

‘Exotic No More’: Tuberculosis, Public Debt and Global Health in Berlin

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Geographical divisions between North and South are coming increasingly undone in the field of global health. Settings in the global North, such as Berlin, are becoming linked up to those in the global South in manifold ways. In this article, I show through discourse analysis and ethnographic research how tuberculosis and its meanings have been transfigured in Western Europe through the worldwide circulation of the disease and its definition as a global health epidemic returning to the North from the South through global migration routes. I then draw attention to the ways in which public health professionals in Berlin make sense of locally implemented economic processes of debt and austerity that have been in effect since the early 2000s. Such processes of indebtedness and privatisation render the strong public health infrastructures that characterise the global North increasingly fragile, and are comparable to the structural adjustment policies that have been imposed upon countries in the global South. I argue that economic processes of austerity in Berlin complement the meaning of TB as an immigrants’ disease, while older meanings of TB as a disease of poverty resurface.

Keywords: tuberculosis, austerity, debt, public health, Germany

Introduction

What is global health? And how global is it? These questions have animated academic publications on health questions for the last two decades. Historian of medicine Randall Packard has argued that global health, as a successor term of what was previously known as international health, has for much of the 20th century been about ‘efforts to improve the health of peoples living in countries that used to be called underdeveloped, or Third World, and are now known as low-income countries’ (Packard, 2016, p. 7). Until today, the term global health is often associated with the older term international health, and thus with diseases and structural problems in resource-poor settings or low-income countries in the global South¹: diseases of endemic proportions, humanitarian emergencies and underfinanced medical infrastructures. Increasingly, however, health experts are suggesting that global health actually refers to ‘the scope of problems, not their location’ (Koplan et al., 2009, p. 1994).

What is at stake in this view is the global amplitude of health issues rather than a specific geography. ‘Increase in speed of travel, as well as the economic interdependency of all nations’, a collective of global health scholars wrote in *The Lancet* a few years ago, ‘has led to a new level and speed of global interconnectedness (...), which is a force in shaping the health of populations around the world’ (Koplan et al., 2009, p. 1994). The authors argue that diseases and economic conditions affecting the health and well being of people transcend national, regional and continental boundaries, and make global health a truly worldwide affair, not only one that concerns the so-called global South or ‘developing world’.

In this article, I would like to make a similar but adjusted claim from an anthropological study of tuberculosis, suggesting that geographical divisions between North and South, along which international health was once organised, are being increasingly undone. I do so by exploring the meanings and imaginaries of tuberculosis, one of the ‘big three’ global infectious diseases, and its control in a resource-rich setting of the global North: Berlin. I thereby intend to engage with global health in Germany ‘*from the South*’ (Comaroff & Comaroff, 2011), to think about North–South divisions ethnographically from a location that has been investigated as a departure point for global health interventions, but less so as a place where some of the problems and stakes of global health inequalities come to the fore.

I borrow the term ‘*from the South*’ from the widely received book *Theory from the South* (Comaroff & Comaroff, 2011), in which John and Jean Comaroff show how neoliberal regimes of healthcare have been experimented with in the global South since the 1980s through structural adjustment policies, making the global South the historical predecessor of ongoing processes of precarisation in the global North. I thus intend to restate, with the Comaroffs, that the line between North and South is endemically unstable, ‘at best porous, broken, often illegible’ (Comaroff & Comaroff, 2011, p. 46), in the global political economy, which makes life and getting by more precarious across the world because of the ever-

expanding capitalist logic of economisation and profit making, as an ‘*économie-sans-frontières*’ deploys ‘fluidity, flexibility, and the free flow of labor and capital’ (Comaroff & Comaroff, 2011, p. 71). In this situation of complex and multi-directional global economic and financial flows, locations and people across the world become enrolled in the global neoliberal economy with different everyday effects. An analytical viewpoint ‘from the South’ allows heightened attention to such issues of economic coevalness, which reveals similar and concurrent processes of economisation and privatisation, but without reducing their specificity and local materialisations.

As public health scholar Nora Kenworthy writes, today the ‘effects of austerity are not limited to poor countries (...) Debt creates the founding conditions for global health efforts’ (2014, p. 72). Debt economies, in other words, are part of those global processes of precarisation and privatisation that affect how diseases are experienced and endured unequally, as well as how biomedical care is unevenly distributed and put into practice among people in different locations. The precise consequences of such global economic processes have been shown with particular acuity by medical anthropologists using the example of structural adjustment policies in the health care sector in South American, African and Eastern European settings (Han, 2012; Keshavjee, 2014; Kim, Millen, & Gershman, 1999; Koch, 2013; Pfeiffer & Chapman, 2010). More recently they have also begun to be investigated in Europe (Brand, Rosenkotter, Clemens, & Michelsen, 2013; Karanikolos et al., 2013; Stuckler & Basu, 2014). Studies working towards theorisations of impoverished locations and decaying medical infrastructures in the global North as an ‘other global South’ (Meyers & Hunt, 2014), and very recent studies on the relationship between austerity policies and the precarisation of health care in Southern Europe (Cabot, 2016; Kehr, 2014), have shown how processes of austerity and the privatisation of health care undermine North–South divisions, as similar stakes regarding infrastructural decline are at play, even if the scale and

consequences of such processes are highly dependent on the location and the population. With this article I intend to participate in this nascent research field of austerity studies by showing how health professionals in the field of TB control in Berlin made sense of global economic phenomena such as public debt and structural adjustment as they slowly unfolded before their eyes at the end of the 2000s.

