bluntly that his company had co-opted the activist role. To make government act properly, he suggested, “You don’t need the activists, just buy our drugs and you will save money.”

The fact is that government-purchased medicines make up a formidable market in Brazil (Gertner 2010). The health ministry spent more than \$2.5 billion on the acquisition of drugs in 2007, accounting for 10.7 percent of its total expenditures that year, twice the 2002 percentage (Vieira 2009). However, new drugs are often available only for private purchase. Furthermore, we know that drug prices in Brazil are, overall, 1.9 times higher than in Sweden and 13.1 times greater than the mean bulk-unit prices listed in the International Drug Price Indicator Guide.

Let me pause to unpack what I mean by describing the judicialization of the right to health as part of a broader pharmaceuticalization of care and of public health. First, the concept of “pharmaceuticalization” builds on and revises the related notion of “medicalization,” understood as a modern form of social control that obscures the political, economic, and social determinants of health by approaching disease and treatment in exclusively biomedical terms (Conrad 2007; Davis 2009; Scheper-Hughes 1992). Scholars have traced the public health policy and treatment consequences of the medicalization of a range of complicated social problems, from hunger and malnutrition to substance abuse and depression. In particular, critics note that the phenomenon has led to an overemphasis on access to health care (especially medicines) in health policy at the expense of equally needed improvements in financial and food security, education, housing, and environmental conditions (Lantz et al. 2007). Medicalization, it is argued, strains health care systems, national economies, and household finances alike. Sociologist Peter Conrad and colleagues (2010) have gone as far as to estimate that in 2005, the pervasive medicalization of social conditions cost the United States \$77 billion—3.9 percent of total domestic spending on health care.

Increasing reliance on pharmaceuticals in treatment has gone hand in hand with the growing dominance of biomedical epistemology. Spending on prescription drugs in the United States was \$234.1 billion in 2008, more than double what was spent in 1999 (Gu et al. 2010). The increase is especially noteworthy in the antidepressant class: From 1998 to 1994, just 1.8 percent of Americans reported having used antidepressants in the preceding month; from 2005 to 2008, that number jumped to 8.9 percent (National Center for Health Statistics 2011:319). Antidepressants were the third most common class of prescription drugs taken by Americans of all ages in 2005–08 and the most frequently used by people 18–44 years (Pratt et al. 2011). With the advent of so-called second-generation antidepressants, the number of disabled mentally ill in the United States—that is, citizens receiving monthly Social Security Disability Insurance payments—more than doubled, from 1.25 million people in 1987 (the year the Food and Drug Administration approved Prozac) to 3.97 million in 2007 (Whitaker 2010).

The concept of “pharmaceuticalization,” however, stands for something more complex than an increase in the quantity of medications societies consume (Biehl 2007a). In the last decade, medical anthropologists have critiqued the medicalization paradigm for being overly deterministic (Lock 2003); while the culture of biomedicine is undeniably powerful, people do not simply become the diagnostic categories applied to them—they inhabit them to greater or lesser degrees, refuse them, or redefine and deploy them to unanticipated ends (Biehl 2005; Han 2012; Petryna et al. 2006). Likewise, both policy debates and patient struggles surrounding access to pharmaceuticals are part of broader transformations in public health (Biehl 2007b; Ecks 2008; Reynolds Whyte et al. 2013). Understanding pharmaceuticalization requires moving beyond the unidirectional construction of patient subjectivity by medical diagnostics and treatments to account for the entanglement of multiple social forces and markets, the chemical concreteness and circulation of pharmaceuticals and illnesses, and the role of patients’ agency and desires.

I also emphasize that contemporary processes of pharmaceuticalization have historical antecedents in international health policies and interventions. While health development programs once focused primarily on large-scale public health measures (e.g., sanitation, availability of clean water, hygiene), in recent decades, global health organizations have increasingly focused on access to pharmaceuticals as an indicator of health care development.

This trend is crystallized in the WHO’s “Essential Medicines” list, first proposed in 1975 and then codified in a published list revised every two years (Greene 2010). According to historian Jeremy Greene, while the idea that public health should be rooted in essential medicines “has taken on somewhat of a moral universality . . . and commonsensical status” (2011:28), creating such a taxonomy of fundamental drugs has revealed ambiguities and raised difficult questions. Access to new medical technologies and treatment strategies is increasingly thought of as a human right, like shelter, education, and clean water—but how are “essential” medications selected? Can effective but new and experimental treatments be considered “essential”?

