



**RESEARCH IN ECONOMIC ANTHROPOLOGY**  
**VOLUME 26**

**THE ECONOMICS OF HEALTH AND  
WELLNESS: ANTHROPOLOGICAL  
PERSPECTIVES**

**DONALD C. WOOD**  
Editor

THE ECONOMICS OF HEALTH AND  
WELLNESS: ANTHROPOLOGICAL  
PERSPECTIVES

# RESEARCH IN ECONOMIC ANTHROPOLOGY

Series Editor: Donald C. Wood

- Volume 20: Research in Economic Anthropology – Edited by  
B. L. Isaac
- Volume 21: Social Dimensions in the Economic Process –  
Edited by N. Dannhaeuser & C. Werner
- Volume 22: Anthropological Perspectives on Economic  
Development and Integration – Edited by  
N. Dannhaeuser & C. Werner
- Volume 23: Socioeconomic Aspects of Human Behavioral  
Ecology – Edited by M. Alvard
- Volume 24: Markets and Market Liberalization:  
Ethnographic Reflections – Edited by  
N. Dannhaeuser & C. Werner
- Volume 25: Choice in Economic Contexts: Ethnographic  
and Theoretical Enquiries – Edited by D. Wood

RESEARCH IN ECONOMIC ANTHROPOLOGY VOLUME 26

# THE ECONOMICS OF HEALTH AND WELLNESS: ANTHROPOLOGICAL PERSPECTIVES

EDITED BY

**DONALD C. WOOD**

*Department of Social Medicine, Akita University School of  
Medicine, Japan*



ELSEVIER  
JAI

Amsterdam – Boston – Heidelberg – London – New York – Oxford  
Paris – San Diego – San Francisco – Singapore – Sydney – Tokyo

JAI Press is an imprint of Elsevier

JAI Press is an imprint of Elsevier  
Linacre House, Jordan Hill, Oxford OX2 8DP, UK  
Radarweg 29, PO Box 211, 1000 AE Amsterdam, The Netherlands  
525 B Street, Suite 1900, San Diego, CA 92101-4495, USA

First edition 2008

Copyright © 2008 Elsevier Ltd. All rights reserved

No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means electronic, mechanical, photocopying, recording or otherwise without the prior written permission of the publisher

Permissions may be sought directly from Elsevier's Science & Technology Rights Department in Oxford, UK: phone (+44) (0) 1865 843830; fax (+44) (0) 1865 853333; email: [permissions@elsevier.com](mailto:permissions@elsevier.com). Alternatively you can submit your request online by visiting the Elsevier web site at <http://www.elsevier.com/locate/permissions>, and selecting *Obtaining permission to use Elsevier material*

#### Notice

No responsibility is assumed by the publisher for any injury and/or damage to persons or property as a matter of products liability, negligence or otherwise, or from any use or operation of any methods, products, instructions or ideas contained in the material herein. Because of rapid advances in the medical sciences, in particular, independent verification of diagnoses and drug dosages should be made

#### British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library

ISBN: 978-0-7623-1421-8

ISSN: 0190-1281 (Series)

For information on all JAI Press publications  
visit our website at [books.elsevier.com](http://books.elsevier.com)

Printed and bound in the United Kingdom

08 09 10 11 12 10 9 8 7 6 5 4 3 2 1

Working together to grow  
libraries in developing countries

[www.elsevier.com](http://www.elsevier.com) | [www.bookaid.org](http://www.bookaid.org) | [www.sabre.org](http://www.sabre.org)

ELSEVIER

BOOK AID  
International

Sabre Foundation

# CONTENTS

LIST OF CONTRIBUTORS	vii
----------------------	-----

INTRODUCTION <i>Donald C. Wood</i>	1
---------------------------------------	---

LAKOTA HEALTH CARE ACCESS AND THE PERPETUATION OF POVERTY ON PINE RIDGE <i>Kathleen Pickering and Bethany Mizushima</i>	11
---	----

THE POWER OF CULTURE IN SELECTING HEALTH CARE PROVIDERS IN RURAL BANGLADESH: AN ETHNO SCIENTIFIC ANALYSIS <i>Azizur R. Molla</i>	35
---	----

REINVENTING MENTAL HEALTH CARE: PUBLIC-PRIVATE SYSTEMS <i>Sue Gena Lurie</i>	55
--	----

FAILED URBAN MIGRATION AND PSYCHOSOMATIC NUMBING: CORTISOL, UNFULFILLED LIFESTYLE ASPIRATIONS AND DEPRESSION IN BOTSWANA <i>Seamus Decker</i>	75
---	----

ATTRIBUTIONS OF DANGER AND RESPONSES TO RISK AMONG LOGGING CONTRACTORS IN BRITISH COLUMBIA'S SOUTHERN INTERIOR: IMPLICATIONS FOR ACCIDENT PREVENTION IN THE FOREST INDUSTRY <i>Patrick B. Patterson</i>	103
MISSED CONNECTIONS: HYPERTENSION AND OCCUPATIONAL HEALTH AT THE SAN FRANCISCO MUNICIPAL RAILWAY <i>Beverly Ann Davenport</i>	127
PAWNING FOR FINANCING HEALTH EXPENDITURES: DO HEALTH SHOCKS INCREASE THE PROBABILITY OF LOSING THE PLEDGE? <i>Kristiano Raccanello, Jayant Anand and Eder Gibran Bielma Dolores</i>	151
BASIC NEEDS AND EXPENDITURE ON HEALTH CARE IN A SHANTY TOWN OF LIMA <i>Mònica Guillén Royo</i>	173
POLITICAL ECONOMY AND THE HEALTH AND VULNERABILITY OF BATTERED WOMEN IN NORTHERN VIETNAM <i>Lynn Kwiatkowski</i>	199
THE ECONOMIES OF HEALTH IN WESTERN BUDDHISM: A CASE STUDY OF A TIBETAN BUDDHIST GROUP IN FRANCE <i>Lionel Obadia</i>	227

## LIST OF CONTRIBUTORS

<i>Jayant Anand</i>	Department of Anthropology, Texas A&M University, College Station, TX, USA (Currently Assistant Professor of Sociology in the Department of Social Sciences at the University of Puerto Rico, Mayagüez, Puerto Rico)
<i>Eder Gibran Bielma Dolores</i>	University of Colorado, Denver, CO, USA (currently freelance)
<i>Beverly Ann Davenport</i>	Department of Anthropology, University of North Texas, Denton, TX, USA
<i>Seamus Decker</i>	Department of Anthropology, University of Massachusetts, Amherst, MA, USA
<i>Mònica Guillén Royo</i>	Department of Social and Policy Sciences, Wellbeing in Developing Countries (WeD) ESRC Research Group, University of Bath, UK
<i>Lynn Kwiatkowski</i>	Department of Anthropology, Colorado State University, Fort Collins, CO, USA
<i>Sue Gena Lurie</i>	Department of Social and Behavioral Sciences, School of Public Health, University of North Texas Health Science Center, Fort Worth, TX, USA
<i>Bethany Mizushima</i>	Department of Anthropology, Colorado State University, Fort Collins, CO, USA



<i>Azizur R. Molla</i>	Department of Social Work, Anthropology and Sociology, Mansfield University, Mansfield, PA, USA
<i>Lionel Obadia</i>	Faculté de Sociologie et d'Anthropologie, Université Lyon 2 – Lumière, Bron, France
<i>Patrick B. Patterson</i>	Population Health Intervention Research Centre, University of Calgary, Alberta, Canada
<i>Kathleen Pickering</i>	Department of Anthropology, Colorado State University, Fort Collins, CO, USA
<i>Kristiano Raccanello</i>	Department of Economics, Fundación Universidad de las Américas, Puebla, Mexico
<i>Donald C. Wood</i>	Department of Social Medicine, Akita University School of Medicine, Japan

# INTRODUCTION

Donald C. Wood

This 26th volume of *REA* focuses on the economics of health and wellness, and in doing so attempts to bring together two fields of research – economic anthropology and public health – that tend not to merge as often as they should. The volume includes 10 chapters that explore the general theme of the economics of health and wellness in an anthropological fashion and in a variety of settings and ways. All of them passed a selection process that included double-blind peer-review, and have been revised to various degrees based partly on the suggestions of the referees. On this note, I would like to extend my gratitude to the various scholars who took time out of their very busy schedules to review manuscripts for this volume. The chapters here all benefited greatly from their anonymous comments and recommendations.

The role of economics in health and wellness is, of course, widely recognized. It is deep-rooted and complex. Problems like obesity (see Critser, 2003) and tobacco-related diseases (see WHO, 2002; Gately, 2001, for an engaging history) have long been intertwined with geopolitics and trade, for example. In many parts of the world, there is a specific health care sector of the larger national or regional economy. This sector may be governed by rules that are codified and easily accessed and understood by most people. Even so, many are actually participants only in a marginal sense. The USA, which possesses enough overall wealth to provide adequate care to all residents, is currently unable to do so because of economic, political, and logistic disagreements. Basically, as everyone knows, it all boils down to money. In the words of Howe (2002, p. xi), this system “is characterized by high cost, highly variable access, and high dissatisfaction

---

**The Economics of Health and Wellness: Anthropological Perspectives**

**Research in Economic Anthropology, Volume 26, 1–10**

**Copyright © 2008 by Elsevier Ltd.**

**All rights of reproduction in any form reserved**

**ISSN: 0190-1281/doi:10.1016/S0190-1281(07)26012-3**

among all participants.” To this should probably be added the phrase, “and non-participants as well.” In other parts of the world, people are currently learning to cope with expanding and rapidly-developing health care systems that yet lie largely beyond their reach or level of comprehension. According to Charles Phelps (2003, p. 2), the health care sector of an economy is characterized by an especially large collection of “unusual economic features” that are generally not found all together as often, and are not as pronounced, in other sectors of an economy. These features are, (1) a high degree of government involvement, (2) considerable uncertainty, regarding illness and treatment for example, (3) a wide gap in the amount of knowledge between providers and consumers of health care, and (4) numerous externalities, meaning that health-related choices and actions on the part of each individual have a high chance of impacting other participants – in the form of costs or benefits – participating in the same system.

Of these four factors, the dominant one would appear to be uncertainty. After all, the inability to predict what is going to happen in the future in terms of injuries and illnesses, and even the outcome of treatments, cuts through the other three factors in myriad ways. In fact, as Phelps (pp. 2–5) points out, government involvement in health care has a great deal to do with the high degree of uncertainty. Medical doctors generally stand high above their patients due to the nature of their knowledge and their concurrent power to impact the lives of the people with whose wellbeing they are charged. Yet extreme uncertainty plagues them as well. Furthermore, the various costs and benefits (externalities) that people face due to the actions of others in the health care marketplace (or field, in the case of heavy state control) come about due to difficult-to-predict individual decisions that are usually made in the face of much uncertainty. The production and maintenance of health is a gamble.

To differing degrees, chapters in this volume address these factors, with that of uncertainty probably being the most prominent. The importance of economics in health and wellness – the uncertainty factor included – has been studied by a great variety of researchers: economists, sociologists, public health experts, and more. Anthropology brings a special set of tools to this endeavor, the most important of these probably being meticulous ethnographic investigation, which has the power to elucidate and dissect the most mundane and commonplace details of life. Such details are easily missed by broad regional or nationwide surveys of health conditions. Ethnography also has the ability to accurately measure the importance of particular economic factors on health and wellness in specific locations, or on individual households or specific individuals. The chapters that comprise

this volume all share a strong emphasis on empirical, ethnographic methodology. One of the most noticeable overall themes of this volume is the reaction to the challenges that uncertainty presents. In this, there is much emphasis on household-based economic action in relation to individual health, or perhaps even *household* health. It is hoped that this volume will make a notable contribution in this area of health economics studies, to name one, and help encourage greater interest in related problems on the part of economic anthropologists.

In the first chapter, Kathleen Pickering and Beth Mizushima take an intimate look at a particular cross-section of North American society that has been largely unable to participate effectively in the greater health care market due to its geographic location, a shortage of available services, and, most importantly, poverty. Indeed, Native Americans living on reservations tend to be plagued by various lifestyle-related diseases that are largely brought about and worsened by economic factors (see Smith-Morris, 2004, for example). Lakota people on the Pine Ridge Indian Reservation in South Dakota, Pickering and Mizushima show here, have low life expectancies and high rates of heart disease and other maladies. In the spirit of Karl Polanyi (1970, pp. 47–55), the authors argue for the importance of “non-market” (or “equalizing” – see Halperin, 1993) activities, such as reciprocity and redistribution, and they also focus on household-based strategies for the maintenance of health in the wake of massive shortcomings on the part of the private sector. Households, they show, change their composition fluidly in response to short-term economic conditions and immediate health care needs. The authors argue that the dominant biomedical market model of the United States, steeped in the mode of market exchange, is not only inadequate for understanding the health needs and health-related behaviors of such marginalized peoples, but also unable to provide them with the care that they need.

The second chapter of this volume considers the case of rural people of Bangladesh. Like the authors of the previous study, Azizur Molla concentrates here on households as the primary units of social economic action, but Molla focuses specifically on household heads, since they exert much control over the behavior of household members. Also, like the people of the Pine Ridge Indian Reservation existing on the margins of a highly-developed health care network, the people of Molla’s study are unable to access well the most medically advanced components of the national system. However, they do have access to a variety of treatments that are usually not as readily available to people in a system dominated by an industry-driven, biomedical model as in the United States, for example. Molla attempts to

identify the factors that contribute to households' choices between different types of health care provision in this pluralistic and rapidly-changing healthcare environment. Money is, of course, a major factor, but tied to this is the occupation and sex of the household head. Cultural beliefs in general are also shown to play a large part.

Next, Sue Gena Lurie takes an insider-ethnographer's look at developments in government reorganizations of public-private mental health care systems in my own native state of Texas. While serving as an advisory board member during the time of her fieldwork, she was able to look deeply into the institutional relationships in which the state health economy is embedded. Eschewing an overly-critical stance on neoliberalism in general, she shows how and why attempts at privatization met with difficulties in the face of scarce resources, but also that the overall safety net of basic services was maintained by the efforts of the county MH/MR agency. This study well illustrates the high degree of government involvement in health care, as discussed by Phelps.

Fourth, Seamus Decker investigates rural-urban work migration in Botswana, a Southern African state with a relatively strong economy and a rather stable political situation, yet also with a high unemployment rate and pronounced rural/urban income disparities. Decker combines qualitative ethnographic information with quantitative data derived from a clinical study of salivary cortisol in order to measure the relative wellbeing of men who migrated to urban areas to seek better working and living conditions, only to fail in this attempt and return to the rural areas of their origin. His data indicate that such failed attempts at building a life in such a city environment may cause more personal harm in the way of stress and depression than success, and his conclusion that rises in total material affluence do not necessarily produce greater relative happiness measurable in a linear fashion helps lend support to the argument that perceived socioeconomic disparities are more important in considering overall human wellbeing than is socioeconomic status measured on an absolute scale. Although clinical methods are not often employed in economic anthropology, Decker's study does resonate well with the greater body of ethnographic work on development and individual wellbeing, especially in its tendency to view disparities in regional development with a critical eye (see discussion in Cohen & Dannhaeuser, 2002, for example).

In the fifth chapter, Patrick Patterson takes a close look, both as an ethnographer and as a former (and current) worker, at the logging industry of British Columbia – an industry fraught with excessive uncertainty and loaded with risk. In the case of this business, uncertainty and risk are not

only related to production and profit but also directly linked to the physical wellbeing of the workers, for being hit by a falling tree or rolling a truck or other piece of equipment only once could easily result not only in injury and loss of income but also death. The factors of uncertainty and risk have been well-considered in economic anthropology, especially in regard to work (including employment, production, trade, and more), but Patterson's study makes a special contribution to this volume by way of its focus on these factors in direct relation to the health and wellbeing of the workers. He shows that there is a strong tendency on the part of individuals in the industry to cope with uncertainty by taking a very pragmatic attitude toward work. Also, while there does appear to be a tone of fatalism beneath the surface of the logging business that Patterson describes, the situation also provokes a strong sense of individuality in the workers. These appear to become linked in the minds of the workers, who tend to place the blame for accidents in the forest on carelessness or lack of knowledge on the part of individuals. As the state also seems to increasingly place blame on individuals or their employers, this situation has the potential to result in increased absolution of responsibility on the part of the government. However, as Patterson shows, employers also try to diminish risks by hiring friends and relatives, and also by otherwise forming closely-knit work crews. He ends on a positive note, suggesting that the situation may give rise to better regulation and safer practices in the future.

The next chapter also deals with occupational health. Here, Beverly Davenport offers an analysis of a case in which workers face danger not so much in the form of physical injury or death from single, sensational, accidents (although these can occur) but rather from the daily grind of working under stressful conditions with very low levels of control over their jobs or the conditions under which they labor. Indeed, as Davenport explains, public transportation operators have a high tendency to develop hypertension. However, this has not gone unnoticed by their employers. In this chapter, Davenport investigates the efforts on the part of the San Francisco Municipal Railway (Muni) to tackle this problem over the past 25 years, following the course of several successive programs initiated by Muni authorities. Similar to the case investigated by Patterson in the previous chapter, workers are shown to employ a variety of discourses in apparent attempts to exercise control over their work environments and empower themselves: as loggers tended to claim to have their own safety in their own hands, bus drivers claimed to have "sanity barriers" or to be separated from their passengers by planet of origin. Both of these chapters also well illustrate the institutional relationships between government and

public/private bodies and the people whom they employ, and they also call attention to state regulation of labor and health – regulation which is largely designed to cope with uncertainty in both the workplace and in workers' wellbeing. In addition, both chapters speak of an increasing tendency to shift responsibility for health and wellness from the employers and the regulators to the employed, a generally fatalistic attitude about this and other occupational challenges, and also reveal a basic failure to effectively address the structural problems that make positive changes so difficult to achieve.

In the seventh chapter in this volume, Kristiano Raccanello, Jayant Anand, and Eder Gibran Bielma Dolores take a look at the pawning of items in order to pay for health-related expenses in Puebla, Mexico. Pawning, as the authors point out, has not been much considered in the social science literature in relation to covering health care expenses, but this economic activity is a major part of the lives of many so-called "working poor," who generally lack access to health insurance and must cover their own health care costs by obtaining relatively large amounts of cash in some way and in a short time frame – even in the United States (see Shipler, 2004; Duncan, Huston, & Weisner, 2007, for example). Pawn shops were fairly common in my home area in central Texas, where I spent a number of years working in restaurant kitchens. I worked alongside quite a few people who literally lived from paycheck to paycheck, and who had to make drastic adjustments in their lives each time they were stricken with an illness that required the attention of a specialist, or even if their car broke down. They often relied on pawn shops. Although I never had to do this, I did buy from pawn shops. When I was in college I shared an apartment with a fellow student from northern Italy. Together we bought a used VCR at a pawn shop, but when I explained to him how they function, he was quite surprised. To him, buying from a pawn shop was simply a case of benefiting from another's misfortune. Here, the focus of Raccanello et al. on pawning in Mexico is a very welcome one, given not only the lack of scientifically-derived information on the topic but also the high prevalence of pawning there, and also the low level of health insurance coverage. Relying primarily on a quantitative survey, they find that a significant proportion of residents utilized pawn shops for covering health-related monetary expenses – health shocks – even despite having health insurance, and also that the chance of losing pawned items was negatively correlated with income but positively correlated with the number of pawned items and with the presence of catastrophic health costs.

Next, Mònica Guillén Royo looks at a different kind of market activity relating to health-related monetary expenses, in a different part of

Latin America – the outskirts of Lima, Peru. Here, Guillén Royo investigates basic needs satisfaction (in accordance with individuals' personal conceptions of a good life) in the form of consumption of goods and services. Good health is clearly shown to be a major prerequisite for having a good life in the minds of the study subjects. Her chapter calls into question universalist conceptions of personal values while taking a critical stance on the misguided consumption of goods and services that appear to aid the buyer in achieving the “good life” but actually do not serve that purpose. Most importantly, the study shows that many people were not only suffering from poverty, insufficient health insurance coverage (if at all) and inadequate access to, and trust in, the public health system, but also from a serious lack of information about health goods and services that they were consuming in their attempts to maintain or improve their health. Due to severe shortcomings of the system, the people of Guillén Royo's study were shown to be largely unable to make informed judgments about health-related consumption. The reported over-dependence on vitamin supplements, certain to make manufacturers happy, at the expense of nutritious, balanced meals, appears to be a serious problem.

In the ninth chapter of this volume, Lynn Kwiatkowski considers wife battering in rural Northern Vietnam, where the problem is shown to be quite pronounced. In addition to being rooted in cultural values, the phenomenon is tightly connected to national and local economic development and the social position of women amidst this. Kwiatkowski takes a critical perspective on the problem, drawing from the theoretical perspective of political economy, and shows that poor women are particularly vulnerable because not only are they very limited in their ability to protect themselves (by fighting back or leaving abusive husbands) but they also have far less access to professional health care than their urban or more wealthy counterparts, for example. Over the last 20 years, implementation of the state's *doi moi* policies, which outline the communist party's form of market socialism, have brought about gradual economic change that appears to have done much toward spreading wealth in the nation and also toward empowering women, and should have the potential to do more. In the case of health care, controlled privatization seems to have helped improve overall national access to care and given people more choices, but at the same time poorer people may be slipping behind their better-off peers. Kwiatkowski's chapter draws attention in particular to the state's efforts at encouraging women not to leave their families, or to return to abusive husbands, apparently in order to avoid a weakening of households and possibly necessitate greater public support for victims of domestic violence.



Finally, Lionel Obadia investigates the spread of Buddhism in the West, where it has been interpreted not so much as a “faith” but as a philosophy, and more recently as therapy for the perils of modern-day urban life and a model for a better, more healthy way of living. Specifically, he focuses on the case of Tibetan Buddhism in France, relying on ethnographic investigation of a particular group. Obadia’s chapter draws attention to the market for “exotic” Asian therapies, and their packaging, for Western maladies. It is through the interpretive lens of this market that Buddhism and other belief systems have been translated and packaged for consumers both by native practitioners and by “authentic” spiritual authorities, such as the Dalai Lama himself. But taking a critical perspective, Obadia points to class-based differences in the Western consumption of Buddhism, in which it takes on a more esoteric meaning for upper-class, wealthier people and a more down-to-earth quest for a better way of living among those of the lower-class or the disenfranchised, for whom the embedded concept of suffering carries more meaning. Judging from Obadiah’s essay, more research into the economics of religious diffusion – especially in relation to health and wellness – seems warranted.

Overall, one theme in particular emerges from the collected chapters in this volume – a theme that takes us back to the beginning of this introduction. It is the problem of how to cope with the ubiquitous issue of uncertainty relating to our health. Chapters by Pickering and Mizushima, Molla, Raccanello et al., and Guillén Royo point to household-based strategies. In the absence of adequate insurance coverage, cash to pay for treatment, or of facilities or providers in general, people are attempting to handle health problems, or maintain their health, as members of households, which may even change their composition much over time. Similar to the portraits of small-scale and peasant producers painted by the “householding” (see Netting, 1993) and “moral economy” (see Scott, 1976) theoretical perspectives, those in unfavorable or unstable economic situations may choose to solidify their social foundations for security by consolidating their labor and energy in the household, and they may be unlikely to take unnecessary risks. Especially, this should be the case regarding health, for a farmer might take a chance on a different crop one year only to find himself struggling to make up for a loss the following growing season, but it is difficult to make up for lost revenue due to diminished health, and it is difficult to rebuild damaged health, especially without access to facilities and the safety nets of good insurance and workers’ compensation.

Chapters by Patterson, Davenport, and Kwiatkowski share a focus on the attitudes and actions of individuals in dangerous situations – situations that

place their health and wellbeing in peril, yet which are at the same time important (if not necessary) for their very survival. Workers need their jobs, however dangerous they may be, and a woman with few options for survival may find it hard to leave her family, or even only her husband, for greater personal safety. In fact, leaving might not be an attractive option at all. The fatalism-tinged pragmatism apparent in all of these chapters should come as no surprise. What should give cause for concern is the equally apparent trend towards shifting blame and/or responsibility onto the individual by the corporation or the state. More objective, ethnographic research into this problem seems warranted.

One more theme that emerges from this set of chapters is that organizational culture in health care, particularly in relation to the problem of uncertainty. Organizational culture, which might be defined as the overall social environment of an organization or the sum-total of the social relationships between its constituent individuals and groups, can be both divisive and agglomerative at the same time. It has to do with the ways in which the personnel of an organization relate to one another and think and behave as parts of that larger body. Different constituent groups may, of course, have their own cultures, or sub-cultures. Organizational culture can work either for or against change in an organization, and it may be especially difficult to build in healthcare environments, where there is a great diversity of highly-trained professionals employed, and where the actual customer (the receiver of the services or perhaps the actual payer of the bills) may be hard to identify (Smith, Waldman, Hood, & Fottler, 2007). Problems identified here by Sue Gena Lurie in a healthcare environment and by Patrick Patterson and Beverly Davenport in other work environments might be related to difficulties with organizational culture where managers and bureaucrats are seeking to limit responsibility and minimize uncertainty.

In sum, this volume of *REA* is an investigation into the economics of health and wellness that looks at a variety of related problems from a variety of angles, all with a strong emphasis on ethnographic methodology and empirical observation. People have been shown to deal with uncertainty about health and in health care in a number of different ways. Households may often provide much support and comfort, and individuals may also act largely on their own. Organizations, including governments, also attempt to deal with undesirable situations and improve their circumstances through top-down management and privatization. Overall, chapters here address two major points of great concern in health studies today: (1) differential access to healthcare (see Farmer, 2003; Farmer, Furin, & Katz, 2004, for example),

and (2) a trend of shifting responsibility for health and wellness from the state or the corporation to the individual (see also Moberg, 2002). These are healthcare trends that deserve much greater attention from economic anthropologists. Hopefully this volume will help encourage greater interest in these problems, and at the same time increased crossover between the fields of economic anthropology and public health.

## REFERENCES

- Cohen, J. H., & Dannhaeuser, N. (2002). Introduction – Development in practice and theory: A positive role for anthropology. In: J. H. Cohen & N. Dannhaeuser (Eds), *Economic development: An anthropological approach* (pp. xi–xxx). Walnut Creek: Altamira.
- Critser, C. (2003). *Fat land: How Americans became the fattest people in the world*. New York: Penguin.
- Duncan, G. J., Huston, A. C., & Weisner, T. S. (2007). *Higher ground: A new hope for the working poor and their children*. New York: Russell Sage Foundation.
- Farmer, P. E. (2003). *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. Berkeley: University of California Press.
- Farmer, P. E., Furin, J. J., & Katz, J. T. (2004). Global health equity. *The Lancet*, 363, (May 29). 1832.
- Gately, I. (2001). *Tobacco: A cultural history of how an exotic plant seduced civilization*. New York: Grove Press.
- Halperin, R. H. (1993). The concept of equivalencies in economic anthropology. *Research in Economic Anthropology*, 14, 255–298.
- Howe, R. K. (2002). *Where have we failed? A systemic analysis of U.S. health care*. Tampa, FL: American College of Physician Executives.
- Moberg, M. (2002). Erin Brockovitch doesn't live here: Environmental politics and 'Responsible Care' in Mobile County, Alabama. *Human Organization*, 61, 377–389.
- Netting, R. McC. (1993). *Smallholders, householders: Farm families and the ecology of intensive, sustainable agriculture*. Stanford: Stanford University Press.
- Phelps, C. E. (2003). *Health economics*. Boston: Addison Wesley.
- Polanyi, K. (1970). *The great transformation*. Boston: Beacon. (orig. 1944).
- Scott, J. C. (1976). *The moral economy of the peasant*. New Haven: Yale University Press.
- Shipler, D. K. (2004). *The working poor: Invisible in America*. New York: Knopf.
- Smith, H. L., Waldman, D., Hood, J. N., & Fottler, M. D. (2007). Strategic management of internal customers: Building value through human capital and culture. *Advances in Health Care Management*, 6, 99–126.
- Smith-Morris, C. M. (2004). Reducing diabetes in Indian Country: Lessons from the three domains influencing Pima diabetes. *Human Organization*, 63, 34–46.
- WHO (2002). *The tobacco atlas*. Retrieved May 1, 2006, from [http://www.who.int/tobacco/statistics/tobacco\\_atlas/en/](http://www.who.int/tobacco/statistics/tobacco_atlas/en/)

# LAKOTA HEALTH CARE ACCESS AND THE PERPETUATION OF POVERTY ON PINE RIDGE

Kathleen Pickering and Bethany Mizushima

## ABSTRACT

*Poor health conditions are a major factor in perpetuating poverty on the Pine Ridge Indian Reservation. This chapter explores the ways in which market-based health care delivery systems shirk health care costs of Lakota households on the periphery of the market economy. Furthermore, the economic value of health care services provided by these same marginal households is understated because market-based health care privileges commodified biomedicine. Examining economic activity beyond formal market integration reveals how households least able to bear the costs of health care subsidize the market economy at the expense of their own efforts to move out of poverty.*

Lakota people living on the Pine Ridge Indian Reservation in South Dakota face some of the worst health conditions in the U.S., including extremely low life expectancy and alarmingly high rates of heart disease, cancer, and diabetes. Additionally, Pine Ridge is one of the most impoverished areas in the U.S., struggling as many other American Indian reservations do to generate economic development on the narrowest margins of the world

---

The Economics of Health and Wellness: Anthropological Perspectives

Research in Economic Anthropology, Volume 26, 11–33

Copyright © 2008 by Elsevier Ltd.

All rights of reproduction in any form reserved

ISSN: 0190-1281/doi:10.1016/S0190-1281(07)26001-9

economy. Synergies between ill health and poverty spiral downward, as individuals' health problems not only reduce their abilities to pursue education, wage work, or self-employment, but also divert household resources as family members shift from generating household support to providing uncompensated home-based health care.

Based on primary data gathered from 300 Lakota households on the Pine Ridge Indian Reservation over the last six years, this chapter argues that household activities beyond market-based transactions are critical to understanding Lakota responses not only to poverty but also to inadequate health care access as well.

## **1. SOCIALLY EMBEDDED ECONOMIES AND SOCIALLY EMBODIED HEALTH**

Health care access is an economic development issue. In Eurocentric economic and medical practice, the individual is elevated as the central actor. Access to health care services is an act of individual exchange on a free market, just like entering an employment contract or buying groceries. However, for communities with a strong history of collective consciousness and weak ties to market economics, individuals act in socially embedded spheres of exchange, where the health of an individual is fully integrated into the dynamics of household production. By looking at the household as the unit of analysis, it becomes apparent that health problems pose a significant demand on the time and limited financial resources of households. Health problems also impact the economic vitality of a much larger portion of the population than is apparent when individual disease prevalence is used as the unit of analysis. Furthermore, experiences with biomedicine are in fact interpreted collectively, not through the individualized market model, so that group experience informs health care perceptions and ultimately affects health care access.

However, the activities of marginalized, impoverished communities within the structures of capitalism continue to be overlooked and under-theorized. Typically, social scientists conceive of economic activity as being from one of two distinct worlds. The world associated with the prosperity of the U.S. is an orderly, formal, structured, industrialized, market-based economy with associative relations and cash-based, materialistic consumption. The world associated with poverty, indigenous peoples, and societies in need of economic development is theorized in contrast to the idealized capitalist

world to be amorphous and unstructured, with non-market forms of exchange, kin-based relations, and non-monetarized, uncommodified forms of consumption (Evers, 1991; Haynes & Bosworth, 1996; Sacks, 1995, p. 250).

In practice, however, poor people are moving fluidly between these two worlds, allocating time, consuming, and socially interacting across this theoretically constructed divide (Halperin, 1990; Nash, 1994; Peterson, 1989; Stack, 1974). Within the U.S., the area of overlap between these two worlds is potentially greater than the areas of separation. For households in poor communities, their economic practice is a dynamic combination of formal and informal, arms length and social, regulated and unregulated, and market-based and reciprocal activities.

As Karl Polanyi observed, the “human economy is embedded and enmeshed in institutions, economic and non-economic” (Polanyi, 1957, p. 250). Polanyi postulated four modes of economic integration, all of which are present to some degree in every society, but vary across societies and over time in terms of which mode is dominant or subordinated (Polanyi, 1944; Polanyi, 1957, p. 253; Halperin, 1994; Halperin, 1991). Since the economy is an instituted process embedded within society, the economies within different societies may be instituted in significantly different ways (Hopkins, 1957, p. 295). Redistribution, which occurs when goods are accumulated through familial or political relationships and then redistributed to establish social ties and support throughout the community, is common among tribal societies where the social structure is based on the collective interests of kinship groups. Reciprocity is most often defined by gift giving, with some acknowledged obligation to make a return gift at some time in the future (Mauss, 1990; Sahlins, 1968). Forms of barter that take into account the social relationship between the parties to the exchange also constitute reciprocity. Householding refers to the movement of goods and services within and among household members, also referred to as resource pooling by some authors (Halperin, 1991; Peterson, 1989). These three modes of integration are all explicitly based on the social relationship between the parties to the exchange. There is no sense of faceless, alienated participants in these exchanges, or of invisible forces defining what is fair or equitable. The imbalance in the value of gifts exchanged between mother and child is explained and accepted by their social relationship, as is the redistribution of meat to a family whose primary hunter suffered a severe injury.

Market exchange, in contrast, is where prices are determined at arms length, and has been the dominant mode of integration accompanying the

global spread of capitalism over the past five centuries. And, while markets do in fact depend on people acting within the obligations and constraints of society, the ideology of the market economy stresses the independence and freedom of individuals to make choices and accumulate wealth without obligation to anyone in particular or to society in general (Mingione, 1994). In the current world economy, the market is often assumed to be not only the dominant but also the universal and exclusive mode of integration for all societies, as it is in most industrialized societies.

However, as the global economy evolves, areas which were almost exclusively dedicated to market practice but have become redundant to the global system now exhibit renewed and expanded efforts in reciprocal and redistributive domains. Similarly, areas which have only had weak ties to the global market economy may continue to demonstrate strengths in other forms of economic integration, often centered around kinship systems and the importance placed upon familial obligations, while market exchange remains subordinate (Annis, 1987; Halperin, 1991). In such settings where market exchange is not the dominant mode of integration, analyses that are limited to formal market transactions and relationships run the risk of missing the full array of activities involved in meeting household needs, and misrepresenting significant areas of economic life as inactivity, leisure, or inefficiency (Pickering, 2000; Pickering, 2004; Pickering et al., 2006).

In relation to health care access, the biomedical model of health delivery systems is embedded in the mode of market exchange. Projections of health care coverage are based on the costs of fully commodified goods and services dedicated to health and medical treatment. As a result, health care practices governed by other modes of economic integration and their social costs are often left out of biomedical models, which focus rather on formal hospital or clinic settings with services provided by fully compensated wage workers. Furthermore, the market-driven biomedicine of the U.S. implies that only those participating in market-based economic activities deserve health care coverage. Virtually every other industrialized nation has created a redistributive government health care system in which the contributions of those currently working offset the health care costs of those unable to engage in market-based economic practices.

For places in the U.S. like Pine Ridge, where formal markets continue to be weak, the real costs of preventative, acute and long-term health care fall back onto reciprocal and householding modes of integration through the uncompensated labor of household and extended family members. This shift of health care costs onto households with the most limited resources works

to perpetuate poverty in two ways. First, short-term, seasonal, and regional employers are able to avoid these health care costs by imposing them onto the reservation households of their employees (see Meillassoux, 1981). As a result, uncompensated, home-based health care provided by peripheral households ends up subsidizing the market economy at the expense of their own efforts to move out of poverty. Second, the uncompensated labor of households providing health care is left out of formal market equations governing the productivity and human capital potential of the community. As a result, a distorted portrait of economic inactivity is constructed by businesses to further marginalize and undercapitalize these communities, perpetuating poverty once again.

## **2. UNCOVERING REAL HOUSEHOLD ECONOMIC PRACTICE**

To understand how the processes of health care access and economic marginalization intersect, primary data was drawn from longitudinal economic and health data gathered on the Pine Ridge Indian Reservation in South Dakota from 300 Lakota households over the last six years. The objective of the overall research, funded in part by the National Science Foundation, is to analyze the relationship between time allocation, household consumption, and social networks in structuring household economic opportunities and decision making. By using the household as the unit of analysis for longitudinal research, it becomes possible to move away from the static and atomistic picture of individuals engaged in fixed relationships and activities, and move toward a more accurate understanding of how household membership and economic resources are dynamic and contested strategies that change, in some cases radically, over time (Knack, 2001; Pickering, 2004). The data-gathering portion of the project began in the summer of 2001 and was concluded in the summer of 2006.

To randomly select the 300 household participants for this study, every housing unit on the reservation was identified, marked, and numbered from aerial photographs of the reservation taken in 1994 by the USDA-FSA Aerial Photography Field Office's National Agriculture Imagery Program (NAIP). These photographs were updated with ground level observations, and with aerial photos from 2004 that were made available also by NAIP. A set of random numbers was then generated by computer and used to



identify participant households. Each year, beginning in 2001, 60 new households were added to the sample, and follow-up interviews were conducted with households that had been selected and surveyed in prior years. In 2005, the final 60 randomly selected households were added to the sample. The random sample was stratified to be proportionate to the percent of housing units in each of the eight reservation political districts, so that variations and conditions within a given district could be compared and contrasted to the conditions for the reservation as a whole (Bernard, 2006, pp. 154–155).

Each randomly selected household was approached in person and the residents were asked to respond to a standard form questionnaire eliciting a mixture of qualitative and quantitative responses. New questions were added each year in response to suggestions and concerns offered by Lakota households and organizations. For example, while the initial survey did not address health issues directly, this area of inquiry was added and expanded after Lakota people expressed the enormity of the burden of poor health on households and the tremendous loss to the community from premature deaths and disabilities. The longitudinal aspect of this study helped enhance the accuracy of the data because each follow-up interview was devoted in part to confirming information from prior years concerning household membership, income, and expenses. Trust and familiarity also developed over the years with the residents of the participant households in the process of conducting follow-up interviews each year.

### **3. THE HEALTH OF THE ECONOMY AND THE ECONOMICS OF HEALTH ON THE RESERVATION**

Pine Ridge has presented a special challenge to economic development. The reservation is an area of persistent poverty, ranking in the top five counties for the highest rates of poverty over the last 30 years (Pickering et al., 2006). It suffers from persistently high levels of unemployment, well in excess of those experienced across the U.S. during The Great Depression. The largest source of employment is a combination of federal, state, and tribal government jobs. There is virtually no private sector. With one or two exceptions, no local business employs more than 20 people, with a more likely number of two or three employees outside of immediate family members. In all total, there are no more than 50 small businesses on the reservation. There are virtually no banking services on the reservation, an

area the size of Connecticut, and only one bank operates a mobile banking unit that drives to the reservation to provide certain banking services on a weekly basis (Adamson, 1997). Furthermore, household economic composition is dynamic, as members shift fluidly from wage work, often sporadic and temporary, to other forms of productive activity, such as subsistence hunting, gathering, or home-based enterprise, and government programs. Most households participate in a dynamic mixture of temporary or part-time wage work, microenterprise for cash sales, and intra-community gifts and barter of goods and services (Sherman, 1988; Pickering, 2000). A good deal of wage and microenterprise activity is undertaken to meet a specific cash need, and therefore tends to be short term and sporadic. Social networks also work to redistribute goods, food, and cash through ceremonial and community events (Pickering, 2004). Otherwise, household income supplements include retirement pensions, Social Security and Supplemental Security Income (SSI) benefits, Food Stamps or Commodities, and Temporary Assistance to Needy Families (TANF) (Pickering, 2000; Pickering et al., 2006).

Household composition is dynamic and fluid, with the concept of family comprising many different relationships and individuals. The boundary between extended and immediate families is obscured by the fluidity and size of household composition, as well as the close interaction that family members have on a daily basis. Families living under the same roof are often multigenerational, including grandparents, aunts, uncles, cousins, nieces, nephews, as well as parents and siblings. Family members may help raise children from their extended family for short or long periods of time depending on the situation and the needs of the people involved. Finally, adult family members may come and go. As individuals fluidly enter and exit the households because of work, education, or interpersonal relationships, they bring with them different skill sets and abilities to promote a diversified livelihood strategy which draws upon all individuals within the household. Understanding the economy on Pine Ridge through the lens of household dynamics provides insights into how market exchange, redistribution, reciprocity, and householding are all drawn upon and integrated into everyday life, especially in relation to the health needs of the Lakota.

Ill health greatly influences the ability of individuals to keep their employment. As the Lakota emphasize respect and responsibility to their family and loved ones, and appreciate the tenuous nature of purely market exchange in comparison to more socially embedded forms of economic life, social relationships become more important than wage labor employment. Therefore, if a family member becomes ill, it is most likely that one of their

loved ones will reduce their other responsibilities and obligations to become a caregiver. The prohibitive costs associated with long-term, institutional forms of health care also weigh in favor of intra-family caregiving.

Like the larger American Indian population, the Lakota people of Pine Ridge are faced with some of the worst health disparities in the U.S., including extremely low life expectancies. Many households are affected by chronic ill health such as heart disease, diabetes, cancer, alcoholism, chronic respiratory illness, weight problems, automobile accidents, and other accidents and injuries (Associated Press, 2007). Although the health of American Indians has improved since 1955 and infectious disease rates have gone down, in part by the creation of the Indian Health Service (IHS), chronic illnesses, such as diabetes, heart disease, and cancer, have skyrocketed (Bergman, Grossman, & Erdrich, 1999, p. 571; Dixon & Roubideaux, 2001, p. xx; Sandefur, Rindfuss, & Cohen, 1996, pp. 9–10; Zuckerman, Haley, Roubideaux, & Lillie-Blanton, 2004, p. 53). As the Lakota on Pine Ridge are one of the poorest nations in the U.S., their socioeconomic status prevents Lakota people from purchasing health insurance plans or affording out of pocket health expenses. Even basic needs that could be considered aspects of preventative health care, such as healthy foods, clean housing, running water, heat, and electricity, are often difficult to consistently obtain. Additionally, access to health care services is geographically, logistically, and economically difficult.

Because of the peripheral position of Pine Ridge to the market economy, most adults have some wage work experience, but that experience either is part-time, temporary, or seasonal work that does not provide health care benefits, or is from periods of time spent away from the reservation and does not extend health care after returning to the reservation. As a result, only 7% of households reported having medical insurance coverage. The IHS is required by law to provide health care for tribal members, derived from treaty rights established under the Fort Laramie Treaty of 1868 whereby the U.S. government pledged to provide food support, education, and health care for the Lakota in exchange for large land cessions from the Lakota. U.S. federal court decisions have determined, however, that while the U.S. government has the obligation to provide health care to tribal members, it is not required to provide adequate health care. Consequently, the health care provided through this delivery system is avowedly inadequate, underfunded, and focused on triage rather than preventative care. Lakota households express the perspective that this inadequate health care is the product of institutional discrimination, and that ethnicity is a risk factor in disease incidence, treatment, and outcomes for Native Americans.

These factors therefore increase the reliance of the Lakota on the limited and often inadequate health care provided by the IHS. The IHS is a public health facility that provides health care delivery to reservations like Pine Ridge. Historically, IHS was founded through the federal Indian trust relationship to raise the health status of American Indians and Alaska Natives, and still today the relationship and obligation of the federal government remains in place. Currently, it is estimated that IHS is operating with less than 60% of the funding it needs (U.S. Commission on Civil Rights, 2003, p. 43). In 2005, IHS spent approximately \$2,100 per person per year for health care, in contrast to the estimated expenditures for the average American of \$5,298, a difference of more than \$3,000 per person per year (Indian Health Service, 2005a). This under-funding of IHS results in the provision of universal but rationed health care to tribally enrolled members (Joe, 2003, p. 532). Within IHS hospitals and clinics, almost two-thirds of the biomedical care needed cannot be provided within the facilities.

#### **4. THE DYNAMICS OF POVERTY ON PINE RIDGE: MARGINALIZED BY AND SUBSIDIZING THE MARKET**

##### *4.1. Fluid Economic Integration*

While the market has been a component of reservation economy for a century, it is difficult to argue that it is the dominant form of economic integration for most Lakota households. Householding, reciprocity, and redistribution continue to represent significant arenas of economic life on Pine Ridge. Based on our data, only 35% of the Lakota population on Pine Ridge over age 16 is employed, while nearly 43% are unemployed (see Table 1).

In contrast, exchanges that would be characteristic of reciprocal, redistributive, and householding or self-provisioning modes of integration are prevalent across Lakota households. For example, 78% of households continue to eat wild resources, such as deer meat, antelope, berries, and wild turnips. Often these wild resources are gathered and consumed directly by the household. Even if no member of a household hunts, fishes or gathers, wild game and plants may still be important to the household and be provided by an extended family member that is a part of the householding network. Wild resources are also part of a larger amount of food that is

**Table 1.** Employment Status for Individuals Living on Pine Ridge Over Age 16, Comparing Results with U.S. Census Figures.

