

Commodifying Health: An Analysis of the Effects of Western Medical Consumerism on Malaria Treatments in Africa

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A world in which medical research is dedicated wholly to the diseases of the affluent—is too painful to contemplate. ~ Paul Farmer (The Lancet 2002:1266)

This paper is a two part analysis of the commodification of health from a critical anthropological perspective. Part one is an examination of Western neo-liberal consumer culture and its links to medicalization and medical consumerism. Part two examines the effects that this commodification of health has had on malaria treatments in Africa. By examining the impact of the commodification of health on malaria treatments in Africa we discover that health is like any other product offered on the open market – it is a commodity only affordable to some. In discussing this impact and bringing it out into the public, we may begin to make changes.

Part One – The Commodification of Health

When you're doing a clinical trial, there are two possible disasters. The first disaster is if you kill people. The second disaster is if you cure them. The truly good drugs are the ones you can use chronically for a long, long time. ~ Alex Hittle, Biotech analyst (in Cassels 2003).

Through the clever manipulations of those with vested interests in a free market economy, health has been turned into a commodity everyone can achieve – for a

price. As Foucault reminds us, “medicine, as a general technique of health even more than as a service to the sick or an art of cures, assumes an increasingly important place in the administrative system and the machinery of power,” . In order to understand how decisions made by the medical-industrial complex’s machinery of power translated into the commodification of health, we need to first explore Western neoliberal ideology.

Neoliberalism is a political ideology strongly associated with the economic doctrines of *laissez-faire* capitalism which asserts the importance of a free and competitive market, deregulation of industry, and privatization (Knuttila and Kubick 2000:51). It further emphasizes self-interest, rationality, and elevating “consumer choice to the level of a right that society is organized to defend,” (Frank 2002:19). Perhaps there is no better example than that of private health care in the United States. In the U.S., as in other corporate entities, private health care providers and insurers have a fiduciary duty (as ruled by the courts) to first and foremost increase profits for their shareholders to the exclusion of all other considerations (Barnes 2006). Particularly noteworthy was how U.S. President Nixon approved private health care in 1971. Approval was based on the condition that, as Erilichman stated, “all the incentives are towards less medical care, because the less care [the health care providers and insurance companies] give people, the more money they make,” (Moore 2007). As Logan and colleagues argue, neoliberal ideology promotes the idea that “medical services should be treated just like any other commodity that can be efficiently

produced and consumed under competitive market conditions,” (Lupton 1997:373).

Personal health consumerism evolved not only out of neoliberal ideology but also from the belief that western populations are living in a state of “risk”. In modern capitalist societies there has been a technological drive to dominate the world, leading to what is referred to as the “risk society” (Beck, et al. 1994:6). According to Beck and colleagues (1994), modern society has produced tremendous wealth, prosperity, and advances, and yet there is no limit to the risks of global financial crisis, pollution, and nuclear war. Over time, society is becoming increasingly self-aware of these limitations, and reflecting on them in a process referred to as “reflexive modernization” (Beck, et al. 1994:6-10). The argument is that the growth of knowledge has created uncertainty everywhere, and thus, society becomes organized around the management and distribution of dangers. Living in a “risk society”, particularly one with a neoliberal ideology, plays a significant role in the propensity for people to feel a sense of personal responsibility for their self and identity. Therefore, individuals employ “a continual search for knowledge to engage in self-improvement,” and consequently, “experience self, the body and the social and physical worlds with a high degree of reflection, questioning, evaluation and uncertainty,” (Lupton 1997:374). Growing reflexivity in society can be seen as a primary characteristic of the Western consumer culture’s *quest for the best* medical goods and services.

In consumer culture, acquiring goods becomes a ravenous mission that goes

beyond simple necessity or *use value*. Instead, goods and services become tied to personal identity, having *abstract value* consisting of “cultural, symbolic and emotional meanings around the good,” (Lupton 1997:379). Further, the drive to attain and accumulate goods results in the easy manipulation of individuals to acquire items they may not really need (Frank 2002). Even though certain health products may be viewed as unnecessary, “the industry can claim that it is only providing for all of humankind what people welcome as useful and effective medications for their own culturally specific treatments and ‘cures’,” (Oldani 2004:27). Often, however, individuals use medical practices and products to separate themselves from others through a process Bourdieu (1984) calls “distinction”. In other words, people may engage in such activities as cosmetic alterations of bodily features or use of particular medical products as a means of status differentiation. Health industry marketing for such products of “distinction” puts the focus of modern health care on the “rich well,” taking emphasis away from the “sick poor” (Moynihan and Cassels 2005:16).

