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## EDITORIAL

# Drugs for All: The Future of Global AIDS Treatment

João Biehl

I am interested in the arts of government that accompany economic globalization and in the remaking of populations as market segments (specifically therapeutic markets). Using the Brazilian response to AIDS as an ethnographic baseline, I examine the systemic relations between pharmaceutical commerce and public health care and the value systems that underscore global AIDS treatment initiatives. The pharmaceuticalization of governance and citizenship, obviously efficacious in the treatment of AIDS, nonetheless crystallizes new inequalities.

Key Words: AIDS treatment rollouts; Brazil; global health; pharmaceuticalization

The World Health Organization estimates that at least seven million people in low- and middle-income countries are in need of antiretroviral therapy and that at the start of last year, two million of them were receiving treatment. Unprecedented alliances among AIDS activists, governments, philanthropic and international agencies, and the pharmaceutical industry have made increased access to antiretroviral drugs (ARVs) possible. The battle for access has been hard-fought. Many public- and private-sector treatment initiatives are being launched worldwide, raising a whole new set of national and global health care policy challenges regarding adequate drug delivery, sustainable treatment access, and the integration of treatment with prevention.

As global initiatives and governments address AIDS therapeutically, they face difficult questions regarding public health priorities and spending. How are other deadly diseases of poverty that have less political support and that go unabated being dealt with? What are the politics of treatment prioritization? Which value systems and policy decisions underscore medical triage? Moreover, how are health professionals and patients in resource-poor settings dealing with drug resistance to first-line treatments? What efforts are underway there and internationally to guarantee access to treatments that are still under patent protection? And, finally, what effects do all these issues have on the experience of living with HIV=AIDS and poverty on the ground?

“GOVERNMENTALITY IN ACTION. . . ENGINEERING SOMETHING ELSE,  
PRODUCING A NEW WORLD”

Brazil has been an innovator and leader in the efforts to universalize access to AIDS therapies. In 1996, it became the first developing country to make ARVs available through its ailing public health care system. The government is paying for the therapies of roughly 200,000 Brazilians. According to the Health Ministry, both AIDS mortality and the use of AIDS-related hospital services have fallen by 70 percent. This essay draws from openended interviews I carried out with activists, policymakers, and corporate actors in both Brazil and the United States between 2003 and 2006. I focus on the political and economic practices that make this policy of *drugs for all* possible and inquire into how it dovetails with global health initiatives. The sustainability of the policy has to be constantly negotiated in the marketplace and I show that one of the

unintended consequences of AIDS treatment scale-up has been the consolidation of a model of public health centered on pharmaceutical distribution.

“The success of the Brazilian AIDS policy is a consequence of the activism of affected communities, health professionals, and government,” Dr. Paulo Teixeira, former national AIDS coordinator, told me in June 2005. I heard a similar explanation from Fernando Henrique Cardoso, Brazil’s former president, in an interview two years earlier. “Brazil’s response to AIDS is a microcosm of a new state-society partnership,” he stated. Cardoso promoted the AIDS policy as evidence of the supposed success of his reform agenda—a state open to civil society, activist vis-a`- vis the market, and fostering partnerships for the delivery of technology. “All the NGO work, treatment legislation, [and] struggles over drug pricing are new forms of governmentality in action . . . engineering something else, producing a new world.”

Throughout the 1990s, different sectors—gay activists and AIDS nongovernmental organizations (NGOs), central and regional governments, and grassroots groups, along with the World Bank—came together, helping to counter what was earlier perceived to be a hopeless situation. Activists and progressive health professionals migrated into state institutions and actively participated in policymaking. They showed creativity in the design of prevention work and audacity in solving the problem of AIDS treatment. After framing the demand for access to ARVs as a human right, in accordance with the country’s constitutional right to health, activists lobbied for specific legislation to make therapies universally available. Beyond confrontation, interest groups and the state cooperated and reciprocally adjusted.

The AIDS policy emerged against the background of neoliberalization, and the politicians involved with it were consciously articulating a market concept of society. In Cardoso’s vision, citizens are consumers and have “interests” rather than “needs.” Or, in the words of economist and former health minister Jose Serra, “The government ends up responding to society’s pressure. If TB had a fifth of the kind of social mobilization AIDS has, the problem would be solved. So it is a problem of society itself.” Here, the government does not actively search out particular problems or areas of need to attend to—that is the work of mobilized interest groups. These public actions are seen as “wider and more efficacious than state action” (in Cardoso’s words). In practice, activism has enhanced the administrative capacity of the reforming state. Moreover, the afflicted have to engage with lawmaking and jurisprudence to be simply seen by the state and the implementation of progressive laws remains subject to a whole range of exclusionary dynamics related to economics and specific social pressure.

