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[Back to article page](#)

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## Who Lives and Who Dies

### Paul Farmer on the iniquities of healthcare funding

What is it like to be a passenger on a bus, or standing in a cheering crowd at the finishing line of a marathon, in the seconds after a bomb goes off, when you know you're hurt but not where or how badly? What's it like to be a child who finds a discarded toy and picks up what turns out to be a landmine? What's it like to be giving birth at home, and see blood pooling between your legs, and look up at the ashen faces of a birth attendant, a midwife, a spouse? What's it like to feel the earth tremble and see the roof and walls of your home or school fall towards you? More to the point, in terms of survival: what happens next? It depends. Not just on the severity of the injury, but on who and where you are. Death in childbirth, once the leading killer of young women across the world, is now registered almost exclusively among women living in extreme poverty, many of them in rural areas. Trauma is now the leading cause of death for children and young adults in much of the world. Who lives and who dies depends on what sort of healthcare system is available. And who recovers, if recovery is possible, depends on the way emergency care and hospitals are financed.

In the thirty years since I began my medical training in Boston, Massachusetts, I've cared for critically ill patients in Harvard's teaching hospitals, as well as in Haiti, Peru, Rwanda and elsewhere in Africa. Study of healthcare financing was almost wholly absent from the curriculum at Harvard Medical School. But after working in rural Haiti I felt it was a necessary topic. I have seen patients grievously injured, often at the point of death, from a weapon or neglect or a weak health system or carelessness. Some died; those who had rapid access to a well-equipped hospital had a better chance of survival. I convinced myself, at first, that the differences in outcome must have been due to worse injuries, greater impact, more blood loss. But with time and broader experience, I was tempted to record the cause of death as 'weak health system for poor people', 'uninsured', 'fell through gaping hole in safety net' or 'too poor to survive catastrophic illness'.

The people I lived with in the hills of central Haiti had a concise way of putting it: these were 'stupid deaths'. It was to prevent such deaths that Partners In Health was founded in

the mid-1980s, with the aim of providing care for the ailments, trivial or catastrophic, that afflicted the poorest, who were doing most of the stupid dying. PIH would also recruit and train others, whether as community health workers or nurses or doctors or managers, and generate knowledge about ‘healthcare delivery’: what’s the best way to treat Aids or cancer or drug-resistant tuberculosis in a squatter settlement in rural Haiti or a slum in Peru? How might we introduce trauma care, much of it surgical, where none exists? How might we prevent and treat malnutrition, which complicated most of the illnesses we diagnosed in children, without importing cheap food from subsidised US farms (which would further decrease the paltry incomes of local farmers, the parents of the malnourished)? How would we help the people who lived in these places, and had the most at stake, to get trained and qualified?

Our grandiose 1987 mission statement – most of us were still students – even promised to serve as ‘an antidote to despair’. Much of the despair we’d seen was generated by the ‘OOPS approach’ to sickness. ‘Out Of Pocket Spending’, a leading cause of destitution in countries rich, poor and in-between, was largely responsible for the stupid deaths we witnessed, since the care people paid for was expensive and mostly bad. PIH committed itself to the fight for healthcare as a human right. Such a right was in principle guaranteed by governments, even if they were unable, alone, to provide both healthcare and protection from destitution caused by a lack of health insurance. That meant PIH would try to help public health authorities to do their jobs, an aspiration dismissed as silly or worse by most other NGOs. We knew little about (and had nothing against) private health insurance, but we’d seen what it meant to be poor and sick or injured. The vast majority of Haitians had no insurance, public or private; they paid for their poor-quality healthcare, and inadequate education, with their own scarce cash.

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One afternoon in October 1988, I was leaving a friend’s house in Cambridge, Massachusetts in a self-important rush: a medical student also getting a degree in anthropology, I was headed back to Haiti, then experiencing a great political upheaval. My friend was one of the founders of Partners In Health, which we believed, even then, might make a difference in rural Haiti and beyond. But that’s not the reason I was in a rush: I was eager to correct the proofs of an academic paper (my first) before boarding an early flight to Port-au-Prince, where electricity and postal services were uncertain. The paper was on the political economy of health and illness in Haiti. I was also distracted (distressed, really) because three of the Haitian founders of PIH, all in their twenties, had recently died stupid deaths. The first of puerperal sepsis shortly after childbirth; the second of cerebral malaria in a psychiatrist’s waiting room after being misdiagnosed as psychotic; the third of typhoid fever, a rare infection where there is modern sanitation; it had eaten through his small intestine and he died as he was being rolled into one of the operating

rooms of Haiti's large, dysfunctional university hospital. My three co-workers, seriously ill, found themselves at the door of the House of No, even as they were working to dismantle it.

