

Introduction

In 2011 I returned home to the city of Cali, in southwestern Colombia, to begin ethnographic fieldwork on biomedical cancer care. When I arrived, I found myself in the middle of a series of popular uprisings, policy reforms, and legislative actions aimed at counteracting the inequities exacerbated by the 1993 neoliberal transformation of the national health care system. This new for-profit structure had dismantled the welfare state and created a market of insurance and health care providers. One of its main goals was to guarantee a model of universal medical care coverage, regardless of patients' socioeconomic status. Many of my interlocutors, however—especially at resource-scarce public hospitals—were frustrated with the failed promises of the 1993 reform and appalled by the destruction of the medical services it sought to guarantee in the first place.¹

Despite the atmosphere of unrest and enervation I encountered, these same interlocutors referred to the crisis as a unique opportunity for moving beyond the for-profit logic and toward social justice and health care equality. Their hope for structural transformation had been fueled in part by the Constitutional Court's declaration of health as a fundamental right in 2008, which would later unleash landmark legislation to further protect and regulate this right.² Harnessing the ripple effects of the court's declaration and its potential for guaranteeing health care to all Colombians, President Juan Manuel Santos (2010–18), a savvy establishment politician and member of a traditional family from Bogotá, sought to enact health policy changes aimed at reducing inequities and enforcing stricter financial vigilance of the health care market.³

Nearly thirty years after the neoliberalization of the health care system and numerous government efforts to amend its failures, the initial promise of universal



MAP 1. Colombia and surrounding regions. The city of Cali (1) and the Valle del Cauca department (2) are highlighted. Credit: Shadowxfox, https://commons.wikimedia.org/wiki/File:Colombia_Valle_del_Cauca_loc_map.svg.

health insurance enrollment has finally been achieved.⁴ In addition to such an important milestone, Colombia became one of the countries in the region with the lowest out-of-pocket medical expenses. My interlocutors' hope about the materialization of radical changes appeared to be unfolding, in a way.

"Health care for all," however, never translated into prompt and equitable access for all Colombians (Marmot 2013). When patients suffer from high-cost

conditions such as cancer, the time it takes to access standard oncology treatments (surgery, radiotherapy, and chemotherapy) is correlated to their socioeconomic status and the type of health insurance they qualify for. As a result, cancer may get transformed into a chronic, livable condition for some patients while life is merely promised to others.

During my ethnographic research in Cali, I was puzzled by the contrasting biomedical practices, which led me to one of the questions that inform this book: How do socioeconomic status and health insurance enrollment shape oncological practice, and what are its consequences? Practicing medicine, after all—like any other scientific endeavor—involves different tools, processes, and participants and their articulation across spaces (Mol 2002). Hence I began paying attention to cancer treatments as they were being practiced across hospitals, health insurance offices, and patients' homes. One of the implications of this approach, echoing Isabelle Stengers's *Ecology of Practices* (2005b), is that no practice can be understood apart from its surroundings.⁵ Only by locating a practice within its milieu—studying how it arises from and is embroiled in its circumstances⁶—can we be positioned to understand it (Marenko 2021).

Coinciding with Stengers's work but going beyond it, my ethnography studies the borders of practices where a series of divergent interests *intersect*. My emphasis on *intersections* allows me to point at articulations between practices, which have a common interest like curing or treating cancer but which must juggle other interests as requisites—for instance, the health insurance sector's financial vigilance and the hospital's need to sell more services. *Cancer Intersections*, therefore, is an attempt to study health insurance and biomedical practices and their entanglements with a disease of voracious growth in a market of unlimited growth. It discusses the complex, multiple, conflicted, and even paradoxical efforts to treat cancer in the aftermath of the 1993 neoliberal transformation.

My first few months of fieldwork in Cali transpired at Fundación Valle del Lili, a private nonprofit hospital that was built in the 1990s. Funded by some of the most traditional families and businesses in the region, Valle del Lili's core mission is to provide high-complexity medical services to all individuals living in Cali (and the rest of Valle del Cauca department), who until that time had to travel to other parts of the country to receive specialized medical treatments. Soon after opening the doors of its main facility in south Cali, this hospital became one of the top third-level medical settings in the country and in Latin America.⁷ Over the years it has continued to grow and expand into less affluent neighborhoods beyond its original location nestled among high-end malls, country clubs, and elite university campuses.⁸ Recently, Valle del Lili announced that its oncology department was ranked first in the nation in terms of its state-of-the-art technology, internationally renowned medical practitioners, treatment outcomes, and active research agenda.

Crucially, while both public and private hospitals are encouraged to sign contractual agreements with all health insurance companies in the market, not all



FIGURE 1. One of the entrances to Valle del Lili hospital. Courtesy of Maria Cristina Piñeros.

insurance companies are created equal. The neoliberal transformation of 1993 created a “portfolio” of insurers that cater to different kinds of patients and their differing socioeconomic status. The result is that the timing of patients’ access to medical services comes down to their insurance and how competitive their insurance companies are in the health care market, their financial liquidity, the number of enrollees (potential hospital clients), and their proven record of timely payments to medical providers.

Before long I was granted access to a public hospital, Hospital Universitario del Valle (HUV), the Universidad del Valle’s flagship hospital. HUV was funded in 1936. It is one of the few third-level medical institutions in Colombia’s southwest.⁹ Its patients, who are typically enrolled in health insurance for the poor or the unemployed, have typically sought specialized medical interventions such as oncological treatments. Despite its long history and crucial importance for the health of millions of Colombians, it was on the verge of bankruptcy during my fieldwork. This is a common pattern among public hospitals in the country that were transformed into self-reliant businesses (Abadía-Barrero 2022).



FIGURE 2. Main entrance to Hospital Universitario del Valle. Credit: Remux, <https://commons.wikimedia.org/w/index.php?curid=28472191>.

Because my first encounters with cancer treatment in Colombia had taken place at Valle del Lili, with its cutting-edge oncology services and integral palliative care approach, when I arrived at HUV I was struck by the ordinariness of untreated pain and the ubiquity of metastatic cancers among patients. The contrasts in medico-insurance practices and cancer prognoses across these hospitals were puzzling and would become the prime motivators for writing this book. By moving across these worlds of medicine, I explore how social class determines timely access to oncology treatments (often high-cost) and how even in resource-rich settings patients suffer as a result of market imperatives that shape how cancer treatments ordinarily unfold.