<i>N</i> = 655	Total Employed (%)	Full-Time (%)	Part-Time (%)	Total Not Working (%)	Over 63 (%)	Disabled (%)	Full-Time Student (%)	Select Not to be in the Labor Force (%)	Unemployed (Looking or Discouraged) (%)
Pickering study (2005)	35.42	30.23	5.19	64.58	7.95	4.28	3.21	6.4	42.74
2004 US Census	34.3				5.0	24.9		Not in the Labor force 48.8	16.9

shared between different households of extended families, or distributed by a central member of the tiyospaye or large extended family through ceremonies, public dinners, and gifts. A tiyospaye, composed of many subgroups of immediate families, will host a giveaway or public meal, and family members connected to the tiyospaye will donate material items and food, so that the entire community can receive the goods. These social events always include a meal, which the family who is hosting the event provides, and those attending the event usually bring containers to take food home. At these events there is food that would be considered traditional by most Lakota, like wojape (a chokecherry pudding) or buffalo stew, and non-traditional food such as fried chicken, macaroni salad, and ham. Instead of monetizing the amount of goods it takes to host a social event, usually individuals discuss it in the amount of time. For example, individuals generally estimate that it takes about two years to accumulate the supplies to host a giveaway (Pickering, 2000, pp. 57–58). These social events redistribute an incredible amount of food and goods throughout the community.

Microenterprise is another economic activity that cuts across several modes of integration. Examples of different types of microenterprises include carpentry services, babysitting, car repair, rummage sales, and Lakota traditional goods such as beadwork, star quilts, the production of Indian dancing outfits, or food items such as Indian tacos and fry bread. Although these different microenterprises may appear at first to be driven toward cash exchange, on the Reservation, they are often not. Services, goods, and food are commonly traded or provided in reciprocity. Additionally, people on the Reservation may allow trade or reciprocity with certain community members or family members while expecting cash payments from others. Furthermore, when there is a cash exchange for these goods, prices may be differentially set according to who is purchasing the good. For example, those providing the service or good will sometimes ask how much the purchaser can afford to pay, or set the price according to how much they assume the person can pay based on their perceived socio-economic status (Pickering, 2000, p. 55). Therefore, the individuals involved and the context define the mode of integration for microenterprise activities.

Furthermore, household economic composition is dynamic, as members shift fluidly from wage work, often sporadic and temporary, to other forms of productive work, such as subsistence hunting, gathering, or home-based enterprise, and government programs. The Lakota economy relies on social networks that include participants in cash income generation, although the particular individuals with cash access change constantly. Of the participant

**Table 2.** Percent of Households that Receive Various Types of Income.

Type of Income Source	Percentage of Homes from Sample with At Least One Member of Their Household Receiving Income from the Specified Source (%)
Wage work	49.6
Home-based enterprise	50.6
SSI	24.2
TANF/GA	22.1
Social security, VA, or any other pension	29.6
Unemployment	3.3
Food stamps	40.8

households, 49.5% had some wage income among the household members (see Table 2). However, this does not imply that these households have stable access to wage income. For example, of those households who had wage income in 2004, 25% of them did not have wage income in 2003. Similarly, of those households who had wage income in 2003, 12% of them did not have wage income in 2004. In total, that means 37% of households had a change related to access to wage income in the household in only a two-year period. Only 23% of households never had wages over the last four years. Furthermore, while 23% of households had only wage income between 2003 and 2004, 61% of households had 2 or more sources of income, reducing the risk associated with the loss of any one source of income.

These dynamics are consistent across all the potential sources of income for households. The only constant is change. There is no guarantee of security for anyone in this extremely peripheral economic margin. As a result, programs or policies based on stable households with stable access to resources are completely irrelevant. These dynamics must be the foundation of any health care or development planning.

#### *4.2. Households, Ill Health and Poverty*

Unfortunately, the prevalence of chronic poor health conditions has a negative impact on the economic productivity of households in Pine Ridge. Individuals regularly report acute and chronic health care concerns, such as

diabetes, cancer, heart disease, and physical injuries. When asked “how do you rate your overall health,” nearly 40% responded fair or poor.

By looking at health problems on a household, rather than individual, basis, it becomes apparent that health problems are a drain on limited household resources. The illness of a household member demands dedication of some or all of the time allocation and financial resources of the household to the care of members with chronic, life-threatening disabilities. For example, 40% of the households had at least one person in the household with diabetes, and 10% had a least one person in the household with cancer.

When ill health decreases one’s ability to engage in activities, other activities, family members, and modes of integration must accommodate this loss. Without this flexibility and expansive amount of economic diversity, the ill health of one individual could be devastating. However, it is important to understand that these economic shifts are not always easy for households to endure. A family member becoming ill can create large amounts of stress, anxiety, and difficulty making ends meet. For example, one participant lives on \$601 of Food Stamps each month, which feeds her and her four children, and presently has no other form of income because she and her infant are ill. When she received a health care bill from the Mayo clinic of \$107,000, no amount of shifting between activities and modes of integration would have been enough to cover the expense.

#### *4.3. Wage Labor and Health Care Access: Subsidizing Employers*

In a context of prevalent and severe health problems, access to quality health care delivery systems would seem essential. However, access to adequate health care is limited to those households with a member engaged in long-term, permanent wage work. Because of the peripheral position of Pine Ridge to the market economy, however, the number of permanent wage labor jobs is extremely limited.

A full 92% of adults on Pine Ridge report having some wage work experience. However, the vast majority of the wage work individuals have had is part-time, temporary, or seasonal jobs that are not eligible for benefits such as health care insurance. For example, one participant works a seasonal job at Cedar Pass Lodge, a private concession facility for tourists in the North unit of Badlands National Park, and pays payroll taxes for four months a year. This is not long enough to become covered by the concession company’s health care plan, even though she works there seasonally year



after year. Therefore, the full cost of her labor contribution to the market system is not born by her employer. Another major category of wage work experience comes from short or longer periods of time living away from the reservation. Even if health care benefits were a part of the off-reservation work, that job and therefore that health care coverage terminates when the worker returns to the reservation.

As a result, despite the fact that 92% contributed their labor as a commodity through some wage work history, only 7% of households reported currently having private medical insurance. This figure highlights the extreme peripheral position of Pine Ridge in relation to the market economy. While only 28% of American Indians nationally have health insurance, with 55% relying solely on the IHS for their health needs (U.S. Commission on Civil Rights, 2003, p. 35), this percentage seems large in comparison to the health insurance access on Pine Ridge. More than 90% of the Lakota households on Pine Ridge responded that the IHS represented their only access to health care, with a few also reporting eligibility for Medicaid or Medicare coverage, or access to Veterans Administration health facilities.

The IHS hospital on the reservation provides care free of charge to tribally enrolled members, but the care provided is avowedly inadequate. The inability of the IHS to provide adequate care largely stems from the lack of funding allocated by the federal government to the IHS. The IHS hospital on Pine Ridge, a 46 bed facility that is staffed by 16 physicians to provide 24-hour medical, obstetrical, pediatric, surgical, and dental services, provides services to more than 28,000 tribal members living within the reservation boundaries, and another 15,000 members living in border towns or regional cities who come to Pine Ridge for health services. There are also four satellite clinics, which are open to see patients once a week in a village, and two health centers on the reservation (Indian Health Service, 2005a).

Although the hospital and the clinics are available locally, they do not have the ability to provide all the services needed by the population. IHS does have some limited Contract Health Services (CHS) funding to refer patients to contract care providers with the facilities or specialized training to handle conditions beyond the capacity of IHS. For example, victims of serious physical traumas, such as car accidents, in need of emergency care must be flown 120 miles away to Rapid City Regional hospital for treatment. The local IHS hospital is also strained by the increasing demands from chronic illnesses such as diabetes, chronic heart disease, or cancer, and ends up referring many of these patients to Rapid City Regional as well. IHS, therefore, directly subsidizes health care services through contracts

with private providers, particularly for specialized services and other services not available in IHS direct care facilities (Cunningham, 1996, p. 289).

However, because IHS is severely under-funded, funds for CHS are not always available. Often patients are denied the services they desperately need. Nationally, the denial rates of CHS have drastically increased over the last 10 years, so that 23,368 American Indian patients were denied contract services in 2004 (Indian Health Service, 2005b). Even those who have been sent out from IHS to a different hospital or service provider off the Reservation may still receive a bill if CHS denies payment. For example, a Lakota man in his forties went to IHS twice complaining about the pain in his foot. Each time he went in for an examination, they told him that it was a sprain and they sent him home with aspirin. It turned out that he had a broken bone in his foot, not just a sprain, and it had become infected, thus needing to be amputated. IHS referred him to Rapid City Regional to have the amputation because the Pine Ridge IHS could not perform the surgery. Afterwards, he was billed \$40,000 even though CHS had approved his surgery. Stories like this are not uncommon. Our research found that 27% of households have been denied CHS care. Those who have had care provided to them from other hospitals have often come home to find bills they did not expect.

Lakota people who receive care at IHS clinics and hospitals voice their concerns about the treatment they receive. People express at least annoyance, and often anger, fear, and resentment stemming from negative experiences at IHS. Although it is most often individuals who experience negative interactions or situations, individuals share those occurrences with their family and friends. These individual accounts then become shared collective community memories and beliefs, which reinforce the perceived inadequacies of IHS. For example, one participant went into the IHS hospital after injuring her knee. She waited in the emergency room lobby for three hours, watching two people die, one an elderly woman and the other a young man bleeding from a gun shot wound. She finally left the hospital without having her injury treated. She continues to tell friends and family her story, and vows she will never go to the IHS hospital again. Another participant stated, "I do not go to the IHS anymore, not since my sister almost died there." Horrific experiences are shared with friends and family and, in turn, a loss of faith in the health care delivery system is amplified throughout the community.

Our research indicates a strong presence of perceptions of racial and ethnic discrimination in the health care delivery system. When the

**Table 3.** Lakota Perceptions of Discrimination at IHS.

A	B	C	D	E	F	G	Scale	Responses
17.19%	20.34%	11.96%	7.10%	6.32%	17.03%	23.12%	5	Strongly disagree
47.40%	44.63%	43.48%	29.51%	17.89%	41.21%	40.32%	4	Disagree
10.94%	14.69%	13.59%	15.85%	11.58%	6.59%	5.91%	3	Neutral
15.63%	11.30%	16.30%	31.15%	36.32%	26.92%	22.58%	2	Agree
8.85%	9.04%	14.67%	16.39%	27.89%	8.24%	8.06%	1	Strongly agree
1	1	1	1	1	1	1	Total	

A: I experience discrimination when I go to IHS facilities.  
B: I experience discrimination when I go to Contract Health Facilities.  
C: My access to diagnostic technologies and therapies has been limited because I am Indian.  
D: Racial/ethnic discrimination is a risk factor in disease incidence, treatment, and outcomes for Native Americans.  
E: Institutional Racism is prevalent in health care delivery systems or policies toward Native Americans.  
F: I have trouble communicating with the IHS doctors and staff who are not Native Americans.  
G: It is difficult to always follow doctor’s orders.

affirmative responses of agree and strongly disagree are combined, nearly a quarter of the respondents agreed with the statement “I experience discrimination when I go to IHS facilities” (see Table 3). Nearly, a third of the respondents felt that “My access to diagnostic technologies and therapies have been limited because I am Indian,” and nearly half agreed that “Racial/ethnic discrimination is a risk factor in disease incidence, treatment, and outcomes for Native Americans.” Finally, an incredible 64% agreed that “Institutional Racism is prevalent in health care delivery systems or policies toward Native Americans.” These perceptions and experiences of racism further undercut the quality of health care received through IHS.

*4.4. The Tribe and Households Pick Up the Slack*

Given that reservation health care access overall is inadequate, Lakota households end up providing for the health care needs of family members. Wage workers who are not currently employed have no access to the market-based health care delivery system. It is the family members of the ill person providing care for them at home, and not in hospitals or nursing

homes, who bear the brunt of providing care, not the system itself. For example, one-fifth of the household participants reported personal or family health conditions as the reason why their last job ended. In addition, 42% reported having to quit work for family reasons. Not only do they lose the opportunity to apply their labor to other economic pursuits, either within market exchange or some other aspect of the reservation economy, but also the labor they contribute in health care services for their family member is not compensated by the market interests which initially consumed that ill person's labor. As a result, individuals who are already marginalized by the global market economy end up subsidizing the system.

Some support is provided by the Oglala Sioux Tribe for health care. Revenues from a modest casino operation are distributed through the local districts to help families with transportation costs to visit relatives who are hospitalized. The Community Health Representatives (CHRs) for each district will give patients a ride to the hospital or clinic for doctor appointments or to pick up medications, and will visit the homes of people with chronic conditions like cancer or advanced diabetes. The Tribe's Oyate Blihelya program conducts diabetes screenings for household members through door-to-door campaigns across the reservation and for children through the school system. These programs have the potential of supporting alternative health care delivery systems that are decentralized, household-based, and flexible to meet the lived social context of individuals with chronic illnesses.

#### *4.5. Community Solutions to Poor Health Care*

When designing and implementing health care programs, community ideas, perspectives, culture, and the dynamics of the economy all affect whether a health care program is appropriate and effective. Involving the ideas and perspectives of community members in both the creation and the evaluation of health care programs integrates the abstract theories of health care delivery with the collective practice of accessing that health care system. For example, Potvin, Cargo, McComber, Delormier, and Macaulay (2003) discuss a diabetes intervention and research project in the Kahnawake schools in Canada that focused on community partnership. The concept of having the community as an equal partner helped to ensure that the community's interests were being addressed and that the intervention aspects of the project were culturally appropriate and community driven. This research followed the philosophy emphasized by the World Health

Organization, that health promotion and health programs should incorporate community participation in both decision making and action processes, so that the community can define what the results of health programs should be, and how the program should operate (World Health Organization, 2002, p. 1).

Through a community-based approach, the perspectives of community members are integral to the development of a health care delivery system. On Pine Ridge, individual experiences with IHS hospitals and clinics have become collective memories and beliefs about the inadequate, dangerous, and discriminatory services provided at these facilities, rendering the facilities themselves ineffective in improving health for this community. Similar findings were made in research on the interpretations of local Pima women about that it means to be at risk for diabetes. Pima women interpreted the risk of diabetes from large “collective banks of memory and experience that may or may not support biomedical accounts of disease” (Smith-Morris, 2005, p. 160). Arguably, abstract ideas of what it means to have a borderline diagnosis, contradicting the idea that either you have diabetes or you don’t, become even more complicated when the collective memories and experiences of the community describe diabetes as physically destructive and irreversible. Without taking local perceptions into account, diabetes programs directed at educating individuals about their borderline diagnosis were destined to fail. Community experience, perspectives, culture, and economics all need to be incorporated to inform the development, implementation, and evaluation of successful health care programs.

Another tension in the design of health care programs exists between population health statistics and the political, economic, historical, and cultural context of that population. For example, a majority of the diseases on the reservation, such as diabetes, are increasing now not only among American Indians but also for other marginalized populations around the globe. The concept of what it means to be at risk, or an at risk population, goes beyond the choices of individuals within that population, and implicates structural conditions of poverty, oppression, and socioeconomic displacement. As Rock argues, political, economic, cultural, and historic forces contribute to mental health issues, like stress, duress, and social suffering from marginalization, that compound ill health among native peoples (Rock, 2003; see Gravlee, Dressler, & Bernard, 2005). Individuals and their health status cannot be separated from their collective marginalization. Without health programs that resonate with local perceptions, beliefs, and knowledge, poor health will continue to increase (Rock, 2003, p. 173).

The integration of community perspectives into health care delivery systems is still controversial, however. In a recent review of a proposal to National Institutes of Health (NIH) whose “objective is to solicit ideas from Native Americans themselves regarding ways of changing the IHS to reduce perceptions and experiences of racism,” a reviewer asserted that “Improving health care systems requires economic and personnel resources as well as a tremendous amount of highly specialized technical knowledge. Native American users of the IHS are unlikely to have practical, workable ideas that can be easily or feasibly implemented” (Summary Statement for Application No. 1R03CA 129901-01, 3/08/2007). From the point of view of this reviewer, the biomedical model of health care delivery can remain oblivious to the devastating critiques of collective memory and experience, and nevertheless will be able to improve the health of people who believe these facilities are places where you go to die.

Alternatively, if the biomedical model were to bend to the realities of reservation economic life, households might be supported in the strategies they engage in to navigate the current health care system. For example, IHS funds could be allocated to households as home health care providers. With expanded reliance on tribal programs like the CHSs and Oyate Bliheya, specialized medical services and professional monitoring could be brought into households, not only reducing the costs of transportation needed to bring patients and their families into centralized hospital facilities, but also reducing the operating costs of those facilities as well. State TANF programs could recognize home health care as a qualifying work activity so that the care provider would be eligible for welfare benefits. Federal Earned Income Tax Credits could be extended to individuals providing home health care to family members as a form of home-based enterprise. Through each of these initiatives, not only would the true economic contributions of home health care providers be recognized, but also the quality and consistency of both preventative and acute health care would improve.

## **5. CONCLUSION**

We conclude that health care access is an economic development issue, and that viewing households solely through the lens of the market economy occludes not only the full extent of their economic activities, but also the ways in which market-based health care delivery systems result in the accumulation of substantial resources from households in poverty to the private sector. As Pine Ridge faces devastating ill health, it is important

to understand not only how ill health affects the economy on the reservation, but also how the economy affects ill health. Four key factors highlight the relationship between economics and health for Pine Ridge residents.

First, the market is not the dominant form of economic integration for most Lakota households. As Polanyi theorized, social relationships encompass and define economic practice. The myth of market individualism is thinly veiled in the deep economic periphery of Pine Ridge (Mingione, 1994). Rather, social relationships define the dynamic adaptations of Lakota households to all aspects of economic life. Householding, reciprocity, and redistribution continue to represent significant arenas of economic life on Pine Ridge.

Second, the prevalence of chronic poor health conditions has a negative impact on the economic productivity of households. An ill family member reduces the number of wage workers in the household, as is true in mainstream society. However, since the market system is relatively weak on the reservation, it becomes apparent that individuals who are ill not only lose potential market productivity, but also lose productivity within redistributive and reciprocal economic activities and reduce their ability to participate in and contribute to the householding economic patterns of the household. Furthermore, as kinship responsibilities are important to the Lakota, family members will reduce their economic productivity to help care for the ill family member. Subsistence, barter, and other non-market activities of the household are impeded as other household members must reallocate their labor and resources toward the health care needs of their ill family member. Therefore, other individuals and other modes of integration within the household economy must act as safety nets and pick up the slack.

Third, access to adequate health care is limited to the small percentage of households with a member engaged in long-term, permanent wage work. Most households must rely on limited access to grossly under-funded services from the IHS. With the increasing prevalence of chronic illness, the future economic prospect for the reservation looks dim without interventions that improve the health status of the Lakota, which in part requires the ability to utilize quality health care.

Finally, employers who use Lakota labor on a short-term, part-time, or regional basis do not bear the health care costs of these workers. These employers, therefore, are subsidized by Lakota households who must divert their limited resources to the health care needs of family members. Viewing households solely through the lens of the market economy occludes not only the full extent of the economic activities of Lakota households, but also the

ways in which households in poverty must expend their limited resources to provide health care shirked by the private sector.

When analyzing the economy and developing health intervention programs, ideological pitfalls of perceiving health and economics solely in the realm of the market economy may blind us to the real practices of communities with other dominant modes of integration. As this case study of the Pine Ridge Indian Reservation reveals, increasing the health status of marginalized peoples is a crucial step in any approach to economic development, but health programs should focus their attention on economic activities and modes of integration other than the market economy. Although we cannot remove biomedicine from the market economy, we can redirect its focus and funds to support the actual providers of health care operating outside of the formal market economy.

## ACKNOWLEDGMENTS

The research reported in this chapter was funded in part by a National Science Foundation Career Award No. 0092527, and the Monfort Family Foundation's Colorado State University Monfort Professors Award. Special thanks to research associate Richard T. Sherman, translator Annabelle between Lodge and graduate research assistants Heather Schwartz Novak, Benjamin Jewell, James Van Lanen, Bradley Morse, and Erica Ferro.

## REFERENCES

- Adamson, R. (1997). Native American credit market: Opportunity knocks, but relationships stay. *The Journal of Lending and Credit Risk Management*, 80(2, October), 32–35.
- Annis, S. (1987). *God and production in a Guatemalan town*. Austin, TX: University of Texas Press.
- Associated Press. (2007, May 15). Data shows Indians have more health risks. *Rapid City Journal*, A1–A2.
- Bergman, A. B., Grossman, D. C., & Erdrich, A. M. (1999). A political history of the Indian Health Service. *The Milbank Quarterly*, 77(4), 571–604.
- Bernard, H. R. (2006). *Research methods in anthropology: Qualitative and quantitative approaches* (4th ed.). Lanham, MD: AltaMira Press.
- Cunningham, P. J. (1996). Health care utilization, expenditures, and insurance coverage for American Indian and Alaska Natives eligible for the Indian Health Service. In: G. D. Sandefur, R. R. Rindfuss & B. Cohen (Eds), *Changing numbers, changing*



- needs: American Indian demography and public health* (pp. 289–314). Washington, DC: National Research Council.
- Dixon, M., & Roubideaux, Y. (2001). Introduction. In: M. Dixon & Y. Roubideaux (Eds), *Promises to keep* (pp. xix–xxi). Washington, DC: American Public Health Association.
- Evers, H. D. (1991). Shadow economy, subsistence production and informal sector: Economic activity outside of market and state. *Prisma*, 51, 34–45.
- Gravlee, C. C., Dressler, W. W., & Bernard, H. R. (2005). Skin color, social classification, and blood pressure in southeastern Puerto Rico. *American Journal of Public Health*, 95, 2191–2197.
- Halperin, R. H. (1990). *The livelihood of kin: Making ends meet the “Kentucky way.”* Austin, TX: University of Texas Press.
- Halperin, R. H. (1991). Karl Polanyi’s concept of householding: Resistance and livelihood in an Appalachian region. *Research in Economic Anthropology*, 13, 93–116.
- Halperin, R. H. (1994). *Cultural economies past and present*. Austin, TX: University of Texas Press.
- Haynes, T. L., & Bosworth, R. G. (1996). Social scientists and subsistence resource management in Alaska. *High Plains Applied Anthropologist*, 16, 63–68.
- Hopkins, T. (1957). Sociology and the substantive view of the economy. In: K. Polanyi, C. M. Arensberg & H. W. Pearson (Eds), *Trade and market in the early empires* (pp. 271–306). Glencoe, IL: Free Press.
- Indian Health Service. (2005a). *Aberdeen area: Indian Health Service*. Retrieved November 28, 2005, from <http://info.ihs.gov/Issues/asp>.
- Indian Health Service. (2005b). *Contract health services*. Retrieved November 28, 2005, from <http://info.ihs.gov/Issues/asp>.
- Joe, J. R. (2003). The rationing of healthcare and health disparity for the American Indians/Alaska Natives. In: B. D. Smedley, A. Y. Stith & A. R. Nelson (Eds), *Unequal treatment: Confronting racial and ethnic disparities in healthcare* (pp. 528–551). Washington, DC: National Academy of Sciences.
- Knack, M. (2001). *Boundaries between: The Southern Paiute, 1775–1995*. Lincoln: University of Nebraska Press.
- Mauss, M. (1990). *The gift: The form and reason for exchange in archaic societies*. W.D. Halls (Trans.). New York: W.W. Norton.
- Meillassoux, C. (1981). *Maidens, meal, and money*. Cambridge: Cambridge University Press.
- Mingione, E. (1994). Life strategies and social economies in the postfordist age. *International Journal of Urban and Regional Research*, 18, 24–45.
- Nash, J. (1994). Global integration and subsistence insecurity. *American Anthropologist*, 96, 7–30.
- Peterson, J. T. (1989). Interhousehold exchange and the public economy in three highland Philippine communities. *Research in Economic Anthropology*, 11, 123–142.
- Pickering, K. (2000). *Lakota culture, world economy*. Lincoln: University of Nebraska Press.
- Pickering, K. (2004). Decolonizing time regimes: Lakota conceptions of work, economy and society. *American Anthropologist*, 106(1, March), 85–97.
- Pickering, K., Harvey, M., Summers, G., & Mushinski, D. (2006). *Welfare reform in persistent rural poverty: Dreams, disenchantments, and diversity*. University Park: The Pennsylvania State University Press.
- Polanyi, K. (1944). *The great transformation*. New York: Holt, Reinhart and Winston.

- Polanyi, K. (1957). The economy as instituted process. In: K. Polanyi, C. M. Arensberg & H. W. Pearson (Eds), *Trade and market in the early empires* (pp. 243–270). Glencoe, IL: Free Press.
- Potvin, L., Cargo, M., McComber, A. M., Delormier, T., & Macaulay, A. C. (2003). Implementing participatory intervention and research in communities: Lessons from the Kahnawake schools diabetes prevention project in Canada. *Social Science and Medicine*, 56, 1295–1305.
- Rock, M. (2003). Sweet blood and social suffering: Rethinking cause–effect relationships in diabetes, distress and duress. *Medical Anthropology*, 22, 131–174.
- Sacks, J. D. (1995). Culture, cash or calories: Interpreting Alaska Native subsistence rights. *Alaska Law Review*, 12(2), 247–291.
- Sahlins, M. (1968). *Tribesmen*. Englewood Cliffs, NJ: Prentice-Hall.
- Sandefur, G. D., Rindfuss, R. R., & Cohen, B. (1996). Introduction. In: G. D. Sandefur, R. R. Rindfuss & B. Cohen (Eds), *Changing numbers, changing needs: American Indian demography and public health* (pp. 1–13). Washington, DC: National Research Council.
- Sherman, R. T. (1988). *A study of traditional and informal sector micro-enterprise activity and its impact on the Pine Ridge Indian Reservation economy*. Washington, DC: Aspen Institute for Humanistic Studies.
- Smith-Morris, C. M. (2005). Diagnosis controversy: Gestational diabetes and the meaning of risk for Pima Indian women. *Medical Anthropology*, 24, 145–177.
- Stack, C. B. (1974). *All my kin: Strategies for survival in a black community*. New York: Harper & Row.
- U.S. Commission on Civil Rights. (2003). *A quiet crisis: Federal funding and unmet needs in Indian Country* (July). Washington, DC: U.S. Commission on Civil Rights.
- World Health Organization. (2002). Community participation in local health and sustainable development: Approaches and techniques. *European Sustainable Development and Health Series*, 4, 1–100.
- Zuckerman, S., Haley, J., Roubideaux, Y., & Lillie-Blanton, M. (2004). Health service access, use, and insurance coverage among American Indians/Alaska Natives and whites: What role does the Indian Health Service play? *American Journal of Public Health*, 94(1), 53–59.

This page intentionally left blank

# THE POWER OF CULTURE IN SELECTING HEALTH CARE PROVIDERS IN RURAL BANGLADESH: AN ETHNO SCIENTIFIC ANALYSIS

Azizur R. Molla

## ABSTRACT

*This study examines the decision process of household members in visiting local health care providers. It also explores the effect of various household level socioeconomic factors on motivating rural people to visit traditional versus modern health care providers in rural Bangladesh. I used the Population, Environment, and Poverty data collected from eight villages of rural Bangladesh in 1998 in addition to self-collected ethnographic survey information. The data suggest that a large majority of rural households attempt to visit locally available untrained health care providers first, and then trained doctors as the sickness worsens. The data also suggest that socio-cultural and economic factors are important in shaping their decision to visit traditional as opposed to modern health care providers. Training the traditional and untrained health care providers will be a wise option to ensure health care to the villagers.*

---

The Economics of Health and Wellness: Anthropological Perspectives

Research in Economic Anthropology, Volume 26, 35–53

Copyright © 2008 by Elsevier Ltd.

All rights of reproduction in any form reserved

ISSN: 0190-1281/doi:10.1016/S0190-1281(07)26002-0

## INTRODUCTION

The overall health situation of Bangladeshi people is not very good. The life expectancy at birth is only 59 years, and 36% of the citizens live under the poverty line, defined as 2,122 kcal of food intake per day (Hossain & Sen, 1992; Ravallion & Sen, 1994; Sen, 1995). This can also be considered as the starvation line. Health is a major problem for the government, for health workers, and for most of the populace in general. On the average, there was only one qualified doctor for 4,500 people in 2000 – a situation that clearly influences villagers to visit traditional health care specialists and to consult untrained health care providers for disease treatment. More than 80% of the 140 million people in Bangladesh live in rural areas, where the infant mortality rate is about 66 per 1,000 live births, and the maternal mortality rate is 3.4 per 1,000 live births (BBS, 2001).

Health care service in Bangladesh is classified into modern medicine, ayurvedic medicine, homeopathic, and traditional healing medicine. These four types of health care services are available all over the country. The latter three types are provided by small, private ventures. Only modern medicine has a formal nationwide structure. Although all the tertiary care hospitals and specialized health centers are located in Dhaka, the capital city, basic health care services are provided at all four administrative levels (division, district, thana or sub-district, and union) of the country (Fig. 1).

Several hundred households make a village, a collection of villages makes a union, several unions make a thana (equivalent to a county in the United States), several thanas make a district and several districts make a division. The union is the lowest administrative unit of the country. There are 4,484 unions, 507 thanas, 64 districts, and 6 divisions in the country (BBS, 2001). There are six divisional health offices. One of their roles is to provide medical and related supplies for the 64 district health offices, which in turn provide supplies and specialist services to thana offices. The district offices are also in charge of district hospitals, which offer outpatient care, ambulatory care, and surgery. Thana hospitals are staffed by doctors, paramedics, laboratory assistants, technicians, and nurses, and have limited medical equipment. These hospitals perform small-scale surgery and they usually refer patients to district level hospitals which are better equipped for more serious surgery. For appendicitis surgery, for example, most people go to district hospitals. Thana hospitals tend to be underequipped, underfunded, and understaffed. Furthermore, most rural people cannot afford to take time off from work and also pay to travel three to six miles (on average) to these hospitals. The Family Welfare Center (FWC) is the lowest ranking

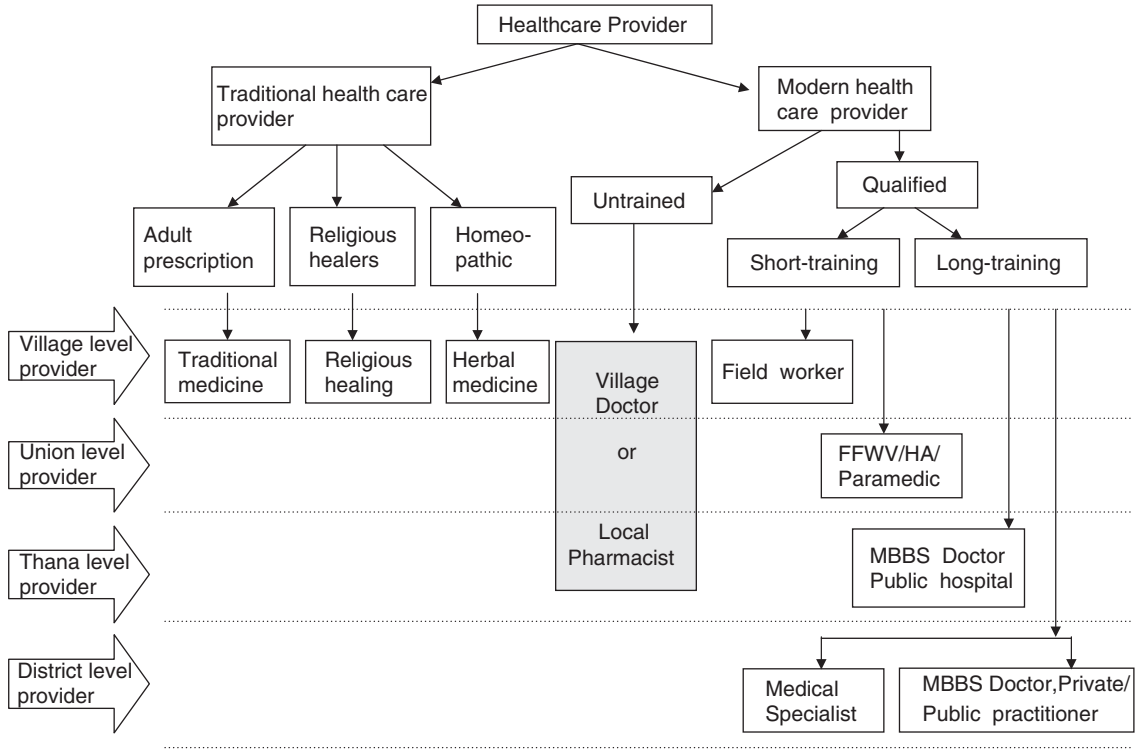


Fig. 1. Structure of Health care Providers in Bangladesh.

and most easily accessed center for modern health services. Each FWC should be run by a doctor, but they are often actually operated by senior paramedics (Family Welfare Visitors, FWVs). FWCs, which are usually located near the center of counties and serve roughly 30,000 residents, offer basic health care services, including prescribing some medicines, but no surgical procedures. They are usually located an average of two to four miles from a rural resident's home. Like the thana hospitals, however, the FWCs lack both funding and staff to see to the needs of all patients, and also they are not accessible enough for all people because of travel costs. By law all residents are entitled to free health care and some basic medicines such as paracetamol (Tylenol) from government clinics or hospitals. However, some institutions have recently started asking token fees for their services. This further diminishes their accessibility.

While both traditional and modern systems of health care facilities are common in rural Bangladesh, the government tries to encourage the use of modern medicine. Politicians repeatedly promise to improve the quality of life every election year by increasing the number and availability of qualified doctors. Almost every developmental plan prioritizes modern health care facilities in rural as well as urban areas of the country. But, in reality, villagers still depend heavily on traditional as well as locally available untrained pharmacy health care providers. The existence and importance of both traditional (non-Western) as well as modern (Western) health care facilities in Asia is well documented (e.g., see Leslie, 1976; Rogers & Solomon, 1975; Nepal South Asia Center, 1998). The co-existence of both Western and non-Western forms of health care has been termed medical pluralism (Subedi, 1989).

According to Rogers and Solomon (1975), a general traditional system of health care consists of herbalists, midwives, mystics, and herbal cures. This system also includes faith healing practices followed by religious healers. According to Kroeger and Franken (1981), these traditional health care providers are preferred by people in rural areas due to the lower social distance. The modern sector consists of scientific medicine, provided by doctors, nurses, clinics, and hospitals. In a system of medical pluralism, rural people have many alternatives when they get sick. Some rural households prefer to visit traditional healers, others prefer to visit modern but locally available untrained health care providers, and some attempt to visit qualified doctors. For example, Fosu (1989) identified the use of clinics, drug stores, and traditional headers to deliver health care service in Ghana. As for factors in making choices, Young (1980) found that severity, economic resources, and prior experience with an illness influenced

decision-making as well as treatment in a Tarascan Indian village in Mexico. Weller, Ruebush II, and Klein (1997) found in their study in Guatemala that “enabling factors” (e.g., availability of health care services and financial services to avail such services) were not strongly associated with treatment choices. They also found that the presence or absence of treatment sources within a village was not a strong determinant of treatment strategy.<sup>1</sup>

However, the decision process utilized by households to visit alternative health care providers is not clear. Moreover, not much is known about what household level demographic and socioeconomic characteristics influence a household’s decision to visit traditional vs. modern health care providers in rural Bangladesh. The purpose of this study is to investigate the decision process used by household members in visiting traditional vs. modern health care providers, and to explore various household level demographic and socioeconomic factors that motivate people to visit these health care providers in rural Bangladesh.

According to Kroeger (1983) and Stoner (1985), characteristics of the subject, characteristics of the disorder and human perception of it, and characteristics of the service (enabling factors) are determinants in the selection of health care providers. The characteristics of the subject are the various socioeconomic and demographic factors of the individual health seekers such as age, sex, socioeconomic level, occupation, marital status, ethnic background, education, household size, cultural adaptation, access to resources, and interaction of the individual with family, neighbors, and community. Characteristics of the disorder that might affect the choice of health care providers include the individual’s beliefs regarding the nature or etiology of the illness. These indicators include chronic/acute, severe/trivial, natural/supernatural, and expected benefits of different types of treatment (modern/traditional). Characteristics of the service (enabling factors) include the appeal of different healers (individual attitude toward traditional or modern healers), their acceptability, quality of care, communication between health care provider and patient, and monetary costs. Subedi (1989) identified a number of demographic, socio-cultural, economic, and “need” factors in a study of modern health care services and patient decision-making behavior in Nepal. Items in this last category included the severity, length, and type of medical problems.

Following from these studies, I use demographic characteristics, socioeconomic characteristics, enabling factors, and need factors to examine the choice of health care sought. Most other studies have focused on characteristics of the sick person as predisposing factors. However, I concentrate instead on the characteristics of the household head because he



is the decision maker in households in this study, and therefore I expect that his characteristics largely determine the decision to use a particular health care provider. The enabling factor includes family income, intention to spend money for treating disease or use a community network to use traditional healers to do the same, access to modern health care services, community help (i.e., getting money for travel to a modern health care center like a thana hospital), and transportation. While the need factors signify the degree of the illness, severity of the illness influences selection of health care provider.

## METHODOLOGY

The data for this chapter comes from the households of eight villages in rural Bangladesh, collected in 1998 for the Population Pressure, Poverty and Environmentally Endangered Areas research. The information is supplemented with focus group discussions (FGDs) and ethnographic surveys. For the survey, initially, four rural thanas were selected based on high population density and different agro-ecological zones (AEZs) of Bangladesh. After that, from each thana, two villages were randomly selected. A total of eight villages (two from each sub-district) were chosen at random for the study. From each village, 65 households were randomly picked, thus making a total of 520 households. The survey was administered to the head of each household. In addition, eight FGDs and eight ethnographic surveys, one in each study village, were conducted in order to understand in more detail the health behavior and culture of the villagers.

*Dependent variable:* The outcome of interest in this study is the preference of health care providers. This outcome is measured as a three category nominal variable: preference to visit a (a) traditional, (b) modern but untrained, and (c) modern qualified health care provider. In the survey, the information was collected by asking, "If anyone in your family gets sick, where do you take him/her first?" A number of alternatives were provided. The responses were categorized as above.

*Independent variables:* Since the purpose of this study is to explore various household level factors, I used socio-demographic characteristics of the household head, socioeconomic characteristics of the household, and need factors. Age, sex, education, and occupation are the variables used as the characteristics of a household. Similarly, number of working age individuals and the number of dependents are considered as the household demographic factors, while land size, availability of the type of toilet facilities in the home,

and electricity facilities are considered as the socioeconomic characteristics. Since visiting modern health care facilities is associated with need (e.g., suffering from disease), I considered anyone suffering from diarrhea and malaria in the past 12 months as having need-based factors.

## RESULTS

One of the objectives of this study is to explore various household level factors contributing to the decision to visit traditional vs. modern health care providers. Traditional health care providers include (1) traditional religious healers, including faith healers and (2) ayurvedic health care providers. Modern health care providers include (1) untrained health care providers and (2) trained health care providers. The untrained health care providers are the local pharmacies, also called the village doctors. These village doctors provide modern allopathic medicines to sick people. The trained or qualified medical providers are the Village Welfare Assistant (FWA), Family Welfare Visitor (FWV) or trained medical doctors and medical specialists. In addition, there are homeopathic doctors who belong to both the trained and untrained categories. I examined the net effects of various household level characteristics on the use of traditional vs. untrained and traditional vs. qualified health care providers by using multinomial logistic regression.

According to the descriptive statistics in Table 1, among 520 household heads, 14.6% visit traditional health care providers, and about 13% of them would visit qualified health care providers if any person gets sick in their household.

Of those who suffered diarrhea in the past 12 months, a large majority of them (72%) reported that they would go to untrained health care providers, followed by 17% to traditional healers, and only 11% to qualified doctors. Similarly, among the households who suffered from malaria in the last 12 months, 85% of the household heads responded that they would go to untrained health care providers, followed by 9% to traditional healers, and about 6% to the qualified doctors. Most diarrheal episodes are not life threatening, are a common occurrence in Bangladesh, and can be dealt with adequately by a wide variety of people. The degree of disease, like diarrhea, as well as traditions, guides villagers to visit untrained health care providers. Results of multinomial logistic regression analysis that examine the effect of various household level demographic, characteristics, socioeconomic, and need factors on visiting untrained vs. traditional health care providers in

**Table 1.** Descriptive Statistics of Variables Included in the Analysis (N = 520).

Variables	Traditional (n = 76)		Untrained (n = 377)		Qualified (n = 67)	
	Mean	SD	Mean	SD	Mean	SD
<i>Characteristics of household head</i>						
Sex (female = 1)	0.16	0.37	0.12	0.32	0.27	0.45
Age (years)	47.21	16.99	48.95	14.29	50.09	14.99
Education (illiterate = 1)	0.84	0.37	0.71	0.46	0.70	0.46
Occupation						
Farming	0.78	–	0.53	–	0.55	–
Small business	0.05	–	0.17	–	0.13	–
Non-agriculture laborer/worker	0.09	–	0.18	–	0.10	–
Others	0.08	–	0.12	–	0.21	–
<i>Household characteristics</i>						
Number of working age individuals	3.09	1.25	3.63	1.81	3.08	1.24
Number of dependents	2.39	1.23	2.75	2.06	2.39	1.23
Land size						
Landless	0.24	–	0.27	–	0.39	–
Less or equal to 0.5 acres	0.22	–	0.25	–	0.10	–
0.51–5 acres	0.49	–	0.37	–	0.33	–
More than 5 acres	0.05	–	0.12	–	0.18	–
Toilet facilities						
Open	0.26	–	0.11	–	0.45	–
Slab/sanitary toilet	0.40	–	0.68	–	0.42	–
Hanging	0.34	–	0.21	–	0.13	–
Electricity facility (no = 1)	0.72	0.45	0.72	0.45	0.61	0.49
<i>Need (disease)</i>						
Diarrhea in last 12 months (no = 1)	0.45	0.50	0.53	0.50	0.59	0.49
Malaria in last 12 months (no = 1)	0.87	0.34	0.76	0.43	0.91	0.29
<i>Thana</i>						
Jamalpur	0.01	–	0.22	–	0.67	–
Sonagazi	0.03	–	0.28	–	0.25	–
Chandina	0.17	–	0.31	–	0.02	–
Modhupur	0.79	–	0.17	–	0.06	–

rural Bangladesh are presented in Table 2. The results are provided as odds ratios.

Models 1–3 are the results of the effects of various factors to visit untrained health care providers vs. traditional health care providers. Similarly, the results of Models 4–6 provide the effects of various factors

**Table 2.** Odds Ratio Estimates from the Multinomial Logistic Regression Predicting the Relationship Between Visit to Health Care Providers and Various Other Factors ( $N = 520$ ).

Variables	Untrained vs. Traditional Health Care Providers			Qualified vs. Traditional Health Care Providers		
	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
<i>Characteristics of household head</i>						
Sex (Ref = female)	3.469*	3.315*	3.040 <sup>+</sup>	1.700	1.822	1.732
Age	1.001	0.994	0.993	1.007	1.001	1.000
Education (Ref = illiterate)	1.529	0.802	0.865	1.901	0.851	0.940
Occupation (Ref = farming)						
Small business	3.417*	3.346*	3.540*	3.417	2.168	2.072
Non-agriculture laborer/worker	2.596 <sup>+</sup>	2.482	2.711 <sup>+</sup>	2.596	1.814	1.984
Others	0.581	0.858	0.832	0.581	0.664	0.640
<i>Household size</i>						
Number of working age individuals	—	1.033	1.040	—	0.844	0.845
Number of dependents	—	0.821	0.830	—	0.762 <sup>+</sup>	0.771 <sup>+</sup>
<i>Enabling</i>						
Land size (Ref = landless)						
Less or equal to 0.5 acres	—	1.040	1.170	—	0.377	0.434
0.51–5 acres	—	1.031	1.116	—	0.857	0.930
More than 5 acres	—	3.587 <sup>+</sup>	3.733 <sup>+</sup>	—	8.902*	9.353*
Toilet facilities (Ref = open)						
Slab/sanitary toilet	—	9.850***	10.599**	—	1.858	2.053
Hanging	—	2.291	2.333	—	0.343	0.365
Electricity facility (Ref = no)	—	0.596	0.547	—	1.554	1.737

**Table 2.** (Continued)

Variables	Untrained vs. Traditional Health Care Providers			Qualified vs. Traditional Health Care Providers		
	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
<i>Need (disease)</i>						
Diarrhea in last 12 months (Ref=no)	–	–	0.607	–	–	0.691
Malaria in last 12 months (Ref=no)	–	–	1.493	–	–	1.959
<i>Thana</i> (Ref= Jamalpur)						
Sonagazi	0.419	0.259	0.281	0.419	0.165	0.174
Chandina	0.070*	0.037**	0.031**	0.070***	0.001***	0.001***
Modhupur	0.008***	0.003***	0.003***	0.008***	0.000***	0.000***
Intercept	3.465**	3.507**	3.710**	3.203**	4.586***	4.698***
Model chi-square	227.234***	294.130***	296.750***	227.234***	294.130***	296.750***
DF	18	34	38	18	34	38
-2LL	466.449	513.852	511.233	466.449	513.852	511.233

+ =  $p < 0.10$ ;\* =  $p < 0.05$ ;\*\* =  $p < 0.01$ ;\*\*\* =  $p < 0.001$ .

on visiting qualified health care providers vs. traditional health care providers. In Models 1 and 3, only the characteristics of the household head and the socioeconomic characteristics of the household are presented. In Models 2 and 4, need factors, suffering from diarrhea and malaria in the last 12 months for example, are included in the analysis.