Unlike my Haitian co-workers, in 1988 I escaped a stupid death. Outside my friend's house in Cambridge, I ran to catch a bus. A car in the first lane slowed and waved me across Huron Avenue. I turned back to my friend and, referring to my paper, said: 'You're not paying attention.' A car in the second lane hit me, knocking me in front of the bus, which swerved just in time. I tried to get up and out of the way of the traffic, but failed: my left leg was broken. But lying in the road, I was already grateful for two things: that the bus I'd missed had missed me, and that I would soon be in a proper hospital. The doors to the House of Yes would swing open. But there was more than a touch of the OOPS plan evident here, too, and a dysfunction I could see even before I reached the emergency room. 'We're taking you to Sancta Maria Hospital,' one of the ambulance crew said. I'd never heard of Sancta Maria; the ambulance service, a private and for-profit concern, must have had some sort of contract with it. I asked instead to be taken to the Mount Auburn, a Harvard teaching hospital less than half a mile away. From the Mount Auburn I was transferred, again by ambulance, to the emergency room of Massachusetts General Hospital, which I'd just left after a long clinical rotation. My orthopaedic surgeon would be Dr Boland, the surgeon for the local professional football team.

The first dose of morphine (a cheap drug, but one largely unavailable in Haiti as in much of the poor world) made me voluble and almost cheerful. If Dr Boland could patch up the New England Patriots and return them to the field, surely he could put me to rights; I'd be back in Haiti in no time. In the second ambulance with me was another friend, an emergency physician from Colombia. We talked about Pinochet – it was the day of the plebiscite in Chile that denied him another eight years in power – whose many sins had included the dismantling of the country's public healthcare safety net.

The emergency room of MGH was, in those days, chaotic, poorly laid-out and slow, as the Colombian doctor complained to the nurse. My morphine-induced euphoria began to give way: the pain returned and my leg looked less amenable to repair. Nausea, whether from the morphine or from too little of it, was taking over. It was some time before the orthopaedic resident showed up. Knowing I was a medical student, she spoke telegraphically: 'Your knee is destroyed. You will go to the OR as his first case.' She was referring to Dr Boland. 'Anaesthesiology will come and see you tonight; not sure when; they're busy too.' In those days, doctors-in-training and students, rather than phlebotomists, drew blood at night, with varying success (this at one of the best resourced hospitals in the world, and one of the oldest in the US). The resident stuck a needle in the crook of my arm and popped a glass tube into the plastic sleeve on the bevelled surface of the other end of the needle. Instead of dark, homogenous venous blood, a raspberry-

and-cream swirl of blood and fat came out of my arm. Fat in the bloodstream after an injury like mine signalled the possibility of a fat embolus, a rare but potentially fatal complication of long-bone fractures. 'I will have the anaesthesia resident come right away,' she said, more gently. 'Just in case.'

I gave myself up to illness. The next dose of morphine, long overdue, made me vomit, and by morning I was happy to be wheeled to Dr Boland's operating room. It was more than a month before I returned to Haiti, in a wheelchair, and three months before I walked without a crutch or a cane. But I knew, even as I saw – for the first time as a patient – the imperfections of our medical system, that I'd been given excellent surgical and nursing care. After five years between Harvard and Haiti, I knew I was lucky to receive it.

What did my failure to look before crossing the road cost? It's smarter to think of price, rather than cost, in the crazy and profoundly ideological arena of healthcare financing. All told, the price of my care was about twice my widowed mother's annual salary as a grocery store cashier. How was it paid, given that in 1988 she, like all but one of her six children, was a student? By the private health insurance provided to students at Harvard. It covered most of the bills, though I was hounded for more than two years by the ambulance service that had taken me to two of Harvard's teaching hospitals in one night. For some reason my student insurance didn't cover that expense, or perhaps I made a mistake filling out the stacks of forms that piled up along with the 'co-pays' for medication, crutches, renting a wheelchair and physical therapy – all obtained from different companies rather than from the hospital.