A clarification: Even though public and private hospitals in the country must provide care for all Colombians, regardless of their ability to pay, not all hospitals are willing to sign contractual agreements with every health insurance company in the market, especially those that have defaulted on payments or are on the verge of bankruptcy (usually companies that offer insurance to the poor or unemployed population). In the end, the risk associated with partnering with these insurance companies is typically taken on by public hospitals, most of which, like HUV, have pressing financial needs too. Hence the common

interest in treating or curing cancer must first satisfy hospitals' corporate financial requirement to increase sale of medical services, health insurance companies' need to limit treatment, and physicians' ethics concerning curing or slowing the pace of cancers.

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At HUV I met one of my closest interlocutors, whom I call Dr. Masa. He is a senior oncologist. A former university professor, he is skillful at translating medical knowledge for nonexperts like me, a cultural anthropologist without medical training. Anticipating my bewilderment during my first visit to HUV's oncology wards, Dr. Masa said nonchalantly, "Young man, cancer care in Colombia is complicated. Poor patients have the right to access medical services, but at the same time they don't. Es como tener madre—pero muerta. ¿Si me hago entender? [It is like having a mother—but dead. Am I making sense?]."

"Tener madre, pero muerta" (to have a mother—but dead) is a popular expression in Colombian Spanish used to describe the coexistence of seemingly incompatible states of being—a possible impossibility (Derrida 2007). How can someone—like a mother—*be* and *not be* at the same time? This phrase describes something that does exist, at least nominally, but because it is dysfunctional, it has been interrupted or allowed to die. Dr. Masa used this phrase to illustrate the systematic obstacles to accessing cancer treatments in a country where health care is universal and a fundamental right but also a commodity "understood as an individual responsibility to be purchased in a 'regulated' insurance market" (Abadía-Barrero 2022, 103).

I took seriously Dr. Masa's popular sayings. His explanations informed my thinking and shaped my discussion on biomedical cancer care and its paradoxes. But his social skills and rapport with patients were far more pivotal. Throughout my time at HUV, Dr. Masa introduced me to many of his patients and their family members, with whom I built long-lasting relationships. Thanks to him, patients felt comfortable with my presence and were willing to invite me into their lives. Building on my encounter with one of them, below I flesh out Dr. Masa's words and discuss how the policies designed to fight inequities are, in fact, exacerbating them.

Jairo has stage IV prostate cancer with metastasis to his liver,¹⁰ which means that his disease has moved beyond its original location and become incurable. For several months, Dr. Masa sought to treat his cancer with a series of radiotherapy and cisplatin-based chemotherapy protocols to slow the growth of his tumors, to no avail.¹¹ Jairo spent nearly two months waiting for insurance approvals and additional time trying to schedule appointments at HUV for his intravenous (IV) infusions.

After several attempts to get in touch with someone at the oncology wards, a nurse finally picked up the phone and confirmed that his chemotherapy infusion had been scheduled the following morning. Yet Jairo was frustrated and protested, "¡Ya para que!" (roughly translated as "Now for what!"). Because his tumors kept

growing as a result of systematic delays in the provision of prescribed chemotherapy, his chances for living longer with the disease were dramatically reduced.

“So, you know, I am waking up every morning with extreme fatigue and swollen legs,” he explained. “But the pain, this pain [points to his groin] is unbearable. And it gets worse when I get out of bed, roll up my catheter, and walk to the toilet. That’s when things go out of control. [Long pause.] That’s when I wonder whether my current situation would have been different had I gotten all my treatments on time.”

With a mix of irony and mild irritation, he mumbled, “I told the nurse *gracias por nada señorita* [thank you for nothing, miss], that I sincerely appreciated the time she had taken to notify me ahead of time.” He grabbed my arm and pulled me forward. Jairo wanted to make sure he was getting my undivided attention. Looking directly into my eyes, he went on to say, “Can you believe it? I was notified about my appointment just the day before I am supposed to show up at the hospital. Had I not dialed the phone like a madman, I would never have come to know about my appointment.”

Jairo went silent for a few seconds before continuing his account.

“So, I couldn’t help it and hung up the phone. What else was I supposed to do?” he mumbled with frustration. “A number of times I have woken up early in the morning and taken buses to the infusion room just to be sent back home because the hospital union is picketing. Can you believe it? So, in addition to my cancer, the slow queues, the waiting, and the paperwork, now it turns out we must also check in advance the union’s protest schedules and plan accordingly.”

To help him get his chemotherapy infusion on time, I had a rather simple plan.¹² I would take a taxi at dawn, pick him up at his home in the Ciudad Córdoba neighborhood,¹³ and head to HUV’s oncology wards. A taxi would save him time, and Jairo would be more comfortable in a car than in a packed bus that follows no set schedule. To play it safe, I had already checked with health care practitioners and ruled out any possible protest that day.

Although he was visibly fatigued, dealing with untreated pain and swollen legs, and frustrated by the last-minute notice about his appointment, he was willing to do whatever it took to access the medical services he was prescribed. Jairo mused in a combative tone: “I might have an advanced cancer, but it does not mean I will just sit down and cross my arms. I will get them [treatments], you will see. Slowly but surely [*lento pero seguro*] I will keep fighting; slowly but surely I will get all the medical services I am entitled to.” Jairo was not planning to let go, regardless of the burdensome health insurance obstacles and disease prognosis. His contentious words took me by surprise after learning that his metastatic cancer had turned more aggressive over the past few weeks—and will ultimately be the cause of his death.¹⁴

The following morning, he sat in the taxi’s backseat by himself. Hoping to ease his pain, he leaned against a door and fully extended his swollen legs on the seat. On our way to the hospital, he shared stories about his unshakable resolve to keep hopping on buses and trying to arrive on time for his chemo appointments. As someone who

has—luckily—never been a cancer patient, I can hardly imagine how he manages to endure long bus rides while dealing with a metastatic disease and spend hours in waiting rooms just to be sent back home after learning that health care practitioners are picketing to demand the immediate payment of their salaries.

