**Biopolitics and Capital: Poverty, Mobility and the Body-in-Transplantation in Mexico**

**Introduction**

Organ transplantation has become a prominent topic in a series of debates within the social sciences, medical anthropology in particular (Cohen, 2002; Crowley-Matoka, 2005; Hamdy, 2010; Lock, 2001; Strathern, 2009; Scheper-Hughes, 2008). These debates have largely coalesced around the complex biopolitical consequences of transplant technologies for different populations: different constituencies of givers and receivers (Avera, 2009; Cohen, 2002; Author, 2011). Transplant technologies remind us that bodies constitute powerful ‘carnal’ analogues of social and cultural formations (Douglas, 1970). They are both readable and read as embedded in and expressive of wider forms of conflict, contestation and controversy, particularly in instances where biology becomes the focus of political action. The intensification of the relationships between technology, life and power are said to capture, as Lemke suggests “something essential about our present era” (Lemke, 2011: xi): epochal ruptures that coincide with the conditions of modernity and postmodernity (Esposito, 2008; Hardt and Negri, 2000); the changing structures of economics, politics and systems of governance (Foucault, 1980; Agamben, 1998; Hardt and Negri, 2000); strategies for regulating and managing life processes for populations and individuals (Foucault, 1980; Rose and Novas, 2005); the moral economies and spaces where exception and rule, exclusion and inclusion become legitimised and normalised (Agamben, 1998; Fassin, 2006); rapidly expanding fields of scientific knowledge, in particular, the molecular sciences and the new genetics (Flower and Health, 1993; Rabinow and Rose, 2006) as well as the increasing opportunities for capital these new fields afford (Cooper, 2008; Sunder Rajan, 2012).

The interest in these relationships has given rise to a profusion of approaches to capture, at root, *what* is being re-configured by medical technologies in our time and *how* such reconfigurations unfold. Attempts to pin specific forms of biopolitics down have served to elaborate a range of related conceptual devices: biocapital, biolegitimacy, bioavailability, recombinant biopolitics, bare life, and so on. Each presents variant orientations to, and readings of the connections between power, knowledge and life. Though offering invaluable insights, questions can be raised, however, about their stability as categories of reference and their explanatory power across history and location. Of particular concern to this paper, is an anthropological question, one formulated with an eye to the fields of practices these elaborations of biopolitics seek to mark out: how do we approach the transnational character of organ transplantation while remaining sensitive to the specificities of context and place?

Rather than arbitrate between positions, and to avoid over-determining the analytical ground of biopolitics, I want to treat transplant technology and its consequences as topics for description in and of themselves; ‘matters of concern’, which are historically and interactionally situated, locally framed and contested (Latour, 2004). I want to show how transplant technology is invoked and animated by the partisans in question; for whom and under what circumstances it comes to matter. The contexts within which transplant technologies acquire their meaning –nation states; market formations; modes of government – do not come pre-formed. I am, therefore, interested in what Michael Lynch, after Alfred Schutz, describes as a reframing of the topic/resource distinction; in this case, the practices and conditions of possibility that enable us to understand how transplant technologies come to be part of the everyday lives of individuals. It is these conditions of possibility that constitute the analytical circumstances of relevance for this paper (Lynch, 2008).

**Aim of Article**

Drawing on recent ethnographic research, the aim of this article is to explore these issues through a discussion of ‘actually existing’ organ transplantation, to show how the relationship between transplant technologies, life and power emerge as ‘matters of concern’ in the context of a specific country’s, Mexico’s, predominantly living transplant programme. Taking up the Mexican case, the article examines the social and political conditions under which kidney transplantation takes its particular forms, more specifically the ways in which transplant medicine produces and conscripts the populations it has come to rely on. These populations are, I argue, constructed in socially stratified terms, while organ transplantation itself is reconstructed as a site for the extraction of surplus value. Without a visible or coherent logic of healthcare access, transplant medicine produces catastrophic consequences for the country’s poor. In carrying the costs (moral, social and economic) and burden of care, the practices of poor patients and their families offer an important critical vantage point from which to assess the interplay between state, market and the body – the terrain of biopolitics – in the context of transplantation. The approach taken might be described as ‘epistemographic’, as well as ethnographic (Lynch, 2008). While certainly driven by theoretical developments at the intersections of medical anthropology, science and technology studies and approaches to biopolitics, its purpose, following Michael Lynch “is not simply to ‘make sense’ of things we see as empirical observers of the world through frameworks that are already given. It is, instead, to make sense of a problem when the very nature of the problem is at stake” (Lynch, 2008:5).