Should Berlin, a location in the global North, be seen as an ‘other global South’, as Todd Meyers and Nancy Lee Hunt (2014) have argued for Detroit in the United States? Another Global South, in their perspective, is a place in which ‘health and survival are profoundly uncertain’ (ibid., p. 1921), no matter where in the world that place is. With this definition of other global Souths, Meyers and Hunt express scepticism concerning the political and practical value of North–South distinctions in the field of global health. Instead, they propose an approach that focuses ‘on specific forms of harm and their consequences (...) for broadening discussions and practices of global health beyond ex-colonial worlds in the South to precarity throughout the globe’ (ibid.). Using the example of TB control in Berlin, I also question North–South divides in global health, which continue to inform its conceptions, albeit without stating that Berlin is another global South. Rather, I suggest that TB control in Berlin can be analysed as an ‘enclave’ (Geissler, 2015) of global health. I do so, however, not in the sense that Wenzel Geissler uses the term to talk about abundant financial resources in otherwise deprived settings, but rather in the opposite sense: to show how health professionals in the realm of TB control struggle to give meaning and value to their largely invisible work in the German medical landscape where high tech medicine is highly valued, while TB control on the ground is increasingly governed by limited means due to economic concerns over public resources as well as a representation of tuberculosis as a disease of poor immigrants. TB control in Berlin is an enclave of global health in the North due to the limited resources allocated to its public health infrastructures as well as the highly precarious and

vulnerable persons to whom it attends.

I conducted ethnographic fieldwork (observations and interviews) in 2007 with doctors and social workers in two centres of tuberculosis control in Berlin. The centres were publicly funded institutions responsible for implementing TB prevention and control through contact tracing, systematic screening through x-rays and patient surveillance. While doing fieldwork, the two centres were merged with a third one, where I did additional short term fieldwork in 2009. Staff that did not take up a position in the centre following the merger were appointed to positions in other fields of public health or proceeded to early retirement. In this article, I show how doctors and social workers who had worked in the city's TB centres for over 20 years reflected on and criticised the ongoing public policy tendencies of austerity, financialisation and indebtedness in Berlin's landscape of public health and TB control. I base this on analysis of the semi-structured interviews that I conducted with doctors and social workers during my fieldwork, which is also complemented by document analysis (policy documents and public health literature) as well as observations during fieldwork.

My article is composed of two parts. First, I show how tuberculosis and its meanings have been transfigured in Western Europe through the worldwide circulation of tuberculosis and its definition as a disease of global health returning from the South through global migrations to well-off regions in the North in the form of a disease of racialised *Others*. To make this larger claim about TB in Europe, I also use ethnographic material from France, where I did a comparative study on TB control between 2006 and 2010. In a second step, I draw attention to global economic processes of debt, structural adjustment and austerity that have come to frame global health interventions worldwide, and which have also been implemented in Berlin. Such global economic processes of indebtedness and privatisation render the solid public health infrastructures that once characterised the global North increasingly fragile, and are thus comparable to the structural adjustment policies that have

been experimented with in the global South. Economic processes and the precarisation of living in Germany thus complement the contemporary meaning of TB as an immigrants' disease, just as older meanings of TB as a social disease of poverty resurface. Easy North–South divides and imaginaries of 'here' and 'there' are troubled, even if they remain partly in place.

North–South in tuberculosis control

In their 2011 annual report, *Médecins du Monde* announced an imminent 'sanitary crash' in France, which would render the living conditions of poor people unbearable. As the director of *Médecins du Monde* stated: 'In a context of crisis, whose effects are utterly felt by the precarious, health indicators are gravely deteriorating'. At the same time, epidemiologists started to publish data in high level medical journals on a general rise in infectious disease in austerity stricken European countries (Brand et al., 2013; Karanikolos et al., 2013; Stuckler, Basu, Suhrcke, Coutts, & McKee, 2011). 'Long forgotten plagues' (Hilbk, 2000), as the German weekly journal *Die Zeit* called tuberculosis at the turn of the century already, were feared to be flourishing again in European cities after the 2008 economic crisis. Camps of homeless people at docks along the Seine in France or images of tent towns of refugees in Germany are but two examples of potential 'hot spots' for tuberculosis and other infectious diseases in the middle of Western Europe, a region in which tuberculosis had supposedly been relegated to the past (Kehr, 2012b). The public face of TB has today become racialised and exoticised: TB is primarily framed as an immigrants' disease within epidemiology and the mass media, while public health interventions target those who are fleeing conflict or violence and who cross borders or seek asylum in search for a better life.

