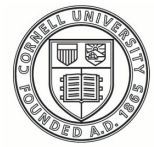

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Achieving Access: Professional Movements and the Politics of Health Universalism

Joseph Harris
Boston University

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Abstract

[Excerpt] This book examines efforts to expand access to health care and AIDS medicine in Thailand, Brazil, and South Africa. Although these countries are geographically far apart, they share many similarities as newly industrializing countries engaged in processes of democratic opening. Scholars have often suggested that expansionary social policy is the product of left-wing parties and labor unions or bottom-up people's movements. From a strictly rational perspective, that these groups would be at the forefront of such change makes perfect sense. After all, expanding access to health care and medicine would seem to be in their interest, and they would appear to have a lot to gain.

While this book recognizes the role they often play, it focuses on a different, more puzzling set of actors whose actions are sometimes even more decisive in expanding access to health care and medicine: elites from esteemed professions who, rationally speaking, aren't in need of health care or medicine themselves and who would otherwise seem to have little to gain from such policies. This group includes doctors like Sanguan Nitayarumphong and Paulo Teixeira, whose work with the poor and needy informed their advocacy for universal health care in Thailand and Brazil while also putting them into conflict with the medical profession of which they were a part. How is it that these people would play such an important and active role in making change happen?

Keywords

health care, AIDS, social policy, poverty, Thailand, Brazil, South Africa

Disciplines

Health Policy | Immune System Diseases | International and Comparative Labor Relations | International Public Health | Labor Relations | Other Public Health | Social Policy

Comments

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Achieving Access

Professional Movements and the Politics of Health Universalism

Joseph Harris

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Introduction

This book is about explaining historical change: how parts of the developing world transitioned from a moment characterized by what I call "aristocratic health care" to an altogether different moment characterized by "health universalism." Prior to the 1990s, access to health care and life-saving drugs in the developing world was largely a matter of privilege. In the era of "aristocratic health care," only the privileged (and politically active) few—the rich, civil servants, and employees of large businesses—enjoyed the benefits of modern medicine. Very generally, the aristocracy paid for care themselves or received it through membership in elite state or private health insurance schemes. The vast majority—many of whom were poor and living in rural areas—relied on state programs that were narrow and limited, the individual charity of doctors, and the unpredictable effects of "traditional medicine." In the 1990s, however, these exclusionary health care regimes began to give way to a more inspiring but largely unexpected new mode of health universalism. Standing far apart from the kinds of health care programs that existed before them, these programs were "anti-elitist" by nature and, in line with their European counterparts in the Global North, aspired to make increasingly comprehensive access to health care and medicine available to all.

The broadening of state obligations to health care and medicine was especially puzzling because it took place at a time when a variety of factors would seem to have predisposed governments to rein in government spending rather than expand government programs. During the tenures of Ronald Reagan in the United States and Margaret Thatcher in Great Britain, a neoliberal logic had

achieved hegemonic status in the 1980s. This policy program emphasized the privatization of government services, the weakening of social entitlements, and the liberalization of government regulation. At the same time, the emergence of the HIV/AIDS epidemic—an epidemic that disproportionately affected the developing world—had decimated populations and left governments and international organizations scrambling over how to respond. Yet the expansion of access to health care and treatment for AIDS occurred in countries that experts had generally deemed too poor and resource-constrained to support such programs. Moreover, they took place at a time when health care costs were exploding and medical expertise was scarce.

While the broadening of state obligations to health care and medicine unfolded unevenly throughout the world, by the 2000s their growing significance and clout could increasingly be seen in bold new transnational institutions. In January 2012, Thailand hosted an awards conference for scholars and practitioners in public health, with the theme "Moving towards Universal Health Coverage." At the conference, representatives from some sixty countries agreed to the Bangkok Statement on Universal Health Coverage. The statement made reference to the World Health Organization's *World Health Report* of 2010 and the World Health Assembly's Resolution 64.9 of May 2011, both of which drew attention to the issue of universal health coverage. Just three months later, delegates from twenty-one countries (including the United States) met in Mexico and signed the Mexico City Political Declaration on Universal Coverage. However, the surprising shift in support of universal coverage was perhaps embodied nowhere more forcefully than at the United Nations, where on December 12, 2012, the UN General Assembly passed a resolution in support of universal coverage with some ninety co-sponsors. WHO Director General Margaret Chan has since called universal coverage the "single most important concept that public health has to offer" (Chan 2012), and in recent years, more than one hundred countries have sought WHO technical assistance to achieve universal coverage (Chan 2016, 5).

Illustrating the extent of the shift, even conservative international organizations, which had previously promoted policies eroding health care coverage, embraced the movement toward universal health care. David de Ferranti, former vice president of the World Bank, and Julio Frenk, former minister of health for Mexico and dean of the Harvard School of Public Health, penned an op-ed in the *New York Times* in 2012 titled "Towards Universal Health Coverage" that drew attention to efforts to institutionalize universal health care programs in such places as Brazil, China, Colombia, Ghana, India, Mexico, the Philippines, Rwanda, South Africa, Thailand, and Vietnam (de Ferranti and Frenk 2012). The op-ed was particularly symbolic given that de Ferranti, while an executive at the World Bank, had coauthored the 1987 flagship report *Financing Health*

Services for Developing Countries: An Agenda for Reform. The report expressly called on government to *get out of* the business of health care and to dismantle measures intended to make access to health care easier. The World Bank itself would subsequently embark on not one but two major projects that aimed to support national efforts to implement universal coverage.

However, as remarkable and sweeping as this shift was at the international level, even more remarkable were the dynamics driving policy change inside many countries. Often, the countries making radical new commitments to universal coverage were newly emerging democracies. And in some of these countries, reform efforts were being led *not* by those most in need but rather by movements of doctors who had seen the devastating effects of exclusion under dictatorship and had sought to expand access to health care *on behalf of* those in need following democratization. In countries like Thailand, progressive doctors working as state bureaucrats convinced an innovative new political party to put universal health care on their campaign platform. They then ensured that the party fulfilled its promise by implementing the policy as a national pilot project before it became law. In Brazil, a similar movement of medical professionals concerned with public health embedded principles of universalism, equity, and participation in the country's new constitution. They then played key roles drafting legislation in the Health Ministry and promoting programs to bring health care to the masses and to hold the state accountable.