**Organ Transplantation and the State-Market-Body Nexus**

The problem or rather *cluster of problems* ‘at stake’ are ones which have been taken up in a number of ways by contributors to this journal. Of significant interest are the ways in which innovations in medical knowledge have been linked to shifts in state and market formations (Waldby 2012), most notably, the move towards post-Fordist modes of production, driven by speculative growth, devolved government and the increasing blurring of the boundaries between production and consumption (Cooper, 2012; Neilson 2012; Race 2012). These processes are judged to be foundational to the rise of the ‘biocitizen’: the autonomous neoliberal subject, who exercises new frames of biomedical understanding to “act upon” him/herself (Rose and Novas, 2005). The capacity to act upon oneself has been taken up by Cooper, for instance, to show the paradoxical character of these new subject positions. She shows how the right to take therapeutic risks – an outcome of patient activism – has inadvertently facilitated the outsourcing of pharmacological innovation and experiment to on-line, self-organised patient forums. The consumption of ‘off-label’ drugs has not only been integral to a (co)production of value accumulation but to new forms of distributed, immaterial labour(Cooper, 2012).

Though such innovations in the production of surplus value have opened up the market-state-body nexus to new theoretical challenges and insights, there are recognised difficulties, however, in drawing too heavily on what are, in effect, Anglo-American modes of understanding as guides for what might be happening elsewhere. With attention to the globalised south, Das acknowledges the capacity of individuals to engage with varying forms of state and science cannot be assumed in advance (Das, 2001). Nor indeed may these individuals be knowable or governable in similar ways. According to Race, the intersections between state, market and bodily health have yet to be worked through in ways that do not fall into problematically delocalised forms of critique, modes of analysis that ultimately mask contextual arrangements and calculative practices and their variations from place to place and, we might add, time to time (Race, 2012). Following these insights through, thus requires methodological sensitivity to the multiple ‘significations’ of human biology and how they take shape at these intersections (Ticktin, 2011) but also to the significations that owe to time and place – something frequently missing.

A general reliance on analyses of contemporary biopolitical forms grounded in ‘temporal ruptures’ or ‘epistemic moments’ works against this analytical grain, making it harder to examine the conditions under which different regimes of state and market activity develop and acquire determinate local forms with implications for sick bodies (Esping-Andersen, 1990). In Mexico, it is, for instance, difficult to understand entitlements to healthcare outside of the historical dynamics of the post-revolutionary state, the consequences of state corporatism, the significance of NAFTA, of recent debt crises, the structuring of inequality and particular patterns of disease emergence which have grown along its vectors. The acceleration of problems which underpin both the rising incidence of Chronic Kidney Disease (CKD) and the replacement technologies upon which it depends presents a thick, volatile mix of conjuncture and contingency. While this article cannot attend to these issues individually, they are part of the background of socio-political relevancies against which access to healthcare materialises, is understood and articulated as problematic in this context.

For this reason, and in an effort to avoid over-determining the account by reaching for explanatory frameworks before the fact, this article builds upon other ethnographic literatures which focus on the situated realities of organ and other bodily transfers and their complex forms of exchange (Copeman, 2009; Hamdy, 2010; Sanal, 2011; Sharp, 2006; Simpson, 2009). In so doing, its focus is less on the ways in which the bodies of citizens come to be medicalised or become targets for new regimes of knowledge and governance, but to show – in the context of Mexico – how the practices, or ‘body-work’ of these citizens are co-constitutive of medicine and the markets upon which it increasingly relies. This is about bodies which are at once medicalising as well as medicalised.

Proceeding in this way owes much to work in anthropology which focuses specifically on organ transplantation and the production of those publics and populations which generate the resources upon which transplantation depends. Commonly configured as organ givers, donors and sellers, their various constitutions and subjectifications have been taken up in the literature in conjunction with the well-instituted anthropological themes of exchange, gift-giving, commodification and forms of reciprocity to link together the social and the biological across both local and global terrains (Cohen, 2002; Hamdy, 2010; Author, 2011; Sanal, 2011; Scheper-Hughes, 2008; Sharp, 2006). The specific ways in which these terrains, sites and settings are so linked have been investigated in the corresponding literatures on various forms of medical migration and tourism, again concerns taken up in this journal (Cohen, 2011; Ticktin, 2011; Wilson, 2011).