The real picture of the rural Bangladeshi health care system in operation is not a very pretty one for several reasons. Most of the rural people are not getting treatment from modern and qualified health care providers as expected by the general populace. The traditional health care providers are more sincere in their provision of services, but they do not have enough skill to treat patients. Due to cultural factors (i.e., social distance) and lower costs, villagers prefer to go to traditional health care providers. If the situation deteriorates, then they go to an untrained provider. If the situation further deteriorates, and the problem is beyond the control of the local traditional or untrained modern health care providers, these providers are forced to take the patient to a qualified doctor.

## **DISCUSSION**

According to the household survey data, a large majority of the households (73%) responded that they would visit untrained health care providers. These statistics indicate that a large majority of households would visit either traditional and/or village level untrained pharmacists, also called village doctors. About 71% of these household heads were illiterate. Slightly over half (53%) of the household heads had a farming occupation.

Variations in choice were also observed by size of land holding. Households with more land were more likely to visit qualified doctors (as opposed to traditional untrained health care providers) than were households with less land. Similarly, a large proportion of households with slab/sanitary toilet facilities and electricity in the home responded that they would visit either untrained or qualified doctors as opposed to traditionalists.

Model 1 (see Table 2) shows the effects of the characteristics of household head on the preference to visit modern but untrained health care providers vs. traditional health care providers. The results indicate that sex and occupation of the household head significantly contribute to preference for modern but untrained health care providers. For instance, controlling for the effects of other household head characteristics, having a male household head significantly increases the likelihood of visiting modern health care

facilities over having a female household head (odds ratio = 3.469;  $p < 0.05$  in Model 1). Similarly, having a literate household head increases the odds of visiting modern health care facilities by about two times (odds ratio = 1.529). Similarly, occupation of the household head is also an important determinant in visiting untrained health care providers in rural Bangladesh. In comparing household heads who have farming occupations with those operating small business, non-agricultural workers, or those belonging to other categories are significantly more likely to visit modern health care facilities available at the local level. For example, as compared to farmers, small business owners are more likely to visit modern but untrained health care providers (odds ratio = 3.417;  $p < 0.05$ ), whereas those working in the non-farm sector were over three times more likely to visit modern health care providers. The age of the household head was not a significant contributor to the choice to visit modern health care providers.

When a household's socioeconomic characteristics and household level need factors were adjusted for, the effects of sex and education turned out to be statistically not important in determining whether to visit these health care providers. However, the effect of occupation remained statistically significant except for the other categories (Model 3). This result indicates that occupation is one of the most important factors contributing to the choice to visit modern but untrained health care facilities. The finding implies that if a household head's occupation is other than farming, members are more likely to visit modern health care facilities in rural Bangladesh. Therefore, it implies that socioeconomic status is the most important factor in selecting health care providers.

The effects of household head characteristics were also compared in the choice to visit traditional health care providers vs. the choice to visit modern but qualified health care providers (Models 4–6). Adjusting for the effects of other characteristics of the household head, education and occupation significantly contributed to choosing modern but qualified health care providers. However, the age and sex of the household head were not statistically important in this case. When the socioeconomic factors were controlled, these effects still remained (Model 5). But the effect of education was reduced when need factors were controlled (Model 6). The findings from this section indicate that household occupation is important in the decision to visit modern health care providers in rural Bangladesh.

The effects of land holding, availability of toilet and electricity facilities in the home and number of independent workers and dependents were also examined. Controlling for other household socioeconomic characteristics, the presence of working age members, and the availability of slab/sanitary

toilet facilities in the home significantly increased the odds of visiting modern but untrained health care facilities, whereas possessing a smaller amount of land decreased the odds of visiting both untrained as well as qualified health care facilities. When the effects of the household characteristics and household need factors are controlled, the effect of the number of working age individuals and the effect of the availability of slab/sanitary toilet facilities still remained, suggesting that these two factors significantly contribute to the decision to visit local untrained pharmacists as opposed to traditional health care providers. Toilet type is considered to be a proxy for socioeconomic characteristics. The toilet itself is an indicator of the household head's perspective on sanitation, cleanliness, etc. Its presence may also speak of the political abilities of the household head – the means and know-how to garner enough development funds for a toilet. Of course, there are a number of other possible explanations for the presence of a toilet in a house. For example, the number of working age individuals may be a factor – more people earning wages can mean a higher overall socioeconomic level. However, the behavior of the villagers needs to be judged from a holistic point of view. This view includes the economic, socio-cultural, and educational characteristics of a household. Among other factors, the availability of electricity in the home was positively associated with the decision to visit modern qualified health care providers, but these factors were not statistically significant. Moreover, farming households with five acres of land or more were significantly more likely to visit qualified health care providers as compared to the landless households.

Having an immediate need for health care services would be expected to affect responses on a survey such as the one used for this study. Therefore, the effect of whether any individual in a household had experienced diarrhea or malaria in the past year on the decision to visit health care providers was examined. Interestingly, a household in which any person had suffered from diarrhea in the last 12 months was significantly less likely to visit untrained or local pharmacists as compared to those that had not suffered from diarrhea. However, households in which any person had suffered from malaria in the past 12 months were significantly more likely to visit local pharmacists. The result is significant even after controlling for the effects of the characteristics of the household head as well as household socio-economic characteristics. It seems likely that households do not prefer to visit modern health care providers when any member is affected by diarrhea. It could be because diarrhea is not considered as a severe disease in the Bangladeshi culture. Or, it could be because local traditional healers might have solutions to diarrhea, such as a taking salt with water for indigestion or



pre-diarrhea symptoms, for the salt is said to help with food digestion and ultimately cure the patient. Sometimes the healers also suggest that patients consume the juice of certain roots for the same. It is important to investigate whether these rural people are appropriately treating diarrheal disease at home. However, villagers should know that malaria is a severe disease, and that it cannot be cured at home, if at all, as can diarrhea. It could be the reason why they are more likely to visit locally available untrained pharmacists as compared to local traditional healers. Once it is known that a disease is malaria, local pharmacists can provide anti-malaria tablets and the disease may be cured, however, patients in critical condition are usually referred to qualified doctors and hospitals.

Traditional healing medicines are being used to cure almost any disease, and patients get relief from some diseases easily and quickly. While most of the household heads felt that it takes time to cure some kinds of disease, if it seems to take too long then patients look for alternative treatments. However, a greater proportion of male household heads gave their perspectives on selecting traditional vs. modern health care providers than female household heads. A different picture may emerge with a greater number of female household head responses.

The ethnographic findings are based on data from eight (one in each study village) FGDs and participant observation. Most of the FGDs were attended mainly by males, particularly due to the patrilineal structure of society in Bangladesh. In almost every household, major decisions are made by males, who are usually the heads of the household and are the bread earners. The household economy is controlled by the household head. Therefore, a housewife has very little or no influence in family decisions. However, more highly educated women have recently been getting involved in family decisions.

The health culture of rural Bangladesh is characterized by traditional beliefs and practices. People tend to believe that the source of disease is evil power rather than viruses or bacteria. From a religious point of view, it is believed that health is proof of purity of faith (Iman) in Allah (God). When a baby is born, the elders, including the mother, will start feeding blessed water and put oil on the baby's body. Amulets are placed on the baby to get rid of evil powers (*kharap batas*).

Traditional social customs also contribute to the health culture in Bangladesh. For example, particularly in rural areas, pregnant women are kept in a dark room when their delivery date approaches. This is done because of a belief that bad air may enter into the room and harm the expected baby. Therefore, all the ventilation passages such as windows and doors are closed. Moreover, smoke is always present in the room to ward off

evil influences. Men are not allowed in the room, and their help in delivery is discouraged.

From the FGD, it is evident that Bangladeshi villagers, in general, go through three steps in treating disease. They: (1) try traditional (social and religious) treatments; (2) get help from untrained health care providers such as uncertified pharmacists; and (3) go to trained health care providers (medical graduates, i.e., MBBS doctors). At the initial stage of sickness, a sick person usually takes traditional medication as suggested by the elders. For example, juice from particular leaves or roots is provided to cure jaundice. Sometimes they also take the patient to a religious healer who usually prescribes blessed oil and/or water and an amulet containing holy words as a remedy, for instance, for broken bones. If this step does not cure the sick person, then they take further action. In the second step, they go to local pharmacists or village doctors who prescribe certain medications based on their experience. In my observation, these health care providers give antibiotics, which are available all over Bangladesh without prescription, just for treating fever or even seasonal influenza. In the next step, depending on the severity of the disease, people seek help from a qualified doctor. However, today a large majority of households prefer to visit local untrained pharmacists and a few of them try to visit qualified health care providers. Bangladeshi villagers visit traditional, modern (untrained) and modern (qualified) health care providers when they get sick. A majority of them visit modern but untrained health care providers. Characteristics of the household head, household composition, and the enabling factors influence the choice of health care providers. Considering the existing facts, provision of training to the locally available traditional and modern (untrained) health care providers would increase the number of trained health care providers and the villagers would get better health care service.

According to the ethnographic survey, it is clear that a large majority of the households prefer to visit local pharmacists, followed by traditional and qualified health care providers. Visits to these health care providers depend on the local culture, accessibility, and resources. From the multivariate analysis of the survey data, it is clear that characteristics of the household heads – particularly occupation – are important in the decision to visit local pharmacists or qualified health care providers. Above all, household heads with small businesses are significantly more likely to visit both of these health care providers as compared to farmers. While households with relatively more working age members as well as sanitary toilet facilities were more likely to visit local pharmacists or untrained health care providers. Availability of relatively better toilet facilities in the home was related to a

lower likelihood to visit qualified health care providers. Since traditional healing medicine cannot heal malaria, the local pharmacists mostly treat affected people. Households who suffered from diarrhea in the last 12 months were significantly less likely to visit these health care providers. The villagers are poor and cannot afford to spend money on health care service. The government has “free” medical care services at the union and thana levels, but in reality people cannot actually seek treatment through these channels with empty pockets.

While I was talking to a group of people at a tea shop one day, one man stated, “Sir, do not say the public hospital doctors provide free treatment. They do not see a patient until they get money. They take the money sitting right on the same chair they hold as a public doctor.” Another day laborer complained with sadness:

My whole family lives on my daily earning, once my wife got really sick so I had to take her to the thana hospital but heard that the doctor wasn't in. Later I heard he was available and so we went to his home, and to see him we had to pay his fee of 60 taka (about \$1.00 US), which is two or three days' income for me. Now you tell me why should I go there, missing work, and spending money for bus and rickshaw fair.

It is very important to understand the reality the villagers are facing in getting access to modern medicine. Intervention by non-governmental organizations and encouragement from the government appear to have made some villagers seek better care from modern health care providers, but practical problems with access tend to force them to go back to traditional medicine.

In addition to economic hardships, social norms simply do often not favor seeing a qualified health care provider. For instance, one Mrs. Jamila<sup>2</sup> said, “Seeing a qualified doctor in most case is based on my husband's ... sometimes my father-in-law's ... decision, and not the severity of the disease.” Another woman said:

I have been suffering from a woman's disease for a long time and it is getting worse but I cannot explain it in detail to the elderly male in our family and my husband cannot make the decision as he does not have control on family money ... it is a joint family ... only Allah can help me from the disease, otherwise I might die one day due to the disease, haah!

The force of culture shapes our behavior and the force itself may be totally wrong. Traditional beliefs may be hard to break. In rural Bangladesh, due to the convergence of monetary costs and these beliefs, traditional as well as local health care providers continue to be preferred over qualified health care providers. However, some people are compelled to use traditional health care providers against their will. For instance, a

Mr. Amin said, “You know if I get sick it is my mother who notices first and passes the information to my father, he suggests some medication including holy blowing/blessings from the religious healer, so I have to follow that even though sometimes I do not agree with this kind of treatment.” Some other individuals prefer traditional healers due to their accessibility and the effectiveness of the treatment. For example, a Mr. Zafar said, “See these (traditional) treatments are readily available and they work fine too, I know some treatments are not good enough to cure big diseases but they’ll cure even jaundice, so I think the local traditional treatment is worthy because it gives good results with no cost.”

About the preference for local untrained pharmacists, one person said, “We sometimes go to our village doctor and the pharmacy at our bazaar, they give expensive medicine but it does not cure our disease, however, they are not as expensive as the thana hospital doctor.” When I asked about the union level health clinic, some of the villagers said, “That clinic functions on paper, not in reality. There is no doctor, no paramedic, there. It’s locked almost all the time. Sometimes we visit the clinic, but they don’t have any equipment to help make diagnoses, and there’s no medicine for patients.” Another person complained, “They (the Family Welfare Visitor and health assistant) bribe the thana hospital doctor so that they do not have to come to the clinic everyday, it is too far for them, they all want to stay at the thana headquarters. They get medicine from the government free of cost, but they sell it, as they did in our bazaar, too.” Anthropology examines any social system from a broad perspective as it provides us the opportunity to understand a system better. The ethnographic findings from Bangladeshi villages are no exception. Despite the fact that the country is one of the poorest in the world, it has a good health care service structure right from the village to the capital level. However, due to inadequate monitoring as well as a lack of money, the system is not really working efficiently. Intervention may not change stubborn traditions and unhealthy situations overnight, but it can start a movement to make it better. In the case of rural Bangladesh, working on cultural, medical, and economic issues simultaneously will produce the best results.

## CONCLUSION

This study examined the persistent phenomenon of rural Bangladeshi villagers choosing traditional health care providers over modern health care providers in great numbers. Excluding other factors, toilet type as a proxy

for villagers' socioeconomic characteristics was significantly associated with choice of health care provider. Moreover, severity of the disease was shown to be very important. If it is not life threatening, or if it will not interfere too much with their daily economic work, they are also strongly inclined to rely on traditional treatment. Household financial capacity and strength of belief and trust in traditional practices are powerful guiding forces in making such selections. Qualitative data reveal that although most (71%) of the villagers are illiterate, they are very knowledgeable about the local health care system as well as why it is not effective in taking care of their health care needs. They know modern medication can cure them more quickly, but it is not easily accessible. On the other hand, traditional medications and methods may not cure them as quickly, but they give considerable overall comfort because they are rooted in their own beliefs, values, and traditions, and they are far more affordable as well.

Here, I have used both quantitative and qualitative methods to examine factors associated with household decisions in selecting health care providers. This chapter explored economic and socio-cultural factors which affect such decisions. A household's economy, education, socio-cultural code, and level of access to health care services are deeply interrelated. The decision process goes through a spider web-like network. If all the interdependent channels work smoothly, then a villager's choice will produce better results; he or she will actively seek health care services from a trained provider. Considering the financial part, the government should pursue a long-term plan to train all the traditional doctors as well as the pharmacists. These professionals then can provide whatever service they can handle. Otherwise, they will refer patients to better facilities suitable for the villagers.

## NOTES

1. This study, however, finds a different situation – villagers do have a village-based health worker, but economic problems and poor communication have prevented expected improvements in overall wellbeing. Conservative patterns in female mobility might be a factor.

2. All names used here are pseudonyms.

## REFERENCES

- BBS (Bangladesh Bureau of Statistics). (2001). *Statistical pocketbook of Bangladesh 2001*. Dhaka: Planning Division, Ministry of Planning, Government of Bangladesh.

- Fosu, G. B. (1989). Access to health care in urban areas of developing societies. *Journal of Health and Social Behavior*, 30, 398–411.
- Hossain, M., & Sen, B. (1992). Rural poverty in Bangladesh: Trends and determinants. *Asian Development Review*, 10, 1–34.
- Kroeger, A. (1983). Anthropological and socio-medical health care research in developing countries. *Social Science and Medicine*, 17, 147–161.
- Kroeger, A., & Franken, H. P. (1981). The educational value of participatory evaluation of primary health care programs: An experience with four indigenous populations in Ecuador. *Social Science and Medicine*, 15B, 535–539.
- Leslie, C. (Ed.) (1976). *Asian medical systems: A comparative study*. Berkeley and Los Angeles, CA: University of California Press.
- Nepal South Asia Center. (1998). *Nepal human development report 1998*. Kathmandu, Nepal: Nepal South Asia Center.
- Ravallion, M., & Sen, B. (1994). *When method matters: Towards a resolution of the debate over Bangladesh's poverty measures*. Policy Research Working Paper no. B59. World Bank, Washington, DC.
- Rogers, E. M., & Solomon, D. S. (1975). Traditional midwives and family planning in Asia. *Studies in Family Planning*, 6(5), 126–133.
- Sen, B. (1995). *Recent trends in poverty and its dynamics, experiences with economic reform: A review of Bangladesh's development*. Dhaka: Center for Policy Dialogue and UPL.
- Stoner, B. P. (1985). Formal modeling of health care decisions: Some implications and limitations. *Medical Anthropology Quarterly*, 16(2), 41–46.
- Subedi, J. (1989). Modern health services and health care behavior: A survey in Kathmandu, Nepal. *Journal of Health and Social Behavior*, 30, 412–420.
- Weller, S. C., Ruebush, T. R., II., & Klein, R. E. (1997). Predicting treatment-seeking behavior in Guatemala: A comparison of the health services research and decision-theoretic approaches. *Medical Anthropology Quarterly*, 11(2), 224–245.
- Young, J. C. (1980). A model of illness treatment decisions in a Tarascan town. *American Ethnologist*, 7, 106–131.

This page intentionally left blank

# REINVENTING MENTAL HEALTH CARE: PUBLIC–PRIVATE SYSTEMS

Sue Gena Lurie

## ABSTRACT

*Social and economic trends toward local governance form the context for health and mental health policy and the reorganization of care systems for cost-containment in the United States. Local management of public–private collaborations is promoted by state agencies as a means of rationalizing mental health care and community support services. This chapter analyses the local process of developing public–private partnerships for mental health care, based on an ethnographic case study of county Mental Health/Mental Retardation and behavioral health committees and coalitions in Texas, from 1995 to 2001. Following this period, local service agencies continued collaboration to increase community awareness and resources for care. Findings were that while the rapid transition to local control under conditions of reduced resources impeded implementation of a public–private mental health care system, commitment to a service safety net for persons with mental disabilities was sustained.*

---

The Economics of Health and Wellness: Anthropological Perspectives

Research in Economic Anthropology, Volume 26, 55–73

Copyright © 2008 by Elsevier Ltd.

All rights of reproduction in any form reserved

ISSN: 0190-1281/doi:10.1016/S0190-1281(07)26003-2



## **SOCIAL AND ECONOMIC TRENDS IN MENTAL HEALTH POLICY**

Current social, political and economic trends in the United States toward local governance and control form the context for change in health and mental health policy, and reorganization of care systems for cost-containment. Mental illness has remained a social problem that “successively gains and loses standing on the national political agenda” (Rocheftort, 1988, p. 134). This has been repeatedly demonstrated by unsuccessful Congressional efforts to create “parity” for mental health and health insurance. Changes in care and support systems in the United States have posed challenges for persons with mental illness over the last decade.

The need to expand community mental health services was addressed by the Medicaid Intensive Community Mental Health Treatment Act, sponsored by the National Mental Health Association and National Alliance for the Mentally Ill (Valentine, 2000). This act allows states to provide intensive community services for adults with severe, persistent mental illnesses and children with serious mental and emotional problems, including those who have had repeated hospitalizations or poor outcomes from less intensive care, or have been arrested for minor offenses.

Comparative international research on community mental health services has found that for persons newly diagnosed with mental illness, “exploratory” health beliefs affect the process of seeking care (Williams & Healy, 2001). From a systemic perspective, community mental health care has been found to be effective in improving patient outcomes and cost-savings, in countries of various income levels (Wiley-Exley, 2007). In the United States, the cost of diagnosis and treatment of psychiatric disorders was estimated at \$85 billion and substance abuse treatment at \$18 billion in 2001 (Mechanic, 2006). Care-seeking and service networks are loosely organized due to the variety of practitioners, diagnostic inconsistencies, and lack of comprehensive insurance reimbursement policy.

In 2002, the President’s New Freedom Commission on Mental Health found mental illness was underrecognized as a public health problem in the United States. Major obstacles impeded effective care: stigma, restrictions by private health insurance, and the fragmented service system. At that time, 5–7% of adults were estimated to have a serious mental illness, and 5–9% of children, to have a serious emotional disturbance (Department of Health and Human Services, 2002, p. 2). The fragmented community service delivery system, and lack of prevention were found to lead to disability, school failure, unemployment, homelessness, incarceration, and inadequate care for older adults.

Goals of transforming the system were to: (1) enhance understanding of mental health as essential to health; (2) make mental health care “consumer and family-driven”; (3) eliminate disparities in mental health services; (4) expand screening, assessment, and referral; and (5) enhance technology for access to care and information in the public and private sectors. States were to develop comprehensive plans to coordinate programs, and individualized care was to be based on choice, self-monitoring and accountability, by expanding roles of consumers and families in managing funding for services (Department of Health and Human Services, 2002).

Changes in state health and mental health care responsibilities and organizational structures have been stimulated by the federal political-economic “devolution revolution” toward local resource control (Winston, 2002). This is paralleled by rhetoric and policy for reduction of the public sector, decentralization of health care systems (Atkinson, 2002), and public-private partnerships for essential health care (Baker et al., 1994). Along with managed behavioral health care, including Medicaid, insurance payments, and behavioral health contracts, this process fostered the privatization of mental health and mental retardation services (Ware, 2000; Willging, Waitzkin, & Wagner, 2004). Managed care reduced inpatient care, length of psychotherapy and costs, with drug formularies and clinicians who are less expensive than physicians; however, quality of care for persons with serious and chronic conditions is variable (Mechanic, 2006). Local management of public-private collaborations is promoted by state health and Mental Health/Mental Retardation (MH/MR) agencies as a means of rationalizing care and community support services.

Major theoretical and research issues have been identified in the shift from state to local responsibility for health and mental health care. These issues center on the dynamic implications of local control, relationship of states to regional centers and county political units, and the process of formalizing local interorganizational and professional networks. Such issues are integrally linked to state political actions that shape the direction of change in health and mental health care for local communities. These actions recast, in contemporary perspective, previous policy changes toward deinstitutionalization of patients with mental illness or disabilities (Grob, 1997), and development and use of community support systems (Morrissey, Hall, & Lindsey, 1982; Rochefort, 1988; Rogler & Cortes, 1993; Scott & Black, 1986; Tausig, 1987).

This chapter analyses the process of state and local development of public-private partnerships for community mental health care, based on an ethnographic case study of policy change and organizational planning for

mental health services in a metropolitan county in Texas, from 1995 to 2001. The research problem was to understand the policy process and potential impact of transforming a public mental health service system into a public-private system. This process was undertaken to address the dual social and economic goals of strengthening community mental health care and improving the cost-effectiveness of services using the rationale of integrating "best value" with increased "consumer choice" of services, for persons with mental illness or disabilities.

## **PRIVATIZING PUBLIC MENTAL HEALTH CARE IN TEXAS**

### *Purpose and Methods*

This case study is based on ethnographic research on policy and program change by a local community MH/MR agency that coordinated public clinic, outpatient and inpatient services, over a six-year period from 1995 to 2001. The goal was to analyze and understand the process of evaluating and changing the organization of public services in an effort to transform the system toward privatization, under a new state policy. Three overlapping organizational phases of this process were identified as integrally linked in the transformation of the community mental health service system.

Ethnographic and qualitative research methods (Coriel, 1995) and an "insider anthropology" approach (Cerroni-Long, 1995) were applied in a case study of group processes in restructuring local mental health services. During the study period, the author served as a volunteer member of the initial North Texas Behavioral Health Care Network (NTBHCN), Tarrant County MH/MR Network Development Advisory Committee (NAC), and participant in community planning meetings with the Mental Health Connections coalition. Methods included: participant observation in monthly open NAC meetings, to review state and local mental health service reports by MH/MR agency staff, and evaluate proposals; preparation of committee reports; participant observation in MH/MR board, other advisory committee and coalition meetings, public meetings on legislative funding, regional and state conferences, with consumers and advocates. For each of the three phases in the case study, findings from these sources were compared and integrated with published agency and media reports.

*State and Local Mental Health Policy in Texas*

Mental illness is one of the major reasons for hospitalization in Texas, and was the fifth most frequent diagnosis for those discharged from hospitals at the time of the study (Huff & Classen, 2000). Public funding for services is combined from several sources: general revenue from sales or value-added taxes and other revenue, in the absence of a state income tax; and Medicaid reimbursement. Although the state designates small grants for local mental health care programs, legislative decisions, and agency shortfalls restricting public service capacity have led to further reduction of minimal funding for mental health care.

From 1995 to 2000, Texas limited allocations for local MH/MR agencies, with significant impacts on the mental health care system. Despite a revenue surplus in 2000, the state was 43rd in per capita spending for mental health care, and 34th in spending for mental retardation services (Benton, 2000, p. 4). It provided inadequate support for persons without Medicaid or other insurance, which comprised half of those served by local mental health and retardation agencies, while Medicaid funding for rehabilitation services decreased. Local agencies were required to provide specific information about services, persons who received them, costs and expected outcomes (Texas Council of Community Mental Health Centers, 2000).

To enhance legislative support for mental health and mental retardation clients, the comprehensive Community Services Coalition (1) of 12 state advocacy organizations was formed. The goals of this statewide coalition were to: repair and strengthen the community "safety net" of services; divert persons with mental disabilities from the criminal justice system; end waiting lists for essential services for 23,000 persons with mental disability, primarily home care for children; and increase program flexibility. Specific fiscal goals were to achieve equitable funding for support services and medications for Texas communities by 2003, and raise funding to the national average by 2005 (Community Services Coalition, 2000). This coalition collaborated with the statewide Texas Council of Community MH/MR Centers (agencies) to increase public awareness of mental disabilities, and potential for rehabilitation and recovery of clients.

The need to provide mental health services for all those who need them, while protecting the civil rights and safeguarding against involuntary commitments, became an issue with a state proposal to divert persons with mental illness who have committed misdemeanors from the criminal justice system. The proposal was for intensive community services for medication, housing and supported employment, using the Assertive Community

Treatment (ACT) model that has proven effective in reducing the rate of psychiatric hospitalizations for seriously mentally ill patients in other states: ACT in South Carolina and PACT in Wisconsin (Estroff, 1982). However, the Texas Mental Health Consumers Network was concerned about the impact on persons who had not committed crimes, eligibility of incarcerated persons for services, protection of due process and right to refuse treatment. Consumers posed an alternative: the PACE model of consumer choice and personal assistance with peers as case managers, to promote self-sufficiency through work incentive and savings programs (Halligan, 2000).<sup>1</sup>

During the study period, the behavioral health care system faced a major issue for community care of persons with mental illness and/or retardation: the escalating cost of medications. This was a consequence of national treatment paradigms that evolved with the medicalization of mental disorders and the public policy of deinstitutionalization (Archer, 1982; Grob, 1997), coinciding with the development and adoption of newer, more effective medications.

In Texas, outpatient psychiatric treatment methods tended toward replacement of psychotherapeutic counseling by medications, since effects are more predictable using prescriptions, patient monitoring and measurable outcomes. Despite or because of this trend, state-mandated and managed care policies demanded control of dramatically increasing pharmaceutical costs. Assessments of medication effectiveness by regional mental health centers and advocacy organizations were used to negotiate funding for effective treatments, with fewer side effects and long-term potential for reducing psychiatric hospitalizations (Texas Alliance for the Mentally Ill; Texas Council of Community Mental Health/Mental Retardation Centers, 1996).

In the metropolitan county of the case study, psychoses were the third most common diagnosis for patients discharged from hospitals (Huff & Classen, 2000), while costs of care had risen from \$366,000 in 1989 to over \$6 million in 1999 (Yednak, 2000, p. 1B). The comparative efficacy of various psychiatric medications was assessed by the county MH/MR agency, under grants for specific medications.

Treatment costs must be examined in the context of the changing system care for persons with mental disabilities. Prospects of expanding managed health care, with plans to incorporate Medicaid patients, eventually led to the politically controversial merging of state health and MH/MR departments, into one Department of State Health Services. Prior to this, demonstration programs for local management of public and private services under quasi-governmental MH/MR Centers (service coordination agencies) were piloted in selected regions, and adopted throughout the state.

The Texas MH/MR agency was restructured as a State Authority in 1995 (HB 2377), with the responsibility of contracting and managing delivery of services to persons with primary diagnoses of mental illness and/or retardation. Regional and county Community MH/MR Centers (agencies) became Local Authorities, with basic goals of developing local MH/MR service management, while stimulating competition by incorporating private providers into the public care system. The rationale was to improve choice of services for community MH/MR clients, labeled “consumers”, by selecting providers that offer “best value” in service quality and cost, as mandated by the state. Best value was to be assessed as “the overall worth of a service taking into consideration long and short term costs ... and immediate and future benefits to the individual receiving the service” (Tarrant County MH/MR Services, 2000).

As an alternative to external management of MH/MR care, county MH/MR programs were to compete with private providers for service contracts with the Local Authority, using “best value” criteria of access, professional staffing, standards of care, quality and cost. After pilot programs were implemented in selected counties, state guidelines for each pilot site to develop a process for ensuring best value were disseminated in June 2000, using the county program in the state capitol as a model. An overarching issue for pilot projects was the extent to which the safety net of state-mandated mental health and retardation services would remain in the public system, or would be contracted to private providers.

### *Phase 1: Regional Behavioral Health Care Network (1995–1996)*

In the county of the case study, the initial regional NTBHCN of public and private care providers, an interagency collaboration in 1995, was formed prior to the local pilot of the model state MH/MR program. This network was designed in response to anticipated state change toward managed behavioral health care, although a consultant to NTBHCN from California found Texas relatively “immature” with respect to managed care. The county MH/MR agency director’s rationale for developing NTBHCN was that clients who need a variety of services should not have to negotiate their way through various administrative structures. Other local agencies in this network were: Family Services, Inc.; county hospital psychiatric inpatient unit; Cook’s Children’s Hospital; Child Study Center for developmental diagnoses and care; private residential behavioral care (Lena Pope Home) for abused and abandoned youth; and Catholic Charities residential

program for emotionally disturbed children. The author participated in planning meetings in her role as a Catholic Charities board member at that time.

The Behavioral Health Care Network explored models for joint management of care and referrals, with economic and legal implications. Members agreed to incorporate the Behavioral Health Care Network as a non-profit organization, with planning to be done in five phases: (1) network membership and services; (2) cost, capitation, clinical system and management; (3) analysis and management consultation; (4) implementation; and (5) marketing and operations. Clinical goals were to develop a model treatment system and protocols, outcome measurement, credentialing and accreditation. Catholic Charities later withdrew from NTBHCN due to cost and reduced state support for its residential program for children, which was eventually closed; it formed a partnership with the home for youth, under a state contract for foster care with Child Protective Services. The private Children's Hospital assumed leadership of the Behavioral Health Care Network.

Over this period, there were important changes in local resources for behavioral health care: the number of child psychiatrists in the county declined; the local state school for mentally retarded persons closed; and there was an increasing scarcity of inpatient services and community resources for children and adolescents. Decline in public psychiatric care for adults was anticipated, with negotiations for sale of the county hospital to a major private hospital initiated by changes in state Medicaid reimbursement in 1996, but this did not occur. The county hospital developed its own local clinics and managed care network, separate from the private hospital HMO that became part of a national managed care corporation.

Within the county, abrupt decline in inpatient mental health care for adults was precipitated by closure of the private Psychiatric Institute, part of a national hospital system, due to unethical practices of extending patients' length of stay, to receive maximum insurance reimbursement for the hospital. This followed aggressive efforts by a number of for-profit psychiatric hospitals in the state to maximize patient revenue dating from the late 1980s through the early 1990s (Vandenberg, 1999). Closure of the local private inpatient facility created a dramatic exodus of psychiatrists from the county and lack of mental health practitioners that was further exacerbated by changes in other inpatient and outpatient services. When the local pilot of the model state MH/MR program for public-private service partnerships was implemented (Phase 2), the Behavioral Health Care Network ceased to function.



*Phase 2: State Policy and Local Public–Private Care  
Network (1996–2000)*

In one of the three regions selected by the state to implement the pilot project for public–private partnerships, and to assess impacts on cost, quantity, and quality of mental health care, Tarrant County MH/MR Board of Trustees established Community Advisory Committees: Mental Health, Addiction Services, Children’s Mental Health, and Mental Retardation. The NAC was also created as an impartial group representing the local community, to monitor the development of comprehensive public–private services, separate the “authority” from “provider” functions of the county MH/MR agency, and advise the MH/MR board. This committee was a nominal but symbolic group, with a minimum of four members; half were to be clients or advocates.

When the Community and NAC were formed, volunteer members were recruited in the media or invited to join through informal or professional networks. They underwent extensive orientation by MH/MR administrators, staff and consultants on pilot legislation, goals, objectives, and roles in planning, design, management and evaluation of the public–private care system. The author participated on the basis of prior membership in behavioral care network, postdoctoral training in mental health policy, research and teaching with mental health professionals and advocates.

The NAC relied on extensive information on mental health and mental retardation services from staff, management, board liaisons, and legal counsel to review MH/MR programs, set criteria and evaluate proposed private services for “best value.” Since the countywide needs assessment was not completed until several months later, the committee had to approve alternative programs based on the previous assessment (National Service Research, 1997) and current MH/MR service priorities.

Local MH/MR service provision remained impeded by funding that was historically lower than in other regions of the state, but lagged behind population growth. Although the state reimbursed the agency for services for 6081 adults and 708 children in 2000 (Yednak, 2000, p. 7B), increased numbers led to a waiting list for clients who called the crisis line for screening, assessment, and services (Huff, 2000). Local professional practice of prescribing medications most effective for individual clients, rather than restricting clients to medications designated by state formularies, resulted in a search for additional funding, to avoid reducing other services.

In its mission to transform the system, NAC’s review of proposed services by new providers began in response to a major crisis in adult psychiatric



care, precipitated by sudden closure of the county hospital inpatient unit by its director, due to the declining number of patients. The committee undertook an extensive process of reviewing proposals for alternative private adult inpatient services, setting and applying evaluation criteria to applicants, and ranking proposals. However, under political pressure from county commissioners to avoid sending clients to the state hospital, the county hospital reopened its psychiatric unit. Although the network committee had recommended three private providers, the MH/MR administrator and board renegotiated the adult inpatient contract with the Hospital District. Critique of this process was voiced by the committee chair, a psychologist and parent of a client, who then moved to a state position.

As new NAC chair from 1998 to 1999, the author participated in training by the regional Texas Council of Community MH/MR Centers (agencies). As they continued to assess services, NAC members reassessed their effectiveness in network development, and attributed delays to state bureaucracy and county political influences. There was ongoing turnover in NAC membership due to resignations for professional reasons, schedule conflicts, and the death of an active elderly member who was the parent of a client. A former psychologist, the parent of another client, remained as a strong advocate of increasing consumer choice. The next chair, a county United Way administrator, soon moved to membership in the MH/MR board, and his committee role was filled in turn by the former board chair. NAC encountered challenges of members' participation, lack of ethnic, racial and geographic diversity, and difficulty of balancing members who were social service or health professionals with those who had business experience.

Yet the committee persisted in assessing public and private programs and new proposals, based on information from the MH/MR Director of Network Development, who eventually moved to a position in a private psychiatric hospital. With subsequent reorganization of the MH/MR agency, the Chief of Managed Care became Chief Administrative Officer; key roles were assumed by a new Director of Network Development, Chief Operating Officer, and Chief of Mental Health Essential Services.

The issue of primary concern to NAC was the difficulty of expanding the private provider network, in the fluid behavioral health and managed care environment. This complex process included renewal of the contract for public crisis inpatient services at the county hospital. The contract review was based on an annual report on admission and diagnostic processes; levels of care, including 23-hour observation, acute inpatient care, and partial

hospitalization; discharge and follow-up services; staff relations; cost of care; and criteria for patient transfer to the state psychiatric hospital. While those services appeared adequate, infrequent reports and changing priorities delayed their evaluation.

Despite the ongoing lack of psychiatrists and fragmented service coordination, the number of clients who were served in the county steadily increased with the population. NAC strove to apply strategies for developing a network of service providers to increase access, choice and efficiency of a variety of mental health and mental retardation services. Members reviewed needs and proposals for: medication management by psychiatrists; mental health care for children and adolescents; rehabilitation and support services; psychological testing for mental retardation, to expand choice and reduce waiting times; respite and vocational services for persons with mental disabilities. Lack of mental health crisis care for children and adolescents or follow-up care for inpatients resulted in joint recommendations by NAC with the Children's Advisory Committee. Critiques were focused on types of services available and the cost-efficiency of public services was compared with that of privatization. Complexity of the system and state procedures, inconsistent data, contradictory priorities, declining resources, and unpredictable change in local providers hindered the overall service assessment by NAC.

A basic objective of this pilot project was to assess public services in the "safety net," to determine the value of contracting them to private providers. Key issues were access to care, quality of services, cost-cutting, efficiency, and management. The committee reviewed reassignment of clients to other programs based on Medicaid eligibility, with anticipated decline in state funding. This was expected to result in the increased use of mental status exams by physicians, participation in the Medicaid managed care program, collaboration with other services and/or transferring clients to other providers.

When the MH/MR agency completed its county needs assessment, this enabled NAC to systematically compare current services with community needs. NAC members ranked priorities for strategic planning, reviewed consumer satisfaction and provider surveys, and contracted mental retardation services. The overall waiting times for clients were eventually reduced, but times for some programs increased, due to limited funding.

The economic goals of rationalization and cost-reduction in public services were emphasized in evaluation of the local MH/MR agency's innovative programs at selected community clinics: (1) to increase staff support for physicians; (2) to substitute Advanced Practice Nurses (APN's)

for physicians at an urban clinic serving Hispanics and compare cost-effectiveness, quality of care and client satisfaction. However, these goals conflicted with community preferences. After MH/MR's decision to contract psychiatric care at this clinic to a private managed care corporation was reviewed by NAC, negotiations with the provider and responses of mental health professionals to perceived threats to quality and control led to an unsuccessful contract. Care was resumed by the MH/MR agency, and service coordination and patient satisfaction improved.

To complement comprehensive public services, a private ACT program was successfully implemented to provide intensive, community-based mental health services for homeless adults. Since the private program was for a different client group than a similar public program for persons with chronic mental illness, although the programs were comparable in goals and services, the issue of consumer choice was not actually addressed.

Additional demands on the public mental health care system led to creation of a waiting list in the spring of 2000 for persons in need of crisis care, whose numbers had doubled over two years, and the phasing out of a public community support program on life skills for mental health clients, who were then transferred to private programs. To these were added a state-mandate for community placement of a large number of persons released from institutions such as the residential school for mentally retarded persons in nearby Denton County, under the Olmstead Act of 1999.

In 2001, the NAC began state-mandated evaluation using "best value" criteria, for selected services such as mental health community support training and treatment in a residential setting, for patients discharged from the state hospital or in need of comprehensive care; supported housing and employment; and mental retardation respite services. Members compared the value of public services with that of services by contracted providers. They also reviewed the Mental Health Services budget deficit, and reasons for delays in evaluating services using state procedures. Major issues remained: ensuring both quantity and quality of services, and mental health case management; lack of psychiatrists; decline in funding; and need for community outreach to support mental health care.

Throughout its existence, NAC members had to integrate complex information from MH/MR administrators and staff, to assess proposed contracts and develop the network. Committee members and staff varied in their evaluations of system change toward privatization or managed behavioral health care, and alternative models for a safety net of services for chronic patients. Over this period, the policy context fluctuated with the process of deinstitutionalization, and with state and federal mandates to

increase services and clients. At the same time, turnover in managed behavioral health care corporations and non-profit agencies due to financial difficulties, such as closing of Family Service Agency that had provided employee counseling, led to negative impacts on the local system.

Comprehensive community mental health services by private providers remained vulnerable with declining federal support, placing the burden of treatment on the county hospital, and public services were also in jeopardy. When a residential unit for homeless mentally ill persons was opened in an urban homeless shelter, loss of the grant from the Department of Housing and Urban Development to the Family Service Agency left 370 homeless persons in area shelters without psychiatric services or referral for follow-up care. Of these, 21% had been treated for mental illness; 40% had a history of alcohol or drug abuse and grant funds were depleted due to cost of medications, while clients waited for care (Tharp, 2000). This crisis revealed competition between public and private agencies and fragmentation of the service system, that was only temporarily ameliorated by federal grants to eight local agencies for mental health care, housing, child care, counseling, and substance abuse programs for homeless persons.

In anticipation of regionalization, the county MH/MR agency developed information technology contracts with other local agencies, but was less effective in recruiting psychiatrists and other providers to expand the mental health service network. Another behavioral health care corporation closed one of two providing comprehensive mental health and substance abuse treatment in an adjacent county; still another similar corporation faced financial jeopardy, and services by other HMO's declined. The local medical school clinic closed and psychological and medical services were combined, prior to merging psychological and psychiatric care by the county hospital in 2005.

The demand for services was again increased by closure in 2001 of a regional public rehabilitation center for psychiatric care for elderly adults and Alzheimer's patients. Although that region had the lowest per capita funding of 42 state programs, population growth had doubled the number of mental health court cases (Barbee, 2000). The crisis center, adult substance abuse treatment, housing and support programs for families with mentally ill or retarded members were eliminated. Alternatives were to transfer patients, many with serious medical problems, to the state psychiatric hospital or other facilities, or to open a small inpatient psychiatric unit. The local Mental Health Association advocated equity in state funding for mental health services; this was added as an "exceptional item" in the state budget, and limited to adult rehabilitation.

Eventually, with the reorganization of state agencies, merging of health and mental health agencies into the Department of State Health Services, and statewide extension of local MH/MR pilot programs for public/private services, the NAC was terminated. At this point, the potential of private–public mental health care systems to improve consumer choice and assure best value of services was considered ambiguous. The statewide “Texas Community Solutions” coalition reviewed standards for the numbers of persons local MH/MR agencies must serve, increase in clients, need for services and projected costs. Contrary to expectations, less-impaired clients were found to be more able to obtain services and incurred increased costs. This was interpreted as supporting a diagnosis-based reimbursement system for mental health care, and the analysis of annual number of service units, rather than number of clients served.

### *Phase 3: Issue-Oriented Coalitions (2000–2001)*

Toward the end of the local pilot program in Phase 2, efforts to privatize public mental health care were complicated by county population growth and increasing numbers of clients, along with simultaneous increase in numbers the state required the county to serve, despite reduced funding. Options for private care declined with the departure of several behavioral health care corporations from the county, and the collapse of a major behavioral health care system. Closure of three hospitals in Dallas and Tarrant Counties resulted in cancellation of a new contract for private children’s mental health care. This necessitated negotiations by MH/MR to reopen inpatient psychiatric care for adolescents at the Tarrant County hospital in 2000, along with care at the private children’s hospital.

With decreased reimbursement from managed care, the total number of county psychiatric beds for children and adolescents had declined from over 500 in the 1990s to fewer than 50 in 2000 (Huff & Brooks, 2000). The urgent need for public inpatient psychiatric crisis care for children and adolescents was addressed by a task force of over 30 local mental health service organizations that began in 1999, led by the county MH/MR agency. This new collaboration of public and private providers sought to expand adolescent mental health care by the county hospital and care for children by the private children’s hospital. The county Mental Health Council, renamed “Mental Health Connections,” collaborated with MH/MR Children’s Advisory Committee and members of a coalition of substance

abuse agencies. The legislative agenda was to promote parity for mental health and health insurance, increase funding, and enhance local control. Ultimate local goals were to integrate MH/MR with county hospital psychiatric services, and to demonstrate the ability of the public sector to manage behavioral health care, in contrast with failing private managed care systems.

The Mental Health Connections coalition received a \$75,000 state grant to assist six to ten families in “wrap-around” services for children with multiple mental health care needs, and coordinate services for respite care, translation, support groups, insurance, and other services (Brooks, 2000a, July). As a pressure group, “Mental Health Connections” was successful in persuading the county hospital to reopen its 16-bed adolescent psychiatric unit for teenagers, with follow-up services by private agencies. This afforded local treatment for young patients, including those who were violent, rather than sending them to the state hospital or juvenile justice system. However, although the county hospital set up ambulatory psychiatric care at three urban health clinics, limits on its capacity to care for mentally ill adolescents in crisis were dramatized by the media in the case of a teenager with mental illness, retardation, and epilepsy. This patient was not treated in the psychiatric emergency room or admitted to the hospital, and was unable to read, write, speak or understand the admission process (Brooks, 2000b, November).

The county MH/MR agency strove to coordinate and improve the quality of each category of services for persons with mental disabilities: essential and provider services; addiction services; and Early Childhood Intervention. The agency was the sole public coordinator of crisis, intake, assessment and referral services, and five outpatient clinics, as well as community support programs: supported housing and employment, and one residential facility. Specialized services included psychiatric and rehabilitation services for incarcerated and homeless persons, coordinated with the county jail, homeless shelters, and day programs (Mental Health/Mental Retardation of Tarrant County, 2002).

