In the London Review of Books, Paul Farmer argues the case for building hospitals as a necessity, not a luxury, for poor countries and rich countries alike. Farmer points to the hypocrisy of a ‘basic minimum package’ for ‘resource poor settings’ that excludes the tertiary care that we assume to be our right as tax-paying citizens in the rich world. Specialist hospital care encompassing all the necessary ‘staff, stuff and systems’ (as Farmer puts it) saves the lives of those suffering complex trauma, infectious disease and complications of childbirth. The poor need these services as much as the rest of us, even if they also need clean water and vaccination programmes.

The neoliberal trend towards privatising profits while simultaneously socialising the losses involved in healthcare provision hits poor countries hardest. In the search for new ways of funding healthcare across the globe, mechanisms to pass the costs to the ‘consumer’, reducing public sector spending, have current primacy. Since hospitals for poor people, especially in rural or sparsely populated areas, cannot be built for profit, they are labelled unsustainable. Hospitals are unsustainable for poor people and so the poor die from, TB, cancer or serious injury. This is illustrated by an ethnography of a provincial hospital in Papua New Guinea where the lack of staff (doctors, nurses, cleaners), stuff (equipment, drugs, food, accommodation) and systems (inter-disciplinary communication, pathology services, professional development to name but a few), compounds the suffering of marginalised people (both staff and patients) who have no alternative recourse. In global economic terms it is not the hospital that is unsustainable, but the poor.

In the rich world our hospitals were built by statutory money from central taxation, from charitable donations and philanthropic gestures. Charitable or developmental aid sources of funding are now dismissed as unsustainable for the world’s poor. To illustrate how profit is not the hospital that is unsustainable, but the poor.

In the city of Maseru in Lesotho with a construction in Mirebalais, in central Haiti. Drawing on local labour and voluntary technical assistance from US craftsmen, the Mirebalais hospital cost less to construct than the one in Maseru, and, in its first year of operation has treated a similar number of patients. Furthermore, the running costs in Mirebalais are less than the private-financed Maseru hospital. Training programmes have been launched in Mirebalais and one estimate suggests that for every dollar invested in the hospital (now central Haiti’s biggest employer), two are generated in the local economy. Could the hospital in Mirebalais, which is the largest solar-power hospital in the developing world, also be halting the emigration of trained healthcare staff? The exodus of staff, to the capital city, to local foreign-funded research or clinical settings is often part of the story of failing hospitals.

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Hadassah hospital, a big state hospital in Jerusalem treats all Israeli citizens; Jews and Arabs alike. The corridor meeting of Jewish and Arabic patriarchs, in the wake of cancer treatment, is described as a comic and hopeful scene by a fellow cancer patient. Providing life-saving treatments to citizens, regardless of their background, has been central to medicine’s role in nation-building and provides hope, not just of bodily recovery, but of social cohesion.

Hope is what fuelled the philanthropic building of hospitals in industrialising cities of the 19th century: a hope that medicine could benefit the poor and rich alike. This echoes the hope of an Israeli hospital offering non-partisan treatment in the face of deeply entrenched divisions elsewhere in society. The pioneering solar-powered hospital in Haiti is exemplary in being a centre of excellence for quality care that is free of charge.

What is the point of a hospital? To provide specialist care. To provide a centre of employment and training. But most of all to provide hope. Hope of recovery, both individual and social.

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