Halfway to HUV we hit heavy traffic. The early morning momentum had been replaced by a soporific state—at least for me. I began nodding in the passenger seat, but when I suddenly looked through the rearview mirror I saw Jairo crouching on the backseat. His pain had returned with a vengeance, and I wasn't sure how to help him. I asked the taxi driver to speed up and find an alternative route to HUV or drop us off at a different hospital. But we were stuck in traffic and would remain at the same intersection for nearly half an hour. When the taxi finally dropped us off at HUV's main entrance, I rushed inside the building in search of a wheelchair for Jairo, but there were none available in the designated area—just a pile of scrap furniture and a metallic bin overflowing with trash. As is often the case for so many public hospitals in Colombia, HUV was going through one of its worst financial crises. At the time of my research its aging infrastructure was overdue for critical renovations, its machines were often broken, and stretchers and wheelchairs were nowhere to be found.

Jairo and I arrived an hour late at the oncology wards. I announced him at the front desk and requested a painkiller to ease the pain. A nurse handed me the usual hospital paperwork and asked that Jairo sign it and wait. "Because his appointment time has passed, I can't guarantee he will get seen today. But you are welcome to stick around and see whether a spot becomes available for him," she mused.

Her words left us wondering if we would be stuck in the waiting room until late afternoon, just to be asked to come back at a later date. Hoping to get a better idea about our odds, I stepped closer to the front desk and asked with slight trepidation, "I am sorry, but when will that be?" Visibly irritated, the nurse looked at me and said, "Look, sir, *se hace lo que se puede* [we do what we can]. Can't you see the high volume of patients we have today? Besides, you guys are late. Please have a seat."

Indeed. There was not much Jairo or I could do at this moment, except, perhaps, get a drug to ease his pain.

"What about his pain?" I gently insisted, hoping she had not forgotten my plea.

"Yes, yes, whenever he gets called," the nurse said while nodding toward the chemotherapy infusion room.

Given the prospect of a long day at HUV, Jairo would need to get as comfortable as possible. Each passing minute had the potential to make his symptoms unbearable. Jairo's immediate priority was to raise his swollen legs and keep them up for as long as possible. The challenge, however, was finding a spot to lie down in a packed waiting room.

I walked around the facility and managed to gather a few vacant chairs. Jairo dragged them against a wall—in a straight line. He laid down and tried several

positions. He slightly bent his back to the sides, placed padded support under his head, and flexed his legs to relieve his back pain. In the meantime, I paid a quick visit to the hospital pharmacy. Hoping to find a strong pain medication, I instead settled on a box of ibuprofen. Getting stronger (and government-controlled) pain medications like hydromorphone, an opioid, requires providing pharmacists with an official prescription—which Jairo had lost.

Jairo's frustrating attempts at getting his chemotherapy infusions were in part shaped by the neoliberal Ley 100. This is the law that transformed the model of health care delivery in 1993 from social insurance and publicly financed health care institutions to regulated competition in the administration of universal health insurance. According to the new law, people were required to establish contracts with health insurance companies known as EPSs (*empresas promotoras de salud*, or health promotion companies). These EPSs are the public, private, or mixed for-profit entities that play a role as intermediaries between the government,¹⁵ health care providers, and patients.

This model of universal health insurance is based on financial solidarity between rich and poor populations—whereby the wealthy spend more than the low-income populations.¹⁶ As I explain elsewhere (Sanz 2017), it is structured on two regimens of EPS enrollment: a contributive regime (CR) for individuals whose incomes are twice the minimum wage and a subsidized regime (SR) that covers low-income and unemployed Colombians with funds transferred from the CR and the government.¹⁷ Ley 100 also created a market for private prepaid insurance, known as *medicina prepagada*, which provides coverage for the highest socioeconomic strata beyond that offered by EPSs.¹⁸ This expansion of coverage was revolutionary in and of itself and transformed Colombia into one of the countries with the lowest out-of-pocket expenses in the (so-called) developing world (Castaño 2023).

This insurance stratification model, however, came to be superimposed on the preexisting class divisions that have plagued Colombia since colonial times and that have transformed the country into one of the most unequal in the region. As a result, this health insurance model shapes the type of medical services patients get and dictates the timing for accessing treatments, especially among those individuals considered “high-cost.” In a market where insurers and providers compete for clients, only those who offer the “best” business potential get to sign contractual agreements with highly coveted providers, like Valle del Lili. For insurance companies, the potential for growth revolves around being able to offer hospitals the highest (more competitive) rates in exchange for the medical services they provide to their enrollees and to guarantee timely payments. For hospitals, it means offering medical services with the highest quality at the lowest rates compared to their direct competitors. The result is highly unequal access to high-cost medical services in a health care system in which the common goal is to treat or cure cancer but which must pursue financial interests as requisites.

Unlike other countries in the region, in Colombia the issue is not so much the lack of resources or the improvisation of medical practices but the waiting required to access treatments that all citizens are entitled to by law.¹⁹ Here I build on Javier Auyero's now-classic work in Argentina, *Patients of the State* (2012), which responds to Pierre Bourdieu's (2000) call for analyzing the waiting experiences of poor people. As a biopolitical technique through which bodies are governed (Foucault 2008), Bourdieu explained, waiting is a way of "turning down" without "turning off," of keeping patients motivated without driving them to despair.²⁰ As such, deferring, delaying, and raising false hopes are practices through which low-income individuals are transformed into responsible and disciplined citizens. In Auyero's ethnography of a social service office in Buenos Aires, he describes how low-income populations must patiently comply with seemingly arbitrary and confusing state requirements to access welfare services. He shows how waiting is stratified. Waiting time is inversely correlated with individuals' socioeconomic status.

Equivalent to the experience of poor individuals in Buenos Aires, the amount of waiting endured by cancer patients in Colombia is correlated with their socioeconomic conditions and health insurance regimes.²¹ Crucially, waiting or wasting time, I argue, is not only a biopolitical technique (Foucault 2008), but a practice required to negotiate the health care system's burdensome bureaucracy and financial costs (Abadía and Oviedo 2009; Hull 2012).

