Introduction: Glocal pharmaceuticalization

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1 Introduction
Glocal pharmaceuticalization

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The pharmaceutical nexus is large, international and successful. It is also very complex. Heterogeneous in its components, stretching both upstream to research, clinical trials, product development and disease construction, and downstream through doctors and experts, it enables and enrols regulatory bodies, lawmakers, lobbyists, judicial systems, marketing professionals, producers, medical practitioners and consumers. And it does this on a global scale, dominating the medical approach in advanced Western countries and spreading its territory to domains in the developing world. Pharmaceuticals are colonizing and creating new markets in geographically and socially diverse parts of the world and throughout all aspects of the industry. The pharmaceutical industry is trying, and succeeding, to work and profit in very different contexts, with very different regulatory frameworks, marketing needs and consumer bases. And while the industry has had an international approach since before World War II, the global market for pharmaceuticals and the profit margins, which large, multinational companies are chasing, have grown exponentially in recent decades.

These themes are prevalent in critical studies of global pharmaceuticals from within the social sciences (see Elliot 2003; Moynihan and Cassels 2005; Petryna and Kleinman 2006; Williams et al. 2011a). In this book, we present a close look at the glocal of global pharma in Sweden. By attending to the specificities of the local in Sweden within a conceptual framework of global pharmaceuticals, we will be showing global trends and local responses in a Western/Northern, highly developed and regulated state. To do so, we employ the term glocal to signify that the local specificities of a cultural context, including its regulatory bodies, do something to the global pharmaceuticals that are integrated into it, and, likewise, global pharmaceuticals impact the local context.

Critical studies of pharmaceuticals have developed out of academic work on medicalization, a concept often traced back to work inspired by Parsons’s analysis of the sick role in the 1950s. Medicalization became a sociological tool with which to think about the interplay between medicine, individuals and society. Parsons’s proposition, that the sick role allows the individual to avoid blame for his/her illness while simultaneously legitimating and excusing his/her shortcomings in the workplace or family as long as the individual seeks medical help (Parsons 1951), has resonated throughout medical sociology and influenced the development of
the field since. Within sociology, studies of medicalization initially focused on the hospital as a professional institution within which the patient figured, but where doctors (and to a lesser extent, nurses) were particularly interesting to study as they assumed professional roles, made decisions, directed practice and policy and (almost peripherally) attended the ill (see Eaton and Weil 1955; Balint 1957; Fox 1959; Becker et al. 1961; Coser 1963; Freidson 1963). One finds echoes of the sick role in Illich (1976), Fox refers to it in her work on medicalization in America (Fox 1977, 15), and current interests in the process of pathologizing emotions (Healy 2004) and behaviour (Hart et al. 2006; Conrad 2007) touch on the interplay between illness and society.

How exactly medicalization occurs is, of course, up for debate, as is what should be included in the term. Illich famously called it ‘iatrogenesis’, combining the Greek iatros, ‘physician’, and genesis, ‘origin’ (Illich 1976, 3), yet it is used to convey a very broad set of processes, sites and actors beyond the physician and his/her workplace. The concept of medicalization has expanded beyond the idea of the sick role, to include ideas of how a patient’s complaint becomes a medical diagnosis (Balint 1957), and how social deviance becomes medicalized (cf. Fox 1977). It now applies to ‘a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders’ (Conrad 2007, 4), including, and worryingly, the transformation of difference into pathology (Conrad 2007, 148). Forty years ago, Illich pointed to the way ill health is created by what he termed the medical bureaucracy, which defined the need for medical care – defined non-normative ways of being as diseased and in need of medical treatment – and discursively limited the ability or opportunity for other forms of care, be that social, familial, spiritual or self-care (Illich 1976, 40). Critical studies of medicalization in the social sciences today look beyond the immediate medical context to explore how commercial, state and media interests also produce illness. And while, within medical sociology, medicalization is still largely used to direct attention to issues of how illness is understood and used in social contexts, work by Mol (2002) and other science and technology studies (STS) researchers broaches and questions the illness/disease divide, and has begun to approach biomedical technologies with a critical lens (Berg and Mol 1998; Johnson and Berner 2010). These examine how illness and disease are enacted, but also how their particular formations shape medical practice and governance.

