Emerging Socialities in 21st Century Healthcare

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Part II
TRANSFORMATIONS IN HEALTHCARE POLICY—
Politics and ethics
Selling global HPV

Pharmaceutical marketing and healthcare policymaking in the case of human papillomavirus vaccination in Austria and Japan

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Introduction

Infections with human papillomaviruses (HPV) and associated social practices are noteworthy, even remarkable, in several regards. Here are some of them: With an infection rate of up to 80% of the world’s population, virtually ‘all of us’—meaning sexually active humans—have it, or have already had it, or will have it perhaps again. There is not one single HPV strain, but more than 100 different genotypes and even more are still being discovered. About 30 of them affect anogenital tissues and are primarily transmitted by sexual contact (if not necessarily sexual intercourse), making HPV the proximate cause for the most common sexually transmitted infections. Most of these infections are transient and go unnoticed. When persistent, HPV may induce benign genital warts (low-risk HPVs, predominantly strains 6 and 11) and, above all, cervical and other anogenital and oropharyngeal cancers (in particular associated with the high-risk strains 16 and 18). Thus it appears that HPVs profoundly redefine these cancers, particularly cervical cancer, as infectious, sexually transmitted diseases.

Yet, the link between HPVs and the diseases concerned is far from being deterministic. Having been exposed to HPV, someone may or may not be infected and subsequently may or may not develop warts or cancers. The causal connection between exposure, infection, and resulting diseases has been established by statistical probability. According to the Deutsches Krebsforschungszentrum (German Centre for Cancer Research), ‘less than one in 100 women infected with one of the high risk types will develop a cervical carcinoma on an average of fifteen years after the initial infection’ (DKFZ, 2009).

However, the pharmaceutical industry was able to provide good news: In 2006, Merck & Co. (in Europe represented by Sanofi Pasteur MSD) introduced Gardasil, an HPV vaccine against strains 6, 11, 16, and 18; one year later GlaxoSmithKline (GSK) launched Cervarix, a bivalent serum against strains 16 and 18. Since these viruses are supposedly transmitted during
first sexual contact, both vaccines predominantly targeted girls and young women prior to their first sexual experiences.¹

In subsequent years, GSK and Merck & Co. introduced their vaccines in more and more national healthcare systems, starting with rich industrialized countries in Europe, North America, Australia, and Japan. Today, millions of girls and young women around the world are vaccinated. However, it is still unknown how long protection against HPV infection lasts (ECDC, 2012). Thus, even those who are vaccinated may not feel safe.

Instead, it is quite likely that they will be infected at least once in the course of their sexually active lives with one of the other HPV types that are not targeted by the vaccines. And it is all but certain that these women will transmit one of the potentially malign viruses to their sexual partners.

In 2006/2007 the general public as well as health policymakers, physicians, and social scientists not only learned about HPV-induced diseases and the new vaccines for the first time, but also about HPV itself: a specifically configured entity that did not exist in the public domain until then—despite the fact that according to biological and medical experts it is an age-old virus that has been afflicting mankind since its dawn. Countries subsequently responded quite differently to this ‘new’ agent and to the availability of HPV vaccines both in terms of public debates and health policymaking.

In this contribution, we look at how HPV vaccination has become (or has not become) part of public health programmes from a comparative perspective, using the cases of Austria and Japan.² Based on analysis of interviews with actors in the field, media accounts, and websites, as part of ongoing ethnographic studies in both countries, we focus particularly on interrelations between public debates and policymaking involving HPV vaccinations, on the one hand, and marketing strategies of the pharmaceutical industry, on the other.

