patent regimes and hence an ally of global civil society groups fighting for access to medicines. Cipla's history reveals a record of consistent action in its own market interests, and an attempt to define a market terrain in terms of those interests; but it also reflects certain explicit nationalist and (more recently) global humanitarian sentiments, in ways that open up questions about the postcolonial and ethical investments of these market actors. I then think through the global geopolitical landscape that structures these different ethical incorporations in antagonistic and power-laden ways. The conclusion is an attempt to think through the implications of this analysis for considering the future trajectories of politics engaging global biomedicine and global capital.

At the end of each chapter is a postscript that spells out the chapter's concerns to pharmocracy as a politically salient concept. It marks the site of questions concerning the nature of the political as it emerges in and through domains of health that are appropriated by global capital. These postscripts do not provide answers or explanations; they are meant as a reminder that the real challenge here—empirically, conceptually, and politically—is to remain attentive to how pharmocratic regimes put both health and democracy at stake.

Situating Pharmocracy

It is important to locate the analysis of pharmocracy in this book in relation to the specificities of place, history, and event that constitute its empirical substance. The task here is not to provide some sort of comprehensive explanation of what value or politics or knowledge is in some definitive sense as much as it is to multiply the situations from which its various articulations can be seen. Each situated perspective from which this book is written—of speculative, financialized, multinational pharmaceutical capital, of public scandal, of judicialization and the Indian courts, of monopoly capital, of Indian free market capitalism, and of global geopolitics—affords a locus for observing articulations of value, politics, and knowledge.[43]

This book is immediately concerned with a very particular situation in place and time, post-2005 India, in the domain of a specific industrial sector (pharmaceuticals), and with politics concerning health. On the face of it, the story that I am about to tell could be seen as one of a pharmaceutical industry acting and developing in the cause of more innovation and greater ethical consciousness. But it could equally be seen as one of the expanding domain of global capital and of multinational corporate hegemony, resulting

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in new Third World national regulations that are called upon to facilitate First World corporate interests. Such expansion occurs at the expense of the world's poor, who become guinea pigs in clinical experiments even as they find it harder to access essential medication. The reality involves understanding these hegemonic movements in all their fullness, but also and at the same time the ways in which they are contested. Contemporary India is important in this regard. India occupies a central place in global pharmaceutical politics by virtue of its strong national generic industry, which has been an important source of affordable medication for the Global South over the past two decades. For instance, MSF procures 25 percent of its essential medicines for worldwide distribution and 75 percent of its antiretrovirals from India.[44]

In addition to situating India thus, it is important to situate the period that this book focuses on. Specifically, 2005 serves as an empirical entry point because the legislative events that took place that year signify broader transformations of pharmaceutical political economies. But more generally, the time at stake is the contemporary.[45] How do we situate these legislative moments and the political events that surround them in relation to a broader historical movement in the global pharmaceutical economy and in contemporary India? In order to address this conceptually and methodologically, I turn to Gramsci's notion of the conjuncture, as a conceptual and methodological framework within which to situate my analysis in this book.[46]

Gramsci discusses two kinds of historical movements in relation to one another: the "conjunctural," which "appear as occasional, immediate, almost accidental," and the "organic," which are "relatively permanent" (2000, 201). Conjunctures could most certainly be marked by significant events; indeed, in order for them to be recognized as conjunctures, they probably are. But Gramsci finds them significant not just as historical markers of some kind of epochal shift (as events that radically cause a separation between then and now), but as political ones: the conjuncture provides a terrain upon which politics plays out. This could be a politics that attempts to preserve existing forces and relations, or one that attempts to overturn them. When I say that India's becoming party to the WTO or its attempts to globally harmonize ethical regulatory regimes for clinical trials provides the conjuncture in which this book is written, it does not imply in any simple sense that these events in and of themselves allow for an epochal shift in pharmaceutical economies. What it means is that they are markers of a reconfiguration of the terrain of the political in relation to these economies. Whether we think about the operations of multinational pharmaceutical companies in India, Indian generics companies, or sick Indians who are also citizens and consumers, life

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(and death), health (and illness), and the nature of markets, production and consumption come to be configured differently in a product patent regime than a process patent one, or in a liberalized clinical trials regime than in a more restrictive one.