Medicalization conceptually sets the stage for the idea of pharmaceuticalization, understood to mean the introduction and acceptance of drug-based responses to (and creation of) health issues, as illustrated in Dumit’s (2012) book Drugs for Life. Williams, Martin and Gabe use the term pharmaceuticalization to interrogate how many different aspects of life are becoming opportunities for pharmaceutical intervention. In their usage, pharmaceuticalization is a broad term, and can be applied to processes of ‘discovery, development, commercialization, use and governance of pharmaceutical products centred around chemistry-based technology’ (Williams et al. 2011a, 711). This is opposed to Abraham’s more medically focused use of the term (Abraham 2010, 604). In its broader definition, which
we embrace in this book, *pharmaceuticalization* can also be applied to the use of pharmaceuticals to address issues currently outside of medical practice, like some lifestyle drugs or the use of nicotine replacement therapies in chewing gum or e-cigarettes (see Elam 2012). This broader stance is not as new or controversial as the Abraham (2011) versus Williams and colleagues (2011b) exchange would suggest. As Illich pointed out long before our current obsession with lifestyle drugs, pharmaceuticals do not need doctors and hospitals to pervade society, nor are most ‘poisons’, ‘remedies’ and ‘placebos’ necessarily destined for the sick (Illich 1976, 61).

Reminding us of pharma’s ambiguity, Illich noted: ‘The Greek’s only word for “drug” – *pharmakon* – did not distinguish between the power to cure and the power to kill’ (Illich 1976, 45). While not as radical in their take on pharmaceuticals as Illich, Williams and colleagues point out that both *medicalization* and *pharmaceuticalization* are ostensibly value-neutral terms (Williams et al. 2011a, 711), and *medicalization* and *pharmaceuticalization* both describe processes that may imply benefits or drawbacks to society and individuals. But, as has been the case with medicalization, in social science studies of pharmaceuticalization there seems to be a tendency to see these processes as negative, or at least suspicious. Abraham echoes this reticence towards pharmaceuticals when he writes ‘that increased pharmaceuticalization can sometimes be suboptimal for significant therapeutic advances in the interests of public health’ (Abraham 2010, 603).

The relationship between pharmaceuticalization and medicalization is sometimes very intertwined, and many critical studies of pharmaceuticals have shown how drugs are being used to manufacture diseases which can then be treated with them. But the process of pharmaceuticalization can imply more than just increased medicalization. Many examples exist where pharmaceuticalization changes the method of treating an already existing medical condition. As Abraham notes, ‘pharmaceuticalization can grow without expansion of medicalization, because some drugs are increasingly used to treat an established medical condition involving no transformation of a non-medical problem into a medical one’ (Abraham 2010, 605; emphasis in the original). This volume discusses the influence of pharmaceuticalization on the treatment of established medical conditions, as well as on marketing communication and the governance of access to such treatment, using the example of Viagra and the treatment of impotence.

What is the subject of the process of pharmaceuticalization? Williams and colleagues use the term *pharmaceutical regime* to cover the networks of institutions, organizations, actors, artefacts and cultural values one can identify in studies of pharmaceuticalization. Others have used the term *pharmaceutical nexus* (cf. Petryna and Kleinman 2006), and Abraham talks in terms of processes (Abraham 2010). What we take from these discussions is the idea that pharmaceuticals are one actor within a complex and heterogeneous *collectif* (Callon and Law 1995) of actors, institutions and ideas, including clinicians, patients, consumers, regulators, sales reps and marketing departments. This *collectif* of actors notably includes the drugs themselves in very specific technological forms – pills, patches, sticks and shots. We treat these material artefacts as a useful prism to see through and with,
to bring into focus and refract various values, ideas and desires that are manifested in and through the drugs we are studying.