Public health policies, not only in the case of HPV vaccination, involve claims of care. While physicians working in clinical practice and national politicians usually limit their arguments about HPV to a local, national level, the pharmaceutical industry represents itself as responsible and competent ‘for battling disease and promoting wellness on a global scale’, as Merck &

¹ Meanwhile the age limit for women has been abrogated; boys and young men may be vaccinated up to age 26 (Gritsch, 2012, p. 73).
² We wish to thank all our informants for their willingness to share their knowledge and viewpoints with us. Bernhard Hadolt also thanks Hagiwara Takuya and Shimoda Motomu for their support with data collection in Japan when he stayed as a visiting professor at the Institute for Research in Humanities, Kyoto University, in 2011.
Co. claims. For pharmaceutical companies, introducing a drug in a new market requires adjusting organizational tasks to local conditions, such as ensuring the availability of the drug, setting up pathways for its distribution, and making decisions about pricing. In addition, it also entails a ‘downscaling’ of the globally constructed meanings of the drug to the local level, in other words, framing the need for a drug in medical terms, envisioning its benefits, defining target groups, etc., yet with close reference to and as part of claims of global care.

In order to achieve the goal of creating and pushing a global demand for their vaccines, pharmaceutical companies themselves act globally and, to a remarkable degree, in accordance with one another. Kalman Applbaum (2006), in discussing the introduction of new antidepressants to the Japanese health market, identifies a key element in these concerted strategies. Unlike some 15 years ago, pharmaceutical products themselves are today no longer altered to best suit their regional environment: ‘Instead, firms are working strategically and in some regards cooperatively to alter the total environment in which these drugs are or may be used’, thus creating a ‘new paradigm in pharmaceutical marketing: the “global drug-marketing platform”’ (Applbaum, 2006, pp. 86–87, emphasis added).

We argue that in the case of HPV vaccination, Austria and Japan are engaged with this global drug-marketing platform through which transnational pharmaceutical corporations seek to market their vaccines with high revenues. By comparing these two countries as they have been engaged with HPV vaccination up until the time of writing in 2013, we seek to shed light on how global marketing and the flow of commodities and services engage different localities in specific configurations and vice versa.

Global HPV

HPV and its associated diseases are global phenomena, which have created equally large global markets for the pharmaceutical companies. In 2008, only two years after the launch of Merck’s Gardasil, the vaccine was sold for US$1.4 billion (Merck & Co., 2009), albeit almost exclusively in the rich countries of the North and West. It was only later that GSK and Merck & Co. started to provide their products on a larger scale in less developed areas, transforming those regions into so-called emerging markets. In these

countries the burden of disease with regard to cervical cancer is generally much higher, as access to effective measures for early-stage diagnosis, in particular Pap smear screening and treatment, is often virtually inexistent. Of the approximately 275,000 women who die from cervical cancer every year, 88% (242,000 women) live in the developing world (Sichero and Villa, 2013, p. 84). It is often argued in national HPV debates that cervical carcinoma is the second-leading cause of all cancer-related female deaths. Considering the numbers above, this argument only holds if women worldwide are taken into account. In industrialized countries it does not come second: in the UK, death from cervical cancer ranks seventeenth, in Austria twelfth, and in Japan eleventh (Piso, 2010; Hamashima et al., 2010).

In the wealthy, industrialized world, the vaccines were marketed rather strenuously as soon as they were allowed to enter the market, despite the fact that cervical cancer, in epidemiological terms, is not a major health problem in these countries. For the same reason, there has been serious opposition to the preventative vaccination of healthy (uninfected) young girls. Both these debates and the national policies for the implementation of HPV vaccination demonstrate significant national differences that can be contributed to a variety of associated sociocultural and historical factors. For example, in the discussion in Germany, the medicalization of healthy girls at a young age, the problematization of adolescent sexual behaviour, the exploitation of mothers’ sense of responsibility for their daughters’ healthy futures, and the supposed profiteering of the pharmaceutical industry were main issues (Sabisch, 2009; Kolip and Schach, 2010). In the UK, the introduction of the HPV vaccination was profoundly influenced by two controversies concerning infant organ transplantation in the 1990s and the measles, mumps, and rubella (MMR) vaccine in 1998. Both ‘influenced the public’s trust in vaccination programmes, however, parental opposition to the HPV vaccine was based on concerns about the vaccine’s long-term safety and questions about whether or not one could trust public health officials’ (Stöckl, 2010, p. 259). Not least, in many countries including Germany and the United States, questions were also raised concerning vaccine safety (Sabisch, 2009; Casper and Carpenter, 2008).