Spanning a total of seven years of ethnographic fieldwork in Cali, with the most intensive stretch in 2011–13, *Cancer Intersections* discusses how the market decides whose cancers are worth transforming into chronic conditions and whose bodies are *already dead*. The literary theorist Eric Cazdyn (2012, 163), who coined the term "already dead," describes it as a "state when one has been killed but has yet to die, or when one has died but has yet to be killed." In the context of Colombian cancer care, the *already dead* refers to the killing of high-cost/low-income patients who may not die immediately. In this double future, a conditional past does not exist. *El hubiera no existe* (*Hadn't does not exist*) simply because individuals' future with a deadly cancer has already unfolded into their present.

In the case of Jairo, there is little he could have done differently in the past—getting screened, for instance—to increase the likelihood of being cured or living longer with the disease. After all, primary health care is fragmented in Colombia, and barriers to medical services persist, especially in rural and remote areas (OECD 2015). In addition, these medical services have revolved around temporary fixes that fail to account for the role played by structural determinants of health (Mull 1990; Basilico et al. 2013; Abadía-Barrero and Bugbee 2019). And there is not much poor patients can do in the present, like accessing traditional cancer treatment modalities to cure or slow the pace of growing tumors. Even when low-income patients get access to their anti-cancer treatments, it is often too late; their

diseases are too advanced, often metastatic.²² “¡Ya para que!” Jairo had grudgingly told the nurse. “¡Ya para que!” if his cancer would not respond to the cisplatin regime originally prescribed by Dr. Masa.

My ethnography highlights two major reasons that cancer treatments often produce more exhaustion and pain for Colombians. The first is the delays by health insurance companies to maximize their profit (see chapter 1). The second is the tendency of biomedical practice (especially under capitalism) to encourage aggressive, early, and costly interventions to treat cancer (even when the diagnosis is unclear; see chapter 3) and extend life (see chapter 5). As the anthropologist Amy Cooper urged me to bear in mind,²³ this latter dynamic is not only a product of neoliberalism or even capitalism; it is a feature of high-tech biomedicine itself, which happens to meld quite well with market-based logics. People with financial resources are only facing the latter dynamic, while low-income individuals face the former dynamic and to some extent also experience the latter dynamic when they can freely access biomedicine via writs known in Spanish as *tutelas*.²⁴ Paradoxically, as shown in chapters 2 and 4, the *tutela* has played a role in reproducing the same inequalities it was created to counteract. Hence my decision to end this book with a reflection on palliative care and euthanasia (assisted-dying) as emancipatory possibilities. These two medical practices have the potential for developing new relationships with decay and death, as well as for counteracting the tensions between a disease of uncontrolled growth and an economy of unlimited growth.

JUSTICE BEYOND CURE

The situation of many patients at HUV was dire and desperate. But there was something else that struck me. Despite patients’ frustrating encounters with the medico-insurance bureaucracy—their uncontrolled symptoms and metastatic cancers—most of them were usually hopeful and confident about the medical services they were entitled to by law. In Bourdieu’s terms, they had been turned down but not turned off.

Unlike countries where citizens still passively accept the impossibility of accessing high-cost treatments,²⁵ in Colombia the Constitutional Court elevated health to a fundamental right in 2008, whereas before it was just considered a service.²⁶ Through this proclamation, the court ordered the government to address the many structural malfunctions that were preventing patients from accessing the medical services they needed. In 2015, *Ley Estatutaria en Salud* (LES) was promulgated; it established the mechanisms for the protection of the right to health and sought to improve the quality of and access to medical services (Ramirez et al. 2016).

Despite the profound implications unleashed by this landmark legislation, health insurance companies continue to delay access to medical services for low-income patients, especially those who suffer from high-cost diseases such as cancer.

Ironically, it is often when the patient's cancer has metastasized that the state intervenes to "save" the patient's life through tutelas, writs created in 1991 to impart neoliberal justice and protect fundamental rights of all Colombians, such as health and life (Ambito Jurídico 2012; Abadía-Barrero 2015b; Arrieta-Gómez 2018).²⁷ While filing tutelas has become routine for many patients, these writs are not exclusive to Colombia. Their increasingly central role indicates the widespread problems in the functioning of health care systems in many other places in the Global South (Biehl et al. 2012; Biehl and Petryna 2013; Graham 2016; Tichenor 2017; Abadía-Barrero and Bugbee 2019; Iriart and Gibbon 2023).

Over the years, tutelas have inundated the Colombian judicial system because they are easy to file and judges tend to approve them in record time (within ten business days). In 2019, for instance, every thirty-four seconds a patient petitioned the judiciary to issue a writ affirming their right to health care (Defensoría del Pueblo 2019). Most of these tutelas point at EPSs as the main target of complaints (Abadía-Barrero 2015b, 2022), largely because they tend to defer access to care, even medical services included in the national formulary, the Plan Obligatorio de Salud (POS) (Defensoría del Pueblo 2013, 2018).²⁸

Crucially, patients like Jairo are keenly aware of their rights and how to protect them via tutelas (see Gaviria 2020).²⁹ "Los entutelo a todos [I will sue them all]," my friend protested while raising his left arm and making a fist with his hand. Jairo was willing to keep going back and forth to his health insurance office, HUV, and pharmacies. "I might be a poor patient, but I am not *pendejo* [a fool]. The government will have to *poner plata* [chip in], especially now that my cancer is incurable," he said, while rubbing his index finger and thumb together—a gesture that represents money in Colombia and elsewhere. "I would rather be dead than a fool," Jairo concluded. As an *already dead*, Jairo has learned to hold on to the possibility of making the government pay, even if that payment will not cure him (and may not provide quality of life either).

Jurisprudence in Colombia has sought to guarantee access to medical services *but not only*.³⁰ Patients like Jairo often conclude that letting their bodies deteriorate beyond the point of cure may actually provide an edge. Doing so, they reason, could help them prove before a judge that their fundamental rights, such as health and life, have been violated. Under these conditions, the tutela would allow patients to fully engage with the system from the perspective of having a life already lost (Cazdyn 2012). These individuals are caught between the promise of health care and its simultaneous impossibility, that is, knowing one is a subject of fundamental rights that are often protected when they have been violated.