What such studies show is that the stepping up of people moving in search of healthcare has been facilitated by disparities and variability in regulatory control across nations (Petryna, 2006). However, when coupled with technological innovations in transplant medicine, this produces quite complex distributions of ‘bioavailability’ (Cohen, 2011) Examining advances in immunosuppressant therapy, in particular, the drug cyclosporine, Cohen’s work has been significant (Cohen, 2002). In working to suppress immune system responses, important for the prevention of organ rejection, cyclosporine has reduced dependence on *strict* matching of HLAs (Human Leukocyte Antigens) between donors and recipients. It has broadened out who can serve as donors, thus expanding the ‘bioavailable’ reserve, that which is called upon to satisfy those who travel in search of a transplant (Cohen, 2002). Concentrating on the mobility of south Asian populations, Cohen identifies those who can mobilise forms of bodily supplementarity from the bodies of others. His analysis can be seen as a deepening of Scheper-Hughes’ depiction of the global organ trade as following established routes of capital and labour flows (Scheper-Hughes, 2008). Cohen moves beyond the polemics of a world divided along the fault lines of class, to focus on the diasporic flows underpinning local economies of organ trade and their patterning by race (Cohen, 2011). However, as I have argued elsewhere, Cohen, like Scheper-Hughes, has a tendency to take for granted the technologies of organ transplantation as an expression of underlying social relations (neoliberalism, market forces, race), rather than exploring these technologies as sites “for the enactment of social processes and relationships, particularly those adversely affecting women, children, the lives of the poor, both within and across locales” (Author, 2011:1473).

Although the literatures on medical migration make visible the structural conditions under which organs are made available and emphasise the varied ways in which we come to matter to ourselves and to others(Neilson, 2012), the constitution of transplant technologies themselves are seldom interrogated. In the course of analysing the migration of organs, points of origin and points of destination are pulled into view, while local forms of organising transplant medicine are lost. In taking these considerations up, rather than give analytical priority to the logistics of movement *across* borders, this paper focuses attention on what it is that is constructed via movement *within* borders, where we may assume the bulk of patient journeys occur. I focus on those who move, but do not ‘travel’.These are, primarily, Mexico’s poor and uninsured, who cannot be said to consume healthcare so much as work to constitute it for themselves and so provide its grounds of possibility.

As the organs they seek for transplantation are living-related, the issue of bioavailabilty arises primarily within the confines of kinship, as one with gendered consequences. However, to fully understand what this implies means taking into consideration the technologies of transplantation, writ large – diagnostic practices, modalities of dialysis, drug regimens, HLA matching, surgery and so on. Sick bodies are at the core of this therapeutic matrix, but, given the scope of the article, it is not possible to give complete attention to the embodied affects. It is, instead, the incoherent character of this technological assemblage – that which grounds, organises and uses sick bodies - that I want to pull into view.

**Kidney Disease: aetiology, capitalism and the neoconservative State**

Mexico provides an exemplary context for studying CKD and the replacement technologies of dialysis and transplantation. CKD – the deterioration of functioning in both kidneys – is among the 10 leading causes of death in Mexico (Garcia-Garcia et al. 2011). Diabetes is said to be responsible for 56% of incident cases; however, the second major cause is ‘unknown’. In the absence of adequate epidemiological, screening and toxicological data, CKD is gaining increasing attention as a ‘mysterious epidemic’ sweeping throughout Latin America and south-east Asia, one associated with the young, with farm workers and those at risk of toxic poisoning (Ramirez-Rubio et al. 2013). Within Mexico, hospital staff and patients speculate about the country’s increasingly deregulated economic environment, post-NAFTA, particularly in relation to the food and agri-industries, poor toxic waste management, unchecked use of pesticides, environmental pollution caused especially by mining and tanneries, as well as the ever-expanding black market in pharmaceuticals. The residual ‘unknown’ thus represents an important category of reference in terms of sickness and the state in Mexico (Parsons, 1940). It is one which indexes state and market failures as well as social and environmental crises. It is increasingly bound up with and exemplifies the processes of economic, political and social change tied to the neoconservative policies of Mexico’s right wing government.

The country’s public health system, as the locus of organised responses to these problems, reflects the problematic context in which it operates. It is fragmented, multi-tiered, and has shifted backwards and forwards between attempts to centralise and decentralise services. Access to health services is characterised by profound inequalities and administered by way of a complex social security, quasi-insurance system, linked to labour market position. Private-sector salaried workers and their families are covered by the Instituto Mexicano de Seguro Social (IMSS – Mexican Institute of Social Security). IMSS covers 44% of the population, making it Mexico’s largest healthcare provider and an important actor in the context of this paper. The Institute of Social Security and Services for Civil Servants accounts for another 5%; private health insurers for highly paid workers constitute 2% (INEGI, 2012). For those not covered by any insurance – mainly informal, flexible workers and the unemployed – services are provided at a subsidised cost by the clinics and hospitals of the Ministry for Health and Welfare. This safety net is run with no premiums, no guaranteed package of services and at a significant cost to those who use it. Services are limited, often unavailable, and heavily reliant on out-of-pocket payments at the point of use. Health professionals explain that such fragmentation militates against an integrated, nationally organised system for cadaveric transplantation, thus a reliance on organs donated from living donors. In terms of CKD, Mexicans who do not have social security benefits tend to present late to health services. Given the diffuse nature of the symptoms, many are unaware they have kidney disease.