In other words, lucky as I was to receive such excellent care, I was even luckier to have insurance for 'catastrophic illness', as it's known in health economics jargon. Surgical care like mine is estimated to impoverish some thirty million households a year – and those are only the fortunate families that receive care when they need it. By some estimates, the fraction of humanity covered fully for catastrophic illness is between 5 and 10 per cent. It isn't only in the rural reaches of Haiti, Rwanda, Lesotho or Malawi that millions die at the door of the House of No. The south side of Chicago has been called a 'trauma desert' because there isn't a single fully staffed and equipped trauma centre on that side of the city, which is one of the reasons that the outcome of trauma there – much of it caused by guns – is so much deadlier than in more affluent reaches of the third largest city in the US.

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So how do we finance emergency and trauma care? What about cancer care? Hospital care in general? How do we foot these bills as well as bills for prevention and primary care, so often pitted against the sort of hospital care I received but my Haitian colleagues did not? I would have been wise to look both ways before I crossed, but wouldn't have wanted the ambulance crew or the orthopaedic surgeons to lecture me about prevention. My Haitian

friends, though, might well have heard a chorus of such opinion while they were dying of malaria ('should have had a bed net'), typhoid ('should have drunk clean water') or after childbirth: lectures about family planning and handwashing abound in places like Haiti, and most of them are directed at the poorest – typically women – rather than to those responsible for the staff, stuff, space and systems required to deliver such services.

It is vividly apparent that prevention is being pitted against care in comments about the current Ebola epidemic in West Africa. Many are surprised to learn that Ebola kills mostly by causing massive fluid and electrolyte loss through vomiting and diarrhoea. These are treated by fluid resuscitation, a fancy term for replacing what has been lost. It's hard to do this by drinking Lucozade if you're vomiting, which is why the severely dehydrated often need what physicians and nurses call 'supportive care', which doesn't mean handholding but intravenous fluids (often several litres per day), electrolytes and nutritional supplements.

In August the president of Nigeria called a Liberian-American sick with Ebola 'a madman' for seeking treatment in Lagos, even though proper care for the critically ill was unavailable in Liberia: most of its hospitals had closed and the 'Ebola centres' had thus far been more about isolation than care. The blogosphere erupted with similarly uncharitable comments about two American humanitarians who were airlifted from Liberia to Atlanta for hospital care. In September Liberian police shot dead a 15-year-old boy trying to break out of, or protest against, the quarantine of an entire neighbourhood. Sierra Leone made it a crime to shelter an Ebola patient.<sup>[1]</sup> In the US, Ebola – or, rather, the fear and anxiety it triggered – became an issue in the run-up to the midterm elections. Travellers from West Africa, including volunteer doctors and nurses, felt stigmatised.

It's possible to argue, as many politicians did, that the fuss was all about averting an expensive health crisis, but prevention is no longer the issue for those already injured, or sick with Ebola or Aids or typhoid or cancer. Finding equitable ways to finance healthcare, including the treatment of catastrophic illness, is the main challenge for both medicine and public health, along with weaving, or restitching, the safety nets that might protect families from death or disability and the financial ruin that accompanies serious illness.

There are few health economists in the rural parts of the developing world where I've worked, but there are plenty of development economists working full-time, if often from a comfortable distance, on 'poverty reduction' through economic growth. Some of them have been architects of the House of No, calling for the reduction of public expenditure, the privatisation of health services and public investment only in services deemed 'cost-effective'. In all the years of my training, moving between Harvard and Haiti (and parts of Latin America), I rarely heard calls for investment in the treatment of trauma, cancer, diabetes, Aids or drug-resistant TB. Many influential players in the 'donor community'

held that such efforts simply weren't cost-effective. Even the treatment of drug-susceptible TB, which costs less than \$200 per patient and prevents airborne epidemic spread, was thought by experts in 'selective primary care' not to warrant the investment of scarce resources in poor countries. The list of pathologies deemed too costly to cover went on and on.