Consumer culture can also play a direct role in what Lupton (1997) calls the “imperative of health”, where individuals are encouraged by the government or other agencies to become health conscious in the individualized pursuit of health. Indeed, by looking at contemporary discourses on the term “wellness”, Sointu (2005) discovered that the term wellbeing is steeped in Western beliefs in the importance of individuality and autonomy. This means that, “‘wellbeing practices’... enable people

to reproduce themselves as subjects who measure up to prevalent social norms and values,” (Sointu 2005:255). To illustrate, everyone wishes to be a normal weight or to have a normal body shape, and many will engage in activities to achieve these social norms. Consumer culture can thus be seen as playing a lead role in the commodification of health and the medicalization of life experiences.

Medicalization can be understood as the pathologization of life issues and social problems; in other words, the expansion of medicine’s boundaries to include issues that were once considered societal or moral issues. The temptation to medicalize behaviour is advantageous, not only for those wishing to maintain social order but also for individuals preferring to enter the “sick role” (Parsons 1951) rather than being labeled “bad” or deviant. Medicalization, therefore, can have a profound effect on individual subjectivity. To illustrate, a child who cannot sit still with a limited attention span is diagnosed with a disease called Attention Deficit Hyperactivity Disorder (ADHD) (Segall and Chappell 2000:217). This child now has a powerful negative social stigma that has real consequences, socially and subjectively. If the child is only thought of as behaving badly, then being good is possible, whereas if the child is labeled diseased or disabled, the child is then placed in a category of exclusion from normal and change is viewed as difficult. Personal subjectivity can also be impacted by locating the source of the problem within the individual rather than within the larger social context, therefore making it one’s own responsibility for achieving a healthy

status. What rationalization is there for medicalizing and individualizing life issues such as shyness, feeling sad, or being inattentive?

The ultimate rationalization in a neoliberal, capitalist society is the generation of profit. If an individual embraces the norms that the health industry creates, such as seeing inattention as a sign of ADHD and not a product of social breakdown, then life experiences become medicalized and health can be commodified. Conditions are, therefore, created and recreated for the sole purpose of generating profit. As Vince Parry states, “within the pharmaceutical industry, marketing professionals have increasingly taken branding to the next level by branding the disease or condition that a particular product is capable of treating,” (Parry 2003:43) Condition branding can be understood as “giving customers a new way to think about things, and ... transferring the values of this experience to a situation or commodity,” (Parry 2003:43). The power of the drug industry is displayed not only in its ability to brand conditions and create medications to treat those conditions, but in its influence over government regulators such as the Federal Drug Administration (FDA). It has been noted that the pharmaceutical industry pays half of the FDA’s salaries, and funds the FDA’s safety and efficacy research (Liebman 2003). This leads to an atmosphere wherein those employed by the FDA feel they work in the best interests of the pharmaceutical industry rather than for the protection of the public (Liebman 2003). It is salient, then, that what is considered a

disease is influenced not only by biology, but also by society, industry, and culture.

Foucault reminds us that, “‘health’ is a cultural fact in the broadest sense of the word, a fact that is political, economic, and social as well, a fact that is tied to a certain state of individual and collective consciousness,” (Foucault 2000:379). Looking at medical consumerism reveals that “the effects of medical consumerism may ultimately be as great... on those who do *not* themselves receive these services but who live in a society of which these services are a part,” (Frank 2002:16). Thus, medical consumerism has the ability to affect larger social processes. Medical consumerism distorts medicine as a social good that can be bought and sold like any other good. Consumerism turns health into an individual responsibility to buy the right products and services. Medical consumerism also distorts society by creating a system of stratified health care. It encourages a neo-Darwinian concept of “survival of the fittest,” where, “if the poor receive care later than the rich and die as a result, that’s little loss,” (Frank 2002:26). One serious consequence of this is that health may become a commodity only affordable to some, with the needs of the poor forgotten.