In a town hall meeting on mental health care, the MH/MR director and a state senator advocated public awareness of the Mental Health Connections coalition, using a previous incident of the tragic murders of youth and adults at a local church by a mentally ill man in 1999. Inadequate community coordination of health and mental health care for adults was dramatized in 2004, when a patient who had been discharged from the county psychiatric emergency room was found to have died of an undiagnosed medical condition. The Mental Health Connections coalition strongly protested the

lack of increased state funding, due to anticipation by legislators of the Children's Health Insurance program, since children and youth need services before illnesses become worse, and/or before they enter the juvenile detention system and are eligible for care. County MH/MR and Mental Health Association staff concurred in mistrust of the acute care orientation of the Children's Health Insurance program.

Following the study period, with the influx of evacuees from New Orleans and the gulf coast after Hurricane Katrina, state and local governments and private foundations assessed the additional need for mental health services for up to one-fourth of evacuees in Texas, for as long as six months (University of Texas, 2006). However, assessment of ongoing needs for mental health care for adults, children, and families who resettled in Tarrant County was incomplete.

In 2006, the Mental Health Connections coalition advocated local control and increased state funding of mental health services and school-based educational programs to reduce the stigma of mental illness, and collaborated with the Homeless Coalition on public advocacy and needs assessments. In 2007, it participated with other community coalitions to: (1) obtain a federal "Safe Schools and Healthy Students" grant to improve support programs, and (2) sponsor a public symposium on mental health care for children and adolescents, with Lena Pope Home for youth, Texas Christian University and University of North Texas Health Science Center (Mental Health Connections, 2007). These events illustrate the complexity and integration of local interorganizational networks, as well as potential impact of issue-oriented coalitions on community awareness and resources for mental health care.

## **POLITICAL ECONOMY AND PRIVATIZATION OF MENTAL HEALTH CARE**

The political and economic context of policy change for comprehensive, high-quality mental health care, with efforts to reduce cost and increase consumer choice, is highly dynamic and uncertain, as seen in the present case study. In the process of privatizing public services for persons with mental disorders, major problems were addressed by the local MH/MR agency and the Network Advisory Committee: need for mental health case management; inadequate quantity and quality of services; lack of psychiatrists and providers; and decline in funding. However, finding resources to resolve these problems and ensure "best value" was hindered



by the complexity of relationships among national, state and local programs, fragmentation of services, and lack of political and economic support.

While the degree to which system coordination and consumer choice were increased is problematic, given the fluctuation of providers and funding, the commitment to ensuring a “safety net” was sustained by the public system. This goal was recently reiterated in a comprehensive evaluation of crisis services across the state as inadequate, and recommendations for increased support (Texas Department of State Health Services, 2006).

In the rapid transition to local control under conditions of reduced state resources, trends toward privatization, and managed behavioral health care were countered by state-initiated efforts of the county MH/MR agency to maintain the service safety net, while becoming a management organization for public and private services. This public agency sought a leadership role in interagency collaborations to increase resources for mental health inpatient and outpatient services, and regional MH/MR administration. Evaluation of the extent to which this role improved mental health care and patient outcomes poses a challenging area for future research.

To fully analyze the planning process based on the case study, a comparison with other pilot programs in the state and evaluation of outcomes for persons using the current system are required. The impact of the NAC and its role in strategic planning for the county network of care and support services should be assessed for effectiveness in meeting mental health care needs in the community. This is essential to evaluate the local pilot program, as well as to determine the best value for mental health services.

Basic issues underlying mental health system changes, and the dynamic relationship of local programs to federal policy and state governance, include economic fluctuation in public and managed behavioral health care and political priorities. A common result of privatization is decline in crisis care, providers and financial resources for services to chronically ill and/or disabled clients. The challenge is to commit sufficient economic and social resources to achieve a stable system for adequate, comprehensive case management, and appropriate treatment for persons with serious or chronic mental illness or disabilities.

## NOTE

1. Texas Mental Health Consumers, Advocacy, Inc., Mental Health Association, National Alliance for the Mentally Ill, The Arc (Mental Retardation Services),



Private Providers Association, Texas Council of Community MH/MR Centers, Inc., Texas Federation of Families, Texas Mental Health Consumers, Texas Society of Psychiatric Physicians, Capacity for Justice, Texas Depressive and Manic Depressive Association, and Texas Association for Mental Retardation.

## REFERENCES

- Archer, J. (1982). Chronically mentally disabled and "deinstitutionalization". *Annual Review of Public Health*, 3, 445–468.
- Atkinson, S. (2002). Political cultures, health systems and health policy. *Social Science and Medicine*, 55, 113–114.
- Baker, E., et al. (1994). Health reform and the health of the public: Forging community health partnerships. *Journal of American Medical Association*, 272(16), 1276–1282.
- Barbee, D. (2000). Mental health facility will close. *Fort Worth Star Telegram* (December 15).
- Benton, J. (2000). Speaking out. *Texas Network* (June), p. 4.
- Brooks, K. (2000). Mental health task force gets grant from state. *Fort Worth Star Telegram* (July 21), p. 2B.
- Brooks, K. (2000). Mentally ill teen didn't get support. *Fort Worth Star Telegram* (November 24), pp. 1, 4B.
- Cerroni-Long, E. L. (Ed.) (1995). *Insider anthropology*. American Anthropological Association: National Association for the Practice of Anthropology Bulletin #16.
- Community Services Coalition. (2000). *Community services coalition brochure* (July 7). Austin, TX.
- Coriel, J. (1995). Group interview methods in community health research. *Medical Anthropology*, 16, 193–210.
- Department of Health and Human Services. (2002). *Achieving the promise: Transforming mental health care in America*. President's New Freedom Commission on Mental Health. Final Report. Retrieved April 21, 2007, from <http://www.mentalhealthcommission.gov/reports/FinalReport/FullReport>
- Estroff, S. (1982). *Making it crazy: An ethnography of psychiatric clients in an American community*. Berkeley, CA: University of California Press.
- Grob, G. (1997). Deinstitutionalization. *Journal of Policy History*, 9(1), 48–73.
- Halligan, M. (2000). E.D.'s message. *Texas Network* (November), pp. 1, 2, 14.
- Huff, C. (2000). MH/MR crisis callers go on list. *Fort Worth Star Telegram* (April 25), p. 13.
- Huff, C., & Brooks, K. (2000). JPS unit ok'd for mentally-ill teens. *Fort Worth Star Telegram* (July 28), pp. 1, 23.
- Huff, C., & Classen, J. (2000). Clinical analysis—Data offers snapshot of Texas hospitalizations. *Fort Worth Star Telegram* (December 20), p. 1.
- Mechanic, D. (2006). *The truth about health care: Why reform is not working in America*. New Brunswick, NJ: Rutgers University Press.
- Mental Health Connections. (2007). Bridging the gap: Research, practice and policy. Symposium on effective mental health treatments for children and adolescents. Retrieved April 20, 2007, from <http://www.mentalhealthconnection.org>
- Mental Health/Mental Retardation of Tarrant County. (2002). Directory of services, including 2001 annual report information.
- Morrissey, J., Hall, R. H., & Lindsey, M. L. (1982). *Interorganizational relations: A sourcebook of measures for mental health programs*. Washington, DC: US Department of Health and Human Services.

- National Service Research. (1997). *Tarrant county MH/MR services needs assessment study* (October 21).
- Rocheftort, D. (1988). Policymaking cycles in mental health. *Journal of Health Politics, Policy and Law*, 13, p. 1.
- Rogler, L., & Cortes, D. (1993). Help-seeking pathways: A unifying concept in mental health care. *American Journal of Psychiatry*, 150(4), 554–561.
- Scott, W. R., & Black, B. (Eds). (1986). *The organization of mental health services: Societal and community systems*. Beverly Hills, CA: Sage Publications.
- Tarrant County MH/MR Services. (2000). *Best value determination resource folder* (June 9), p. 1.
- Tausig, M. (1987). Detecting “cracks” in mental health service systems: Application of network analytic techniques. *American Journal of Community Psychology*, 15(3), 337–351.
- Texas Alliance for the Mentally Ill; Texas Council of Community Mental Health/Mental Retardation Centers. (1996). *A community forum: New medications: Impact and future value in treating severe mental illness from clinical and budgetary perspectives*. Austin, TX.
- Texas Council of Community Mental Health Centers. (2000). *Monthly board bulletin*, 5(9), October.
- Texas Department of State Health Services. (2006, September). Texas mental health and substance abuse crisis services redesign. Retrieved April 19, 2007, from <http://www.dshs.state.tx.us>
- Tharp, R. (2000). Care for mentally-ill hurt by loss of grant. *Fort Worth Star Telegram* (October 26), p. 1-B.
- University of Texas at Austin. (2006). *Hogg Foundation for Mental Health: News*, 42(1), pp. 1, 5, March.
- Valentine, T. (2000). Two years in the making: The Medicaid Intensive Community Mental Health Treatment Act. *Texas Network* (November), p. 13.
- Vandenburgh, H. (1999). *Feeding frenzy: Organizational deviance in the Texas psychiatric hospital industry*. Lanham, MD: University Press of America.
- Ware, N. (2000). Clinician experience of managed mental health care: A rereading of the threat. *Medical Anthropology Quarterly*, 14, 3–27.
- Wiley-Exley, E. (2007). Evaluations of community mental health care in low- and middle-income countries: A 10-year review of the literature. *Social Science and Medicine*, 64, 1231–1241.
- Willging, C., Waitzkin, H., & Wagner, W. (2004). The death and resurrection of Medicaid managed care for mental health services in New Mexico. In: A. Castro & M. Singer (Eds), *Unhealthy health policy: A critical anthropological examination* (pp. 247–256). Walnut Creek, CA: Altamira Press.
- Williams, B., & Healy, D. (2001). Perceptions of illness causation among new referrals to a community mental health team: “Explanatory model” or “exploratory map”? *Social Science and Medicine*, 53, 465–476.
- Winston, P. (2002). *Welfare policymaking in the states: The devil in devolution*. Washington, DC: Georgetown University Press.
- Yednak, C. (2000). MH/MR approves changes in budget. *Fort Worth Star Telegram* (April 26), pp. 1B, 7B.

This page intentionally left blank

# FAILED URBAN MIGRATION AND PSYCHOSOMATIC NUMBING: CORTISOL, UNFULFILLED LIFESTYLE ASPIRATIONS AND DEPRESSION IN BOTSWANA

Seamus Decker

## ABSTRACT

*The impact of globalization on individual well-being through the interplay of self and standard forms of lifestyle aspirations, has generally received less attention than the merits of globalization at the macro-level. This chapter addresses this question by testing the hypothesis that poor rural-dwelling Botswana men suffer diminished well-being compared to their relatively well-off urban-dwelling counterparts as a result of unfulfilled lifestyle aspirations. The study combines ethnographic, psychological, and psychosomatic data to compare well-being among rural and urban adult Botswana men. Results indicate that failed urban migration associates with low cortisol and high depressive affect, and rural residence is also independently associated with high depressive affect. This psychosomatic syndrome may be similar to that observed in posttraumatic stress disorder, suggesting that the experience of failed urban migration is*

---

The Economics of Health and Wellness: Anthropological Perspectives

Research in Economic Anthropology, Volume 26, 75–102

Copyright © 2008 by Elsevier Ltd.

All rights of reproduction in any form reserved

ISSN: 0190-1281/doi:10.1016/S0190-1281(07)26004-4

*considerably more stressful than the demands of employed urban life in contemporary Botswana.*

*A city is a place where there is no need to wait for next week to get the answer to a question, to taste the food of any country, to find new voices to listen to, and familiar ones to listen to again (Margaret Mead, from a plaque in the Cleveland International Airport).*

## INTRODUCTION

### *Globalization Socioeconomic Status and Well-Being*

Since the 19th century, social scientists recurrently have questioned the impact of acculturation into global capitalism on individual well-being (Fischer, 1984). Much work in developmental economics indicates that the forces of globalization positively affect human well-being in many specific instances (Hutchinson, 2006). However, debates about the relative merits and specific effects of macro-level forces such as corruption, free market versus state-regulation, and social and fiscal policy continue in various academic disciplines and interests groups (Epsteina, Howlett, & Schulze, 2007). From a utilitarian standpoint, the 3.2% world economic growth rate since 2000 is better than the “supposedly idyllic 1950s and the 1960s” (*Economist*, 2006, p. 13). However, the value of a strictly utilitarian perspective for accounting the impact of acculturation and globalization has itself been brought into question. For example:

Market capitalism, the engine that runs most of the world economy, seems to be doing its job well. But is it? Once upon a time, that job was generally agreed to be to make people better off. Nowadays that's not so clear. A number of economists ... and politicians ... think that it ought to be doing something else: making people happy (*ibid.*).

According to Sen (1987a) utilitarian models of “the standard of living,” are based on one of three distinct currencies: pleasure, desire fulfillment, or choice. Sen and others (e.g., Niles, 1999; Willis, 1977) have argued that because of false consciousness and learned helplessness, pleasure, desire, and choice are all insufficient measures of the standard of living. All three “tend to reflect the distortion of idiosyncratic circumstance” (Sen, 1987a, p. 7):

Consider a very deprived person who is poor, exploited, overworked, and ill, but who has been made satisfied with his lot by social conditioning (through, say, religion, or political propaganda, or cultural pressure). Can we possibly believe that he is doing well just because he is happy and satisfied? (*ibid.*, p. 8)

The absence of desire is similarly problematic, “the battered slave, the broken unemployed, the hopeless destitute, the tamed housewife, may have the courage to desire little, but the fulfillment of those disciplined desires is not a sign of great success” (*ibid*, p. 11).

Some degree of opulence or means to fulfill basic needs is clearly a *necessary condition*, but not necessarily a *sufficient condition* of the standard of living. Opulence in excess of a minimum to maintain life and health may afford increasing benefits of various types, including better quality or quantity of commodities or services, better information, better predictability, more options, or a more satisfying range of subjective satisfaction. However, achieving and maintaining higher levels of opulence may involve tradeoffs with well-being, as argued in the following quote:

In 1939, John Maynard Keynes imagined that richer societies would become more leisured ones, liberated from toil to enjoy the finer things in life. Yet most people still put in a decent shift. They work hard to afford things they think will make them happy, only to discover the fruits of their labour sour quickly. They also aspire to a higher place in society's pecking order, but in so doing force others in the rat race to run faster to keep up. So everyone loses. (*Economist*, 2006, p. 13)

In a highly unequal society, in which an affluent person lives among large numbers of disenfranchised, and potentially hostile compatriots, affluence may in fact act as a source of anxiety, fear, and distress. By virtue of processes like these, a more affluent person may actually suffer greater psychosomatic stress, and increased risk of chronic degenerative disease, or psychiatric and behavioral disorders.

Sen concluded that opulence, and the commodities or services afforded by opulence are significant in terms of their relative value to an individual in a specific context, but not necessarily in terms of some absolute sense of utility, beyond the minimum necessary within a specific context:

The need of commodities for any specified achievement of living conditions may vary greatly with various physiological, social, cultural and other contingent features ... The value of the standard of living lies in the living, and not in the processing of commodities, which has derivative and varying relevance. (Sen, 1987b, p. 25)

For example, a Paleolithic hunter-gatherer would be considered a very destitute person by any absolute utilitarian standard of living derived from contemporary industrial contexts. Nonetheless, ethnographic analogy and some archeological case studies make a compelling case that many such societies were better off in terms of health than their descendants, if not more egalitarian and happier (Goodman & Armelagos, 1985).

Therefore, Sen argued that “well-being” should be the focus for questioning the relative merits of globalization and identified three separate elements to well-being: “(1) agency achievement; (2) personal well-being; and (3) the standard of living” (Sen, 1987b, p. 28). Agency achievement is distinguished because “a person may have objectives other than personal well-being” (*ibid.*); for example, serving the interests of their family or society even to the point of sacrificing their own health, or longevity. Personal well-being must be distinguished from the standard of living because even the most affluent people can suffer despite having ample resources and power. For example, the loss of a beloved, even in a condition of undiminished living standard, can have a considerable negative impact on well-being. “One’s well-being may be affected through various influences, and it is the assessment of the nature of the life the person himself leads that forms the exercise of evaluation of the living standard” (*ibid.*, p. 27). Sen’s perspective as an economist seeking more valid models for assessing globalization are paralleled by work in bio-cultural anthropology on psychosomatic “stress” and social change.

In recent years, some bio-cultural anthropologists have argued that emerging incongruities in cultural norms resulting from social changes consequent to modernization, migration, or urbanization cause heightened psychosomatic stress and illness (e.g., elevated blood pressure and depression) (Dressler, 2004; Pollard et al., 2000). But a simpler interpretation is that “employment status is a better indicator of well-being than the residential changes involved with relocation” or change in social norms (Desjarlais, Eisenberg, Good, & Kleinman, 1995). The central theoretical question here is whether the more important determinant of psychosomatic well-being and health is: (i) failure to achieve a minimal standard of living (in absolute terms) that results in deprivation of some basic needs or (ii) failure to achieve a relative – “emic” or perhaps idiosyncratic – standard of living emergent through ongoing acculturation of developing societies. This study addressed this question by testing the hypothesis that poor rural-dwelling Botswana men suffer diminished well-being compared to their relatively well-off urban-dwelling counterparts as a result of unfulfilled lifestyle aspirations.

### *Summary of the Study and Research Findings*

This chapter reports findings from a bio-psycho-social case study comparison of 25 rural and 29 urban Botswana men using multiple

operationalizations of well-being and social and economic status. The study was based on an ethnographic examination of depressive affect, lifestyle, lifestyle aspirations and economic life history, and chronic salivary cortisol as a biomarker of “stress.”

Botswana was an excellent place to conduct such a study because it is in many ways a “best case scenario” of a developing nation (Holm, 1994). Although large parts of the populace are among the poorest people in the world, Botswana as a nation is wealthy (Curry, 1987). Even the poorest of the “remote area dwellers” have benefited from this national prosperity to some extent, mostly in the form of education, health care, and transport (Alverson, 1978). There is an enduring tradition in Tswana society of amassing a herd as a commoditization of male social power. Agro-pastoral commodities have remained an important part of Tswana worldviews about male status (Comaroff & Comaroff, 1990). But, with increasing literacy, professionalization, and urbanization in the major cities (Gaborone, Molepolole, and Francistown), the tradition of male urban labor migration has come to play a perhaps equal or alternative role in male pursuit of adult status and social prestige (James, 1992). Indeed, one can trace through Tswana ethnographies dating back throughout the historical period the theme of labor migration as an informal male rite of passage (Schapera, 1934; Wilmsen, 1989).

This study found that failed urban migrants had significantly higher depression scores and significantly lower salivary cortisol than did non-failed urban migrants. Also, rural residents had significantly higher depression scores than did urban residents. The psychobiological syndrome observed among failed urban migrants (low cortisol and high depression) resembles posttraumatic stress disorder (PTSD) (Brunello et al., 2001; Palmer, Kagee, Coyne, & DeMichele, 2004). It is possible that the psychosomatic syndrome observed reflects long-lasting psychobiological reorganization stemming from the psychologically traumatic experience of failed urban migration (Rohleder, Joksimovic, Wolf, & Kirschbaum, 2004; Yehuda, Resnick, Kahana, & Miller, 1993). This interpretation is supported by cultural models data, which indicate that rural residents and failed urban migrants do not differ from their successful urban counterparts in their lifestyle aspirations. However, an alternative explanation that cannot be dismissed based on the data available is that the observed association between psychosomatic stress, failed migration, and residence are the result of a selection bias. Persons whose temperamental or developmental backgrounds predisposed unrealistic lifestyle aspirations may consequently have been more prone to fail as workers and to suffer



psychosomatic disturbance. Fully addressing causation requires that a developmental, if not a longitudinal life history research design be adopted in future work.

The study supports the idea from bio-cultural studies of social change in developing countries that incongruities between lifestyle aspirations and lifestyle achievements (termed “status incongruity”) resulting from rapid economic changes are implicated in increased psychosomatic disturbance and diminished well-being (McDade, 2002). Anthropologists and economists should seek to consider the influence of status incongruity on well-being in a variety of socio-cultural contexts undergoing rapid social change. The patterns observed in Botswana may neither hold true in developed nations, nor in other distinctive developing nations. In developing nations depression may be higher in urban residents than in rural or peri-urban residents as a result of less time pressure and/or less competitiveness. Alternatively, the much less dramatic urban–rural differences in many developed nations may mean that there are fewer urban–rural differences.

## SOCIOECONOMIC STATUS AND WELL-BEING

How is it that wealth or lack of wealth influence human well-being? In many instances, achieving and maintaining wealth may require considerable effort and competition. On the other hand, possessing the means to consistently acquire the basic necessities of life (adequate hydration and nutrition, shelter from the elements and physical harm, and some degree of social or existential fulfillment) is clearly requisite for human well-being. Obviously, there is some absolute minimum that limits the lower boundary of the standard of living. Improvements on this minimum arguably will tend to have a graded benefit to the life functions which they influence. But the more important point is that, there is an immense range between the minimum standards to survive, or thrive as a human being, and the highest possible levels of SES. Within such a wide range, a variety of complex relationships may exist between the forces that contribute to wealth and the forces that shape well-being. In a milieu with escalating or accelerating rates of wealth acquisition, well-being may be negatively impacted from increasing SES from “inequality, over-work and other hidden costs of prosperity” (*Economist*, 2006, p. 13):

There are many fundamentally different ways of seeing the quality of living, and quite a few of them have some immediate plausibility. You could be *well off*, without being well.

You could be *well*, without being able to lead the life you *wanted*. You could have got the life you *wanted*, without being *happy*. You could be *happy*, without having much *freedom*. You could have a good deal of *freedom*, without *achieving* much. We can go on. (Sen, 1987a, p. 1)

Social epidemiological evidence from a variety of societies indicates that there is a positive association between socioeconomic status (SES) and better health (Adler & Osgrrove, 1999). The beneficial effects of SES on health are generally not attributable to selection bias (Wilkinson, 2000), so there do appear to be real gradations of benefit to human well-being from increasing SES.

However, at higher levels of SES, relative if not “emic” standards (e.g., incongruity between expectations and achievement) may be more important determinants of how SES influences psychosomatic well-being and health (Marmot & Wilkinson, 2001). Material deprivations of poverty may also be exacerbated by increased psychoneuroendocrine (PNE) arousal resulting from disparity in lifestyle expectations and actual lifestyle achievement (Dressler, 1995; Wilkinson, 1999). Consequently, conditions of economic growth and “progress,” such as that shown by the 3.2% world economic growth rate since 2000 (*Economist*, 2006, p. 13) mentioned at the outset, might actually *compromise* well-being as much or more than increasing opulence improves well-being. This could result from at least two distinctive processes: (1) increasing intra-population disparity in wealth distribution, i.e., inequality or (2) incongruity between expectations and reality, termed “status incongruity.”

Status disparity and incongruity may increase predisposition to illness through increased PNE arousal (Gold & Chrousos, 2002; Worthman, 1999). PNE mechanisms that may link status disparity and incongruity to health include glucocorticoid secretions (e.g., cortisol) of the hypothalamic pituitary adrenal (HPA) axis (Flinn, 1999; Flinn & England, 1996), increases in blood pressure and heart rate by the autonomic nervous system (James, 2001; McGarvey, 1999), and catecholamine secretions by the sympathetic adrenal medullary axis (James & Brown, 1997).

The status disparity/incongruity model is supported by the finding that, health differences between populations are better accounted for by the difference in wealth disparity *within* populations than by the difference in mean affluence *between* populations (Marmot, 2002). It is also suggested by evidence that “affluent countries have not got much happier as they have grown richer” (*Economist*, 2006, p. 13). There are clear benefits to health from being economically better off and quantitative evidence of a gradient of SES benefit to health. But such benefits may, under specific

circumstances, be offset by increased anxiety and psychosomatic arousal resulting from living in a social milieu with extreme SES disparity among group members (Stansfeld, Fuhrer, Shipley, & Marmot, 2002), else from the increased levels of demand or competition.

The underlying point is that, more opulence does not necessarily lead to more well-being, and low but sufficient opulence does not necessarily lead to less well-being. Commodities are means to an ends within a particular socioecological context, the ends being termed by Sen “functionings” and the means “capabilities.” Sen argued that “the standard of living is really a matter of functionings and capabilities, and not a matter directly of opulence, commodities, or utilities” (Sen, 1987a, p. 16). In short, the salient matter is neither simply having more wealth, nor what more wealth can do, but the:

social nature of the relationships between commodities (and opulence), on the one hand, and capabilities (and achievements in living conditions), on the other hand. The same capability of being able to appear in public without shame has variable demands on commodities and wealth, depending on the nature of the society in which one lives. (*ibid.*, p. 17)

More wealth can generally afford better living conditions, but it may also result in heightened anxiety, increased psychosomatic stress, and social anomie as a result of more intense competition, or social alienation between haves and have-nots. Poverty cannot buy happiness or well-being, but increasing wealth may not be so good for buying it either.

Large social epidemiological surveys have shown an association between intra-population status disparity and population health. However, large survey data are inadequate to examine the cognitive and psychobiological dimensions of individual adaptation to differential affluence within local cultural contexts of global economic change (Burleson et al., 2002; Kahn, 2001; Wilce Jr., 2003). Thus, the purpose of this study was to test the hypothesis that poor rural-dwelling Botswana men suffer diminished well-being compared to their relatively well-off urban-dwelling counterparts as a result of unfulfilled lifestyle aspirations. The rural–urban case study comparison described here presents one possible ethnographically based bio-psycho-social approach exploring the effects of SES on lifestyle aspirations and well-being.

### *Psychoneuroendocrinology of Status and Status Seeking Behavior*

Research on the epidemiology of status incongruity and health is paralleled by research on the bio-psycho-social origins of stress among nonhuman

primates (Sapolsky, 1999), and a few analogous studies among humans (Decker, Flinn, England, & Worthman, 2003; Seeman & McEwen, 1996; Steptoe et al., 2003). Associations of psychosocial status with PNE stress appear to be largely accounted for by aggressive competition and feelings of control (Griffin, Fuhrer, Stansfeld, & Marmot, 2002). For example, under conditions of social instability and frequent aggressive contest, cortisol levels have been found to be either positively associated with dominance (Cavigelli, 1999; Saltzman, Schultz-Darken, Wegner, Wittwer, & Abbott, 1998) or elevated among group members in general (Sapolsky, 1983). When social power is negotiated through less aggressive interactions such as bluff, intimidation, and alliance-manipulation, a negative association has typically been found between social power and non-reactive HPA secretion levels (Booth, Shelley, Mazur, Tharp, & Kittok, 1989; Sapolsky, 1990).

My past work among adult men in Dominica replicated earlier findings from research among nonhuman primates. This research in Dominica was a bio-psycho-social case study of stress and status in a rural village where wealth disparity is quite low, and successful horticultural subsistence depends on reciprocal labor exchange. The primary finding of the study was that cortisol was negatively associated with peer-ratings of friendship/popularity but not associated with material wealth (Decker, 2000). This study also showed that adherence to group lifestyle norms, and less adverse childhood development associates with significantly lower cortisol among adult men in Dominica (Decker, Flinn, England, & Worthman, 2003). On the whole, past work among both human and nonhuman primates indicates that it is the perception of an experience as “threatening,” or perhaps more inclusively as threatening a loss of reward,<sup>1</sup> which ultimately seems to determine whether the experience results in increased neuroendocrine response (Kirschbaum, Klauer, Flipp, & Hellhammer, 1995; van Eck, Berkhoff, Nicolson, & Sulon, 1996).

Various conceptualizations of psychological vulnerability have been shown to moderate the influence of social experience on stress (Brown, Tomarken, Orth, Kalin, & Davidson, 1996; Vickers, 1988). For humans, worldview influences both how individuals experience their social identity within a society, and their relative risk for exposure to various social or environmental circumstances which may be threatening. Thus, it is also not surprising that a number of bio-cultural studies have shown that attitudes about social and economic status and cultural identity influence biological stress response (Bindon, Knight, Dressler, & Crews, 1997).

## BOTSWANA ETHNO-HISTORICAL CONTEXT

Botswana was a good location for this study for two reasons. First, there is extreme intra-national socioeconomic disparity, with a national GINI coefficient in 2006 estimated at 63 (*Economist*, 2007). Botswana has high unemployment (23.8%) (Curry, 1985, 1987), high poverty (30.3%), and the second highest HIV/AIDS adult prevalence rate in the world (37.3%) (Central Intelligence Agency, 2007). Second, Botswana has been largely spared a history of social turmoil, warfare, famines, violence, and ethnic-conflict, thanks to a high level of national wealth and moderate fiscal and political policies (Datta & Murray, 1989; Forster, 1981). Despite the extreme disparity in SES, the nation has not been ravaged by the common social cataclysms that have plagued many post-colonial nations (Campbell, 1990), the effects of which would represent a serious confound for the research hypothesis.

Botswana's pre-independence colonial experience has been labeled as "benign neglect" (Charlton, 1991), and Botswana is touted as one of "Africa's success stories." In 1966, the nation achieved non-violent political independence from the British Commonwealth. Since then, it has shown a history of consistent multi-party democracy, along with steady national economic growth and infrastructure development, and intolerance for corruption. Citizens have benefited from social welfare measures modeled after the Scandinavian nations including state-sponsored primary school and secondary school (Good, 1994; Molomo & Mokopakgosi, 1991; Molutsi, 1987).

Botswana has been one of the most rapidly developed nations in Africa, and social changes in recent decades are numerous: sudden and dramatic urbanization; expanding cash economy; rapid macroeconomic and infra-structural development; increasing exclusive reliance on wage-based employment; widespread access to primary education; implementation of state-provided health care; rapid population growth; and falling infant mortality (Curry, 1987; Somerville, 1994). Despite rural-urban transhumance and interreliance, more rapid changes in cities appear to have created socioecological disparities between rural and urban communities more striking than those that exist in most industrialized nations. Some Botswana journalists, politicians, and playwrights have denounced urbanization and social change for causing increases in various social crises (Jarle, 1994; Kent, 1995; Perry, Chapman, & Snyder, 1995). Social changes resulting from rapid urbanization have commonly been seen as problematic for African societies (Dubb, 1974; Gutkind, 1969; Schapera, 1934). However, there is a lack of

sound evidence to compare and contrast the costs and benefits of differential degrees of urbanization in African societies.

European contact with the Tswana began in the early 17th century. Post-contact Tswana history has been predominated by transformations of traditional social structures – ancestral religion; chiefly authority; kin-based society; extended family, community cooperation; subsistence agriculture; and community economic self-sufficiency – into European mercantile, and subsequently capitalist social structures. This includes the conversion to Christianity; creation of a national bureaucracy and political authority; imposition of market-based exchange and taxation; increased individuality and individual autonomy; and rural underdevelopment and “proletarianization” (Central Statistics Office, 1988; Comaroff, 1978, 1995; Comaroff & Comaroff, 1991; Molutsi, 1991; Vengroff, 1975; Watanabe, 1984). The impact of such transformational processes has often been attributed as being relatively greater in urban than rural areas (Schapera & Comaroff, 1991).

Although urban areas have transformed in more ways, and more profoundly than have remote rural areas, the repercussions of social transformations in Tswana society as a result of European encroachment have in fact permeated the entire society. Indeed, Wilmsen (1989) argued convincingly from archeological evidence, that socioeconomic transformations from European trade predated the first European travelers in the area by many decades if not centuries, as a result of trade networks stretching through East Africa, and up the Nile Valley. Cumulatively, Europeanization and more recently globalization have contributed to the emergence of certain novel social traditions in Setswana culture. Most notably with respect to the present study, there has been an historical increase in a tradition of urban migratory work as a male rite of passage (Brown, 1983; Comaroff, 1995).

During the late 19th and early half of the 20th century, it became a sign of distinction and adult competency for Setswana men from rural areas to travel to work in an urban area, but more commonly to work in mines in the Republic of South Africa (Schapera, 1934). Successfully negotiating the social and physical challenges of the migrant, laborer became a marker of adult male prestige, status, and respect, even if the actual monetary rewards of such work proved to be relatively negligible.

## METHODS

This study compared cortisol, depression, SES, and lifestyle aspirations among randomly recruited healthy adult men (ages 20–58 years, median age

32 years) in two economically disparate communities, Botsheka ( $n=25$ ) a remote-rural subsistence-farming village (Pop. 500), and Gaborone ( $n=29$ ), the capital of Botswana (Pop. 150K). During 15 months of ethnographic fieldwork the following interview methods were used in dual Setswana-English format: (1) the Beck Depression Inventory (BDI) (Cronbach's Alpha ( $\alpha=0.84$ )) and (2) semi-structured interviews about lifestyle, economic life history, social networks, and attitudes toward social change and lifestyle aspirations. Field methods also included twice-daily visits to each participant to observe daily life history experience, and to collect ambulatory un-stimulated saliva samples (min=7.2, mean=12.4 samples per participant) which were transported back to university laboratories and analyzed for cortisol content using a radioimmunoassay procedure. Unusually, low or high cortisol is widely regarded as a reliable and valid indicator of psychosomatic stress, or failure to optimally adapt (Decker, 2006).

### *Salivary Cortisol*

Many studies indicate that, stimuli that are perceived as psychosocially threatening provoke increased HPA activity (Dickerson & Kemeny, 2004) resulting in fluctuations in cortisol levels that are measurable in saliva. While acutely or chronically elevated cortisol has received the most attention as a "biomarker of stress," chronically low cortisol levels have been increasingly recognized as a possible consequence of chronic hyper-reactivity by the HPA (Young, Tolman, Witkowski, & Kaplan, 2004). Thus, either unusually high or low cortisol may be indicative of psychosomatic stress depending on the type of stressor, the duration of past exposure, or specific vulnerabilities of the individual. Debates are ongoing about why "stress" is manifested as acute or chronically elevated cortisol in some studies, and apparently as chronically if not acutely low cortisol in others (Decker, unpublished manuscript).

In the absence of acute stimuli that provoke an increase or decrease in cortisol level, individual cortisol levels vary as a function of time of day, with highest levels shortly after awakening and an overall drop in levels during the course of the day. Therefore, single point measurements are insufficient to estimate either naturalistic intra-individual variability, or mean level (Coste, Strauch, Letrait, & Bertagna, 1994), and it is preferable to take measurements on multiple days, and at least two different times each day.

In this study, a repeated measures approach was taken, and estimates of individuals' median cortisol level were derived from a hierarchical linear



regression model of cortisol by time of day. An attempt was made to collect a total of 14 saliva samples from *each* subject: a morning sample and an evening sample, each day, for seven days. Additional details of this sampling approach and the radioimmunoassay procedure are available in previous publications (Decker, 2006).

### *Interview and Questionnaire Instruments*

Participants who were literate preferred to complete questionnaires autonomously, but at least two interviews of between one and two hours duration were conducted with all participants either to complete all questionnaire items, or to clarify responses which they had written themselves. All questionnaire items were presented in both English and Setswana translation, and for participants who were not fluent in English, a bilingual interviewer was present.

A 15-item semi-structured questionnaire was used to gather information about each participant's life history, with a particular focus on their economic and educational experiences. Semi-structured items dealt with the following topics: number of children and dependents; years of school completed or specialized training completed; yearly income; marital status; birth date and location; number of siblings and relationship with parents; parents occupations; and caretakers, and location of residence during childhood. Two open-ended items dealt with the following: What places have you lived in your life? What jobs have you done in your life?

Based on responses to these two open-ended questions, and cross-referenced with responses to other items, it became obvious that, in addition to urban-rural residence, participants' economic life histories belonged in one of the two categories: attempted urban migration with success (sometimes returning to live in their rural natal village) ( $N=39$ ); and attempted urban migration with failure, and subsequently had to return to live in their natal rural village as a "failed urban migrant" ( $N=15$ ). Table 1 shows the number of men in each life history category cross-tabulated by place of residence.

Based on interviews, the common factor distinguishing failed urban migration from success was whether the migrant was able to attain and maintain a source of cash income adequate for self-sufficient living in the city within six months of arrival. In some cases, failed migrants were able to live in the city and subsist from gratuities or allowances from friends or family for nearly a year. But in every case where a migrant was unable to



**Table 1.** Proportions of Participants Whose Interview Responses Placed them into Each of the Four Economic Life History Categories (*N* = 54; Rural Residency at Time of Study *N* = 25; Urban Residency at Time of Study *N* = 29).

Source	Rural Resident	Urban Resident
Migrated successfully	12	27
Failed urban migrant	13	2
Employed	10	25
Unemployed	15	4

gain and keep employment for the first six months, ultimately he was forced to return to live in his home village because of unwillingness by friends of family to continue to support him.

The BDI and all other instruments were first translated by a bilingual research assistant from English into Setswana, and then back translated by a second assistant to correct errors. This process revealed problems with rendering a non-ambiguous and concise translation for BDI item eight “self-accusations” and consequently this item was excluded from the scale, resulting in a total of only 20 items instead of the normal 21. Cronbach’s Alpha ( $\alpha=0.839$ ) based on pair-wise correlations among all 20 items in the BDI used in this study indicates high internal reliability and validity for the measure ( $\alpha=0.795$  for urban subjects calculated separately, and  $\alpha=0.801$  for rural subjects calculated separately).

*Analyses*

Median salivary cortisol and BDI scores were both tested separately as dependent variables, with the following variables as predictors: income, migration history, employment status, and residence status. The categorical independent variables (treated as random effects dummy variables) in this study were: urban/rural residence; employment/unemployment status; and history of failed/non-failed urban migration. The ordinal- else ratio-scale independent variables were: age (control variable); estimated yearly income (\$US equivalents); median-adjusted income (control variable); and BDI score. The influence of independent variables on each of the two dependent variables was assessed using a backwards stepwise multi-variate general linear regression analyses using a licensed version of the Systat 10.2

**Table 2.** Regression Statistics Comparing Depression by Urban–Rural Residence and Failure–Success of Urban Migration Attempts ( $N = 54$ ,  $R^2 = 0.403$ ). Rural Residents and Men with a History of Failed Urban Migration Attempts Tend to Have Higher Depressive Affect.

Source	df	<i>F</i>	$\eta$	<i>p</i>
Residence	1	6.83	2.9	0.012
Migration	1	10.43	4.0	0.002
Error	51	–	–	–

*Note:* Neither income, nor employment status, nor any interaction effects achieved partial  $p$ -value  $\leq 0.24$  when included in the model with migration history and current residence.

**Table 3.** Regression Statistics Comparing Time-Standardized Mean Salivary Cortisol by Failure–Success of Urban Migration Attempts ( $N = 54$ ,  $R^2 = 0.177$ ). Men with a History of Failed Urban Migration Attempts Tend to Have Lower Salivary Cortisol.

Source	df	<i>F</i>	$\eta$	<i>p</i>
Migration	1	11.17	–0.189	0.002
Error	52	–	–	–

*Note:* Neither urban–rural residence, nor income, nor employment status, nor any interaction effects achieved partial  $p$ -value  $\leq 0.16$  when included in the model with migration history.

statistical package (Kleinbaum, Kupper, & Muller, 1988; Wilkinson, Hill, & Vang, 1992). The influence of age and standardized income were examined as control variables and all possible interactions among residence, migration history, employment status, and income were tested. Starting models included all variables, and variables were subsequently removed in a stepwise fashion, with alpha levels of  $\geq 0.05$  and tolerance of  $\leq 0.70$  (measure of multi-collinearity) as criteria for removal. The results of these stepwise procedures for median cortisol and depression score are discussed below, and summarized in Tables 2 and 3.

RESULTS

Analyses revealed that spurious negative associations of income and current employment status with depression were accounted for by urban

migration history and rural residence. As shown in Table 2 men who had succeeded in one or more attempts to gain employment and establish residence in a city reported significantly lower depressive affect  $F(1, 53)=10.43, p=0.002$  than men who had failed at urban migration attempts.

Current urban residence was also independently associated with lower depressive affect  $F(1, 53)=6.86, p=0.012$  relative to current rural residence. Men who were currently employed reported lower depressive affect than men who were not, but this factor was insignificant  $F(1, 53)=0.02, p=0.9$  when included in the same model with migration history.

Table 3 presents the regression statistics comparing median cortisol between men who were failed migrants and men who were non-failed migrants. Men with a history of failed urban migration attempts tend to have lower salivary cortisol  $F(1, 53)=11.17, p=0.002$  than men who had failed in such attempts, even when such “non-failed migrants” were currently unemployed out of preference for a rural agro-pastoral subsistence lifestyle, or of lower income, or both.

Unemployed men and failed migrants reported significantly lower income. However, when included in the model with residence and migration factors, neither unadjusted, nor median-standardized income showed any association with depression  $F(1, 53)=1.33, p=0.26$  or cortisol. All possible interactions among residence, migration history, employment status, age, and unadjusted and standardized income were tested and none exceeded  $p\text{-value} \leq 0.16$  as predictors of either depression or salivary cortisol. Both of the two urban residents who had not found steady work for the previous six months (see Table 1) and were categorized as “failed urban migrants,” departed the city to return to their rural natal village shortly after participating in the study. Both of these men had high depression and low cortisol. There were two other urban residents who had been unemployed for two and four months, respectively, so neither was categorized as a “failed migrant.” However, both these men showed incipiently high depression and low cortisol (Fig. 1).

In sum, residence in the rural village and the past experience of having tried and failed at an attempt to migrate into the city for employment accounted for 40% of the variation in depressive affect, and 17.7% of the variation in salivary cortisol. In contrast, employment status and income did not account for variation in depressive status or salivary cortisol as long as residence and migration history were included.

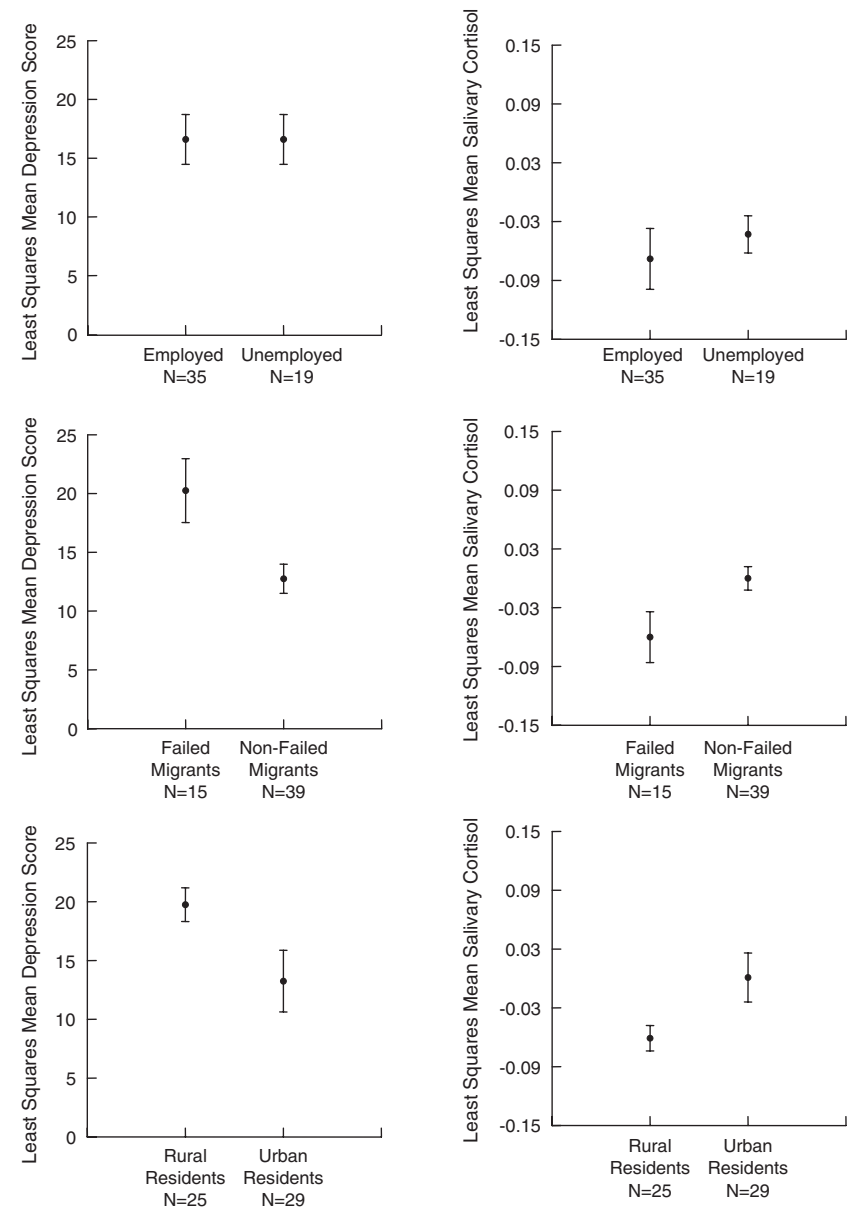


Fig. 1. Left: Least Squares Mean Scores from the Bilingual Translation of the Beck Depression Inventory with Standard Errors (Regression Statistics are Shown in Table 2). Right: Least Squares Mean Salivary Cortisol Scores with Standard Errors (Regression Statistics are Shown in Table 3).