As a result, when patients decide to "waste time" on their quest to access medical services, their decision may not respond to their desire to get cured but rather to the possibility of becoming visible before the state and have it "pay" for the treatments they have missed—regardless of prognoses and outcomes.³¹ *Cancer Intersections* discusses how universal health care is intimately connected to the

delay in the provision of cancer treatments and the reproduction of historical inequalities. The promise of universal health care, after all, as the Indian public health expert Imrana Qadeer (2013, 149) argues, has the potential to become the “Trojan horse of neoliberal strategies.” In neoliberal Colombia, therefore, *tutelas* may set perverse financial incentives that encourage patients to wait and deteriorate while EPSs continue delaying the provision of “high-cost” treatments and maximizing their own profit.

NEOLIBERALISM AND ITS PARADOXES

In Latin America, neoliberalism has been typically understood as a set of economic practices—known as structural adjustment policies—that were imposed from above by international financial institutions, corporations, and governments. From privatization and financial deregulation to reductions in social protections, the continent has been experiencing the effects unleashed by these neoliberal reforms implemented during the 1980s and 1990s (see Martínez 2018). From that point forward, an expanding collection of scholarly works has sought to analyze how these policies propelled from above were unsustainable and unable to fulfill the assured promises (Harvey 2005; Homedes and Ugalde 2005b; Hartmann 2016).

Echoing social scientists who have studied neoliberal practices in Latin America (Han 2012; Gago 2017; Abadía-Barrero 2022), this book does not seek to portray neoliberalism as a historical moment or set of homogeneous arrangements among markets and the state or as the newest iteration of *laissez-faire* capitalism (see Povinelli 2012). As a category of analysis, the value of neoliberalism is often limited, hence the importance of not rushing to conclude that certain policies and practices may be labeled neoliberal (Mains 2012). Its value, after all, “depends on its landings and connections with concrete situations” (Gago 2017, 160).

In Ethiopia, for instance, instead of echoing what other scholars have described as the thinning of the neoliberal state (Harvey 2005; Ferguson 2006), Dan Mains (2012, 5) has observed the “state reemerging and playing a central role in generating linear development.” In that country the privatization of infrastructural development does not fit easily with this common conception of neoliberalism. People in Ethiopia, Mains notes, have often assumed that the state has “the power to create jobs, transform the city, and improve life” (5).

Veronica Gago’s (2017) work in Argentina has described how neoliberalism gets restructured into a new dynamic that overflows its classical definitions. In her ethnography of La Salada market in Buenos Aires, Gago refers to neoliberalism as a set of practices characterized by a new type of rationality that can hardly come exclusively “from above.” Gago’s thesis is that “neoliberalism survives as a set of practices that are manifested from above, as a renewal of the dispossessive form and, from below, as a rationality that negotiates profits in this context of dispossession” (5).³² By neoliberalism “from below,” she is referring to a set of conditions

that are materialized beyond the will of the government. The encounter between neoliberal dynamics from above and from below gets simultaneously negotiated, Gago further explains.

Informed by these ethnographic findings, *Cancer Intersections* pays attention to the landings of neoliberalism in the context of biomedical cancer care in Colombia and explores its paradoxes. Neoliberalism's nature, I suggest, is precisely defined by an articulation of apparently irreconcilable differences in such a way that it no longer requires to rectify what had contradicted it.³³ This book discusses how neoliberalism does not emerge from dichotomic relations between independent parts—above and below, state and market—but through a mutual becoming.³⁴ Following Deleuze and Guattari's (1987) famous account of the wasp and the orchid, elements that are seemingly different need each other because without the other neither would be able to achieve its goals. For instance, to grow and become self-propelled entities, malignant cells must build on regular cellular biochemistry and mimic their behavior to avoid being detected by our immune system; to protect the right to health, low-income patients must first endure its violation; to create profit, insurance businesses rely on the state's disbursements of funds, a form of subsidized growth.³⁵ Practices that were intended to stay separate may actually come together. When studied at their borders, where they intersect and diverge (Stengers 2005b), these practices are often described as paradoxical.

The word *paradox* refers to a self-contradictory statement or a statement that goes against one's expectation. *Para-* means "alongside," "beyond," and "contrary to." *Paramilitary* groups, for instance—like the ones that blossomed in Colombia during the 1990s and early 2000s³⁶—are groups of soldiers (assassins) that resemble and often fight *alongside* the official military forces of the state (Valencia 2007). They are the same but different; their actions seem to emerge from outside the state, but they do not. In the field of oncology, physicians are familiar with *paragangliomas*, a type of neuroendocrine tumor that forms *near* certain blood vessels and nerves outside of the adrenal glands; in the literary world, *paraphrasing* means to reword something written or spoken in such a way that the new wording is still close to the original's meaning. From military organizations to physiological structures and ways of communicating, things and practices unfold alongside their seeming opposites.

Doxa or *doxon*, on the other hand, comes from the Greek word *dokein*, meaning "popular opinion," "belief," or "to seem." In his *Outline of a Theory of Practice* (1977), Bourdieu used the term *doxa* to highlight a society's taken-for-granted, unquestioned truths. It encompasses what belongs to the domain of the possible, that which "goes without saying because it comes without saying" (167).

Together, *para* + *doxa* make up a word that refers to something that goes alongside or against taken-for-granted truths or claims. As such, a *paradox* is a statement containing seemingly opposite ideas that make it seem impossible or unlikely, although it is probably true.³⁷ It allows for impossible simultaneity or,

as Dr. Masa would have it, “to have a mother—but dead.”³⁸ That is, medical and insurance practices may seem to buttress the right to health and universal access to health care services while at the same time render these unpalatable. While Ley 100, for instance, guarantees access to medical services, it kills “low-income/high-cost” cancer patients in the process—even though it is presented as their salvation.

By tracing the paradoxical relations through which actors and their practices come to be intertwined, *Cancer Intersections* sets out to provide an analysis of bio-medical cancer in the aftermath of the 1993 neoliberal reform. The chapters in this book analyze what happens on the ground when a disease of *self-devouring growth* meets an economy of unlimited growth (Livingston 2019).³⁹

A PATHOLOGY OF EXCESS

“Cancer” is an umbrella term for thousands of diseases that have in common uncontrolled cellular growth and excess (Livingston 2012). It is not a foreign invader—a virus or a bacteria—or a dysfunction of our organs.⁴⁰ The life of this disease has been described by the oncologist Siddhartha Mukherjee (2012) as a recapitulation of the life of the body, that is, a mirror of our own life. Following this author, cancer starts when our cells undergo mutations and lose “key safeguards” that usually keep their growth in check. As a result, this disease acquires the potential for transforming tissues into its source of nutrients—hence its self-devouring growth (Livingston 2019). Over time, cellular descendants keep acquiring new mutations. While some of these may not have immediate biochemical implications, others will render cells far more efficient at multiplying and tricking the immune system.