GSK, Merck & Co., and Sanofi Pasteur MSD acted and reacted deliberately in regard to the diversities of regional health markets, as we demonstrate below for Austria and Japan. On a global scale their discursive strategies

for introducing their upscale products show some recurring elements: an emphasis on altruistic motives in the public interest, the staging and exploitation of the fear of catching a contagious disease and developing cancer respectively (Gritsch, 2012, p. 93), and the claim to possess what Jordan (1997) calls ‘authoritative knowledge’. By that she means ‘the knowledge that participants agree counts in a particular situation, that they see as consequential, on the basis of which they make decisions and provide justifications for courses of action’ (Jordan, 1997, p. 58; emphasis in original).

The discursive production of fear associated with HPV deserves particular attention, as it constitutes a main method in the marketing strategies of the pharmaceutical industry in order to alter the ‘total sales environment’ and hence develop key markets. This can be understood as being part of what medical sociologists Williams and colleagues (2011), conceptualizing the ongoing processes of the pharmaceuticalization of societies, refer to as ‘disease mongering’ and ‘selling sickness’. They define this as:

a process in which the social construction of illness is being replaced by the ‘corporate construction of disease’. [...] This involves: (i) turning ordinary ailments into medical problems; (ii) seeing mild symptoms as serious; (iii) treating personal problems as medical; (iv) seeing risks as diseases; and (v) framing prevalence estimates to maximize potential markets. (Williams et al., 2011, p. 713)

Disease mongering as a corporate construction of HPV-related suffering is closely connected to the production of HPV itself as a killer of women, a dangerous, contagious agent causing sickness, cancer, and death. This entity was not only new to the public, but via its connection to cervical cancer it also became highly gendered, thus creating a huge target group and conceptualizing women—once again—as one category: cervical cancer requires having a uterus. Consequently, as the U.S. Centers for Disease Control and Prevention puts it, ‘[a]ll women are at risk for cervical cancer’, and girls, young women, and mothers all around the world thus need to be not only informed, but educated. For several years only Austria, Australia, and the United States recommended HPV vaccination for both girls and boys (Kunze and Böhm, 2010, p. 658), but still emphasizing women as the primary concern. Only recently have boys and men received more attention as possible target groups for vaccination—not only as carriers of HPVs and

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sufferers from genital warts, but also as possible victims of HPV-related cancers (Giuliano et al., 2011; Newman et al., 2013).

**HPV in Austria**

Austria was the first European country that recommended the vaccines despite having an effective cervical cancer prevention programme already in place since the late 1960s. The programme consists of opportunistic, cost-free, Pap smear screening, recommended annually for all women aged 20 or older. Haidinger and colleagues (2008, p. 222) report: ‘In 2005, 95.7% of all women aged 20–69 years knew about Pap smear screening (1995: 94.0%), and 88.0% were screened at least once (1995: 76.2%). 52.6% of all women can be classified as having been screened optimally.’ Cancer incidence and mortality have constantly decreased since the implementation of the programme. At the time of writing, every year about 380 Austrian women are diagnosed with cervical carcinoma and about 140 die from it (Statistik Austria, 2011a, 2011b).

Nevertheless, when Gardasil and Cervarix were introduced in 2006 and 2007 respectively, their promotion as a ‘vaccine against cervical cancer’ worked well, and Austrian media, physicians, and health politicians were all in favour of widespread vaccination coverage. Educational work and awareness campaigns funded in part by the pharmaceutical industry amplified consent in the public sphere, too. ‘The acceptance for our vaccine in Austria was spectacular!’, recalled a pharmaceutical marketing manager to whom we talked about the market developments at that point. He continued: ‘The sales figures per capita were higher than in any other country’.