At the same time that this movement to expand access to health care was gaining steam, a separate but related movement to expand access to medicine for victims of HIV/AIDS was also forming. While scientists had discovered that AZT (zidovudine) could slow the progress of the AIDS virus in the mid-1980s, in 1996 scientists at the International AIDS Conference announced that a combination of these antiretroviral (ARV) drugs had the power to stop the progression of AIDS in its tracks and turn a once-fatal illness into a chronic disease. By 2015, some 17 million AIDS patients around the world would have access to this life-saving cocktail of medication (UNAIDS 2016). The international community would play an important role helping to finance national efforts to expand access to the cocktail through new global health institutions—like the Global Fund to Fight AIDS, Tuberculosis, and Malaria—as well as the U.S. government's President's Emergency Plan for AIDS Relief (PEPFAR). Collectively, these organizations would funnel billions into efforts to provide ARV treatment in countries devastated by AIDS. Yet the uneven expansion of access to this new "essential medicine" in different countries would underscore the critical role of *national* politics in the life-and-death stakes of emerging treatment for AIDS.

Unlike the movements to expand access to health care, the movements to expand access to life-saving medicine were by and large not being driven by

doctors. A vocal AIDS movement played an important role in advocating for treatment through traditional social movement activities that included street protests and demonstrations. While physicians were frequent participants, even more important was the role of lawyers and other activist medical professionals with legal training. In countries like South Africa and Thailand, these movements were embodied in organizations like the AIDS Law Project and the Drug Study Group, social movement organizations in which use of the law was not merely a tactic to expand access to medicine but was inscribed much more fundamentally into the organizations' identity.

This book examines efforts to expand access to health care and AIDS medicine in Thailand, Brazil, and South Africa. Although these countries are geographically far apart, they share many similarities as newly industrializing countries engaged in processes of democratic opening. Scholars have often suggested that expansionary social policy is the product of left-wing parties and labor unions or bottom-up people's movements. From a strictly rational perspective, that these groups would be at the forefront of such change makes perfect sense. After all, expanding access to health care and medicine would seem to be in their interest, and they would appear to have a lot to gain.

While this book recognizes the role they often play, it focuses on a different, more puzzling set of actors whose actions are sometimes even more decisive in expanding access to health care and medicine: elites from esteemed professions who, rationally speaking, aren't in need of health care or medicine themselves and who would otherwise seem to have little to gain from such policies. This group includes doctors like Sanguan Nitayarumphong and Paulo Teixeira, whose work with the poor and needy informed their advocacy for universal health care in Thailand and Brazil while also putting them into conflict with the medical profession of which they were a part. How is it that these people would play such an important and active role in making change happen?

In the countries I examine, efforts to expand access to health care and AIDS medication have been led by a certain kind of elite. While specialists and other doctors working in large urban (and often private) hospitals often hold conservative ideological positions, oppose major reforms, and seek to uphold a status quo that serves their interests, my work draws attention to "professional movements" of progressive doctors, and lawyers, and other medical professionals with access to state resources and training in the law. Doctors and lawyers in these movements often began their careers as activists championing the interests of marginalized populations. Although their knowledge, networks, and privileged positions in the state set them apart from ordinary citizens, they frequently occupy a status on the periphery of the profession. How these relatively marginal

professional subdivisions manage to triumph over the opposition of the broader profession is therefore an important issue taken up in this book.

This focus on professional movements is not to suggest that the traditional social movement activism of HIV-positive AIDS activists played no role in some of the dramatic changes that swept the globe related to access to AIDS treatment. After all, important accounts have illustrated how lay citizens have "forced science to be open to nonscientific frames of reference based on human rights" (Chan 2015, 7) and, in South Africa, turned "a dry legal contest into a matter about human lives" (Heywood 2001, 147). Yet, I argue that popular narratives that stress traditional social movement activism leave underappreciated the role that elite professionals with specialized knowledge in the law have played in the expansion of access to AIDS medicine. They also leave untouched the processes by which those in need have had to become experts in the law—often vis-à-vis the efforts of elite professionals who derive relatively limited benefits from these new policies themselves.

At a time when international trade accords increasingly compel countries to protect the patents of brand-name pharmaceuticals under the World Trade Organization's 1995 Trade Related Intellectual Property Rights (TRIPS) accord, expertise in the law plays an especially important role in enabling countries to take advantage of flexibilities that allow them to maintain affordable access to pharmaceuticals. The professional movements I study have dedicated themselves to expanding access to health care and medicine over opposition from the medical profession, pharmaceutical companies, private industry, and conservative international organizations. In making sense of this broad puzzle, this book both offers an account of how changes happened in the fields of health care and medicine and makes a larger contribution toward understanding the role of progressive elites in politics.

The positive role of elites and, more particularly, of members of esteemed professions who would otherwise seem to have little to gain (and potentially much to lose) by upsetting the status quo, has been widely acknowledged but woefully under-theorized. The stories related here are significant because scholars have frequently conceived of elites as self-interested and incapable of delivering for society the promise of a better future. Professions likewise have all too often stood on the "wrong side" of reforms that challenge the status quo, serving as obstacles to policies that would benefit the masses but hurt their own interests. Although conventional wisdom has emphasized the way in which democratization empowers the masses, this book draws out an underappreciated dynamic: the extent to which *democratization empowers elites,* who in turn can have a progressive impact on politics. As I show, these newly empowered (and public-minded)

elites, in turn, often work on behalf of the poor and needy to institute important new social rights.

Grounded in the cases of Thailand, Brazil, and South Africa, this book asks: What explains the difference between the laggard response to expanding access to health care and HIV/AIDS medicine in South Africa and the pioneering responses of Thailand and Brazil? Thailand and Brazil are two countries whose approaches to universal health care and AIDS treatment would lead them to be praised internationally as models for the developing world. However, of the three countries, South Africa would seem to have been most predisposed to the adoption of such sweeping new programs, given the need for improved access to health care and medicine following the transition from apartheid, the unrivaled majorities of the African National Congress, the close ties between the ANC and the South African Communist Party, and plans for a universal health care program by professionals that predated the transition to democracy. And yet, these three countries took remarkably different paths, with Thailand and Brazil enjoying relative success in both domains and South Africa making only incremental gains; in South Africa the government actively obstructed efforts by professional movements seeking more transformative reform.

While important contributions have already been made that have focused on transnational relationships, struggles, and change (Chan 2015; Kapstein and Busby 2013), this book aims to give more fine-grained attention to the domestic politics at play in these national contexts, which I would suggest is sorely needed given that state policy outcomes are the book's ultimate concern.[1]

Health Care through the State, Medicine through the Law

The politics of expanding access to HIV/AIDS medicine and the politics of expanding access to health care would, on its face, appear to be related, given their similar goals and underpinnings in human rights, access, and equity concerns. However, the professions that dominate the politics of each of these fields are different. The politics of health care access operates primarily within the domain of doctors, who control entry into the medical profession; who oversee health care facilities and supervise legions of nurses, midwives, and other public health officials; and whose medical associations mobilize to protect the interests of physicians when their sovereignty and autonomy are challenged.