Despite this, a 'revolution in child survival' began in the middle of the last century, hastened by massive campaigns to end vaccine-preventable illness and diarrhoeal disease. The effect of such campaigns, along with the advent of modern contraception and the promotion of breastfeeding, was – as anticipated – that sky-high child mortality rates began to drop in even the poorest countries, as they had in previous decades in affluent countries (and among affluent families in poor ones). A century of differing health outcomes, especially for infants and children, was at last coming to a close. In *The Great Escape: Health, Wealth and the Origins of Inequality*, the Princeton economist Angus Deaton describes 'the reduction in global poverty since 1980' as 'the greatest escape in all of human history and certainly the most rapid one'.<sup>[2]</sup>

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But economic growth doesn't necessarily lead to a health revolution. For the past decade India has consistently ranked below only China as the world's fastest growing economy, but it has failed to address some of the worst healthcare disparities in the world – and what may well be the highest global rates of childhood malnutrition and stunting. In *An Uncertain Glory: India and Its Contradictions*, Jean Drèze and Amartya Sen consider the plight of hundreds of millions of Indians who still live in poverty, often as a consequence of class, caste and gender inequality, without ready access to education, credit or any sort of social safety net.<sup>[3]</sup> One of the questions Drèze and Sen ask is how to finance health services ranging from prevention to primary care to catastrophic illness:

A health system based on targeted insurance subsidies is very unlikely to meet basic norms of equity in healthcare, as four different sources of inequality reinforce each other: exclusion errors associated with the targeting process; screening of potential clients by insurance companies; the obstacles (powerlessness, low education, social discrimination, among others) poor people face in using the health insurance system ... where access to healthcare is linked with the ability to pay insurance premiums.

Drèze and Sen draw on lessons from across the world, comparing China unfavourably with India in terms of democratic institutions, but noting that since it restored its rural health insurance scheme which was savaged a few decades back, China has surged ahead of India in all standard measures of health and wellbeing. So have Bangladesh, Mexico, Thailand

and many other countries with radically different political systems. All have public health systems that aspire to universal coverage, though with varied success. Drèze and Sen are critical of the healthcare system in the US,

one of the most costly and ineffective in the industrialised world: per capita health expenditure is more than twice as high as in Europe, but health outcomes are poorer (with, for instance, the US ranking 50th in the world in terms of life expectancy). This system is also highly inequitable, with nearly 20 per cent of the population excluded from health insurance, and terrible health conditions and risks among deprived groups.

And some disparities of outcome are growing. As deaths due to Aids, TB, malaria and vaccine-preventable illness are dropping, and life expectancy at birth continues rising, a greater share of deaths in the poorer parts of the world are due to trauma (or other injuries, intentional and unintentional), and to complications of heart disease and diabetes; two-thirds of all new ('incident') cases of cancer already occur in 'low and middle-income countries'. Integrating prevention and care for these pathologies requires not only community health workers and clinics, but hospitals able to care for the injured and patients with 'non-communicable disease'. An injury like mine, sustained because of a jaywalker's inattention, would probably be tossed into this broad category, but so would injuries due to gunshot wounds, especially in trauma deserts, and problems associated with diabetes and heart disease, in food deserts.

Such deserts – most of West Africa is in a public health desert, which is why Ebola spreads, as well as a supportive care desert, which is why it kills – need resources. One of the suggestions of the 2013 *Lancet* Commission on Investing in Health was 'progressive universalism', which is to say publicly financed health insurance schemes, with the rich paying more through taxation than the poor (as with the NHS since 1945, though perhaps not for very much longer). 'Throughout most of recorded history', the British epidemiologist Martin McKee and colleagues recently observed, the concept of universal healthcare 'was essentially meaningless because healthcare had so little to offer'. In much of industrialising Europe, premature mortality began its decline well before the advent of widespread vaccination. The antibiotic revolution seemed to matter less than improved sanitation and living conditions, which led some to argue that access to healthcare was far less important than meaningful improvements in work, education and other drivers of economic growth: there was not much improvement in life expectancy among the Navajo when they were given 'modern' medical care for a limited set of diseases. But such claims were made in the infancy of modern medicine, as is clear from the meagre 'package' of therapies offered to the Navajo.

In discussing settings with ‘limited resources’ – usually code for people living in poverty and without medical insurance – it was widely argued (in discussions about poor people rather than with them) that medical care was a luxury compared to efforts further ‘upstream’ to promote economic development and basic sanitation. Arguments proliferated along the lines of ‘they don’t need new medical technologies or medicines; they need prevention and better living conditions’ – as if it were either/or. In the last decades of the 20th century, the policymakers qualified their prescriptions by drawing on rudimentary notions of ‘cost-effectiveness’ and ‘sustainability’. In the face of rapid medical advances, and dizzying fluctuations in both the cost (to say nothing of price) and effectiveness of these advances, it was increasingly the global poor who were asked to make do with the ‘basic minimum package’.

