

THE CLINIC AND THE COURT
Law, Medicine and Anthropology

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CHAPTER SEVEN

THE JURIDICAL HOSPITAL: CLAIMING THE RIGHT TO PHARMACEUTICALS IN BRAZILIAN COURTS

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THE JUDICIALISATION OF HEALTH

A retired bus driver, Edgar Lemos lives in a lower-middle-class neighbourhood 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 specialised 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.

Raised in 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 more 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 anti-hypertensives and anti-anxiolytics, to soothe additional symptoms.

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During a conversation 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 judicialise, this one I don't judicialise... I only judicialise this medicine because I went into debt paying for it.' A monthly supply of Somazina costs about 200 dollars.

After paying for the drug out of pocket for several months, Edgar had to take out a bank loan. Unable to keep up the house expenses and bank interests, he had 'no other alternative but to judicialise'. 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.

A former union organiser, Edgar had a sense that aspects of racism and socio-economic inequality seemed to be improving with the rise to power of the Workers' Party (PT or *Partido dos Trabalhadores* -- see Anderson 2011). As for why he was not judicialising 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 realising, access to healthcare through the courts, a phenomenon that has been termed the *judicialisation of health* (Biehl et al. 2009; Ferraz 2009; Marques and Dallari 2007). Though patients are suing the government for everything from baby formula to complex surgeries, a large portion of lawsuits are for access to prescribed drugs (Scheffer et al. 2005).

In this chapter, I explore how right-to-health litigation has become (in the wake of a successful universal AIDS treatment policy) an alternative route for Brazilians to access healthcare, 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 judicialised front. Poor people are not waiting for medical

technologies to trickle down; they are leveraging public legal assistance and a receptive judiciary to hold the state accountable to its mandate and to their medical needs, now. The chapter's ethnographic vignettes pave a path towards a relatively unexplored frontier of medical, legal and political anthropology, that zone where technology, medicine and law intersect in unexpected and deeply personal ways, and where our notions about how medicalisation 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 as the '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. Judicialisation 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 2007a; Galvão 2002). Ministry of Health policies and a 2000 ruling by the 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 decentralisation and in an effort to improve the administration of SUS, the federal Ministry of Health divided responsibilities for pharmaceutical distribution among three levels of government (Ministério da Saúde 2010). 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 *specialised medicines* which are dispensed 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 programmes for the control of certain infectious diseases such as HIV/AIDS, tuberculosis and leprosy, as well as rare disorders such as Gauchers disease (Ministério da Saúde n. d.).

Despite these laws, policies and judicial rulings, the experience of patients in realising access to medicines has been uneven. Today, about 200 000 Brazilians take ARV drugs paid for by the government. At the same time, many citizens go to local public pharmacies only to find that essential medicines are out of stock and that the newer medicines they seek are not included in official formularies (Mendis et al. 2007). Decentralisation delegated responsibility but did not ensure sustainable funding and technical capacity at local levels. Regional and municipal governments have not been able to adequately budget and administer the growing complexity of medical needs and technological and infrastructural demands 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 US \$25 billion in 2012 according to a business association (SINDUSFARMA 2012). 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 the case of Edgar) 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 few years, I have been coordinating a multisited 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.¹ 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 judicialisation of health calls upon and calls into question. Some of the core queries that guided our investigation included: Is the judicial system an effective venue for implementing socio-economic rights? Which social fields and practices of citizenship and governance are crystallised in these 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 seventh 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: the judiciary as a sort of pharmacy, the public defender as a physician, the physician as an activist, the patient association as a legal counsel and the patient citizen becoming the consumer, among other translocations and displacements. I found Michel Foucault's tentative reflections on biopolitics and neoliberalism (Foucault 2008) helpful, as I tried to understand the form and reach of these novel medico-socio-legal realities, in particular what he describes as 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 1978–1979 Lectures at the Collège de France, Foucault argued that we can adequately analyse 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 healthcare 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 judicialisation 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 the development (Ferguson 1994; Sharma and Gupta 2006) of transnational politics and neoliberalism (Comaroff and Comaroff 2011; Englund 2006; Petryna 2002; Ong 2006), and of the affective domains and subjective experiences of political life (Povinelli 2011; Biehl et al. 2005). 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).