But soon the debates and attitudes changed, leading Austrian HPV policy down a very different path. By early 2008, when the HPV debate in Germany was at its peak (Sabisch, 2009), in Austria the topic had already vanished from newspapers, talk shows, and the public interest in general (Gritsch, 2012). As of October 2013, the vaccination rate in Austria is still lower than 5%, compared to up to 90% of girls and young women in Great Britain, Australia, and Canada; and up to 60% in Germany, France, and Belgium (Hörandl, 2010).

As to the historical processes that led to this situation, the stakeholders in the field seem to share a consistent view, summarized by one of our informants, who is an expert in social medicine at the Medical University of Vienna, as an ‘unfortunate mix of misinformation’, involving the discursive entanglement of the vaccination and the death of a nineteen-year-old
Austrian woman in October 2007. Despite an autopsy report that could not substantiate a causal relation to the dose administered, there was a short but violent flare-up of the topic in Austrian media, which led to considerable anxiety about the vaccine, not only in the public, but also among many gynaecologists. In addition, in early 2008 the then Austrian health minister Andrea Kdolsky decided not to subsidize HPV vaccination (by incorporating it into the national vaccination programme) due to its extraordinary high price (see also Stöckl, 2010). ‘Because of all these factors’, the medical expert continued, ‘HPV vaccination is dead and virtually non-existent in our country’. Similarly, a representative of the pharmaceutical industry described the HPV vaccine as a ‘burnt-out’ topic in Austria.

Arguments employed by stakeholders in the field to interpret this Austrian development vary, depending on individual positioning for or against vaccination. It seems that on a pragmatic level, the vaccine manufacturers’ original price led to a stand-off between industry and politics: the Ministry of Health did not accept the costs to its budget; the Austrian branch offices of the pharmaceutical companies showed an unwillingness to negotiate. Subsequently, not least due to the commissions required by their parent companies, they withdrew from the Austrian market. A spokesperson of the medical profession told us: ‘On the one hand patients mostly are not able to afford these prices, and on the other there are the huge corporations. The local firms are not allowed to do what they want, and the parent companies don’t care about whether a handful of Austrians get vaccinated or not’. Consequently, most of the industry’s awareness-raising campaigns concerning HPV vaccination were almost completely halted, which led to a considerable lack of knowledge about HPVs not only in the public sphere but also in the medical domain.

In 2011, the issue of HPV vaccination re-entered the political stage: GSK and Sanofi Pasteur MSD established a joint HPV working group with the dual goal of raising awareness among Austrian healthcare policy stakeholders and disseminating new information. A GSK spokesperson explained this step to us in the following way: ‘Considering the Austrian situation right now, it does not make sense to act solitarily. It is more reasonable to form one interlocutor who also gets acknowledged as a partner by public authorities.’

Additionally, the companies reduced the high prices of their vaccines to a more moderate level and resumed negotiations with the Austrian Ministry of Health for subsidizing vaccination within the national vaccination

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6 The original price for a complete immunization with either vaccine was €624 (€208 per dose).
programme. Consequently, as of 2012 mentions of the vaccination and the virus began to reappear on a sporadic but a regular basis in the Austrian media and medical journals. Finally, in August 2013 Health Minister Alois Stöger declared that, starting in February 2014, vaccination would be state funded for children aged nine as part of a school-based HPV vaccination programme.

What is remarkable here is the inclusion of boys in the vaccination programme alongside girls. As the first European country to subsidize HPV vaccination for boys, Austria is resuming its leading role in making HPV a relevant issue for both women and men, as it had done when it recommended HPV vaccination for both girls and boys in 2006. This Austrian policy decision lines up with a general change in discourse. While boys were mainly seen affected as transmitters of HPVs until recently, they are now becoming increasingly perceived as potential sufferers from HPV-related cancers.