## DISCUSSION

### *Psychosomatic Failure Syndrome: Possible Etiologies and Explanations*

Results are generally supportive of the hypothesis that poor rural-dwelling Botswana men suffer diminished well-being compared to their relatively well-off urban-dwelling counterparts as a result of unfulfilled lifestyle aspirations. The higher depressive affect and lower cortisol suggest that failed urban migrants and rural residents suffer more severe psychosomatic disturbance than those who did not fail at past urban migration attempts and live in the city.

The psychosomatic pattern of low cortisol with depressive affect is similar to that which has been observed in a growing number of reports in which chronically low cortisol is increasingly seen as being diagnostic of some subtypes, else etiological stages of depressive disorders, lumped under the term “atypical depression” (as opposed to “melancholic depression” in which HPA is elevated) (Strickland et al., 2002). This cluster of depressive types may have overlapping symptomology, or etiology with PTSD, and PTSD-like ailments such as chronic fatigue syndrome (Heim, Ehler, & Hellhammer, 2000).

Mason and colleagues have argued that lowered HPA levels in PTSD are a manifestation of a secondary compensatory psychosomatic numbing in response to primary symptoms involving shame-laden guilt and recurrent reliving of the past negative event (Mason et al., 2001). This conclusion is supported by findings in experiments that induced self-blame (Dickerson & Kemeny, 2004). Although persons suffering psychosomatic numbing syndrome may have *chronically low levels of HPA response*, exposure to reminders of the past trauma which precipitated the syndrome (e.g., reminders of childhood abuse) may actually evoke *increased acute episodic HPA reactivity* (Elzinga, Schmah, Vermetten, van Dyck, & Bremner, 2003).

Given the importance of labor migration as a marker of adult male prestige in Botswana, it is speculative, though possible, that the experience of failed urban migration may result in primary symptoms of shame-laden guilt and recurrent reliving of the past negative event, consequently leading to the observed pattern of secondary compensatory “psychosomatic numbing” (low cortisol and high depression). Unfortunately in this study, no systematic data were collected that can adequately confirm or deny such an etiological model. As noted above, successful urban migration is a rite of passage for adult Botswana men. Therefore, failing to migrate into a city to

find semi-permanent work in and of itself may be the cause for the observed psychosomatic numbing among failed urban migrants, with rural residence acting as a predictor through similar identity or status incongruity mechanisms. Future investigators should consider collection of a simple PTSD symptom checklist, and life history items that might help to assess the influence of failed urban migration or other past traumatic economic life history events as etiological forces in the psychosomatic syndrome observed.

When the effects of residence and migration history were included in the multi-variate model, there was effectively no association between income and either cortisol or depression. This finding suggests that, it is not absolute status deprivations resulting from failed migration or rural residence that are the determinants of heightened psychosomatic stress. It appears that, while failure *is stressful*, success does not show clear signs of ameliorating stress beyond a threshold of benefit from not-failing. In this particular segment of Tswana society, “success” is evidently deeply tied up with achieving urban residence and successful migration. The patterns observed in this study may neither be found in developed nations, nor in other distinctive developing nations. In developing nations depression could be higher in urban residents than in rural or peri-urban residents as a result of less time pressure and/or less competitiveness in rural settings. Alternatively, less pronounced urban–rural differences in developed nations may mean that there are fewer urban–rural differences in status incongruity, PNE status, and well-being.

It is also possible that these findings are the result of a selection bias in which individuals with temperamental or developmental predispositions to the observed psychosomatic pattern are also more likely to fail at labor migration, and to return to rural residency. What is needed to conclusively address this alternative explanation are retrospective data on childhood temperament and development, or ideally a longitudinal research design that follows participants from childhood onward.

### *Social Change and Incongruities in Expectations and Achievements*

Interview responses to open-ended items about lifestyle aspirations indicate that the psychosomatic numbing observed among failed-migrants and rural residents is associated with unfulfilled lifestyle expectations. While not conclusive, this suggests that the experience of failure and unfulfilled expectations is involved in the etiology of psychosomatic numbing. In

response to the question "What do you worry about most?" 15 of 15 men who were failed urban migrants reported that, not having a job for money was what they worried about most  $\chi^2 = 12.22$ ,  $p < 0.001$ , whereas 20 of 39 men who were non-failed migrants reported that they worried most about things other than a job or money (e.g., disliking their community, gossip and fights, health, finding a female partner, or insuring the well-being of their family). In response to the query, "What do you have to do to be happy with life in Botswana?" 13 of 15 failed urban migrants said that a job or money was most important  $\chi^2 = 4.7$ ,  $p < 0.03$ , whereas 15 of 39 non-failed migrants said that things other than a job or money were most important (e.g., getting along with other community members, farming or herding, or a good relationship with wife or family).

Although the causal process remains unclear, overall the qualitative ethnographic evidence suggests that psychological disturbance resulting from unfulfilled lifestyle expectations in the context of rapidly modernizing Botswana accounts for more variation in PNE stress process (cortisol level and depression) than does absolute material affluence. Interview data on attitudes indicate that this rural stress syndrome results from feelings of lifestyle dissatisfaction, and a sense of personal failure. These characteristics of worldview may be the consequences of childhood socialization appropriate for becoming an adult rural herd man, versus adult aspirations to become an urban worker. Rural men's responses in unstructured interviews and participant observation indicate that the cognitive vulnerability factors shaping this psychosomatic failure-stress syndrome emerge through life histories guided by unrealistic aspirations for affluence coupled with failure to achieve such aspirations because of poor preparation to succeed as urban workers.

Many rural participants' discourse suggested profoundly inaccurate appraisals of the tradeoffs involved in life as a successful urban wage-earner, including time-allocation requirements, leisure opportunities, competitive demands, and role inflexibility. A number of men recounted stories of their failed urban migration attempts which clearly were painful memories for them. Many rural men evinced seemingly disingenuous naivety about why their previous urban employers had terminated their employment because of recurrent tardiness, lack of attention to detail, blatant laziness, or arriving for work intoxicated. Recurrently men conveyed lingering senses of confusion and betrayal that their attempts to become a "Town Man" had been thwarted by bosses who fired them for behaviors that were perfectly normal when tending to livestock at rural cattle posts (e.g., tardiness, laziness, or intoxication at work). This confusion reflects the

dramatic differences between the texture of daily life for Tswana herdsmen, and life as a time- and role-constrained urban worker.

Life for many rural men and boys is highly unstructured, and lacking in time-constraints, or production-related competitiveness. The majority of failed urban migrants reported that, they had often missed school as a boy in order to spend weeks or months at a time tending to the herds of an older male relative at a remote cattle post. Life as a herder is characterized by long stretches of inactivity, spent in relaxed daily social interactions with friends and relatives (playing games, drinking beer, and singing), and little sense of production-related competitiveness, industriousness, or ambition. Most herders seek to engage in daily “shebeens,” comprising sociable beer parties in which a communal cup of traditional beer is passed around. Life as a herder is dramatically different from the life of an urban worker given that herding involves ample leisure opportunity with minimal daily time-constraints, minimal competitive demands, virtually no focus on production quality or efficiency, and very little role of inflexibility.

Often failed urban migrants recounted stories exemplified in the following synthesis of comments from rural unstructured interviews:

It is no longer possible to be a farmer, success is in the city ... My relatives in town have jobs, and they can buy nice things ... It is silly to be “traditional” ... Even if I did have a big herd, and work hard each year where will it get me!? Large herds die in drought just like small ones, but in town the drought does not matter to them ... Boitumelo [former girlfriend] went to town to marry a Town Man who has a good job and can buy her things. But, how can I get a job in town!? At the hotel, they wanted someone to speak English ... The contractor fired me when I was late and I drank before work.

A story about a conversation I had with one of the most highly educated rural-dwelling men, whom I will refer to as “Boikanngo” exemplifies the profound confusion that even relatively well-informed but disadvantaged persons may suffer in situations of rapid social change like Botswana. Boikanngo had completed primary school, and a vocational training program leading him to work for about one year in Gaborone as a cabinet maker. Subsequently, he had chosen to return to his home village to pursue a life as a farmer out of a personal preference to live close to his kin, and to care for his own herd and land. While he expressed contentment with life as a rural agro-pastoralist, he was not totally satisfied, particularly with the difficulties of finding a suitable bride willing to live in Botswana.

One evening, discussion turned to the full moon illuminating the compound of mud huts where we chatted. When I explained that the darker patches visible on the moon are craters, Boikanngo asked disingenuously “Have you been there?!” In subsequent discussion, it became clear that



Boikanngo had a number of inaccurate notions about life for successful urban wage-earners in Gaborone, let alone a wealthy American such as me. These inaccurate notions included the assumption that many successful people, particularly wealthy Americans or Europeans, engage in routine travel to other planets.

Rural residents' notions of economically advantaged urban life form out of a life time's accumulation of disarticulated exposures to vestigial scraps of "modernity," including glimpsed television programs, dog-eared magazines passed round the village, a handful of cinema visits, and a year spent as an alienated resident witness of life for successful urban dwellers who visited the cabinet shop wearing fine clothes and driving expensive automobiles. Boikanngo and many other rural participants had exaggerated notions of the opportunities and under-estimated notions of the challenges and demands of success in distant urban centers. A related point of confusion that was recurrent was the idea that rich people, especially relatives, in cities had enough money that they could easily give away large sums to their unemployed rural kin, but did not simply because they were stingy. The most poignant thing about this sort of confusion is the way in which it may contribute to invidious notions of self-worth and diminished self-esteem.

Compared to the opportunities to be had by successful Botswana urbanites, the life of a traditional herdsman seems bleak at best, particularly for those who have failed in urban migration attempts. On the other hand, having grown up in rural settings where there is little focus on education, many Botswana men are simply not prepared to adapt to the challenges of daily work in an urban setting, and consequently fail in their urban migration attempts. This leaves many men with the feeling that they have been abandoned and alienated. Not only do they feel left behind by the accelerating modern world, they also feel betrayed by the traditional culture in which they were raised. Put simply, the habitus of a rural agro-pastoral herd man for which rural Tswana childhood had prepared many participants, did not serve them well in urban migration attempts.

## CONCLUSIONS

This study indicates that globalization can have negative impacts on psychobiological adaptation among the poorest by fostering desires among economically marginalized people for affluence without commensurate preparation to compete for such affluence. However, the lack of any buffering effects on depression or cortisol function from increasing SES

among urban men leaves open the possibility that globalization causes stress of a different sort at the successful end of the SES continuum. Increasing material affluence is not necessarily protective of psychobiological well-being in a consistent linear gradient fashion under conditions of extreme SES disparity, as in Botswana. This study suggests that, correspondence between aspirations and lifestyle, i.e., relative or perceived personal socioeconomic disparity, accounts for psychobiological well-being better than does absolute SES.

Current thinking in international health and social epidemiology highlight the global health significance of the bio-cultural mediators and psychobiological mechanisms examined in this study (Auerbach & Krimgold, 2001; Wilkinson, 1996). With post demographic transition declines in infectious disease, and increasing lifespan, the so-called Diseases of Civilization – mental illness, cancers, adult onset diabetes, and cardiovascular disease – have grown in salience for human well-being. Risk for these and other chronic degenerative diseases are thought to be highly moderated by diet, and exercise, but also by chronic psychobiological stress response (Panter-Brick & Worthman, 1999). This study contributes to a growing consensus in anthropological and international health research that the experience of socioeconomic disparity moderated by worldview is critical for lifetime psychobiological stress process. Consequently, such bio-cultural processes are important to a more thorough understandings and more effective amelioration of global human health and well-being.

## NOTE

1. With “reward” conceived broadly as the range of psychosocial experiences which may contribute to *psychobiological states of reward* in brain regions (such as the “anterior cingulate cortex” or “dopamine-mediated pathways between the ventral tegmental area and the nucleus accumbens”) which are integral to what is increasingly thought of as “reward network(s)” or “incentive salience pathway(s)” (Bush et al., 2002).

## REFERENCES

- Adler, N., & Osgrrove, J. (1999). Socioeconomic status and health: What we know, and what we don't. *Annals of the New York Academy of Science*, 896, 3–15.
- Alverson, H. (1978). *Mind in the heart of darkness: Value and self-identity among the Tswana of Southern Africa*. New Haven, CT: Yale University Press.

- Auerbach, J., & Krimgold, B. (Eds). (2001). *Income, socioeconomic status, and health: Exploring the relationships*. Washington, DC: National Policy Association.
- Bindon, J., Knight, A., Dressler, W., & Crews, D. (1997). Social context and psychosocial influences on blood pressure among American Samoans. *American Journal of Human Biology*, 103, 7–18.
- Booth, A., Shelley, G., Mazur, A., Tharp, G., & Kittok, R. (1989). Testosterone, and winning and losing in human competition. *Hormones and Behavior*, 23, 556–571.
- Brown, B. (1983). The impact of male labor migration on women in Botswana. *African Affairs*, 82(328), 367–388.
- Brown, L., Tomarken, A., Orth, D., Kalin, H., & Davidson, R. (1996). Individual differences in repressive-defensiveness predict basal salivary cortisol levels. *Journal of Personality and Social Psychology*, 70(2), 362–371.
- Brunello, N., Davidson, J., Deahl, M., Kessler, R., Mendlewicz, J., Racagni, G., Shalev, A., & Zohar, J. (2001). Posttraumatic stress disorder: Diagnosis and epidemiology, comorbidity and social consequences, biology and treatment. *Neuropsychobiology*, 43(3), 150–162.
- Burleson, M., Poehlmann, K., Hawkey, L., Ernst, J., Berntson, G., Malarkey, W., Kiecolt-Glaser, J., Glaser, R., & Cacioppo, J. (2002). Stress-related immune changes in middle-aged and older women: 1-year consistency of individual differences. *Health Psychology*, 21(4), 321–331.
- Bush, G., Vogt, B., Holmes, J., Dale, A., Greve, D., Jenike, M., & Rosen, B. (2002). Dorsal anterior cingulate cortex: A role in reward-based decision making. *Proceedings of the National Academy of Sciences of the United States of America*, 99(1), 523–528.
- Campbell, A. (1990). *On the nature of Botswana: A guide to conservation and development*. Harare, Zimbabwe: IUCN.
- Cavigelli, S. (1999). Behavioral patterns associated with faecal cortisol levels in free-ranging female ring-tailed lemurs, *Lemur catta*. *Animal Behaviour*, 57, 935–944.
- Central Intelligence Agency, U.S. (2007). *The world factbook*. Retrieved April 11, 2007, from <http://www.cia.gov/cia/publications/factbook/index.html>
- Central Statistics Office, Botswana. (1988). *Household income and expenditure survey: 1985/86*. Gaborone, Botswana: Government Printer.
- Charlton, R. (1991). Bureaucrats, and politicians in Botswana's policy-making process: A re-interpretation. *Journal of Commonwealth and Comparative Politics*, 29(3), 265–282.
- Comaroff, J. (1978). Rules and rulers: Political processes in a Tswana chiefdom. *Man*, 13, 1–20.
- Comaroff, J. (1995). *Body of power, spirit of resistance: The culture and history of a South African people*. Chicago, IL: University of Chicago Press.
- Comaroff, J., & Comaroff, J. (1990). Goodly beasts, beastly goods: Cattle and commodities in a South African context. *American Ethnologist*, 17(2), 195–216.
- Comaroff, J., & Comaroff, J. (1991). *Of revelation and revolution: Christianity, colonialism, and consciousness in Southern Africa*. Chicago, IL: University of Chicago Press.
- Coste, J., Strauch, G., Letrait, M., & Bertagna, X. (1994). Reliability of hormonal levels for assessing the hypothalamic-pituitary-adrenocortical system in clinical pharmacology. *British Journal of Clinical Pharmacology*, 38(5), 474–479.
- Curry, R. (1985). Mass unemployment, poverty, macroeconomics in Botswana. *American Journal of Economics and Society*, 44(3), 71–87.

- Curry, R. (1987). Poverty and mass unemployment in mineral rich Botswana. *American Journal of Economics and Society*, 46(4), 473–488.
- Datta, K., & Murray, A. (1989). The rights of minorities and subject peoples in Botswana. In: J. Holm & P. Molutsi (Eds), *Democracy in Botswana: Proceedings of a symposium held in Gaborone, 1–5 August 1988*, MacMillan, Gaborone, Botswana (pp. 58–73).
- Decker, S. (2000). Cortisol and social status among Dominican men. *Hormones and Behavior*, 38(1), 29–38.
- Decker, S. (2006). Salivary cortisol and depressive affect among rural Botswana men: Reliability and validity of laboratory result. *Journal of Physiological Anthropology*, 25(1), 91–101.
- Decker, S. (unpublished). Cortisol and psychoneuroendocrine processes as adaptations: Distinguishing adaptation and stress with psychoneuroendocrine research.
- Decker, S., Flinn, M., England, B., & Worthman, C. (2003). Cultural congruity and the cortisol stress response among Dominican men. In: J. Wilce, Jr. (Ed.), *Social and cultural lives of immune systems* (1st ed., Vol. 10). London and New York: Routledge, Taylor and Francis Group.
- Desjarlais, R., Eisenberg, L., Good, B., & Kleinman, A. (1995). *World mental health: Problems and priorities in low-income countries*. New York: Oxford University Press.
- Dickerson, S., & Kemeny, M. (2004). Acute stressors and cortisol responses: A theoretical integration and synthesis of laboratory research. *Psychological Bulletin*, 130(3), 355–391.
- Dressler, W. (1995). Modeling bio-cultural interactions: Examples from studies of stress and cardiovascular disease. *Yearbook of Physical Anthropology*, 38, 27–56.
- Dressler, W. (2004). Culture and the risk of disease. *British Medical Bulletin*, 69, 21–31.
- Dubb, A. (1974). The impact of the city, Chapter 15. In: W. D. Hammond-Tooke (Ed.), *The Bantu-speaking peoples of Southern Africa*. London and Boston, MA: Routledge & Kegan Paul.
- Economist (2006). Happiness (and how to measure it). *Economist* (December 23), p. 13.
- Economist. (2007). *Pocket world in figures 2007 edition*. London, UK: The Economist in Association with Profile Books Ltd.
- Elzinga, B., Schmahl, C., Vermetten, E., van Dyck, R., & Bremner, J. (2003). Higher cortisol levels following exposure to traumatic reminders in abuse-related PTSD. *Neuropsychopharmacology*, 28(9), 1656–1665.
- Epsteina, P., Howlett, P., & Schulze, M. (2007). Trade, convergence, and globalisation: The dynamics of the international income distribution, 1950–1998. *Explorations in Economic History*, 44(1), 100–113.
- Fischer, C. (1984). *The urban experience*. Fort Worth, TX: Harcourt Brace Jovanovich College Publishers.
- Flinn, M. (1999). Family environment, stress, and health during childhood. In: C. Panter-Brick & C. Worthman (Eds), *Hormones, health, and behavior* (pp. 105–138). Cambridge, UK: Cambridge University Press.
- Flinn, M., & England, B. (1996). Childhood stress and family environment. *Current Anthropology*, 36(5), 854–866.
- Forster, B. (1981). Introduction to the history of the administration of justice of the Republic of Botswana. *Botswana Notes and Records*, 13, 89–100.
- Gold, P., & Chrousos, G. (2002). Organization of the stress system and its dysregulation in melancholic and atypical depression: High vs low CRH/NE states. *Molecular Psychiatry*, 7(3), 254–275.

- Good, K. (1994). Corruption and mismanagement in Botswana. *Journal of Modern African Studies*, 32(3), 499–521.
- Goodman, A., & Armelagos, G. (1985). Disease and death at Dr. Dickson's Mounds. *Natural History*, 94(9), 12–17.
- Griffin, J., Fuhrer, R., Stansfeld, S., & Marmot, M. (2002). The importance of low control at work and home on depression and anxiety: Do these effects vary by gender and social class? *Social Science and Medicine*, 54(5), 783–798.
- Gutkind, P. (1969). African urban family life and the urban system. In: P. Meadows & E. Mizruchi (Eds), *Urbanism, urbanization, and change: Comparative perspectives*. Reading, MA: Addison-Wesley Publishing.
- Heim, C., Ehler, U., & Hellhammer, D. (2000). The potential role of hypocortisolism in the pathophysiology of stress-related bodily disorders. *Psychoneuroendocrinology*, 25, 1–35.
- Holm, J. (1994). Botswana: One African success story. *Current History*, 93(583), 198–202.
- Hutchinson, F. (2006). The new development economics: After the Washington Consensus. *ASEAN Economic Bulletin*, 23(3), 391.
- James, D. (1992). Urban life and the struggle for autonomous culture in some Transvaal communities. *African Studies*, 51(1), 1–7.
- James, G. (2001). Evaluation of journals, diaries, and indexes of worksite and environmental stress. In: W. White (Ed.), *Blood pressure monitoring in cardiovascular medicine and therapeutics* (pp. 29–44). Totowa, NJ: Humana Press.
- James, G., & Brown, D. (1997). The biological stress response and lifestyle: Catecholamines and blood pressure. *American Journal of Human Biology*, 26, 313–335.
- Jarle, F. (1994). "There is no respect!" Modernization and the changing status of elderly men. In: F. Jarle, M. Mugabe & Y. Coombes (Eds), *The situation of the elderly in Botswana: Proceedings from an international workshop*. Gaborone, Botswana: NIR, University of Oslo Centre for Development and the Environment.
- Kahn, J. (2001). Anthropology and modernity. *Current Anthropology*, 42(5), 651–680.
- Kent, S. (1995). Unstable households, stable communities in Botswana. *American Anthropologist*, 97(2), 297–312.
- Kirschbaum, C., Klauer, T., Flipp, S., & Hellhammer, D. (1995). Sex-specific effects of social support on cortisol and subjective response to acute psychological stress. *Psychosomatic Medicine*, 57, 23–31.
- Kleinbaum, D., Kupper, L., & Muller, K. (1988). *Applied regression analysis and other multivariable methods*. Belmont, CA: Duxbury Press.
- Marmot, M. (2002). The influence of income on health: Views of an epidemiologist. *Health Affairs*, 21(2), 31–46.
- Marmot, M., & Wilkinson, R. (2001). Psychosocial and material pathways in the relation between income and health. *British Medical Journal*, 322(7296), 1233.
- Mason, J., Wang, S., Yehuda, R., Riney, S., Charney, D., & Southwick, S. (2001). Psychogenic lowering of urinary cortisol levels linked to increased emotional numbing and a shame-laden depressive syndrome in combat-related posttraumatic stress disorder. *Psychosomatic Medicine*, 63(3), 387–401.
- McDade, T. (2002). Status incongruity in Samoan youth: A bio-cultural analysis of culture change, stress and immune function. *Medical Anthropology*, 16(2), 123–150.
- McGarvey, S. (1999). Modernization, psychosocial factors, insulin, and cardiovascular health. In: C. Panter-Brick & C. Worthman (Eds), *Hormones, health, and behavior* (pp. 244–282). Cambridge, UK: Cambridge University Press.

- Molomo, M., & Mokopakgosi, B. (1991). *Multi-party democracy in Botswana*. Harare, Zimbabwe: Bardwells.
- Molutsi, P. (1987). Post-colonial social research in Botswana: A critical summary. In: R. Hitchcock, N. Parsons & J. Taylor (Eds), *Research for development in Botswana* (pp. 253–264). Gaborone, Botswana: The Botswana Society.
- Molutsi, P. (1991). *Social stratification in Botswana*. Unpublished Ph.D. dissertation, Oxford University, Oxford.
- Niles, F. (1999). Toward a cross-cultural understanding of work-related beliefs. *Human Relations*, 52(7), 855–867.
- Palmer, S., Kagee, A., Coyne, J., & DeMichele, A. (2004). Experience of trauma, distress, and posttraumatic stress disorder among breast cancer patients. *Psychosomatic Medicine*, 66(2), 258–264.
- Panther-Brick, C., & Worthman, C. (Eds). (1999). *Hormones, health, and behavior: a socio-ecological and lifespan perspective*. Cambridge, New York: Cambridge University Press.
- Perry, P., Chapman, D., & Snyder, C. Jr. (1995). Quality of teacher worklife and classroom practices in Botswana. *International Journal of Educational Development*, 5(2), 115–125 and 127–140.
- Pollard, T., Ward, G., Thornley, J., Wooster, G., Wooster, J., & Panther-Brick, C. (2000). Modernisation and children's blood pressure on and off the tourist trail in Nepal. *American Journal of Human Biology*, 24, 478–486.
- Rohleder, N., Joksimovic, L., Wolf, J., & Kirschbaum, C. (2004). Hypocortisolism and increased glucocorticoid sensitivity of pro-inflammatory cytokine production in Bosnian war refugees with posttraumatic stress disorder. *Biological Psychiatry*, 55, 745–751.
- Saltzman, W., Schultz-Darken, N., Wegner, F., Wittwer, D., & Abbott, D. (1998). Suppression of cortisol levels in subordinate female marmosets: Reproductive and social contributions. *Hormones and Behavior*, 33(1), 58–74.
- Sapolsky, R. (1983). Endocrine aspects of social instability in the olive baboon. *American Journal of Primatology*, 5, 365–372.
- Sapolsky, R. (1990). Adrenocortical function, social rank, and personality among wild baboons. *Biological Psychiatry*, 28, 862–878.
- Sapolsky, R. (1999). Hormonal correlates of personality and social contexts: From non-human to human primates. In: C. Panther-Brick & C. Worthman (Eds), *Hormones, health, and behavior* (pp. 18–45). Cambridge, UK: Cambridge University Press.
- Schapera, I. (1934). Present-day life in the native reserves. In: I. Schapera (Ed.), *Western civilization and the natives of South Africa* (pp. 39–62). London, UK: Routledge & Kegan Paul Ltd.
- Schapera, I., & Comaroff, J. (1991). *The Tswana* (2nd revised edn.). London: Kegan Paul International.
- Seeman, T., & McEwen, B. (1996). Impact of social environment characteristics on neuroendocrine regulation. *Psychosomatic Medicine*, 58, 459–471.
- Sen, A. (1987a). The standard of living: Lecture I, concepts and critiques. In: G. Hawthorn (Ed.), *The standard of living* (pp. 1–19). Cambridge, UK: Cambridge University Press.
- Sen, A. (1987b). The standard of living: Lecture II, lives and capabilities. In: G. Hawthorn (Ed.), *The standard of living* (pp. 20–38). Cambridge, UK: Cambridge University Press.
- Somerville, K. (1994). Botswana at the cross-roads. *World Today*, 50(2), 22–24.

- Stansfeld, S., Fuhrer, R., Shipley, M., & Marmot, M. (2002). Psychological distress as a risk factor for coronary heart disease in the Whitehall II Study. *International Journal of Epidemiology*, 31(1), 248–255.
- Steptoe, A., Kunz-Ebrecht, S., Owen, N., Feldman, P. J., Willemsen, G., Kirschbaum, C., & Marmot, M. (2003). Socioeconomic status and stress-related biological responses over the working day. *Psychosomatic Medicine*, 65(3), 461–470.
- Strickland, P., Deakin, J., Percival, C., Dixon, J., Gater, R., & Goldberg, D. (2002). Bio-social origins of depression in the community – interactions between social adversity, cortisol and serotonin neurotransmission. *British Journal of Psychiatry*, 180, 168–173.
- van Eck, M., Berkhoff, H., Nicolson, N., & Sulon, J. (1996). The effects of perceived stress, traits mood states, and stressful daily events on salivary cortisol. *Psychosomatic Medicine*, 58(5), 447–458.
- Vengroff, R. (1975). District councils and social networks in Botswana. *Political Anthropology*, 1(2), 155–174.
- Vickers, R. (1988). Effectiveness of defenses: A significant predictor of cortisol excretion under stress. *Journal of Psychosomatic Research*, 32(1), 21–29.
- Watanabe, B. (1984). Rural poverty in Botswana. *World Development*, 12(2), 115–127.
- Wilce, J. Jr. (Ed.) (2003). *Social and cultural lives of immune systems* (1st edn., Vol. 10). London, UK: Routledge.
- Wilkinson, R. (1996). *Unhealthy societies: The afflictions of inequality* (1st edn.). London, UK: Routledge.
- Wilkinson, R. (1999). Health, hierarchy and social anxiety. *Annals of the New York Academy of Science*, 896, 48–63.
- Wilkinson, R. (2000). *Mind the gap: Hierarchies, health, and human evolution*. London, UK: Weidenfeld & Nicholson.
- Wilkinson, L., Hill, M., & Vang, E. (1992). *SYSTAT: Statistics*. Evanston, IL: SYSTAT, Inc.
- Willis, P. (1977). *Learning to labor: How working class kids get working class jobs*. New York: Columbia University Press.
- Wilmsen, E. (1989). *Land filled with flies: A political economy of the Kalahari*. Chicago, IL and London: The University of Chicago Press.
- Worthman, C. (1999). Epidemiology of human development. In: C. Panter-Brick & C. Worthman (Eds), *Hormones, health, and behavior* (pp. 47–104). Cambridge, UK: Cambridge University Press.
- Yehuda, R., Resnick, H., Kahana, B., & Miller, E. (1993). Long-lasting hormonal alterations to extreme stress in humans: Normative or maladaptive. *Psychosomatic Medicine*, 55, 287–297.
- Young, E., Tolman, R., Witkowski, K., & Kaplan, G. (2004). Salivary cortisol and posttraumatic stress disorder in a low-income community sample of women. *Biological Psychiatry*, 55, 621–626.

# ATTRIBUTIONS OF DANGER AND RESPONSES TO RISK AMONG LOGGING CONTRACTORS IN BRITISH COLUMBIA'S SOUTHERN INTERIOR: IMPLICATIONS FOR ACCIDENT PREVENTION IN THE FOREST INDUSTRY

Patrick B. Patterson

## ABSTRACT

*Logging industry fatalities recently became a focus for policy change in British Columbia. Through re-analysis of ethnographic data collected in 2001–2002 this chapter aims to investigate logging contractors' attitudes toward workplace danger and to comment on the likelihood of success of the proposed policy changes. The contractors attributed workplace danger to the forest environment and to human error, which shaped their behavior and their attitudes toward taking risks. The contractors accepted the risk of physical harm rather than face almost certain economic loss. The proposed policy changes do not address the conditions that promoted this acceptance.*

---

The Economics of Health and Wellness: Anthropological Perspectives

Research in Economic Anthropology, Volume 26, 103–125

Copyright © 2008 by Elsevier Ltd.

All rights of reproduction in any form reserved

ISSN: 0190-1281/doi:10.1016/S0190-1281(07)26005-6



## INTRODUCTION

Late in 2005, the British Columbia logging industry featured prominently in Canada's national news media. The topic of the stories was not environmental protests on the west coast or the on-going softwood lumber dispute with the United States; it was the unusually high number of injuries and fatalities suffered in the industry over the past year (CBC News, 2005, 2006). Although the number of fatal logging-related accidents in 2005 was nearly three times the previous year's total (Workers' Compensation Board of British Columbia, 2006), serious injuries and deaths have long been common and constitute a prominent part of the folklore surrounding the logging industry (see, e.g., Grainger, 1996; Trower, 1999; Wayman, 1993; White, 1983). On average, each year between 1993 and 2003 in British Columbia 25 logging industry workers were killed and 92 received serious injuries among the 24,000 people employed in it (British Columbia Government, 2007; Forest Safety Task Force, 2004). This average annual fatality rate, 10.4 per 10,000 is much higher than in other hazardous occupations in British Columbia, such as mining and oil and gas or transportation, which have rates of 5.1 and 3.0, respectively (British Columbia Government, 2007; Workers' Compensation Board of British Columbia, 2006). British Columbia is not unusual in identifying logging as a hazardous occupation and research by anthropologists, sociologists, and epidemiologists indicates that high logging industry injury and death rates are a widespread concern in industrialized societies where forestry is an important economic activity (Lilley, Feyer, Kirk, Gander, & Atkinson, 2002; Mason, 1976; Ostberg, 1980; Reed, 2003; Salisbury, Brubaker, Hertzman, & Loeb, 1991; Satterfield, 2002; Satterfield, 1996; Slappendel, Laird, Kawachi, Marshall, & Cryer, 1993; Sundstrom-Frisk, 1984; West, Shkrum, & Young, 1996).

In British Columbia recent government and industry responses to fatalities among loggers have varied. In 2003, the Workers' Compensation Board of British Columbia established a Forest Safety Task Force to provide recommendations for reducing accident rates (Forest Safety Task Force, 2004). Their final report suggested a four-part action plan based on cultural change, building capacity, sharing responsibility, and rigorous implementation. Their recommended approach to reduce logging accidents was based on recognizing multiple contributing factors and working with industry participants at all levels of the workforce to encourage safe practices (*ibid.*). The BC Ministry of Forests adopted a different approach following the release of the 2005 fatality numbers. The BC Forests Minister

promised more regulation of the safety practices in the logging industry, including audits of the level of safety training workers received (CBC News, 2005). Under the proposed changes to be phased in over a two-year period firms that provide high levels of safety training will receive an incentive in the form of reduced Workers' Compensation premiums and forestry companies will be encouraged not to hire sub-contractors who fail their audits (*ibid.*). The current government's approach is based on the assumption that lack of training is the cause of fatal accidents and that a "carrot and stick" approach using incentives and punishments will improve compliance with a training level target.

Identifying beliefs and practices that may contribute to accidents is important in assessing the likelihood of success of accident reduction strategies. Ethnographic research is particularly well suited to uncovering these practices and attitudes. This chapter presents a re-analysis that draws on semi-structured interviews and participant observation conducted in 2001–2002 in British Columbia's North Okanagan/Shuswap region. Although the focus of the original study was not on safety, questions about safety were included in the interviews, and this secondary analysis provides an ethnographic look at what the logging contractors saw as workplace hazards, what they attributed these dangers to, and how they responded to the risks they faced at work. These insights will shed some light on the likelihood of success of the accident reduction strategies the British Columbia Government is pursuing.

## **BACKGROUND**

Commercial logging has a long history in British Columbia and has been a prominent industry in the province. The first sawmills were established in BC on southern Vancouver Island and along the lower Fraser River in the mid-19th century and in the southern interior in the 1890s (Drushka, 1998; Harris, 1997). The BC forest products sector expanded quickly and throughout the 20th century wood and paper products were the province's main exports, only declining in importance relative to other manufactured goods in the 1990s (British Columbia Government, 2007). In spite of the shift in the BC economy toward manufacturing and services, wood and paper products remain important, constituting 41% of the value of all manufactured goods and 39% of the province's exports (*ibid.*). Dependence on the forest sector is particularly high in areas outside the main government and manufacturing centers of Victoria and Vancouver (Horne & Penner,

1992). Although the North Okanagan/Shuswap region's economy is more diverse than in many other areas of the BC interior, 10% of the region's income comes from the forest sector, which is higher than the provincial average (Horne & Penner, 1992; British Columbia Government, 2006). This pattern of relative dependence on the forest industry is repeated on a smaller scale within the North Okanagan/Shuswap and nearly all of the research participants lived in smaller communities or rural districts, rather than in Vernon, the main regional center.

There are several features of the British Columbia forest industry that need to be considered in order to understand the dynamics within its logging sector. The first is the tenure system that allocates the timber harvesting rights to individuals and firms. The division of powers established by the Canadian constitution delegates responsibility for administering forested land that is not privately owned, what is known in Canada as Crown land, to the provincial governments. In BC, the mountainous terrain is largely unsuitable for agriculture and much of it remains forested. BC's policy on Crown forests was established in the late 19th century. Rather than selling the Crown land to private firms for forestry, as was the practice in the United States at that time, high timber prices resulting in part from land speculation in the US Pacific Northwest convinced the BC government that administering Crown forests could be a long-term source of revenue and the province moved to make further privatization of its Crown forests illegal (Drushka, 1999). As a result of the terrain and the government's decision to retain title to Crown land, the provincial government currently holds title to over 95% of the forested land in British Columbia (*ibid.*).

The administration of British Columbia's forested land is the responsibility of the Ministry of Forests. The ministry sets a limit on the volume of timber that can be cut each year from Crown forests and firms and individuals are allocated timber volume according to the harvesting licenses they hold (Marchak, Aycock, & Herbert, 1999). Several types of harvesting licenses are available through the Ministry of Forests. For the purposes of this chapter the specific details are less important than the fact that most of the annual timber volume is allocated to licenses that provide long-term, often renewable, harvesting rights to specific areas (*ibid.*). The limited availability of timber for allocation and the long terms of the licenses, usually over 20 years, have resulted in a trend over the past 50 years toward larger timber volumes held by a shrinking number of firms (Drushka, 1999). The firms that hold large timber volumes are referred to within the BC forest industry as major licensees, or simply as "majors," and they have considerable influence over the opportunities for logging in the areas where

they hold licenses. Between October 2001 and March 2002, when the data analyzed in this project were collected, five major licensees operated mills and held harvesting tenures in the North Okanagan/Shuswap (British Columbia Government, 2002). Since then two of the larger firms have merged, further concentrating harvesting allocations.

Another important feature of the British Columbia forest industry is how logging operations are organized. In the coastal forests the average size of the trees is much larger than in the interior and this has contributed to the development of two main variations within the BC logging industry, one along the coast and another in the interior. In the coastal forests logging the big trees required larger crews and more investment in equipment than was generally the case in the interior (Drushka, 1998). One result of this high concentration of labor and capital was large logging camps, which were easier for labor organizers in the 1920s and 1930s to organize (Drushka, 1999). After consolidation of harvesting licenses in the late 1940s most major licensees operating at the coast found it more advantageous to run logging operations as divisions within their firms than to hire logging contractors (*ibid.*). Some independent logging operations, known as “gyppos,” remained in the coastal industry but they were the minority (*ibid.*). The economic changes of the 1970s and early 1980s eliminated many of the advantages of in-house logging operations in the coastal forest industry and most major licensees operating there have since adopted flexible production methods based on contracting out harvesting to logging contractors (Hayter & Barnes, 1997).

In the British Columbia interior, smaller average trees allowed smaller crews to harvest timber profitably with less capital investment in equipment, which reduced the incentives for lumber companies to establish in-house logging divisions (Drushka, 1998). The small crews also made it more difficult for labor organizers to establish a strong union presence in the interior. After the consolidation of the harvesting licenses some major licensees based on the coast expanded into the interior and established unionized in-house crews (Drushka, 1998; Marchak, 1986). Those firms quickly switched over to contract logging in the early 1980s and non-union contract logging crews have been the norm in the interior throughout the industry’s history (Drushka, 1998; Marchak, 1986).

The result of these differences in logging organization is that contractors now harvest 80% of the timber cut each year in the British Columbia, and in the interior virtually all logging is done by contractors (Resource Systems Management International, Randy Sunderman and Associates, and Guidelines Consulting, 1999). As well, very few contract logging crews are

unionized and even in the coastal forest industry loggers are a small portion of the membership of the unions representing forestry workers (Drushka, 1999). The logging industry in North Okanagan/Shuswap region is no exception to this pattern. At the time of the research none of the area's major licensees operated in-house logging crews. None of the contractors who participated in the study identified themselves as members of unions and they did not describe their crews as unionized.

## METHODS

The data analyzed for this essay were collected in the course of an ethnographic study of the occupational culture within the forest harvesting industry of the North Okanagan/Shuswap region.<sup>1</sup> I grew up in the area and I worked for several small firms involved in the forest industry. I drew on that first-hand knowledge when designing the ethnographic study. In particular, I knew that contractors provided almost the entire "forest floor" labor force within the area's forest industry.<sup>2</sup> Forest industry contractors' status as entrepreneurs gives them an important role in setting the norms among the people they mobilize (Barth, 1963). That made logging contractors important people to talk to about industry norms in the bush. It also makes analyzing contract logging in BC an important starting point for understanding the practices of the logging workforce and their attitudes toward safety. The people contacted for the study were a theory-driven sample focused on forest harvesting contractors.

My previous experience working in the region also provided me with contacts in the forest industry. I intended to use a "snowball" sampling method, starting with individuals I knew in the region who fit the theory by being in some way connected with forest harvesting contractors. Snowball sampling was less effective than I expected, as most of the contacts participants referred me to proved to be unavailable or were not interested in participating in the study. Rather than continue using snowball sampling, I contacted potential participants by telephone using numbers obtained through chamber of commerce business listings, advertisements placed by logging contractors in industry periodicals, and contractor lists provided by major licensees and the Ministry of Forests. I limited the sample contracted through the telephone listings to contractors located in the North Okanagan/Shuswap region. Most of the participants included in the final sample were people who I did not know prior to starting the field research.

Logging contractors were the largest category within the sample ( $N=8$ ). It also included people who were not logging contractors, but who had extensive contact with them and could be expected to provide insight. These included other forest industry contractors ( $N=4$ ), retired loggers ( $N=2$ ), government and industry association personnel ( $N=4$ ), and the spouses of several participants ( $N=3$ ). I informed each of the participants who I was and that I was conducting research and obtained consent from them prior to collecting any data. I was also open about my previous involvement in the local forest industry, and in most cases it seemed to improve the participants' impression of my trustworthiness. In order to protect the participants' confidentiality, all names used in this chapter are pseudonyms.

The data were collected mainly through interviews conducted during 7 months of fieldwork, from October 2001 to March 2002. The interviews were done at sites chosen by the participants, such as homes, offices, and work sites, including in the cab of a logging truck while the owner-operator worked. I was able to watch what the participants did during those interviews and some of the observations allowed comparison between what they said and what they were doing. On the advice of the manager of a local forestry contractors' lobby group, who pointed out that loggers can be "timid" around highly educated strangers and that people might be more forthcoming if the atmosphere of the interviews was casual, the interviews were not tape recorded. Instead, I took notes during the interviews to capture the essence of the participants' explanations and I wrote down short verbatim quotes when their words seemed particularly apt. I also collected data during some participant observation sessions. I worked as a "swamper" (a swamper is a general laborer and safety person working with a machine operator) for a total of six days at three sites with a firm I had worked for several years previously. While my focus during those days was on work, rather than data collection, I was able to observe the contractor's interactions with the crew and with several members of the general public.

The re-analysis done for this chapter was informed by the following question: Why are logging fatalities high? The analysis started with comparing the participants' statements about hazards and safety in their work and inductively identifying themes in them. In particular, to what did they attribute danger and safety at work? One common thread that emerged was that they associated unpredictability with danger. Further analysis consisted of inductively identifying themes surrounding sources of unpredictability and the participants' responses to it.

## RESULTS

The logging contractors and others interviewed in this study identified a range of hazards they faced while working in the forests. In particular, they identified certain workplace activities as “high risk.” When I asked Jim, who was in his mid-sixties and owned a large logging firm that employed several crews, whether he worried about safety he replied that everyone has worries. He said that felling and bucking trees is hazardous work (felling is cutting trees down, bucking is removing the tree limbs and cutting the trunk into the lengths required for transport and milling), and that logging is safer with the use of mechanical harvesting equipment (mechanized harvesting is logging using specialized heavy machines to fell trees). That assessment of the relative risks involved in mechanized and non-mechanized logging was echoed by Sean, who was in his late forties and also operated a multi-crew company. Sean said that the workers on the ground are in more danger than machine operators, but he also pointed out that machine operators suffer from more “slip and fall” injuries. This suggests that while mechanization may reduce the rate of fatalities, it may also introduce other hazards. Another contractor, Garth, who was in his late fifties and continued working as a machine operator in his own single-crew logging company, expressed a similar view when asked about safety. He suggested that insurance companies discriminated against loggers and that while fallers were at a very high risk category in the opinion of outsiders and have trouble in getting coverage, logging truck drivers were also at high risk for fatal accidents. He also pointed out that aggravation of old injuries was common in the industry as a whole. Several participants also identified deafness, nerve damage, and the aggravation of injuries as continual hazards that they faced.

The contractors were often forthcoming about their experiences with hazardous situations or injuries at work. Several described “near misses” that they had experienced. John, who is in his mid-fifties and runs an excavator in his small road maintenance firm, related a story about feeling an old bridge give way while he was crossing it with his machine. He was going to deactivate a road along a steep hillside (gravel roads in mountain environments change water flow patterns and can increase erosion; in British Columbia in order to avoid continuing erosion old logging roads are “deactivated” by digging up the surface and restoring the original slope) and was traveling to its dead end to begin work when he drove over the bridge and felt it start to move under the machine. He accelerated across it and stopped on the other side to investigate. The main wooden beams holding



the bridge up were cracked but it had not collapsed, so he continued to the end of the road and worked back from the dead end until he got back to the spot. He said that there was not much he could do, there was no way out and no way to lift the machine over the bridge, so he kept the machine's weight to the uphill side and kept the door open so that he could try to jump if he needed to and he drove across as fast as he could. He said that the bridge held but his heart was pounding the whole time. Some of the participants who worked in logging also recounted near miss situations. Bill, a logger in his late sixties who was retired at the time of the interview, said that on one occasion just after he finished felling a tree he saw movement in his peripheral vision. He jumped backward and narrowly missed being struck by a falling snag (snags are standing dead trees). He said the vibrations caused by the tree he had just felled caused the snag to topple toward him.