Part Two – Malaria in Africa

The drug industry’s calculus in apportioning its resources is cold-blooded, but there’s no disputing that one old, fat, bald, fungus-ridden rich man who can’t get it up counts for more than half a billion people who are vulnerable to malaria but too poor to buy the remedies they need. ~ Ken Silverstein (2003:430)

Malaria imposes economic costs of more than 12 billion U.S. dollars a year in sub-Saharan

Africa (New York Times October 16, 2006) and kills close to 1 million of its people annually (Snover 2005:189). In this modern era of medical advancement and pharmaceutical innovation, why are millions of people around the world dying from malaria, a disease not only preventable, but curable? Two theories have emerged to account for this seeming paradox. The theory advanced by the medical-industrial complex argues that much of the blame can be placed on drug-resistant mosquitoes, problems with controlling mosquito populations, and individual non-compliance with medication regimens (Snover 2005:189). The theory advanced by critical medical anthropologists¹ contends that the capitalist interests of the western medical-industrial complex preclude making it a priority to research, develop, and introduce affordable solutions to disadvantaged populations.

In order to understand why malaria in Africa is a problem and to determine how this issue might be solved, it is important to look at malaria’s etiology and treatment history. Malaria is caused by the *Plasmodium* parasite (particularly *Plasmodium falciparum*, the deadliest) which enters the bloodstream when an infected mosquito bites a human (World Health Organization 2009). The parasites multiply in the liver and then infect the red blood cells. Symptoms of malaria can include, “fever, headache, and vomiting, and usually appear between 10 and 15 days after the mosquito bite. If not treated, malaria can quickly become life-threatening by disrupting the blood supply to vital organs” (World Health Organization 2009). This cycle

¹ See Singer’s (1994) discussion of “syndemics” and Konner’s (1993) examination of the professional socialization of doctors. Also see Lock and Scheper-Hughes’ (1990) examination of the body politic.

becomes complete after another mosquito bites the infected person, thereby picking up more parasites to transfer to other people. According to the WHO, the most effective strategies for controlling malaria include: “prompt and effective treatment with artemisinin-based combination therapies; use of insecticidal nets by people at risk; and indoor residual spraying with insecticide to control the vector mosquitoes,” (World Health Organization 2009). Studies have suggested, however, that insecticide-treated bed nets, though a useful tool in the struggle against malaria, are used by only 1% to 2% of people in malarial zones and furthermore, the nets are not effective in areas where mosquitoes have adapted and bite throughout the day (Gorman and Robinson 2004:51). Thus, there is still need for anti-malarial pharmaceutical treatments.

In the 1880s, within a few decades of the discovery of the malaria parasite by Laveran, malaria was almost completely eradicated in the U.S. and in Northern Europe. This was accomplished through “environmental interventions, accelerated urbanisation, agricultural expansion, and socioeconomic improvements,” (Majori 2000:34). By 1948, the insecticide DDT was being used as a cheap and effective solution to protect Western soldiers on the field of battle. DDT, a nearly indestructible spray that kills the mosquito and its larvae, leaves a residue that can continue to kill even years later. In 1955, the WHO declared that with enough DDT, malaria could be eradicated from the face of the planet. “Successful postwar malaria-control campaigns with DDT provided the ground for optimism until the mid-1960s,” (Majori 2000:34). Soon it was apparent that the

Anopheles mosquito was developing DDT resistance. Further, by 1963 the U.S. had stopped funding the WHO DDT campaign. The campaign was halted because of the terrible effects DDT has on humans and the environment, including killing fish, birds, and beneficial insects (Mosquito Info 2008). What transpired next was a massive return of mosquitoes to regions that no longer had resistance to malaria (Mosquito Info 2008). To illustrate the consequences, in India in 1961 there were fewer than 100,000 cases of malaria, but by 1977, cases were in excess of six million (Shah 2006:12).

In 1934, *chloroquine*, an inexpensive and effective anti-malarial drug, was discovered by a Bayer researcher in Germany (Gorman and Robinson 2004:50). However, by the 1970s, the malarial parasite had become resistant to chloroquine because of its widespread use for not only malaria, but for all types of fevers (Gorman and Robinson 2004:50). Adaptation also occurred due to individuals only taking half doses of the medication because of cost, or not completing the regimen. The anti-malarial drug *mefloquine*, discovered by U.S. military researchers during the Vietnam War, lost its effectiveness in the same way (Silverstein 2003:430). Researchers then turned to *sulfadoxine-pyrimethamine* (SP), but within 5 years the malarial parasite was developing resistance (Gorman and Robinson 2004:50). The latest addition to the pharmaceutical arsenal against malaria is *artemisinin* combination therapy (ACT). ACT is proving to be highly effective in treating drug-resistant malarial parasites in the bloodstream (Gorman and Robinson 2004:50). With efficacy proven, the only

issues revolving around its use are costs, delivery, and sustainability.