As the HIV/AIDS epidemic increased in severity in the early 1990s, the WHO did not identify any ARVs as essential medicines, because of their high prices and how recently they had been developed. The disease, however, claimed a larger and larger portion of total deaths in developing countries, and activists forcefully challenged the absence of ARVs on the Essential Medicines List (Greene 2011:23). While the WHO now considers some ARVs essential, the HIV/AIDS epidemic continues to provoke the difficult question of whether access to treatments that extend lives—but ultimately do not save them—should be considered a human right. This question of which things are “truly indispensable” to health and living and who is legally and

financially responsible for making these things available is central to how the characters of this article both invoke and critique biopolitics: from Edgar's comment in the beginning of the article—"I know that the state cannot give everything to everyone"—to the state official's deployment of evidence-based medicine to both rationalize care delivery and authenticate misrecognition and disregard.

In Brazil, pharmaceuticals clearly have become key elements in the state's public health arsenal. As AIDS activism migrated into state institutions and the state played an increasingly activist role in the international politics of drug pricing, AIDS became, in many ways, the "country's disease" (Biehl 2007b). In May 2007, for example, Brazil broke the patent of an AIDS drug (Efavirenz, produced by Merck) for the first time—a step that had already been taken by Thailand—and authorized the import of a generic version from India. Activists worldwide hailed this sovereign decision as a landmark in struggles over the sustainability of countrywide treatment rollouts.

Yet, while new pharmaceutical markets have opened and ARVs have been made universally available (in the case of AIDS, the state is actually present through the dispensation of certain medicines that carry high political stakes), it is up to individuals and makeshift communities to locally take on the roles of medical and political institutions as they learn to interact with and navigate in expert domains. These individuals and groups use survival strategies that require extraordinary effort and self-transformation and, increasingly, undergo juridical initiation as they become formal subjects of rights and engage the ritual travails of the courts (Biehl and Petryna 2011). In the process, the question of what is frugal and essential to health and well-being—what one can do without and what one has to have to survive—is ever more tangled and contested.

### The return of the juridical subject

Despite the growing number of and costs associated with lawsuits for access to medicines in Brazil, and amid polarized debate about the phenomenon, there has been scant information concerning the content of lawsuits, the characteristics of patient litigants, and the legal strategies and rationales deployed by the various stakeholders. States' data collection systems remain tenuous at best, and concerted efforts to gather comprehensive data on lawsuits for access to medicines are only in their beginning stages.

Research into right-to-health litigation has also been constrained by small samples, limited geographic coverage, and the few variables examined (Borges and Ugá 2010; Da Silva and Terrazas 2011; Messenger et al. 2005; Pepe et al. 2010; Pereira et al. 2007; Vieira and Zucchi 2007). Most studies tend to corroborate the arguments of public health administrators that the judiciary is overstepping its role and that judicialization generates enormous administrative and



Figure 5. State judge Francisco Moesch in front of hundreds of right-to-health lawsuits he has to review, Porto Alegre, August 2011. Photo by Torben Eskerod.

fiscal burdens, distorts pharmaceutical policies, widens inequalities in health care access, and encourages irrational drug use within the public health care system.

To better understand the burgeoning number of right-to-health lawsuits in the state of Rio Grande do Sul, our research team first examined electronic registries of health-related lawsuits in the health secretariat (Biehl et al. 2012). We found that the number of new lawsuits grew more than 1,000 percent in just seven years, from 1,126 new cases in 2002 to 17,025 new cases in 2009. The majority of these judicial claims involved access to medicines, making up 70 percent of cases in 2008 and 2009.

As a second step, we created a database of medicinal lawsuits against the state of Rio Grande do Sul. Our data collection team worked in the Office of the Attorney General, which is responsible for defending the state. From September 2008 to June 2009, we analyzed 1,080 lawsuits being reviewed by state prosecutors.<sup>4</sup>

Edgar's case was not among these lawsuits, but his travails are not exceptional. Among the plaintiffs who reported their employment status, more than half were retired, and about one-fifth were unemployed. Among those who reported income, over half earned less than the monthly national minimum wage (about \$300) and relied on the free legal services of public defenders.

Past research has suggested that right-to-treatment litigation is, for the most part, a practice of the financially better off (Chieffi and Barata 2009; Vieira and Zucchi 2007) and that low-income patients tend to sue for low-cost medicines, while higher-income patients tend to sue for very expensive medicines (Da Silva and Terrazas 2011:12). In contrast, our results suggest that patients who procure medicines through the courts are mostly poor individuals who are not working and who depend on the public system for both health care and legal representation.