Other participants were not so fortunate and several mentioned injuries they had suffered at work. Don, a contractor in his late forties who works as a faller in his own mid-sized logging firm, said that he had been injured once early in his career when the butt of a tree he felled hit him in the arm. He attributed the accident to his own inexperience and not moving far enough away from the falling tree. Garth also reported having been hit by the butt of a tree and in his case he lost 14 months of work due to his injuries. He described himself as lucky. He is probably correct; several other participants said they had witnessed serious accidents, including deaths, during their logging careers. Don said that when business is slow for his company he periodically works as a faller for other contractors. He said that during one job he heard emergency sirens (prior to the introduction of inexpensive and durable portable radios in the 1990s, sirens were used to send signals between workers during logging operations) and headed to the muster point. He said that when he arrived the crew was "dead silent" and he learned that a trail along the hill had collapsed under a bulldozer and the operator had been crushed to death.

The contractors attributed the hazards they faced to a variety of causes. The unpredictability of the forest environment, particularly trees and slopes, figures prominently in many of the accounts. Trees and slopes were both mentioned in several of the accidents and near miss incidents participants described. Weather was another unpredictable aspect of work in the bush that the participants often identified. According to several contractors weather conditions, such as rain and snow, often added to the dangers posed by trees and the terrain. Excessive rain could weaken slopes and roads and make driving conditions more dangerous. Snow is also a common problem



for loggers working in British Columbia because winter is the main logging season. Snow depths of two meters are not unusual at higher elevations in the North Okanagan/Shuswap region and snow often covered hazards that the participants said they would otherwise have noticed. Don talked at length about felling trees in the snow and described the winter season as “five months of misery.” He mentioned a recent near miss when a tree he felled landed on a snow covered branch, which flew up and hit him in the leg. Snow also influences the condition of logging roads, which presents hazards for workers traveling to and from sites, as well as for logging truck drivers. I interviewed Chuck, a logging truck owner-operator, in his truck in November during a trip to pick up a load of logs. The road to the logging site was locally known for its steepness and switchback turns and although the road had been ploughed it was covered with a layer of packed snow and ice. After leaving the highway, at the bottom of the logging road Chuck parked the truck and put chains on the tires. He radioed ahead before starting the ascent and found that the road was clear of traffic. On the way up we continued the interview and when I asked Chuck about safety he grinned and said that he had not had any really close shaves and had only “flopped [his] truck over once.” At the logging site he put a full load of logs on the truck and we started back down the hill. The atmosphere in the cab was much different on the way down; Chuck’s attention was on the road and on his truck and he barely spoke at all during the descent. My attention was also completely focused. Once we reached the bottom of the hill the tension eased immediately and we continued the interview.

Rain and snow, as well as heat during the summer months, also add to the physical stress of an already demanding workplace. Some of my days doing participant observation were in early March and although the weather was warm, we were working in snow. As a swamper, my role was to provide general labor, including shoveling gravel, hooking up chains and chipping ice off equipment. Each day I started with warm, dry clothes but before noon my boots and mitts were soaked through. Despite a change of socks and mitts at lunch, the cold took its toll and by the end of the day I was completely exhausted. In my experience, the conditions I was working in were not particularly bad, I had worked in much worse situations before, but they did make it difficult to keep my manual dexterity and mental focus during work in the latter part of the day. In addition to direct impacts on workers weather also influences work scheduling. The threat of forest fires during dry summers, and the possibility of an early break-up (break-up refers to the period in the spring when logging operations stop as the roads

thaw, usually in March, April, and May, although the specific period of time depends on the conditions in the forests) in the spring may shorten the work season, intensifying pressure to work quickly.

The participants also identified human error as an important cause of accidents and fatalities. They described some poor practices as responses to the difficult physical conditions in the bush. When Don discussed hand-felling in the winter he suggested that working safely in deep snow depended on the faller's endurance because people tend to cut corners when they get tired. The example he gave was digging "escape routes" away from the base of each tree. He said that the proper practice is to dig the snow away from the base of the tree, then to clear two "escape routes" at least three meters long in different directions before cutting it. He said that, "After the first couple of trees in a day that second escape route doesn't get dug out very often." The contractors interviewed also suggested that poor practices often resulted from inexperience and inattention. According to Bill, the retired logger, each of the three fatalities he saw during his career was the result of bad practices by "guys without proper training."

The participants also blamed working under pressure to maximize productivity for contributing to accidents. When I asked what some of the difficulties in his occupation were, Len, who was in his late fifties and owned a mid-sized logging company, identified the contracting system. He said that a logging contractor negotiates to survive and the challenge is how to exist at the rates he can get, since, "you are only as good as you can negotiate." He said that while there is some room for negotiation with the licensees, the mills' accounting departments decide how much they will pay a contractor before he walks into the office to discuss it. The negotiated pay rates can become a point of contention with the licensees. Don also said that the licensees dictate contract rates and he actually stopped working for one of the large licensees in the area because he objected to their negotiation methods. In the contractors' opinions, they were under extreme pressure to produce as quickly as possible so that they could move on to the next contract and maximize their income, mainly by working long hours. According to Sean, his crews worked up to seven days per week during busy periods. He said that they "went to work in the dark and came home in the dark," working from 7:00 a.m. to 3:30 p.m., not including a one-and-a-half to two-and-a-half hour commute each way from the sites. I kept similar hours when working as a swamper and each work day was over 12 hours, including the commutes.

A factor the contractors often identified as adding to their production pressures was regulation of logging practices by the provincial Ministry of

Forests. Logging has been regulated to some extent throughout the history of the industry in British Columbia but through most of the 1990s the British Columbia New Democratic Party formed the provincial government and their forest policies significantly increased the regulation of logging (Hoberg, 2003). Len said that changes in the forest policies often caused delays because additional documentation was necessary and because the local Ministry of Forests officials often did not know what practices would meet the new standards. He gave as an example his experience putting in a temporary crossing over a stream shortly after new regulations were introduced. He said that he done all of the preparation work, had the temporary bridge ready to go, and had someone from the Ministry of Forests on site but the official refused to sign off on the proposed crossing. The official insisted on driving back to town to check the manual but he would not be back out to the site for several days. Len said that he eventually lost his patience and told the official to go and get his book, but he was going ahead with the crossing, which he proceeded to do. He said he never saw the official back at the site and never had any complaints about the crossing. Len said that some of the regulations were written in response to conditions in other parts of the province and did not reflect the reality of the local situation. Chuck, the logging truck driver, made a similar observation about regulations related to logging trucks. He said that although some operators are not as careful about maintaining their trucks as they should be, the regular checks and surveillance was a nuisance and avoiding them was a standard practice.

The contractors attempted to manage in a variety of ways the dangers that they faced at work. One of these was to avoid working alone. When he was asked about safety, Garth suggested that swampers were supposed to get help if a machine operator got into trouble and that fallers were supposed to check in a 30-minute intervals. He did not mention whether or not that worked in practice, but he did say that when he was working alone the previous season he called in regularly. Relatively inexpensive two-way radios and satellite telephones are two technologies that help reduce the isolation of logging industry workers and I saw both in use while I was swamping.

The contractors were also emphatic about the importance of being aware of their surroundings and of potential dangers. The effectiveness of that approach depends on being able to identify risks in advance, which most of the contractors did not take for granted. Mark, who does the felling in his small logging company, said that he tries to be conscious of the dangers, especially when working on steep slopes, and that he “never takes

any potentially lethal risks.” He then pointed out that the bush is an unpredictable place to work because there are too many variables in the environment. Len expressed a similar sentiment and said that a logger has to respect the environment and the risks because situations are unpredictable. He said that loggers always have to be aware of what is going on around them. The contractors also pointed out the importance of experience. John, the road maintenance contractor, said that risk control is important and he takes precautions in unsafe situations but his experience was what allowed him to “go by feel” in situations where the exact risks were unknown. Don said that in logging there are too many variables to be in complete control so, “to be a healthy faller you need a healthy imagination,” and anticipate problems before they occur.

The contractors also used information about people to reduce uncertainty when choosing employees and sub-contractors. When I asked about employees and sub-contractors, Mark said that he is cautious about recruitment and that reliability is what he looks for. Other contractors expressed similar opinions, and Garth pointed out that the opinions of members of the crew about each other are also important because everyone has to work together. Most of the contractors expressed a preference for working with people they already knew and dealt with a relatively small number of trusted sub-contractor and employees whenever possible. Don said that he tries to keep experienced people in his crew. He suggested that there are fewer administrative expenses with an experienced employee because less supervision is necessary, compared with, “a green guy [who] loses you money for a year.”

Their preference for working with people they know is also reflected in the recruiting techniques they said they used. Don said that he recruits through his personal contacts and “friends of friends.” He also employed family in his logging company and his oldest son worked in the business as a skidder operator. Nevertheless, Don maintained that finding good employees was still, “a craps shoot,” and new workers often did not work out. All of the other contractors also mentioned working with relatives and friends in their logging operations. Some of the contractors mentioned that if their own friends and relatives were not available to work then they relied on referrals from their employees and on word of mouth within the local logging industry. Only one mentioned using advertising or employment centers to recruit new employees, only as a last resort. Although provincial certification is needed for some jobs, such as felling and driving logging trucks, formal training was not a criterion that the contractors mentioned when they talked about their employees. Sean suggested that experience was

important and that he tried to pair new employees with experienced ones so that they would learn the skills they needed from someone who knew the work.

Even with their attempts to reduce the risks in their work, most of the contractors admitted that they were not in control and they were often fatalistic when they discussed the risks involved in logging. Garth suggested that a person cannot avoid everything dangerous while working in the bush and a logger learns to live with it. The logging contractors saw leaving the industry as the alternative to accepting risk. In his discussion of safety, Sean said that some loggers lose their nerve and quit because it is, "a job where you can do everything right and still get killed." While the contractors often said that they did not worry much about their own safety, they did admit worrying about their workers. Jim, whose company employed several of his sons and grandsons, said that safety is a big concern for him and that he worries about the crew. The contractors interviewed also suggested that, although some risks are always present, people outside the industry generally consider logging more dangerous than it actually is. Don suggested that driving long distances to and from the work sites is the most dangerous aspect of logging, and that it is the same risk anyone takes when they drive. When I asked about danger in logging, Len admitted that some of the work is dangerous but he said that it was similar to other occupations, such as fire fighting.

While most of the contractors were fatalistic about the dangers they faced at work, they also often described risks in positive terms. When I asked Sean what some of the benefits of owning a logging company were, he said that he loved the "adrenaline rush" from logging and he enjoyed the camaraderie of the crew, where a man could be rough around the edges but still be accepted. Several of the contractors attributed their affinity for working in the logging industry to their personalities. Chuck, the logging truck driver, said that he liked the independence he gained from operating his own company. He said that getting through difficult situations gave him a sense of accomplishment and he described himself as a thrill seeker. He told me that he specifically scheduled our interview so that our trip to pick up the load of logs would be "interesting," and my impression was that although he had to concentrate intensely on the descent from the hill he was enjoying the drive. Don also said that he likes the risks in logging. When I asked him what the benefits of being a logging contractor were he grinned and said, "There are none!" He then said that he liked having a relatively high level of independence and control over his destiny and that, "danger is exciting and empowering. It keeps your attention."

## DISCUSSION

Before discussing the results presented above, and their implications for British Columbia's forest safety policies, an important limitation of this study should be considered. The data were originally collected to answer a research question other than the one addressed here and the sampling reflects the original study question, which intentionally focused on contractors. This limits the perspective of the analysis and leaves open the possibility that employees working in the logging industry have a different view of workplace dangers and their causes. There are several reasons to believe that the views of employees in contract logging firms are not radically different from those of the contractors. All of the logging contractors interviewed for this study began their careers in the logging industry as employees. In addition, all but one were still active in day-to-day logging operations as fallers or machine operators. These factors would produce a large degree of overlap between the experiences of the contractors interviewed and the experiences of the employees working for them. Any differences in their viewpoints would be those resulting from the contractors having taken on an additional role as entrepreneurs interacting with outside organizations, such as major licensees and the Ministry of Forests. The hazards the contractors identified and the causes they attributed them to also generally correspond with those identified in other studies investigating injuries in the logging industries of other parts of Canada and other countries. The Workers' Compensation Board of British Columbia identifies trees, unstable ground surfaces, vehicle accidents, and heavy machinery as important sources of injury in the forestry and log hauling industries (Workers' Compensation Board of British Columbia, 2006). Salisbury et al. (1991) and West et al. (1996) both identify features of forest work sites and heavy equipment as hazards, while Ostberg (1980), Sundstrom-Frisk (1984), and Lilley et al. (2002) all show relationships between economic pressures and safety behaviors.

The correspondence between the dangers the contractors identified and those highlighted in the literature also suggests that their workplace behavior is not usually due to a lack of knowledge about what the hazards are. Ostberg (1980) and Sundstrom-Frisk (1984) make similar observations in their studies, pointing out that loggers are generally well aware what constitute dangerous situations in logging operations. They also point out that fallers and supervisors consistently underestimate the degree of risk in situations that are known to be dangerous (Ostberg, 1980; Sundstrom-Frisk, 1984). The question to answer in explaining injuries and fatalities in logging

operations is why the workers and supervisors accept the risks when the consequences are potentially fatal.

Most studies that have considered the role of economic systems in logging accidents have found that piece-work payment is related to accident rates and severity (Lilley et al., 2002; Ostberg, 1980; Sundstrom-Frisk, 1984). Mason's (1976) findings are partially contrary; he found that piece-work payment was not associated with accident rates, but that it was associated with higher accident severity. The studies suggest that piece-work payment systems tend to encourage ignoring safety practices if they are time consuming and they encourage working longer hours without adequate rest in order to increase production (Lilley et al., 2002; Ostberg, 1980; Sundstrom-Frisk, 1984). Piece-work may also encourage taking short-cuts, which is often identified in the literature on logging injuries as an important cause of serious accidents (Ostberg, 1980; Salisbury et al., 1991). Most logging industry employees in British Columbia are paid an hourly wage over \$CDN 20 per hour, even in non-union crews, and piece-work payment is not common (Resource Systems Management International, Randy Sunderman and Associates, and Guidelines Consulting, 1999). Contracting is very common in the BC logging industry (Resource Systems Management International, Randy Sunderman and Associates, and Guidelines Consulting, 1999), however, and according to the logging contractors interviewed, their contracts are paid by volume. The system is piece-work at the small firm level and it places intense production pressures on the logging contractors. These pressures, and the short-cuts they encourage, are shown clearly in the logging contractors' descriptions of their schedules and practices. If the contractors who supervise logging operations are avoiding equipment checks and neglecting to clear escape routes it is likely that the loggers in their crews are as well.

While the contracting system in the BC logging industry encourages behaviors that increase the probability of accidental injuries and deaths, it also influences the system of beliefs surrounding risks. Collinson (2003) points out that in the western industrialized countries contracting adds a degree of uncertainty, and that is the case in the North Okanagan/Shuswap logging industry. He and other theorists (Collinson, 2003; Douglas & Wildavsky, 1982; Gudeman, 2002; Lupton & Tulloch, 2002) have suggested that uncertainty and risks can have important influences on how people see the world around them. One common response to uncertainty is to behave pragmatically, using whatever practices seem likely to be effective within the immediate context (Douglas & Wildavsky, 1982; Gudeman, 2002). The tendency toward pragmatic responses was also noted in a study of small



business owners' responses to workplace health promotion programs (Eakin, 1992). Like the small business people Eakin (1992) studied, logging contractors are more concerned with the day-to-day requirements of running their businesses than with points of abstract principle.

Another response to uncertainty is for individuals to adopt a self-identity that reduces their sense of vulnerability. Collinson (2003) suggests that capitalist economic systems within individualistic western societies are particularly prone to uncertainty and that self-identification with occupations tends to be strong. He goes on to suggest that highly competitive work environments tend to promote careerist self-identities. These self-identities are marked by devotion to one's job, by using personal relationships with family and friends to assist in one's work, and by a strong sense of personal accomplishment and pride (*ibid.*). While the careerist self-identity tends to focus attention on the job and increase the individual's success in a competitive atmosphere, it also often has consequences for individuals. These include promoting an excessive sense of individual responsibility for successes and failures, encouraging individuals to push themselves in ways that over-extend their capabilities, leaving them vulnerable to status loss when they are surpassed by others, and potentially damaging other aspects of their lives, such as relationships and leisure activities (*ibid.*). The features indicating careerist self-identities are common in the accounts the contractors in this study gave of their work lives, particularly in their descriptions of the positive aspects of workplace risks and in their view that the individual is responsible for identifying and avoiding danger. While other aspects of a person's life, such as family relationships, recreational activities, and community involvement could also contribute to a sense of identity, thereby lessening reliance on work for self-esteem (*ibid.*), in the case of forest industry contractors the fact that they often weave family life into their work and that they have little time away from work during the logging season serves to narrow the focus of their identities toward their work.

Uncertainty and risk may also shape self-identity on a more general level. Neutralization theory suggests that rather than changing their behaviors to fit wider society, people who are considered dangerous or deviant risk-takers tend to fit their justifications to the norm, and in doing so minimize their apparent divergence from it (Peretti-Watel & Moatti, 2006). They do this by scapegoating some group members to appear normal by comparison, by drawing comparisons that equate their own risky behaviors with those that are socially accepted, and through self-confidence that they are able to avoid harm that the risks they take could bring (*ibid.*). People who are identified with risk-taking may also respond to feelings of uncertainty, helplessness, or



domination with voluntary risk-taking, which restores their sense of personal control (Lupton & Tulloch, 2002; Peretti-Watel & Moatti, 2006). All of these ways of framing risky behaviors are shown in the logging contractors' discussions about their work. They scapegoated injured workers by attributing their accidents to inexperience, poor training, or being unobservant. Even when they talked about their own accidents, they framed them as being the result of inexperience which they had subsequently learned from, which reinforced the image of their own self-confidence and skill. They compared the risks in their own work with those in fire fighting, and with risks in mundane activities, such as driving, in order to minimize the sense of difference. This was further reinforced when they suggested that people outside the industry have an exaggerated sense of the risks in logging. These attempts to minimize or neutralize the association between logging and danger were not consistent, however, and they also described their own risk-taking in positive terms as thrill-seeking and overcoming challenges.

Although the analysis presented in this chapter draws mainly on data provided by individuals occupying a specific niche within the British Columbia forest industry, and who live and work in a relatively small geographic area within the province, the insights drawn from it have implications for attempts to reduce logging industry fatalities. Recent responses by the BC government to high logging industry injury rates have gone in two directions. The Forest Safety Task Force, convened before the peak in fatalities in 2005, concluded that logging injury rates resulted from multiple causes, which were often interlinked. They argued that effective injury reduction policies required co-operation from all of the people working in the forests or overseeing the work (Forest Safety Task Force, 2004). In contrast, the BC Ministry of Forests is approaching logging fatalities as a problem of poor training and insufficient oversight (CBC News, 2006). This difference in approaches is at least partly due to the drastic increase in logging fatalities in 2005 having increased the controversy surrounding the issue. Regulating the logging industry is one of the responsibilities that the Ministry of Forests already has and increasing surveillance of it is a solution that can be enacted within a short period of time. It is also a solution that places the responsibility for accidents on the workers and their immediate employers, the contractors, without seriously questioning the existing power structures within the forest industry as a whole.

It is clear from the logging contractors' accounts that their views on workplace danger are not limited to the risks posed by the forest environment or work practices; social relationships, economics, and values

are also closely entwined with the decisions they make daily in the bush. It is also clear that in their view it is not possible to maximize their own safety and take care of their other concerns at the same time. Logging contractors, and by implication their employees as well, see themselves as facing a choice between accepting almost certain economic loss, and with it valued social relationships and self-identity, and continuing to accept a continuous but individually relatively low probability of serious injury or death. Douglas and Wildavsky argued that in such circumstances, “we [human beings] do not follow the simple rule that says to reduce uncertainty; when the prospect is negative, however enormous the possible loss, if its probability is low, we can generally push it out of the arena in which we are choosing. So we are actually creatures who habitually tolerate risk” (1982, p. 79). The contractors interviewed in this study would whole-heartedly agree. Increased surveillance by the Ministry of Forests and the major licensees does nothing to change the conditions the contractors and their workers are faced with, except to reinforce the sense that they are not in control.

This sense of uncertainty is one of the factors that contribute to cultural views in the logging industry that are difficult to reconcile with changing work practices toward emphasizing safety rather than production. It is the contractors’ attempts to manage uncertainty by retaining experienced workers and hiring friends and family which produce the closely knit crews that make advocating for new practices difficult for employees. The members of a crew know each other as individuals and criticisms of their work practices are likely to be taken personally; criticisms question the experience and skill that they value as measures of their identity and personal worth. The contradictory, but simultaneous, tendencies toward a fatalistic view that the forests are unpredictable and risks cannot be avoided and toward an individualistic view that accidents are the fault of individuals, are also reactions to uncertainty in logging. Both tendencies focus attention away from system-level causes and are unlikely to lead to new safety practices. If the contractors’ accounts of their past behaviors, and the reasons given for them, can be trusted, it is very likely that in spite of the Ministry of Forests initiative they will continue to accept the risk of dying at work and changes in their practices will be minimal.

The report by the Forest Safety Task Force presents an alternative approach to reduce logging industry injuries and fatalities. That task force solicited input from a broad range of people who were involved in the British Columbia forest industry and their report recognizes that multiple factors, including social and cultural norms, contribute to accidents. The task force report also pointed out that the factors overlap

and influence each other, and that interventions will need to address multiple aspects of the logging industry if sustainable accident reductions are to be achieved (Forest Safety Task Force, 2004). The recognition expressed in the report of the interrelated nature of the logging industry and the causes of accidents is a hopeful sign that workplace safety interventions in BC may start addressing accident prevention at the system level.

Research by social scientists could make important contributions to designing and evaluating these interventions. The analysis presented in this chapter shows that the logging contractors identified a range of hazards, including features of the physical environment, human behavior, and the economic system, and that they had consistent responses to the risks the hazards posed. The consistency of the responses should not be taken as an indication that logging contractors, or the industry in general, are incapable of change. Logging contractors are entrepreneurs who pragmatically apply innovations in order to improve their businesses and the similarities between their responses are the result of interacting with a similar set of challenges over time. This pragmatism is likely to generate resistance to new safety regulations if the contractors believe that the financial costs will put their livelihoods at risk, and their previous experience with government regulators and the major licensees is such that they expect be forced to bear the burdens from any new policies. The contractors' pragmatism is more nuanced than simple economic maximization, however, and they do not put their employees at risk callously; the employees are usually their friends or family, and they are recognized as valuable contributors to the success of the business. This gives logging industry contractors a personal stake in the well-being of their employees, which may be important in encouraging them to adopt new safety practices. If safety policies in the British Columbia logging industry, or any other industry, are guided by detailed understanding of linkages between economic and cultural systems it will improve the chances that the policies will be able to harness potential for positive change and avoid piecemeal approaches that struggle against social, cultural, and economic dynamics within the workplace.

## NOTES

1. The original study was the field research component of my Master of Arts program in Social Anthropology at the University of Calgary. The research protocol was submitted to the University of Calgary's Conjoint Faculties Ethics Review Board for ethical review and was approved prior to my starting the field research.

2. The term “forest floor” workforce distinguishes forestry workers from the “shop floor” workforce in the mills, although some authors do not make the distinction (e.g., Dunk, 1994). In the current forest industry, forestry and mill-work are both full-time occupations and the workforces are almost mutually exclusive, although they did historically overlap to some extent on a seasonal basis in some parts of the BC interior (Arruda, 1999).

## ACKNOWLEDGMENTS

Funding for this research was provided through Graduate Research Scholarships administered by the Department of Anthropology at the University of Calgary. I am grateful to the residents of the North Okanagan/Shuswap, whose interest in this project and hospitality during my research was a great help. I would like to thank Dr. Doyle Hatt, Dr. Alan Smart, Dr. Penny Hawe, and Dr. Melanie Rock, each of whom has contributed, and continue to contribute, to my understanding of this subject. I would also like to thank the anonymous reviewers for their encouragement and helpful comments.

## REFERENCES

- Arruda, T. F. (1999). “You would have had your pick”: Youth, gender and jobs in Williams Lake, British Columbia. In: *Beyond city limits: Rural history in British Columbia* (pp. 225–233). Vancouver: UBC Press.
- Barth, F. (1963). Introduction. In: F. Barth (Ed.), *The role of the entrepreneur in social change in northern Norway* (pp. 5–18). Oslo: Universitetsforlaget.
- British Columbia Government. (2002). *Ministry of Forests – Apportionment system: TSA AAC, Apportionment and Commitments, Okanagan TSA*. Retrieved June 11, 2002, from [http://www.for.gov.bc.ca/ftp/Branches/Resource\\_Tenures\\_&\\_Engineering/external!/publish/apportionment/Okanagan.pdf](http://www.for.gov.bc.ca/ftp/Branches/Resource_Tenures_&_Engineering/external!/publish/apportionment/Okanagan.pdf)
- British Columbia Government. (2006). *Regional District 37 – North Okanagan, statistical profile. BC Stats* [On-line]. Retrieved February 10, 2007, from [http://www.bcstats.gov.bc.ca/data/sep/rd/Rd\\_37.pdf](http://www.bcstats.gov.bc.ca/data/sep/rd/Rd_37.pdf)
- British Columbia Government. (2007). *A guide to the BC economy and labour market-2006 edition. BC Stats* [On-line]. Retrieved February 9, 2007, from <http://www.guidetobceconomy.org/Library/GBCE.pdf>
- CBC News. (2005, December 5). *BC logging industry deaths more than double in 2005*. CBC News [On-line]. Retrieved December 6, 2005, from <http://www.cbc.ca/story/canada/national/2005/12/05/logging-051205.html>
- CBC News. (2006, January 19). *BC investigating jump in logging deaths*. CBC News [On-line]. Retrieved January 19, 2006, from <http://www.cbc.ca/story/canada/national/2006/01/19/logging-deaths060119.html>

- Collinson, D. L. (2003). Identities and insecurities: Selves at work. *Organization*, 10, 527–547.
- Douglas, M., & Wildavsky, A. (1982). *Risk and culture: An essay on the selection of technological and environmental dangers*. Berkeley, CA: University of California Press.
- Drushka, K. (1998). *Tie hackers to timber harvesters: The history of logging in British Columbia's interior*. Madeira Park, BC: Harbour Publishing.
- Drushka, K. (1999). *In the bight: The BC forest industry today*. Madeira Park, BC: Harbour Publishing.
- Dunk, T. (1994). Talking about trees: Environment and society in forest workers' culture. *Canadian Review of Sociology and Anthropology*, 31, 14–34.
- Eakin, J. (1992). Leaving it up to the workers: Sociological perspectives on the management of health and safety in small workplaces. *International Journal of Health Services*, 22, 689–704.
- Forest Safety Task Force. (2004). *A report and action plan to eliminate deaths and serious injuries in British Columbia's forests: A final report of the Forest Safety Task Force*. Vancouver: Workers' Compensation Board of BC.
- Grainger, M. A. (1996). *Woodsmen of the west*. Toronto, Ont.: McClelland and Stewart.
- Gudeman, S. (2002). Economic anthropology. In: A. Barnard & J. Spencer (Eds), *Encyclopedia of social and cultural anthropology* (pp. 172–178). London: Routledge.
- Harris, C. (1997). *The resettlement of British Columbia: Essays on colonialism and geographical change*. Vancouver: UBC Press.
- Hayter, R., & Barnes, T. (1997). The restructuring of British Columbia's forest sector: Flexibility perspectives. *BC Studies*, 133, 7–34.
- Hoberg, G. (2003). The British Columbia forest practices code: Formalization and its effects. In: M. Howlett (Ed.), *Canadian forest policy: Adapting to change* (pp. 348–377). Toronto, Ont.: University of Toronto Press.
- Horne, G., & Penner, C. (1992). *British Columbia community employment dependencies: Final report*. Victoria: Ministry of Finance and Corporate Relations.
- Lilley, R., Feyer, A.-M., Kirk, P., Gander, P., & Atkinson, P. (2002). A survey of forest workers in New Zealand: Do hours of work, rest and recovery play a role in accidents and injury? *Journal of Safety Research*, 33, 53–71.
- Lupton, D., & Tulloch, J. (2002). "Life would be pretty dull without risk": Voluntary risk-taking and its pleasures. *Health Risk and Society*, 4, 113–124.
- Marchak, M. P., Aycock, S. L., & Herbert, D. M. (1999). *Falldown: Forest policy in British Columbia*. Vancouver: David Suzuki Foundation and Ecotrust Canada.
- Marchak, P. (1986). Labour in a staples economy. In: K. L. Lundy & B. Warne (Eds), *Work in the Canadian context: Continuity despite change* (pp. 24–44). Toronto, Ont: Butterworths.
- Mason, K. (1976). The Effect of piecework on accident rates in the logging industry (incorporating a different approach to the exposure problem). *Journal of Occupational Accidents*, 1, 281–294.
- Ostberg, O. (1980). Risk perception and work behaviour in forestry: Implications for accident prevention policy. *Accident Analysis and Prevention*, 12, 189–200.
- Peretti-Watel, P., & Moatti, J.-P. (2006). Understanding risk behaviours: How the sociology of deviance may contribute? The case of drug-taking. *Social Science and Medicine*, 63, 675–679.
- Reed, M. (2003). *Taking stands: Gender and the sustainability of rural communities*. Vancouver: UBC Press.

- Resource Systems Management International, Randy Sunderman and Associates, and Guidelines Consulting. (1999). *The contract harvesting industry in British Columbia: Final report*. Victoria: Science Council of BC and Forest Renewal BC.
- Salisbury, D. A., Brubaker, R., Hertzman, C., & Loeb, G. R. (1991). Fatalities among British Columbia fallers and buckers 1981–7. *Canadian Journal of Public Health*, 82, 32–37.
- Satterfield, T. (2002). *Anatomy of a conflict: Identity, knowledge and emotion in old-growth forests*. Vancouver: UBC Press.
- Satterfield, T. (1996). Pawns, victims, or heroes: The negotiation of stigma and the plight of Oregon's loggers. *Journal of Social Issues*, 52, 71–83.
- Slappendel, C., Laird, I., Kawachi, I., Marshall, S., & Cryer, C. (1993). Factors affecting work-related injury among forestry workers: A review. *Journal of Safety Research*, 24, 19–32.
- Sundstrom-Frisk, C. (1984). Behavioural control through piece-rate wages. *Journal of Occupational Accidents*, 6, 49–59.
- Trower, P. (1999). *Chainsaws in the cathedral*. Victoria: Ekstatis Editions.
- Wayman, T. (1993). *Did I miss anything? Selected poems 1973–1993*. Madeira Park, BC: Harbour Publishing.
- White, H. (1983). *The men there were then*. Vancouver: Arsenal Editions.
- West, R., Shkrum, M. J., & Young, J. G. (1996). Commercial logging fatalities in Ontario, 1986–1991. *American Journal of Forensic Medicine and Pathology*, 17, 299–304.
- Workers' Compensation Board of British Columbia. (2006). *Safety at work: Statistics for forestry. Worksafe BC* [On-line]. Retrieved February 9, 2007, from <http://www2.worksafebc.com/Portals/Forestry/Statistics.asp>
- Workers' Compensation Board of British Columbia. (2006). *From awareness to action. Worksafe BC* [On-line]. Retrieved February 9, 2007, from [http://www.worksafebc.com/publications/reports/statistics\\_reports/default.asp](http://www.worksafebc.com/publications/reports/statistics_reports/default.asp)

This page intentionally left blank

# MISSED CONNECTIONS: HYPERTENSION AND OCCUPATIONAL HEALTH AT THE SAN FRANCISCO MUNICIPAL RAILWAY

Beverly Ann Davenport

## ABSTRACT

*This chapter analyses efforts of the union and the management of a large urban transit company to address the high prevalence of hypertension among transit operators. Ethnographic evidence recounts the efforts to change the structure of work in order to decrease the problem. The chapter's key finding is that the features of the work environment that produce hypertension in transit operators in the first place also make it difficult for them to work together with their union leadership to push for lasting work changes necessary to improve their health over the long run.*

*The irony is, we've been reporting this stuff for a long time.  
It's hard to believe that things are going to change.*

—Health and Safety Committee Member, June 2000

---

The Economics of Health and Wellness: Anthropological Perspectives  
Research in Economic Anthropology, Volume 26, 127–150  
Copyright © 2008 by Elsevier Ltd.  
All rights of reproduction in any form reserved  
ISSN: 0190-1281/doi:10.1016/S0190-1281(07)26006-8



*However simple the change, really it takes a lot of political maneuvering to get it done.*

—Union Official, December 2001

Transit operators are highly likely to develop hypertension over the course of their employment; this is a well-known occupational health risk (Evans & Johansson, 1998; Kompier, 1996; Ragland, Krause, Greiner, & Fisher, 1998). This chapter is a case history examining efforts undertaken by the union and management of the San Francisco Municipal Railway (Muni) to address the high prevalence of hypertension in the transit operator workforce. It recounts attempts to ameliorate this problem through union–management collaboration and describes how some innovative approaches to change structural features of work devolved into a series of workshops for Muni employees known as the Ambassador Program which emphasized personal responsibility for health and stress management. It argues that this focus on personal responsibility – an idea plucked out of neoliberal discourse – normalized and naturalized *job strain*, the chief cause of the transit operators' hypertension (Belkic, Savic, Theorell, Rakic, & Ercegovic, 1994; Karasek & Theorell, 1990; Landsbergis, Cahill, & Schnall, 1999; Marmot & Theorell, 1997; Schnall, Landsbergis, & Baker, 1994; Schnall, Schwartz, Landsbergis, Warren, & Pickering, 1998; Syme, 1990; Yen, Frank, & Auerbach, 2002). In addition, this emphasis on the individual helped to foster distrust and cynicism among the rank and file and operated against group efforts to improve working conditions.

The data reported in this chapter were collected as part of a two-year ethnographic research project (2000–2002) on hypertension management practices in San Francisco bus drivers or, as they're formally known, transit operators. Material on the events that occurred prior to 2000 (i.e., the innovative approaches referenced just above) comes from interviews with union leaders including members of the Health and Safety Committee, long-time transit operators, first-line supervisors and representatives of senior management at Muni, and the principals of the Stress and Hypertension Study (see Case History), as well as unpublished and published material (Antonio, 1991; Caldwell, undated; Syme, 1998). Material on the Ambassador Program was obtained through documents and interviews as well as participant observation; I attended sessions of the Ambassador Training Program in fall 2000, winter 2001, and winter 2002.

## THE STAKES: BACKGROUND AND LITERATURE REVIEW

Neoliberal trends dominating public health discourse of the late 20th and early 21st centuries consistently point to the individual as the bearer of responsibility for his or her health and welfare (Lupton, 1999; Petersen & Lupton, 1996). For companies to encourage or even insist that employees take small steps to improve their health behaviors seems benign and reasonable, but corporate and bureaucratic enterprises often evade responsibility for the health of their employees through this tactic. In cases where conditions of work are known to cause very serious health problems, the focus on individual responsibility allows employers to relieve themselves of the burden of having to change the structural circumstances of the workplace. The Sago mine catastrophe in West Virginia in 2006 draws one's attention to the extreme forms of this employer failure (Legal Publication Services, 2006).

The instant case is a more subtle example of this. Its implications resound in the work lives of many "everyday" occupations where employees work in "high demand, low control" jobs, facing an occupational health risk known as *job strain* that has been repeatedly implicated in all kinds of chronic health problems (Karasek & Theorell, 1990; Marmot, Bosma, Hemingway, Brunner, & Stansfeld, 1997; Schnall et al., 1994; Yen et al., 2002). Occupational health research has shown that job strain can be mitigated by altering structural aspects of the workplace, including allowing individual workers a greater degree of decision-making ability, or *job latitude* (also referred to as *job decision latitude*) (Ala-Mursula, Vahtera, Kivimaki, Kevin, & Pentti, 2002; Marmot et al., 1997; Syme, 1990; Wallerstein, 1992). Not surprisingly, the research also shows that efforts to change work structures are often hotly contested among the interested parties within a given organization (Albright, Winkelby, Ragland, Fisher, & Syme, 1992; Elovainio, Kivimaki, & Vahtera, 2002; Evans, Johansson, & Rydstedt, 1999; Kivimaki, Leino-Arjas, Luukkonen, Riihimaki, & Vahtera, 2002; Kompier, 1996; Netterstrom & Hansen, 2000).

In the late 1980s through the 1990s bus drivers in San Francisco had a strong hand to play in their efforts to ameliorate their job strain. They had a relatively strong union, support from a highly credible academic institution (UC Berkeley), and abundant research data revealing the work-related causes of their ailments. Despite these advantages, the work structures in 2002 (when the data collection phase of this research was completed) were little different from what they were in 1989.

I rely on three related theoretical ideas to analyze what happened at Muni. The first comes from Michael Burawoy, who sought to explain why Marxist theory positing a unified working class interest did not fit his observations of worker behavior in a tool and die manufacturing plant in the Midwest. His ethnography, *Manufacturing Consent*, demonstrated that a shop floor culture centered on the “game” of “making-out,” that is, engaging in work behavior that functioned to maximize a worker’s individual interests above those of the group, resulted in thwarting the development of a cohesive group identity and interest (Burawoy, 1979). In the case to follow, the reader will see a similar pattern at work at Muni, captured and succinctly described in the frequently heard statement: “everybody’s looking to get paid.” Like Burawoy’s tool and die makers, Muni transit operators work in a society with a capitalist mode of production whose market-based system has the remarkable effect of making:

... relations among producers appear as relations among things. ... *As a lived experience*, the “commodification” of social relations (and, the opposite side of the coin, the personification of things) detaches itself from the conditions that produced it; it thus assumes an autonomy of its own and *appears to be natural and inevitable* (Burawoy, 1979, pp. 16–17, emphasis added).

The shorthand term for the “commodification of social relations” is “commodity fetishism” (Marx, 1977 [1844], pp. 435–445). The consequence of living and working within a social system governed by the capitalist mode of production is that “consciousness” does not defeat commodity fetishism’s “realness.” In other words, one’s awareness of the distinction between the lived experience of work where social relations are commodified and the true basis of the system in a set of social relations (i.e., consciousness) will not suffice to override the power of the ideology under-girding this mode of production to influence behavior. As Burawoy declares, “[i]t makes no difference whether the occupant of a place in production be Karl Marx, John Rockefeller or Joe Hill, the fetishism of commodities will be equally real for all” (1979, p. 17).

Durrenberger also found that little relationship between union consciousness and activism on the part of shop stewards in a hospital service union in a Midwestern city. He cited Jean Lave’s research based in practice theory to point out the difference between knowledge gained in formal settings and understanding gained in practical lived experience (Durrenberger, 1997). Durrenberger’s interpretation of practice theory is the second analytical strand of this chapter. Durrenberger and Erem explore this theoretical idea

in their book length ethnography of the union to explain both the successes and the failures of its organizing activities (Durrenberger & Erem, 2005). Knowledge alone will not change behavior they argue, because “patterns of thought are situational, determined by changing social structures” (Durrenberger & Erem, 2005, p. 49). Practice theory’s supple conceptualization of power offers a way out of the determinism that is implied in Burawoy. Both Durrenberger and Erem and Burawoy highlight the centrality of lived experience, but Durrenberger and Erem’s interpretation of practice theory allows for a more organic interpretation of human action and social change. Yes, the past informs human behavior, but it doesn’t absolutely determine it.

The approach that Durrenberger and Erem employ is also especially germane to my research because their project examines health care workers, who, like the employees of Muni, a publicly funded transportation agency, find themselves squeezed between a now outmoded civic value system that made room for expenditures on behalf of the public good without reference to profit or loss and the present day focus of governmental entities on competition, efficiency, and the bottom line reflecting the neoliberal ideology that pervades modern life (Durrenberger & Erem, 2005; Grengs, 2004).

Both Burawoy and Durrenberger and Erem draw attention to, albeit from different angles, the powerful difference between consciousness and action or, reframed, between knowledge and practice, and they both stress that it is *lived experience* that guides action (or inaction). Burawoy’s point that the hegemonic nature of the capitalist mode of production that shapes lived experience links to the third strand of theory relevant to this chapter. Foucault famously wrote, “It is in *discourse* that power and knowledge are joined together” (Foucault, 1990 [1978], p. 100). I argue that hegemony is the fulcrum of the power/knowledge axis that defines discourse.

Consider for a moment how transit operators describe their feelings about their work. Operators told me how they learned to distance themselves from their emotions about their jobs. One man told me, “all those crazy people on the bus are from Mars.” By making them extraterrestrial others, he didn’t have to worry so much about reacting to them: “trying to stay calm, that’s an important part of my profession.” Another woman referred to her driver’s compartment as a “sanity barrier.” Others told me how they had decided to either ignore or control their emotions; one man said, “my whole philosophy is I don’t deal with my emotions.”

The transit operators have come to take their responses to their jobs for granted and their language reflects the all pervasive stress discourse common

in late 20th and early 21st century America (Young, 1980). Whether to call this discourse ideological or hegemonic is only a matter of deciding on the degree to which one thinks that modern ideas about stress are so axiomatic that they are not “normally the subject of explication or argument,” because as Comaroff and Comaroff observe, the main difference between the two is that hegemony “is that part of a dominant ideology that has been naturalized and having contrived a tangible world in its image, does not appear to be ideological at all” (Comaroff & Comaroff, 2002, pp. 28–29).

The stress discourse gains power through the spiral of legitimation created by conflating the popular and scientific uses of the word and abetted by media reports on biomedical and psychological research which serve as the channel between the popular and the scientific domains. A “truth effect” emerges from this practice – the stress discourse creates and reifies a “modern, ‘stressed’ subject.” Stress becomes taken for granted; it is now “natural” and/or “biological,” and in the process, disconnects from historical and ideological/political contexts (Newton, Handy, & Fineman, 1995, p. 7).

The stress discourse goes hand in hand with the ideology of capitalism, an ideology that helps to separate workers from their own consciousness via the power of commodity fetishism. “Lived experience presents what is socially produced as ‘natural’ and beyond human control. It is unaffected by knowledge and the consciousness individuals carry” (Burawoy, 1979, p. 17). This is where these three analytical strands twist together. Despite the transit operators’ awareness of the occupational source of their stress, their consciousness could not help them significantly to alter their trapped relation to their work circumstances. The case narrative reveals this process as it moved through four phases: the origins of the “stress study,” the cable car experiment, the 22-line experiment, and the Ambassador Program.

## **CASE HISTORY: DOES “JOB STRAIN” OR “THE STRESS OF LIFE” EXPLAIN WORKERS’ HYPERTENSION?**

### *The Stress Study*

In 1978, June Fisher, a young doctor who had been on the faculty of Stanford Medical School, became the first medical director of the Occupational Health Service/Employee Health Service Clinic at

San Francisco General Hospital. One of the major tasks of the clinic was to perform pre-employment and required biennial Department of Motor Vehicles (DMV) medical exam for Muni transit operators. Dr. Fisher's mentor had been Bertil Gardell, an innovative occupational health researcher (Gardell, 1977; Gardell & Gustavsen, 1980). He was also a mentor to Karasek and Theorell, the originators of the job strain model discussed earlier (Karasek & Theorell, 1990).

Dr. Fisher's shoe leather epidemiology was picking up unusually high numbers of cases of hypertension among the transit operators who reported to the clinic for their biennial DMV health exam. She was aware of the Morris study which first brought to light the disparity in cardiovascular disease rates between London Transport drivers who sat all day and the conductors whose jobs required them to walk about collecting fares (Morris, Heady, Raffle, Roberts, & Parks, 1953a, 1953b; Morris, Kagan, Pattison, Gardner, & Raffle, 1966). She wondered whether the sedentary nature of the work of the bus drivers in her charge might contribute to their high rates of hypertension. Her curiosity led her to collect epidemiologic data from the clinic's earliest days.

Dr. Fisher contacted S. Leonard Syme, a professor of Social Epidemiology at University of California, Berkeley School of Public Health, and he and his postdoctoral student, David Ragland, were soon involved with her in launching an ambitious research program in collaboration with the Transport Workers Union Local 250-A (TWU Local 250-A), the bus drivers' union. This project became known as "the Stress and Hypertension Study" (Fisher, Greiner, Ragland, & Krause, 1996, p. 1).<sup>1</sup>

There are several things the circumstances of this research reveal. Muni operators have been "research subjects" for a long time. The original study design involved the participation of practically every member of the active workforce of Muni during the initial period of data collection (1983–1985); the same is true of its subsequent phases in the early and middle 1990s. Most of the long-time drivers I encountered were familiar with Berkeley and what they called "the stress study." It also demonstrates the apparent commitment to the research shown by both Muni management and the union. Since the cost to the agency was minimal, it isn't hard to understand why management would cooperate with the researchers. The reasons for such commitment from the union are just as obvious. The TWU has a long history of engagement with workers' health issues, going back to the time of its founder, Mike Quill. For example, in 1939, Quill was central in the establishment of a free medical plan for transit workers in New York City (Freeman, 1989, pp. 13–14). Historically, health concerns have had pride of

place in union activism, and the TWU has continued this tradition into the present (see, e.g., the cover photo of the *American Journal of Public Health*, April 2003, depicting TWU Local 100 (New York City) workers protesting the threatened loss of their health benefits and accompanying editorial (Quinn, 2003)).