Globalisation and tuberculosis' 'return' from the South

In the early 1990s, shortly after the breakdown of the Soviet Union and the collapse of the

Cold War organisation of the world, discourses and images of a novel tuberculosis crisis returning to Europe from abroad came to the fore (Rieder, Zellweger, Raviglione, Keizer, & Migliori, 1994). Not only did public health experts at the World Health Organisation (WHO) fear that tuberculosis would be fuelled by the growing AIDS epidemic (WHO Tuberculosis Programme, 1994). It was also assumed that immigrants from Eastern European and African countries would re-import this old disease of poverty to affluent societies in Western Europe, where tuberculosis had been in steady decline since the 1950s. Estimations of the globally rising incidence of tuberculosis (Raviglione, Snider, & Kochi, 1995), coupled with concerns about co-infection, multidrug-resistance and immigration, led WHO experts to proclaim tuberculosis a 'global emergency' in 1993: 'If worldwide control of tuberculosis does not improve, 90 million new cases and 30 million deaths are expected in the decade 1990 through 1999. The magnitude of the global tuberculosis problem is enormous', a WHO expert group pronounced (Raviglione et al., 1995, p. 220).

In Europe, though tuberculosis figures were comparatively low in the mid 1990s, they had 'failed to decline' (Raviglione et al., 1995, p. 220), as public health experts stated with concern. Prior to this, tuberculosis eradication through effective antibiotic therapy and continuous social progress had been a powerful medical aspiration since the 1950s (Kehr & Condrau, 2016), leading to TB being declared a 'rapidly declining' disease in 'industrialised countries' (WHO Tuberculosis Programme, 1991, p. 57). As a consequence of these efforts, the disease had become less and less visible in public space, and the public health campaigns and systematic screening measures for the entire population that were highly common during the 1960s and 1970s were gradually downscaled. In the 1970s, among the wider public and within general medicine, TB turned into a barely visible 'disease without a future' (Kehr, 2012b). An increasingly future- and technology-driven biomedicine, which had lost interest in TB, thus stopped investing in TB research (World Health Organisation, 1982) and

downscaled its infrastructures of control, including social services; actions that garnered little attention. ‘Tuberculosis (...) rarely made (...) medical headlines’, Salam Keshavjee and Paul Farmer wrote in their history of TB, ‘in part because its importance as a cause of death continued to decline in areas in which headlines are written. In such settings, (...) the social determinants of tuberculosis — extreme poverty, severe malnutrition, and overcrowded living conditions — became the exception rather than the norm’ (Keshavjee & Farmer, 2012, p. 932). The historical apparatus of TB control, including contact tracing, home visits, patient isolation and treatment surveillance, which had been set up at the beginning of the 20th century when TB was known in Europe as ‘the white plague’, was thus in a process of transformation and reduction in many Northern countries at the very moment when the WHO proclaimed a global TB emergency in 1993 (Draus, 2004; Story & Citron, 2003). Only when the truism that ‘tuberculosis knows no borders’ became a commonly heard phrase was tuberculosis linked to the novel features of a globalised Western Europe at the close of the 20th century. ‘The new [multidrug-resistant] tuberculosis’ (Farmer, 1997) that emerged in the 1990s was framed as a disease of worldwide connection and migration. In short, it became a disease of global health (King, 2004; Koch, 2008), and as such worthy of renewed attention, also in the global North.

In Europe in the 1990s, epidemiologists started to ask new questions and to produce novel epidemiological data on tuberculosis incidence by systematically distinguishing between ‘indigenous’ and ‘foreign’ populations. While the ‘indigenous population’ (Rieder et al., 1994, p. 1545) was less and less affected by the disease, as the new epidemiological statistics showed, immigrants were shown to have much higher disease rates. A growing epidemiological apparatus developed at the WHO, with a number of special studies realised in 1989 and 1990 demonstrated that the global TB ‘reservoir’ was situated in Africa and Asia, with an annual risk of infection excessively higher than in Europe, the latter of which showed

slow or non-declining disease incidence (WHO Tuberculosis Programme, 1991, p. 57).

Tuberculosis experts and public health actors were concerned that TB might return to the North from the South through international migration, as a WHO European region position paper stated (Rieder et al., 1994). This framing problematised TB as a question of biosecurity (Koch, 2008; Lakoff, 2010) and legitimised public health surveillance and targeted intervention towards immigrants in those places where TB had steadily declined (Coker, 2004; King, 2004). It is thus through global circulations and fears of a public health emergency ‘coming home’ from abroad, especially through international migration, that TB became an issue in Western Europe in the 1990s once again – and thereby earned a new meaning. The new tuberculosis of global health became a ‘strange’ disease from a European perspective, a disease of travelling migrants and the global South. The public face of TB became racialised and ‘tropicalised’ (Rees, 2014, p. 460). The words of Rebecca, a white middle class secretary from France, who had tuberculosis when I interviewed her in the hospital a decade ago, are representative of this widely held imaginary in Western Europe:

TB is a strange disease, a disease that I did not suspect to have at all. (...) It’s a disease of the middle ages. Dirt, I don’t know, tramps, bad living conditions and all the rest of it. Famine, you see, all these little things. But not today, not in the environment we live in. We eat well, how to tell you, we don’t live in poverty (...). If we were, say, in Africa, ok, I can see the disease there. Over there, I associate tuberculosis with all the other diseases. But not here, not in France! (Patient interview, 13 December 2006).