Roughly two-thirds of the medicines requested were already on governmental drug formularies. About a quarter of lawsuits were exclusively for access to specialized high-cost medicines, though low-cost essential medicines were frequently requested alongside them. Off-formulary medicines requested by plaintiffs were also often low cost, and many had been available in the Brazilian market for a long time. This suggests that government pharmaceutical programs are failing to fulfill their role of expanding access and rationalizing use (Departamento de Ciência e Tecnologia, Secretaria de Ciência e Tecnologia e Insumos Estratégicos do Ministério da Saúde [DECIT] 2006; Guimarães 2004).

Moreover, judges at district and higher court levels almost universally grant access to all medicines requested, recognizing that their provision is consistent with Brazil's constitutional right to health. For example, in almost all cases, district judges granted plaintiffs an immediate injunction for access to medicines. In cases in which the initial ruling was in favor of the provision of medicines, the state's higher court usually upheld the decision.

This staggering number of lawsuits is generating significant legal and administrative costs. In 2008, the state, which has a population of about 11 million people, spent \$30.2 million on court-mandated drugs. This expense represents 22 percent of the total amount spent by the state on medicines that year (Biehl et al. 2009).

While decentralization tried to establish clear responsibility at specific administrative levels—municipal, state, federal—our analysis found that plaintiffs tend to hold the regional state responsible for medicines, regardless of the designated responsible party, and that judges rarely disagree. State attorneys frequently argue that the state is not responsible for the provision of certain services. Judges, however, cite the principle of “unity” between levels of government to assert broad shared responsibility in guaranteeing the right to health. Lawsuits become the sites of a reluctant and undisciplined cooperation. In this way, the judicialization of the right to health momentarily instantiates the state as the singular governmental entity responsible for the provision of social rights.

### **Chronically ill**

Patients in our sample of 1,080 lawsuits were, for the most part, chronically ill. Almost half of patients (48 percent) reported conditions such as cardiovascular disease, diabetes, lipid metabolism disorders, and pulmonary diseases. Some 16 percent of the patients reported neurologic and psychiatric conditions. Patient plaintiffs in our sample had various comorbidities and procured multiple drugs for their treatments. On average, they reported 1.5 diagnoses and requested 2.8 drugs. Among the 25 most requested drugs, 23 were medicines to treat chronic diseases, and only seven

were not included in official drug formularies. However, we also found patients with a single disease who demanded one high-cost treatment.

Patients with chronic hepatitis C, for example, made up a significant number of cases. These patients typically demanded ribavirin and peginterferon alfa, both of which are on the federal government's specialized medicines formulary. The high frequency of requests for drugs to treat chronic hepatitis C in our sample stands in sharp juxtaposition to the rare request—a single case—for medicines for HIV/AIDS. Both pathologies have a similar prevalence in the south of Brazil, and treatments for both are distributed by governmental programs at no cost.

What are some of the possible reasons for this sharp contrast?

It may reflect variations in the efficiency of governmental pharmaceutical distribution programs. While the strategic medicines program that distributes HIV/AIDS drugs is centrally managed and funded by the federal health ministry, with a single acquisition process for the entire country, the specialized medicines program is decentralized: It is managed by states, which are federally reimbursed. The latter program depends on administrative cooperation between federal and state government and is vulnerable to the vagaries of regional health policy and management.

The contrast may also result from the specific eligibility criteria and, in some cases, from the detailed treatment protocols through which specialized medicines must be accessed in the public health care system. When patients fall outside eligibility requirements and protocols, they may use lawsuits to access treatment. In addition, patients who were granted requests may use lawsuits to expedite treatment delivery or to guarantee provision of medicines when the government fails to provide them.

Lawsuits may be a mechanism for challenging treatment protocols that limit access based on cost-effectiveness and epidemiologically derived risk-benefit considerations. Our results show that, rather than accepting these protocols, judges give broad deference to individual circumstances and physicians' prescriptions—deference that may undercut efforts to rationalize pharmaceutical use (as the health secretariat cited earlier in the article would have it). As the case of a patient named Nelson Silveira illustrates, the judiciary seems to offer citizens that are at once diseased and politically injured the possibility of articulating a time-sensitive legal effort to make the state act biopolitically to guarantee the possibility of survival.