Despite the efforts to collaborate, the TWU Local 250-A and Muni management have never had a smooth relationship. Muni's status as a city agency has engendered a highly politicized and bureaucratic work environment with a long history of controversy about the way the system is run (Perles, 1981). Transit operators feel the burden of this critique most intensely – they become whipping boys in the press reports and in the public's mind for the failures of the agency, but receive no praise when it is doing well (Davenport, 2004). Thus, the accumulating scientific evidence of health problems related to working conditions became a bargaining chip, a bit of political capital to be strategically deployed in contract negotiations, for example. This is the nature of power politics, of course. The really important question is, was there an effect caused by using "stress" as a bargaining chip that led to real change in operators' work lives? Let's examine the efforts to change working conditions for answers to this question.

### *Fixing the Schedule I: The Cable Car Experiment*

From the late 1980s onward an abundance of data from the Stress and Hypertension Study as well as other research elsewhere revealed that the two biggest sources of occupational stress for drivers were the schedule and the threat of violence (Carrere, Evans, Palsane, & Rivas, 1991; Evans & Johansson, 1998; Evans et al., 1999; Greiner, 1997; Kompier, 1996; Ragland et al., 1998). The Muni schedule had not been comprehensively updated in many years and failed to factor in the dramatic changes in traffic and ridership patterns that had occurred in the City of San Francisco. Indeed, in my own conversations with almost every transit operator I spoke to, the schedule was singled out as one of the most frustrating aspects of work. Acknowledging the deficiencies in the schedule, around 1990 the union and management agreed to try an unusual experiment, allowing the cable car drivers to create their own schedules, based on their "on the ground" knowledge. This experiment was noteworthy because from all reports it appeared to have included significant input from the gripmen and conductors who run the cable cars. The cable car experiment was an



attempt at increasing job latitude – a major adjustment for an organization known for its top-down management style and military-style chain of command.

Cable cars had been operating on a “turn and burn” system. When a team of operators got to the end of the line, they had to physically turn the cable car by positioning it on a piece of track that was on a round rotating platform (like a lazy susan) and then pushing the car, sitting in that bit of track, 180 degrees so that the front end was facing in the proper direction for the return trip. No time was allowed at either end of the trip for “recovery time” and “rest time,” two of the three “Rs” of transit scheduling considerations. The third “R” is *running time*, the time that it takes a bus to make a trip from one terminal of the route to the other, taking into account traffic and passengers at various times during the day. *Recovery time* means *vehicle* recovery time, that is, the leeway calculated into the schedule to account for unforeseen delays during a given trip. *Rest time* is the *operator’s* time, the time allowed for taking a short break, standing and stretching, using the restroom, etc., that is, calculated into the schedule. This is the most expendable time element in a schedule from the standpoint of a transit agency.

The turn and burn system had taken a high toll: the Cable Division led the agency in absenteeism and workers compensation claims – approximately one-third of the total – of particular note given the small number of operators who work in this Division (approximately 100 out of a total transit operator pool of approximately 2,000). In addition to the effect of job strain on blood pressure, cable car crews were also subject to musculoskeletal problems related to the turning around of the car at the terminal points and the generally higher degree of physicality required for the job, leading to a greater degree of wear and tear on their bodies (Ragland et al., 1998; Winkleby, Ragland, Fisher, & Syme, 1988)

The experiment allowed for a more flexible approach. Senior cable car operators were assigned responsibility for making the judgment of when to send out the next car, with the agreement that the operators would have 12 minutes of recovery time *guaranteed* at the end of a run. This plan “virtually eliminated the need for a transit inspector [to police] the working crews because it gave them a form of job latitude that is unprecedented in the transit industry [in the U.S.],” the union president reported at an international conference on transit safety in 1991 (Antonio, 1991). This experiment was modeled on the kind of activities to restructure work organization taking place in Sweden and other northern European countries which were taking the research on job strain by Karasek and Theorell as



been very seriously (Ala-Mursula et al., 2002; Evans et al., 1999; Gardell, 1977; Gardell & Gustavsen, 1980; Johanning, Landsbergis, Geissler, & Karazmann, 1996; Karasek & Theorell, 1990; Kivimaki et al., 2002; Schnall et al., 1994).

The conclusion of the story of the cable car experiment as told to me in an interview with the union official was revealing. Despite the reported success of the experiment using senior operators who “knew how to operate,” this experiment in job latitude – letting those closest to operations have some control over the nature of the operations – eventually fizzled out. Attempts to elicit more detail from the union leader as to why produced no more than a shrug conveying the message “that’s just the way it is here [at Muni].”

### *Fixing the Schedule II: The 22-Line Experiment*

Begun in early 1997, the 22-line experiment was an early manifestation of what became known as the Ambassador Program (see below). It was an ambitious effort to change structural features in the work organization for transit operators. The 22-Fillmore line was selected for this intervention because it was thought that its problems would not threaten to overwhelm the effort to fix them. It was a major line, one of the electric trolley coach lines operating out of the Potrero Division. It intersected with several other major lines in both the east–west and north–south directions, including the 38-Geary, the 1-California, all of the light rail lines (J, K, L, M, and N), the F- Market – the antique trolley line, newly beloved by tourists and locals traveling between the Castro District and Fishermen’s Wharf, and the 14-Mission, the longest trolley bus line in the city. Its problems included difficulties with traffic, especially double-parked delivery trucks in the trendy shopping district of the upper Fillmore. For a trolley bus, where the ability to get around stationary obstacles is limited by the length of the poles connecting it to its overhead power source, an obstruction in the traffic lane is not trivial. In addition, that line had two middle schools and one high school along its route, and there had been problems with behavior of the school kids on the bus. In short, the 22-Fillmore was an ideal test case because it was a major line, but as a union official told me, not the biggest of them all. The problems it faced seemed solvable and the lessons learned could then be applied to other lines.

The main things that were considered when it came to developing a plan for improving the 22-line were “safety, scheduling, and community relations” (interview, senior union official, January 2002), but the number

one issue was the schedule. The plans focused on identifying where time adjustments were needed. The second focus was on safety, specifically to address problems with school kids' rowdiness. This is a growing problem on city buses – one more way in which the bus has become a microcosm of the social world outside. In 2003 for example, an honor student was murdered on a Muni bus as he tried to intervene in a dispute between two other young people (Zamora, 2003). Muni was vilified in the press in the aftermath of this crime – blamed for not having figured out a way to manage the bus schedule to prevent the swarming of school kids on buses that routinely occurs from 2:00 PM to 3:30 PM, and also for failing to anticipate the crosstown rivalries among the teenagers from different schools and different “hoods” who might end up boarding the same bus (Knight, 2003; San Francisco Chronicle, 2003).

Operators are in a difficult situation here. Modern buses are huge, often “articulated,” that is, with an accordion-like hinge in their middles to facilitate their ability to negotiate turns. It is difficult to see what's going on in the back half of a 60-footer under normal conditions, much less when it's crowded, and they carry no weapons and run the risk of grave personal harm themselves. The buses are outfitted with both radios and silent alarms to alert Central Control (the nerve center of transit operations) and the police, but response times to these calls for help are often much slower than needed in a volatile situation.

These were the target issues in the 22-line experiment. A serious effort went into improving the situation, including the transit agency's hosting of a series of community meetings held in all of the various communities that the 22-line serves. It turned out that the new schedule was much better for the operators but this schedule required more than just time adjustments – it meant an increase in ticketing of commercial vehicles on Fillmore Street, which required both manpower and time from both the Department of Parking and Traffic and the San Francisco Police Department. It also meant a deployment of transit line coordinators (a.k.a. street inspectors or street supervisors) to monitor the situation on Fillmore Street on the ground to assess what was going on and begin to identify the routine traffic patterns that were causing problems for the buses on the route.

It quickly became apparent that the 22-line needed more buses in order for the experiment to have a chance at success. In fact, the issues facing the 22-line demonstrated the interconnectedness of various operational issues at Muni. Giving the 22-line more buses meant, at least in the short run, starting a zero-sum game since these buses would come from the existing stock. Since Muni was still recovering from more than 10 years of deferred

maintenance (from the mid-1980s to the mid-1990s), the supply of adequately maintained, “good” trolley buses was limited. In order for the 22-line to have good buses and enough of them to prevent excessive crowding, some other part of the system was going to have to suffer.

To control the unruly behavior of the school children, efforts were made to have the San Francisco police ride on the 22-line during the peak afternoon hours. This required formal collaboration with the San Francisco Police Department because Muni has no separate police unit. Although the police have a formal “ride-along” program with Muni, asking for specialized, focused attention along the 22 route meant that resources would have to be drawn from somewhere else. A zero-sum game, once again.

In the short run, the 22-line experiment was a success. As previously mentioned, the schedule changes were well received by the operators. S. Leonard Syme reported in an article published in 1998 that early reports on the project that increased job latitude afforded the drivers of the 22-line “made for measurable improvements in the service, and measurable improvements in operators’ morale” (Syme, 1998, p. 200). Regrettably, the data that would have linked the increased job latitude to improved blood pressure of the transit operators working on the 22-line could not be collected because operators move off and onto given bus routes in a pattern that would make it difficult to correlate blood pressures of operators with a given route, but it was clear that in terms of measurable work organization variables, the experiment had made a difference.

In the end, however, changes to the 22-line caused resources to be drawn away from other parts of the organization and ultimately that disparity caused the experiment’s demise. The operators on the 22-Fillmore line became both targets and exemplars of the Muni system – the most visible symbols both *within* and outside of the transit agency. Behind them lay a whole range of system changes that need to happen: improvements in maintenance of current equipment, procurement of new equipment (no Muni buses had been purchased in 10 years), a realistic appraisal of the schedule for this bus line – a schedule which had last been evaluated in 1970s. And the apparent unfairness of the extra attention being devoted to this single line when the general needs of the transit agency were so great caused irresolvable problems. Again, the conclusion of union official is telling: “And just like everything here at Muni, sustaining programs is very difficult unless you have somebody constantly kicking them in the tail.” Like the cable car experiment, the 22-line experiment ultimately fizzled out.

*Devolution: The Ambassador Training Program*

The Ambassador Program began in late 1999 and included the following elements:

- The Ambassador *Training* Program, a series of six all-day workshops designed to train transit operators and other Muni employees in communication, conflict resolution, and stress management (this activity was commonly referred to as “the Ambassador Program”).
- The Ambassador Newsletter, a glossy 8½ × 11 page periodical full of newsy articles about improvements to transit operators’ working conditions and profiles of operators and others around the property who were “making a difference.”
- Friends of Muni, a community outreach and education component.
- The Employee Assistance Program, a peer-based drug and personal problem referral service.

My remarks in this section focus specifically on the Ambassador Training Program, the most highly touted element. The union leadership and agency management portrayed the Ambassador Training Program as beneficial to and supportive of the transit operators, with no apparent awareness of the irony implicit in the term “ambassador.” The remarks of a senior union officer can be viewed in stark contrast to those of a rank and file employee in this regard. The union officer said: “the Ambassador Program is geared to supporting the operator, you know? ... give them the necessary support so that they can be ambassadors ... we made sure that they got trained first in the Ambassador Training Program ... then we said while that’s going on what can we do to improve their work environment so that they can be good ambassadors.” When I told the rank and file bus driver that I had to leave the gillie room (the break room) one rainy November morning and head over to one of the sessions of the Ambassador Training Program she said, “The Ambassador [Training] Program! When they sent me to that, I thought it was because I had done something wrong! I thought I was being punished!”

The Ambassador Training Program was led by independent consultants. Two days focused on diversity training, two days were for conflict resolution, and two days were devoted to stress management. During my observations of the stress management sessions the consultants provided an array of material on “self-care” – an eclectic collection of ideas from the popular culture about how to control stress, occasionally bolstered by inaccurate “scientific” information – in short, a hodgepodge pulled directly

out of the stress discourse. The handouts I collected taught the participants the language of stress and served as a way to remind them of their own personal responsibility to alleviate the stress in their lives.

For example, one of the handouts that they used was a multi-page booklet with the title on the first page, “Stress is an Occupational Issue,” followed by a series of symptoms introduced by the question: “Do you as a bus driver experience any of the following?” The symptoms – back pain, headaches, frequent tiredness, swollen or upset stomach, shortness of breath, numbed or tingling limbs, dizziness, difficulty in sleeping, high blood pressure, occasional pain in the chest or heart area, and mental overload – are a primer of the classic symptoms from the stress literature, and were followed by a list of the chief sources of “stress” in the job environment:

- The possibility of assault by passengers.
- Traffic congestion and peak running times.
- The risk of carrying large amounts of money.
- Lack of information about company management and no chance to suggest changes.
- No recognition of work well done.

Though this document seemed to acknowledge the very real problems with the work of a bus driver, it was misleading. By calling “the possibility of assault by passengers” (a common operator experience) something as generic as “stress,” it misses the more complex and accurate ways of describing that emotional response, for example, by naming it “fear.” Further, speaking about these work experiences in the same breath as the “normal daily stresses of everyday life” (e.g., traffic during your morning commute, worry over your children) trivialized the extremity of the wear and tear of the *occupational basis* for the “stress” (job strain) that the operators experienced.

Indeed, the Ambassador Training Program stress management sessions were notable for their emphasis on *personal* approaches to solving the problems defined as “stressful” on the job front. The helpful “hints” for managing stress were also personal – “control your attitude, eat right, sleep right, take care of yourself.” Of course, there is nothing wrong with this advice, it is sound and sensible, but it fails to acknowledge or take into account the reality of job strain and what is necessary to mitigate it.

This extended even to the public relations for the Ambassador Training Program. In the printed references to this training, it was consistently touted as a major effort on the part of the organization to improve things for operators. For example, on the cover page of the Ambassador Newsletter

for June 2001, an issue devoted specifically to promoting the Ambassador Training Program, there is a picture of the then chief operating officer of Muni with a quote from her extolling the training: "Muni is completely committed to this program. Its [sic] for everyone – managers to operators." Next to her, there's a transit operator's image with his remark: "The stress reduction techniques are what helped me the most." Inside are more quotes from operators attesting to the value of the Ambassador Training Program, including the following: "The classes really help you deal with the stress of being out there everyday."

The result of minimizing and normalizing occupational stress is that it influences operators' beliefs in their ability to effect change in the work environment. In all of the Ambassador Training Program sessions in which I was a participant observer there was a segment toward the end in which operators were asked to itemize problems on the job. The facilitators told the participants that their feedback would be compiled and given to management. Operators' comments often spoke to their frustration over their inability to exercise independent judgment to solve problems: having to go through Central Control was frequently described as a nuisance (at best) since the people who worked there often had no way of assessing the vagaries of a particular traffic situation that an operator was dealing with in the moment.

For instance, one operator told a story of a time when he was driving the 28-line, a major north-south route on the west side of the city. The operator explained that he had been at the northern terminal of this route (Fort Mason) one Sunday afternoon when he received a call from a fellow operator who told him that a eucalyptus tree had fallen across three northbound lanes of 19th Avenue (the major street this line traverses) and was tying up traffic in both directions. He also learned that three 28 buses were stacked up heading north (inbound) in this traffic snarl. When he called Central Control for guidance he was nevertheless told to start his southbound run. In his opinion this was unfathomably bad advice because he already knew he would then get tangled up in existing mess. It is impossible for us to judge what the right or wrong decision might have been in this context, but the point of this example is to illustrate an occasion where, from the point of view of the transit operator, his being thwarted from exercising intelligent independent judgment (i.e., job latitude) made a difficult situation that much more so.

Similarly, operators were asked at the end of the stress management modules I participated in (as the note-taker for the group) to imagine how a set of *personal* coping skills (closeness, communication, problem-solving,

flexibility) might be applicable to *structural* problems that they had identified as significant: bad equipment, budget issues, and “not-out” runs – bus runs that are scheduled but for one reason or another do not leave the barn. The operators shrugged, related their stories and then took a “you can’t fight city hall” attitude toward it all. They viewed the collection of complaints and suggestions as a *pro forma* activity, not an endeavor likely to effect real change.

The reaction of one of my key informants was fairly typical. She thought the stress management sessions were phony and irrelevant to her everyday experience. “It’s all about the money,” she repeated frequently. This came up over and over again in conversations with operators. They said, “Everyone is looking to get paid” – management, union leadership, the rank and file – and money considerations trump everything else. For example, the union leader quoted earlier said that the difficulty with pushing management to “deal with some of those things [changes to the structure of work] was because they were all money items and they were looking at them as being money items and not looking if it did work it would save money on the other end.” Short-term financial considerations colored almost every decision that Muni made, even extended to the funding mechanism of the Ambassador Program itself, and played a central role in its radical reconfiguration toward the end of my time in the field.

The Ambassador Program had been funded by the “Muni Improvement Fund” (MIF), which was written into the 1996–2000 M.O.U. (Article 6). The original funding (\$800,000) came out of overpayments to the “trust fund,” a Muni budget line item which had formerly been used to reimburse operators for health insurance costs which they used to pay for directly, and which had been a contentious issue back when Willie Brown ran for mayor in 1992. The MIF Board consisted of five representatives of the union (all senior office-holders) and five city appointees. A four-page leaflet written by an activist member of the union which was distributed widely to operators in late 2001 reaffirmed much that I heard through the ethnographic grapevine – that the consultants were grossly overpaid for the work that they did, that the “coordinator” for the MIF was also receiving generous consulting fees (\$30,000 per month, not including expenses) for what didn’t appear to be much work. Nothing in this leaflet said anything that would have changed the opinion of those operators who said, “everybody’s looking to get paid” and who then concluded that the better part of valor was to “make do” by making sure that one’s own personal interests were protected.



This echoes what my research participants said when they were asked about their expectations of the union leadership and of management at temporally separate points during our interviews. Those who had more senior leadership positions in the union (with one notable exception) declared that things were getting better, that it just took a long time and contended that the most important job of the union was to protect the membership's pay and benefits. Others, whether activist (e.g., regular attendees at union meetings, office-holders at either the division or local level) or not, fundamentally argued that the union leadership was to a greater or lesser degree complicit – “the Union is Muni!” – and that most of their co-workers were uninformed and not interested in putting forth any effort to get informed about the political and economic issues facing their employer and the impact of these on their own work lives.

As for their opinion of management, the prevailing point of view of my research participants was that “Muni is set up to fail.” There was one exception, a woman operator, and interestingly, the least senior of my research participants (with only six years of experience under her belt) who believed that “we have the power; we need to do more than just complain.” Another participant put the majority opinion most succinctly, “Management knows about the stress of the job, they just don't want to do anything about it.”

By the early winter of 2002 the Ambassador Program was under fire because there were major questions about how the money that had been allocated for the activity was actually being used by the trustees. The Ambassador Training Program sessions I attended toward the end of the intense phase of my fieldwork in January 2002 were sparsely attended. It seemed that upper and/or middle management had already begun to pull the plug on the program by tacitly encouraging dispatchers to “forget” to assign operators to attend the sessions. The stated objective of having employees from other departments participate as well seemed completely forgotten. Fifteen months earlier, in November 2000, there had been lively participation of about 15 people from many different segments of Muni. When I attended this same training module in January 2002 only three operators were present on the first day and it was canceled on the second. This was a harbinger of the decision to stop paying the outside consultants to run the training and to bring it “in-house,” to be taught by the Muni Training Department. My contacts with the organization have informed me that as of early 2005, the Ambassador Program has been officially retired.



*Small Successes*

For every disappointment cataloged on the previous pages, there are small successes to note, actions that have made a lasting difference in the work lives of transit operators. The common element running through the following examples is that of an individual or small group who took the initiative and maintained the effort to push for change in the working conditions. Some kind of change eventually happened, though most often it was in painfully slow increments, largely the result of the structural limitations in which the actors are bound.

*Cutting Down Exhaust Fumes*

Citing the health dangers of exhaust fumes which she researched and downloaded from the Internet, one of my research participants had succeeded in getting the management of her division to change the policy so that bus engines were not kept running at all times in the garage. This same operator was also working as a committee member of the Downtown Management Group, attending monthly meetings on her own time to figure out ways to help the police more effectively enforce diamond traffic lanes (limited to buses only) and red (no parking) zones downtown.

*Bathrooms on Bus Routes*

During my fieldwork I picked up Muni Bulletin 01-061, the 61st memo to operators published in 2001, which had a revised list of bathrooms for Muni personnel organized by transit line. The list was 14 pages long and included both Muni-built restroom facilities and restroom facilities located in restaurants, convenience stores, gas stations, and other locations where Muni has expressly made an arrangement with the owner or proprietor for transit operators to use. This seemingly mundane accommodation represented years of organizing and haranguing, largely on the part of women who began to work as transit operators in numbers in the late 1970s and early 1980s. The former Secretary-Treasurer of the Union described how different things were for women back then in a speech posted on the University of California Center for Labor Research and Education web site entitled “Surviving in a Man’s World” (Caldwell, undated). In the speech she itemized the accomplishments of the Women’s Committee of the union local, one of which was the passage of Proposition B, a half-cent sales tax that funded 22 stand-alone restrooms that Muni built.

*Operator Safety*

The Women's Committee also claimed responsibility for the installation of radios on buses for driver security, and a rule in the contract that stated "All equipment in use shall be equipped with *operable radios*. No operators shall be required to operate equipment not so equipped after 8:00 PM and prior to 4:00 AM." The question of violence on buses was also addressed by a newly hired occupational health and safety specialist who conducted focus groups in the early 1990s which led to the creation of a violence prevention policy, part of the injury and illness prevention policy that California state law requires of all employers. The policy included a statement assuring that operators didn't have to "risk violent injury in the course of performing his or her job," and in addition, promised upgrades of radios and silent alarm equipment on older buses and the inclusion of security cameras on newer buses.

## CONCLUSION

What do the examples of the cable car experiment, the 22-line experiment, the Ambassador Training Program, and the small successes just itemized reveal besides the obvious point that institutional change is at best incremental and at worst, fleeting? The impact of the "everyone is looking to get paid" philosophy recounted on the previous pages reflects Burawoy's point about the power of commodity fetishism over "consciousness" (Burawoy, 1979). The union officials had once been transit operators, but their ability/motivation to act on their knowledge of the relationship between work conditions, job strain, and the hypertension of transit operators may have been partially foiled by the "game" they were playing with Muni management. The transit operators I knew were not fools or dupes; nonetheless, they were similarly bound in a game that required that they look out for their own individual interests. Translating consciousness in active efforts to change the system required more than "will"; practical, lived experience guided their *actions*.

There is another perspective, though. In 1994, toward the end of his tenure as General Manager, Johnny Stein, one of the last of the breed of Muni general managers to work their way up through the ranks from transit operator, wrote a stunning "Bulletin to Operations Personnel." Titled "Results of the 'Study of Stress and Hypertension in Transit Operators,'" it provided a lengthy summary of the findings of the Berkeley researchers' work to that date and highlighted their recommendations. The first three of

these focused on efforts “to address the *underlying occupational causes of hypertension*” and included (1) the suggestion to test a system of guaranteed layover time (i.e., that expendable R in the 3Rs – rest time); (2) operator input in scheduling decisions; and (3) physical and social support for operators including improving radio contact and emergency responses and implementation of policies to assist operators during and after crises (San Francisco Municipal Railway, 1994).

This memo from the highest manager at Muni laid out the rationale for the cable car and the 22-line experiments, as well as the violence prevention policy. Indeed, the cable car experiment began during Stein’s tenure as GM. Did his lived experience as a former operator give him *added insight* that enabled him to loosen control in at least one area of the Muni workforce? It would be speculation to make such a claim, but Stein’s memo at least troubles the easy and automatic assumption of perpetual opposition between union and management.

Here is where Durrenberger and Erem’s more flexible characterization of consciousness and lived experience, available through the lens of practice theory lifts us out of the deterministic despair implicit in Burawoy’s contention that “[i]t makes no difference whether the occupant of a place in production be Karl Marx, John Rockefeller or Joe Hill, the fetishism of commodities will be equally real for all” (1979). All cultures are dynamic; even the most hidebound of organizations change though such changes may be difficult to discern in the short or even medium term. At Muni, one of the difficulties in sustaining change in the work structure was the frequency of turnover at the top. For example, between 1990 and 2002 – a 12-year span – there were six general managers, a fact perversely underscoring the salience of the expression, “the more things change, the more they remain the same.” It also underscores the messiness that history imposes on sharp-edged theories of power and institutional change. The uneven flow of public money available for Muni which has been an element in its history since the beginning and one that is likely to be exacerbated under the continuing neoliberal trends in the financing mechanisms of U.S. cities limits the opportunity for major restructuring as well (Grengs, 2004).

The transit workers’ awareness of their occupational health hazards was in dynamic tension with the “stress discourse” pervading their everyday lives but participated in efforts to change the structures of their work where they could (Newton et al., 1995). As Durrenberger and Erem observe, “working class awareness of structures is less a cultural convention than a recognition of the reality of powerlessness” (Durrenberger & Erem, 2005, p. 52). Given

the dynamics of their lived experience at work, the transit operators recognized that limited victories might be the best they can achieve. It is easy to scoff at the small successes like new toilets, or violence prevention policy statements without the necessary enforcement teeth, and to point to short-lived efforts to improve the system like the cable car and 22-line experiments as failures. But the toilets are permanent structures, there to stay, and the violence prevention policy affords operators a modicum of protection in the form of their rights to refuse to operate vehicles without the proper safety equipment. Every effort to improve work organization, failed or not, contains lessons to be learned for next time.

## NOTE

1. Early funding sources included the Urban Mass Transit Administration and the U.S. Department of Transportation; later sources include the National Institute of Occupational Safety and Health, the NIH, NIAAA, California Heart Association, AAA Research Foundation, Institute for Transportation Studies, UC Berkeley, Alcoholic Beverage Medical Research Foundation and the SF Municipal Railway Transit Fund (Fisher et al., 1996, p. 3).

## ACKNOWLEDGMENTS

Many thanks go to Donald Wood and the anonymous reviewer of this chapter for their very helpful comments, a well-mixed blend of positive reinforcement and constructive criticism that has made the final product much better (I think). I am responsible for any remaining flaws, of course. I am forever grateful to the Transport Workers Union Local 250-A for its willingness to help me. I also wish to thank those members of Muni management who opened themselves to me. I hope that June Fisher and David Ragland know that I really appreciate all the doors they opened for me. Their memories of the early days of the Stress and Hypertension Study were invaluable. This project would not have been completed without the thoughtful criticism and kind encouragement of my dissertation committee: Judith Barker, Gay Becker, Philippe Bourgois, and S. Leonard Syme. The research was partially supported by the University of California Institute for Labor and Employment Dissertation Fellowship and the National Institute on Aging (Minority Dissertation Research Grant, 2001–2003 [R03 AG 19830]).

## REFERENCES

- Ala-Mursula, L., Vahtera, J., Kivimäki, M., Kivimäki, M., & Pentti, J. (2002). Employee control over working times: Associations with subjective health and sickness absences. *Journal of Epidemiology and Community Health, 56*(4), 272–278.
- Albright, C. L., Winkelby, M., Ragland, D. R., Fisher, J., & Syme, S. L. (1992). Job strain and prevalence of hypertension in a biracial population of urban bus drivers. *American Journal of Public Health, 82*(7), 984–989.
- Antonio, R. (1991). *The transit "hot seat."* Unpublished.
- Belkic, K., Savic, C., Theorell, T., Rakic, L., Ercegovic, D., & Djordjevic, M. (1994). Mechanisms of cardiac risk among professional drivers. *Scandinavian Journal of Work and Environmental Health, 20*(2), 73–86.
- Burawoy, M. (1979). *Manufacturing consent: Changes in the labor process under monopoly capitalism*. Chicago, IL: University of Chicago Press.
- Caldwell, C. (undated). *Surviving in a man's world*. Center for Labor Research and Education, Institute for Labor and Employment, University of California. Retrieved June 28, 2001, from the World Wide Web: <http://ist-socrates.berkeley.edu/~iir/clre/programs/muni.shtml>
- Carrere, S., Evans, G., Palsane, M. N., & Rivas, M. (1991). Job strain and occupational stress among urban public transit operators. *Journal of Occupational Psychology, 64*, 305–316.
- Comaroff, J., & Comaroff, J. (2002). Ethnography and the historical imagination. In: J. Comaroff & J. Comaroff (Eds), *Ethnography and the historical imagination* (pp. 3–48). Boulder, CO: Westview Press.
- Davenport, B. A. (2004). *Driving driven: Urban transit operators, hypertension and stress(ed) management*. San Francisco, CA: University of California.
- Durrenberger, E. P. (1997). That'll teach you: Cognition and practice in a Chicago union local. *Human Organization, 56*(4), 388–392.
- Durrenberger, E. P., & Erem, S. (2005). *Class acts: An anthropology of service workers and their union*. Boulder, CO: Paradigm Publishers.
- Elovainio, M., Kivimäki, M., & Vahtera, J. (2002). Organizational justice: Evidence of a new psychosocial predictor of health. *American Journal of Public Health, 92*(1), 105–108.
- Evans, G., & Johansson, G. (1998). Urban bus driving: An international arena for the study of occupational health psychology. *Journal of Occupational Health Psychology, 3*(2), 99–108.
- Evans, G., Johansson, G., & Rydstedt, L. W. (1999). Hassles on the job: A study of a job intervention with urban bus drivers. *Journal of Organizational Behavior, 20*, 199–208.
- Fisher, J., Greiner, B., Ragland, D., & Krause, N. (1996). *Muni health and safety project: Presentation made to the meeting of San Francisco Planning and Urban Research Association*. Unpublished.
- Foucault, M. (1990[1978]). In: R. Hurley (Trans.), *The history of sexuality: An introduction* (Vol. 1). New York: Vintage Books.
- Freeman, J. B. (1989). *In transit: The transport workers union in New York City, 1933–1966*. New York: Oxford University Press.
- Gardell, B. (1977). Psychological and social problems of industrial work in affluent societies. *International Journal of Psychology, 12*(2), 125–134.
- Gardell, B., & Gustavsen, B. (1980). Work environment research and social change: Current developments in Scandinavia. *Journal of Occupational Behaviour, 1*(1), 3–17.
- Greiner, B. (1997). Job stress in urban transport. *Urban Transport, 1* (April/May), 11–15.

- Grengs, J. (2004). The abandoned social goals of public transit in the neoliberal city of the USA. *City*, 9(1), 51–66.
- Johanning, E., Landsbergis, P., Geissler, H., & Karazmann, R. (1996). Cardiovascular risk and back-disorder intervention study of mass transit operators. *International Journal of Occupational and Environmental Health*, 2, 79–87.
- Karasek, R., & Theorell, T. (1990). *Healthy work: Stress, productivity and the reconstruction of working life*. New York: Basic Books.
- Kivimäki, M., Leino-Arjas, P., Luukkainen, R., Riihimäki, H., Vahtera, J., & Kirjonen, J. (2002). Work stress and risk of cardiovascular mortality: Prospective cohort study of industrial employees. *British Medical Journal*, 325, 857–861.
- Knight, H. (2003, November 11). *Cops want schools to do more to end student violence; Pleas made after Muni killing* (p. A-11). San Francisco Chronicle.
- Kompier, M. A. J. (1996). *Bus drivers: Occupational stress and stress prevention*. Geneva: International Labour Office, Conditions of Work and Welfare Facilities Branch.
- Landsbergis, P. A., Cahill, J., & Schnall, P. (1999). The impact of lean production and related new systems of work organization on worker health. *Journal of Occupational Health Psychology*, 4(2), 108–130.
- Legal Publication Services. (2006). *MSHA and Sago Mine Facts based on questions asked of Mine Safety and Health News editor Ellen Smith*. Retrieved December 9, 2006, from the World Wide Web: <http://www.minesafety.com/pages/sagominefacts.html>
- Lupton, D. (1999). *Risk*. London: Routledge.
- Marmot, M., & Theorell, T. (1997). Social class and cardiovascular disease: The contribution of work. In: P. Conrad (Ed.), *The sociology of health and illness: Critical perspectives* (5th ed., pp. 93–105). New York: St. Martin's Press.
- Marmot, M. G., Bosma, H., Hemingway, H., Brunner, E., & Stansfeld, S. (1997). Contribution of job control and other risk factors to social variations in coronary heart disease incidence. *The Lancet*, 350, 235–239.
- Marx, K. (1977[1844]). The fetishism of commodities. In: D. McClellan (Ed.), *Karl Marx: Selected writings* (pp. 435–445). Oxford: Oxford University Press.
- Morris, J. N., Heady, J. A., Raffle, P. A. B., Roberts, C. G., & Parks, J. W. (1953a). Coronary heart-disease and physical activity of work. *The Lancet*, CCLSV(II, July–December 1953), 1111–1119.
- Morris, J. N., Heady, J. A., Raffle, P. A. B., Roberts, C. G., & Parks, J. W. (1953b). Coronary heart-disease and physical activity of work. *The Lancet*, CCLSV, 1053–1057.
- Morris, J. N., Kagan, A., Pattison, D. C., Gardner, M. J., & Raffle, P. A. B. (1966). Incidence and prediction of ischaemic heart-disease in London busmen. *The Lancet*, II(July–December), 553–559.
- Netterstrom, B., & Hansen, A. M. (2000). Outsourcing and stress: Physiological effects on bus drivers. *Stress Medicine*, 16, 149–160.
- Newton, T., Handy, J., & Fineman, S. (1995). *“Managing” stress: Emotion and power at work*. London: Sage Publications.
- Perles, A. (1981). *The people's railway: The history of the municipal railway of San Francisco*. Glendale, CA: Interurban Press.
- Petersen, A., & Lupton, D. (1996). *The new public health: Health and self in the age of risk*. London: Sage Publications.
- Quinn, M. M. (2003). Occupational health, public health, worker health. *American Journal of Public Health*, 93(4), 526.

- Ragland, D. R., Krause, N., Greiner, B. A., & Fisher, J. M. (1998). Studies of health outcomes in transit operators: Policy implications of the current scientific database. *Journal of Occupational Health Psychology*, 3(2), 172–187.
- San Francisco Chronicle. (2003). DeShawn's needless death. *San Francisco Chronicle (Editorial)*, A-24, November 14.
- San Francisco Municipal Railway. (1994). Bulletin to operations personnel, "Results of the study of stress and hypertension in transit operators" (J. Stein, author).
- Schnall, P. L., Landsbergis, P. A., & Baker, D. (1994). Job strain and cardiovascular disease. *Annual Review of Public Health*, 15, 381–411.
- Schnall, P. L., Schwartz, J. E., Landsbergis, P. A., Warren, K., & Pickering, T. G. (1998). A longitudinal study of job strain and ambulatory blood pressure: Results from a three-year follow-up. *Psychosomatic Medicine*, 60(6), 697–706.
- Syme, S. L. (1990). Control and health: An epidemiological perspective. In: J. Rodin, C. Schooler & K. W. Schaie (Eds), *Self directedness: Cause and effects through the life course* (pp. 213–229). Hillsdale, NJ: Erlbaum Associates.
- Syme, S. L. (1998). Social and economic disparities in health: Thoughts about intervention. *Milbank Memorial Fund Quarterly*, 76(3), 493–505.
- Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for health promotion programs. *American Journal of Health Promotion*, 6(3), 197–205.
- Winkleby, M. A., Ragland, D. R., Fisher, J. M., & Syme, S. L. (1988). Excess risk of sickness and disease in bus drivers: A review and synthesis of epidemiological studies. *International Journal of Epidemiology*, 17(2), 255–262.
- Yen, I. H., Frank, J. W., & Auerbach, J. A. (2002). *Improving the health of working families: Research connections between work and health with further implications for policy (by Auerbach)* (302). Washington, DC: National Policy Association.
- Young, A. (1980). The discourse on stress and the reproduction of conventional knowledge. *Social Science and Medicine*, 14B(3), 133–146.
- Zamora, J. H. (2003, November 7). *Gunfire on Muni hits teenage bystander; 17-year-old is tutor for younger kids* (personal collection of the author). San Francisco Chronicle.

# PAWNING FOR FINANCING HEALTH EXPENDITURES: DO HEALTH SHOCKS INCREASE THE PROBABILITY OF LOSING THE PLEDGE?

Kristiano Raccanello, Jayant Anand and Eder Gibran  
Bielma Dolores

## ABSTRACT

*Evidence from developed countries shows debt and bankruptcy to be correlated with medical expenditures. In Mexico, the formal financial sector does not lend for health needs. So, the solution is often found by borrowing from relatives, friends, and moneylenders, or pawning belongings after using savings, if any. Despite the recent and growing literature on income and health, and health financing, we have not come across a single study analyzing pawning and health. Our study fills this gap using a sample of 400 government owned pawnshop users from Puebla, Mexico. The findings from the study revealed that health expenditures are a significant reason for pawning and having medical insurance does not reduce the probability to pawn. Also, catastrophic health expenditures are correlated with a higher probability of not*

---

The Economics of Health and Wellness: Anthropological Perspectives

Research in Economic Anthropology, Volume 26, 151–172

Copyright © 2008 by Elsevier Ltd.

All rights of reproduction in any form reserved

ISSN: 0190-1281/doi:10.1016/S0190-1281(07)26007-X



*redeeming the pledge. We found that most pawnshop users have low income and losing a pledge is positively correlated with low or middle income and the number of people in the household.*

## BACKGROUND

The poor are perhaps the most vulnerable group of the society, exposed to a variety of risks: social, economic, environmental, and health among others. Risks can be idiosyncratic, when affecting an individual or household, or covariant, when groups of households, communities, regions, or even nations are involved (World Bank, 2001). There are formal and informal mechanisms to manage risks. These mechanisms aim at reducing and mitigating risks, and if risks do materialize, coping with subsequent shocks. Risk reduction mechanisms tend to reduce the probability of shock while risk mitigating strategies can be aimed at reducing the impact of shocks. Coping measures are adopted as (partial) response when shocks occur. Savings account, private or public insurance, and loans from financial institutions, among others, are considered as formal mechanisms. Informal mechanisms, rely, but not exclusively, on income diversification, safety-nets transfers, reduced food consumption, and child labor (World Bank, 2001).

In general, low level of income and low saving capacity, combined with the difficulty to accumulate assets, limit household ability to face the shock. According to Johannes Hoozeveen, Emil Tesliuc, Renos Vakis, and Stefan Dercon (2004), a health shock is the manifestation of (health) risk which leads, when being uninsured, to undesirable welfare consequences. In this chapter, we consider a health shock as every disease affecting family members that compels household medical expenditures. Health shock consequences can be tackled with formal insurance, informal insurance, or a combination of both which frequently imply out of pocket expenditures.

The worldwide landscape presents a difficult challenge: around 1.2 billion individuals live on less than \$1 a day, 75% of these are women. Many of these individuals do not have access to medical insurance or health programs, and also lack food and other basic services. Additionally, poverty is associated with low empowerment and high vulnerability, as well as low physical and social development. Diseases that affect individuals result in direct costs such as medical attention and treatment (Sinha & Lipton, 1999), as well as opportunity costs (loss of income, transportation costs, or schooling abandonment – permanent or temporary) that are related to

wealth reduction (Gertler & Gruber, 1997). The duration of a disease, its frequency, and the moment at which it takes place also influence consequences. For example, AIDS produces devastating effects for the poor since it causes a reduction in labor supply and a fall in the household income that forces families to sell not only non-essential, but also key productive assets to pay for the treatment (UNAIDS, 2004).

Bad health, low levels of education and low income are mutually reinforced: bad health prevents the acquisition of skills during school age; and, low levels of education translate into low income during adulthood. Under an intergenerational approach, low levels of income can drive into bad health and opportunity losses for future generations (Khandker & Faruquee, 2003). Because health accumulation, like human capital, is a process that begins from the conception of the individual, it is natural to analyze the early stages of the individual's development (childhood). The high degree of dependency on parents during childhood makes children particularly vulnerable. Anna Case, Darren Lubotsky, and Christina Paxson (2001) observe that the gradient presents antecedents related to childhood. In particular, chronic health shocks not only affect children from the poorest homes, but children's health also relates to their parents' long-term income average. The result is that the effects of these conditions are reflected in inferior academic results during the scholastic stage and worsened health in adulthood. Furthermore, this could harm the future income possibilities, emphasizing the intergenerational character of the vicious cycles due to the inter-temporary reinforcement of the relation: low health–low income–low health (Haddad & Alderman, 2000).

## **PERSPECTIVES ON HOUSEHOLD FINANCING**

Empirical evidence shows that the poor use many mechanisms to smooth their consumption due to income fluctuations to avoid a decline in their well-being. Once the household has undergone a shock, the related expenses can be paid by working more hours or by taking on an extra job (Kochar, 1999). Even if the poor generally draw on informal mechanisms *ex ante* in order to diminish the probability of asset loss when shocks materialize (Morduch, 1995), the literature indicates that households smooth their consumption only partially (Townsend, 1994). Ravallion and Chaudhuri (1997) find that informal insurance does exist, although it does not work perfectly. In other words, the poor cannot eliminate all the risk. Gertler and Gruber (1997) analyze how Indonesian households insure consumption

against health shocks. Their findings show that households can smooth consumption only to a certain extent and this is smaller if the shocks are of great magnitude. Jyotsna Jalan and Martin Ravallion (1997) find similar results for China. Susan Lund and Marcel Fafchamps (1997) observe that informal insurance has an age component since smoothing is easier for the young as compared to older individuals.

Insurance markets are present in both developed as well as in developing countries. Unfortunately, especially for the latter, due to contract failures and moral hazard problems, there is a shortage in the supply and only a few people can afford insurance given the relatively high monthly payments compared to wages. During the year 2000, only 1% of the population in Mexico had private health insurance, 40% had public insurance, and approximately 58.9% had no protection at all (Ministry of Health – Mexico, 2003).

According to Catherine Mansell Carstens (1995), financial services provided by the formal financial sector are not available to the poor because of their high cost. In addition, the lack of information about the credit status and a large income share coming from informal activities for the poor is used by formal financial institutions to justify credit rationing. In this case, people excluded from formal insurance market are forced to use other options that belong largely to the informal sector.

Melissa Jacoby, Teresa Sullivan, and Elizabeth Warren (2001), with data from the Consumer Bankruptcy Project in the US, observed that an important element in decisions of bankruptcy for US households is their out of pocket health expenditures. According to the empirical evidence they gathered for the US, from 1964 to 1997, the percentage of individuals in debt that have declared bankruptcy due to medical expenses varies between 2% and 50% (Jacoby et al., 2001, Table 1, p. 379), increasing with age. Additionally, being insured did not necessarily protect the household, since only one-fifth of those in bankruptcy did not have some type of medical insurance. This result concurs with those of Yu-Chu Shen and Joshua McFeeters' study (2005) with data from the National Survey of America's Families 2002. Although this study cannot determine causality, it does indicate that the problem of medical debt is worsened by the simultaneous presence of bad health and low income. Unfortunately, many of the studies reviewed by Jacoby et al. (2001, Table 1, p. 379) used different methodologies. Even though these studies are not directly comparable, they do show that the problem of debtors with medical 'cause' of bankruptcy is certainly present. The pressure of medical debt seems evident since many families declared bankruptcy after medical problems related with illness or

injury. According to Jacoby et al. estimations (2001, p. 377): during 1999 “nearly half of *all* bankruptcies involved a medical problem.” Grace Rollins (2003) reports financial problems related with medical expenditures, as well as with collection practices, for patients and relatives. Due to the intrinsic urgency of receiving medical attention, people are prone to sign almost any document for being attended. However, after having solved the ‘health problem’ in the short run, medical bills are often too high to be paid with available personal financial resources. Consequently, there is no option but to incur some sort of debt. Consequences of medical debt drive households into another kind of problem which varies between delaying additional health care and extra debt because of their inability to work (Pryor & Gurewich, 2004).

Households facing health shocks meet a difficult situation because there are several other problems that are an outcome of being in debt: electricity or water service suspension attributable to lack of payment, resigning medical visits, or not being able to afford medical prescriptions (Himmelstein, Warren, Thorne, & Woolhandler, 2005). All these complications make people susceptible to stress and anxiety related disorders (Gurewich, Seifert, & Prottas, 2003). We must mention that medical debts refer to obligations that originate legally. However, sometimes people also have to pay other informal headings that are related to the service obtained, and in other cases, with inefficiencies in the health system (Ensor & Savelyeva, 1998).

The literature that analyses informal financing in developing countries mainly looks at it from the viewpoint of directing resources toward productive aims and not consumption. Credit is viewed as a production input but not as an alternative source of finance for consumers. According to Manfred Zeller and Manohar Sharma (1998), informal financial markets are used by the poor to finance consumption, which formal credit institutions do not consider as a productive investment. Nevertheless, food and health financing allows maintaining the most important productive asset for unprotected people: their physical conditioning on which the sustenance of their households depends. For this reason consumption and investment are two inseparable elements (Zeller & Sharma, 2000).

Stuart Rutherford (2000) as well as Zeller and Sharma (2000) indicate that the poor want access to financial services since saving and obtaining loans allow a better handling of their resources and provides methods to smooth the impact of income losses on consumption. Since health needs, depending on their gravity, cannot always be postponed, alternatives to supply financial resources to individuals, other than savings, are used: viz. the sale of assets (as previously mentioned), loans, mortgages, or pawning some

items, among others (Rutherford, 2000). However, it should be noted that in some cases there is no option but to delay medical care (Al Serouri, Balabanova, & Al Hibshi, 2002). Robert Seifert (2004) points out that people with medical debts are more likely to turn to predatory loans. Kristiano Raccanello (2005) has shown that there are several mechanisms such as Rotating Savings and Credit Associations (ROSCAs), personal safety nets (mostly relatives, and, to a lesser extent, friends), moneylenders and, pawnbrokers are available to low-income people to finance health needs. These options are used more intensively by uninsured people but not in the same proportion.