The theoretical framework of pharmaceuticalization employs analysis of heterogeneous aspects of pharmaceuticals in society, and can productively be approached from within different disciplines. Because of this, the work in this book is multidisciplinary. It is positioned in social science and cultural studies approaches to pharmaceuticals, and employs theories and terms that attend to the flexibility of pharmaceuticals as medical technologies, especially when they become mobile across countries, regulatory frameworks and value systems (cf. Dugdale 2000; Kruse 2016). Our book can be read as a study of pharmaceuticals at an intersection of political, economic and ethical dimensions (cf. Petryna and Kleinman 2006; Brody 2007). Approaching such a multi-scaled and complex nexus demands an analytical toolbox which is heterogeneous and broad, so we have mixed liberally from our disciplinary backgrounds to create an approach drawing from posthumanities studies, STS and medicine and management and organizational studies. This approach is influenced by the authors’ own boundary crossings into and within interdisciplinary fields: gender studies; STS and medicine; and social studies of accounting. We bring with us theoretical and methodological baggage from our respective fields, including a shared interest in the materialities of pharmaceuticalization. Methodologically, our research, like much of that we draw inspiration from, is qualitative, and relies on close readings of visual and written discourses. These discourses are taken from regulatory contexts (legal and court documents), professional debates (medical journals and testimonials from medical experts, court witnesses and committee members) and commercial material (advertisements for the drugs, often on ‘informational websites’ and other Internet forums, to circumvent the Swedish prohibition on direct-to-consumer (DTC) advertising of prescription pharmaceuticals). The different discourses are then analyzed to trace the glocal contours of Swedish Viagra and the Swedish Viagra man.

Despite our disciplinary promiscuity, or ‘theoretical eclecticism’ (cf. Williams et al. 2011a, 722), and the diversity of material we analyze, the overarching theoretical framework in all three sections of this book can be related to the concept of pharmaceuticalization (Abraham 2011; Williams et al. 2011a), from which we garner specific questions to query the shapes and forms that global pharmaceuticals assume as they are integrated into local discourses, and how the discourses and the pharmaceuticals change in the process. Pharmaceuticalization has many aspects. Abraham, for example, argues that it involves dimensions from biomedicinalism, medicalization, industry drug promotion, consumerism and the ideology or policy of the regulatory state (Abraham 2010, 606). Williams and colleagues (2011a) identify several more aspects, including the role of the media and the use of drugs outside of the medical domain. In this book, we specifically attend to three aspects of pharmaceuticalization that we think are particularly tangible and visible in the case of Swedish Viagra, yet also relevant to a discussion of glocal pharmaceuticalization. These are: the way pharmaceuticals change forms of governance; the redefinition of health problems as issues with a pharmaceutical solution; and the creation of new techno-social identities around drugs and the way
pharmaceuticals become essential actors in relationships between subjects. Our analysis of these aspects in Sweden shows how the local context is an important influence on the process of pharmaceuticalization.

The first aspect of pharmaceuticalization, which we will discuss in this book, is the way pharmaceuticals reshape forms of governance. In the global debate, examples of pharma-governance are often related to questions about emerging markets, equitable access, cost and patent protection, with political decisions at the nation state level contravening international decisions and regulations – and sometimes even forcing these regulations to change (see Biehl 2006). However, the presence and influence of international pharmaceuticals is also very tangible in governance decisions and policy responses in established and well-regulated nation states, like Sweden, that have a reputation for being obedient to international treaties and understandings. While our material does not provide examples of patent infringement and black or grey market infringement, it does show a nation state finding new ways of regulating and governing pharmaceutical access and subsidies, changing the role of medical doctors and regulatory decision makers at the point of clinical diagnosis.

Critical studies of pharmaceuticals also discuss the redefinition of health problems as issues with a pharmaceutical solution (see Healy 2004; Kassirer 2005; Moynihan and Cassels 2005; Law 2006; Moynihan and Mintzes 2010; Williams et al. 2009, 712). As Moynihan notes, this process involves, among other things, examples of how pharmaceutical advertising and regulation turn ordinary ailments into medical problems, present mild symptoms as serious, and treat inter-personal problems as medical (Moynihan and Cassels 2005). Our study of the medical discourses around Viagra show this happening very clearly in the Swedish context. Predictably, impotence became erectile dysfunction, and urology replaced relationship counselling and sex therapy as the site of treatment for erectile problems. Yet because of the ideological framework of the Swedish health care system, Viagra was also discursively connected to diabetes, multiple sclerosis and spinal injuries, which tints the identity of the drug and the Swedish Viagra man in the medical discourse.