I first heard this term in a public health course at Harvard in the mid-1980s, when it was asserted that our attentions in places like Haiti, or most of Africa, should be focused on a package called ‘Gobi’. ‘That’s what we should be financing,’ I heard. Believing Gobi to be a desert in Mongolia, but clearly in a minority (the public health students, unlike the medical students, seemed to know it was an acronym for ‘growth monitoring, oral rehydration, breastfeeding and immunisation’), I wondered, and still do, how medical care could ever fit into so small a package. What had happened to ‘health for all by the year 2000’, the goal endorsed by most of the world’s health ministers at a meeting in Alma Ata, in the Kazakh Soviet Socialist Republic in 1978?

A ‘minimum package’ presupposes the existence of a bigger, even a maximum package. If your child has leukaemia, then you’d better hope the package includes chemotherapy (it didn’t and, in most countries, still doesn’t, although its main components have long been off-patent). If you’re hit by a car and need surgical care, you’d hope – I merely assumed as much – that you’d get it (another big no). Most of the misfortunes that exclusively afflict the poor weren’t even on the Gobi agenda. The vaccines and drugs required to treat ‘emerging infectious diseases’ like Ebola do not yet exist because there’s no money to be made from them. The kind of care that ‘we’ receive isn’t ‘affordable’ or ‘sustainable’ for ‘them’ – the poorer inhabitants of indebted countries under pressure to shrink their public budget and healthcare payroll. Across sub-Saharan Africa, with a few notable exceptions such as Rwanda, hospitals are either private, expensive and out of reach of the destitute sick, or publicly financed, underequipped, understaffed and frequently avoided by the destitute sick, who know that the quality of care is dismal. They are often huge drains on the scant budgets of health ministries and offer little ‘value for money’. They are, in the words of experts in public health and development, ‘unsustainable’.

But how did we, the already sustained, get access to sustainable healthcare? How did those long shut out of modern medicine come to have the same aspirations – to be cared for when sick, to be protected from financial ruin – dismissed as unsustainable? The word



‘sustainable’, Haun Saussy has written,

is a migrant from the sphere of engineering and environmentalism to that of business, and thence to that of political economy ... When used by specialists in international economics, the term refers to a fantasy in which the costs of development (say, the building of a healthcare infrastructure) are borne by the beneficiaries, something that was certainly not the case for Europe during the Industrial Revolution, and is unlikely to occur elsewhere.

This anti-hospital bias, though quietly espoused by many experts in ‘global health’, is bad news for poor people requiring hospital care. It’s really the poor who are ‘unsustainable’ if they get cancer or suffer serious injury. Proper care for trauma or cancer often requires surgery, anaesthesia, chemotherapy and diagnostic capacity (such as computerised tomography or laboratory testing); such services are often delivered within hospitals or clinics and should also be complemented by home-based care.

The need for hospitals is uncontroversial in parts of the world where there are already many – often too many – of them. But the need for improved hospital care in parts of the world where there is little or none of it is hotly contested, in large part because these places also lack the staff, stuff and systems to deliver primary and preventive care. Without such basics, ‘Third World’ hospitals, almost always in urban areas, come to consume the lion’s share of expenditure even as they provide poor quality care. Unsafe spaces, they are also epicentres of drug-resistant bacterial infections that can only be stopped by the prudent use of antibiotics and, like Ebola, by proper infection control. Development economists and public-health specialists may argue that hospitals are a bad investment, but politicians know that cutting off funding to public hospitals is politically and socially unsustainable. The debate is too rarely informed by a consideration of what it might or should cost to link hospital care to better primary care. Everyone, everywhere, is likely to need both at some point between birth and death.

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Lesotho, one of Africa’s poorer countries, is tiny, landlocked and completely surrounded by South Africa, the continent’s economic and medical powerhouse. Most of the Basotho people live in rural, mountainous areas: the first time I went to one of the highland outposts where Partners In Health was working, I travelled with a young Haitian doctor with whom I’d worked for several years. As our tiny plane landed on an unpaved airstrip, it started to snow. He looked at me accusingly: ‘You didn’t tell me it snows in Africa.’ He worked there for two years: he was the first doctor in recent memory to live full-time in the region.