Nearly every developed country has pledged support in getting artemisinin drugs to impoverished African nations.

Unfortunately, material support is not nearly as forthcoming as the expressed desire. For instance, in Malawi, costs of malaria remedies still consume 32% of the income of poor households; this figure rises to 34 % in Ghana (Teklehaimanot and Mejia 2008:33). The Ugandan government indicates that ACT drugs are too expensive and not readily available for many in Africa (Moszynski 2008:1134). Artemisinin drugs in Uganda can cost up to 60 times more than chloroquine which, therefore, translates into a cost of 91 days of an average family's household income for a supply (Moszynski 2008:1134). In Tanzania, studies have shown that high anti-malarial prices have been a decisive factor in the low proportion of individuals seeking malaria treatment (Goodman, et al. 2009:727). Unfortunately, because of the higher cost of ACT, aid agencies continue to purchase older, ineffective drugs such as chloroquine to disseminate throughout Africa (Moszynski 2008:1134). It is no wonder that a 2006 article in the *Lancet* accused the WHO and the World Bank's Roll Back Malaria campaign of medical malpractice for providing ineffective drugs to malaria victims (Attaran, et al. 2006:247). It is clear that the pledging of support has not translated into providing support.

In 2000, the richest 23 countries in the world, plus the World Bank (WB) provided about \$100 million U.S. to fight malaria. This is less than one tenth of the

annual sum needed to meet the stated goal of cutting the death toll in half by 2010 (Attaran, et al. 2006:247). Not only has the WB failed in delivering the needed funds for anti-malaria treatments, but it has also, along with the International Monetary Fund (IMF), provided "billions of dollars in strings-attached loans" that allow both organizations to "lay heavy hands on the health care of the global poor" (Shah 2006:12). For instance, according to the WB, sanitation and improved water containment that eradicated malaria from the west is considered "not cost effective as a health measure," (Shah 2006:12). Further,

A 1998 World Bank report noted that "about 40 per cent of projects in the Bank's [health, nutrition and population] portfolio and nearly 75 per cent of projects in sub-Saharan Africa included the establishment or expansion of user fees". Studies have shown that such fees simply decrease people's use of medical services... People die of easily-treatable diseases because they cannot afford to buy the medicines [Sexton 2001].

In Nigeria, Kenya, and Ghana, the flow of patients to hospitals "slowed to a trickle, dropping by half within days of the imposition of new fees," (Shah 2006:12). The WB's 1993 annual report, *Investing in Health*, maintains that "the primary goal of public policy should be to promote competition among providers" (World Bank 1993:72) and that regulated private ownership is preferable to public ownership. The report advocated giving incentives for the purchase of private insurance,

privatization of public health services and promotion of market competition (World Bank 1993). The WB and IMF strategies, which force Third World countries to immiserate their populations to make payments, are eliminating the option of effective malaria treatments by dismantling African public health care systems.

With the failures of the WB, IMF, world governments, and WHO, we are left with the pharmaceutical giants to provide low cost, effective anti-malaria medications for African nations. Unfortunately, only about 1% of all new medicines brought to market by multinational pharmaceutical companies between 1975 and 1997 were designed specifically to treat tropical diseases (Silverstein 2003:430). Further, according to Angell (2004), the top 10 pharmaceutical companies in 2002 spent 31% of their sales for marketing and administration, compared with only 14% for research and development. Total expenditure worldwide for malaria research in 1993 came to \$84 million U.S. while, according to industry analysts, research and development on animal health products approached half a billion dollars U.S. (Silverstein 2003:43), suggesting that pharmaceutical companies are more concerned with treating depression in First World pets than they are about third world malaria.

