Toward The Viewpoint of the Most in Need. Health as a Human Right. "Every Careful Survey, Across Boundaries of Time and Space, Shows Us That the Poor Are Sicker Than the Non-Poor" (Farmer, p. 140).

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Abstract

Health as a human right has been equivocated, denied, and circumrotated in global health policies across the world with a view of social justice designed from a sociocentric viewpoint of to whom and where we prioritize. This paper discusses Paul Farmer's contributions in bringing into question the rationale of perspectives from which we deliver equity within medical care delivery, advocating the implementation of a combined five viewpoints from which such equity can be ethically and responsibly delivered. This paper argues that a neutral position of cultural or moral relativity in the face of poverty is inequitable; that dimensions of poverty must be taken into consideration in global funding allocations; that structural barriers within communities must be weighted in favor of resource distribution, and that the central value of ethical consideration lies in a pragmatic solidarity toward the viewpoint of the most in need.

1. Introduction

This paper is about health as a human right. It is about violation of human dignity, and the murky reflection of medical ethics. It is about the structural violence that upholds the architecture of poverty. It is about how the world of people with voices has turned its back on those who are suffering in silence, or whose voices have not been heard. It is a shameful story about a dark secret of double standards that has its roots in social memory. It is a dialogue that needs to be continued with vigor and activism "to identify the forces conspiring to promote suffering" (Farmer, 2005) "with the understanding that these are weighted in different settings" (p.50) and to challenge all mechanisms and obstacles; those social structures that are standing in the way of health rights for all human beings worldwide. To forge the way for a new generation of medical anthropologists to reach out, emboldened and strengthened in purpose, to bring the voices of the silenced to the discourse table on health care as a human right; to build bridges, share resources, and forge a new exemplification to the meaning of "pragmatic solidarity" (Farmer, 2005).

Five Viewpoints on Violations of Health as a Human Right

Paul Farmer's book "Pathologies of Power" (2005) is a whirlwind, epic, and haunting tour of poverty as an institution, controlled, directed and starved by a world of economic greed and power. It traces the roots of colonialism and slave trade to present day poverty and discrimination in Haiti, Mexico, Siberia and the Soviet Union as well as some domestic focus. I would like to illuminate briefly in this paper the following of his central thesis statements and apply them to our discipline of medical anthropology.

- The viewpoint of structural violence (taken from Liberation Theology) as the complex socio-economic infrastructure of structural barriers in place that prevent marginalized communities and poor people benefiting from health care or help.
- The viewpoint that social justice must be held to account and the dimensions of poverty considered in the management and allocation of health and human resources.
- The viewpoint that sentiment is not enough and destruction occurs with inaction. The viewpoint again that health is a human right.

- The viewpoint that we can make changes and we can make them now. We can redefine and activate Liberation Theology's core value of pragmatic solidarity.
- The viewpoints of moral relativity and ethics.

Structural violence is in place, and holding in place every poverty stricken community. An old Haitian saying: "A cockroach can never be right when in the presence of a hungry chicken" (Farmer, 2005. p.79) is a distressingly poignant inside viewpoint from people who are suffering because of the affluence of others and the gross inequality of distribution of basic needs and resources. Farmer in his book on the pathology of this power (2005) cites a series of structural barriers arising from lack of funding, from economic and hierarchical structures and laws as the scaffolding creating the problems that lead to sickness,hygiene problems, from lack of sewage systems, housing that fails to protect from the weather and heat, clean water, education, safety in the workplace and access to basic health care as some of the structural obstacles in place that perpetuate this disorder and pathology. Although "the rights of the poor" (p.142) have been discussed at length through history by many, liberation theology finds fault with the notion of human rights as defined within liberal democracies because it focuses on observance, and a cultural relativity that opts out of holding a perpetrator or group responsible for the oppression that has caused the suffering and neglect of fellow human beings elsewhere. Liberation theology is a Christian school of theology that developed in Latin America in the 1960s and 1970s, focusing on liberation of the oppressed. It was initially expressed in the Medellín documents issued at the second conference of the CELAM (*Conselho Episcopal Latino Americano*—Latin American Episcopal Council) in 1968 (online source).

Taking liberation theology as a philosophical starting place I would like to explore Farmer's take on social justice, supposedly the core value of all public health policy. Yet, as Whitefield and Padros, cited in Singer (2012: 197) write: "policies are not neutral, but rather reflect and represent the concepts and ideas of the groups that have the power to make them". Which makes me question from *whose viewpoint* or perspective *is* social justice? Is it in fact socially *relative*? Or a sociocentric concept? Lebra and Smith cited in Scheper-Hughes and Lock (1987:14) accurately draw attention to the fact that justice is in context in, for example, Japan where an individual is bound by the justice of a group and "self -identity change(s) with the social context". This affects how social justice is defined. Social justice as Farmer sees it, outside the restraints of cultural relativity, is a concept relating to equality within social structures; an even and fair distribution of resources and facilities related to health. "Without a social justice component, medical ethics risks becoming yet another strategy for managing equality" (p.201), again Farmer says it best.