There's little doubt of the need in a place like Lesotho for a robust primary care system in which preventive efforts reach the rural poor via community health workers. But as in Haiti, some of the biggest problems in rural Lesotho were catastrophic illnesses: obstructed labour, trauma, Aids, cancer and TB, including its drug-resistant forms. TB also afflicted many Basotho patients with Aids, most of whom had been working in South Africa (often in mines) and had come home to die. Some international public health experts advised caution in investing in such costly endeavours as treating HIV disease, which afflicted up to a third of the young adult population. As these infections rapidly became the leading killers of adults and children, low pay and difficult working conditions – no staff, no stuff, no safe space – fuelled an exodus of health professionals. By 2007, when we began working in Lesotho, there were said to be more Basotho doctors and nurses outside the country than in it.

There was no medical school in Lesotho, which claimed independence from Britain in 1966. The only public referral hospital, named after Queen Elizabeth, in the capital city, Maseru, was decrepit, poorly run and subject to explosive outbreaks of drug-resistant TB: few if any Basotho mourned plans for its closure and replacement. The question was who would build a new hospital and how it would be paid for. Under pressure to privatise a poorly functioning and worn-out public institution, and to improve the quality and cost-effectiveness of care, the government turned to Netcare, a South African company which promised to build a proper teaching hospital for more or less the same amount as Queen Elizabeth was costing to run. This was in 2009. With the help of the International Finance Corporation, part of the World Bank, Lesotho and Netcare negotiated an 18-year contract, which set a cap on the number of patients to be cared for and specified the precise services to be provided. The ministry of health would own the hospital (and its debt) – this was a 'public-private partnership' – and pay extra for referrals to South Africa for specialist care unavailable in Lesotho.

A year after the opening of the hospital – an enormous improvement on its crumbling predecessor – it is perhaps too early to say, as a recent Oxfam report does, that the institution represents a 'dangerous diversion' of public money to a private concern. But there are significant financial problems and many disappointments. By 2013 the hospital was consuming more than half of the health ministry's budget, the cost of referrals to South Africa was significantly higher than planned, and programmes to train medical specialists (to care for patients with cancer, for example) had still not begun. The ministry of health also had to pay, as debtors do, late fees which amounted to \$755,000 by April 2014. This was the debt of a small sovereign nation to a private consortium, following the usual pattern: privatising profit, socialising risk. The Oxfam report suggests that, within a couple of years, the agreement may consume 80 per cent of Lesotho's public health budget; high-ranking government officials (beset by criticism, although they weren't part of the

administration that signed the deal) are considering renovating the old hospital in the hope of providing some of those services within the public sector. That won't solve the basic problem: most Basotho live in rural areas with no doctors, few nurses and dilapidated clinics. Travelling to Maseru for medical care is often perilous and always expensive.

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Haiti faced an even graver crisis in 2010, when an earthquake destroyed much of the health infrastructure in its capital. The health ministry collapsed, as did other federal buildings; an estimated 20 per cent of public health employees were killed or injured. The ministry asked Partners In Health to build a teaching hospital in Mirebalais, a small city in central Haiti outside the earthquake zone. (I'd lived there 25 years earlier; it's where I went to convalesce after breaking my leg, and where, along with Port-au-Prince, my three colleagues received late diagnoses and substandard care.)

Completed in 18 months, it's the largest solar-powered hospital in the developing world. Built by local workers, with volunteer technical assistance from US carpenters, plumbers and electricians, it cost roughly one-fifth what the smaller Maseru hospital did. It's hard to compare the two – one is for-profit, the other isn't – but while the Haitian government made the largest contribution in the first year of operations, the Mirebalais hospital doesn't consume even 15 per cent of the health ministry's budget. During that first year, the hospital saw roughly as many patients as the Maseru hospital and its directors launched training programmes in surgery, paediatrics and internal medicine; others in specialist nursing, management and emergency medicine are now underway. It's the biggest employer in central Haiti. One French economist has estimated conservatively that each dollar invested in the facility generates almost two dollars in the local economy.

