

Health Care is a Right, Not a Commodity: The Legacy of Dr Paul Farmer MD PhD

Introduction and excerpts by Conner Gorry MA
From an interview by Connie Field for the film *¡Salud!*

Deaths averted, doctors trained, clinics staffed, communities reached, minds changed, lives touched: the metrics for measuring the impact of the late Dr Paul Farmer (1959-2022) are impressive in themselves. As a physician, medical anthropologist, professor, author and public health activist, Dr Farmer's commitment to advancing health equity is felt from Boston to Peru, Rwanda to Haiti—contexts where he worked on the ground and shoulder-to-shoulder with some of the world's most vulnerable populations.

While living in and serving these communities, training local health professionals and learning from their experience, Farmer cemented a philosophy and approach based on equity, humanism and access to quality care that take into account social determinants and structural violence.

These were radical ideas in 1987 when Farmer co-founded Partners in Health (PIH), an international NGO dedicated to guaranteeing health care as a human right by providing services and training, catalyzing policy innovation and improving health systems through a community-based clinical model. From its first programs and initiatives in rural Haiti, PIH now offers care and training in 12 countries including Lesotho, Liberia, Malawi, Kazakhstan, Mexico and the Navajo Nation (USA).

This goal to shift the global health paradigm towards quality care for all—especially in the world's most impoverished contexts—forged Farmer's reputation as a 'partner to the poor.' As Chair of the Department of Global Health and Social Medicine at Harvard Medical School and chief of the Division of Global Health Equity at Brigham and Women's Hospital, he inspired students and colleagues alike to value all lives equally and provide a level of care that reflects that commitment. In addition to his multiple roles and awards, Paul Farmer is author or



Still from the film *¡Salud!*

co-author of a dozen books (see Sidebar) and was editor-in-chief of the peer-reviewed journal *Health and Human Rights*.

MEDICC Review shares the vision of health for all, our editorial focus dedicated to moving the needle towards a more just, equitable and healthy world underpinned by health care as a human right. In honor of Dr Farmer's contribution to the health, education and empowerment of patients, practitioners and communities where he worked, we excerpt this exclusive interview conducted in 2006 for the MEDICC-produced documentary exploring the Cuban health system, *¡Salud!*. This previously unpublished conversation between Dr Farmer and *¡Salud!* Director Connie Field of Clarity Films dives deep into his philosophy, dedication to his patients, the importance of community-based primary care, strengthening health systems globally and lessons he learned working with populations and professionals, including Cuban doctors, in vulnerable contexts.

Partners in Health started in Haiti, one of the most disadvantaged countries in the world. After several decades of in-country experience, what have you learned and how has your work evolved?

Haiti, which you know suffers from the worst poverty in this half of the world, has literally hundreds, if not thousands, of non-governmental organizations and church groups. Usually, NGOs go into poor parts of Latin America and Africa and set up shop all alone—they're silos. And they're really doing almost nothing to support public education and public health. We'd been there ten years working, hard work, yeoman's work, trying to deliver basic health services to poor people in central Haiti before we asked ourselves: 'what have we done to beef up the public sector?' A decade is a long time to

ask that question. We concluded that we hadn't done enough; from that point forward, we decided all of our expansion would be solely in the public sector. So, we began expanding rather rapidly in the public sector from a base in the middle of a squatter settlement. And now we're trying to bring other NGOs on board.

The public sector is the primary guarantor of health and education to the poor. This flies in the face of the current fashion in Latin America and the Caribbean, which is privatize, privatize, privatize. And it's not an accident for example that in Haiti, the least literate country in this hemisphere, 85% of all education is private. It's in the hands of NGO's or churches, not in the public sector. And you see the same thing in health care...you can't ignore the public sector if you're interested in health.

It's easy in a place like Haiti for groups like ours to say 'we're doing great. We've built an operating room, we've put in a blood bank'... but you know you can always do better. Before I came to Haiti, I used to think, 'pre-natal care is how you stop maternal mortality.' Curbing maternal mortality doesn't only have to do with prenatal care. It also has to do with whether or not there's access to cesareans, to surgery, and often, a blood transfusion. But above all, it's a problem of trained personnel. The standard of care, the best that we can do, is to have a physician trained in doing cesarean sections and nurses who are trained in giving anesthesia for example. And we quickly learned training community health workers to provide follow-up care can improve that standard of care. With the systems we put in place in rural Haiti and rural Rwanda, we train community health workers to give good follow-up care.

Community-based primary care, supported by specialists and integrated into the national public health system, is the backbone of the Cuban approach at home and abroad. Can you speak about your work alongside Cuban doctors?

