

Without alternatives?!

Challenging political-economic dogmas in the field of health and healing

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Abstract

Human health and well-being are closely contingent upon economic ideologies and political dogmas, and health professionals as well as policy makers in all parts of the world have long contended about how to organize equitable health care. Historically, both excessive neoliberal agendas and socialist processes of enforced communization have had disastrous effects on affected people's physical and mental health. And more recently, nationalist-oriented actors push for drastic cutbacks of international (development) aid and prioritize service provision for particular populations within 'their own' countries, thus exacerbating unequal access to health care 'at home' and abroad. Such different approaches are often presented as being without alternative, i.e. as unnegotiable in face of previous failures and specific political and financial constraints. We invite papers that ethnographically explore how such logics of lacking alternatives are created, conveyed, defended, and (in)validated. What are the implications for the structuring of health systems, practices and ethics of caregiving, involved social relations and moral normativities, and individual experiences of suffering? How do such logics relate to the notion of health (care) as a fundamental human right and public good? What are the consequences in terms of the commodification of health and the (re)distribution of responsibilities for its maintenance and promotion? Which disparities regarding access to therapeutic means and innovation do they tackle but also engender? We further wish to attend to the sites and workings of resistance to such forms of discursive and practical closure: Where and how are respective logics contested and practically levered out? How and to what effect do patients, health practitioners, and policy makers maintain their openness to think and act alternatively in their endeavor to sustain and support their own and others' health and well-being?

Program

Alter-Health: From profitable destruction to decolonial alternatives

Keynote, César Abadía-Barrero, University of Connecticut

In this paper I reflect on how Buen Vivir, as an alternative and decolonial epistemology of life, can help us confront the deepening agenda on health care privatization. My activist-oriented research of the last 14 years has centered in Colombia; a country known for its entrenched and wide-ranging neoliberal reforms and, more recently, for the peace accord signed in 2016 to end the armed conflict between the state and the oldest guerrilla on the planet, FARC. First, I draw upon a 10-year collaborative ethnography at the oldest child and maternity university hospital in the country, to discuss how health care privatization transformed medical care. Then, I examine current efforts from communities of farmers, indigenous people, and former combatants to move the 2016 peace accord's agenda on health forward. These efforts are centered on rural territories and the Andean indigenous political philosophy of Buen Vivir. By drawing on current collaborative and network-based research, I reflect on how Buen Vivir, as a decolonial proposal from the south, can constitute an alternative epistemology to health. At stake, I argue, are the battles over the meaning of what health is or can be.

Nosotros: human interaction as the unit of health

Carolina Gonzales-Schlenker, University of Texas

We contend that given scientific evidence, the unit of human health should not be an individual but an interaction. That the (normalized) force traumatizing human life trajectories is the brutal substitution of organic interdependencies by the economic transaction as the unit of social reproduction. Moral disengagement between seller and buyer is concealed by the resolution of tension and the easy calculability at the unit's completion, giving a false sense of order. From money's linear value comes an acceleration of human activity that explains our pandemic of chronic disease, as organic times fail to keep pace with modernity. Capitalism has deceived humanity as a tumor misleads our body into feeding it to death. However, it is the damage to our sensitivities that exposes our species' exquisite design. So there lays the alternative: to become the creatures we already are. We propose trust as the unit of human health. Present a 7-year experience of trust-building as device to transcend economic valuation. The setting is a primary care clinic serving low-income Latinos in San Antonio, TX. The model is based on care and virtue ethics and inspired by the worldview of the Maya.

The values of the National Health Service (NHS)

Piyush Pushkar, University of Manchester

In the UK, activists are campaigning against reforms in UK healthcare that are tied to an austerity program affecting all public services. I draw on ethnographic research with these activists, and the managers and politicians pushing the reforms through. The managers and politicians describe their own values in similar terms to the activists. However, the actions of the managers are in contradiction to those of the activists. In this paper, I reflect on the

tension between these diverging actions and mirroring discourses of ostensibly similar moral projects. While managers and politicians claim to share the same values of universality and comprehensiveness of a free service, they must also consider costs. Managers and politicians argue that the “reality” is that they must stay within their budgets, pre-set by central authorities. Marx’s insight that the apparently inflexible reality of the commodity’s exchange value conceals a suite of social relations is recognised by activists, who seek to focus on exposing these relations. They counter the managers’ economic argument emphasising necessity and constraint, with an ethical argument emphasising political choices and possibility.