HPV in Japan

GSK’s Cervarix was first to launch in Japan in December 2009, and Merck & Co. followed with Gardasil in September 2011. Compared to the launches of HPV vaccines in other parts of the world, this was a rather late development. This ‘vaccine gap’ (Saitoh and Okabe, 2012) of about three years seems to have been due to the Japanese drug-approval procedure that requires pharmaceutical corporations to submit additional clinical trials done in Japan because of the supposed physiological specificities of Japanese people (see also Applbaum, 2006). However, according to a GSK sales manager, this ‘vaccine gap’ of about three or four years, which, compared to other pharmaceutical fields, was rather short, had the advantage that Japan’s branch of GSK already had knowledge about ‘what is going on globally’ and could adjust their marketing strategies accordingly.

As several Japanese gynaecologists have complained in interviews, gynaecological check-up rates in Japan are rather low, particularly the rate of Pap smear test as a preventive measure against cervical cancer, with an estimated number of 15,000 women developing cervical cancer per year, and 3500 women dying from it. Women in their 30s and 40s in particular do not have gynaecological check-ups, since, according to interviewed gynaecologists, they conceive of cancer and other gynaecological problems as older women’s problems. In Japan, the Pap smear rate now is about 40%,
but only a couple of years ago was around 20%; compare this, for example, to the rate in the United States of about 85% (OECD, 2013).

This fact is significant in at least two regards: First, young women in Japan neither knew nor cared much about cervical cancer and the risk of developing the disease, at least until Cervarix entered the scene. Second, the low rates of Pap smear tests enforced the argument that HPV vaccination was urgently needed in order to save women from dying of cervical cancer. Both points were explicitly voiced as urgent rationales for vaccination by practically all stakeholders in the policymaking process, and especially by gynaecologists.

When GSK launched Cervarix in Japan, the company had to ‘start from scratch’ and ‘dig into the market’, as the GSK sales manager put it. Besides getting the vaccine approved GSK took major efforts to ‘raise awareness’ about both cervical cancer and the fact that HPV vaccination can prevent cervical cancer. According to the GSK sales manager they had to educate all people involved: mothers, girls, young women, media people, local and national policymakers, and not least doctors. They did so using multiple strategies.

The key message geared towards the public at the time of the vaccine’s launch in 2009 was the same as in other countries and comprised three dimensions: every woman has a risk of developing cervical cancer, the cause of cervical cancer is HPV, and HPV vaccination can prevent it and consequently save lives. GSK spread this message through manifold channels, including newspaper articles, TV advertisements, radio features, and the organization of public discussions as part of a large-scale, direct-to-consumer advertising campaign. The company collaborated with self-help groups, advocacy groups (such as the Japan Cancer Association), and doctor’s associations (such as the Japan Gynaecology Association and the Japan Society of Gynaecologists and Oncology).

According to the GSK sales manager, within a few years awareness about cervical cancer and HPV vaccination rose from a very low level up to 90% of Japanese women due to such activities. In 2011 GSK shifted its key message to a ‘higher level’, as the sales manager put it, also stressing the importance of Pap smear testing. He explained:

[W]e are a pharmaceutical company selling a vaccine but we have to deliver the message about screening as well. [...] We have to say: The vaccine is not perfect and cervical cancer is only perfectly prevented both by screening and the vaccine. So we shift to the other message as well and [put] more weight on the screening because we are quite afraid that
some people will misunderstand: ‘Oh, I got the vaccine and I never will get cervical cancer’. And 10 years later she has no Pap smear, then gets cancer. It’s possible, so there is quite a worst [case] scenario for us as well.

The sales manager repeatedly stressed the importance of safety issues for GSK’s marketing strategies as: ‘Japanese are very, very, very, sensitive about safety’. In particular, he thought that rather than weighing benefits against risk, many Japanese people would not consider vaccination at all if concerns about major side effects of the vaccine were raised.