The particular events in question, whether in relation to clinical trials or to intellectual property and access to medicines, were themselves contingent events. Nothing was predetermined about India becoming signatory to TRIPS. Indeed, there had been much civil society opposition to India's participation in the Uruguay Round of GATT negotiations in the early 1990s. But trade pressures from the United States, driven by the strength of the multinational pharmaceutical lobby in the U.S. government, coupled with the Indian government's strategic rationalizations that belonging to a multilateral free trade forum would be in the country's economic interests, held sway. Similarly, the political mobilization of CRO interests drove the liberalization of clinical trials regimes, which was hardly an obvious or predetermined movement. Yet elucidating the contingencies that underlie these conjunctural moments alone is insufficient. It remains to be asked at the level of empirical specificity: Why is it that these contingent conjunctures happened together? Why did they happen at a moment of the broader appropriation of various domains of health in India by global capital? And what is the relationship of these multiple, convergent (if contingent) events to the logics of capital and its institutional materialization in corporate strategies and global geopolitics?

For Gramsci, what was most important about the conjuncture was the way in which it always poses the question of its own relationship to the organic. The theoretical task, he suggests, is neither just the elucidation of the conjuncture (which ultimately privileges the contingent as an end in itself or, in Gramsci's terms, leads to "an exaggeration of the voluntarist and individual element" [2000, 202]), nor simply the elucidation of some fundamental organic movement as underlying the conjuncture (which leads to structural determinism). It is rather the determination of the relationship between the conjunctural and the organic.

For this, it is important to locate the conjuncture of pharmaceutical politics in India that I am marking in the context of a broader political economic conjuncture, within a broader trajectory of capitalization of the life sciences and of India. One has seen the progressive privatization of clinical trials since the 1970s alongside the capture of the multinational R&D-driven industry by speculative financial capital, a process I describe in detail in chapter 1. Concomitant to this has been India's transformation into a global market economy, a process initiated in earnest by the 1991 Congress Party–

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led government and marked since by various forms of economic liberalization in the interests of global capital. One can see this manifest in relation to changing intellectual property regimes under the guise of free trade and of changing ethical regimes in the cause of good clinical practice. But these are just sectoral instantiations of broader movements of global capitalization in the Indian economy writ large, marked by the opening of markets to foreign investment; intense wealth generation among certain segments of the population in the context of widening inequality and wealth disparity; new kinds of urban-rural divides, along with new forms of sociological mobility (and immobility); the emergence of parallel private infrastructures for essential services such as health, water, and electricity for those who can afford it; and the apparent handing over of the reins of the state to the market.[47]

Yet this period has also been marked by populism of the representative Indian state in relation to the poor. This is different from the feudal populism of political patronage networks, which has existed throughout the history of independent India and which, as Partha Chatterjee (2008) has argued, is important for understanding the functioning of informal economies in India today. It is also different from the state socialist populism of the 1970s, marked by Indira Gandhi's *garibi hatao* (remove poverty) manifesto. Rather, it is deeply coupled to instruments of global capital. An example of this in relation to pharmaceutical economies is the National Rural Health Mission (NRHM), launched in 2005. This initiative has emerged alongside the building of institutional capacity for public health education and research that was previously lacking in India, but also alongside the establishment of global health as a central focus in American medical schools and public health curricula. Programs such as these are closely articulated to institutions of global expertise such as the Gates Foundation, operate with top-down imaginaries of public health, involve public-private partnerships, and are often deeply technocratic in their mind-set.

There are many symptoms of neoliberalism in these formations, but they emerge in the context of representative populism toward the poor as an object and target of state intervention.[48] The NRHM, for instance, happens at precisely the conjuncture that sees India liberalizing its clinical trials regimes and changing its patent regimes to become WTO compliant. But it also happens alongside or anticipates a host of other initiatives launched by the Congress government that was elected in 2004 (and continued in power, albeit with a different set of coalition partners, until 2014) that are similarly populist, and often hitched to rights: for instance, the right to food, right to education, right to employment, and right to information.[49] All of these in various

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ways represent unfulfilled promises, but they have become important sites of political action. They signify not just the state's acknowledgment of obligations toward its citizens, but also represent modernist promissory notes that emerge out of a conjuncture of economic liberalization. What is at stake here is an understanding of history for the articulation of value and politics, "not the reconstruction of past history but the construction of present and future history" (Gramsci 2000, 202).