The third viewpoint of the five listed, concerns a warning of action over inaction. Farmer writes a very powerful case for the ease with which well-intended charity can misfire and be toxic. He argues that sentiment and feeling sorry for the oppressed is a media fuzzy screen that quickly changes its picture so that each story of horror is replaced by the next and observers are rendered confused and *inactive*. At least this is one of my interpretations of how inaction can manifest. Pharmaceutical companies, who choose to withhold patents for generic versions for example, and therefore making these life saving drugs more accessible to poor countries, withholding aid for trade reasons, slow or "selective" intervention if at all during disease epidemics and suffering. Where is the moral discourse in political responsibility of inaction?How can we convince politicians, bureaucrats, businesses to invest or risk getting involved whenthere is a perceived threat to homeland security or erroneous fears of safety?We need a map. We need information of how inaction makes us compliant, and I believe this is a mapmedical anthropologists can be a foundational part of; "laying out the research questions" and "developing the advocacy, policies and actual interventions" (Kleinman, 2012 p.127) that can and must direct a meaningful social justice.

Which brings me to viewpoint four. "Pragmatic Solidarity" was and is another approach or movement like structural violence, born out of Liberation Theology. Liberation theology "has always been about the struggle for social and economic rights" (Farmer, p.141)For all the pain and horror that Farmer, as a physician and anthropologist, has born witness to and reported on, he remains hopeful. His belief is that we can make changes and there is no better time to do so. He stresses the importance of bringing the silenced and suffering people to the front of the stage and letting them speak. He argues for training within communities and his "Partners in Health" organization promotes this 'inside' aid. Certainly, as Alexander Roedlach speaks of in his lecture (Online lecture, Creighton University) the voices of real people with real suffering and real stories of hardship are "evocative". Narratives are important, "they unsettle us" Roedlach says. They need to be brought to the attention of that old enemy the media "in the interests of full disclosure" (Rapp & Ginsburg, 2012 p.164) and in a sensitive and carefully orchestrated way.

Providing "pragmatic services to the afflicted is one obvious form of intervention. In other words, we cannot exclude social and economic rights from the campaign for health and human rights. But the spirit in which these services are delivered makes all the difference….it can be pragmatic solidarity, linked to the broader goals of equality and justice for the poor" (Farmer, 2005, p.227).

While hope is a good note to end a discussion, there is more. My final viewpoint to discuss briefly, is arguably the one that still needs the most discussion among all the players or groups of people in a position to make major changes in this equality and justice for the poor. Medical ethics has been a critical area for medical anthropologists, challenging as they have done ethics from culturally and morally relative perspectives, forging new questions and discussions on lines between right and wrong. Farmer writes: "When is a life worth preserving? …. (this) is a question asked largely of lives one click of the switch away from extinction, lives wholly at the mercy of the technology that works to preserve some" (p.174).This is a tragic rendition of the state of medical ethics. I would like to ask not only ***when*** but ***whose*** life is worth preserving. To quote Gunderman (2005 p.175):

"Do patients and their suffering exist in some fundamental sense for the benefit of the physician, the hospital, or the stockholder? Or do the physicians and the entire medical enterprise of which they are a part exist for the benefit of patients and the relief of human suffering?"

Farmer calls into questionthe ethical 'double standard' practice comparatively with his work in both Boston medical care and medical care in Haiti. He describes how he is asked in bio-ethical discourse to explain how effective treatment for HIV patients is "cost effective" (p.204) yet in Boston he has to beg patients to take their HIV antivirals. How quantitative data is collected on persons in Haiti with AIDS and the conclusive research analyses calls for preventative medication health care programs; prioritizing prevention over treatment, and in doing so surreptitiouslyperpetrating the inequality and racism of a bio-ethical medical status quo. For surely, if the same tests were being done in a more visible public arena such as North America, and more specifically rich North American communities, the priority outcome of such research would be for treatment.

Conclusion

There is so much left to say and more importantly to do. With confines of page count I write less than a teardrop in the ocean of inequality worldwide that needs to be exposed and redressed. I will end this paper simply by summarizing that in the assessment of who deserves health care and treatment we must call out the "chain of complicity" (Farmer, 2005, p.232) for the "double standards" (p.201) distorting "official analyses, constructed by conflating structural violence" (p.233) and bring to the forefront in written research and in media coverage the extent of suffering that is hidden and in doing so call upon a worldwide pragmatic solidarity in a bid to repair and end this "war on the poor" (p.245).

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