Clearly anthropologists have stayed attuned to politics – even as the substance of what is considered 'political' has varied with disciplinary conversations – be it in the inequalities of the field, as activists, or in their theoretical concerns with postcolonial disorders, structural violence, social suffering and biopolitics, for example (Comaroff and Comaroff 2011; Chatterjee 2004; Das 2007; Good et al. 2008; Farmer 2003; Hansen and Stepputat 2001; Holston 2009; Kelly 2009; Merry 2006; Riles 2000; Scheper-Hughes 1992; Tate 2007). Most compellingly, anthropologists have begun to examine the politics involved in the formation of 'para-infrastructures' 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, 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, facing off and disputing over responsibility, evidence and cost-benefits, these various parties bide their time and become empirically present and permeable at once.

Although precarious, para-infrastructures such as the judicialisation 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 'judicialisation 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 crystallise amid 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 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 judicialisation of health without claiming that it is seamless. Instead, I urge readers 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 pharmaceuticalisation and judicialisation 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.

Ethnographic realities can help us to refine, complicate and even dislodge totalising assumptions about neoliberal structural adjustments and market-driven societies. In the Brazilian judicialisation of health, we do not see a top-down biopolitical model of governance in which population wellbeing 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, of atomised and ambiguous political subjects of rights and interests to the biomedical market.

Surprisingly, the decentralisation of state authority has created the space for a return of the juridical subject, but in an altered form. Not fully subject to the state or the market, these new political subjects 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 (*Defensoria Pública*) in Porto Alegre, during our first encounter in August 2009. This is where the poor get free legal assistance and where the majority of the lawsuits requesting medicines from the state originate. Souza did not mince her 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 wellbeing is no more. When this infirmed 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 emphasised 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). In its normative dispositions, the Constitution also stipulated the creation of Public Defender Offices to give poor people access to the judiciary.

In Rio Grande do Sul, the Public Defender's Office was established as early as 1991. Yet throughout the 1990s, due to political manoeuvres 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 400 attorneys offering services throughout the state and in 2010 alone, the Public Defender's Office attended to about 450 000 cases, a considerable growth from 225 000 cases in 2006.

Souza speaks of her work in the Office as an attempt to ameliorate human suffering and to restore to the person his/her rights. 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 judicialisation, she reasons, state politics would remain populist and only electorally minded, 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; 'An injection of reality' 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 address the issue of pharmaceutical dispensation in 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 centre 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 accumulated knowledge of 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 emphasised '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 General Attorney's Office has created its own taskforce of medical consultants to verify or disqualify claims for treatment access and efficacy.

With the judicialisation 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 want to suggest, this process also makes the judiciary a site in which the state's biopolitical disregard (i.e. the ability 'to "let" die')² – in collusion with the market – is exposed for public critique.

THE PHARMACEUTICALISATION OF HEALTH

While the justiciability of the right to health is of increasing interest internationally (Gauri and Brinks 2008; Yamin and Gloppen 2011), the volume of individual right-to-health lawsuits in Brazil stands out. In 2009, 5536 cases appealing high court rulings related to the right to health reached the Superior Court of Justice and about half of these cases (n = 2583) 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 non-medicinal cases concerned access to things such as medical devices, prostheses and special foods, as well as the availability of hospital beds and specialised facilities for paediatric or drug dependence treatment.

In 2009, the federal Health Ministry spent US \$47.8 million on court-attained drugs, a significant increase from the US \$20.4 million spent in 2008 and US \$4.2 million spent in 2007. By comparison, in 2003 federal expenditure on court-attained drugs was US \$58 800 (Collucci 2009). In the past decade, Brazilian states have also seen the numbers of lawsuits and costs for court-attained drugs rise dramatically, particularly in the south-eastern and southern regions of Brazil (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 113 000) have been filed in the state of Rio Grande do Sul ('Saúde conquistada na Justiça' 2010).

HIV/AIDS activists were among the first to successfully equate the constitutional right to health to 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 2007a), an incremental change in the concept of public health has also been taking place. In 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 *pharmaceuticalised* and *privatised*.

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% of the adult population (about 60 million people) uses pharmaceuticals on a daily basis. This is where the state comes into picture: pharmaceutical access.

In 2008, during a conversation 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 politicised access to treatments and healthcare in the recent past. Referring, for example, to the ongoing struggle over continued access to state-of-the-art antiretroviral 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 US \$2.5 billion on the acquisition of drugs in 2007, accounting for 10.7% of its total expenditures that year, and twice as much as in 2002 (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 price of the same drugs cited by the International Drug Price Indicator Guide.

Let me pause to unpack what I mean by describing the judicialisation of the right to health as part of a broader pharmaceuticalisation of care and of public health. First, the concept of pharmaceuticalisation builds on and revises the related notion of 'medicalisation', 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; Scheper-Hughes 1992). Scholars have traced the public health, policy and treatment consequences of the medicalisation 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 healthcare (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). Medicalisation, it is argued, strains healthcare systems, national economies and household finances alike. Sociologist Peter Conrad and colleagues (Conrad et al. 2010) have gone so far as to estimate that in 2005, the pervasive medicalisation of social conditions cost the US \$77 billion – 3.9% of total domestic spending on healthcare.