As the prime message of GSK’s awareness-raising activities was focused on the protection of women from cervical cancer, the fact that other HPV-related cancers might be a health problem too hardly surfaced in the debate. This was even more the case with the notion that men also might benefit from vaccination and hence boys should be vaccinated alongside girls. The sales manager justified GSK’s decision to not submit its vaccine for approval for boys as well by referring to limited public health funds and women being the primary beneficiaries of the vaccine. In their awareness-raising activities, GSK furthermore aimed to omit, as much as possible, the fact that HPVs are transmitted via sexual contact, because they feared that the issue would be misconstrued as encouraging sex among girls at a younger age. Female promiscuity had already become an issue in the public HPV debate in the United Kingdom, among other places (see Hilton et al., 2010; Stöckl, 2010).

The ultimate goal, according to the sales manager, was to make HPV vaccination an ordinary thing to do: ‘Japanese people tend to follow everybody else: When everyone does it, I do. [...] So when everyone starts [doing] it, the rest of the population starts to follow’. Alongside the consideration of safety issues, the elision of HPV as being sexually transmitted was considered a key aspect in developing, in the words of the sales manager, ‘our own way’ of promoting HPV vaccination in Japan.

Expert knowledge about cervical cancer and HPV vaccination was also spread to doctors, in particular gynaecologists, paediatricians, and internists. GSK trained doctors, organized seminars, and contributed to major conferences for the Japan Association of Obstetricians and Gynaecologists and the Japan Society of Gynaecologic Oncology where topics associated with cervical cancer and HPV vaccination were discussed. The company also collaborated with researchers at high-ranking Japanese universities, such as Osaka University, to gather epidemiological data on the prevalence of HPV infection and the long-term effectiveness of HPV vaccination in Japan. Additionally, GSK provided health policymakers and civil servants
with cervical cancer-related information, lobbied for a fast approval of its vaccine, and advocated that HPV vaccination be financed with public funds.

On the whole, GSK was indeed successful in regulating the flow of information about cervical cancer and HPV vaccination in Japan by the time Merck & Co. entered the market with Gardasil in 2011. Most interviewed stakeholders referred to informational materials that had been distributed by GSK when asked about the source of their knowledge. Furthermore, consensus about the effectiveness and safety of Cervarix among stakeholders was high at that time. Health officials from one major city reported that all of Japan’s major cities planned to petition the national government to make HPV vaccination mandatory for girls.

As early as spring and summer 2010, several local governments throughout Japan started to cover all or part of the costs of approximately ¥50,000 (about €400) for immunization with Cervarix (Fujiwara et al., 2011; Hayashi et al., 2012). By the end of 2010, the national government announced the establishment of an HPV vaccination fund; in February 2011 this fund in cooperation with local governments began fully subsidizing the vaccine for girls aged twelve to sixteen. According to GSK, in summer 2011 the average vaccination rate already was about 50% for this age cohort. This interim nationwide programme was made permanent when in April 2013 HPV vaccination became included in the national immunization programme following a revision of the Japanese Preventive Vaccination Act.

However, only a few months later, in June 2013, the Ministry of Health, Labour, and Welfare withdrew its recommendation for HPV vaccination, following reports of several cases of supposed significant side effects including severe pain, convulsions, and numbness. Two medical expert groups were set up by the ministry to examine these cases. At the time of writing, findings of such investigations have not yet been made public and the Japanese HPV-vaccination policy continues to be marked by a situation in which the vaccine is still available free of charge, yet without the governmental recommendation for its use. Thus, a development that looked favourable to pharmaceutical interests has taken quite a sudden turn of events.

Concluding remarks

A new paradigm of pharmaceutical marketing, the global drug-marketing platform (Applbaum, 2006), alters ‘total sales environments’ to make them fit for pharmaceutical products. Such environments include not only policy and economic factors, but also people’s ideas and behaviours, which are
modified by persuading them that they are not well and are in need of drugs to get well again. Concerning preventive vaccines, this entails a shift from present to future problems, to diseases that are prognosticated instead of diagnosed. Consequently, the making of ‘being at risk’ is most crucial here, since the industry’s success requires people to become aware that they face possible disease and mortal danger.