Today, TB still emerges in public discourse primarily as a disease either relegated to the past or to the global South. Especially in the mass media, tuberculosis is consistently related to immigration, as could be observed in 2015 during Europe’s most recent ‘refugee crisis’, where articles pictured dark-skinned men waiting in long lines for screening interventions at mobile x-ray units. Such media accounts paint a similar image of TB as the

one circulating in the 1990s and 2000s: a disease returning to Western Europe from the South via refugees and asylum seekers. North–South boundaries are permeable for disease through migration (King, 2004), but the actual location of TB is imagined to be in the South, among poor people of colour. As of late, however, this imaginary of TB as a distant disease concerning the North primarily through migration has been complemented by the older image of TB as a social disease of poverty.

Austerity and the fragility of tuberculosis control in the global North

The 2008 economic crisis and its succeeding politics of austerity raised fears of a resurgence of TB in Europe, particularly in Southern Europe. ‘The descent to hell of Greece’s public health system: hospitals attend to emergencies, while tuberculosis and malaria come back’ was one such headline in the French newspaper *Le Monde* in November 2012, a few months after the first studies on the consequences of the economic recession on European health systems had been published (Brand et al., 2013; Karanikolos et al., 2013; Kentikelenis et al., 2011; Legido-Quigley et al., 2013). Europe’s journal of public health surveillance, *Eurosurveillance*, bluntly asked ‘Can the economic crisis have an impact on tuberculosis in the EU?’ (van der Werf, Giesecke, & Sprenger, 2012), and concluded affirmatively: ‘Given the likely influence of an economic crisis on the functioning of healthcare systems and on factors that affect the epidemiology of TB, it is expected that the current economic crisis will have an effect on the TB situation in EU countries’ (van der Werf et al., 2012, p. 2).

In such articles and studies, epidemiologists and health policymakers linked a possible resurgence of tuberculosis in Western European countries to the ongoing economic crisis and its politics of austerity (Reeves et al., 2015). As I have shown, until the late 2000s it was less about economic downturn and decreased funding of public health infrastructure that animated concerns of a return of TB in Europe than about an immigrant *Other* in a globalising world of new risks. Today, however, media reports about so-called third world living conditions in

Europe, about the deterioration of health infrastructures through insufficient funding, and about a retreat of the welfare state and thus of renewed poverty, are also much present. The figure of the immigrant from the developing world reintroducing long forgotten health problems to Europe is thus now complemented by an image of potentially unhealthy and economically vulnerable European societies, which will no longer be able to control diseases of poverty in current disaster regimes of austerity. TB becomes a revenant of past times when poverty and precariousness were much more present, and which had been kept at bay by a strong public health apparatus of disease control, social welfare programs and public commitment; that is, by the social and economic potentials of the welfare state as a caring and curing institution for the sick and the poor, as historians have shown (Barnes, 1995; Foucault, 2004).

Such potentials have become uncertain in Europe today, especially in its Southern parts, 'where some of the logics of debt and indebtedness that have ravaged the Global South' (Muehlebach, 2016, p. 2) can increasingly be observed. Potentially rising incidences of tuberculosis in austerity stricken countries not only prefigure a second modernity of TB in those places that had thought of themselves as part of the global North (Knight & Stewart, 2016), but also serve as a reminder of the fragile potentialities of Western European health care regimes, whose affirmed solidity served as a critical sign of distinction between health care in the North and the South.

Looking at a paradigmatic disease of poverty in a rich country of Western Europe allows me to adopt a critical perspective on North–South divisions and disease trajectories, but also on the future of global health and its dream of 'health for all' (Mahler, 1988). The presence of TB, if seen as a revenant, relates to not-so-distant pasts where public health care and modern welfare were only in the making. A potential resurgence of tuberculosis in austerity stricken countries might thus prefigure the vanishing of disease control and social

security in the future of the global North. At least this is what it looked like for my research collaborators in the domain of TB control in Berlin, the capital of Europe's largest national economy, even before the 2008 economic crisis. In a context of the significant public service reductions that were realised in Berlin in the aftermath of German reunification and the city's high debts, doctors and social workers employed in TB control already uttered their concerns on the increasing conditions of scarcity in their professional domain. Such worries were also internationally recognised in the 2007 Berlin Declaration on Tuberculosis of the WHO's European Office, where national and international actors noted that 'TB has re-emerged as an increasing threat to health security in the WHO European region', in which 'many countries face a shortage of competent and motivated human resources for TB control' (WHO European Region Ministerial Forum, 2007).