The rationale behind this type of research and development is strictly business according to the pharmaceutical industry. Pharmaceutical giants state they are mandated by the courts as beholden to making profits for their shareholders (see Barnes 2006). They argue that the profit

margin for producing medications for Third World populations are far slimmer than producing lifestyle medications to treat baldness, pets, toenail fungus, and impotence (to name a few) of their First World customers. Thus, their stated goal is to shift sporadic medication use to chronic use within wealthy populations so as to increase their market shares (see Moynihan and Cassels 2005). To further compound the issue of malaria treatment in Africa, reports are now surfacing out of Cambodia of artemisinin drug-resistant strains of mosquitoes (Shay 2009). Unfortunately, however, “there are no new medicines in advanced stages of development to replace artemisinins, nor are there alternative insecticides. This places even current malaria control and elimination efforts at considerable risk,” (Mendis, et al. 2009:808).

Thus, the capitalist rationalization for the commodification of health, originating with those in the machinery of power (the WB, the IMF, the pharmaceutical industry, and world governments), has played a direct role in today’s current malaria crisis in Africa.

Conclusion

Antonio Gramsci said that social reformers should have pessimism of the intellect and optimism of the will. This means that one must have the intellectual ability to see how bad things are and the emotional ability to look forward with hope. It’s a hard combination to sustain, but if you can do it, you can change the world. ~ Andrew Solomon (The Noonday Demon 2002).

The commodification of health developed as a consequence of the Western neoliberal consumer culture and modern risk society.

Health commodification creates a worldwide issue of stratified health care, where one's health needs are met on a sliding scale correlated to one's fiscal position. From a medical frame of reference, neoliberal ideology shapes individual awareness of medical problems and willingness to address them. In this way, although malaria is a serious disease affecting over 300 million people a year (Gorman and Robinson 2004:50), the Western medical-industrial complex generally does not seem to perceive this as something requiring much attention. As Freund argues, "clearly, the perceived social value of the victims of [malaria] influences the definition of the condition as an epidemic worthy of research and resources," (Freund, et al. 2003:206). Thus, consumer culture has translated into millions of lives lost from curable and preventable diseases because it is simply more profitable for pharmaceutical companies to create drugs for developed nations "met un-needs" than for developing nations "unmet needs" (Moynihan and Cassels 2005:31).

Neoliberal capitalist nations have re-translated the Hobbesian principle of scarcity *ipso facto* conflict to scarcity *ipso facto* profit. Yet scarcity does not have to translate into conflict or profit, it can lead to cooperation. "We keep hearing that we live in 'a time of limited resources' [but] the wealth of the world has not dried up, it has simply become unavailable to those who need it most," (Farmer 2000:104). It is possible to change this, as is evidenced by the role that Bill and Melinda Gates are taking in eradicating malaria. They have contributed large sums of money for malaria research and treatment (Roberts and

Enserink 2007). This is a step in the right direction, but much more than money is needed, including:

- 1) Appropriate, culturally-resonate drug delivery systems must be put in place;
- 2) The population must be educated about malaria and how best to protect themselves;
- 3) Sanitation and water supply must be improved;
- 4) Better and more culturally appropriate health care systems must be created;
- 5) Black market, ineffective treatments must be eradicated;
- 6) The financial burden placed on these countries by the WB and IMF must be removed;
- 7) Research into newer malarial treatments must be encouraged by limiting government approval for new lifestyle drugs if the pharmaceutical industry does not also produce medications for third world issues such as malaria.

These are just some of the necessary steps that must be taken in the fight to save lives in Africa.

The most important step to fighting malaria is a radical reconfiguration of macro-political and economic power relations. What is required is an educated and informed public working together to become an historical agent of change; being transformed from mass consumer citizens into a force for the common good. Though attempting to hold back a firmly entrenched

capitalist empire may seem radical in light of the need to accept capital as part of the solution, the true task is to not to eliminate capitalism, but transform it.

The role of academics in the fight against malaria is not to lay claim to all the solutions, but to contribute to a body of problem-solving knowledge; to help devise release for the oppressed; to find new methods of advancing the human race; and to improve the human condition through research, discourse, and education. The key for academics is to help wake up the public to what is occurring so that we can work together for change.²

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² While some may argue that this is an elitist view of an academics role, the true elitists are those academics who research and instruct for personal gain, accolades, and promotion in their various fields, for they view their own worth, superiority, and achievement ahead of those that their research and knowledge impacts upon.

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