Head down, Nelson Silva walked into the Public Defender's Office in August 2010 accompanied by his wife Sandra, who did most of the talking. At first, attorney Souza and I mistook Sandra for the patient, but it soon became evident that the “we” she referred to in our conversation was a kind of domestic advocacy group. “We cannot interrupt the treatment one more time,” said Sandra. Her husband was a



**Figure 6.** Public defender Paula Pinto de Souza is helping hepatitis C patient Nelson Silva and his wife Sandra Silva to file a lawsuit for treatment access, Porto Alegre, August 2010. Photo by João Biehl.

retired steel-factory worker and she still worked as a kindergarten teacher. They resided in the nearby city of Esteio and had two adult children. Sandra begged the public defender to “treat us,” for “we know that people who come here get the medicine they need.”

Nelson had chronic hepatitis C, and he was greatly benefiting from a 48-week treatment regimen of ribavirin and peginterferon alfa. His doctor said that he needed 24 extra weeks of treatment, but the state’s medical expert denied the request for the medication, and “my doctor told me to come here,” Nelson said. “It’s just a matter of the judge releasing the treatment.”

“Our first treatment,” Sandra continued, “was in 2001 with regular interferon.” Nelson added, “But after a while the state pharmacy did not have interferon, so I had to interrupt the treatment.” In 2005, he fell ill and a doctor at Hospital Conceição prescribed ribavirin and peginterferon alfa. The health secretariat denied Nelson’s treatment request, alleging that it would constitute “retreatment,” which was not allowed by the medical protocol in place. “Then we had to file a lawsuit for him to get it,” Sandra stated. In 2009, he was declared eligible for retreatment and now needed medicines for the 24 additional weeks.

“The doctor gave me the meds for two weeks,” Nelson continued, “but I am afraid that the legal procedure will take too long and that by the time I get the meds, if I get them, I will have to stop treatment for it failed once again. I need it fast.” Nelson was desperate to adhere to the treatment. For him and so many other patient plaintiffs facing a fatal condition, judicialization is a temporal lever. “We don’t want to stop everything we started,” lamented Sandra. In line with the philosophy of “I will not let the citizen die,” Souza gave the couple a road map of all they had to do and the documents they had to produce so that she could open

the lawsuit the following day. Here, the court system—so often thought of as a place where claims go to die a quiet, bureaucratic slow-motion death—winds up being a surprising milieu of catalysis for the uncertainty and time-sensitivity of the body and its possibilities of repair and, ultimately, of survival.<sup>5</sup> “Afterwards,” Souza told Nelson, “you open a lawsuit against the state for medical injury.”

### Open-source anarchy

According to legal scholar David Fidler, developments in health jurisprudence “have produced open-source anarchy and a more elastic relationship between power and ideas in global politics” (2008:410). In such an elastic relationship, “changes in material capabilities of state and non-state actors, and changes in the world of ideas, have more impact on each other than in the closed, state-centric system that prevailed during the Cold War” (Fidler 2008:410). Fidler recognizes a “deeper importance for law in public health endeavors within and between countries” (2008:394; see also Fidler 2007).

Anthropologists John Comaroff and Jean Comaroff have been attending to such a “judicialization of politics” in postapartheid South Africa and how it has affected social mobilization, particularly in the field of HIV/AIDS. Class struggles, they argue, “seem to have metamorphosed into class actions. Citizens, subjects, governments, and corporations litigate against one another, often at the intersection of tort law, human rights law, and the criminal law, in an ever mutating kaleidoscope of coalitions and cleavages” (Comaroff and Comaroff 2006:26).

The judicialization of right-to-health litigation speaks to a productive “open-source anarchy” at both macro- and microlevels in Brazil as well. Political scientist Luis Werneck Vianna (1999) would say that this is only one part of a broader pattern of the judicialization of politics in the country. For him, judicialization does not necessarily reflect judicial activism. Rather, it can be understood as a lever for multiple minority actors (from political parties to public defenders to civil society groups) to constitutionally challenge the political majority’s efforts to determine the fundamental norms and objectives of government. In attending to these concrete and dynamic processes, the complex way in which the judiciary actively participates in everyday politicking in a large country with a young constitution comes to the foreground (Fonseca and Schuch 2009). The question is thus not who—the judiciary or the executive—is right in the debate over judicialization, but how to integrate their actions to best serve individuals and collectives while making democratic institutions more robust (Vianna and Burgos 2005).