After working for over 20 years in central Haiti, one of the most significant problems we've had is recruiting medical specialists. There are almost none in Haiti serving the rural poor. We knew we were going to have a hard time recruiting and retaining specialists and we tried the obvious routes—recruiting Haitian specialists—but there wasn't a lot of interest in living in rural Haiti where they might not have electricity or hot water and their families don't feel comfortable. So, we started campaigning early on for help from Cuban physicians, specifically requesting a senior surgeon and a pediatrician, a request approved by both the Haitian Ministry of Health and the Cuban medical aid program. The express purpose of the Cuban program is to help strengthen the public sector, which is exactly what was needed.

There were delays, but the first two specialists finally arrived and spent two years working with us. The Cuban surgeon had been practicing for 30 years and could do any kind of emergency surgery, general surgery; he was very broadly experienced. The pediatrician had 27 years of work experience. One of the things that I admire was their tremendous work and professional ethic. They were great teachers and it was wonderful, almost magical, how humane they both were. The pediatrician for instance...you would think after 27 years, someone would be hardened and used to the tragedy around pediatrics. But she was so emotional in the best way, so open and kind to families. And I realized that it wasn't just about personality. It was about their training. They had been trained to be humane and ethical physicians.

We have some very committed Haitian physicians and nurses, but the presence of these two very mature physicians, with a lot of public health experience, served to raise the level of care across the entire hospital. Having experienced doctors impart their way of delivering care to others—to trainees, to those who are younger or less experienced—there's no substitute for that in medicine. Cuban health professionals have been cycling through Haiti for two-year stints since then.

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BOOKS BY AND ABOUT PAUL FARMER

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As a professor at one of the United States' most respected teaching hospitals, and with a long history working with Cuban doctors, can you talk a bit more about what differentiates their medical training?

The Cuban medical system is exceptional in that physicians are required to know public health. Even clinicians—a urologist, for instance or an ophthalmologist—are expected to know something about public health. They are also trained to know the communities they serve. In Cuba, your neighbors are also your

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patients and physicians do home visits, for instance. These are largely gone from American medicine and are something we've tried to reintroduce in our training and service programs at Harvard; the physicians who train with us, whether they work in Boston or Rwanda or Haiti or Peru, they all do home visits. And of course, they're all being trained in public health. But I think that's an exception for medicine in the United States. In Cuba, it's the rule.

In Cuba, prevention and health promotion are also an important part of the medical school curriculum from the first year and throughout training. These concepts are highly regarded and even surgeons, for instance, are expected to know about health promotion and preventive medicine. Contrast this to training in the United States where prevention, maintenance and promotion just aren't a focus. These fields of medicine are not highly regarded among students, faculty and trainees, who are more focused on pathophysiology and responding to illness, not preventing it.

Let me add that the Cuban medical system, unlike some other countries, hasn't pushed primary care forward to the detriment of sub-specialty care. I wouldn't want to live in a place where there's no ophthalmologist or urologist and everybody is a primary health-care practitioner. But Cuba has managed to provide specialist care, promote research on a very limited budget and at the same time strengthen primary health care. And in Cuba, health care is considered a right, not a commodity; a commodity is something you buy and a right is something you have—whether you can buy it or not. It's yours because you're human.

In order to respond to complex health problems among the poor, you need a public health system. And you need physicians trained in public health. That's the strong point of the Cuban training program, it's visionary and is helping us find our way back to public health and primary health care.

Promoting health care as a right underpins your work in the United States and around the world. Why is it slow to take root?

If you look at schools of public health, for example, in the United States, they're teaching about 'health care reform' or 'cost recovery' or 'sustainability.' None of these strategies are about health care as a right. And indeed, if you go to a US school of public health and talk about the right to health care, you are smirked at. Sure, the response is, 'oh, yes, we all agree' but obviously, some people don't agree that health care should be a right. Or it would be—certainly in a place where it could be, like the United States.

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If we could push that forward as the number-one priority, other things would follow. For instance, if you strengthen the notion of health care as a right and put in place strong measures to protect that right, then you would be ready

for whatever disaster came upon you. And it's not about the money: it's not that there's not enough money to do this work, to assure health care globally—there's plenty of money, even if we didn't have support from other affluent countries, the United States could pay the bill itself.

If it's not about the money, why is over half the world's population still without access to primary care?

It's complex, but brain drain is one of the reasons: for much of Africa and especially sub-Saharan Africa, professionals leave on the classic trajectory: from poorer African nations to South Africa (the continent's wealthiest country), and from there to England, over to Canada and the United States. The standard interpretation is that health professionals are seeking better wages. And they are. But that's not the whole explanation by any stretch of the imagination. If you study a hospital in Africa and talk to the physicians and nurses, they don't only talk about salaries and providing for their children. They're also going to say: 'we have lots of sick people but we don't have any diagnostic tools or medicines. We can't do our jobs.' Physician burnout is another reason.