The politics of access to medicine operates differently. In a world governed by international trade rules that center on the protection of patents, knowledge of intellectual property law is increasingly understood as critical to effective

advocacy for human rights. Success often hinges on the skills and expertise of professionals trained in the law who interpret and build national and international laws; who negotiate with and bring challenges against the pharmaceutical industry; and who hold the state accountable for obligations written into national law and represent the needs of ordinary citizens in court. While lawyers with formal training often lead these efforts, they frequently work hand in hand with other professionals—pharmacists, doctors, and health economists—whose knowledge and expertise in the law comes through professional experiences working on issues related to pharmaceutical access.

Transformative health care reform that makes access to comprehensive care a right of citizenship typically relies on the cooperation and interest of political parties who must pass laws in Parliament. In the face of competing policy priorities and tight government budgets, movements seeking to enact major new reforms must look for resources that enable them to have influence on the policy process. The case studies illustrate how access to state offices and legal expertise provides professional movements not only with the type of agenda-setting power frequently associated with "epistemic communities" but also with more wide-ranging influence on the policy process.[2] While their power is not complete in matters of public policy, I show that their influence is much more sweeping than currently accounted for in the literature.

In the domain of universal health care, the cases draw out the way in which the occupation of the state bureaucracy (a phenomenon I have in other work called "developmental capture"[3]) provide professional movements with access to resources that allow them to outmaneuver larger entrenched professional associations who oppose reform. These resources include but are not limited to the ability to set principles, mandates, and guidelines for state responsibilities for health care in new constitutions; to implement national pilot projects of health care programs before statutory laws that give such programs legal standing are even in place; to draw on the support of international organizations to advance reform in Parliament and stem the influence of opposition; and to put in place mechanisms that give citizens an active role in ensuring new policies operate as they should. Operating from these privileged positions in the state, professional movements push policy outcomes by affecting agenda-setting, policy formulation and adoption, and implementation as well as mechanisms that hold the state accountable for the policy once it is in place.

In the field of AIDS treatment, the case studies suggest that state occupation can be useful for the expansion of access to pharmaceuticals. However, this book points to an even more important, if overlooked, insight that bears centrally on the domain of pharmaceutical access: When authoritarian governments relinquish absolute control over the "rules of the game" following democratic

transition, this frequently has the effect of dramatically empowering progressive elites with legal training, who become free to pursue social change through legal avenues that were closed to them under dictatorship. And they are likewise afforded greater opportunities to forge alliances with other technically savvy organizations abroad. These resources set them apart from ordinary citizens and allow them to hold the state accountable for rights outlined in newly created constitutions and to design effective strategies for countering pressure from pharmaceutical companies and industrialized nations. Drawing on these resources, legal movements act on behalf of patients in need of medication through litigation in court and hold the state accountable for living up to the promises embedded in a country's laws; challenge efforts by foreign governments and pharmaceutical companies to restrict access to medicine cheaply; and create new transnational institutions aimed at building an international environment that is more conducive to affordable access to generic medication.

The argument developed in this book points to the role that heightened political competition in the wake of democratic transition plays in providing openings for well-organized professional movements to influence the policymaking process. As the successful cases of Thailand and Brazil illustrate, environments in which political competition is fierce and no one party dominates predispose parties to being receptive to policy innovations proffered by professional movements who use the state to advance health care reforms and the law to widen access to treatment. However, the case of South Africa demonstrates that heightened political competition does not always result from democratic transition. In such cases where an ascendant party's dominance is essentially guaranteed and the ruling party enjoys the luxury of unrivaled power, entreaties for transformative reform from even the most well-organized professional movement may be ignored or taken up in piecemeal fashion.

Where legal cases demanding that the state expand access to medicine have strong grounds, governments may eventually be compelled to act, even in contexts where political competition does not flourish. However, initial government intransigence and the long and drawn-out process of legal mobilization (which sometimes includes appeals to higher courts) helps explain why we often see delayed action by governments in this area rather than no action at all. But this delay can have disastrous consequences for citizens' health in countries where a party's electoral success is a foregone conclusion versus those in which it is not.

In drawing together disparate threads of theory related to the importance of professionals in health care policymaking and fashioning a broader theory of the importance of professional movements in the expansion of social policy during periods of democratic transition, this work has implications for broader theories of the professions, political transitions in emerging nations, the welfare state, and

democracy. In pointing to the important role played by professional movements in policy reform in these cases, this work draws attention to some counterintuitive findings, chief among them that democratization empowers elites; that those most responsible for advancing major social policies are frequently those least in need; and that professional movements achieve reform by virtue of privileged positions in the state, knowledge, and networks that are largely inaccessible to the common man.

The Cases

Enormous complexity characterizes different countries' health care systems, which are themselves shaped by social, economic, and demographic factors; unique individual political histories and struggles; and past policy decisions. These factors ensure that no two countries' health care systems will ever be exactly the same. Of course, this does not mean that the reform experiences of different countries should never be compared. Rather, it means that the complex differences between them have to be acknowledged, since countries frequently operate from different starting points, hold different values, and have different constellations of interest groups and political dynamics. These differences frequently make reforms easier or harder. In writing such complex comparative history, one must therefore strive to make these differences clear and explicit while observing scope conditions that make comparison reasonable.

As emerging economies engaged in processes of democratization, study of Thailand, Brazil, and South Africa gives us purchase for understanding how commitments to universal health care are shaped in countries grappling with high levels of inequality, limited resources, and competing policy priorities. All three countries emerged from authoritarian political arrangements and experienced an opening of the democratic sphere. In this new environment, the optimism associated with democracy in the wake of a repressive past left the countries ripe for more inclusionary social policies. Thailand experienced a shift from authoritarian rule (before 1992) to competitive democracy under a new constitution (1997–2006). Brazil saw the end of rule by the military and a competitive democracy emerge (beginning in 1985), and South Africa experienced the fall of apartheid and the transition to a democratic era marked by rule of the ANC (after 1994).

However, the selection of Thailand, Brazil, and South Africa for study is also beneficial for another reason: with 35 million deaths around the world since the epidemic began, HIV/AIDS is *the* major epidemic our time (UNAIDS 2016). As countries that all confronted the HIV/AIDS epidemic at the same time that

discussions around health care reform occurred, examination of these countries offers a window into the ways in which the dynamics of AIDS policymaking related to HIV/AIDS compares with the dynamics of policymaking related to universal health care.