In this new chapter of the Brazilian history of citizenship and the right to health, then, the judiciary has become a powerful arbiter and purveyor of care and medical

technology access. Interviews we conducted with judges, attorneys, and health officials revealed divergent and conflicting views on the litigation pathway. Policy makers and administrators contend that the judiciary is overstepping its role and that judicialization skews budgets and increases inequalities in health care access. Some acknowledge, however, that legal pressure has improved the distribution of some medicines.

Many local judges working on right-to-health cases feel they are responding to state failures to provide needed medicines and that these waves of lawsuits are a milestone in the democratization of a culture of rights. For these judges, the poor Brazilians who are working through modes of legally arbitrated justice to access health care are not just fighting against legalized privileges and legitimated inequalities, as in James Holston's (2009) chronicle of "insurgent citizenship" practices in Brazil's urban spaces. Rather, they see widespread litigation as the expression of a distinct, equalizing legal system and of a novel rights-conscious society. Whether such a democratization of socioeconomic rights can be attained through individual claims and in courts, however, is contested. In fact, judges employ idiosyncratic rationales and create their own standards in adjudicating right-to-health cases. They tend to rule in terms of "risk of death" and "right to life" and base their rulings for the most part on constitutional interpretations and personal experiences—having specific tragic cases in mind.

District judge Eugenio Terra, who is in charge of all health-related cases in Porto Alegre, does not agree that the judiciary is exceeding its role. In line with the experience of attorney Souza at the Public Defender's Office, he too finds that lawsuits are largely filed by poor and desperate patients seeking treatments that should be available in the public system.

"I am doing social justice, one by one," he told me in an interview in August 2010. "When I am issuing an injunction for cancer treatment provision, I am also indicting services that have not kept up with people's needs." It did not escape Terra that the high number of right-to-health lawsuits in southern Brazil might well speak of "a distinct political culture" fostered by numerous administrations of the Worker's Party both in the capital and at the state level in the past two decades (PT regained state power in 2011).

Rather than accepting one-size-fits-all medical protocols, judges give broad deference to individual circumstances and physicians' prescriptions, a practice that may appear to undercut state efforts to rationalize pharmaceutical use. State high court judges like Denise Oliveira Cezar are also holding pharmaceutical companies accountable, particularly to patients participating in clinical trials. As she puts it, "We struggle for jurisprudence. We are challenged to create the right and to enable the person of rights."

Dr. Marga Tessler, president of the southern Brazilian federal court, says that the judiciary is not activist but,



**Figure 7.** State high-court judge Denise Oliveira Cezar, Porto Alegre, August 2011. Photo by Torben Eskerod.

rather, "active" by challenging state politics in the name of the constitution. She suggests, however, that some limits have to be placed on what the state can actually provide for its citizens given pressing infrastructural needs and the accelerated development and circulation of medical technologies.

### Case by case

Even as judges recognize the constitutionality of individual lawsuits and grant requested medicines in the overwhelming majority of cases, the judiciary has repeatedly avoided directly mandating changes in policy or issuing decisions that would broadly affect the public health system. In 2007, Minister Ellen Gracie, then chief justice of the Federal Supreme Court, overturned a lower court's decision to include sex reassignment surgery in the list of procedures freely provided by the public health care system. Minister Gracie stated that cases for access to such treatment should be decided "case by case, in a concrete manner, and not in an abstract or generic manner" (Supremo Tribunal Federal 2007).

In April 2009, the Brazilian Supreme Court held a rare public hearing to examine the pressing challenges posed by right-to-health litigation (Supremo Tribunal Federal 2009). Public health officials, lawyers, physicians, activists, and academics testified before the court, providing varied viewpoints and recommendations on how to respond to the enormous judicial demand for medical goods. As an immediate outcome, there was a long overdue updating of governmental drug formularies. The Brazilian National Council of Justice also issued a set of recommendations for local judges, asking them to more systematically attend to scientific evidence and to strive for "more efficiency" when ruling on health-related cases (Conselho Nacional de Justiça n.d.).

If access to AIDS therapies was the litmus test of the right to health in the 1990s, access to genetic therapies now



**Figure 8.** Twelve-year-old Alexandre, who suffers from the inherited metabolic disorder mucopolysaccharidosis, and his mother Cleonice Lima de Moura in their house in Sapiranga, Rio Grande do Sul, August 2011. Photo by Torben Eskerod.

plays this role. Twelve-year old Alexandre Lima de Moura suffers from mucopolysaccharidosis (MPS), an inherited metabolic disorder. Every week, the fourth grader travels with his mother, Cleonice, to Hospital de Clínicas in Porto Alegre, where he receives enzyme replacement therapy, a treatment that costs about \$200 thousand per year. Because of his age, Alexandre was not allowed to enroll in a clinical trial taking place at the hospital. Without “the right to be researched,” as the mother of another MPS patient put it, Alexandre became a patient litigant.