Public health and financial debt in Berlin

In 2006, Berlin's mayor stated in his five year financial statement to the local senate that the financial situation of Berlin was marked by a 'public budget in high deficit' and a public service 'largely overstaffed in comparison with the rest of the country'. With regard to the 'gravity of this critical situation', as he expressed with concern, he demanded the implementation of a program of 'restructuring and modernisation', through which the state should 'back down to its fundamental missions' in order to 'diminish the public deficit'². An economic program of internal competition and a decrease in public spending was designed, which also impacted Berlin's public health services. Social workers and doctors in the domain of tuberculosis, who were at the forefront of these restructuring processes, were concerned about the program.

Tuberculosis control as austerity labour

'Poor but sick? Berlin's public health reform project', read the title of an article in the journal

Berliner Ärzte, the formal organ of the city's local medical association. In the article, an infectious disease physician practicing in Berlin's legendary lung health hospital *Lungenklinik Heckeshorn* accused the local government of inaction regarding the 'aggravation of social contrasts' and the 'striking relationship between poverty and health' (Schönfeld, 2008, p. 14) in Germany's capital:

Trapped between the guidelines of a 'New Public Health' and the notorious demands for savings, the aims of an engaged vision for public health were pulverized by bureaucracy. The losers: an ever growing number of socially and medically disadvantaged in Berlin and the decreasing number of public servants who are supposed to sort it out (ibid.).

The article, written by a senior physician and local expert on tuberculosis engaged in Christian charity, conveyed deep rage against an economised system of local public health, whose operations were increasingly limited due to money savings in one of the most indebted federal states in Germany (<http://www.haushaltssteuerung.de/verschuldung-gesamt-deutschland-bundeslaender.html#entwicklung-laender-im-zeitablauf>). The physician's portrayal of work in public health infrastructures in decline comes close to what Andrea Muehlebach has recently termed 'austerity labour', namely the labour of bureaucrats 'who are today tasked with managing the radical dismantling of the very apparatus that sustains them' (Muehlebach, 2016, p. 8). Furthermore, Schönfeld bitterly assessed the harmful social and medical consequences of the local public health reform project on an increasing number of poor people that he saw as the 'losers' of governmental reform.

This hospital physician was not alone in his assessment. In the tuberculosis prevention centres where I observed the daily tasks of TB prevention and control, social workers and doctors alike similarly complained about the potentially dire consequences of public service restructuring in the name of financial savings. Two public health physicians, both women in their late 50s who had worked in one of Berlin's centres for TB control for more than 20

years, commented to me on the planned budget cuts and administrative restructuring during an interview :

Dr. Z : There is much danger in the restructuring, but at the moment, nobody is interested in it.

Dr. I: This might not be something for your research, but, well, at the moment we can very well understand the frustration of the German Democratic Republic and how they were liquidated [*abgewickelt*]. Now we are being liquidated in much the same way. [Towards her colleague] Or do you not agree?

Dr. Z: Yes, what is currently happening is probably somehow comparable.

Dr. I: Finances are of course important. But we are not manufacturing toilet seats, and thus we simply cannot work in a self-covering way. It is our duty to protect the population, the general public. With these cuts, we can't really do this anymore.

Dr. Z: We might well become a bureaucratic outpost in the future, with our head cut off. These are the perspectives.

JK: Why do you think that these developments are occurring?

Dr. I: The criterion is to save money. The state is bankrupt. There is the idea that there are fewer and fewer TB cases and thus fewer and fewer sick people, and that one can thus reduce the state budget. But if you ask me, these considerations do not take into account that even today, TB can be extremely dangerous. (...) If you ask me, and I don't even know if I am allowed to say this as a civil servant, the only thing at stake is the budget (Interview, public health doctors, 6 November 2007).

Budget cuts as a great danger; restructuring as 'liquidation' (*Abwicklung*); the ignored threat of an old disease; the dictates of budgets and finance; the transformation of a strong apparatus of public health in a 'bureaucratic outpost', whose social vocation is no longer discernible: such were the terms in which the above two physicians described the public health reform project they were witnessing. Both heavily critiqued the policy of decreased public funding in a domain in which, in their eyes, there was already not much left from the once shining apparatus of tuberculosis control. Their statements insinuated a deep frustration

regarding the loss of recognition for their work, even more so as their everyday work was not much recognised in the wider biomedical domain. The word ‘liquidation’, or *Abwicklung* in German, is indeed not innocent in the German language and in German history. It directly refers to the dissolution of former East German enterprises and professions following reunification, and their subsequent integration into the neoliberal political system on which the post-National Socialist West German state was founded (Foucault, 2006, p. 112-147).

