Hence there was a sense not just of violation, but of continued violation by multinational corporate interests.

One resident of the slums told me that he does not go to the hospital anymore, because "they do trials there, and we come out dead."[1] Satinath Sarangi, who runs a free clinic in the slums for the gas victims, subsequently described this to me as a continuation of the "circle of poison" that started with chemical companies and continues to be propagated by pharmaceutical companies.[2] He reminded me that a pharmaceutical company is just another kind of chemical company. Santosh told me, as our conversation continued, that he wants to become a biologist when he grows up, because he wants to do research that can improve the health of people like his who live in the slums.

BOMBAY, 2008—I was talking to Yusuf Hamied, the chairman of Cipla, India's oldest surviving pharmaceutical company. I asked him about the impact of World Trade Organization (WTO)-imposed patent regimes on access to medicines in India. His response: "What a silly question, Professor Sunder Rajan. What we are witnessing is selective genocide."[3]

Representations of Health

It is an obvious truism that there are investments in health across social positions. These investments are variously monetary, bodily, and affective. But what health might mean, how health might be achieved, and what imaginations of social relations and relations of production underlie various conceptions of health differs depending on institutional location, social hierarchy, and power relations. Clinical trials are thought of as benefiting humanity even as they are considered scandalous; hospitals are seen as spaces of cure but also in certain situations as spaces of death; intellectual property rights are argued for as necessary for innovation even as they are decried as being genocidal.

This book seeks to understand the political economy of health in contemporary India as it operates in relation to global biomedicine. It concerns emergent biomedical regimes of experimentation on the one hand, and therapeutic production, circulation, and access on the other. These regimes are operating in political economic environments that are highly capitalized, albeit through different mechanisms, business models, and industrial forms. In turn, these capitalized political economies foreground forms of biomedicine

that focus on pharmaceutical production, access, and consumption, rendering forms of care that are not so commodity- and artifact-driven less visible as a matter of policy or political concern. This capitalization operates at national and global scales, and is not without contestation. Arguments and considerations pertaining to value—both market value and ethical value—come to be front and center in these politics.

Further, the politics at stake is a representative politics, one whose forms and spaces are emergent and contingent, but that nonetheless operate within and in relation to structures of power and modes of production that are enduring. With their invocations about helping India's rural poor, the investors at the Burrill conference in San Diego were not shy about taking on the role of representatives promoting public health—just as Satinath Sarangi has been doing by providing free care for gas victims through his clinic in Qazi Camp in Bhopal, even as he has been at the forefront of the more than three-decade struggle for justice for the victims; as Yusuf Hamied has been doing, as a vanguard nationalist industrial leader who was one of the pioneers of the Indian pharmaceutical industry as a nationally viable industry that could reverse engineer generic versions of drugs to sell in domestic markets at competitive cost, and who in the early 2000s became a major player in global politics of access to essential medicines by selling generic antiretrovirals in African markets at a fraction of the price that Euro-American companies were selling their patented medications. Indeed, even as Santosh was aspiring to do, in his hopes of becoming a biologist who could contribute to the health of the people of his community.

And so, the democracy that investors at the Burrill conference lamented is neither an abstract philosophical concept nor simply a formal macropolitical exercise in choosing leaders; nor even just an expression of popular or community sentiment. Rather, it speaks to particular kinds of representative relationships: individuals and institutions acting on behalf of the marginalized, the vulnerable, or the disenfranchised in the cause of a more public health. But they suggest radically different conceptions of how health, value, and politics might be conceptualized, in and of themselves and in relation to one another.

While I was in Bhopal conducting research on clinical trials conducted on gas victims, I interviewed an oncologist who was at the time running trials on forty cancer patients, many of whom were gas victims. We were sitting in his outpatient office. He pointed to an old man sitting hunched next to me and said, "Look at him. He is a gas victim. He has stage IV pancreatic cancer. Either I enroll him in a clinical trial to give him experimental medication, or

he dies."[4] The image of that scene has stayed with me, of a man whose only chance of living was to be on experimental medication. But what I remember most is not the man himself, but rather the pointing finger of the doctor—directed at a dying man sitting in front of him, as he talked about that man to a stranger in English, a language he could not understand. He was pointing not just to a dying man, but to the situation of treating gas victims as their tissues turned malignant, in a context that has been marked by a failure of both health care and the law for over three decades. The doctor was engaging simultaneously in experimentation, therapeutic intervention, and representation, even as he was involved in a deeply politicized situation that had already been rendered scandalous.

How do we think about value that emerges here, in such spaces and through such relationships? How do we think about the politics that emerges here? How do we think about the health that emerges here? How do we think about the democracy that emerges here? I ask such questions by following ways in which health, value, and politics are constituted globally, in and through speculative metrics of value established on Wall Street, or pharmaceutical corporate lobbies in Washington, DC, or through local, national, and global civil society advocacy around health issues as they play out in high courts in India, in the calculations of brokers in clinical research located in Seattle and Hyderabad, North Carolina, and Northern Andhra Pradesh, in the investments of Indian capitalists with nationalist inheritances attempting to be global health players, in trade negotiations happening behind closed doors within bilateral and multilateral forums, in the pages of public health journals, or in legislative debates in the Indian Parliament. These are questions of pharmocracy.

Pharmocracy

In early 2005, the Indian government passed two consequential pieces of legislation for the pharmaceutical sector. Both involved bringing national laws in line with global regulatory frameworks, a process referred to as harmonization. One involved an amendment to Schedule Y of India's Drugs and Cosmetics Rules of 1945, in order to harmonize guidelines for the conduct of clinical trials with those mandated by the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH), the purpose being safe, efficient, and ethical processes for the testing, approval, and registration of drugs for market. The second change was to India's patent laws to make them compliant with the mandates