With the legal support of a well-organized patient association in São Paulo (partially funded by the drug manufacturer), the family won a court injunction forcing the federal government to begin providing the therapy. Like all parents of MPS children we spoke to, Cleonice suggested that not obtaining this treatment would be unconscionable and tantamount to killing her child. She knew that the federal attorneys would appeal and was ready for the struggle: “Besides entering the judiciary, we also entered the media.” Cleonice has taken Alexandre’s cause to all possible media outlets and is also using his condition to educate neighbors, local medical personnel, and officials about the meaning of, in her words, “citizenship” and a “normal life.” “Ela é uma mãe boa” [She is a good mother], says Alexandre, who is thriving in school and seems to be responding positively to treatment.

One of the latest right-to-health landmark cases involves a request for a high-cost medicine for a genetic disease. This treatment was not recommended by the Ministry of Health’s therapeutic guidelines and was not publically available. In March 2010, the court rejected the state’s argument that it was not responsible for providing the medicine and decided in favor of the provision of the treatment. In his ruling, Justice Gilmar Mendes stated that once the disease



**Figure 9.** A patient who suffers from mucopolysaccharidosis holding an enzyme replacement therapy vial. After successfully participating in a clinical trial, he led a group of trial participants in a lawsuit demanding that the state pay for the high-cost therapy, Porto Alegre, August 2010. Photo by Torben Eskerod.

was medically confirmed and treatment was indicated, “the Ministry of Health’s guidelines can be questioned.” Moreover, “the state has to provide resources, not only to support and fund the provision of universal care for its citizens, but also has to provide variable resources to attend to the needs of each individual citizen” (Supremo Tribunal Federal 2010).

The role of market forces in judicialization—a mix of clinical trials and marketing strategies that target physicians’ prescriptions and fuel patient demand and of industry lobbying to have new treatments included in governmental drug formularies while facing limited regulatory oversight—must not be overlooked (Petryna 2009). Ample evidence shows how laboratories’ monopoly on medico-scientific information and pharmaceutical marketing strongly inform physicians’ prescriptive habits and patients’ demands (Lakoff 2006). Additional qualitative studies are in order—they could help us chart how judicialization has become part of a pharmaceutical business plan in Brazil, supporting patient associations and lawsuits for access to high-cost medicines specifically to open or enlarge markets (Diniz et al. 2012; Souza et al. 2007).

There is a heated debate in Brazilian courts on the positive duty the constitutional right to health imposes on the state and the extent to which the courts must enforce this right. But the country lacks a substantial public debate about the meaning of the right to health in light of medical advancements and financing, between what is possible and feasible and what is frugal and essential. As a “right to pharmaceuticals” is consolidated in Brazil, the various branches of government have yet to develop a systematic approach to tackling drug value and financing and the responsibilities of private health insurance plans to cover drug costs. Moreover, how can access to

new medical technologies be reconciled with systems that foster the equitable inclusion of people in preventive as well as basic and sustained care initiatives? Is there a way to balance individuals' urgent demands for health care, often in the form of medicines, with the long-term, programmatic aspect of health care management and reform? Attention is also needed on the many other factors that play into the right to health, such as education, water quality, sanitation, vector control, air pollution, and violence prevention. These complementary concerns, which can be understood as social determinants of health, are critical to addressing the health needs of both the chronically ill and comorbid individuals in our database and the Brazilian population more generally.

Meanwhile, hard-to-pin-down *patient-citizen-consumers* draw from human rights language and jurisprudence and make governments work for them as they negotiate medical inclusion and the vagaries of the market and survival. The judicialization of health has, indeed, become a para-infrastructure in which various public and private health actors and sectors come into contact, face off, and enact limited "one by one" missions.

### Patient-citizen-consumers

How is the subject of rights constituted in the face of the late-liberal political economies?

There is no pre-given biopolitical population in Brazil today to which Edgar, Nelson, Alexandre, and thousands of other atomized subjects of rights belong. Yet, in their private efforts to become such subjects, individuals have to rely on social relations and temporary collectivities that crop up at the intersection of patient-family demand, state institutions, therapeutic markets, and law.