The creation of new techno-social identities around drugs

In our analysis of the Swedish patient information pages on pharmaceutical webpages, men, doctors and the partners of men with erectile dysfunction are enrolled into a Viagra discourse which presents them with specific tasks and functions in the recognition of, need for and enabling of Viagra. As Chapters 6 and 7 describe, these roles are similar to patient, doctor and partner identities in North American Viagra advertising yet also tweaked to fit perceived Swedish values and norms. As the concept of pharmaceuticalization would predict, Viagra is positioned as a necessary component in these identities and, important, in the relationships between the subject positions that Viagra facilitates. But the shape and shades of these identities and relationships reflect very traditional understandings of the local culture, an interesting example of glocal identities.
Much of the work on global pharmaceuticals explores encounters between developing, non-Western/Northern countries and a commercial pharmaceutical industry. We see the value of this work, and laud its approach to questions of social justice, equitable access to health care and global commercial forces as they discover and create new markets (see Lakoff 2005). We draw theoretical lessons from these studies. For our work, the most useful studies of this global process examine local manifestations of pharmaceuticals with close, qualitative and ethnographically inspired approaches (i.e. Petryna and Kleinman 2006; Wailoo et al. 2010) For example, analysis of knowledge about, access to and use of antiretroviral therapies in Uganda articulates how social relations and distinctions are embedded in the social meanings of medicines, as well as how the medicines enable and articulate the doing of family relationships (Whyte et al. 2006, 260), articulations we see resonances of in our material on Viagra. Just as Applbaum (2006) shows in his study of antidepressants in the Japanese market, and with Lakoff’s work on antidepressant use in Argentina (Lakoff 2006, 133), our work shows how the market, medical profession and regulatory actors all struggle to define disease and patient groups, and to influence each other in the process. As Lakoff writes, ‘the mutual imbrication of science, regulation and business in the circulation of pharmaceuticals is best seen not as a contamination of pure science but rather as part of a distinctive and emergent regime for authorizing knowledge claims and expert action’ (Lakoff 2006, 111–12). We draw inspiration from this approach in our analysis of relationships enabled by pharmaceuticals, as well, and with an eye to our own culture, but we challenge the tendency in this body of research to see **global** as a euphemism for West versus the Rest (Löwy 2010; Stockel 2010; and Lindén 2013 are exceptions to this). We assert that it is also interesting and valuable to explore relationships between the local and the global in a developed, Western/Northern, non-US context.

**Pharmaceuticals in Sweden**

Medical care available in Sweden can be characterized as technically advanced, ‘scientifically grounded’, evidence-based medicine soundly positioned in the Western/Northern medical knowledge paradigm. This knowledge paradigm is based on the idea that universal medical facts about the body and health exist, and that these should not be dependent on cultural context. Medical facts should travel unhindered across geographical borders. It is this assumption that makes the global reach of pharmaceuticals (and other medical responses to health and illness) possible at the theoretical level. It is also this assumption that allows the global analysis of pharmaceuticals to assume that the West/North is one unit of analysis.

In our close reading of pharmaceuticals in Sweden, however, we problematize this assumption by showing the uniqueness of the Swedish case, and demonstrating that Western/Northern medicine is not a useful analytical category. Western/Northern is actually a trope that hides a great deal of diversity, even beyond the obvious difficulties of placing countries like Japan and Australia in this nominally...
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geographical category (see Abraham 2011, 727). The nation states that would fit into it are a heterogeneous group which responds to global pharma in unique ways. This is an important point to remember in social science and cultural studies work on the pharmaceutical industry and the medical practices it engenders.