In the case of the rapid implementation of HPV vaccination into healthcare services in the industrialized world, this marketing of risk has involved a number of discursive elements. These include the highly gendered ‘disease mongering’ (Williams et al., 2011) of cervical cancer as a major killer of women, the redefinition of cervical cancer as being caused by HPV, and the assertion that virtually ‘all of us’ carry the virus. The discursive association of the fear-laden ideas of cancer, virus, contagion, and sexual transmissibility sustained the marketing message about the HPV vaccine being a ‘vaccine against cancer’, rather than a vaccine against a virus, or against specific strains of HPV. On the whole, HPV vaccination was framed predominantly in medical terms.

In both Austria and Japan, this discursive configuration constituted the basis on which national debates were shaped and pharmaceutical industry marketing strategies were built: enrolling medical associations and patient support groups for awareness-raising campaigns, providing authoritative knowledge to politicians via lobbying, and using a rhetoric of altruistic motives and public interest with the media. Together these constitute an encompassing strategy of change, exemplifying what a global drug-marketing platform looks like in the case of HPV vaccines. At first glance, the Austrian situation seemed early on to be a case of the potential failure of the pharmaceutical marketing strategies described. At the local level, this might have been the case, notwithstanding the fact that Austria recently has joined other industrialized countries in subsidizing HPV vaccination. But put in a global context it proves otherwise: it is economically all too logical that globally active companies withdraw a product from a rather small, unviable market such as Austria when marketing strategies are not successful.

The cases of Austria and Japan also show that while the broad lines of the above discursive configuration were the same, they were also shaped by distinctive local conditions. In Austria, as in other countries such as Germany and the United Kingdom, a counterdiscourse surfaced within a short time after the public debate started that was critical of HPV vaccinations. This counterdiscourse highlighted possible deficiencies of the vaccine, including adverse side effects, and its low benefits in a situation where an effective
screening programme was already long in place. In a cost-benefit calculation, the risk of developing cancer was weighed against the risk of side effects, and the public costs for HPV vaccination weighed against the benefits of investing in other health areas. In addition, the issue of boys as possible beneficiaries of the vaccine was part of the discussion right from the beginning.

In Japan, the situation was almost reversed: until recently, the pharmaceutical companies, particularly GSK, dominated the dissemination of HPV-related information and both the risk of severe side effects and the fact that HPVs are sexually transmitted were carefully avoided. The issue of boys as a target group for vaccination was set aside in the drug-approval procedure, in the public debate, as well as in the policymaking process. In order to find a ‘Japanese way’ of promoting HPV vaccination, GSK also prioritized making it an ordinary thing to do, so that most people would follow the vaccination recommendations once set in motion. When major safety concerns finally did emerge, they radically marginalized the talk about possible benefits of the vaccination and state authorities had to withdraw their recommendation for vaccination.

The cases of Austria and Japan highlight that the marketing of drugs has to be understood as a process that may include sharp turns, as demonstrated in Austria by the policy shift towards state-subsidized HPV vaccination, and in Japan by the shift away from state support of the vaccine. These idiographic situations and processes show that the global drug-marketing platform works in a multidirectional fashion rather than as a one-way street. While local environments are indeed altered in order to become receptive to pharmaceutical products, this to some extent also applies to the global marketing programme and products. By way of actively adjusting their marketing strategies to local needs and circumstances, products are also ‘adjusted’: some of their properties become highlighted and others downplayed. By carefully modifying the meaning of a pharmaceutical product, a kind of ‘contact zone’ is constituted between the product, local discourses, and medical practices that may make it appropriate for implementation. It is along this global/local contact zone that authoritative knowledges, fears of a disease-infested future, and rhetorics of (global) care and promised cures are played out—together giving form to new disease entities, risky selves, and new markets.

References