Seen from the perspective of these medical subjects—undesirable, according to actual care delivery policies, budgets, and state public relation efforts—biopolitics is an insecure enterprise, indeed, more a symptom of the limits of government than a marker of its presence and control. The ethnographic realities presented throughout this article also suggest that the subject of rights and the economic subject may actually be included or excluded according to shared or similar logics, practices, technologies, and knowledges and that the pursuit and enforcement of rights may be a key means by which one becomes part of a market segment.

If, for Foucault, "the question of the frugality of government is indeed the question of liberalism" (2008:29), then in Brazil's late-liberal moment, one could argue, the biopolitical question is not necessarily about the "futility" of the rehabilitation of diseased and underserved poor subjects (Biehl 2005) but about the expansion of frugal government in the form of pharmaceutical access in lieu of infrastructural reform. Thus, in this contemporary republic of inter-

ests, we see the consolidation of an "inclusionary state activism without statism" (Glauco and Martin 2010) coupled with extraordinary market expansion and the vanishing of "civil society" as a viable transactional reality.

"Judicialization today is a relation of individual consumption," stated Miriam Ventura, a legal and public health scholar, during a 2010 interview in Rio de Janeiro. Ventura was the first lawyer in the country to successfully file treatment access lawsuits on behalf of HIV patients. The judicial activism of the 1990s used individual lawsuits to lay broad claim to collective rights, she argued, "individually, but always in search of a collective demand for the solution to the problem."

Ventura is critical of right-to-health litigation as an end in itself: "It is necessary, and an important guarantee, but it is not sufficient to create any health policy." While HIV/AIDS judicial activism created "a strong subject of rights . . . so that those people could be recognized as citizens," contemporary judicialization is no longer one of social mobilization, she lamented. Even for patient associations, "the judiciary is not treated as a political instrument, it is merely instrumental."

For Ventura, the political subject of judicialization, and the judiciary itself, is very much subject to the market and to consumer ideology: "When you enter with a class action, and there are ever fewer, judges normally are more cautious; they do not give a speedy decision, because they recognize that it will have an impact. Now, on the other hand, if you enter three hundred individual actions, a thousand individual actions, they will grant those thousand individual requests." With Brazil's economic boom, the citizen is visible through participation in the market, she argues, but demands based in the right to health are ultimately limited to those that can be articulated as access to consumption: "We have a very strong demand and there is a low politicization of citizenship."

In her critique, Ventura assumes a certain kind of political subject, one who recognizes and represents him or herself as such, and she regrets the dying out of the civil society paradigm for politics. But is there another possibility for citizenship in Brazil today that can navigate between a state that presents itself as activist and socially protective (beyond the minimum neoliberal state) and emerging therapeutic markets?

I have written elsewhere about ambiguous political subjects in light of the country's pioneer policy of universal HIV/AIDS treatment access as it was actualized in urban poor contexts: "Their political subjectivity is articulated through pastoral means, disciplinary practices of self-care, and monitored pharmaceutical treatment" (Biehl 2007b:324–325).

For Souza and her patient citizens at the Public Defender's Office, politics is not a sphere but a lack, a technology, and a process all at once. In Brazil today, medical



**Figure 10.** The staff of the Public Defender's Office in Porto Alegre tells pensioner Alcinda Moreira what documents she needs to successfully file a lawsuit for treatment access, Porto Alegre, August 2011. Photo by Torben Eskerod.

commodities work in tandem with other ways of claiming citizenship, and desperate and creative interactions occasion novel public sites in which rights and health are privatized alongside the emergence of novel political subjectivities.

In the face of this situation, the public defender puts up a fight. Souza's pragmatic critique of the state brings attention to the symbiotic relationship between a hybrid government of social protection and market expansion and the ways that public institutions, in their frugality or futility, acquiesce to the social and biological death of those too ill or too poor to live in the new economy. Yet, as abandoned and injured as they are by various levels of actual government, some people still understand themselves as the subjects of present rights and try to access care via the judiciary. People refuse to be stratified out of existence.

Souza's humanism and in-your-face politics produces a pathway to improving patients' situations. Against institutional realities that undermine health, control, and effectiveness, public defenders utilize medical and legal modes of veridiction and the framework of constitutional rights and human dignity to sustain their work and demand that the state act biopolitically.