**Seguro Popular: reform, rhetoric and reality**

A highly contested package of reforms was introduced in 2001 as a response to the deficiencies of the healthcare system. Known as Seguro Popular (Popular Health Insurance), its aim is to universalise public health access for the poor by shifting the federal budget to demand-based allocation, separating purchaser and provider and by integrating subsidies by federal and state governments along with premiums paid for by families to insure against risk and medical impoverishment. Designed in accordance with market principles rather than a social rights agenda, it was initiated by Julius Frenk, Health Minister for Partido Acción Nacional (PAN)and has been implemented and evaluated in conjunction with the same body of international health experts (Frenk et al. 2006).

The reforms are the subject of controversy. With no independent analysis of their effects, Frenk and his team, supported by the WHO and the Lancet, are claiming that Mexico is close to providing universal healthcare coverage, with Seguro Popular hailed as *the* example of health reform for low and middle income countries to follow (Knaul et al. 2012). These claims to universality are contested, and have been described as a corrupt and pernicious move by Mexico’s neoliberal elite to mask their attempts to engineer greater market competition at the expense of the poor (Eibenschutz et al., 2008; Laurell, 2011).

The tensions at the core of these reforms (access versus marketisation) are clearly exhibited in the case of kidney disease. Dialysis and transplantation are not included as part of the treatments covered and, given the disproportionate impact CKD has on the poor, Mexican families face increased economic and social impoverishment in the absence of adequate support outside of charging regimes. Organisational inequities thus overlay with a critical public health problem. However, Seguro Popular has increased access for some conditions, such as hypertension, HIV (antiretroviral therapy), childhood leukaemia, cervical cancer, and care for prematurely born babies, and so, one cannot assume similarities of experiences across chronic conditions (Knaul et al. 2012). As a result, Seguro Popular has a marked presence in those health services run by the Ministry of Health, and so represents another important aspect of the background to this study.

**The Public Hospital: a critical intermediary in the flow of patients, technology, capital and power**

The starting site for the ethnography is Guadalajara in the State of Jalisco, a city of 4 million people in a state of approx 7 million. It is home to two substantial transplant programmes: one based at IMSS, the social security institute for the employed and the other at Hospital C, which has provided services to Jalisco’s poor since the 18th Century. Hospital C is financed by state and federal funds, private donations and contributions from non-governmental organisations. Patients are charged a negotiated fee according to level of income, usually nominal to reflect the constituencies of low paid, insecure works who access services there. The transplant programme has been running since 1990 and while it carries out both living and cadaveric transplants, it is mainly dependent on living organ donors, the majority of whom are womendonating to their children, husbands or parents (Crowley-Matoka, 2005).

The hospital has a small haemodialysis unit (used primarily as a back-up service due its high cost) but mainly relies on a large peritoneal (home) dialysis programme, the most common form of renal replacement therapy in Mexico. Because peritoneal dialysis is carried out in patients’ homes, it is cheaper for the health services but transfers costs to Mexican families. The hospital suffers a shortage of nephrology staff and is reliant on residents and nurses to support the transplant programme. With few exceptions, medical staff also hold private practice positions at IMSS, working with both private and public patients and very often moving them between both institutions. They effectively double-job to make money and provide an informal conduit between different providers and patients. Medical staff, as I will show, are thus located at the intersections of intensely fractured and informal routes to healthcare.

The city university is academically and administratively responsible for the Hospital. Both are formally and informally embedded in the wider political governance structures of the city, and are widely known to have little actual autonomy outside of the city’s religious and political institutions. Hospital C is, therefore, an important intermediary in local flows of patients, technology, capital and power, a site where organs acquire a socio-political life and are made into marketable and traceable things. The hospital maintains its reputation for helping the poor by virtue of the informal, ‘hidden’ work of many of its committed medical staff, who spend time manipulating insurance forms or writing letters of introduction for patients to get drugs, tests and treatments for free. A prominent institution within state transplant medicine, Hospital C has also been the subject of prior ethnographic research (see Crowley-Makoka, 2005). This present study moves out from Hospital C to follow the lives of those who move through it, thus presenting important opportunities to understand how those involved in the transplant project, particularly patients and their families, secure care. It is to this I now turn.

