Interview

Health, Equity, And Political Economy: A Conversation With Paul Farmer

Working tirelessly to connect the dots between poverty and disease, Paul Farmer and Partners In Health have had one overriding goal: to serve the most destitute.

by Fitzhugh Mullan

ABSTRACT: Physician, anthropologist, and pied piper for global health equity, Paul Farmer is one of the world's leading voices for health and development. His mix of applied humanitarianism, scholarship, and charisma have brought focus to the plight of the world's poor and demonstrated that strategic health and socioeconomic interventions can make a difference. In 1987 he cofounded Partners In Health, an international organization that works to provide care in resource-poor settings around the world. In this interview with *Health Affairs* contributing editor and global workforce expert Fitzhugh Mullan, Farmer talks about the state of global health and the interplay between health, equity, and political economy. [*Health Affairs* 26, no. 4 (2007): 1062–1068; 10.1377/hlthaff.26.4.1062]

Fitzhugh Mullan: You've been working on global health—really, global health equity—for most of your adult life. A lot has changed since you first went to Haiti as a student in 1983. How are we doing? Has the world made progress in regard to global health?

Paul Farmer: If we look at the possibilities now compared to twenty years ago, I think we are doing better. The world is paying more attention to the diseases of poverty: There is new concern about malaria and tuberculosis [TB], and we are finally reaching poor people with AIDS with lifesaving antiretroviral drugs. But I also think we have to be self-critical. Things looked very up in the 1970s when the smallpox eradication effort proved successful, and there was a lot of optimism about transnational interventions. A lot of people came together from all over the world to try to eradicate smallpox—and it worked.

But if you look at the subsequent two decades, there have been fewer victories to point to: malaria was recrudescent; HIV came along and devastated an entire generation of young adults in some regions; TB remained a problem and has become increasingly resistant to antibiotics; and, of course, other chronic noncommunicable diseases and problems like child mortality persisted or grew. So, I think there was a high point in the 1970s, but by the end of the 1990s there were a lot of dispirited people and underfunded efforts.

Mullan: Dispirited in the sense that people had previously thought that disease eradication on a massive scale was within our grasp, but, in fact, it proved not to be?

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Farmer: Exactly. Whether you talk about infant mortality or infectious disease, funding never really was sufficient. And First-World interest in the diseases of the poor—not just the ones I mentioned above, but a lot of tropical diseases—in disease control, in strengthening of health systems—seemed to falter. For a long time there was nothing like the Global Fund to Fight AIDS, TB, and Malaria, which came into being only four years ago; there were few new multilateral programs. There was really no support for treatment efforts that could strengthen health systems in poor countries.

Now, in 2007, there are many new initiatives to fund such efforts. The Gates Foundation, to the surprise of many, declared itself dedicated to finding solutions to the health problems of the world's poor. This was unprecedented. There is a lot about which we can be optimistic and a lot of reasons why we have the chance to make real progress. Now we have to show we can do it.

"The policy environment has changed: Ideas about social justice linked to access to medicine and public health now have a chance to grow."

Partners In Health

Mullan: You have been active all over the world, notably in the seemingly unrelated countries of Haiti, Peru, Russia, and now Rwanda. Is there a theme to the places that you chose to focus on, and where is that theme likely to take you?

Farmer: Partners In Health [PIH] works in places where there is significant inequality of access to prevention and care, and we work with those who are most deprived. The absolute poverty in rural Haiti is obvious. Our mission also led us to the slums of Latin America, where people were displaced by violence, and to the prisons of Siberia. We have learned, over and over again in each of these settings, lessons about the need to reinforce public health systems. We find ourselves with a lot of knowledge not only about AIDS and TB, but also about how to work effectively in conflict or postconflict situations. In Rwanda, the poor are struggling with a significant infectious disease problem and with trying to rebuild public health infrastructure after violence. We felt we could be especially effective in such a setting. So, while happenstance may have played a significant role in where we went during the first fifteen years of our history, our expansion in Africa is fairly well thought out.

Mullan: When you say "we," you are referring to Partners In Health, the organization that has been the vehicle for your work and leadership. You are based at Harvard University and yet you seem to have a vision and independence that makes PIH a global presence of its own.

Farmer: When we started twenty years ago, we called our organization Partners In Health because we knew that we'd have to build partnerships. That meant building or strengthening sister organizations if we were to have any hope of what might be termed *intellectually and programmatically sustainable interventions.* You need people to believe in what you're doing locally, or else how are you going to scale it up?