AIDS therapies are boundary- and institution-making technologies. As I documented in my ethnographic research in the northeastern state of Bahia, the distribution and use of ARVs make certain populations visible to the state. These drugs are also the means through which grassroots groups take on and improvise the work of medical institutions. Poor and abandoned AIDS patients self-select for social and medical regeneration in more than 500 care units called *casas de apoio*, which are spread throughout the country. These “houses of support” mediate the relationship between AIDS patients and the precarious public health care infrastructure. Pastoral units address the paradox that ARVs are available but public institutions are barely working. “Did bad things happen in the process?” asked Dr. Teixeira. “Yes, but without outsourcing there would not have been advancements either. Evolution is never unidirectional—it is forward and backward. We hope that it is two steps forward and one backward.”

## GLOBAL HEALTH MARKETS

Behind Cardoso’s concept of *model policy* stands a new political economy of pharmaceuticals. Just a few months before approving the AIDS treatment law in November 1996, the Brazilian government had given in to industry pressures to enshrine strong patent protections in law.

Brazil was at the forefront of developing countries that supported the creation of the World Trade Organization (WTO), and it had signed the Trade-Related Aspects of Intellectual Property Rights treaty (TRIPS) in December 1994. Parallel to the new patent legislation, pharmaceutical imports to Brazil had increased substantially. Between 1995 and 1997, the trade deficit in pharmaceutical products jumped from \$410 million to approximately \$1.3 billion. Currently, Brazil is the 11th largest pharmaceutical market in the world—in 2005, this market reached \$10 billion. The fact is that the Brazilian government was able to reduce treatment costs by reverse engineering ARVs and promoting the production of generics in both public- and private-sector laboratories. The Health Ministry also negotiated substantial drug price reductions from pharmaceutical companies by threatening to issue compulsory licenses for patented drugs. Media campaigns publicized these actions, generating strong national and international support.

“Patents are not the problem,” Dr. Jones, an executive of a company that sells ARVs to the Brazilian government, explained to me. “Things worked out in Brazil because of political will. Brazil is an example of how you can do the right thing in terms of public health, understanding the needs of both the private sector and the government and its population.” By juxtaposing the arguments of both corporate actors and policymakers, one can identify the logic of such a pharmaceutical form of governance. Here, political will means favoring novel public-private cooperation over medical technologies. Once a government designates a disease like AIDS “the country’s disease,” a therapeutic market takes shape—the state acting as both the drug purchaser and distributor. As this government addresses the needs of its population (now unequally refracted through the “country’s disease”), the financial operations of the pharmaceutical industry are taken in new directions and enlarged, particularly as older lines of treatment (generic ARVs) lose their efficacy, necessitating the introduction of newer and more expensive treatments (still under patent protection) that are demanded by mobilized patients. Patienthood and civic participation thus coalesce in an emerging market.

Development agencies and new public-private initiatives assist in this process, which has crucial ramification for the nature and scope of national and local public health interventions. Magic-bullet approaches (i.e., the delivery of technology regardless of health care infrastructure) are increasingly the norm, and companies themselves are using the activist discourse that accessing ARVs is a matter of human rights. This pharmaceuticalization of public health has short- and long-term goals, as Dr. Jones put it: “It is not just a matter of guaranteeing access to the available drugs but to the new ones being developed. You have to find a way to align yourself and trade with the companies who are doing this work.”

Internationally, Brazil has become proof that the badly needed full-scale assault against AIDS is indeed possible. “We have changed the discourse and paradigm of intervention,” Dr. Teixeira told me. “It has become politically costly for development agencies and governments not to engage AIDS.” Yet, the operations of global AIDS programs and their interface with governments and civic organizations “reflect and extend existing power relations, and this synergy can be quite negative,” he added. “The negotiating power of developing countries is simply too low, be it at the United Nations or at the World Trade Organization.” Dr. Teixeira helped coordinate the joint WHO and UNAIDS “3 by 5” campaign, aimed at providing antiretroviral drugs to three million people by 2005. Funding bottlenecks, personnel shortages, and continuing debates on drug pricing and patents have limited this and many other AIDS initiatives. As he put it, “Drug companies are paralyzing the WHO.”

In October 2005, I talked to Dr. Jane Walker, the executive vice president of a U.S.-based pharmaceutical company. For her, the Brazilian AIDS treatment program worked “not so much because of politics, but because of a good allocation of resources.” As for treating AIDS in poorer regions, Dr. Walker insisted that “drug price is not the problem; the problem is infrastructure.” Dr. Walker was now leading her company’s efforts to “not just” bring ARVs to

women and children in hard-hit places in Sub-Saharan Africa, “but to build up local treatment capacity.” This medical care and research endeavor was carried out in partnership with global AIDS initiatives, local health care groups, and NGOs. For this executive, it seemed matter-of-fact that public-private partnerships did better infrastructural work than state institutions alone. This discourse of state replacement, I thought, added an activist and morally urgent spin to a central tenet of neoclassical economics: the idea of a self-regulating market. The challenge, Dr. Walker told me, “is to find treatment models that can be inexpensively scaled up. The solution is not medicine as we practice and as we know it. We must save every one of these lives.”