**Fractured Routes to Care: navigational practices of uninsured Mexican families**

The ethnographic research this article draws on comprised 105 interviews with 138 respondents, inclusive of CKD patients, family members, health and social-care professionals, charities, medical suppliers and Mexican scholars, in conjunction with analyses of documentary evidence and observations at medical consultations, in hospital wards, in patients’ homes and at various meetings and events. Taken together, they provide detailed and complex accounts of attempts to access and provide healthcare. However, despite the diversity, commonalities emerged around the restricted character of access to organ transplantation through the common constraints placed upon patients and their families and the work they thus were required to do. In what follows, I present data from an ethnographic case-study, drawn on as an exemplar and chosen for its capacity to typify the structural character of a family’s experience: the case of Elena and her family. The story, which follows, broken down into four sections, is a detailed one; the importance of attending to those details is something which will be discussed at greater length below.

**Episode One: the search for a diagnosis; the necessitation of movement**

Elena was an 18 year old transplant recipient. Like other patients interviewed, she was young, with no medical explanation as to why she had developed CKD as her kidneys were too small to biopsy. She received her transplant in March 2011. She was interviewed the following July at the hospital and again in August with her family at home. On first meeting, she was lying in the nephrology ward, awaiting test results. Her nephrologist Anna, was annoyed – Elena had been missing post-transplant consultations and now had complications and a urine infection.

Elena’s kidney was donated by Rita, her older sister, a mother of two small boys. Rita lives near to Elena and her family in a small town, surrounded by maize fields, on the outskirts of Guadalajara. They are a large working class family of eleven children. Their mother works in the home, their father in a nearby fibreglass factory[[1]](#footnote-1).

Prior to diagnosis, Elena had been experiencing headaches, nausea and vomiting. She went to see three private physicians; two diagnosed her with a throat infection, the third, on the insistence of her mother, sent her for blood tests to the Hospital General de X, a public hospital.

Thinking her symptoms might be linked to CKD, the doctors advised her to go to Hospital de Y, a tertiary facility who provided free testing, but the family opted for Hospital C, because of its reputation for helping the poor. There, she was diagnosed. Her kidneys were in ‘end stage’ and she needed dialysis immediately. She was prepared for peritoneal dialysis, but the catheter failed, and she was put back on haemodialysis. Although the family were paying, the hospital couldn’t continue to treat her. The unit was full and the machines were only to be used for initial sessions. Because Elena’s parents had IMSS insurance, they were sent to IMSS facilities. However, as Elena had stopped attending school due to sickness, now outside of formal state systems, she was excluded from their coverage. For the next year and two months, she and her family would move continually between institutions in search of care.

The significance of actually achieving a diagnosis cannot be taken lightly. While little is known about sufferers of CKD outside of formal healthcare systems, and screening is still in its infancy, doctors assume that many more patients, particularly the rural poor, simply die at home. Of those who actually manage to reach diagnosis, approximately half die within 6 months of their first visit to a nephrologist (Gutierrez-Padilla, 2010). Obtaining a diagnosis ‘unlocks’ the therapeutic interventions which follow – testing, monitoring, modalities of dialysis, drug regimens, surgery and so on. They are the practical ground of organ transplantation, and serve to ‘open up’ the body in all manner of ways. The treatment and functioning of renal bodies is suspended in these webs of practical medical work.

In following the changing status of the renal body along the varied routes it takes to organ transplantation, it is important to recognise the gendered manner in which the bodies of others are made into (bio)available resources. While the many male organ donors committed to the care of their families should not be ignored, it is, nevertheless, mothers, daughters and sisters who play the central role. Elena’s case exemplifies the work women do to support a loved one: the sourcing and resourcing of care, in addition to the provision of organs.

This goes beyond a strict ‘feminisation of poverty’ (Pearce, 1978): the increasing visibility of women as citizens who are caught by the vagaries of neoliberalism and their responsibilities for home and health (Moghadam, 2005). Healthcare is a gender problem with dual and specified configurations. In Mexico, gender is an explicit ‘product’ of welfare regimes whose stratifying effects place women in ever-more vulnerable positions (Esping-Andersen, 1990). Gender inequity has been central to the aggressive processes of industrialisation, post-Nafta, which have transformed opportunities for financial independence into new sites of exploitation and violence, best seen through Mexico’s expanding *Maquiladoras* (Gaspar De Alba, 2010) Mexico is, thus, characterised by what Haraway (2001) would call its own differentiated ‘informatics of domination’; disjunctures in the flows of goods, life chances, power and government. These not only conscript women, in new ways, but do so by laying claim to traditional forms of economic and gender cleavage, where women’s roles – and bodies – are already culturalised as responsible for the ‘burden of caregiving’ (DiGirolama and Salgado de Snyder, 2008) and made pivotal to the production and reproduction of family and social life.