In part because of deep ambivalence about services for the poor, whether they live in rich countries or poor ones, and in part because of a relentless push to privatise profits as we socialise losses, we are still asking how to pay for the staff, stuff and systems required to build the House of Yes and make it a space that can serve those most in need. New ways of financing healthcare – and of making it easier to stay healthy – are needed to get beyond the impasse, especially if the hope is to reach those most at risk of untimely death and disability. Only a fraction of the innumerable mechanisms and 'instruments' used by specialists in accumulating capital are ever considered for use in providing healthcare as a public good. A global financial transaction tax has been proposed by activists and politicians in dozens of countries: a tiny sliver of each such transaction would be diverted to healthcare for the global poor, as would 'sin' taxes on noxious or luxury items from cigarettes to champagne. Last summer, a consortium of corporations, banks and charitable foundations announced, from the White House, that they would raise billions through

‘social impact bonds’ designed to finance malaria control and other efforts that might be shown to save lives while saving money.

Philippe Douste-Blazy, a former French health minister, doggedly pursued the idea of a voluntary – the customer could opt out – two-dollar tax on plane tickets to finance the treatment of Aids, TB and malaria. Clinton and Chirac were solidly behind it, as was Brazil’s President Lula. In its first three years, run by a skeleton crew of French bureaucrats, the airline tax raised \$1.06 billion, all of which went to prevent and treat the ‘big three’ pathogens. ‘By April 2007,’ Douste-Blazy said, ‘we had 23 countries on board. Their leaders had all agreed to introduce the airline ticket tax, and at least half a dozen of them would be collecting it by the end of the year.’ It was time ‘to go back to our harshest critic’:

Just as before, the members of the Bush administration were blunt. ‘It’s a great idea,’ they said, ‘but do you know what your French historian Alexis de Tocqueville wrote about our country? It’s all about freedom of choice. You say a child dies every thirty seconds from malaria. If I want to save him, fine, I can pay. But if not, I’m not going to pay.’

The scheme is still running, but the US has never taken part.

As it happens, the US government has chosen to be the largest contributor to efforts to stem these plagues and many others, including Ebola; it’s also the biggest donor to some of the multilateral funds established towards the same ends. And so the notion of a voluntary contribution – as opposed to a tax – helped to move billions of dollars to pay for the treatment of Aids, TB and malaria where they cause most deaths. But it’s difficult (perhaps almost impossible) to achieve equity of access to decent healthcare when neoliberal market paradigms underpin care delivery. Drèze and Sen argue that building a strong publicly financed health system is critical, even if there are other, non-public insurers (and donors) in the mix. In the absence of fine-mesh public safety nets, quality services are by definition reserved for those who can pay for them. Holes in the nets – even the contraction of the notion of common goods like social protection – are one of ‘the causes of the causes’ of both ill-health and the impoverishment it so often triggers or complicates.

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Thomas Piketty argues that ‘economics should never have sought to divorce itself from the other social sciences and can advance only in conjunction with them.’ Anthropology is one example: *Blind Spot*, by the physician-anthropologist Salmaan Keshavjee, offers a lesson on the impact of dogma over data.<sup>[4]</sup> The Soviet healthcare system once reached, rather unevenly, into the highlands of Tajikistan; so did pensions and public works. The quality

of care was never very good and the centralised system wasn't able to avoid medicine shortages, perverse incentives or demoralisation among care providers. But the collapse of the Soviet Union was catastrophic, leading to the rapid erosion of public institutions – such as they were – and the worsening of social inequalities, themselves exacerbated by the disappearance of social safety nets. While Keshavjee was carrying out his fieldwork, which began in 1995, the collapse was followed by a chaotic proliferation of 'civil society institutions' with competing agendas, rooted in a range of disparities and asymmetries: public-private, centre-periphery, urban-rural, mountains-lowlands, practitioner-patient, foreign-local. The gulf widened between the tottering public health system and the well-resourced, arriviste aid agencies and NGOs. Keshavjee became a consultant for one of them: its projects were openly designed to 'change the mentality' of the 'clients' of health services. The aid-givers talked of 'privatisation', 'user fees' and 'more efficient' ways of 'managing' healthcare delivery with 'free trade' and 'competition'. Patients were known as 'clients', 'consumers' or even 'customers'. When Keshavjee was assessing a revolving drug fund – it was 'sustainable', the claim went, because some of the receipts from the direct sale of pharmaceuticals were used to replenish the fund after the initial investment, and the rest went to 'finance primary healthcare' – one of his Tajik informants told him: 'You can't sell medicines to starving people.' But that doesn't stop people trying.