Chronically ill and poor people find their way into the judiciary reluctantly, tinkering with available human and material resources. They are neither governable nor disruptive of the system. This minimum biopolitical belonging is part and parcel of the immanent field people invent to live in and by as they navigate the vagaries of market inclusion and survival in wounded cities.

## Conclusion

Novel forms of social becoming at the interface of law and medicine show how politics matters differently to a growing number of low- and middle-income sick Brazilians. People's

life chances and health outcomes are overdetermined by the kinds of marketized-judicial subjects they are able to become through appeals to the judiciary, government, and research and health industries driven by profit and the construction of new therapeutic market segments. As ethnographers, we must attend to the forms of statecraft (national and regional) and jurisprudence as well as to the kinds of medico-scientific literacies and political subjectivities that are built into the para-infrastructure of rights and interests that the judicialization of health has occasioned. We must consider both the possibilities opened up and the exclusionary dynamics at work at the judicialization front evident throughout Brazil and in other emergent powers. Thus, from the perspective of judicialization, health in the time of global health is a painstaking work in progress by monadic juridical subjects acting in relation to therapeutic markets, ailing public health infrastructures, and improvised medical collectives.

It is, paradoxically, by revealing the fragility of biopolitical interventions, showing how they are constantly entangled with and shaped by other (often economic) imperatives, that the stories of these patient litigants point to the temporal dimensions of medical technologies and to their own power to remake subjectivities and social worlds as they open up new spaces for claim making, contestation, and ethical problematization. It is at the intersection of the therapeutic imperative, the biotechnical embrace, and market reasoning that the intensity of survival becomes visible and the political battle over what is frugal and what is vital is played out.

## Notes

*Acknowledgments.* I want to express my deepest gratitude to Joseph J. Amon, Mariana P. Socal, and Adriana Petryna for all their creative insights and wonderful help with this research project. I have had the good fortune to have Torben Eskerod join me in the field to make the visual documentary "Bodies of Rights and Medicines." I am forever thankful for the time and creativity he has dedicated to this and other joint projects. This study would not have been possible without the generous engagement of legal and professionals as well as patient litigants and their families in southern Brazil. Whenever requested, names of informants were changed to protect anonymity. I have also had the distinct pleasure of working with a superb group of postdoctoral fellows and graduate and undergraduate students over the last few years. I want to thank Ramah McKay, Peter Locke, Amy Moran-Thomas, Alexander Wamboldt, Igor Rubinov, Alex Gertner, Joshua Franklin, Jefferson Barbosa, Raphael Frankfurter, and Naomi Zucker, whose help has been particularly important. I benefited greatly from the comments and suggestions of the article's four anonymous reviewers, and I am very grateful to them and to Angélique Haugerud for her superb editorial guidance at every step. Special thanks to Linda Forman for her close reading and sharp editing. The Ford Foundation and Princeton's Health Grand Challenges Initiative and Woodrow Wilson School of Public and International Affairs generously supported research. Thank you also to the School of Social Science of the Institute for Advanced Study for a visiting membership in 2012–13.

1. This article derives from a 2008–12 multidisciplinary investigation of the judicialization of the right to health in southern Brazil (see Biehl n.d.). Funded by the Ford Foundation and by Princeton University's Health Grand Challenges Initiative, the project sought to characterize this patient–plaintiff population, to identify its medical needs and legal strategies, and to apprehend the expanding role of the judiciary in remediating the limitations and failures of public health management. The study was carried out in collaboration with Adriana Petryna, Joseph J. Amon, Mariana P. Socal, Ingo W. Sarlet, Laura B. Jardim, Paulo D. Picon, Ida Vanessa D. Schwartz, Paula Vargas, Claudia W. Fonseca, and Torben Eskerod, and it involved (1) compilation of a database of lawsuits for access to medicines in the state of Rio Grande do Sul; (2) monitoring of evolving right-to-health jurisprudence in Brazil; (3) interviews with key institutional actors (judges, public counsels, lawyers, physicians, policy makers); (4) ethnographic research with patients and families filing lawsuits for treatment access; and (5) visual documentation of the people involved in right-to-health litigation.

2. I want to thank one of this article's anonymous reviewers for this insight and phrasing.

3. See the Foucauldian definition of biopolitics as the power “to make live and let die” (Foucault 2003:241).

4. See <http://www.princeton.edu/grandchallenges/health/research-highlights/aids/Database-project.pdf>.

5. I want to thank one of the anonymous reviewers for this insight and phrasing.

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