This understanding of history, in this book, is grounded in nine years of ethnographic fieldwork with a range of actors involved in various aspects of global biomedicine, pharmaceutical capital, and the politics of health. The research for this project started in early 2006 and involved following the burgeoning CRO industry in India, specifically its attempts to drive regulatory harmonization. This was where, it seemed, all the action was at the time. I was interested in following the intense conversation that was developing within the industry about the importance of developing an ethical infrastructure for the conduct of clinical trials; but the ethics in question was an instrumental and purely procedural one, concerned with good clinical practice and developing the apparatus for informed consent. I became interested in how this conversation around ethics was taking shape, not just for what was being said but also for what was not being said by the actors who were most powerfully involved in substantiating regulatory harmonization on the ground. Specifically, there was no regulatory conversation about whether drugs tested in India would be marketed in India, let alone be made available at affordable prices. The fact that this was happening at a time when actual access to medication could potentially become more difficult under the newly instituted product patent regime exacerbated the stakes of the issue. And so, what seemed as significant as the discourses of ethics that were being articulated were the discursive gaps that were at the heart of this articulation.[50]

I published a piece with this argument fairly early in the game, along with an op-ed in the *Indian Express* (K. Sunder Rajan 2007, 2008). Consequently and unsurprisingly, my access to CRO executives, who were initially very keen to talk to me, started drying up. By this time, my interests were in any case shifting to the question of access to medicines, a shift that followed naturally from attending to the discursive gap at the heart of the conversation on regulatory harmonization. If the CRO actors and clinical trials regulators were not talking about access to medicines, who was? I did not have far to look, since this was the very time when the politics around interpreting the 2005 Patent Act was at its height and becoming heavily judicialized through the Gleevec case. What was a discursive gap in one biomedical and regulatory domain was

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a site of deep political contestation and thick discourse in another, at exactly the same time. Much of my fieldwork at this point shifted to following the trajectory of the Gleevec case, which involved following its contestation and resolution in the courts, but also tracking the strategies of the multinational, Euro-American pharmaceutical industry in response to this judicial politics, and having conversations with civil society advocates for access to essential medicines and members of the Indian generics industry who had formed alliances with these advocates. I assumed that the clinical trials side of the project was done and dusted, having raised certain questions that I had followed into new research. I thought I had moved on.

But in 2011, I was sucked back into it with a vengeance, as clinical trials became the subject of scandal in India. The specific event that precipitated this was the HPV vaccine study, which became the focal point of political mobilization around unethical clinical trials. At the same time, a slew of other such cases came to light. This included the trials conducted on victims of the Bhopal gas disaster, trials conducted in a hospital in Indore that apparently did not conform to standards of good clinical practice, and trials conducted in Ahmedabad on poor volunteers in the apparent absence of proper informed consent.[51] The specific events in each of these cases was different, but they all suggested that the capacity building undertaken in the mid-2000s to make India a global experimental hub had led to a proliferation of poorly regulated clinical trials. There was no way that the clinical trials issue was a past concern, either politically or for my research.

Hence, part of the structure of this research simply comes from having conducted it in many sites, a process of following significant actors and events around. But more substantially, it comes from thinking about two domains of biomedical politics, concerning clinical trials and intellectual property and access to medicines, together. On the one hand, the specific actors and events that I was tracing in these two domains were different. On the other hand, they were parts of structurally interrelated biomedical and political economies. What I came to be concerned with was the relationship between these two domains, which raised two inverse conceptual problems. The first involves understanding the problem of variance that presents itself here: how it is that similar logics of capital materialize in such different political trajectories, mobilizing different strategies and institutional mechanisms. The second involves understanding norms: how it is that in spite of obviously different and contingent materializations of politics in these different domains, one sees the consistent establishment of certain political economic trajectories and power hierarchies that lead to the progressive capitalization of health.

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It is this conjoined relationship between historical variance in the context of structural norms, and conversely of historical normalization of biomedical political economy in the context of contingent variance, that provides the anthropological problem space of this book. It seeks to provoke conceptual and political questions concerning how value, politics, and knowledge come to be related to one another in contemporary global pharmaceutical economies in ways that put both health and democracy at stake.

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