Killing a cancerous cell in isolation is a rather easy task. Nearly any chemical poison can get rid of malignant cells almost immediately, paraphrasing Mukherjee (2012). However, when these cells grow inside living bodies, killing them may have devastating collateral effects for patients, especially when they have spread beyond their initial location and into other organs or tissues.

In her ethnography of an oncology ward in Botswana, Livingston (2012) describes cancer as a disease of “temporal urgency.” The sooner these versions of ourselves are excised by surgery or killed by chemotherapy and/or radiotherapy, according to standard medical knowledge, the better the chances we have for getting cured or living longer. Precancerous lesions should ideally be identified before they become malignant or diagnosed at stage I when the disease is still self-contained, or *in situ*.⁴¹ Following this logic for acting quickly and early, then, it would make sense to periodically assess our risk levels for developing certain forms of cancer—in terms of environmental, genetic, or lifestyle factors—and undergo screenings and checkups (see Dumit 2012).

Therefore, it is understandable that cancer patients and their treating physicians would often make the choice of pursuing aggressive treatments to play it safe, even if the benefits are unclear. Yet cancer is an unpredictable disease. Just as there

are highly aggressive and lethal malignancies that take root in vital organs such as the pancreas, there are other indolent incarnations commonly associated with the prostate or breast that may take years or decades to turn into a life-threatening condition. Despite the crucial advances in our understanding of this disease, physicians are debating how to better define cancer (Esserman and Eggen 2023), especially some of its early manifestations that may never grow and metastasize.

My ethnographic observations were largely focused on IV chemotherapy, an umbrella term for a wide variety of medications that include cytotoxic (cell-killing) agents—known to be occupationally hazardous.⁴² Elsewhere I have discussed that its effects are most powerful—and less toxic—when taken during fleeting *windows of opportunity* (Sanz 2017). In each of these windows, cells undergo specific morphological and biochemical transformations that make them vulnerable to certain chemicals, dosage quantities, and frequencies of administration. No two treatments in the life of cancer can be equally matched to the same chemotherapy regime—just as the same shoe size won't fit the rapidly growing toddler's feet for too long. Thus physicians often must conduct screenings and run tests on patients to recalibrate chemo protocols and/or dosages. In other words, there needs to be a permanent reassessment of tumors to get an edge on their growth and mutations (see chapter 1).

For low-income patients in Colombia who receive care at resource-scarce hospitals like HUV, however, this periodic reassessment of tumor's biochemical behavior was a rare event. During my longest stretch of fieldwork, nearly 70 percent of patients in Colombia who were diagnosed with this disease had metastases of some sort (Ministerio de Salud y Protección Social 2012). Other anthropologists working in the Global South have demonstrated that cancer is usually hosted in bodies that cannot keep up with its uncontrolled growth (Livingston 2012; Martínez 2018; Banerjee 2020). The entanglement of class inequities and fragmented primary care makes it difficult for patients like Jairo to get screenings and checkups that may catch cancers in their early stages, increasing chances of getting cured or living longer. Under these conditions, exacerbated by ensuing exhaustion and chronic stress,⁴³ even indolent cancers may become death sentences.

TOGETHER BUT NOT JUMBLED (JUNTOS PERO NO REVUELTOS)

This book discusses how cancer is rendered visible and (un)treatable at intersections of health care that emerge alongside each other—sometimes inside the same hospital or in the same neighborhood. Even though patients who inhabit these intersections may often run into each other at the same medical consultations and waiting rooms, their accounts of health care experiences are often difficult to reconcile.

To illustrate the ordinariness of these differences, let me introduce Felix, an Astra-Zeneca pharmaceutical representative who has been visiting the oncology wards at HUV for more than six years. He spends most of his time following doctors, swinging by their offices, and reminding them about Astra-Zeneca's oncology products. The high volume of cancer patients at HUV makes this hospital a high priority for him. Its location too is strategic in terms of his sales goals; HUV is walking distance from Imbanaco hospital, a top-notch private institution that often represents a coveted high-end market for the pharma industry. Felix can easily walk back and forth between these two medical settings. During a regular week, he often meets physicians for lunch at Imbanaco and later grabs coffee at HUV.

When I was telling Felix about my research on health care inequities and the role played by EPSs, he immediately felt compelled to correct my approach.

"You need to be careful," Felix said. "Don't focus on the negative things." Immediately, he went on to clarify his words, sort of: "What I am saying is that you need to avoid reaching the simplistic conclusion that cancer patients die because EPSs delay their access to treatments in order to increase their profits. That is not necessarily true. Not all EPSs are that evil. Some of them have been providing excellent service to their patients for a number of years. In fact, EPSs allow the health care system to be sustainable; they oversee expenses in health care and manage budget constraints. In so doing, these businesses guarantee that public funds are not misused. Otherwise, anyone could end up getting sumptuous treatments or aesthetic procedures."

Throughout my fieldwork, while observing in hospitals or following patients at EPSs, I would recall Felix's words. His advice made me more aware of how my own assumptions and beliefs shape the analysis presented in this book. Taking his words seriously, I have tried to avoid pointing at EPSs as the poster child of the health care crisis.⁴⁴ There are, in fact, a variety of medico-insurance practices and conflicting interests that shape how high-cost diseases are treated (or not) in Colombia. My intention is not to present an exposé of the inner workings of health insurance. In any given system—following the Colombian health policy expert Ramon Castaño (2023)—whoever assumes the role of payer or financial overseer will often be seen as mainly responsible for violating the right to health. While it may be the case that a small number of EPSs obtain profit via what he calls virtuous actions,⁴⁵ most patients at HUV were enrolled in health insurance that systematically engaged in "perverse actions," that is, practices that seek to fulfill their short-term contractual obligations by denying or deferring patients' access to medical services—even covered care—which end up pushing these institutions into a never-ending cycle of financial crisis (Abadía-Barrero 2022).