We have a small but committed group of supporters, and happily that group has grown with time. PIH is still a pretty small organization, but we have thousands of partners in Haiti, in Russia, in Africa, and in Latin America. We have a group approach to taking on poverty and inequality. It's not the only approach, but it has worked for us. Collectively, we know a lot about how to start "virtuous social cycles." Regardless of the specific social and health problems faced by a group, we can always think first about the poorest. Doing right by the destitute sick can lift entire families and communities out of desperate poverty. However, a strategy that focuses only on public health and medicine and neglects agriculture, clean water, and primary education doesn't get the job done, doesn't start a virtuous social cycle. No one is going to argue that pub-

lic health and medicine are not needed, but our work doesn't stop there. Others agree with this approach, fortunately, and we have received good support from partners like the Clinton Foundation and, of course, from ministries of health and education. Even some of the mainstream international financial institutions that had been unenthusiastic about these efforts now seem to be on board. The policy environment has changed: Ideas about social justice linked to access to medicine and public health now have a chance to grow.

Impact Of Structural Adjustment On Health

Mullan: The history of international funding in the developing world in the postcolonial period has been characterized by aggressive lending in the 1960s and 1970s followed by massive indebtedness in the 1980s and 1990s. This led to organizations such as the World Bank and the International Monetary Fund dictating fiscal austerity (often called "structural adjustment") in indebted nations. These dictates placed strict limits on public employment—creating particular hardships for doctors, nurses, and teachers, who are predominantly civil-service employees in these countries. What impact did that have on health development from your perspective?

Farmer: Structural adjustment plans have different features locally, but, on the whole, their impact on health systems in the poorest countries has been very negative. The capping of public expenditures on education and health sapped already weak colonial health structures, some of which had actually started to flourish postindependence. It's pretty sobering that forty years after independence, health indicators are in fact worse in many postcolonial countries. In many countries, health and education programs and outcomes weakened steadily in recent years—years that coincide pretty neatly with structural adjustment programs.

"Right now there is a huge void in many developing-country health systems, a void created by privatization and structural adjustment programs."

New Partners

Mullan: In the last decade, many new organizations have joined the effort to improve health and reduce poverty in the developing world—new, large global donors such as the Global Fund, the Gates Foundation, and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). There has also been augmented funding from bilateral donors such as the U.S. Agency for International Development (USAID) and its counterparts in other developed nations, as well as proliferating numbers of nongovernmental organizations (NGOs) of various sizes and missions. What is your view of the impact of these programs on health and development?

Farmer: This focus and support has great promise, but the advent of new funding will have a salutary effect only if it is actually used to strengthen public health systems—something funders and NGOs don't always seem to understand. Right now there is a huge void in many developing-country health systems, a void created by privatization and structural adjustment programs—huge weaknesses in personnel and programs. Many of the new funding mechanisms were, in effect, created to fill the gaps in these weakened public health systems. The problem is that new money will not fix broken public health infrastructures unless it is consciously designed to do so. There's nothing magical about the arrival of new NGOs and the appearance of new money. Unfortunately, new donors can fall into the neoliberal trap of filling in the gaps without rebuilding public infrastructure. This is a problem, but it's a problem we can fix. We need to raise this issue and work to make sure that new organizations and new efforts do target the rebuilding of public health and public infrastructure, rather than creating parallel systems.

Mullan: NGOs have their proponents and their detractors, and the success of NGOs has

varied from place to place. This is true particularly in terms of the health workforce. In many places, well-intentioned NGOs have initiated programs offering salaries that pull physicians and nurses out of critical public-sector jobs, crippling local public health programs.

Farmer: I'm optimistic about the role of NGOs—especially if we (and I include Partners In Health) are sensitive to local economies and are more self-regulating. Also, I am not opposed to having certain limits and norms imposed upon groups like ours. If I were in charge of a ministry of health in an African nation suffering from the brain drain, I would take measures to ensure that NGOs do not further weaken the human resources or infrastructure of the public sector. In PIH's new programs in Latin America and Africa, we've expanded only in the public sector for exactly this reason. We work with and through the public health system so that we don't exacerbate the brain drain. In fact, we try to bring new resources and staff to the public sector.

"In poor communities around the world there are people with experience and interest in health work who could easily be engaged as community health workers."

Health Personnel And The "Brain Drain"

Mullan: The migration of physicians, nurses, and others from the developing to the developed world—the brain drain—has increased in intensity and visibility in recent years. Two recent publications, *The Joint Learning Initiative* and the 2006 World Health Report, *Working Together for Health,* have focused attention and begun to develop metrics in this important area. What are your observations about health worker migration and the level of workforce depletion in poor countries? What's the way out?

Farmer: Well, the landscape of the brain drain is largely the landscape of political economy, meaning that people move from resource-poor settings, to less resource-poor settings, and on to places in which resources have been piled up and accumulated. Personnel go, for example, from rural Kenya to urban Kenya to South Africa to Canada to the United States. Economics is part of the motivation to migrate, but there is another factor, too: clinical frustration. Many health professionals in poor countries don't have the tools they need to do their jobs—the tools they've been trained to use. They don't have the diagnostics and therapeutics that their patients, many of whom live in poverty, need in order to receive decent care. Many health professionals wouldn't leave if they had the tools they needed to do their jobs.