**Episode Two: mechanisms and forms of exchange**

On advice from a doctor at Hospital C, Elena and her family went to ‘Victor Sanchez’, a small private clinic, which provided low-cost dialysis, approximately $84 USD[[2]](#footnote-2) per session. The doctor helped to organise a ‘discount’ for the first few sessions, after which the family had to pay the full costs of three dialysis sessions per week.

## At ‘Victor Sanchez’, another doctor provided a letter for the Jalisco DIF office (Desarrollo Integral de La Familia – a national charity with Federal, State and Municipal offices). There, they received support for four free sessions. Other letters took them to Caritas, the international Catholic social welfare provider, then to a DIF municipal office in Zapopan, and then to another DIF office in Guadalajara, all providing a little further financial support. Elena’s mother, Lupita, took charge of these financial negotiations. After three months in ‘Victor Sanchez’, they moved to Sanefro, a private clinic run in conjunction with Pisa, a pharmaceutical company, which manufactures and distributes dialysis supplies. This they did with support from DIF Guadalajara. When this support ran out, they were told of a philanthropic organisation, by fellow patients and found support for eight further sessions.

The unpredictable lines of movement all must take to secure support means poor and sick bodies draw around them all manner of events, processes and interactions which embody radically different kinds of exchange between very different kinds of actor. They include:

* gifts solicited and unsolicited; conditional and unconditional forms of support; social transfers in the forms of benefits and social insurance payouts; contractual obligations, barter and monetary exchange
* an unpredictably varied cast of agents; kinship and friendships networks, operating across national and transnational boundaries; state actors at federal, regional, and municipal level multiplied by the number of services provided: welfare, healthcare, education; supranational actors and expert knowledge employed for national and political interests; private sector actors, again fantastically varied: pharmacompanies, medical suppliers, laboratories, pharmacies and the doctors who shift from being state actors to part of private enterprise depending on how they are approached; a multiplicity of civil society and non-governmental actors, but also employer networks, philanthropists, political parties and the media
* and, not to forget, the new science and technology capabilities which realise themselves in the presence of a growing transplant industry and the movement it necessitates.

These forms of exchange and the infrastructures of care they connect to are not only complex and contingent, they cannot be specified in advance. In order to enact such chains of support, patients and their families petition doctors to produce ‘resumés’. These are legitimising scripts patients must have when attempting to broker healthcare across public, private and charitable domains. Within the clinical encounter, doctors also ‘informally’ manipulate prescriptions for medications, downplaying CKD in favour of conditions which over-lap as co-morbidities – conditions which *are* covered by Seguro Popular – such as hypertension and diabetes or, indeed, will increase prescription quantities so that those with access to insurance can share with those without. The meaningful appearance of the body – as sick and treatable in Mexico – is dependent on these sets of relationships and the capacity to work through these formal and informal interfaces. These local arrangements underline the vulnerability of care for patients but they also show doctors practices too to be highly circumscribed. As one nephrologist told me on my first visit to Hospital C, “no transplant programme in the UK would begin as we do – without resources”. Resources, are instead, assembled *en route*, through the immaterial, nomadic labour of families in conjunction with various statutory, public and private bodies.

**Episode Three: social entitlement as a navigational strategy, not a right**

One year into her dialysis treatment, Elena’s family made an ‘informal’ arrangement with a neighbour who had a cleaning company to ‘hire’ Elena and so qualify for IMSS insurance. The family, in turn, agreed to pay the employer and employee’s contributions. With this in place, Elena received the remainder of her dialysis (two months) free of charge at an IMSS affiliated hospital. However, this was restricted to one session a week rather than the optimal three.

Lupita had also applied for Seguro Popular, but was told it did not cover CKD. She wanted to know if they might cover hospitalisation, but were told they wouldn’t. Seguro Popular did agree to cover consultations ($5 USD), but the family preferred to pay themselves as this meant they could avoid the long queues that patients with Seguro Popular had to endure.

Throughout Elena’s time on dialysis, her sister, Rita explored options for a transplant. Despite making the informal arrangement for Elena’s IMMS insurance, the family were reluctant to use it. IMSS, as the largest healthcare provider is known to be notoriously slow. It would take 1.5 years just to get through all the protocols and tests required for transplantation. After some deliberation they opted for paying at Hospital C .