Almost all of the doctors and social workers in the prevention centres expressed to me their indignation over such financially legitimated processes of dissolution. They increasingly felt like powerless players in an economic game whose rules they did not subscribe to. This feeling was accompanied by the impression of not being listened to despite having something to say about the social and medical consequences of budget cuts in the domain of public health. But with TB’s decreasing disease rates, doctors and social workers did not have a loud enough voice to sound a public health alarm in a world that primarily listens to numbers and crises, a world informed by short-term visions and questions of money. When I asked the three social workers at one of Berlin’s TB control centres, all of whom had worked there for more than fifteen years, about the most important changes they had experienced in their everyday work throughout their careers, they replied:

Mr. P: The domain of health insurance, histories of co-payments. The problems begin when people cannot pay 10 Euros per quarter for the surgery fee and the doctor puts pressure on us because they send away patients [with TB] or they call us and want us to pay for them. All this does not get better.

Ms. D: I also think that bureaucracy is getting worse. The whole thing with people on benefits [*Hartz4 Empfängern*]. And people don’t get that they have to pay the surgery fee, then they have to pay the prescription fee for TB medication. Some people just don’t have this money. And there are really people who cannot go to the surgery and get their medication because they cannot make the co-payments (...). It would be nice if we had some sort of fund, there are so many funds for all

sorts of things (...). If we could organise medication through our centre. But one always has a bad conscience because we know that we are budgeted and that the whole centre is poor and every day we hear that we are constantly in the red and that positions have to be slashed.

Mr. A: True.

Ms. D: And when one already has in mind, 'Oh my god, we might have to admit a patient to the hospital and the public health office has to pay' and it costs a lot, well, one does not want this either (Interview, social workers, 6 November 2007).

The social workers portrayed the public health office as poor. Furthermore, an increasing number of patients, in their experience, did not have enough money to make ends meet, and thus could not pay for their necessary medications as well as their visits to the physician – which are obligatory in Germany if one has a contagious form of TB. Social workers wished to have 'some sort of fund' that might balance out the decreasing financial commitment of the indebted regional government, and thus make it easier to provide treatment for poor patients.

One can read in the above quotes a harsh critique of the German state and its medical and social reform policies since the 2000s, in the aftermath of the so-called 'Agenda 2010'³. In the physicians' and social workers' eyes, all these actions potentially compromised TB control, which functioned as a signifier of much larger economic and social transformations within German society and its increasing precarisation. Tuberculosis, for them, was not only a disease of immigrants or of elsewhere. Even if a significant part of their clientele were indeed asylum seekers, refugees or 'foreigners', as they expressed it, TB, for them, had also always been a social disease with the potential to come back in the changing economic environment of declining public commitment and rising precariousness that they were observing in their daily work.

My interlocutors' concerns might sound like what one would call in German 'lamenting on a high level' when compared to peoples' stories and sufferings as outlined in

articles that deal with global health situations in former colonial worlds. Nevertheless, my interlocutors' worries hint at the fragilities of disease control that come with the gradual withdrawal of state funding from public health programmes, and thus to the multiple and locally differentiated manifestations of the inequalities of the national and global political economy in neoliberal times (Comaroff & Comaroff, 2011; Narotzky & Besnier, 2014).

Precarisation of tuberculosis control

There is indeed a remarkable similarity between the doctors' and social workers' portrayal of a slow and steady reduction in public health infrastructure and anthropological narratives of neoliberalism's 'stealth revolution' (Brown, 2015) in tuberculosis control in post-Soviet countries that have gained prominence in recent global health research (Keshavjee, 2014; Koch, 2013). In looking at long-term transformations of public health since the late 1970s, medical anthropologists have described the 'infiltration' (Keshavjee, 2014) of neoliberal market models in the domain of tuberculosis control, which resulted in the undoing of public health infrastructures in an environment of increasing poverty and economic insecurity. International actors such as the World Bank and the International Monetary Fund, as well as national governments, participated in this process, where cost-effectiveness concerns dominated, putting at stake public disease control and poor patients' lives and allowing multidrug-resistant diseases to prosper (Keshavjee & Farmer, 2012).

What has been happening in Berlin since the late 2000s in the domain of TB control follows a similar economic logic, albeit on a very different scale, and involves public service reductions in the name of savings in highly indebted settings, the increasing problematisation of public health in economic terms, and growing problems with long-term patient care due to the introduction of user fees and co-payments. Such transformations of tuberculosis control in conditions of declining public commitment are facets of what Lauren Berlant calls a 'neoliberal feedback loop' (2011, p. 192) in her work on the precarisation of the present. The

consequences of this economic feedback loop in late capitalist societies are multiple, including the degradation of social welfare structures and greater precarity in the domain of labour across different parts of the population. Berlant therefore argues that this loop distributes and shapes ‘the experience of insecurity throughout the class structure and across the globe’ (Berlant, 2011, p. 192-193).

Following Berlant, today insecurity and precarisation are no longer exclusive features of the global South, features that one can observe from a distance, elsewhere. They are part of everyday livelihoods and labour in many different and formerly unimagined locations, including Western European cities such as Berlin. Doctors and social workers in TB control work at the frontline of care for the precarious, and thus have something to say about the decaying landscape of service provision that hits hardest those who have the least, such as poor refugees, asylum seekers or those living on scarce benefits. By listening to their concerns, I do not intend to ‘weigh’ experiences with precarity or disease burden in different countries against one another, but to make similar processes of precarisation and the downscaling of public services comparable from the perspective of those who work in disease control. I aim to shift perspective from the trajectories of disease (South–North) to the slow transformation of infrastructures of care (across the globe).

