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HEALTH POLICY

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A Critical Anthropological Examination

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EDITED BY
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To our respective children,
Diane and Naiara Appaix-Castro,
and Jacob and Elyse Singer,
who are our expressions of hope for a future
in which health policy might truly be healthy for all.

CONTENTS

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II. National Health Policies and Social Exclusion

Introduction

Anthropology and Health Policy: A Critical Perspective

MERRILL SINGER AND ARACHU CASTRO

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Policy is governed by entrenched myth.

—PETER MARRIS, 2003

IN RECENT YEARS, a number of anthropologists have argued that their field—which traditionally focused on detailed ethnographic description of the unique cultural patterns of small-scale societies around the globe—is at risk of becoming irrelevant in a changing and shrinking world unless its shifts direction and takes on new challenges. Central to this shift in thinking about the mission of anthropology has been a concern that the discipline be "inside the loop" and get invited to the table in public discourse on pressing health or social issues. As a counter to the fear that anthropology is becoming irrelevant in the contemporary world, some have called for the development of the discipline as a *policy science*. As defined by Van Willigen (1986), the purpose of a policy science "is to provide information to decision makers in support of the rational formation, and evaluation of policy" (p. 143).

The term "policy" is variously defined but generally is used to refer to the official guidelines implemented by a social institution intended to set direction for action. As used in this book, health policy refers to both codified guidelines relative to health (or policy with another purpose but nonetheless having a direct impact on health) or health-related programmatic actions that reflect either codified guidelines or what is sometimes referred to as "unstated policy." Since the nineteenth century, one of the defining features of the "modern" state (at the national, regional, and local levels) has been the implementation of policies and policy-guided programs to protect and promote the health of the body politic. Health-related policies are also formulated by international organizations, development organizations, and health care providers.

Given its usual public identity as an academic discipline, it is often overlooked that the first professional positions for anthropologists in the United States were not in universities, but in governmental policy research settings. Anthropological work at the Bureau of American Ethnology, for example, which was established 120 years ago, a decade before the first university department of anthropology in the United States, had the explicit goal of producing research findings that would have practical utility in the administration of Indian affairs. In this sense, in the United States but elsewhere as well, anthropology emerged as a policy-oriented field, most notably in the arena of colonial management of subjugated peoples. Despite this early, and indeed troubling, association of anthropology with one sector of the field of policy development and implementation, it was not until the World War II era that anthropological practitioners began to reflect extensively on their role in the policy arena. Numerous anthropologists found federal employment during the war, some in health policy-relevant institutions. Margaret Mead, for example, was very involved in diet and nutrition issues during this era. She served as head of the federal Committee on Food Habits, which developed policy recommendations on emergency feeding and food rationing. This involvement notwithstanding, anthropology did not readily develop an identity as an explicit policy science during the war.

In fact, the anthropological relationship with policy makers often has been conflicted. Most applied anthropologists have had firsthand experience with seeing their findings and recommendations largely ignored by policy makers because they did not match official truths and politically useful understandings. In the period after the war, a number of anthropologists left government employment with embittered feelings and with ambiguous attitudes about government service. This trend was enhanced during the baby boom era when the significant expansion in the number of academic jobs for anthropologists pulled people out of applied settings to teach a new generation of young adults entering the university. During this heyday of academic anthropology, teaching replaced applied work and social policy concerns for most people in the field. By the 1980s, however, the pendulum began to swing again in the opposite direction, as more and more newly graduated anthropologists were forced to find employment outside of the academy, sometimes in policy-relevant settings. As a result of this second shift, anthropological attention to significantly strengthening the role of the discipline in public policy debates while increasing the volume of the anthropological voice on issues of grave public concern has expanded anew in recent years. The contemporary focus on developing what has been called "a public interest anthropology" exemplifies part of this reinvigorated commitment to policy issues.

Actually, over the years there have been multiple applied roles that anthropologists and like-minded researchers have played relative to social policy beyond pro-

viding information to assist decision makers in developing guidelines, codes, laws, and other policy expressions, including going beyond merely providing findings to making specific recommendations for policy change. At times, although not commonly, anthropologists have themselves become health policy makers, as several anthropologists have either been elected to governmental office or been appointed to a decision-making role in a governmental or otherwise influential institution. In these instances, anthropologists in policy-making position have turned readily and often to their colleagues for anthropologically relevant insights on health and other issues. Anthropologists also have played roles in amending existing policy to be more effective (e.g., by using ethnographic data to demonstrate weaknesses of and needed adjustments to established guidelines) or in helping to draft new policies based on field-based experiences with pressing health and social issues.