Given their status as similar public goods, one might expect the politics of expansive health care reform and AIDS treatment to be the same. And yet the comparison highlights the tensions that characterize the relationship between the two policy domains, offering some insight that helps explain why we cannot lump them together: Apart from the different professions that dominate the domains of health care and essential medicine, universal health care and AIDS treatment are each very costly endeavors. The former program serves a very broad population, while the latter serves a much narrower (and frequently marginalized and stigmatized) one. Frequently, funding support for AIDS treatment can be found abroad, while the financing of universal health care remains predominantly an entirely domestic enterprise. These dynamics sometimes lead advocates of these policies alternately into partnership and conflict with one another. In comparing reform dynamics in these two areas, this study aims to elucidate how and why professional movements succeed in some contexts and fail in others in two separate but related policy domains.

While providing openings for progressive change, decisive moments of democratic transition do not by themselves determine the content or the type of social policies to be enacted. The content of policy in these critical moments was of course shaped in part by past policies and current socioeconomic realities but above all by *agents* of social change who acted strategically to put policy innovations on the political agenda in cooperation with receptive political parties who held power in this new era. The study therefore explores the interaction between democratic transition and major social reforms, an area that other scholars have noted is in its infancy (Wong 2004).

In my study, Thailand—a country that has received scant attention from sociologists and political scientists—is my primary case, and Brazil and South Africa are secondary cases. The selection of these cases helps to extend literature on the welfare state beyond its traditional focus on Europe and North America. Recent work on social policy in Latin America (Ewig 2010; Huber and Stephens 2012; Kaufman and Segura-Ubiergo 2001; Nelson and Kaufman 2004; Weyland 2007), Eastern Europe (Nelson 2001), and Asia (Kasza 2006; Kwon 2011; Wong 2005) has sought to expand focus to the developing world. However, while attention to broad patterns that have occurred across regions is growing (Gough and Wood 2004; Haggard and Kaufman 2008; Sandbrook et al. 2007), rigorous comparative historical study of universal health care and AIDS treatment policy in the industrializing world remains remarkably thin. While the few comparative studies that do exist on universal health care (Wong 2004) and AIDS treatment (Lieberman

2009) are of great quality, they have principally taken aim at comparing the historical experiences of two countries. This book is therefore one of the first to explore the politics of health policy in three major industrializing countries. It is also the first to compare the politics of advocacy in both the domains of universal health care and AIDS treatment.

Thailand

Thailand took a gradualist approach to expanding state obligations toward health care under predominantly authoritarian governments in the 1970s and 1980s. However, in 2001 it made a decisive break with the past by instituting a tax-funded program that expanded health care access to the 30 percent of the population who lacked it. The proportion of the population without coverage was approximately double that lacking coverage in the United States at the time of the signing of the Patient Protection and Affordable Care Act in 2010. And yet, while the ACA did not expand coverage to everyone, Thailand's Universal Coverage program expanded coverage nationwide in less than a year, with expansion beginning just four months after a new political party came to power. This new program made access to health care a right of citizenship and sat alongside two existing state programs for workers in the formal sector and civil servants and their families. Thailand's reform also brought with it important improvements, ranging from new financing arrangements that sought to introduce greater accountability and control costs to a new health information system which aimed to provide policymakers with better data on which to base decisions. Shortly after the country's program was implemented nationwide, on the anniversary of World AIDS Day in 2001, the nation's health minister made a commitment to expand access to antiretroviral medications for AIDS patients. And in the years that followed, Thailand's leadership on the issue of HIV/AIDS access would become even more celebrated on the world stage after its health minister in 2007 became the first to declare a "compulsory license" on the "second-line" AIDS drug, Kaletra, and Plavix, a heart disease medication. This announcement followed an earlier compulsory licensing declaration on a first-line AIDS drug, efavirenz, in 2006.[4] And in 2008 the ministry would issue additional compulsory licenses on four other cancer drugs. The international notoriety Thailand gained on the issue of HIV/AIDS treatment built on the country's earlier fame as a leader on HIV/AIDS prevention and its well-known condom campaigns.

Brazil

Beginning with passage of a universal health care law in 1990—a mere five years removed from military rule—Brazil's health care reform took place in a similar

context of democratization. Prior to reform, the distribution of medical services in Brazil was highly skewed toward developed urban areas, particularly in the south and southeast, and the government's main social insurance program excluded or otherwise provided minimal benefits to some 52 percent of the population (Weyland 1996, 97, 132). Although the military regime extended a thin measure of social insurance to the rural, unemployed, and self-employed, largely to coopt rural pressures for change (Falleti 2010, 40), in practice it provided the rural poor with minimal protection while leaving urban informal workers excluded from coverage entirely (Weyland 1996, 91–92). The country's 1990 Unified Health System (SUS) law sought to correct this by creating a British-style National Health Service that provided equal access to health care for all through the public system and contracting private providers. One of the leading strategies for implementation of the SUS legislation was the Family Health Program, which brought health care to the masses via teams of health care providers working in communities. The SUS also opened up important new avenues for citizen participation in health care decision-making and governance through city, state, and national health councils.

An announcement that the government would provide AIDS medication designed to slow the progression of the virus to sufferers of the disease followed the SUS legislation in 1991. Following discovery that combination antiretroviral therapy could stop the AIDS virus in its tracks, the country passed a law in 1996, making it the first industrializing country in the world to make access to combination ARVs free and universal to its citizens. The country's pioneering negotiations with drug companies would help drive down the cost of ARVs and would lead its response to HIV/AIDS to be hailed as a model for the developing world. Professionals from Brazil with knowledge of intellectual property law would play an active role in institutionalizing new norms related to access to AIDS medication at the WHO, the World Trade Organization, the UN Commission on Human Rights, and the UN General Assembly Special Session on AIDS. The country's impressive achievements, however, are even more remarkable when weighed against the political and economic context of the time: Politics in Brazil had been defined by clientelism. The country had the world's largest foreign debt (Biehl 2007, 54) and between 1980 and 1991 undertook seven structural adjustment packages from the World Bank and IMF (Parker 2003, 180). While the country's new universal health care and antiretroviral therapy programs have taken time to realize their potential, the expansion that occurred did so in improbable fashion, against a backdrop of debt, hyperinflation, and austerity that saw actual per person federal spending on health plunge from $83 in 1989 to $37 in 1993 (Biehl 2007, 59).

South Africa

If Thailand and Brazil's achievements in the provision of health care and AIDS medicine might be regarded as successes, then South Africa's experience in both domains stands in sharp contrast. Christian Barnard performed the world's first successful heart transplant in South Africa in 1967. But under apartheid, the real benefits of the country's health care system were unequally distributed, enjoyed primarily by the country's white minority. However, in the last years before apartheid's end in 1994, reformers sought to change this situation and laid the groundwork for a new universal health care program. The program aimed to overcome the deep divide between the country's top-rated private health care system, which largely served the country's white minority, and the crumbling means-tested public health care system, which served the black African majority.[5] Proposals discussed at the time included plans for both a British-style National Health Service, in which the government both pays for and provides health care for everyone, and a Canadian-style National Health Insurance system, which offered the promise of access to the country's system of private hospitals and clinics by providing everyone with insurance-based health care coverage. Yet the African National Congress has initiated only smaller reforms that aimed to provide free comprehensive health care for children under six and pregnant women through the public system in 1994 and free basic "primary health care" for everyone in 1996, again through the already overburdened public sector.[6] In a political context that is completely uncompetitive, more transformative health care reforms have languished for more than twenty years. Caught between ideological desires and practical realities, the government has convened task force after task force to explore transformative reform but has so far avoided major changes, choosing instead to embrace national health insurance in name only.