Cuts in medical services, rising user fees and the triage of those worthy or unworthy for ever more expensive treatments are domains in which the neoliberal feedback loop leads to the collapse of categorical distinctions between South and North, here and elsewhere, own and other, despite their stubborn solidity and their easy instrumentalisation for powerful politics of differentiation and exclusion, especially in the domain of migrant care (Kehr, 2016). In Berlin, renewed concerns with tuberculosis oscillate between an ongoing faith in techno-medical progress and public welfare and a parallel fear of social and economic decay that might threaten the slowing of disease incidence or even inverse the tendency. Such

processes and concerns make clear the fragilities of public health interventions, which have been built on a strong faith in joint social and medical modernisation and continuous economic growth, accompanied by large public investments, which are no longer given.

What one can observe in Berlin in the domain of TB control is nevertheless not equivalent, neither in scale nor in health consequences, to the stakes of TB control in high-burden countries, where strong public health infrastructures have never been in place to the same degree. Different scales of infrastructural scarcity, disease abundance and severity are at work. We can see similar economic logics across the globe, but locally and historically specific manifestations with non-analogous epidemiological consequences and very different scales of mortality. If one looks at epidemiological data on tuberculosis in different countries, for instance, it becomes clear that the scale of the problem is hardly comparable. In Germany, the overall incidence of TB is about 6.5 / 100,000, with multidrug-resistant cases of tuberculosis making up between two and three percent of cases since the mid 2000s; this means between 50 (2011) and 125 (2015) multidrug-resistant cases in the whole country per year, affecting especially migrant patients from high-burden countries who might have a long and fragmented treatment history. Some patients do die from tuberculosis, especially the elderly, but the mortality rate in 2015 was nevertheless only 0.13 cases per 100,000 (Data online, Robert-Koch-Institute). Second and third line drugs for multidrug-resistant TB are costly but available, and are paid for by obligatory health insurance or public sector medicine, not by patients. By way of contrast, in Tajikistan, where multidrug-resistant TB is an urgent public health problem, as Keshavjee has shown in his anthropological study that I cited above, incidence amounts to 87 / 100,000. Multidrug-resistant TB cases make up 14% of new cases, with a disease mortality rate of 2.6 cases per 100,000, taking into account all forms of TB (Data online, TB country profiles, WHO). In South Africa, a country with one of the highest disease burdens globally, TB numbers even rise to an incidence of 834 / 100,000, and there is

a mortality rate of 46 / 100,000. In such settings, patients' experiences with TB care are 'bound by their poor access to essential resources, multiple life responsibilities (...) limits within the healthcare system, and the stigmatizing social symbolism of their illness' (Daftary & Padayatchi, 2012), as a study on South African HIV/TB care argued.

My interlocutors voiced their concerns with regard to the future of public health in Berlin, as well as overt critique of its increasing financialisation and the transformations of the welfare state. And yet, when compared to how anthropologists have described TB care in post-Soviet or African locations, and if compared to epidemiological statistics about the disease in high-burden countries, these concerns reflect dissimilar degrees of gravity. The concerns are comparable, but the consequences are not. This brief comparison between locations in the North and South reveals two things. The comparison brings to the fore economic coevalness that is a contemporaneous feature of economic processes in the domain of health care, in the form of structural adjustment, austerity policies and the downscaling of public services. And yet the scales and consequences of this economic coevalness remain very different, despite their similarities. Berlin matters as a place with infrastructural histories and presents that bring about quite different materialisations and problematisations of disease and care than those in Cape Town or Dushanbe, Tajikistan's capital, to name but two examples. Berlin is therefore not another global South, as Meyers and Hunt have argued for Detroit. Public health infrastructures are in place, and health and survival are not 'profoundly uncertain' (Meyers & Hunt, 2014). But uncertainty does affect many people, some with much more gravity than others. In Germany, poor immigrants, some undocumented or with a highly precarious political status as a refugee or asylum seeker, suffer most severely from TB's consequences due to difficulties in getting-by, unequal access to medical care, discriminatory institutional treatment and a fragile legal status (Huschke, 2014; Kehr, 2012a). Berlin, as many other locations across the world, is thus situated on a continuum of shifting resource

allocations in the domain of health that are dependent on worldwide concerns for economic liberalisation and financial priorities, which make health care uncertain, especially for the most disadvantaged. In sum, across the globe, economic and financial priorities put those people whose lives are marked by different kinds of precarity, exclusion and hardship most at risk for disease – be it in Germany or elsewhere. It is in this sense that TB control in Berlin is part of global health and its inherent inequalities, even if Berlin is not another global South.