Increasing reliance on pharmaceuticals in treatment has gone hand in hand with the growing dominance of biomedical epistemology. In 1999, US spending on prescription drugs reached \$100 billion, more than double the figure just ten years earlier.³ A 2010 report produced by the Centers for Disease Control and Prevention notes that Americans' use of pharmaceuticals increased significantly between 1998 and 2008. The increase is especially noteworthy in the anti-depressant class: between 1998 and 1994, just 1.8% of Americans polled reported use

of anti-depressants in the past month; from 2005 to 2008, that number jumped to 8.9%. With the advent of so-called 'second generation' anti-depressants, the number of disabled mentally ill in the USA – that is, citizens receiving monthly Social Security Disability Insurance payments – has more than doubled, from 1.25 million people in 1987 (the year the FDA approved Prozac) to 3.97 million in 2007 (Whitaker 2010).

The concept of pharmaceuticalisation, however, stands for something more complex than an increase in the quantity of medications that societies consume (Biehl 2007b). In the past decade, medical anthropologists have critiqued the medicalisation 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; Petryna et al. 2006; Han 2012). Likewise, both policy debates and patient struggles surrounding access to pharmaceuticals are part of broader transformations in public health (Biehl 2007a; Ecks 2008; Reynolds Whyte et al. 2013). Understanding pharmaceuticalisation 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 want to highlight that contemporary processes of pharmaceuticalisation have historical antecedents in international health policies and interventions. While health development programmes once focused primarily on large-scale public health measures (e.g. sanitation, availability of clean water, hygiene), in recent decades, global health organisations have increasingly focused on access to pharmaceuticals as an indicator of healthcare development.

This trend is crystallised 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', creating such a taxonomy of fundamental drugs has revealed ambiguities and raised difficult questions (Greene 2011: 28). 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 price 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 from the Essential Medicines List (Greene 2011: 23). While the WHO now considers some antiretrovirals essential, the HIV/AIDS epidemic continues to provoke the difficult question of whether access to treatments that *extend* lives – but do not ultimately *save* them – should be considered a human right. This question over which things are 'truly indispensable' to health and living, and who is legally and financially responsible to make these things available, is central to how the characters of this chapter both invoke and critique biopolitics: from Edgar's comment in the beginning of the chapter that 'I know that the state cannot give everything to everyone' to the state official's deployment of evidence-based medicine to both rationalise care delivery and authenticate misrecognition and disregard.

The fact is that, in Brazil, pharmaceuticals have become key elements in the state's arsenal of action. 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 2007a). In May 2007, for example, Brazil broke the patent of an AIDS drug (Efavirenz, produced by Merck) for the first time – a step recently taken by Thailand – and authorised 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 which carry high political stakes), it is up to individuals and makeshift communities to take on the local roles of medical and political institutions as they learn to interact with and 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 wellbeing – what one can do without and what one needs to live with – is ever more tangled and contested.

THE RETURN OF THE JURIDICAL SUBJECT

Despite the growing scale and costs associated with lawsuits for access to medicines in Brazil, and amid polarised debate about the phenomenon, there has been scant information concerning the content of lawsuits and the characteristics of patient-litigants as well as 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 (Messeder et al. 2005; Pepe et al. 2010; Da Silva and Terrazas 2008; Vieira and Zucchi 2007; Borges and Ugá 2010). Most studies tend to corroborate the arguments of public health administrators that the judiciary is overstepping its role, and that judicialisation generates enormous administrative and fiscal burdens, distorts pharmaceutical policies, widens inequalities in healthcare access and encourages irrational drug use within the public healthcare system.

To better understand the scale 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 tenfold, from 1126 new cases in 2002 to 17 025 new cases in 2009. Medicines comprised the majority of these judicial claims, making up 70% of cases in 2008 and 2009.

As a second step, we created a database of medicinal lawsuits against the state Rio Grande do Sul. Our data collection team worked in the Solicitor General's Office, which is responsible for defending the state. From September 2008 to June 2009, we analysed 1080 lawsuits being reviewed by state prosecutors.⁴

Edgar's case (presented upfront) was not among these lawsuits, but as I share some of our results you will see that his travails are not an exception. 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 US \$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 2008: 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 healthcare 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 specialised 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 market for a long time. This suggests that government pharmaceutical programmes are failing to fulfil their role of expanding access and rationalising use (DECIT 2006; Guimarães 2004).