This volume represents yet another role of anthropologists in the policy arena: using research to critically review the intended or unintended negative impact of policy on the lives and well-being of people targeted by social policies. Stated plainly, this alternative public role of anthropologists, the one developed in this book, is the informed critique of policy. Another way to think about these issues is to follow Van Willigen's (1986) differentiation (based on the work of Robert Strauss) between "anthropology in policy" and "anthropology of policy." The first of these terms refers to anthropological work designed to either provide information for utilization by policy makers or the development and implementation of interventions or other applications that stem from and are supported by existing health policy. For example, through the National Institutes on Health numerous anthropologists, including contributors to this volume, have worked on policy research and application initiatives targeted to a wide variety of health issues. By contrast, the anthropology of policy is concerned with studying and assessing the process of decision making, the actions of and influences on decision makers, and the impact of policy on human lives.

Unlike much policy-oriented anthropology, the chapters in this edited volume exemplify the "anthropology of policy." The underlying and shared assumption of the chapters that comprise this book, which it should be noted are not all written by anthropologists, is that health policies are shaped by a number of factors, only one of which (and sometimes the least of which) is concern with public health. Health policy formation and implementation unfold in a world of competitive social interest, opposed class agendas, unequal genders, and overt and covert power conflicts. Health policy may reproduce structural violence, defined as the set of large-scale social forces, such as racism, sexism, political violence, poverty, and other social inequalities, which are rooted in historical and economic processes. As a result, health-related policies, which have the ostensive goal of improving and protecting the health of the general public or sectors thereof, may, in their service

of other masters, harm rather than enhance public health. Grounded in the field research of the respective authors, the chapters in this volume cast critical gazes on the actual nature of health-related policies in varied settings in both developed and developing countries around the globe.

Collectively, the chapters of this volume demonstrate the intricate understandings and keen insights gained through the application of a critical approach to knowledge generation. This approach, which seeks to locate health issues in the intersecting contexts of cultural heritage, human biology, and political economy, offers readers a sharply questioning and nonconventional vantage for thinking about public policy as a reflection of the reigning structure of social inequality.

The appraisals of policy that are presented in this volume are informed generally by the theoretical perspective known as critical medical anthropology (CMA) (Baer, Singer, and Susser 2003). This framework "emphasizes the importance of political and economic forces, including the exercise of power, in shaping health, disease, illness experience, and health care" (Singer and Baer 1995:5). The CMA perspective (1) recognizes that health itself is a profoundly political issue, one that often is contentious if not explosive; (2) is cognizant and critical of the colonial heritage of anthropology and the tendency of conventional medical anthropology to serve as a "handmaiden of biomedicine"; (3) balances concern for unbiased social science with an awareness of the sociohistoric origin and political nature of all scientific knowledge; (4) acknowledges the fundamental importance of class, racial, and sexual inequity in determining the distribution of health, disease, living and working conditions, and health care; (5) defines power as a fundamental variable in health-related research, policy, and programming; (6) avoids the artificial separation of local settings and micropopulations from their wider political-economic contexts; (7) asserts that its mission is emancipatory: it aims not simply to understand but also to change culturally inappropriate, oppressive, and exploitative patterns in the health arena and beyond; and (8) sees commitment to change as fundamental to the discipline.

As an expression of anthropology (as opposed to other approaches to the same issues), CMA does not view its subject matter from a narrow, top-down perspective (i.e., as the uniform enactment of power by dominant players and institutions and the obedient compliance of enfeebled subordinates). Rather, CMA in its approach to policy—which it sees as a conflicted expression of power (and, at times, becomes war by another means)—emphasizes the contested and particularistic nature of policy formation and enforcement. Policies, in short, are seen as reflecting a compromise between and at the same time the relative balance of power among conflicted forces (i.e., social groups with different and often opposed interests) at a particular time and in a particular place. While carefully exploring the undeniable importance of local and temporal conditions in policy, in

its approach CMA is nonetheless centrally concerned with viewing unique actions and contexts from the perch of a more general political economic vista. From this standpoint, and as reflected in the chapters in this volume, there can be unhealthy health policies, including policies that cause tremendous social suffering and policies that can be seen as an expression of structural violence (Farmer 2003).