However, if progress on transformative health care reform in post-apartheid South Africa might be described as glacially slow, then government policy toward expanding access to AIDS medication in post-apartheid South Africa might be described as moving in the wrong direction altogether. According to data from UNAIDS, in the year before Mandela's transition to the presidency in 1993, HIV prevalence rates in South Africa among adults aged 15 to 49 stood at 2 percent. Having inherited a weak institutional apparatus from the outgoing apartheid government and failing to put into place an effective preventative response, that number climbed significantly under the tenure of South Africa's first two presidents after apartheid, Nelson Mandela and Thabo Mbeki. And while it is also important to acknowledge not only colonial institutions but also the distinct epidemiological profile of HIV/AIDS in South Africa as major factors contributing to the growth of the disease,[7] under President Mbeki the government embarked on its disastrous

policy of AIDS denialism, suggesting that HIV does not cause AIDS, asserting that ARVs are dangerous, and proffering charlatan advice on AIDS treatment that emphasized the use of garlic, olive oil, and beetroot. In taking these steps, the administration aligned itself with the views of radical scientific dissidents and actively took steps to prevent the rollout of national programs aimed at preventing the transmission of the AIDS virus from mothers to children. By 2003, when the government finally changed course and agreed to commit itself to a national plan to roll out treatment for pregnant mothers, HIV prevalence rates in South Africa had climbed to nearly 18 percent (UNAIDS 2015). South Africa would have the largest population of HIV-infected people in the world, and scholars would estimate that some 330,000 lives had been lost because a more general ARV treatment program for people infected with AIDS had not been implemented sooner (Chigwedere et al. 2008).

Research Strategy

In the area of social policy, comparative and historical work has been used to explain the creation of major new social programs, as well as differences in state commitments to social programs—and in doing so, this approach has arguably made larger theoretical contributions in the area of social policy than those in other areas (Amenta 2003, 92–103). This work builds on and complements other important quantitative scholarship on globalization and the welfare state (Garrett and Mitchell 2001; Huber and Stephens 2001; Rodrik 1998; Rudra 2002; Rudra and Haggard 2005) and emerging research on the politics of health policy in the developing world (Lieberman 2009; Selway 2015; Wong 2004).

My research utilizes comparative and historical methods as a way to gain analytical leverage on three cases of professional movement-led efforts to expand access to health care and medicine in the industrializing world. As a methodological approach, comparative and historical methods have helped to spur the development of middle-range theory, including efforts to explain empirical anomalies. Building on foundational work in comparative and historical analysis (Moore 1966; Skocpol 1979; Skocpol and Somers 1980), this book takes an inductive approach that aims to build theory through comparative analysis of the cases. In so doing, it follows a well-established path taken by other scholars of health politics who have used comparison to develop arguments and generate hypotheses (Lieberman 2009; Wong 2004). Here, I suggest that the comparison of Thailand and Brazil with South Africa is particularly instructive. While the broad dynamics of political transition in these two countries were marked by important differences, elections in the years that followed were marked by

pronounced political competition. In both cases, professional movements (the Rural Doctors' Movement in Thailand and the *sanitaristas* in Brazil) drew on the power of the bureaucracy to institute universal health care reforms. And in both cases, newly empowered movements of legally minded medical professionals (led by the Drug Study Group in Thailand and *sanitaristas* and lawyers within the AIDS movement in Brazil) drew on legal knowledge and institutions to make their countries the envy of the world in terms of AIDS treatment policy.

Whereas Brazil serves as a kind of ally to the claims I make about the sources of social change in Thailand, in South Africa I find something different altogether. Here, too, vigorous professional movements attempted to play an active role in the expansion of health care and medicine, led by a progressive health movement in the field of health care and the Treatment Action Campaign and AIDS Law Project in the field of AIDS treatment. However, professional movements in South Africa did not achieve the same level of success for reasons I suggest have to do with the lack of political competition in the wake of democratic opening. In the 1994 election, the African National Congress won nearly 63 percent of the vote, and in the election that would follow in 1999, it increased its share to almost 66 percent of the vote with no serious challengers (the Democratic Party finished a distant second, reaping only 9.6% of the vote). Even though the second national election under the new constitution in Thailand in 2005 would bring the first elected majority (rather than coalition) government to power in the country's history, the lopsided political dynamics in South Africa would have no rival with either the cases of Thailand or South Africa—and indeed, few democratic countries ever in the world.

These dynamics, which have essentially brought a one-party government that has no true rivals into power in the years that followed, have created serious and fundamental differences in political interests and incentives that I argue help explain why South Africa's policy outcomes on the issues of health care and medicine differ so radically from those found in Thailand and Brazil. In the absence of serious political competition—and in spite of being the only country of the three whose people have embraced a party with a commitment to communist ideology and that had also already laid the groundwork for transformative health reform at the time of transition—the South African government had the luxury of being able to ignore the entreaties of a well-organized professional movement, to function as an echo chamber and entertain its own flights of fancy, and ultimately to embrace incremental reforms that were easier and less risky than more radical transformative reforms. As prominent scholars have written, the situation has only gotten worse over time, as the ANC has hollowed out structures of participatory governance and extended hegemony over mass politics, largely sidelining civil society from politics (Evans and Heller 2015).[8] The case therefore exists

as a kind of contrary example that highlights the way in which the character of political competition interacts with professional movement advocacy.

As an understudied country whose health policies in both the areas of universal health care and AIDS treatment have garnered attention internationally, Thailand serves as my primary case. While there has been some analysis of the development of the Universal Coverage policy in Thailand, it has generally emphasized the importance of incentives embedded in new constitutional and electoral rules (Hicken 2006; Kuhonta 2008; Selway 2011, 2015) or the importance of a populist political party (McCargo and Pathmanand 2005; Phongpaichit and Baker 2004) and has not explored the role of professional movements in the policy development and implementation. While important work on Thailand's HIV/AIDS policy has drawn out the role that social movements have played (Ford et al. 2004; Ford et al. 2009; Kijtiwatchakul 2007, Suwanphattana et al. 2008; Tantivess and Walt 2008), this public health literature has generally left the legal roots of change underexplored and ignored the broader theoretical implications. My research builds on and complements these studies by drawing out the role that movements of medical and legal professionals have played in expanding access to health care and AIDS treatment. The main source of data in this study comes from primary and secondary materials collected at various archives[9] and in-depth interviews with over 120 key informants in both Thai and English.[10] This research took place over one year (January 2009 to December 2009) with typical interviews lasting between a half hour and two hours, under the auspices of a Fulbright-Hays Doctoral Dissertation Fellowship.