The Bamako Initiative, launched in Mali in 1987, encouraged the health officials of African nations, already heavily indebted to international financial institutions and private banks, to finance a slender package of healthcare for the poor (this is where Gobi and the 'basic minimum package' came into their own) by having the 'consumer' pay for care when sick, in order to 'recover costs' and thus finance healthcare through 'community participation'. The dignity conferred by paying for one's own (or one's children's) care would magically make such programmes 'sustainable' and cut down, Bamako's most zealous advocates suggested, on the sort of 'frivolous spending' and 'moral hazard' allegedly encountered in places like rural Mali. Shifting the costs to private payers – meaning patients and their families – would also lower public expenditure on health and 'decentralise' care.

The health officials all signed on, as did various UN agencies, but there must have been many misgivings in Bamako. The initiative clearly contradicted the Alma Ata declaration of 1978, which had been unanimously endorsed by the world's health ministers. But just as it's difficult to find empirical studies to shore up claims that paying for one's own healthcare when sick recovers a substantial proportion of a health system's costs, so it's hard to find dissenting voices on the Bamako agreement. The reason for the widespread support of the Bamako Initiative was not that Africa's health leaders were suddenly alerted to an epidemic of frivolous health spending in their countries' slums and villages, or that they were resolved to replace the slogan of Alma Ata ('healthcare for all by the year 2000') with a new one ('healthcare for some if they can pay for part of it when they're sick and as

we shrink our public budgets’). They signed on because adopting the Bamako plan was linked, more or less transparently, to the ‘structural adjustment programmes’ hawked by the international financial institutions. It was a hidden condition, a ‘natural’ part of the market globalism that sought to commodify healthcare and to shrink social sector spending.

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When Amartya Sen accepted the Nobel Prize in Economics in 1998, he spoke of his diagnosis, in 1952 at the age of 19, with a cancer of the mouth. He had just won a scholarship to Cambridge, and was living in the Calcutta YMCA, studying at Presidency College, when he noticed a ‘pea-sized lump’ on the roof of his mouth. A local GP dismissed it as a reaction to a fish-bone, but Sen, having borrowed textbooks from a medical student in the next room, self-diagnosed a squamous-cell carcinoma. Untreated malignancies of this sort kill slowly, disfiguring the mouth, then the jaw, then the face; death is usually caused by a combination of starvation and asphyxia. Although Sen was not from a deprived background (his father was a chemistry professor at the University of Dhaka, his mother a writer, dancer and magazine editor), it took him months to arrange a biopsy at Chittaranjan Cancer Hospital; the pathology confirmed his diagnosis. Knowing he had received a death sentence, Sen and his family pushed for what was, in India, a new form of treatment: radiotherapy. In Calcutta, Sen was fitted with a radiation mould and received a total of 10,000 rads, about four times the amount that might be used today. ‘Give me the maximum dose,’ he’d asked. ‘This is my only chance.’ During his treatment, Sen ‘sat there for four hours at a time and read. Out of the window, I could see a tree. What a relief it was to see that one green tree.’

After the acute side effects, which included the usual malaise and difficulty in swallowing even liquids, he went on to suffer chronic ones too, including necrosis of the bones in his palate. But he also went to Cambridge, and then on to a career in economics that might have taken a different path had he not been forced, as a teenager, to consider the misery faced by the sick, even those with access to healthcare. But Sen would have taken no path at all had his cancer not been cured. In most of the places I work – including Haiti, Rwanda, Lesotho, Malawi, Liberia and Sierra Leone – there is, in 2015, still no radiotherapy.

[1] Paul Farmer wrote about the Ebola epidemic in [the LRB of 23 October 2014](#).

[2] Princeton, 376 pp., £19.95, August 2013, 978 0 691 15354 4.

[3] Allen Lane, 448 pp., £10.99, March 2014, 978 0 14 197582 5.

[4] California, 288 pp., £44.95, August 2014, 978 0 520 28283 4.

[Vol. 37 No. 3 · 5 February 2015](#) » [Paul Farmer](#) » [Who Lives and Who Dies](#)

pages 17-20 | 7111 words

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[^ Top](#)