Moreover, judges at district and higher court levels almost universally grant access to all medicines requested, recognising 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 where the initial ruling was in favour of the provision of medicines, the state's higher court most often 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% of the total amount spent by the state on medicines that year (Biehl et al. 2009).

While decentralisation tried to establish clear responsibility at specific administrative levels – municipal, state and 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 site of a reluctant and undisciplined cooperation. In this way, the judicialisation of the right to health momentarily instantiates the state as the singular governmental entity responsible for the provision of social rights.

THE JURIDICAL HOSPITAL

Patients in our sample of 1080 lawsuits were, for the most part, chronically ill. Almost half of patients (48%) reported cardiovascular disease, diabetes, disorders of the lipid metabolism and pulmonary diseases. Some 16% of the patients reported neurologic and psychiatric conditions. Patient-plaintiffs in our sample had various co-morbidities 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 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 exceptional 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 – one single case – for medicines for HIV/AIDS. Both pathologies have a similar prevalence in the south of Brazil and both treatments are distributed by governmental programmes 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 programmes. While the strategic medicines programme which distributes HIV/AIDS drugs is centrally managed and funded by the federal Health Ministry, with a single acquisition process for the entire country, the exceptional medicines programme is decentralised: it is managed by states, which are federally reimbursed. The latter programme depends on administrative cooperation among 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 exceptional and special medicines must be accessed in the public healthcare system. When patients fall outside of 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 with which to challenge 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 rationalise pharmaceutical use (as the Health Secretariat cited earlier in the chapter would have it). As in the case of one patient named Nelson Silva, the judiciary seems to offer citizens that are once diseased and politically injured the possibility of articulating a time-sensitive legal effort to make the state act biopolitically so as 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 Paula Pinto de 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. He had retired as a steel factory worker and she was still 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 people get the medicine they need'.

Nelson had chronic hepatitis C and he was greatly benefitting from the 48 weeks 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 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 that '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 Conceição Hospital prescribed ribavirin and peginterferon alfa. The Health Secretariat denied Nelson's treatment request alleging that this would be 're-treatment' 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 eligible for re-treatment and now needed the medicines for 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, judicialisation 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 them a road map of all they had to do, and the documents they had to bring 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. 'Afterwards,' Souza told Nelson, 'you open a lawsuit against the state for medical injury.'

OPEN-SOURCE ANARCHY

According to legal scholar David Fidler (2008), 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' (2008: 410). Fidler recognises a 'deeper importance for law in public health endeavours within and between countries' (2008: 394; see also Fidler 2007).

Anthropologists John and Jean Comaroff have been attending to such a 'judicialisation of politics' in post-apartheid South Africa, and how it has impacted social mobilisation, 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' (2006: 26).

The judicialisation of right-to-health litigation speaks to a productive 'open-source anarchy' at both macro and micro levels in Brazil as well. Political scientist Luis Werneck Vianna (1999) would say that it is only one part of a broader pattern of the judicialisation of politics in the country. For him, judicialisation 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 judicialisation, but how to integrate their actions in order to best serve individuals and collectives while making democratic institutions more robust (Vianna and Burgos 2005).

The fact is that in this new chapter of the Brazilian history of citizenship and the right to health, 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 judicialisation skews budgets and increases inequalities in healthcare 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 democratisation of a culture of rights. For these judges, the poor Brazilians who are working through modes of legally arbitrated justice in order to access healthcare are not only fighting against legalised privileges and legitimated inequalities, as in James Holston's chronicle of 'insurgent citizenship' practices (Holston 2009) in Brazil's urban spaces; widespread litigation is rather seen as the expression of a distinct, equalising legal system and of a novel rights-conscious society. Whether such a democratisation of socio-economic rights can be attained through individual claims and in courts, however, is contested. The fact is that 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.

The judiciary recognizes that the judicialization of health has the potential to attend to social inequality and to affirm citizens' rights.

Like Souza at the Public Defender's office, Judge Eugenio Terra finds that lawsuits are largely filed by poor and desperate patients seeking treatments that should be available in the public system. He is in charge of all health-related cases in Porto Alegre.