South Africa serves as an important secondary case that puts the findings from Thailand in broader perspective. There is a well-developed literature in the health policy field that emphasizes the roles of various committee deliberations over national health insurance in South Africa (McIntyre and van den Heever 2007; Thomas and Gilson 2004), but this literature generally takes 1994 as its entry point and does not consider the earlier role that professional movements played in putting health care reform on the political agenda. Similarly, there has been an abundance of work on the politics of HIV/AIDS in South Africa (Decoteau 2013; Fassin 2007; Friedman and Mottiar 2005; Gauri and Lieberman 2006; Gevisser 2009a; Lieberman 2009; Nattrass 2004). This work has generated critical insights but has not seriously considered the events in relation to broader processes of democratization and has left the professional character of the movement to expand access to antiretroviral therapy relatively unexplored. My research on South Africa employed the consultation of primary and secondary data,[11] attendance at several local conferences, and interviews with twenty-five key informants in South Africa.[12] This research took place in Johannesburg, Durban, and Cape Town over approximately three months from September to December 2008, with

interviews typically lasting between a half hour and two hours. It was supported through a University of Wisconsin-Madison departmental research grant and a Scott Kloeck-Jenson Award.

Brazil serves as another secondary case that helps broaden the comparison further. Of the three countries, Brazil has enjoyed the greatest scholarly attention to date. A robust literature has developed that considers both the development of the 1990 Unified Health System reform (Buss and Gadelha 1996; Cornwall and Shankland 2008; Elias and Cohn 2003; Falleti 2010; Huber and Stephens 2012; Weyland 1995) and of the country's HIV/AIDS programs (Biehl 2004; Daniel and Parker 1993; Flynn 2013, 2014; Gauri and Lieberman 2006; Lieberman 2009; Nunn 2009; Parker 2003). Because of the abundant work that has already been done, I rely exclusively on secondary sources on Brazil and the helpful advice and assistance of seasoned scholars of Brazil.

Aside from this fieldwork, my knowledge of what has become known as "universal coverage" in health care and AIDS treatment was further informed through my attendance at the 35th Annual Conference on Global Health in 2008 and the 17th and 19th International AIDS Conferences (the theme for the first of which was, appropriately, "*universal* action now") in 2008 and 2012. Since that time, I have become further enmeshed in the practical problems faced by countries seeking to achieve universal health coverage in the developing world through consulting projects. While I do not draw on that knowledge in the telling of the stories that are related here, that experience has been informative in its own right.

The Plan for the Book

The book is organized in the following manner. Chapter 1 explores the literature related to health, welfare, and democracy, providing an account of the major theoretical issues that motivate the study. In this chapter, I lay out how this book builds on previous work and investigates the relationship between well-organized movements made up of elites with professional training and the character of political competition in the wake of democratic transition. Drawing on literature from social movements and the professions, I fashion the concept of "professional movements" and explain why elite professional movements, whose membership is narrower than mass movements, at times exercise such sweeping influence in times of democratic transition.

The first half of the book explores the politics of universal health care in Thailand, Brazil, and South Africa. Chapter 2 looks at the politics of universal health care in Thailand in the wake of transition to democracy. It illustrates the critical role played by a professional movement made up of doctors who put universal

coverage on the political agenda and drew on their privileged positions in the state, their knowledge, and their social networks to institutionalize the policy over opposition from the World Bank and the broader medical profession. Chapter 3 explores these same dynamics in the case of democratizing Brazil, drawing out surprising parallels with Thailand and acknowledging important differences between the two countries. In Brazil, we find a movement of public health professionals (the *sanitaristas*) that is remarkably similar to Thailand's Rural Doctors' Movement, which also drew on the offices of the state, albeit in different ways, to institutionalize universal health care at the most unlikeliest of times. Chapter 4 explores the failure of transformative health care reform in South Africa, where a longstanding movement of medical professionals confronted political dynamics markedly different from the other two countries. Here I show how these dynamics predisposed the ruling African National Congress to commit to only incremental reform and embrace more transformative health care reform (national health insurance) in name only.

The second half of the book examines the politics of antiretroviral access in the three countries. Chapter 5 examines the politics of antiretroviral access in Thailand, drawing out how a movement of pharmacists and medical professionals with training in the law helped make Thailand a global model for AIDS treatment. Chapter 6 highlights the underappreciated legal dimensions of Brazil's well-known AIDS treatment story, which contributed not only to Brazil becoming the first industrializing country to make combination antiretroviral therapy available to all free of charge but also to international efforts to make antiretroviral access more accessible. Chapter 7 explores the reasons for failure of the AIDS treatment policy in South Africa, where ANC executives moved slowly in addressing the AIDS epidemic and adopted a charlatan AIDS policy in an electoral context that allowed them the luxury to do so. While a legal movement eventually succeeded in forcing the hand of the government, these different political dynamics eventually led to the deaths of more than three hundred thousand people. Finally, in chapter 8, I offer some concluding observations, briefly discuss how the current political situation has affected the continued prospects for professional movements and health universalism in those countries, and explore the relevance of professional movements to social change in other policy domains and parts of the world.

DEMOCRATIZATION, ELITES, AND THE EXPANSION OF ACCESS TO HEALTH CARE AND MEDICINE

"We trust our health to the physician, our fortune, and sometimes our life and reputation, to the lawyer and attorney. Such confidence could not safely be reposed in people of a very mean or low condition."

—Adam Smith, *The Wealth of Nations*

"Organizations of teachers, doctors, and lawyers are still apt to look out, first of all, for 'number one.'"

—Abraham Flexner, "Is Social Work a Profession?"

What accounts for the emergence of health rights in new democracies, and why should progressive members of elite professions—who frequently receive no benefit themselves—play such an important role in their expansion? In sociology, the power of elites has often been viewed with a mixture of contempt and suspicion. From C. Wright Mills's *The Power Elite* to William Domhoff's *Who Rules America?*, the discipline has rarely thought of elites as figures capable of delivering for society the promise of a better future. More frequently, they have been imagined as shadowy figures bent on pursuing ways to increase their own power, standing, and capital at the expense of broader society.