Anthropological concern with health issues generally dates to the early years of the discipline. Indeed, the first field expedition (a data-collection tour of the Torres Strait) driven by a distinctly anthropological mission was, in part, concerned with ethnomedical beliefs and practices. As a named subfield of the larger discipline, medical anthropology began to coalesce and to develop a set of devoted adherents, specific academic courses and training programs, specialized subdisciplinary journals, and an organizational structure after World War II. Even prior to the emergence of medical anthropology, anthropologists had developed a long history of participation in national and international efforts to improve health. Anthropologists have worked with epidemiologists to explain disease patterns and have collaborated extensively with public health providers to promote successful, "appropriate," and "culturally sensitive" health interventions. But with few exceptions, anthropologists have focused most of their efforts on analyzing, improving, or evaluating specific problems within health programs, such as discrepancies of beliefs and values between implementers of health initiatives and their targeted recipients. Rarely have they stepped back to examine the wider socioeconomic constraints placed on those who control the budget strings of national and international health policies. Yet, if we are to get to the heart of why some health initiatives succeed in terms of improving health outcomes while others fail or even worsen health problems, we must also examine these constraints and the core principles and policies that guide national and international efforts to eradicate or control disease.

Are the principles guiding health policy based on beliefs in health as a human right and a public good? Are they tied to notions of health equity, with an ethical imperative to protect the poor and other vulnerable groups? Or are they driven more by fear and less benign ideological and geopolitical objectives? What are the implications for poor people of health policies generated from nonhealth concerns? Even when sound epidemiological findings, considerations of equity, and health as a fundamental human right form the core of national, bilateral, and international health policy, well-intentioned health efforts are often undermined at the implementation stage when the interests of capital and the interrelated trilogy of fear, ideology, and geopolitics come to take precedence over public health concerns (Castro and Millen 2001). This book offers multiple examples of how this trilogy comes into play and the consequences it produces.

Structure of the Book

This book is organized into three sections. Part I, "International Institutions and the Setting of Health Policies," demonstrates the distance between health policies that are conceptualized by international institutions and the reality of these policies on the ground, particularly throughout Latin America, Africa, and Asia. Often, these strategies reflect an ideology that does not necessarily respond to the needs of the people for whom they were designed. The chapters offer insightful perspectives on whose interests are served by current health priorities and policies. Chapter 1, by Paul Farmer and Arachu Castro, analyzes the increasingly disproportionate weight of economic arguments within the context of establishing priorities in the fight against HIV/AIDS. By examining the cases of two neighboring countries in the Caribbean—Haiti and Cuba—the authors demonstrate and analyze significant differences. In Haiti, a series of obstacles to the delivery of public health services can be attributed to the abuse and misuse of cost-effectiveness tools and to politicized arguments within the international community on the allocation of external resources to impoverished countries. Conversely, the Cuban case reflects self-determined health policies and resource allocation practices that generally follow and are shaped by the epidemiology of the disease. In chapter 2, Francisco Armada and Carles Muntaner analyze the role of international financial institutions in the reform and increased privatization of health systems in Latin America. The authors argue that this trend, part of the broader neoliberal agenda, primarily benefits national and transnational corporations, thereby reproducing and reinforcing already existing social inequalities. In chapter 3, James Pfeiffer explores the damaging fragmentation of health services in Mozambique, a direct consequence of structural adjustment policies set by multilateral and bilateral funding institutions. Joan Paluzzi, in chapter 4, reminds us of the 1978 Declaration of Alma Ata, which reinforced the importance of primary health care systems, and argues that international institutions continue to privilege restricted, vertical programs at the expense of primary programs. By exploring the Chilean case, Paluzzi demonstrates the interdependence that exists between these two health care delivery models.

In chapter 5, Fouzieyha Towghi analyzes the misguided attempts to integrate traditional midwives into primary health care in Pakistan, and the resulting devaluation of this human resource as a potential collaborator in the reduction of maternal mortality and morbidity. In chapter 6, Salmaan Keshavjee focuses on the implementation of a revolving medicinal drug fund in post-Soviet Tajikistan. Through the prioritization of privatization, the revolving drug fund has actually increased inequalities in access to medicines. In chapter 7, Alice Desclaux explores the impact of user fees on AIDS treatment in Senegal. In addition to the damaging im-

pact on the financial capacity of households, user fees also have become an important factor in the pattern of decreasing drug adherence. In chapter 8, Arachu Castro analyzes the integration of reproductive health services in Mexico. Within the context of promoting contraceptive use as part of the routine birthing experience, health professionals often endorse broader, dominant population policies; as a result, some indigenous women are reluctant to deliver in hospital settings, thus increasing their risk for untreated obstetric complications. In chapter 9, Imrana Qadeer and Nalini Visvanathan examine some of the underlying issues that shape population policies in India, and link them to the trends toward the general privatization of health care and the marginalization of primary health care.