Attempts to gain access to social security, by mimicking entry into formal employment or attempting to negotiate with Seguro Popular, highlights the slippery interface between labour and health. The formal labour market is the key determinant of access to social insurance and in turn access to healthcare. However, in an increasingly flexibilised labour market, citizens move through various forms of work with the same precarity they do various forms of healthcare. Health insurance guaranteed through IMMS is lost regularly through redundancy or gained, temporarily, in circumstances where patients agree informal arrangements with local employers. Indeed, at times, families abandon health insurance in the face of bottlenecks in the system or dissatisfaction with services, choosing to pay out-of-pocket.

‘Universal coverage’ as promised through Seguro Popular is, in practice, grounded in situated arrangements between governmental and medical actors at the interstices of Federal and State administrations. The resourcing of healthcare is regularly an outcome of political bargaining and routinely manifests in the unequal distribution of resources. Families, like Elena’s, have little problem identifying Mexico’s successive attempts at health reform as thinly veiled political strategies. They have little problem keeping the state and state practice firmly in view.

**Episode Four: Transplantation, the un-doing of a medical promise**

Before transplantation could proceed, Elena’s family had to pay for all required pre-transplant protocols and tests, most of which were out-sourced to new private laboratories. To meet the costs, the family sold a small piece of inherited land, appealed to friends, local businesses, the media as well as relatives in the US.

The HLA tests, that both Elena and Rita had to undergo, cost approximately $1,400 USD each, for donor and recipient, in a private lab. These tests had to be run twice, due to Elena’s dialysis-related anaemia and a subsequent blood transfusion. To help reduce the costs, on the second attempt, a social worker from Hospital C sent them to a chemist she knew at IMSS who also worked independently in a private lab. Working on her own time, she charged them a slightly reduced total amount of $2000 USD.

Elena and Rita underwent their respective surgeries at a cost of approximately $17,000 USD. After this, the family could no longer meet their contributions for IMMS and Elena was ‘fired’ losing her minimal insurance. They were forced to go to a money lender to pay for immunosuppressants. At this point, the family’s resources had been so drained they could not find the $37 USD to maintain Elena’s post-transplant monitoring, not to mention the $15 USD taxi fare.

We end the story where we began, with Elena lying in hospital with complications and an infection. Her nephrologist explained that this was the result of overly tight surgical stitching which restricted the flow of urine and remarked that the surgeon hadn’t done a good job. When interviewing Elena in her family home, one month later, she hadn’t returned for her next consultation. The family were desperate. Rita, explained: “we are now between the sword and the wall; we don’t have money for Elena’s immune-suppression or to pay the money lender. We don’t know what we are going to do.”

While other stories could have been used, encompassing different way-marks and bringing their own pronounced difficulties, all would have exhibited the same tortuous structures, all would be underpinned by similar practices and all would show the profoundly compromised, but indispensible status poor bodies have within transplant medicine. They show, as Crowley-Matoka’s research has also shown, that kidney recipients are unlikely to be returned to a labour market or reintegrated into the reproduction of family life. Organ transplantation, in this context, fails its promise to restore the body to ‘normal’ living (Crowley-Matoka, 2005).

**Biopolitics and the analytics of a population on the move: a perpetual motion machine**

In reviewing numerous case-studies, the key point to note is how lives and bodies are governed by movement. In Elena’s case, like others, we see how movement underpins the ways in which people make their way from falling ill to being diagnosed, to being treated on dialysis, to being transplanted, and so forth. It is this perpetual movement which constitutes a population as families piece together a healthcare system for themselves; one created out of radical contingency and variability; out of fleeting encounters and the windows of opportunity for treatment they present across temporarily linkable sites, settings and access regimes. This enforced movement tells of a logic of sickness and poverty as a ‘strict and unforgiving sequencing’ (Garfinkel, 1984). It is strict and unforgiving because it imposes discipline and hardship on those seeking essential healthcare for themselves and others. Moreover, it is in being so sequenced that the practices of the mobile poor link together and make visible the biopolitical character of organ transplantation in Mexico.

It is important to recognise that the mobile poor operate without any synoptic overview of healthcare provision. Unscripted, these bodies-in-motion make their way between various public and private healthcare providers, clinics and laboratories. Without any social protection, families are liable to pay for everything – hospitalisation, surgical procedures, routine check-ups, dialysis, pre-transplant protocols, biopsy needles, surgical stitching, disinfectant, antibodies, and medications. These payments must be borne on top of travel costs, dietary costs, structural housing costs for home dialysis patients, informal care-giving and the loss of formal earnings. What is more, in the absence of integrated administrative systems, patients and their families manage and carry all their hospital files, test results and x-rays as they move between hospitals, pharmacies and laboratories. As I saw on numerous occasions, patients would stand in the street or on crowded buses pointing to their medical files and appealing to fellow citizens for financial help or food. Medical files are not held by any centralised bureaucracy. The patients themselves are their own mobile archives, responsibilised social actors, the principal agent, not the state or any ‘sited’ provider, in the management of their healthcare.