In this philanthropic discourse, one saves lives by finding new technical tools and cost-effective means to deliver care; that is, medicines and testing kits en masse. This trend stretches far beyond ARV rollout and has recently contributed to popularizing blanket treatment approaches for many tropical diseases, including preventative medications for conditions such as childhood malaria and river blindness, as well as antibiotic treatments that have no preventative function in national deworming campaigns for schoolchildren. In the end, governments function on the business side, merely purchasing and distributing medicines, while communities and patients are left to nurture (as I chronicled in Brazil). Critics have rightly pointed out that, generally speaking, the strategies underlying new global health interventions are not comprehensive and ultimately of poor quality. Many question their sustainability in the absence of more serious involvement of national governments and greater authority for international institutions to hold donors and partners accountable in the long-term. These problems of accountability are also deeply linked with issues of priorities, creating particular questions about less technological solutions that would have a dramatic impact on global health —such as community development or the provision of clean water to prevent opportunistic infection. With health policy’s success largely re-framed in terms of providing the best medicines and newest technology, what space remains for the development of low-tech solutions that could prove more sustainable and ultimately more humanistic?

## BEYOND BIOPOLITICS

Brazil faces a complex predicament that other countries treating AIDS will soon face. It has a very inexpensive first line of ARVs, but a growing number of people are starting new, more expensive drug regimens, either because of drug resistance or because newer drugs have fewer side effects. With patients taking advantage of these new treatments, Brazil’s annual ARV budget has doubled to nearly \$500 million in 2005. Despite the country’s generic production capacity, about 80 percent of the medication included in the national budget is patented. “We are moving toward absolute drug monopoly,” Michel Lotrowska, an economist working for Doctors Without Borders in Rio de Janeiro, told me. “We have to find a new way to reduce drug prices; if not, medics will soon have to tell patients ‘I can only give you first-line treatment and if you become drug resistant you will die.’ ”

Consider Roche’s recently introduced drug T-20, a rescue drug that greatly helps patients with treatment resistance. In Brazil, some 1,200 patients were prescribed T-20 immediately after the drug’s debut. This drug costs each patient \$20,000 dollars each year. While doing fieldwork in Salvador in June 2005, I learned that Roche was training local doctors to make T-20 a first line treatment rather than simply a rescue drug. I also heard of cases in which doctors began prescribing the rescue drug Kaletra at the time of its 2002 launch in the United States, before its registration in Brazil. These doctors referred patients to a local AIDS NGO and to public-interest lawyers who pressured the state to provide medication not yet approved by the country’s National Health Surveillance Agency. In the face of pervasive pharmaceutical marketing enmeshed with patient mobilization, regulatory incoherence thrives.

Meanwhile, policymakers have to continually find new strategies to keep the country's pharmaceutical policy in place. In May 2007, Brazil broke the patent of an AIDS drug for the first time. The government stopped price negotiations with Merck over Efavirenz, which is used by 75,000 Brazilians, and decided to import a generic version from India instead.

In sum, multiple institutions and social actors dynamically meet in the Brazilian AIDS policy space. These various institutions and actors have distinctive interests, are somewhat permeable, and mutually readjust. In practice, the AIDS policy is neither a global institution nor a novel state apparatus— it is an *intermediary power formation*. The policy comes into existence in the space between international agencies, global markets, and the reforming state. It is implicated in and meddles with the resources of these institutions as it struggles to intervene effectively. Intermediary power formations are not simply extensions of the macro or the micro— they actually exclude the immanence of both. Their operations do not follow a predetermined strategy of control and do not necessarily have normalizing effects. As evident in the AIDS policy, their sustainability has to be constantly negotiated in the marketplace. Mobilized individuals and groups must continuously maneuver this particular therapeutic formation to gain medical visibility and have their claims to life addressed. The AIDS policy thus becomes a co-function of political and market institutions, as well as individual lives.

ARV rollouts reveal gross deficiencies in national health care infrastructures and in people's basic living conditions. The responsibility for damaging side effects should not be left to the patients themselves, but should be guarded against by more and not less preventive policymaking. Public institutions and meaningful external environments are indeed co-functions of successful AIDS treatment. This calls for ongoing self-examination by those who implement policies to their own effects on events and reaching the afflicted on their own terms, acknowledging struggles for survival and recognition in a largely hostile world. Likewise, at issue is a reconsideration of the systemic relation of pharmaceutical research, commerce, and public health care. As Dr. Paulo Picon, a Brazilian academic scientist, put it to me: "If we don't find intelligent ways to counter this profit extraction from public health, we will be left with an insurmountable indebtedness, a wound that won't heal."

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