Living in an oft-cited example of socialist medicine, Swedish citizens have access to state-subsidized and state-delivered medical care at very little out-of-pocket cost. Funded by the tax system, the Swedish health care structures are based on the idea that everyone should have equal access to the same high quality of care. This is a concept and a system which is firmly ideological and politically linked to the history of socialist rule in Sweden during most of the twentieth century (Shenkin 1973). While the Swedish health care system has not been immune to privatization and neo-liberal impulses during the past decades (see Johanson Krafve 2015), it still remains a system which attempts to provide close-to-free health care for close-to-everyone. This understanding of health care includes heavily subsidized pharmaceutical treatments.

Because the Swedish state subsidizes pharmaceutical costs for all drugs approved within the scheme with a very minimal individual co-pay, our study presents a context in which the individual’s theoretical ability to pay is of little interest. We argue that in Sweden, global pharma is confronted with a very regulated market populated by hyper-individualized patients who are also comfortable with a paternalistic welfare state that has long been responsible for giving them their drugs for almost free, as opposed to the privatized and decentralized health care systems in which states are losing (or have never really had) control of pharmaceutical use (see Petryna and Kleinman 2006). Individuals in Sweden are not familiar with the idea that they should pay for their pharmaceuticals at the point of purchase, but are concerned about the collective costs of pharmaceuticals to their tax bill, even as they demand access to treatment.

This setting problematizes discussions in the extant literature which centre on individuals’ willingness (and ability) to pay. The development of some pharmaceutical therapies (for erectile dysfunction, male pattern baldness or wrinkles, for example) and not others (malaria is a commonly cited one), and the growth of pharmaceutical treatments labelled lifestyle drugs, is testament to the underlying market mechanisms which encourage drug companies to target markets (conceived of as groups of individuals with similar medical and/or pharmaceutical needs) which are capable and willing to pay for their products. ‘As drug costs escalate and access becomes hyperindividualized, pharmaceuticals markets generate new social distinctions based on the individual’s ability to pay’ (Petryna and Kleinman 2006, 7). This common assertion is to some extent an oversimplification. Our book shows with specific empirical studies how this is a more complicated process of market subdivision and creation within well-regulated markets and distribution channels. Specifically, our work provides an example of what happens in pharmaceutical marketing and distribution practices when the tension between cost to the individual meets the Swedish solidarity principle and idea that health care is a general public good. We highlight the tensions in this concept of ‘hyperindividualized’ pharmaceutical consumption, teasing out how state
structures and local and temporal medical consensus can influence access to and use of brand name pharmaceuticals.

Two aspects of the Swedish case are particularly relevant to the glocal relationships of pharmaceuticals: 1) there is a ban on DTC advertising on prescription medicine (with the exception of vaccines), yet the industry seems to sidestep this ban with little reprimand; and 2) the state pays for the majority of the prescription costs for the population. The first has allowed us to analyze ‘Patient Information’ websites about erectile dysfunction and the localization elements they incorporate. The second has created a very interesting economic context within which doctors debate the use of pharmaceuticals in relation to other costs, the state takes interest in limiting pharmaceutical use, and the judicial system tests these decisions, at the same time as the state has developed industry regulations in close collaboration with commercial interests.

Abraham has pointed out that pharmaceuticalization is occurring even in countries which have a DTC advertising ban on prescription pharmaceuticals, suggesting that we need to look at shifts in regulatory ideology or policy to explain pharmaceuticalization, not just commercial forces (Abraham 2010, 606). While this is certainly true, we would assert that analysis of DTC advertising may also need to be expanded to the actual practices pharmaceutical companies employ, not only the legal frameworks they work within. Sweden has a ban on DTC advertising, like the rest of Europe, but there may be reason to suspect that this ban is only partially functional. The industry-supported information pages about diseases sometimes shamelessly propose the use of pharmaceutical solutions. At times, media reports about new drugs read like industry press releases. When Viagra arrived it was advertised on full-sized posters at bus stops in southern Sweden, despite the ban. And, as research has shown, in Sweden (as in the United Kingdom) there seems to be widespread disregard for the regulations restricting DTC advertisement, and little bite to the regulatory bodies which are supposed to police it (Zetterqvist and Mulinari 2013; Zetterqvist et al. 2015). Thus, in the European context, the legality of DTC advertising is not necessarily a sufficiently well-formulated research parameter.