Mullan: Which tools do you mean?

Farmer: I'm talking particularly about lab tests and drugs. These need to be available to patients based on need rather than on ability to pay. In many countries these goods and services used to be provided in public clinics. The whole point of the public health system was to make the fruits of modern medicine and public health available to the poor. That philosophy was sabotaged during the period of structural adjustment and is still being undermined today. Health professionals need to have workplaces that are adequately equipped to take care of patients and to prevent illness. Health professionals also need a decent living wage—something that public health systems in many developing countries frequently don't provide, citing reasons of "economy"—an economy that is often imposed, in part, by international lending agencies.

We also need to make sure that community health workers are central to efforts to stabilize and build health capacity in impoverished settings. In poor communities around the world—especially communities heavily impacted by diseases such as AIDS, TB, and malaria—there are people with experience and interest in health work who could easily, and to great benefit, be engaged as community

health workers. They may be peasant farmers or market women. They might be people living with AIDS. But these people can and would like to be trained as community health workers. We need a commitment to strengthening the participation of local people. We need to make sure that traditional birth attendants, village HIV workers, outreach workers, et cetera are properly trained and supplied and paid for their efforts. This would greatly improve health capacity at a basic level and be a big step in offsetting the brain drain.

Mullan: Given the momentum of the brain drain and the political economy, as you describe it, of many developing countries, do you think it makes sense for donor organizations to invest in improving or expanding medical or nursing schools in the developing world?

Farmer: I fully understand this quandary, but I continue to favor support for medical and nursing schools. It's a good thing to offer educational opportunities to more people. I just think we need to be realistic about the effect of such investments without concurrent strengthening of the public health system. By "strengthening the public health system," I mean the provision of adequate wages, supplies, and facilities and a system of financing that doesn't deny people access to care for reasons of poverty. These changes, linked to improvements in access to education, will keep many more health professionals in-country and working where they are most needed.

Mullan: Many have argued that the United States and other developed nations need to address the "pull" factors within their own societies that promote the brain drain. The chronic shortage of medical and nursing graduates in the North, in particular, creates a vast "market" for health professionals from the South that weakens health systems throughout the developing world by depletion.

Farmer: I am heartened to see increasing policy discussion about addressing Northern pull factors. We—and I include the global health community in this—haven't been honest with ourselves. For too long we've paid too much attention to how we could get involved in addressing this problem personally, by working abroad or finding funding for NGOs. We've been over-focused on our own sense of personal efficacy in this struggle and under-focused on the large-scale push-pull forces. We need to be honest, analytical, and strategic about what causes the brain drain in the first place. I'm all for personal engagement in the problems of global health, but it's not about us—it's about the forces oppressing the poor and generating illness.

Humanitarianism Versus Structural Interventions

Mullan: I take you to mean that the "Schweitzerian" instinct to go and do clinical care is not being matched by the hard work that needs to be done in regard to the economics and politics that underlie the pulls and pushes that lead to health inequity in the world.

Farmer: Exactly. I would be the last to dismiss humanitarian efforts. It's just that humanitarian efforts are not designed as structural interventions—interventions that are needed to change finances, incentives, and systems. But we can design structural interventions that draw on and link to the very noble sentiments that inspire many humanitarian efforts.

Mullan: By "structural interventions," do you mean strategic investment policies by both governments themselves as well as international donor organizations that would address the political economy of countries in a way that would improve health sector finances, improve drug supplies, and the like?

Farmer: Yes, but I would put the international financial institutions at the top of the list, since they have the greatest influence on crucial ministries of finance as well as on ministries of health and ministries of education.

Role Of Corporations

Mullan: Multinational corporations are active in Africa both as an economic force and, increasingly, as a philanthropic presence. Some pharmaceutical companies, for instance, long known for high prices and lack

of interest in research investments in the epidemic diseases of the tropics, have recently cut prices, donated drugs, and contributed to creative health scale-up programs in the developing world. What's your take on this?

Farmer: It's tempting to dismiss corporate philanthropy as disingenuous and self-serving. But I don't think that's smart. I believe that many transnational corporations really want to be involved in efforts to move global health equity forward. The important point is that it is our job to make sure they do it correctly. These companies can be significant contributors to health development in many important ways, including financing, production, distribution, and technology transfer. An example would be Big Pharma companies that we have convinced, in a couple of instances, to forget about their profits in Southern Africa and work with us, instead, to transfer technologies to generic manufacturers to help scale up our programs. It's best to avoid naïveté but at the same time not to assume that we cannot shape these institutions—which are, after all, created and run by fellow humans and subject, one hopes, to laws and regulations.