Government by movement, such as this is, opens up some key questions and indeed perhaps problems in drawing on standardised or ideal-typical accounts of biopolitical regimes. Rather than being situated within an already definable apparatus of control - states, markets, medicine, welfare – which structure visible constituencies and populations, the reverse is almost the case. Rather than functioning as the targets of these domains, the practices of the mobile poor are productive of these domains: as mentioned earlier in the paper, they are their grounds of possibility.

**The Disaggregated Poor: productive sites in the making of market and regimes of power**

In order to understand how the mobile poor are affected, on a population level, we are reliant on ad hoc and opportunistic counting at local institutional levels. This occurs in the absence of nationally organised kidney registries or an integrated epidemiology of kidney disease. This leaves a disaggregated population, who are neither the objects nor subjects of discipline in a strict Foucauldian sense, nor autonomous subjects whose understanding of medicine drives their quest for care, as Rose, for one, recommends. Their status as ‘a population on the move’ is an ambivalent one. As a population, they do not exist through enumeration; instead such techniques are parasitic upon their movement. It provides the conditions of possibility for other types of activity.

For instance, the organs of the poor, frequently considered in commoditised terms, as goods to be bought and sold, are also working sites for the extraction of surplus value, productive of new medical and pharmaceutical markets. As they move, as their bodies are worked on, they generate capital for others (scientific, commercical, social). Other commodities are dragged into orbit around them: dialysate solutions, catheters, antibodies, pharmaceuticals, laboratory testing and the technologies of transplantation itself, and put to work by variously involved parties (doctors, insurance companies, laboratories, etc),all of which have to be paid for by families like Elena’s. They pay to donate their ‘gift of life’ which they then buy back through the services of transplant surgery, a process in which need is translated into market value, opportunities for others’ labour and profit.

Needless to say, survival rates of transplanted organs are contingent on their capacity to pay for immunosuppression. The costs in every sense are high and not only in market terms but in the gendered divisions which too are produced as a result of the continual work families must do as they move in search of care. The ‘transplant body’ rarely moves alone. Following Spivak (2003), Elena’s case helps us see the need to attend to occlusions of difference and what happens at the margins - of health, labour markets, welfare systems, and citizenship. These are sites where subaltern populations come to be produced and made productive, where those most central to the social distribution of responsibility are least resourced to see it through. It is at the margins, then, that regimes of power and government are increasingly exercised.

What the preceding discussion has shown is that labour, capital, the state and politics are immediate presences in the lives of people. Insofar as the consolidation of transplant medicine *is* the elaboration of a biopolitics, these factors retain significance, albeit in a reconfigured manner. By virtue of this, and as I have hoped to demonstrate, the ways in which Mexico’s poor pin-ball between forms of healthcare provision in an attempt to establish a coherency of care show us how the contours of ‘the biopolitical’ become situated matters of concern in a specific place at a specific time. The manner in which they sacrifice themselves and their limited resources to support a system which only benefits them in highly qualified and structurally ambivalent ways, is itself a guide to the socio-political arrangements which both put them on the move and which are constituted in their movement.

**Conclusion**

Transplant medicine in Mexico is neither a site of succour or salvation; it is a place where social divisions are not just reproduced, but reinforced and intensified. As transplant medicine increasingly relies on new markets, it becomes socially disembedded and ambivalent, a harbinger of Polanyi’s ‘stark utopia’ (Polanyi, 2001). What this paper highlights is the critical need for a situated biopolitics of medical technologies, one that shows how they are complicated by variations in the organisation of healthcare, welfare, cost and technical capacity and, as a consequence, the different ways in which constituencies of donors and receipients are produced and conscripted. We, therefore, cannot assume organ transplantation represents a materially stable phenomenon, whose operations and practices are unchanging across different cultural domains. Part of the challenge is to work towards biopolitical approaches capable of analysing such contingency, approaches that help us move beyond the neat analytical breakdowns - gift-commodity, state-citizen; capital-labour; giver-receiver – that have been used to structure our understanding of this domain. Taking a situated focus helps us to rethink our use of master-categories - biopolitics; neoliberalism; gender; the state - “terms which encompass too much and describe too little” in less unitary, homogenising ways (Sundar-Rajan, 2012:7) and instead see them as emergent categories that take their meaning in relation to the contexts, practices and sites where they are made relevant.

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1. Average annual income in Jalisco is approximately $6,000(US) [↑](#footnote-ref-1)
2. All expenses have been translated into US dollars. [↑](#footnote-ref-2)