Classic work within sociology and political science has more frequently pointed to the role of labor unions and left-wing parties who serve as champions of the masses and advance egalitarian social policy. T. H. Marshall's theory of citizenship (1950), now taken as a foundational work in sociology, pointed to the gradual expansion of civil, political, and social rights in Great Britain over three centuries. Although the state ultimately served as the vehicle for the expansion of what Marshall termed "citizenship," social struggle—and the role of labor unions and other actors in society—was at times explicit in his accounts. More recent work by scholars working in the "power resources" school (Korpi 1983; Stephens 1979) has emphasized the importance of working-class power and in particular the role of labor unions and left-wing political parties in the expansion of social policies. The generous social democratic welfare regimes advanced by left-wing parties and labor unions have frequently been set against less generous

arrangements in liberal and corporatist welfare regimes (Esping-Andersen 1990). While the influence of left-party power on the expansion of social policy in Europe has long been acknowledged, its importance in developing countries has only recently received attention (Heller 1999; Huber and Stephens 2012; Sandbrook et al. 2007).

By contrast, Amartya Sen's (1999) theory of development as freedom has spawned an abundance of work that has emphasized the importance of direct citizen participation in human development. From accounts of participatory governance (Fung and Wright 2003) to the role of ordinary (even illiterate) citizen participation in processes of participatory budgeting in Brazil (Baiocchi 2005) to innovative institutional mechanisms of public involvement in Brazil (Cornwall and Shankland 2008), India (Gibson 2012), and twenty-first century developmental states more broadly (Evans and Heller 2015), scholars have convincingly shown that direct citizen participation plays a vital role in human development.[1,2]

While a consensus that democracy enhances human development has been longstanding (Boix 2001; Dreze and Sen 1989; Lenski 1966; Lipset 1959), recent work has interrogated the relationship between democracy and health more specifically. These studies have found mixed evidence on the relationship between regime type and health (Gauri and Khaleghian 2002; Gerring, Thacker, and Alfaro 2012; Gómez and Harris 2015; Ross 2006; Shandra et al. 2004). While some research has found "little evidence that the rise of democracy contributed to the fall in infant and child mortality rates" (Ross 2006, 872), these findings have been called into question (Gerring, Thacker, and Alfaro 2012; Martel-García 2014). Besley and Kudamatsu (2006) find a strong relationship between democracy and life expectancy. James McGuire (2010) suggests that it is not a country's wealth (or spending) that determines its citizens' health but rather a government's commitment to well-financed social services, in particular primary health care. In this context, democratic elections encourage politicians to attend to these needs. Wigley and Akkoyunlu-Wigley (2011) find that democracy has a positive effect on life expectancy independent of its effect on redistributive policies. Following Sen (1999), they theorize that this pro-health effect is due to the fact that democracy enables active citizen participation in decision-making processes and because of the protection democracy affords individual civil and political rights. While Gerring, Thacker, and Alfaro (2012) find only a weak relationship between level of democracy in a given year and health, they report substantially stronger support for the relationship between a country's total stock of democracy over the previous century and infant mortality. McGuire (2013) reports lower infant mortality rates among democracies than authoritarian regimes and likewise finds support for the idea that long-run democratic experience contributes to health.

Within this literature, the relationship between democratization and health is a related issue that has recently been taken up by scholars. In a survey of twenty-eight countries in sub-Saharan Africa, Kudamatsu (2012) finds that infant mortality falls by nearly two percentage points after democratization. Wong (2004, 13, 26, 28) contends that the transition from authoritarian to democratic politics provides policymakers with new incentives to consider universal, rather than selective and piecemeal, health care reforms. The emergence of new actors in civil society broadens existing policy networks and forces new ideas to be taken into account. Frenk, Gómez-Dantés, and Knaul (2009) and Carbone (2011) have likewise pointed to the importance of new political opportunities that emerged in Mexico and Ghana which helped to facilitate the adoption of national health reform.

This book builds on this emerging literature and complicates existing theories in three ways. First, whereas scholarship has emphasized the way in which democratization empowers the masses, this book turns that conventional wisdom on its head by suggesting that democratization empowers elites. Second, it calls attention to the role that newly empowered (and public-minded) professionals play in expanding access to health care and medicine *on behalf of* the poor and those in need. Third, it highlights the importance of differences in the character of political competition in the wake of democratic transition in conditioning the possibilities for well-organized professional movements to institute such changes.

In light of the literature that has emphasized the critical role played by left-wing political parties and broad-based mass movements in expanding human freedom and broadening notions of citizenship, this book points to the need to revise and refine our understanding of the sources of major policy change in industrializing societies. In the developing world, some of the institutions that have typically been relied on for progressive change in the Global North, like labor unions, often represent only the needs of those in the formal sector, leaving out the needs of vast majority—and sometimes even entrenching inequality when new health care programs are enacted that serve only comparatively well-off civil servants and workers in the formal sector.

This book therefore refocuses our attention away from these typical explanations for social policy expansion and points to the important role played by actors from a narrower stratum of society than existing theories suggest. It draws attention to the importance of movements comprised of medical and legal experts who advocate for health care rights on behalf of the poor and disenfranchised in the face of well-established professional and corporate interests. While classic scholarship within the Marxist tradition (including work by Gramsci and Lenin) has also theorized that intellectuals have a role to play in revolution and that the

primary beneficiaries of social change do not always have to be the drivers, my work shows how the knowledge, networks, and positions of elites from esteemed professions play a particularly important role in concrete policy domains characterized by technical complexity.

An Elite-Centered Theory of Welfare State Expansion

Doctors have long been central to health care reform. However, nearly all of the prominent scholarship from sociology and political science suggests that they have been on the "wrong side" of reform, posing as obstacles to efforts to extend access to health care to members of the population who do not have it (Hacker 1998, 2002; Quadagno 2004, 2005; Skocpol 1997; Starr 1982). Classic scholarship in the professions has emphasized the unique professional autonomy extended to the medical profession (and other professions) by the state and efforts by the profession to preserve professional autonomy, authority, and jurisdiction and to protect professional interests in the face of change (Abbott 1988; Freidson 1970; Larson 1977; Starr 1982). This work has explored the historical basis of power, dominance, and authority of the medical profession, its reliance on knowledge and competence for this power, and the degree to which doctors' power sometimes "spills over its clinical boundaries into arenas of moral and political action for which medical judgment is only partially relevant" (Starr 1982, 4–5). This scholarship has suggested that "over the politics, policies, and programs that govern the system, the profession's interests have also tended to prevail" (Starr 1982, 5).