'I am doing social justice, one by one,' Terra 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 Alencar 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 rationalise pharmaceutical use. State high court judges like Denise 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 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 recognise 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 that would include sex reassignment surgery in the list of procedures freely provided by the public healthcare 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.⁵ 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 over health-related cases.⁶

If access to AIDS therapies was the litmus test of the right to health in the 1990s, now it is access to genetic therapies that plays this role. Twelve year old Alexandre Lima de Moura suffers from an inherited metabolic disorder called mucopolysaccharidosis (MPS). 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 \$200 000 per year. Because of his age, Alexandre was not allowed to enrol 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-organised MPS 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 neighbours, local medical personal 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 the 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 publicly available. In March 2010, the court rejected the argument that the state was not responsible and decided in favour of the provision of the treatment. In his ruling, Justice Gilmar Mendes stated that once the disease 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 the monopoly of medico-scientific information by the laboratories and pharmaceutical marketing strongly informs physicians' prescriptive habits and patients' demands (Lakoff 2006). Additional qualitative studies are in order – they could help us chart how judicialisation 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).

There is a heated debate in Brazilian courts on the positive duty that 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 the 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 (which they currently do not). Moreover, how can access to new medical technologies be reconciled with systems that foster the equitable inclusion of people into preventive as well as basic and sustained care initiatives? Is there a way to balance individuals' urgent demands for healthcare, often in the form of medicines, with the long-term programmatic aspect of healthcare management and reform? Attention is also needed on broader aspects of the right to health, such as education, water, sanitation, vector control, air pollution and violence prevention. These complementary rights, 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 them as they negotiate medical inclusion and the vagaries of the market and survival. The judicialisation 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-CONSUMER

How is the subject of rights constituted in the face of the late liberal political economies? There is no pre-given biopolitical population to which Edgar, Nelson, Alexandre and thousands of other atomised subjects of rights belong to in Brazil today. Yet, in their private efforts to become such subjects, they 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 chapter 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 inclusion in terms 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' (Foucault 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 interests 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.

'Judicialisation 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 being now 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 recognised as citizens,' the contemporary judicialisation is no longer one of social mobilisation, 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 judicialisation is very much subject to the market and to consumer ideology, including the judiciary itself: '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 recognise 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 on the right to health are ultimately limited to those who can be articulated as access to consumption: 'We have a very strong demand and there is a low politicisation of citizenship.'

In her critique, Ventura assumes a certain kind of political subject, one who recognises 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 of citizenship in Brazil today which 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 actualised in urban poor contexts: 'Their political subjectivity is articulated through pastoral means, disciplinary practices of self-care, and monitored pharmaceutical treatment' (Biehl 2007a: 324–325).

For Paula Pinto de 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 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 privatised alongside the emergence of novel political subjectivities.

In the face of this, 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 they 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 utilise 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 that people invent to live in, and by, as they navigate the vagaries of market inclusion and survival in wounded cities.

CONCLUSION

This chapter focused upon novel forms of social becoming in the interface of law and medicine to show how politics matters differently to a growing number of low- and middle-income sick Brazilians. People's life chances and health outcomes are over-determined by the kinds of marketised/juridical 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 this para-infrastructure of rights and interests that the judicialisation of health has occasioned. We must consider both the possibilities opened up and the exclusionary dynamics at work in the judicialisation front

evident throughout Brazil and in other emergent powers. Thus, from the perspective of judicialisation, health in the time of global health is a painstaking work-in-progress by monadic juridical subjects 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 power to remake subjectivities and social worlds as they open up new spaces for claim-making, contestation and ethical problematisation. It is at the intersection of the therapeutic imperative, the biotechnical embrace and the reason of the market that the intensity of survival becomes visible and the political battle over what is frugal and vital is played out.

NOTES

- 1 This chapter derives from a 2008–2012 multi-disciplinary investigation of the judicialisation of the right to health in southern Brazil (See <http://joaobiehl.net/global-health-research/right-to-health-litigation/>). 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 their 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, Torben Eskerod, and it involved:
 - i. A database of lawsuits for access to medicines in the state of Rio Grande do Sul;
 - ii. An observatory of the evolving right-to-health jurisprudence in Brazil;
 - iii. Interviews with key institutional actors (judges, public counsels, lawyers, physicians, policymakers);
 - iv. Ethnographic research with patients and families filing lawsuits for treatment access;
 - v. A visual documentary of the people involved in right-to-health litigation.
- 2 See the Foucaultian definition of biopolitics as 'to make live and let die' (Foucault 2003: 241).
- 3 See www.cdc.gov/nchs/nhanes.htm
- 4 See www.princeton.edu/grandchallenges/health/research-highlights/aids/Database-project.pdf

- 5 See www.stf.jus.br/portal/cms/verTexto.asp?servico=processoAudienciaPublicaSaude
- 6 See www.cnj.jus.br/index.php?option=com_content&view=article&id=10547:recomendacao-no-31-de-30-de-marco-de-2010&catid=60:recomendas-do-conselho&Itemid=515

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