In the United States, I wouldn't call it burnout, but rather a disenchantment or dissatisfaction with the medical system. 'Too much bureaucracy, too many lawsuits, insurance costs too much' is what a lot of physicians I meet around the country are saying. They are worn out. But I think some of it also has to do with knowing that more than 40 million Americans are without health insurance.[1] I work at a fantastic hospital in Boston—I don't think I've ever seen a better hospital anywhere in the world, with such an astounding level of care—but if you go down to the emergency room, you'll see patients coming in with very unremarkable problems. And you know that those patients should have received care from primary care physicians, not in the emergency room. I've seen it time and time again: health problems that should have been managed by a primary care physician before it became a problem and landed people in the ER; you really can't deliver good primary health care in the emergency room. And that's just discouraging to US physicians. A big chunk of our population is not well-served under the current system.

It seems like providing access to quality care to all—especially in underserved areas, whether in US inner cities or the most impoverished nations—is an intractable problem. What solutions do you see?

I think there are three things we can do to wipe out 60% of the health problems in poor areas. First, is the personnel issue. We should be training people living in poverty to become health professionals. Second, we need to assure these professionals have access to the 'tools of the trade': medicines, diagnostics and other basics to deliver primary care (to say nothing of a tertiary facility like a hospital). Third, linking these first two to the notion of health care as a right.

This approach is what I call a 'pro-poor strategy:' we have this problem, we have the tools to solve this problem and we have to make these tools available to everyone as rights, not commodities to sell. In short, we have to train people living in poverty to be protagonists in this narrative and involve them in the work to make these services their right. It's hard, but rewarding, and I think this is the way forward.

Cuba has bet big on training thousands of doctors from these poor communities, including from the United States, at the Latin American School of Medicine (ELAM) in Havana.[2] Do you think it will make a difference?

Inviting poor kids from all over the world—the ones I know personally from Haiti who are attending ELAM are poor kids—to give them a full medical education is miraculous to me. The idea is these young people have grown up in or around poverty, they speak the language and are sympathetic to the destitute sick and understand the context and challenges. Training them to be good, humane and equitable physicians and return to poor communities to practice is part of the strategy. The question is, will it work?

The issue remains: once they become physicians, is health care a right or a commodity where they're practicing? If it's the latter, they're going to face the same problems that everybody else does. They'll

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just have better training. Until there are fair systems for financing health care, the full potential of these students is not going to be realized. Real support for this school in Cuba, or similar ones elsewhere, means creating jobs that allow the graduates of these schools to work equitably for poor people. Otherwise, the full promise of ELAM won't be met.

This fits into the pro-poor strategy and transforming poor people into protagonists that I mentioned before. Whether it's a student from a squatter settlement in Haiti or highland Bolivia attending ELAM, we have to remove barriers, creating a job for him or her once they graduate so they can deliver health care to the poor in their home country. Otherwise, the risk is they will go home and end up serving in the capital just like any other doctor.


Can you summarize what you believe has been Cuba's contribution to global health?

The most important contribution Cuba has made to global health is the power of its own example. The idea that you can introduce the notion of a right to health care, establish a comprehensive public health system and wipe out the diseases of poverty—that's a stirring example, especially for other poor countries. Their mandate for equity, South-South technological transfer and vaccines are other areas of Cuban influence globally.

Another important contribution are the Cuban physicians and health professionals serving all over the world. I'm not sure what we would have done in rural Haiti without the Cuban physicians over the past few years; there were probably more Cuban doctors in rural Haiti than Haitian doctors and that's true in other places, too. I've run across Cuban doctors in nooks and crannies in Haiti and Africa where they're the only providers. Although it's hard work and takes adapting, it strikes me that these doctors are game for anything.

Cuba's holistic approach to medicine was also ahead of the curve. Cuban doctors are trained to understand a patient's illness and design effective interventions by looking at the whole picture—how social conditions and a person's habits determine their experience of chronic disease, for example. This is complemented

by problem- and patient-centered learning emphasizing detailed patient exams and clinical histories to provide context for laboratory results.

What I've seen with the Cuban doctors with whom I've worked is a very high level of commitment to the profession and their patients. Their exchanges with patients are extraordinarily warm and that creates respect for and adherence to doctors' recommendations. It's touching. There are shortcomings to Cuban medicine—crises over the past two decades have hurt the health system—but there's this inherent justice in that system that inculcates certain ethical values among physicians, and those values are highly regarded in Cuban society and beyond. To me, this is largely attributable to Cuba's guarantees of universal access and health as a right. 

Notes and References

1. This interview was conducted before the Affordable Care Act was enacted in 2010. Currently, some 26 million people in the United States are uninsured.
2. Since its establishment in 1999, some 30,000 students from 103 countries, including 200 from the United States, have graduated from Cuba's Latin American School of Medicine.