Pharmaceuticalization and the interplay of pharmaceuticals and state regulatory bodies has a long tradition in Sweden, which began regulating approval and marketing of pharmaceuticals in 1934 (Abraham and Lewis 2000, 55), but its form, and that of regulatory systems in the West/North in general, has changed significantly over the past decades. The current state of today’s regulatory framework for pharmaceuticals, developed under neo-liberalism, shows how regulatory bodies have been refashioned to facilitate drug development, rather than protect the public, and in particular how these regulatory bodies are co-opted to serve the industry’s will rather than the public’s need (Brody 2007; Abraham and Ballinger 2012). In Sweden, this has seen the creation of the Medical Products Agency in 1990, which was funded entirely by industry fees and was supposed to accelerate drug approval times (Abraham and Ballinger 2012, 448). As Abraham and Ballinger note, the pattern of establishing a regulatory body to improve approval processes for industry also occurred in the United Kingdom and in Germany during
the 1980s and 1990s, which then influenced the EU supranational drug regulatory system with their neo-liberal approach (Abraham and Ballinger 2012, 449; Junker 2014).

Much academic critique of the regulatory system looks at the regulatory bodies that approve pharmaceuticals before they are made available to the public. The work we present in Part 1, however, particularly in Chapter 2, examines a less commonly discussed regulatory actor – the legal system and court decisions on the appropriate use and funding of drugs. Here the Swedish case is very different from that of the United States, as the state pays for prescription drugs and the use and cost of drugs are thereby regulated by a separate administrative body (the Dental and Pharmaceutical Benefits Agency, previously the Pharmaceutical Benefits Board), whose decisions can be appealed through the court system (see Sjögren 2006). This has traditionally not been a course of action (Abraham and Lewis 2000, 71), but the legal battles over subsidizing Viagra marked a change in the regulatory praxis.

Outline of this book

The Swedish case shows how a highly developed nation, which provides universal health care, including universal access to prescription medicine, responds to and shapes the pharmaceutical solutions that a global market presents through the health care system. The existence of a single, tax-based payer for pharmaceuticals can change the faces (in the STS spirit, we would argue this changes the very products themselves) of the pharmaceutical options available to the public. As the following chapters will show, a global blockbuster drug like Viagra becomes a different product in Sweden than Viagra in the United States, and the users of Viagra are glocalized, too.

This book is divided into three parts. In Part 1, we consider policy and bureaucratic responses to the introduction of new pharmaceuticals, in particular Viagra and the possibility of pharmacogenomics. The work here identifies certain arguments which appear to direct the response: solidarity; provision to those in need; how need is determined; and how the pharmaceutical technologies can actually assist or even replace medical doctors in the determination of need. Close reading of the debates surrounding these products shows how a system founded on the principles of solidarity and equal access to health care, including pharmaceuticals, can respond to the profit-driven industry which is providing these products to the state. Part 1 begs questions about how solidarity, citizen rights and biological rights are related, and how they are created in relationship with each other and with pharmaceuticals.

In Part 2, we analyze the medical discourses that surround the introduction of new pharmaceuticals. The first chapter looks at Viagra and how it has influenced the medical understandings of impotence and erectile dysfunction in Sweden. It shows how the presence of an international drug can have implications for medical terminology and the colloquial use of words to describe a social and medical problem, even in a small, linguistically bounded community like Sweden (with
approximately nine million speakers). Chapter 5 traces debates around the introduction of alpha-blockers for benign prostate hyperplasia to the Swedish health care market and the shift in treatment methods they implied for an already medicalized condition. Together, these chapters present local examples of how the pharmaceutical products redefine existing health problems as issues with pharmaceutical solutions and how their presence frames the medical community’s responses. Impotence shifts from being a condition treated with sex and couple’s therapy to a condition for which one takes a pill. Lower urinary tract symptoms for older men move from being treated with surgery to being treated with a medication. Interestingly, this shift is nearly complete in the Viagra case, but is, fifteen years later, still being contested in the case of alpha-blockers.