Conclusion

In this article, I have looked at an infectious disease of global health – tuberculosis – in a place where it is no longer supposed to be a problem and where it occurs – epidemiologically speaking – on a small scale. This has allowed me to theorise public health in the North ‘*from the South*’ (Comaroff & Comaroff, 2011). I have done so in order to analyse the locally specific meanings of global disease circulation on the one hand, and to reflect on economisation in the domain of public health on the other. Regional biosecurity concerns, as well as world-spanning economic logics of financialisation, come to the fore.

In the Western European public imaginary, tuberculosis primarily exists as a disease of immigrants and of elsewhere. TB is first and foremost associated with countries and contexts of the global South or the post-Soviet East. It is a circulating disease of global connection and migration, a paradigmatic disease of global health. What tuberculosis is and how it is treated and controlled in Berlin thus depends on this global imaginary of South–North disease circulation, or what Nicholas King called the ‘scale politics of emerging diseases’ (King, 2004). But Berlin, as any other place in the world, is also entangled in global processes other than that of unevenly circulating diseases; namely comparable processes of economisation and precarisation, which, notwithstanding differences in scale, follow similar logics across the global North and global South (Bear, Ho, Tsing, & Yanagisako, 2015) and

render public health fragile. I have illustrated such processes from the perspective of public health professionals working in TB control in Berlin, a highly indebted German state where public health services have been heavily downscaled over the last decade. In sum, North–South imaginaries and divisions are well in place concerning the vision of TB as a disease of the global South that concerns the global North only through international migration, though this vision is becoming increasingly fragile within current regimes of austerity, where an old image of TB as a social disease of poverty is simultaneously resurfacing.

In this article, I have shown two ways in which ‘the Global North becomes part of global health (...) beyond the familiar trope of this region adopting the role of an interventionist in settings of destitution and crisis in the Global South’ (Mattes & Dilger, n.d.). On the one hand, the global North is part of global health rhetoric and interventions through globally circulating diseases of global health and related biosecurity concerns (King, 2004; Lakoff, 2010). But it is also part of global health through structurally similar processes of public health downscaling, that are at work in most places of the world today (Biehl & Petryna, 2013).

‘The world is the ultimate geographical limit of anthropology’ (MacClancy, 2002, p. 9), Jeremy MacClancy wrote one and a half decades ago in the edited book *Exotic No More*, whose title I have borrowed. As many before him, he argued that anthropology as a discipline has never only been about the elsewhere, the exotic and the *Other*, despite the prominence of exotic and out of the way places for the imagination of anthropological research and disciplinary identity up to the present, also within anthropologies of global health where locations in the global South remain the primary interest, driver and location of ethnographic research. Rather, anthropologists have always been studying ‘the West as much as the “rest”’ (MacClancy, 2002, p. 2), and productively so. MacClancy emphasised that it is this world-spanning optics that goes beyond East–West or North–South distinctions that constitutes the

‘public value of the discipline’ (ibid.) and its ability to contribute towards the understanding ‘of a wide range of practical social issues’ (ibid.) across the globe.

MacClancy, who was writing at the beginning of the Millennium, used the expression ‘exotic no more’ as a methodological proposition to argue for sustained anthropological engagement with phenomena of unequal power relations across the globe at a time when anthropology was beginning to inquire into globalisation processes, also in the realm of health and medical care. My article contributes to this ongoing debate. I use the expression exotic no more to refer to processes of neoliberal precarisation and debt economies, which are no longer exclusive features of an exoticised global South, as recent anthropological scholarship on the European context has shown for different domains (Knight & Stewart, 2016; Muehlebach, 2016; Narotzky, 2012). By writing about one of the big three diseases of global health, tuberculosis, in the North, I aim to draw attention to the downscaling of strong public health infrastructures that once characterised the global North and to the way in which public health professionals in Berlin made sense of this phenomenon in the mid 2000s. I therefore suggest that there are more reasons than simply the transnational travel of infectious disease, with its adjacent biosecurity concerns, and the global pathways of expert knowledge that are dissolving North–South divisions, through which international health has emerged. Unlike the earlier term of international health, with its close link to ‘technical assistance’ or ‘development assistance’ (Packard, 2016, p. 7) *from the North to the South*, global health indicates a world-spanning complex of actors, problems and interventions, in which diseases, people, technologies, money and ideas transcend and undermine any easy North–South distinctions that ‘development’ or ‘technical assistance’ had once fuelled. They do so in a context in which neoliberal regimes of reasoning continue to distribute different forms of precarity and manifestations of disease highly unevenly among people and settings in the North and the South.

Notes

1. By capitalising the terms North and South, I aim to indicate the social and political imaginaries of locations and North–South divides rather than their actual geography.
2. http://digital.zlb.de/viewer/content?action=application&sourcepath=33334659/bilanz_verw_mod.pdf&format=pdf
3. Agenda 2010, which was implemented in 2003, involved a depletion of social security together with a liberalisation of the labour market, as put forward by the Social Democrat chancellor Gerhard Schröder and his coalition government.

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