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Farmer's Personal Involvement

Mullan: You've been at this personally for almost a quarter of a century, and your pace is only increasing. You are engaged in a kind of Iron Man marathon with no finish line in sight. How does that work on you as you go week to week, month to month? Do you get fatigued, discouraged?

Farmer: First of all, PIH is now a very big team. We work with close to 5,000 people in our projects all over the world. If I'm down occasionally, I'm always working with lots of other people who are not—and that sustains me. I think everyone gets discouraged in this line of work sometimes, but we're never collectively discouraged. Second, it's very encouraging to have some successes, to take on these ostensibly insurmountable health problems and show that they are, in fact, surmountable. Recently it has been the challenge of doing HIV care at the same time we do HIV prevention. Many people said that this was too ambitious and that prevention was the best we could hope for in resource-poor settings. Not so—and we and others are at work all over the world proving that we can treat poor patients with AIDS. When I first went to central Haiti twenty-five years ago, the challenge was to build a sound health system in a squatter settlement. Many said it wasn't possible—limited immunization or infant mortality reduction campaigns, maybe, but not a full-service health system. But it's there now—a full-service health program in a squatter settlement. Conventional wisdom also discouraged treatment of poor people with drug-resistant TB—simply because it was expensive. But we did it in Peru and in Russia through aggressive case finding and treatment and by making common cause with ministries of health, pharmaceutical companies, diagnostic laboratories, and other partners. I know you remember all those arguments of earlier years—that we don't have enough resources for care so we can only focus on prevention, that we can't deliver health care to the very poor. Those were bad ideas. They're morally bad but also epidemiologically bad. They're bad in terms of improving health policy and getting at the roots of health inequity.

Mullan: You have become something of a pied piper in global health, generating an extraordinary following among young people in the health sciences. What is it that connects you to students so effectively?

Farmer: Well, first of all, I teach a lot, and that gives me a direct connection to students.

Second, there is a resident idealism among students that we have tended to stamp out of our professionals. That's a huge mistake. There are lots of young people—medical students and nursing students, but also law students, engineers, journalists, and so forth—interested in health disparities and improving health in general, including global health. I encourage students to be engaged in health equity issues and offer them critical readings about mistakes that we have made in the recent and the remote past. At the same time, I offer them examples of constructive engagement in poor people's health problems. Many students are looking for faculty, programs, and colleagues who are involved in health equity work in a self-critical way. Finally, our work is very much linked to work on the ground—whether the ground is poor neighborhoods in Boston or a squatter settlement in Haiti. If you're teaching medicine from only a theoretical perspective, it's not very effective, of course. The same is true in public health. I think students in general like the connection to what we call, in our work, the effector arm.

Mullan: The effector arm?

Farmer: The effector arm of our work is Partners In Health. PIH is not a policy outfit. It's not a research center. And it's not a training center. It is all these things, but most fundamentally, it's an organization dedicated to the redistribution of wealth with a focus on health. The only way to be such an organization is to effect change at the local level by offering the sorts of services people are asking for. Our mission is to impact the lives of the very poor. We are an atypical organization in that we are based at a research university. We have something in common with teaching hospitals, but that's the only exception I know of. Even graduate schools of education don't run schools for the purpose of addressing disparities in education. Our students and supporters are drawn to PIH's practical connection to on-the-ground work.

Mullan: Has Harvard been receptive to your brand of activism and teaching?

Farmer: It has. We receive good support from students, faculty, and administrators. Although we are embedded in the university, we have taken steps to make sure that Partners In Health is independent so that it remains a nimble and responsive effector arm. We draw on the resources of the university to address glaring health and social problems, but we are not an agent of the university.

Mullan: Your philosophy and your accomplishments have earned recognition for their effectiveness. From a political perspective, they would appear nonideological. Do you consider yourself a partisan of a specific ideology or connected to any particular political persuasion?

Farmer: I could just say no, but let me add more. I count myself a progressive, which to me means a dedication to progress in the reduction of inequality in health, education, and other human essentials. I consider this more of a moral engagement with the world than an ideology. Our movement is about addressing inequalities. I believe, as many of my colleagues do, that to understand disparities in both distribution of disease and access to health care, one needs a deep understanding of history and political economy. Others may consider this ideological. I do not. I find it essential to knowledge—a predicate to understanding. Certainly we know how to make common cause with all sorts of people who are also addressing these same problems, and we would happily ally ourselves with any group of people of good will trying to address disparities of access to human essentials. Partners In Health is here to serve the most destitute. Period.

Mullan: What about your views on public infrastructure versus widespread privatization?

Farmer: We aren't opposed to the weakening of public health infrastructure because we believe in a certain ideology. We believe that history and experience has shown that a nation's public infrastructure is the best way to protect rights and provide services to poor people—especially in regard to health.

Mullan: Thank you, Paul, and good luck in your work.