Felix puffed his cheeks and quickly loosened his tie knot.

“*Pelao* [Kid], please pay attention to what I am going to say. In Colombia it is possible—even for the poorest of the poorest—to live longer and get treated for diseases like cancer. Look,” he continued, “our health care system may not be perfect, but it is one of the best in the region, and has many advantages compared to what existed before 1993.⁴⁶ Back then health care was a privilege just for the rich.”

Felix was referring to a moment in Colombian history when universal health care did not exist. Before the 1993 health care reform, the poor had to beg for services at facilities that were like charity hospitals.

He carried on with his monologue. “Nowadays, the wealthy pay for the poor’s medical services. It is a form of economic solidarity. This kind of setup guarantees a permanent cash flow that allows everyone to get treated. Look around,” he said, while turning his head and pointing at the crowded waiting room. “What kind of people do you see?” Immediately, he answered his own question with another one: “Not the wealthiest, right?”

Although I was unsure where Felix was heading with his spiel, I nodded my head.

“Well, today patients like them have the right to access medical services,” he elaborated. “In addition, there is a long list of drugs that health insurance businesses must provide.⁴⁷ In the case of cancer, this formulary includes brand-name and expensive medications such as Glivec or Herceptin—top-notch drugs. And all the drugs in the list are usually free of cost for most patients. Isn’t this considered social progress?” Felix asked, in a patronizing tone. “Do you think most patients in the US, for instance, would be able to access chemotherapeutic drugs without going bankrupt?”

He checked his watch.

“Let me say it again: Nobody in this country—do you understand?—nobody can deny patients the right to treatments and drugs, especially if these services have been prescribed by a physician and indicated by the medical literature. The law is on patients’ side.”

Suddenly, a nurse waved at Felix, who grabbed his wheeled Samsonite suitcase and stood up. The gesture confirmed the arrival of the oncologist Felix was waiting for. Before disappearing into the consultation room area, he mused, “Of course, no health care system is perfect, not even U.K.’s, Canada’s, or Costa Rica’s. Resources are always limited, after all. So money should be allocated wisely, especially in an underdeveloped country such as Colombia. In other words, you must make difficult decisions at some point. And some people will be unhappy. That’s how things are.”

He approached me and mumbled, “Most patients think the government should be like a *madre* [mother] whose role is to care for her children, to provide the *canasta básica* [basic consumer goods]. It seems they [patients] don’t remember how bad things were prior to Ley 100. If you ever come across these individuals,

just be aware they like to complain and criticize, you know. Is there corruption? Well, yes. Of course, there is corruption everywhere. You know, there is a lot of *robadera* [theft]. Sometimes not even the government knows exactly what happens with the billions of pesos it pays to EPSs. We just need to come to terms with it. Perhaps this is the price we pay for having one of the health care systems with lowest out-of-pocket expenses in the region, one in which everyone gets access to medical services—even high-tech treatments and technologies.”

Felix’s words puzzled me because they contrasted with what I had been systematically observing at public hospitals, where an overwhelmingly large number of patients seemed discontent with the quality of their medical services and the waiting required to access them. The cases I had witnessed at HUV echoed a crude, hopeless reality, a world in which cancer becomes synonymous with metastases and death. I can still recall very detailed images and scenes of fleshy and infected lesions, low-income patients with physical disfigurement, the smell of necrotic human bodies, or bodies undergoing unimaginable stages of decay while still alive.

Health care workers were not immune to this reality either. Physicians were utterly disgusted at the ways in which the financial logic shapes their medical practice while they are trying to do their best to care for their patients. Clinicians at HUV often stood behind picket lines because their salaries were rarely paid on time, because generic drugs were often scarce in the local market, because their low-income patients could not access prescribed treatments on time, and because many health insurance companies (EPSs) were engaged in systematic treatment deferrals and involved in corruption scandals.

Undoubtedly, Felix was a seasoned pharma rep, knowledgeable about the health care system and aware of patients’ and doctors’ frustration and exhaustion. Were our versions of the health care system informed by different events? Even though we were chatting at the same hospital, seemingly surrounded by the same kind of patients, and their desperation and exhaustion, we seemed to be stubbornly referring to different worlds.

These worlds of biomedicine, in fact, do coexist in Colombia.⁴⁸ Yet they rarely cohabit. By law, for instance, all Colombians should have access to any hospital, regardless of their ability to pay. However, not everyone may manage to inhabit the same examination rooms or get access to the same physicians, even at the same hospitals. Hence the Spanish phrase, “Estamos juntos pero no revueltos” (Together but not jumbled).

This book sets out to explore this impossibility of cohabitation (the historical impossibility of being *revueltos*) and analyze what cancer becomes at different intersections of public and private hospitals, health insurance regimes, medical practice, and patients’ socioeconomic statuses.

China Miéville’s fictional work *The City and the City* (2010) helps me reflect about different worlds of cancer care that coexist while failing to cohabit. In his novel, Miéville writes about two cities—Beszel and Ui Qoma—that occupy the

same physical space but are understood as different by their residents. As parallel cities, they exist side by side but rarely come closer or get jumbled. Inhabitants of these cities are educated to recognize features of the other city, even when they have not seen or experienced them firsthand. Disregarding this separation, Miéville writes, is a terrible crime for the people who live and work in these places.

As someone who grew up in Colombia in the 1980s and 1990s, the description of Beszel and Ui Qoma reads eerily familiar. Colombia, after all, is one of the most unequal countries in the hemisphere, and it is known for its extremely classed practice of medicine (Hernández 2002; Ewig and Hernández 2009). Its inhabitants' lives and deaths are typically shaped by *estratos*, or strata, a caste-like system of socioeconomic classification that is correlated with the kind of neighborhoods we live in, the amount of taxes and utility bills we pay, the health insurance regimes we get enrolled in, and, therefore, the quality of medical services we receive. And because these socioeconomic divisions are so deeply ingrained in the Colombian imaginary, they have turned themselves into something quotidian—second nature.

Think about the differences between public and private hospitals. While public medical settings like HUV have been on the brink of bankruptcy many times over the past two decades, private hospitals such as Valle de Lili have managed to thrive financially, building state-of-the-art facilities and acquiring cutting-edge technology for the treatment of cancer. It has been awarded the Joint Commission International Accreditation—the world standard in world health.