While the influence of professional associations may vary by national context (Immergut 1992), the interests and power of the professions is something that scholars have generally taken for granted. Medical associations have played a key role in mobilizing against efforts to extend coverage to citizens when presidential administrations have led efforts to enact health care reform (Quadagno 2004, 2005; Skocpol 1997). Hacker, for example, has suggested that "[i]n no country has the medical profession wholeheartedly embraced national health insurance" (1998, 66) and has pointed to the enduring consequences of early instances of professional resistance to health reform in shaping the character of health care systems today (2002). The historical success enjoyed by the medical profession in resisting threats to its professional autonomy has led Paul Starr to suggest that the United States is perhaps the paradigmatic case in this respect: "Hardly anywhere have doctors been as successful as American physicians in resisting national insurance and maintaining a predominantly private and voluntary financing

system" (1982, 6). While important work has since enumerated challenges to the dominance of the medical profession—the corporatization of health care, the growing influence of the pharmaceutical industry, new health care purchasing arrangements, and large new federal programs—and pointed to evidence of the decline of its autonomy in important respects (Conrad 2008; Light 2010; Timmermans and Oh 2010), few if any are willing to go so far as to suggest that the influence of organized medicine is dead; it is taken for granted as a potent force in politics today in the United States and abroad.

Scholars have pointed to the need to go beyond these traditional ways of understanding the professions and to question the assumptions that have led us to conceptualize professionals as "unproblematic agents of professions" (Lo 2005, 390–91). Although there have been calls for sociologists to investigate the multiple and even ambiguous identities of professionals for some time (Balzer 1996; Hafferty and McKinlay 1993; Lo 2005), with few exceptions (Bucher and Strauss 1961; Bucher 1962; Hoffman 1989; Wolfson 2001) professional subdivisions—and more specifically, their relationships with social movements—have not been a central focus of this literature. While I acknowledge the tendency of medical associations to oppose health care reform efforts, to suggest that the attitude of a profession toward health care reform is always uniformly negative would also be an overstatement. Within the United States, groups such as Physicians for a National Health Program have provided an important alternative to the once-dominant American Medical Association by advocating for national health insurance for almost forty years. In other words, while national associations have traditionally sought to represent the interests of professions as a whole, research has long acknowledged that professions may contain opposing factions, splinter groups, and subdivisions (Abbott 1988, 247; Freidson 1986, 195–96)—even if it has generally been a footnote within the broader literature.

Only recently has work in medical sociology turned its attention to social movements working in the health domain and formalized the study of "health social movements" (Brown et al. 2004; Brown and Zavestoski 2005). While valuable, this scholarship has generally encouraged us to think about social movements in relation to health, rather than in relation to the broader organizational category of the professions, of which movement advocates are a part. And until recently (O'Brien and Li 2006; Steinhoff 2014), study of the interface between law and social movements has likewise been limited, with social movement researchers generally demonstrating little interest in law and legal scholars not taking up social movements (McCann 2006). While growing attention has been given to "cause lawyering" within the scholarship on law and society (Sarat and

Schiengold 2006), the literature on medical sociology has more frequently treated litigation and engagement in legal action as tactics that health social movements might use rather than as professional identities around which to construct new social movements (for example, Brown and Zavestoski 2005, 13; Wolfson 2001, 38–39).

Scholarship has more frequently shown how their different needs, goals, and methods have put scientists and laypeople into conflict in battles over the science related to illness and health (Brown 1992; Epstein 1996; Hess 2005; Joffey, Weitz, and Stacey 2005). Steven Epstein (1996), for example, has documented the struggle over access to experimental drugs before the advent of combination antiretroviral therapy by AIDS activists in the United States. By documenting processes of knowledge-building and the "expertification" of lay citizens, Epstein's work has illuminated the ways in which activists have themselves worked to become knowledgeable about the science of AIDS in order to be able to challenge scientists and advocate more forcefully for improved access to experimental medicines. This work can be read as existing within a broader scholarship that has taken "embodied health movements" as its concern (Brown et al. 2004).

While the work of Epstein and others has drawn attention to efforts by activists to become experts in science in an era in which access to pharmaceuticals could prolong life, but not extend it indefinitely, scientific advances have since changed the game, with new technologies turning previously fatal illnesses into chronic ones. However, the price of these new medicines has not always come cheap, and the need for life-saving medicines has at times come into conflict with their affordability. This conflict has in turn bred both cooperation and contestation among state bureaucrats responsible for public health, activists representing those in need of pharmaceuticals, and pharmaceutical companies tasked with making innovative new medicines. Given the centrality of both intellectual property and human rights to what has come to be known as "essential medicine," the battles between these actors have frequently taken place in a jurisdiction well beyond the established clinical setting of the doctor. Courts have played important roles in distributional conflicts related to expanding access to medicine, leading both activists and doctors to venture outside of their core jurisdictions, to undergo training in the law, and to engage in contentious struggles that rely on expertise. By showing how lawyers and activist medical professionals have engaged the law, I extend this line of research and highlight the way in which treatment advocates have both relied on lawyers and themselves sometimes undergone processes of "expertification," not just in important issues related to science but also in the law. And by pointing to the professional character of these movements, this work interfaces with recent debates within Science and Technology Studies on the

democratization of science and the relative contributions of lay people and elites to problems that are both scientific and social (Benjamin 2013; Brown 2009; Shim 2014).

Professional Movements: Political Actors Who Occupy an In-Between Space

I advance the notion of "professional movements" to describe a category of collective action that occupies an in-between space among the broader categories of the professions and social movements, referring to social movements that operate within and sometimes against broader professions. While others have used the idea of professional movements as an entry point for exploring intra-professional conflict over ideas—particularly in the transnational economic field (van Gunten 2015, 29, 8; also Hirschman and Berman 2014)—this work has not generally taken national policymaking processes as its central focus, exploring instead contests that have taken place in the realm of ideas rather than examining overt strategic political action by professional movements to make policy concrete in national environments. This book examines professional movements as political actors who frequently operate outside the academy, acting purposefully and strategically—drawing on privileged positions within the state and legal institutions—to put policy ideas on the political agenda, to institutionalize new policy innovations, and to hold the state accountable for robust implementation.

In the domains of health care and medicine, professional movements—comprised of medical professionals—engage in strategies and actions that take place *outside* their normal professional jurisdiction. For example, these professional movements include doctors who leave work in clinical practice to take up positions in the state bureaucracy and advance health reform and pharmacists who leave the hospital dispensary to accrue legal expertise on intellectual property issues, which they then deploy on policy issues related to pharmaceutical access. But such movements are not necessarily limited to the domains of health and medicine: In the domains of business and finance, for example, professionals may leave high-paying industry jobs to work to improve consumer protection or advocate for regulation that benefits the marginalized.

Professional movements are distinct from scientific and intellectual movements in that scientific and intellectual movements involve "collective efforts to pursue *research* programs or projects for thought in the face of resistance from others in the scientific or intellectual community" (Frickell and Gross 2005, 206, emphasis added). Professional movements are also distinct from "identity