Challenging the logic of efficiency: Different and conflicting views on the model of Person-centered care

Francesco Diodati, University of Milano-Bicocca

In the global context of aging populations, health authorities have often presented the humanistic ideal of putting the Person again at the center of healthcare services as a solution for decreasing the costs within National Healthcare Systems (WHO 2006). This paper aims to explore the challenging to the validity of political-economic dogmas embedded in this view of the model of Person-centred care (Pcc). By analyzing informal discourses and semi-structured interviews with the providers of an eldercare service in Italy, I will argue that ‘new’ ethics of Pcc ambiguously intertwines with old-standing dominant approaches of quantifying and standardizing the provision of healthcare services (Lydahl 2017). The philosophy of Pcc highly values the building of long-lasting relationships and communication between providers, patients, and caregivers to sustain as long as possible ‘good care at home’, the cultural vision which dominates the discourses on aging (Lamb 2017). And yet providers believe that health authorities’ logic of efficiency constructs a model of Person and care needs that neglects their abilities and efforts in sustaining these relationships within an ideal of Pcc.

Alternatives in the absence of ‘order’: Resistant infections in Tripoli, North of Lebanon

Anthony Rizk, Graduate Institute, Geneva

At the dawn of Lebanon’s post-war ‘reconstruction’ period, Gilsean (1992) noted how discourses of ‘ma fi nizam’ (‘there is no order’) proliferated to capture a “historical...decay, a slip into unregulated free-for-all.” Almost three decades since, an underfunded healthcare system has given way to mass privatisation. Outcries of there being no ‘order’ persist. Studying outbreaks of highly resistant infections in Tripoli, north of Lebanon, I spoke to healthcare workers who themselves describe the healthcare system as one ‘without a conscience’. Meanwhile, amid growing security, economic and financial crises, activist organizing around the right to health is almost absent, except in clearly demarcated spaces. Here, how does ‘no order’ converge with there being ‘no alternatives’? Conversely, what kind of alternatives emerge precisely when there is ‘no order’? I think through ways in which resistant bacteria connect a highly disconnected healthcare system, how resistant infections forge new social relationality and improvised medical responses, and how other understandings of ‘resistance’ emerge in the places where human and microbial worlds collide.

No more excuses not to test for Down Syndrome? New dilemmas surrounding prenatal genetic testing in the era of non-invasiveness

Stefan Reinsch, Universität zu Lübeck / Anika König, Universität Luzern

In her book *The Tentative Pregnancy*, Rothman (1986) showed that the risk of miscarriage gave woman a 'good' reason to decide against testing for foetal chromosomal abnormalities with amniocentesis, while emotional troubles about testing were more difficult to justify. Protecting the life of the foetus was a non-negotiable reason for refusing prenatal tests. Rothman also predicted the invention of prenatal tests by analysing the pregnant woman's blood as an alternative to amniocentesis. So-called 'non-invasive prenatal tests' (NIPT) were introduced in Germany in 2012. Based on 50 qualitative interviews, we look at women's arguments and experiences regarding the use of, or resistance to, the new NIPT. Women who refuse amniocentesis, but 'want to know' if their child has a chromosomal abnormality, welcome the introduction of this new technology. There is, however, more to be said about the ethical and practical implications of non-invasiveness: resistance to the offer to 'know more' becomes increasingly difficult to articulate. 'Non-invasiveness' thus implicitly challenges women's 'right not to know' and creates new moral dilemmas that result from genetic knowledge about the child.

Comments

Janina Kehr, University of Bern