Ethnographically, these differences became evident every time I left Valle del Lili and entered HUV. I would literally travel across worlds of care, through different infrastructure, technology, medico-insurance bureaucracy, and, of course, prognoses. Even the dress codes and Institutional Review Board (IRB) protocols I followed at private and public hospitals were markedly different.

And, of course, I was struck by the fact that these worlds do not usually get jumbled. Even if they are in the same neighborhood, within blocks of each other, these worlds—and the patients in them—are juntos pero no revueltos. In Jairo's case, for instance, getting transferred to Valle del Lili was highly unlikely; his EPS had no contractual agreements with its oncology department. Conversely, for patients who regularly get medical services at Valle del Lili,⁴⁹ switching to HUV may be perceived as a downgrade in care.

Don't get me wrong. Having some of the most cutting-edge hospitals in the region is great news for so many patients who are currently fighting cancer, or those who will develop it at some point in their lives. Hospitals like Valle del Lili have been conceived and built with good intentions. I have no doubt about it. However, in the aftermath of the neoliberal restructuring, private and public settings must compete with each other in the health care market; that is, they are expected to attract a higher volume of patients and sign

contractual agreements with the most competitive and financially robust EPSs on the market. In addition, hospitals, like any other businesses, must follow the same premise that has informed public health policies in Colombia since it was a Spanish colony: large investments should be organic to urban areas.⁵⁰ After all, investing billions of pesos in the construction of a third-level hospital somewhere in the Pacific region would be an irrational decision from the point of view of profit.

A NOTE ON METHODS

After completing the coursework for my anthropology PhD program in Davis, a placid college town in northern California, I returned home to Colombia in 2011 for two years of ethnographic fieldwork in Cali, followed by shorter visits in June and July 2014, June and July 2017, and June 2018. There I spent countless hours observing, listening, and taking careful notes at the intersections of hospitals, health insurances, restaurants, and patients' homes. In addition to its manageable size (2.5 million inhabitants), I chose Cali as my field site because it is located among some of the most neglected areas of the country, where third-level public hospitals are scarce or nonexistent. For patients who struggle to find comprehensive medical care in southwestern departments like Cauca, Chocó, and Valle del Cauca, Cali's HUV is their default destination. Crucially, this influx of rural and low-income patients usually means doctors at HUV are exposed to a wide diversity of pathologies, even rare conditions that are unique to tropical areas. These features, according to physicians I interviewed, make this hospital an exceptional destination for medical training.

When I first arrived in Cali, I was granted access to Valle del Lili. My first interlocutor was a palliative care physician, whom I followed for a couple of months until she was suddenly diagnosed with a type of blood cancer. As soon as she began her aggressive treatments at this hospital, which would eventually put her in remission, I found myself reassessing the feasibility of my original ethnographic plans. During this interim, I was introduced to Dr. Masa. With his patience and support, I transitioned to HUV and was able to successfully complete my ethnographic research.

Inspired by a growing body of work on hospital and clinical ethnography (Livingston 2012; Street 2014; Stonington 2020a, 2020b; Smith-Oka 2021; Abadía-Barrero 2022; Singer 2022), I closely followed five senior oncologists at the above-mentioned hospitals. Dressed in a white coat, I observed how physicians conducted physical examinations of patients, asked questions, evaluated their symptoms, read and interpreted lab tests and imaging technologies, gave diagnoses, and wrote prescriptions. Even though cancer can be transformed into a chronic condition with the appropriate treatments, the vast majority

of patients I came across at HUV had metastatic cancers, typically stages III and IV.⁵¹

I joined patients as they went back and forth between health insurance offices, pharmacies, hospitals, and their homes. While I was able to conduct multiple semistructured interviews with at least twenty-five patients, I ended up conducting intensive fieldwork with only eight of them. This smaller group taught me a great deal about exhaustion, futility, treatment deferrals, and dying. I stayed with them in waiting and consultation rooms, health insurance offices, and their homes. And, finally, I attended their funerals.

Because I have no medical training and I have not been a cancer patient, my participation in this research was inherently partial. Therefore, this book cannot fully grasp the challenges of enduring cancer in Colombia, especially from the point of view of someone getting chemotherapy infusions or lying down on a bed at a public hospital. In addition, my own background (and relative privileges) as a middle-class male *bogotano* has inevitably informed my analysis and shaped my interactions with so many of my interlocutors, as well as the moments of silence that unfolded between us.⁵² Yet I was still able to “participate” in some of the quotidian routines: helping patients fill out hospital forms, requesting doctors’ signatures on behalf of patients, photocopying clinical histories and insurance forms, calling the next patient in line, and joining physicians at social events hosted by the pharmaceutical industry.

My ethnographic observations and conversations, however, were not only restricted to oncology outpatient wards. To learn about cancer, I also followed doctors to informal events: social gatherings, conferences, lunches with pharmaceutical representatives, and breakfast meetings—where clinicians seemed more open to talking about the intimacies of their work. From technical inquiries about clinical procedures to patients’ prognoses and ethical dilemmas, social events were ideal moments for asking questions I did not feel comfortable voicing during consultations.

Finally, I was able to interview three health insurance representatives who worked with EPSs for the poor or for unemployed individuals (the subsidized regime). Through them, I learned about the financial inner workings of these businesses, the burdensome paperwork, and the financial criteria informing their decisions to authorize treatments—especially those deemed high cost. By paying especial attention to their encounters with cancer patients, my book describes how the insurances’ bureaucratic, financial and judicial dynamics shape medical practice, and its consequences.

Informed by anthropology and science and technology studies (STS) research on complexities (Mol 2002; Law 2004; de la Cadena 2015; Haraway 2016), this book is an attempt to describe the biomedical treatment of cancer in Colombia and its paradoxes. Out of these descriptions and encounters, ethnographic concepts arose (Strathern 1991, 2020; de la Cadena 2015, 2021) that

helped me think how biomedical cancer care practices are shaped by patients' positionality in an economy of health care and analyze the relations between jurisprudence, health insurance companies, and patients' socioeconomic conditions under neoliberalism. All these elements participate in the intersections of health care I conceptualize.