Part 3 articulates subject positions for pharmaceutical consumers which are created in commercial discourses in Sweden. Specifically, we examine the advertising, disguised as web-based disease informational pages, for Viagra. By thinking through our cases within a theoretical framework of pharmaceuticalization, we see that pharmaceuticals are creating new subject positions around the drugs. Chapter 6 examines the construction and enrolment of (consumer) subjects which are not directly consuming the pill. Here we see how the commercial Viagra discourse produces and enrolls the man’s partner and his doctor in the production of the Swedish Viagra man. This discourse also directs the relationships the man develops and maintains with his partner and his doctor, and tries to approach the partner and doctor to help them maintain Viagra-mediated relationships with the consuming Swedish Viagra man. Chapter 7 then discusses the creation of the Swedish Viagra man and the particular characteristics assigned to him. It presents an analysis of the culturally specific aspects of Swedish masculinity which Pfizer (or at least its marketing departments and agencies) deemed strong and stable enough to be associated with a product which addresses an image of failed masculinity.

Chapter 8 concludes this volume by returning to the multiplicity of aspects that the term pharmaceuticalization contains. Using the literary trope of the Swedish Viagra man, we discuss how the local and the global interact in the Swedish context.

**Glocal pharma**

The changes in governance practices to reflect pharmaceuticals’ presence, the redefinition of health problems as sites of pharmaceutical treatment and the creation of new techno-social identities around drugs are general aspects of pharmaceuticalization apparent in the Swedish case material we present in this book. However, they are also aspects of the local, specific to the Swedish context, which are important to analyze and integrate into a concept of pharmaceuticalization because they show nodes in the pharmaceutical network which are receptive to influence by local specificities. The results of these local influences are what we refer to as the ‘glocal of pharmaceuticalization’, the local specificities which appear in the discourses embedding global pharmaceutical products and practices.
in local markets. When local responses to global pharma are enacted in Sweden, the local pushes back.

Persistent traces of the local can be interpreted in a couple of different ways. One could see the process of pharmaceuticalization as an irresistible, all-consuming process, and these local specificities can point to weaknesses in the process. Our observations could be interpreted as aspects of pharmaceuticals where they are not quite strong enough to resist and redirect the local context to their will. Or, these nodes of difference could be seen as examples of where the pharmaceutical discourse is flexible enough to consume and adapt to the local context, where it shows its strength through a colonizing, but not neutralizing practice of meeting local cultures. As Williams and colleagues note, ‘there are important sources of resistance to the expansion of pharmaceutical markets from the media, government, medicine, patients and diverse publics thereby making de-pharmaceuticalization a possibility in principle, if infrequent in practice’ (Williams et al. 2011a, 722). Perhaps our examples of the glocal response to subsidizing Viagra in Sweden in Chapter 2 can indicate that this is more than mere optimism. Resistance is possible. But our analysis of the information sites for Viagra treatments and the medical discourse around Viagra and alpha-blockers in Sweden are harder to read as support for this optimism.

In drawing conclusions about the glocal of pharmaceuticalization, it is useful to ask how a drug’s presence has altered the concept of a disease and its treatment, who suffers from it, and how to cure it, in the local context and internationally. This book shows how drugs interact with stereotypical imaginaries of a patient, and include markers of class, race and sexuality. Drugs can influence laws and policies to regulate the practices of both doctors and patients. Yet it is not the chemical compound that prescribes behaviours or identities, it is the network of decision makers, commercial actors, medical experts and consumers who attach the drug to specific demands, images and expectations to influence the behaviours of groups they are trying to govern, cajole or cure. And because actors in different countries have different cultural starting points and are working within different institutional frameworks, how they use a pharmaceutical varies.

By looking at the pharmaceutical nexus and its actors, we can see that a global drug does more than fix the biomedical body’s problems. As the following chapters will show, the mere existence of a pharmaceutical product impacts medical knowledge and discourses, reinforces and even constructs cultural ideas and identities, changes the practices of experts and laypeople, and changes policy. But local circumstances also influence how drugs are presented and prescribed and what they are allowed to be. Together, the global and local aspects of the pharmaceutical nexus create glocal pharma.