Part II, "National Health Policies and Social Exclusion," explores the impact of national health policies on the most disadvantaged people within countries in Latin America, Europe, and North America. Specifically, the chapters in this section reveal the ways in which health policies have contributed to the construction and maintenance of significant social inequality and related human suffering. Moreover, the chapters in this section call attention to health policies that can be beneficial for one group while punishing another—often less privileged—group within society. For this reason, and as documented by the chapters that follow, health policies can become intended or unintended implements of structural violence. Collectively, these chapters provide textured and historically rooted accounts of how health policies can create vulnerable social groups and put them in harm's way rather than protect the poor, women, or people of color. In chapter 10, César Abadía-Barrero analyzes the successful implementation of access to health care—including comprehensive AIDS care—education, and other social opportunities for children who live with HIV/AIDS in Brazil. Because poor children, many of them living on the streets, do not usually have access to these services, being HIV-positive has become a social advantage. Exemplary is Katherine Bliss's analysis, in chapter 11, of the gendered history of syphilis prophylaxis popularization in revolutionary Mexico, including the 1940 criminalization of infection transmitted through sexual contact. In chapter 12, Linda Whiteford and Graham Tobin, based on studying the lives of Ecuadorian people displaced by the eruption of a volcano, argue that emergency evacuation and resettlement policies have actually increased their risk of illness and disease. In chapter 13, Didier Fassin analyzes political choices that, despite the existence of a universal health system, contribute to the increase in health inequalities in France, predominantly among immigrant populations. In chapter 14, Kristen Jacklin and Wayne Warry explore Canadian policies that were designed to enhance self-determination in health care for First Nations peoples but that, in practice, have had very limited benefits for Aboriginal health. In chapter 15, Sarah Horton focuses on the attempts of the U.S. government to reduce the number of people without health insurance through managed

care, and how these attempts actually decreased the number of Latinos eligible for federal health insurance in New Mexico. In chapter 16, Cathleen Willging, Howard Waitzkin, and William Wagner assess how other attempts at managed care to reform the provision of health services to the poor in the United States decreased access to mental health services in rural New Mexico. In chapter 17, Claudia Chaufan analyzes the social construction of the diabetes epidemic in the United States, and discusses how the commodification of health care and the impact of broader social inequalities have contributed to a failure to adequately respond to the needs of diabetics.

In chapter 18, David Buchanan, Merrill Singer, Susan Shaw, Wei Teng, Tom Stopka, Kaveh Khoshnood, and Robert Heimer examine the implications of policies on access to sterile syringes and how they can directly contribute to a decreased incidence of HIV among injecting drug users. The authors compare these policies between Connecticut, where a needle-exchange program exists, and the neighboring state of Massachusetts, where the difficulty of procuring a safe needle puts injecting drug users at a higher risk for HIV. In chapter 19, Merrill Singer reviews the U.S. War on Drugs, revealing thereby that in practice antidrug policies often serve to promote a war on young men of color while producing a number of "secondary benefits" for the dominant social class. In chapter 20, the final in part II, Philippe Bourgois demonstrates some of the ways in which the War on Drugs has backfired and helped to promote incipient inner-city apartheid.

The third and final part of the book, "Impact of Policy on the Practice of Medicine," focuses on the health care system and the role of policy makers in negatively shaping health care delivery. There are three chapters in this section. Chapter 21, by Hans Baer, examines the role of policy in the co-optation of alternative healing as a subordinate system to biomedicine. Chapter 22, by Robbie Davis-Floyd, focuses attention on the ways the health care industry is shaped by health policy, with special reference to recent trouble-filled and stressful interaction between health care providers and midwives. Chapter 23, the final chapter, asks why high-tech medical intervention rather than prevention is the focus of breast cancer policy in the United States. Ironically, the author, Catherine Hodge McCoid, notes that in treating rather than preventing breast cancer, industrial medicine profits from diseases caused by carcinogenic industries.

If, as Paul Farmer (1999:15) has argued, "inequality itself constitutes our modern plague," then health policy must be directed at outlawing inequality as a public health priority. This, however, has not been the case as documented by the chapters to follow. Indeed, the opposite has often been the case. Recognition of this fact provides direction for an anthropological role in health policy, namely contributing to the making of healthier societies through the making of healthier health policies, including policies that help to level an often very unleveled playing field. Rules and guidelines designed to equalize the quality of life across so-

cial strata and vulnerable subgroups, improve access to quality health services for all, and allow freedom from structural violence would aptly be titled healthy health policy (Wilkerson 2003).

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