### PAWNBROKING FINANCING

Pawnbroking has been a source of funding for many centuries and dates back to Babylonian, Athenian, and Roman epochs (Bouman & Houtman, 1988). In Europe, at the end of the 15th century, the Franciscans founded the first formal pawnshop to support the people who were using other high-cost lending systems. Because usury was a sin, and punishable by excommunication, the *monti di pietá* intended to be a cheaper option for people in need, but without any profit aims. Interests paid were necessary to compensate operation costs. The spread of the *monti di pietá* not only reflected the success of the initiative, but also the power of the church. With the reduction in power over succeeding centuries, the church discontinued its charitable work (Peterson, 2004). This did not entail the disappearance of pawn houses. Local governments continued the administration of pawn houses (Caskey, 1991), albeit the original charitable purpose decayed with time. During the succeeding centuries, in many countries, pawning was used frequently by individuals to make ends meet (Francois, 2006; Tebbutt, 1983).

Pawnbroking is often used because it is a simple mechanism to get money. When a person gives a specific asset, it is valued at a certain amount of money and the customer receives a percentage of that value if the offer is accepted. The pawnbroker keeps the asset during the time of the loan contract. On the lender side there is no adverse selection because he already has the asset. This means that there is no need to distinguish a high-risk borrower from a low-risk borrower (Caskey, 1994).

The importance of pawnshops as a source of funds for the needy is demonstrated by Caskey's (1991) study. In his work on the US, Caskey

shows that the number of pawn houses is positively correlated with the percentage of people in the US that fall below the national standard line of poverty, and negatively with the percentage of individuals with at least four years of pre-college education.

More recently, a study on pawning in Great Britain (Collard & Kempson, 2003) found that individuals with low- and middle-income use pawning as an attractive and fast way to obtain liquidity. This system is a source of liquidity and permits the recuperation of pawned assets by a previously settled contract between the customer and the pawnbroker. On the other hand, if the borrower decides so, or cannot pay the interests, the asset becomes a property of the pawn house which sells it most of the times in a public auction. This proves that the service is profitable and attractive for companies that lend money.

Loans coming from pawning are commonly used jointly with other funding options (loans from relatives or friends) with the purpose of financing some daily needs such as food or gasoline and to a lesser extent some unexpected cost such as car repairs (Dominy & Kempson, 2003). According to Caskey's (1994) analysis, in the US, resources obtained through the pawnshops are used for an expenditure pattern that is very similar to that in Great Britain (Collard & Kempson, 2003). However, in developing countries, pawnshops not only finance consumption but also participate in the financial intermediation by funding productive activities (Fernando, 2003).

Rutherford (2000) has shown that in developing countries, the majority of pawnshops accept gold, granting two-thirds of its commercial value like a loan, and charging a monthly interest rate of 3%. For loans on silver, a 5% interest is charged, and in a few cases other metals such as brass are accepted at a monthly interest rate of 9%. In Russia, the amount loaned is somewhere between 40% and 50% of the commercial value of the pledge, sometimes less, because the brand name is not taken into account and solely the value based on the weight of the metal at international prices is relevant (Patchenkov & Schrader, 2000).

It has been observed that insufficient knowledge in financial matters jeopardizes the clients because of their inability to forecast the consequences of the decisions related to the loans (Carr & Schuetz, 2001). In the worst case, these can cause a serious financial destabilization of the household (Carr & Kolluri, 2001). Additionally, this not only harms the indebted person, but also produces negative externalities that affect other members of the family. For example, moving to a cheaper suburb can be associated with less security, more violence, and so on (Peterson, 2004).

## PAWNBROKING IN MEXICO

In Mexico, there are different institutions devoted to lending (pawning) and can be officially divided into private assistantship institutions and private pawnshops. In the first group, the Nacional Monte de Piedad (NMP, founded in 1775), Montepío Luz Saviñón (1902), and the Fundación Rafael Dondé (1905) can be found. The other group is comprised of private pawnshops such as Prendamex, Prendafácil, and Prendacrédito that have been spreading all over the country and are perhaps the most common names among Mexicans. The unofficial segmentation of this market includes a third black sector of pawning which consists of an unknown number of pawn houses that change location frequently and/or operate their business only through newspaper announcements (Blanco, 2004). Outside the NMP (Puebla branch #1), there is a black pawning market composed of some people who usually buy articles not accepted by the institution and also discounted pawn receipts of the NMP. Unfortunately, we do not have any information about the ratio value of the asset – price offered, but we estimate it to be high.

The pawning market is attractive for pawnbrokers since 96% of customers got back their belongings (data for NMP) making Mexico an attractive market for firms like Mister Money-USA Inc. (*Economist*, 2005). Additionally, the pawning market is not tightly regulated in Mexico. Neither the financial and banking official authority (Comisión Nacional Bancaria y de Valores, CNBV) nor the Ministry of Economy (Secretaría de Economía, SE) supervise their activity (Blanco, 2004). In Mexico, a 1943 legislation regulates private assistantship institutions but there is no uniform federal law applying to all Mexicans (CONDUSEF, 2006). Furthermore, no law has been enacted for private pawnshops. This allows private pawnshops to have wide margins and charge high interest rates that can be considered as usury.

The most important pawning institution with largest number of annual transactions is the NMP which finances more than 8 million people through 14 million transactions a year. Approximately 3,500 million Mexican Pesos (318.2 million USD, at an exchange rate of 11MXP/USD) are lent annually (NMP, 2006). The NMP has 22 branches in Mexico City and more than 120 in the rest of the Mexican Republic. In 2005, two of these were located in the city of Puebla; currently there is only one. This institution has two functions: providing liquidity to the users, and through surpluses of its operations, supporting welfare and humanitarian programs. Generally, loans are provided against gold jewelry, and electric or electronic appliances. In a few branches, cars, sculptures, and farming machinery are also accepted.



The monthly interest rate is 4%. However, it must be mentioned that interest rates vary between pawning institutions and depend on the item pawned.

## **DATA AND METHODOLOGY**

Despite the recent and growing literature relating income and health as well as health financing, we have not come across a single study analyzing pawning and health. Since no data related to pawnshop users was available, a survey of 47 questions was applied to a convenience sample design of 400 customers of the NMP branch #1 and #2 during February and March 2005 in the city of Puebla. The survey was applied during office hours (Monday to Saturday, 09:00 a.m. to 02:00 p.m.) and asked for data related to household composition, socioeconomic aspects, reasons for pawning, frequency and number of items pawned during the last year, health expenditures, as well as the information referring to the persistence of the health shocks. Since other sources of financing could be used simultaneously with pawning, these were also investigated. Survey questions were read to customers; then, information provided was recorded in questionnaire forms. It is important to mention that no attempt was made to verify survey responses.

The survey provided interesting information about the distribution of variables for NMP customers. Out of 400 people surveyed (full sample), 79 of them pawned for medical reasons (this is almost 20% of the full sample). In 73.25% of the cases the full sample reported a monthly family income lower than 4,800MXP (436.40USD). This percentage is similar for people who pawned for medical reasons (73.42%). For the full sample, 38% of the people surveyed belonged to households where nobody had any medical insurance. This percentage raises to 48% when focusing on the subsample of individuals who pawned for medical reasons. Also, the great majority of the full and subsample did not have any bank account (77.25% and 83.5%, respectively). This shows that lower-income groups do not have access to the formal financial sector.

The financial landscape for people who pawned for medical reasons is even worse. For 44.30% of the subsample (35 cases out of 79), pawning was not enough to gather all required funds. So, other sources of finance had to be used. These were mainly family and friends safety nets (51.43%), and to a lesser extent, moneylenders/loan sharks (22.86%) and ROSCAs (20%). Additionally, households pawning for medical reasons showed higher instances of other previously owed debts (not for medical reasons) than the full sample – 53.16% vs. 49.59%.



In Mexico, the Ministry of Health defines catastrophic health expenditures as consumption of health goods which represent 30% or more of household income. In annual terms, we found that 18.50% of the full sample incurred catastrophic health expenditures. Among those who pawned for medical reasons, this percentage is even higher at 25.32%. Similarly, the mean of annual health expenditures per capita was 1,721MXP (156.50USD) for the full sample but 2,248MXP (204.40USD) for those who pawned for some medical reason. When pawning for health, the more frequent consequence related to a household member's illness is the reduction of both quality and quantity of food (37.97%).

## HYPOTHESES, MODELS, AND RESULTS

Following Manfred Zeller (1994), two probit models were estimated:

$$Prob(Y = 1|X) = f(I, H, E) \quad (1)$$

Eq. (1) represents the basic model. Where  $I$  is a vector of specific characteristics of the household;  $H$  is a vector that represents the human capital endowment; and  $E$  is a vector that contains information referring to health. It was necessary to include a vector of variables related to education, because literacy and education level also influence the decisions of the household with respect to health (Lindelöw, 2004; Wagstaff, 2002).

### *Hypothesis 1*

**Hypothesis 1.** *Pawning is a method of financing health expenditures when people do not have health insurance.*

We estimated Eq. (2) to test our first hypothesis:

$$\begin{aligned} Prob(pawnmr = 1|X) = & \beta_0 + \beta_1 lowincome_i + \beta_2 incomeprovill \\ & + \beta_3 householditems_i + \beta_4 household\_edu_i \\ & + \beta_5 medins_i + \beta_6 healthexpenditures_i \\ & + \beta_7 children_i + \beta_8 childrensq_r_i \\ & + \beta_9 pawnedbefore_i + \beta_{10} othfin_i \\ & + \beta_{11} ownshouse_i + \beta_{12} bankaccount_i + \varepsilon_i \quad (2) \end{aligned}$$

In this model (see Table 1 for estimation results for several variables' combinations) the dependent variable (*pawnmr*) is binary, taking the value '1' if the family has pawned for medical reasons and '0' if the family pawned for any other reason (viz. school, debts, food).

Since pawning can be used to finance health expenditures, we expect that household probability of pawning for medical reasons (*pawnmr*) is negatively related to low income (household's income smaller or equal to two minimum monthly wages) (*lowincome*) because the household probably lacks valuable items to be pawned.

We expect a positive relationship with the probability of pawning because of a major need of money in the family. We considered if the person affected by some illness is an income provider for the household (*incomeprovill*). If the individual is an income provider the dummy variable takes value of '1', and '0' otherwise. To control the socioeconomic status we considered the variable *householditems* which has an undefined sign due to the fact that having – say – a TV set or a computer does not guarantee having access to the NMP since the loan will depend on the model or processor speed of the item offered. The maximum education level in the household (*household\_edu*) takes values from 1 (primary) to 6 (postgraduate). If the household has a medical insurance (*medins*), a lower need of funds would present a negative correlation. A positive relationship is expected for health expenses during 2004 (*healthexpenditures*: a variable that takes values from 1 to 7; 1 for minor and 7 for a major expenditure on the basis of 30% of annual income according to the number of minimum wages) and the number of children in the household (*children*) and its square (*childrensq*).

We also considered whether the household had pawned in the past (*pawnedbefore*), relied on other sources of funds (*othfin*), owns its house (*ownshouse*), or has a credit or savings account in the formal financial system (*bankaccount*).

### *Discussion of Hypothesis 1*

According to the estimated results, a higher probability of pawning for medical reasons seems to be strongly and positively correlated to having pawned in the past since the dummy variable *pawnedbefore* presents a z-statistic greater than seven in all the models. When households have antecedents of having pawned in the past, they are more prone to pawn again. It could be an inertial factor that drives the families to use this source of funding continuously. Once they take it, they are more likely to use it again.

**Table 1.** Model 1 (Dependent Variable: Pawning for Medical Reasons).

<i>C</i>	−1.877*** (−3.308)	−1.898*** (−3.332)	−2.202*** (−3.617)	−2.150*** (−3.551)	−2.133*** (−3.479)	−2.183*** (−3.535)
<i>Lowincome</i>	−0.015 (−0.057)	0.018 (0.068)	0.009 (0.033)	0.011 (0.041)	0.004 (0.013)	−0.020 (−0.072)
<i>Incomeprovill</i>	9.654 (2.21E−05)	13.879 (8.73E−14)	11.985 (1.09E−05)	13.952 (1.85E−09)	23.002 (7.17E−14)	17.399 (9.75E−08)
<i>Householditems</i>	−0.071 (−0.754)	−0.068 (−0.712)	−0.100 (−0.965)	−0.059 (−0.605)	−0.059 (−0.593)	−0.092 (−0.853)
<i>Household_edu</i>	0.009 (0.088)	0.005 (0.046)	−0.011 (−0.105)	−0.010 (−0.098)	−0.011 (−0.103)	−0.010 (−0.100)
<i>Medins</i>	0.118 (0.486)	0.118 (0.477)	0.136 (0.541)	0.145 (0.578)	0.154 (0.613)	0.152 (0.603)
<i>Healthexpenditures</i>	0.243** (2.136)	0.245** (2.144)	0.267** (2.303)	0.262** (2.265)	0.260** (2.237)	0.271** (2.299)
<i>Children</i>	−0.050 (−0.752)	−0.055 (−0.840)	0.199 (1.134)	0.177 (1.011)	0.175 (1.001)	0.191 (1.080)
<i>Childrensq</i>			−0.037 (−1.560)	−0.035 (−1.474)	−0.035 (−1.473)	−0.037 (−1.538)
<i>Pawnedbefore</i>	2.566*** (7.828)	2.660*** (8.031)	2.769*** (7.884)	2.734*** (7.907)	2.729*** (7.791)	2.757*** (7.764)
<i>Othfin</i>	0.529** (2.114)					
<i>Relatives</i>		0.544* (1.699)	0.554* (1.692)	0.524 (1.607)	0.518 (1.571)	0.546* (1.644)
<i>Moneylenders</i>		1.393*** (2.975)	1.531*** (3.127)	1.469*** (3.050)	1.460*** (3.015)	1.528*** (3.100)
<i>Savings</i>					−10.017 (−5.29E−14)	−7.240 (−5.94E−08)
<i>Roscas</i>					0.022 (0.043)	0.043 (0.085)
<i>Ownhouse</i>			0.216 (0.821)			0.215 (0.814)
<i>Bankaccount</i>				−0.122 (−0.384)	−0.124 (−0.387)	−0.125 (−0.390)
McFadden <i>R</i> - squared	0.623	0.638	0.646	0.644	0.646	0.647
Log likelihood	−74.877	−71.960	−70.422	−70.689	−70.465	−70.129
H-L statistic	8.421	4.718	3.383	3.604	3.504	5.308
Probability (H-L statistic)	0.394	0.787	0.908	0.891	0.899	0.724
Observations	400	400	400	400	400	400

Note: *z*-statistics in parenthesis.

\**p*-value <0.10;

\*\**p*-value <0.05;

\*\*\**p*-value <0.001;

We found that health expenditures are a significant reason for pawning. The variable *healthexpenditures* (during 2004) was also significant at 5% and it was observed with a positive sign as expected. Since the household could have used some other sources of financing at the same time, in the models the variable *othfin* takes into account this possible situation and was found to be significant at 5%. Further, we disaggregated *othfin* into its components: *relatives*, *moneylenders*, *savings*, and *roscas* (with respect to credit, the category of reference). When using the components of *othfin*, only *relatives* and *moneylenders* were significant at 10% and 1%, respectively, showing a positive sign. Although the causality is unknown, a positive correlation exists. This can be interpreted as they being complementary sources of funding in case of need. The variables *savings* and *roscas* were not significant so they were dropped from the models reported without any substantial change in other parameters.

Contrary to the literature pertaining to informal health financing, we did not find any evidence that pawning for health needs is correlated with income or to the maximum level of education in the household. Additionally, having medical insurance (*medins*) does not reduce the probability to pawn. Furthermore, even if it is not significant, its sign is positive and casts doubts on the usefulness of the insurance. The variable *lowincome* as well as *incomeprovill* was never significant. That is to say, the status of the ill person as an income provider for the household had no effect on the probability of pawning.

The variables *children* and *childrensq* were also not significant even if their signs would indicate an inverse 'U' shape behavior. Owning the house where the household resides (*ownhouse*) or having a bank account (*bankaccount*) are not related with the probability of pawning for health reasons even if the last variable has the expected negative sign. The variable *householditems* shows a negative sign but since it is not significant, we cannot relate the number of items owned by the household with the pawning probability. Given the previous results, it is possible to argue that the number of children in the household, having a bank account, or the number of items in the household (car, refrigerator, television, computer, telephone, and cable) are not related to pawning decisions as a result of a health shock but health expenditures definitely do.

## Hypothesis 2

**Hypothesis 2.** *Higher health expenditures are related with a higher probability of not redeeming the pledge.*

Recognizing that depending on the disease severity some asset could be sold in order to reduce cash shortage, the second hypothesis suggests that higher health expenditures are related with a higher probability of not redeeming the pledge. In this case, the NMP would not help households to reduce impoverishment, at least due to health shocks. To test this hypothesis we estimated Eq. (3):

$$\begin{aligned} Prob(pledge\ lost = 1|X) = & \beta_0 + \beta_1 people_i + \beta_2 healthexpenditures_i \\ & + \beta_3 healthcatexp_i + \beta_4 urban_i \\ & + \beta_5 lowmidincome_i + \beta_6 incomeprovill \\ & + \beta_7 phone_i + \beta_8 fridge_i \\ & + \beta_9 ownhouse_i + \beta_{10} itemspledged_i + \varepsilon_i \quad (3) \end{aligned}$$

In this model, the dependent variable (*pledge lost*) takes the value ‘1’ if the household had lost at least one pledge for any reason during the last year, and ‘0’ if it had lost none. We expect that losing some asset at NMP is positively related to the number of people in the household (*people*), health expenditures during 2004 (*healthexpenditures*), especially if they have been catastrophic (*healthcatexp*), and negatively related if the household resides in an urban area (*urban*). On the other hand, we would anticipate a positive relationship, especially among those households with low- and middle-income level (*lowmidincome*). Again, we considered whether the ill person in the household is an income provider; in this case, the dummy variable (*incomeprovill*) takes value of ‘1’. According to the characteristics of this variable we expect to estimate a positive correlation.

To control for the services available to the household, dummy variables such as telephone availability (*phone*) and refrigerator possession (*fridge*) were included in the model. A measure of wealth was considered by the variable *ownhouse*, which took value of ‘1’ if the household owned the house in which they were living. Since the probability of losing a pledge depends also on the number of items pledged the variable *items pledged* (indicating the amount of items that had been pledged) was also included.

### *Discussion of Hypothesis 2*

Based on the estimation results for the probit models (summarized in Table 2) we found that households with low to middle income (between 1 and 10 minimum wages) are more prone to losing the pledge (significant at 10%), a similar conclusion can be drawn from sample descriptive statistics

**Table 2.** Model 2 (Dependent Variable: Pledge Lost).

<i>C</i>	-1.489** (-2.178)	-1.364** (-2.041)	-1.425** (-2.044)	-1.454** (-2.116)	-1.401** (-2.005)
<i>People</i>	0.105* (1.808)	0.092 (1.628)	0.104* (1.778)	0.105* (1.798)	0.103* (1.773)
<i>Healthexpenditures</i>	-0.168 (-0.858)	-0.265 (-1.378)	-0.169 (-0.862)	-0.173 (-0.882)	-0.173 (-0.883)
<i>Healthcatexp</i>	0.888** (2.105)	0.962** (2.328)	0.874** (2.068)	0.884** (2.094)	0.872** (2.062)
<i>Urban</i>	-0.737 (-1.527)	-0.967** (-2.074)	-0.718 (-1.489)	-0.736 (-1.526)	-0.719 (-1.491)
<i>Lowmidincome</i>	0.783* (1.714)	0.813* (1.820)	0.795* (1.738)	0.785* (1.720)	0.795* (1.740)
<i>Incomeprovill</i>	-0.178 (-0.505)	-0.176 (-0.510)	-0.187 (-0.530)	-0.187 (-0.530)	-0.194 (-0.548)
<i>Phone</i>	-0.584*** (-2.862)		-0.550** (-2.516)	-0.554*** (-2.568)	-0.527** (-2.318)
<i>Fridge</i>			-0.113 (-0.439)		-0.101 (-0.390)
<i>Ownhouse</i>		-0.256 (-1.327)		-0.087 (-0.420)	-0.077 (-0.369)
<i>Itemspledged</i>	0.055*** (2.698)	0.060*** (2.998)	0.053** (2.534)	0.055*** (2.679)	0.053** (2.531)
McFadden <i>R</i> -squared	0.139	0.113	0.140	0.140	0.140
Log likelihood	-106.307	-109.547	-106.211	-106.219	-106.143
H-L statistic	8.684	4.301	7.311	10.850	2.710
Probability (H-L statistic)	0.370	0.829	0.503	0.210	0.951
Observations	301	301	301	301	301

Note: *z*-statistics in parenthesis.

\**p*-value <0.10;

\*\**p*-value <0.05;

\*\*\**p*-value <0.001;

(not shown but available upon request). For people with higher income, it would be easier to redeem pledged assets, although they do not often use this method of financing. The variable *incomeprovill* was never significant in any of the model specifications. So, the illness of the household income provider has no effect on pawning probability.

Also, the variable *people* (number of residents in the household) shows a positive sign and is significant at 10%. It is intuitively easy to explain this relationship. Larger households generally face greater expenses and a larger necessity of money, which could make it more difficult to gather the amount needed to redeem the pledge. This will correlate with a higher probability of

losing the pawned article. Having a telephone connection is negatively related with the probability of losing the pledge (significant at 1%). Considering that such households have better economic stability, they exhibit a minor probability of losing the article.

Pledging more items is positively related with the dependent variable at 5% or even at 1% in some model specifications. The most important result is provided by the variable *healthcatexp* showing that catastrophic expenditures in health are positively correlated with the probability of not redeeming the pledge (significant at 5%). For households spending an equivalent of 30% (or more) of their annual income for health needs, a greater probability of losing assets in the NMP was observed. Due to this, we cannot reject the hypothesis that catastrophic health expenditures are related to a higher probability of losing some pawned items.

We found that the zone of residence (measured by the variable *urban*) is significant in only one model (see Table 2) and shows a negative correlation with the dependent variable. That is to say, households in less urbanized areas are more likely to lose pawned articles. Where the variable *urban* is significant (at the 5% level), we find that rural families who pawned are more prone to losing one of the pawned articles.

Other variables included in the models were *ownhouse* and *fridge*, but they were never significant even if the sign was as expected. On the other hand, absolute expense for health reasons in the household carried out during 2004 did not influence the probability to lose a pawned article. Additionally, the sign of the coefficient did not correspond to the result according to economic intuition.

## CONCLUSIONS

According to survey results, out of 400 observations, about 20% of the families who pawned at the NMP during February and March 2005 mentioned that it was due to a health shock. According to sample descriptive statistics, a medical expense was the third reason after home (27.5%) and school expenditures (22.25%). Therefore, in Puebla, people use pawnshops to make ends meet (see Table 3). In addition, households that pawn to cover health expenditures have slightly less wage earners compared to the entire sample and a lower monthly income as well. Members of such households also work more often in the informal sector (69% vs. 59%) and tend to rent their homes (49.37% vs. 39.75%).

**Table 3.** Reason for Pawning.

	Entire Sample	
	%	Observations
Home expenses	27.50	110
School	22.25	89
Medical	19.75	79
Debts	17.75	71
Food	7.50	30
Purchases	2.75	11
Travels	1.50	6
Other	1.00	4
Total	100	400

*Source:* Field surveys.

As expected, a large fraction of pawning households for health reasons (48.10%) do not have any medical insurance. Only 54% of those who have some protection have all household residents insured. Results show a dichotomy in the household behavior when insured: either all people are insured or only those who are working have this benefit (see Table 4). Most of the people surveyed did not have a bank account (77%). People who pawned for medical reasons seem to be even more excluded from the formal financial sector (83.5% do not have a bank accounts). Objects pledged are mainly jewels and appliances but the amount received does not seem to cover all health expenditures, probably because of other debt burden. This necessitates the use of other financial sources simultaneously. Such alternative sources of finance include relatives and friends, and to a lesser extent, ROSCAs and moneylenders (see Table 5). Around 25% of households that pawned for health reasons suffered catastrophic health expenditures.

### *The Econometric Models*

All models presented are correctly specified in accordance with the Hosmer–Lemeshow test. The econometric analysis provides evidence that the probability to pawn during February and March 2005 for obtaining funds to cover health expenditures is positively related to health expenditures during 2004, suggesting that pawning is a coping measure used by households to finance medical expenditures. Pawning seems to be accompanied by other sources of funds with borrowing from moneylenders



**Table 4.** Medical Insurance.

	Entire Sample		Pawned for Medical Reasons	
	%	Observations	%	Observations
Nobody	37.25	149	48.10	38
Somebody	62.75	251	51.90	41
Total	100.00	400	100.00	79
<i>If anybody, whom?</i>				
All	70.52	177	53.66	22
Just the worker	24.30	61	34.15	14
Husband/wife	1.20	3	4.88	2
Children	3.19	8	4.88	2
Brothers/sisters	0.80	2	2.44	1
Total	100.00	251	100.00	41

Source: Field surveys.

**Table 5.** Use of Other Financial Sources.

	Entire Sample		Pawned for Medical Reasons	
	%	Observations	%	Observations
Was not necessary	77.75	311	55.70	44
Was necessary	22.25	89	44.30	35
Total	100.00	400	100.00	79
<i>If necessary, they had money from:</i>				
Relatives/friends	52.81	47	51.43	18
Roscas	22.47	20	20.00	7
Moneylenders/loan sharks	14.61	13	22.86	8
Savings	7.87	7	2.86	1
Credit	2.25	2	2.86	1
Total	100.00	89	100.00	35

Notes: (1) Households face catastrophic expenditures if they spent the equivalent of 30% or more of their income for health purposes in the previous year (2004); (2) Survey questionnaire and additional results are available upon request.

Source: Field surveys.

and relatives being the most frequently used options. Also, there is a strong tendency to use pawning for health needs since having used this mode in the past has a very positive impact on pawning in the future. This is probably because the NMP could be the only financial alternative available to these people.

Contrary to expectation, having low income, children, as well as medical insurance (public or private) were not significant variables. The last result could be due to the fact that despite public insurance providing protection to the poor (while people belonging to higher socioeconomic groups rely on private institutions even when the public health service would attend to them for free) this is seldom used. According to users, this is because attention quality is not considered to be good at public health services (even as the government is trying to improve efficiency and service availability). Additionally, private insurance use is negligible among lower-income groups. A qualitative study for a suburb of Mexico City (Osorio Carranza, 2001) reports that lower-income groups tend to self-medicate. According to Osorio Carranza's study, it is evident that cultural aspects and idiosyncratic characteristics are present in the decision about where and from whom medical assistance is received. In such cases, being insured would not necessarily protect the household except in emergency situations or when surgery is needed.

Owning the house where the household was actually living or having a bank account were also not significant variables. However, losing a pledge is positively related with low or middle income and with the number of people in the household. In addition, the probability of losing a pledge increases with the number of items pledged and the presence of catastrophic health expenditures. The only variables negatively related to the probability of losing a pledge is having a telephone connection and, to a lesser extent, residing in an urban area. This could be explained since having a telephone requires periodic payments. This to a certain extent would imply some financial discipline in the household. The zone of residence measures, to some degree, the socioeconomic level of the household and also the household's access to public services. Unexpectedly, health expenditures were negatively related with the probability of losing a pledge but the coefficient was not significant.

Finally, this study shows that the NMP is another health financing option for the residents of Puebla that contributes to supplying resources to households in need. The results from this research motivate more extensive research on the role of pawnshops among low-income people living in developing countries, and also in informal health financing.

## REFERENCES

- Al Serouri, A. W., Balabanova, D., & Al Hibshi, S. (2002). *Cost sharing for primary health care: Lessons from Yemen*. Working Paper. Oxfam, G.B.

- Blanco, R. B. (2004). Financiamiento informal a las familias [electronic version]. *El Universal*. Retrieved November 12, 2006, from <http://www.eluniversal.com.mx/tudinero/1889.html>
- Bouman, F. J. A., & Houtman, R. (1988). Pawnbroking as an instrument of rural banking in the third world. *Economic Development and Cultural Change*, 37(1), 69–89.
- Carr, J. H., & Kolluri, L. (2001). *Predatory lending: An overview*. Working Paper. Fannie Mae Foundation, DC, Washington.
- Carr, J. H., & Schuetz, J. (2001). *Financial services in distressed communities: Framing the issue, finding solutions*. Working Paper. Fannie Mae Foundation, DC, Washington.
- Case, A., Lubotsky, D., & Paxson, C. (2001). *Economic status and health in the childhood: The origins of the gradient*. Working Paper no. 8344. National Bureau of Economic Research, MA, Cambridge.
- Caskey, J. (1991). Pawnbroking in America: The economics of a forgotten credit market. *The Journal of Money, Credit and Banking*, 23(1), 85–99.
- Caskey, J. (1994). *Fringe banking: Check-cashing outlets, pawnshops and the poor* (1st ed.). New York: Russell Sage Foundation.
- Collard, S., & Kempson, E. (2003). *Pawnbrokers and their customers (report)*. Bristol: The Personal Finance Research Center, University of Bristol.
- CONDUSEF. (2006). Casas de empeño y su funcionamiento [electronic version]. Retrieved November 12, 2006, from [http://www.bumeran.com.mx/aplicantes/contenidos/zonas/a\\_articulos.ngmf?IDZONA=430&IDSUBZONA=2&IDART=52460&ZH=0](http://www.bumeran.com.mx/aplicantes/contenidos/zonas/a_articulos.ngmf?IDZONA=430&IDSUBZONA=2&IDART=52460&ZH=0)
- Dominy, N., & Kempson, E. (2003). *Pay day advances – the companies and their customers*. Bristol: The Personal Finance Research Center & British Cheque Cashers Association, University of Bristol.
- Economist, E. I. U. (2005). Casas de empeño de EU prosperan en México [electronic version]. *La Jornada*. Retrieved November 12, 2006, from <http://www.jornada.unam.mx/2005/12/27/020n1eiu.php>.
- Ensor, T., & Savellyeva, L. (1998). Informal payments for health care in the former Soviet Union: Some evidence from Kazakhstan. *Health Policy and Planning*, 13(1), 41–49.
- Fernando, N. (2003). Pawnshops and microlending: A fresh look is needed. *Finance for the Poor*, 4(1), 1–4.
- Francois, M. E. (2006). *A culture of everyday credit: Housekeeping, pawnbroking, and governance in Mexico City, 1750–1920*. University of Nebraska Press.
- Gertler, P., & Gruber, J. (1997). *Insuring consumption against illness*. Working Paper no. 6035. National Bureau of Economic Research, MA, Cambridge.
- Gurewich, D., Seifert, R., & Prottas, J. (2003). *The consequences of medical debt: Evidence from three communities*. Boston, MA: Access Project.
- Haddad, L. J., & Alderman, H. (2000). *Eradicating malnutrition: Annual report essays*. Washington, DC: International Food Policy Research Institute.
- Himmelstein, D., Warren, E., Thorne, D., & Woolhandler, S. (2005). Illness and injury as contributors to bankruptcy [electronic version]. *Health Affairs-Web Exclusive*, 63–67. Retrieved February 6, 2005, from <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1.pdf>
- Hoogeveen, J., Tesliuc, E., Vakis, R., & Dercon, S. (2004). *A guide to the analysis of risk, vulnerability and vulnerable groups*. Washington, DC: Mimeo, World Bank.
- Jacoby, M. B., Sullivan, T., & Warren, E. (2001). Rethinking the debate over health care financing: Evidence from the bankruptcy courts. *New York University Law Review*, 76(2), 375–418.

- Jalan, J., & Ravallion, M. (1997). *Are the poor less well insured? Evidence on vulnerability to income risk in rural China*. Policy Research Working Paper no. 1863. Washington, DC: World Bank.
- Khandker, S. R., & Faruquee, R. R. (2003). The impact of farm credit in Pakistan. *Agricultural Economics*, 28(3), 197–213.
- Kochar, A. (1999). Smoothing consumption by smoothing income: Hours-of-work responses to idiosyncratic agricultural shocks in rural India. *Review of Economics Statistics*, 81(1), 50–61.
- Lindelöw, M. (2004). *Health care decisions as a family matter: Intrahousehold education externalities and the utilization of health services*. Policy Research Working Paper no. 3324. World Bank, DC, Washington.
- Lund, S., & Fafchamps, M. (1997). *Risk-sharing networks in rural Philippines*. Unpublished manuscript. Department of Economics, Stanford University, Stanford.
- Mansell Carstens, C. (1995). *Las finanzas populares en México*. México, DF: CEMLA, Editorial Milenio & ITAM.
- Ministry of Health – Mexico. (2003). *Health national survey 2000*. México, DF: Ministry of Health, Mexico.
- Morduch, J. (1995). Income smoothing and consumption smoothing. *Journal of Economic Perspectives*, 9(3), 103–114.
- NMP. (2006). Retrieved November 12, 2006, from <http://www.montepiedad.com.mx/>
- Osorio Carranza, R. M. (2001). *Entender y atender la enfermedad: Los saberes maternos frente a los padecimientos infantiles*. México, DF: CIESAS, INAH, INI.
- Patchenkov, O., & Schrader, H. (2000). *Let's go – the history of a post-Soviet pawn shop in St. Petersburg and its chairman*. Working Paper no. 324. Sociology and Development Research Center, Bielefeld University.
- Peterson, C. L. (2004). *Taming the sharks – towards a cure for the high-cost credit market*. Akron, OH: The University of Akron Press.
- Pryor, C., & Gurewich, D. (2004). *Getting care but paying the price: How medical debt leaves many in Massachusetts facing tough choices*. Boston, MA: The Access Project.
- Raccanello, K. (2005). *El rol de los mercados financieros informales para el gasto en salud. El caso de San Andrés, Puebla*. Unpublished manuscript. Department of Economics, Universidad de las Américas, Puebla.
- Ravallion, M., & Chaudhuri, S. (1997). Risk and insurance in village India. *Econometrica*, 65(1), 171–184.
- Rollins, G. (2003). *Uncharitable care*. New Haven, CT: Connecticut Center for a New Economy.
- Rutherford, S. (2000). *The poor and their money*. New Delhi: Oxford University Press.
- Seifert, R. W. (2004). The demand side of financial exploitation: The case of medical debt. *Housing Policy Debate*, 15(3), 785–803.
- Shen, Y.-C., & McFeeters, J. (2005). *Out-of-pocket health spending between low- and higher-income populations: Who is at risk of having high financial burdens?* Working Paper no. 11179. National Bureau of Economic Research, MA, Cambridge.
- Sinha, S., & Lipton, M. (1999). *Damaging fluctuations, risk and poverty: A review (background paper for the world development report 2000/2001)*. Sussex: Poverty Research Unit, University of Sussex.
- Tebbutt, M. (1983). *Making ends meet, pawnbroking and working-class credit*. New York: St. Martin's Press.
- Townsend, R. (1994). Risk and insurance in village India. *Econometrica*, 62(3), 539–591.

- UNAIDS. (2004). *2004 Report on the global AIDS epidemic*. Geneva: Joint United Nations Program on HIV/AIDS.
- Wagstaff, A. (2002). Poverty and health sector inequalities. *Bulletin of the World Health Organization*, 80(2), 97–105.
- World Bank. (2001). *World development report 2000/2001 – attacking poverty*. Washington, DC: World Bank.
- Zeller, M. (1994). Determinants of credit rationing: A study of informal lenders and formal credit groups in Madagascar. *World Development*, 22(12), 1895–1907.
- Zeller, M., & Sharma, M. (1998). *Rural finance and poverty alleviation (food policy report)*. Washington, DC: International Food Policy Research Institute.
- Zeller, M., & Sharma, M. (2000). *The demand for financial services by the rural poor (rural financial policies for food security of the poor, policy brief no. 1)*. Washington, DC: International Food Policy Research Institute.

# BASIC NEEDS AND EXPENDITURE ON HEALTH CARE IN A SHANTY TOWN OF LIMA

Mònica Guillén Royo

## ABSTRACT

*This chapter explores the contribution of health care expenditure to basic needs satisfaction. It focuses on Nuevo Lugar, a shanty town of Lima with access to modern health care services and infrastructures. The research follows a three-step approach beginning with the investigation of what is understood as basic needs through people's concepts of the "good life". It then identifies basic needs satisfiers in the slum – those goods and services people consume motivated by meeting their valued needs. Finally, it explores the case of expenditure on consultation fees, medicines and vitamin supplements. It finds that they might not make a significant contribution to people's physical health due to the lack of information on illnesses and treatments tailored to the local population, together with the high costs of medicines.*

## INTRODUCTION

Peru is one of the countries in Latin America with the greatest consumption disparities. The richest 20% account for 60% of total expenditure, whilst the

---

The Economics of Health and Wellness: Anthropological Perspectives

Research in Economic Anthropology, Volume 26, 173–198

Copyright © 2008 by Elsevier Ltd.

All rights of reproduction in any form reserved

ISSN: 0190-1281/doi:10.1016/S0190-1281(07)26008-1

share of the poorest 20% is reduced to a bare 3.2% (UNDP, 2006). Moreover, around 52% of the population lives under the national poverty line, as measured by comparing household expenditures with the minimum expenditure necessary to satisfy basic needs (INEI, 2006). Although poverty has a higher incidence in the rural areas (72% of the rural population are poor compared to 40% in Lima), inequality is especially visible in the capital city, where wealthy neighbourhoods coexist with a myriad of shanty towns.

Since the 1950s, Lima has experienced generalised invasions of its peripheral lands in order to accommodate the growing number of rural migrants. Nowadays, around 20% of the population live in the shanty towns, which are largely populated by second or third generation rural migrants, most of whom have adopted an urban lifestyle. This is evident in people's patterns of consumption which are nowadays closer to the richer urban groups than to the ones of their districts of origin. Slum dwellers have higher level of expenditure on non-food items than their rural counterparts; mainly on housing services and equipment, transport, leisure and health care (INEI, 2001; Guillen-Royo, 2007). The latter does not imply, for example, that people are increasingly better nourished since in Lima poverty measured by calorie deficiency has increased during the last period of economic growth (from 19% in 2001 to 30% in 2004) (INEI, 2006).

This study examines the case of expenditure<sup>1</sup> on health care in Nuevo Lugar,<sup>2</sup> a shanty town of Lima where the Wellbeing in Developing Countries (WeD) ESRC Research group ([www.welldev.org.uk](http://www.welldev.org.uk)) has undertaken five years of research on the cultural construction of wellbeing. It approaches expenditure on health care from its contribution to satisfy people's felt needs. It relates slum dwellers' accounts on their expenditure to the characteristics that needs satisfiers ought to have from a universalist approach to basic needs such as the Theory of Human Need (THN) (Doyal & Gough, 1991) and to Max-Neef's classification of satisfiers. The study also engages with claims that in Lima people are increasingly consuming positional goods, even in basic categories such as food or toiletries, which might reduce basic needs satisfaction and increase the traditionally high level of frustration of *Limeños* (Schuldt, 2004). The objective is twofold: first, to present a methodology to study the efficiency of goods and services as basic needs *satisfiers* from a bottom-up perspective, and second, to illustrate the proposed approach through the analysis of health care expenditure.

The case examined here draws from 27 in-depth interviews and 3 focus groups that I conducted in Nuevo Lugar during July–August 2005. The information obtained is complemented by WeD quantitative data on basic

needs and resource availability, and ethnographic notes from the WeD local researchers on the structural characteristics of the slum.<sup>3</sup> The structure of the chapter is as follows. First, I present the approach designed to study consumption from a needs-based perspective. Then, I introduce the context of Nuevo Lugar, with special reference to its structural characteristics. Next, people's definitions of the good life are presented and discussed with regards to their universality drawing on the THN. Later, I turn to the goods and services prioritised in the slum and the reasons why people stress their importance, focusing on the ones reported to aim at basic needs satisfaction. Finally, the study analyses health care expenditure; it illustrates how the basic needs approach is useful for unveiling the dissociation between consumption and basic needs satisfaction that is increasingly concerning poor neighbourhoods in Lima.

### **CONSUMPTION AND BASIC NEEDS: A THREE-STEP APPROACH**

Arguably, poor people's consumption is mainly driven by the satisfaction of basic needs. These are not only physiological but also embrace a limited array of priorities that might range from physical security to maintaining meaningful primary relationships. In spite of the fact that basic needs seem a quite narrow concept, the social science literature offers many "lists" or classifications that are not always conceptually comparable. Some theories take needs as societal requirements, others as prerequisites for given objectives and others as behavioural drives.<sup>4</sup>

In order to study how consumption contributes to basic needs it is then essential first to clarify the use of the concept in the research and second to define how the role of goods and services as satisfiers is going to be assessed. In this chapter, I follow Hamilton's (2003) approach that people internalise what is socially accepted as basic needs in a given culture. Once they feel them as their own, that culturally relative specification of basic needs becomes a motive for action. Within this framework, the study of consumption from a basic needs perspective is open to the possibility that needs are talked about as essential societal goals, motives for consumption or both. In order to pin down what is understood as basic needs in Nuevo Lugar and how they affect and are affected by consumption I follow a three-step approach based on a bottom-up research strategy.



*First Step: People's Concepts of the Good Life as Basic Needs*

A first step requires discerning what people consider as basic priorities. In order to do that, this chapter draws on the approach used by Clark (2002) in South Africa in his quest to generate a list of *functional capabilities*: those that are valued by the people targeted by development programmes. His objective was to test whether universalist theories represent people's values. He focused on Nussbaum (1995, 2000) and Sen's (1992, 1999) development ethic and confronted it with the views of poor people in two South African communities. He found that theoretical approaches to the good life were very close to those of poor people but that the latter valued capabilities such as free time, sleep and rest as much as they valued having a proper income or education.

Unlike Clark's approach, which was based on tutored and untutored questions, this research used an open format to investigate participants' concept of a "good life". People were not prompted or offered a predefined record of needs to discuss. The aim was not as much to get to a comprehensive list but to capture what was immediately felt as essential in Nuevo Lugar – to get to people's *felt and valued basic needs*.

In order to discuss the universality of people's accounts they were confronted with the basic and intermediate needs of Doyal and Gough's (1991) *Theory of Human Need* (THN). The THN provides philosophical justification for the universality of the two basic needs of *physical health* (having manual, mental and emotional abilities to function) and *autonomy* (to be able to make informed choices about one's aims and beliefs and about how to reach them), which are achieved through the satisfaction of a set of eleven *intermediate needs*. The latter are characteristics that goods and services should hold if they are meant to contribute to basic needs satisfaction. They are relative to the social context and they are likely to be present in people's description of the good life.<sup>5</sup>

The intermediate needs of the THN can be studied with regards to the basic needs they enhance. It is argued that physical health requires:

- *Adequate nutritional food and water* which should supply the minimum intake required to maintain bodily functions.
- *Adequate protective housing* that facilitates the avoidance of illnesses (although what is understood as adequate housing is relative). Proper dwellings should offer protection from extreme climate, diseases and diseases transmitters, as well as proper sanitation and enough space to avoid overcrowding.

- *Non-hazardous work environment*, work conditions should not entail excessive working hours, exposure to pollutants or health threatening hazards, or be alienating.
- *Non-hazardous physical environment*, meaning that the natural environment is free from high concentrations of dangerous pollutants.
- *Appropriate health care* implies access to medical services that provide the best techniques for preventing, curing and palliating illnesses.

The THN claims that autonomy is enhanced by:

- *Security in childhood*, meaning that children are loved, feel secure, have opportunities to play, and feel praised, recognised and increasingly responsible towards others.
- *Significant primary relationships* involving a set of personal connections that sustain the cognitive and emotional growth of the individual.
- *Physical security* in terms of reduced exposure to violence.
- *Economic security* concerning freedom from poverty, so that people have a standard of living which allows them to participate in their form of life.
- *Safe birth control and childbearing*, meaning that women have access to family planning.
- *Appropriate basic and cross-cultural education* so people learn what is necessary for active participation in the practices of their societies together with basic elements of universal and cross-cultural knowledge.

In the THN, goods and services that do not hold any of the above characteristics are considered as *wants satisfiers* in opposition to *needs satisfiers*. The differentiation between wants and needs is useful to distinguish those goals that if not satisfied result in serious harm for individuals, from those goals relative to personality, culture and social position that if unfulfilled do not threaten human functioning.

### *Second Step: Needs Satisfiers*

A second step aims at bringing to the surface the goods and services that are used as basic needs satisfiers in Nuevo Lugar. Guillen-Royo (2007) showed that for the seven Peruvian communities participating in the WeD research,<sup>6</sup> 76% of consumption was driven by basic needs (as defined in the THN). In this study the focus is not on quantifying the relative weight of motives for consumption but on disentangling which goods and services are seen as satisfiers of the locally identified basic needs. In order to do that

participants in the interviews and focus groups were invited to talk about their priorities of consumption and the motivations they had to choose them.

Those priorities that people linked to the local concept of basic needs, as defined in step one, were labelled needs satisfiers in the context of Nuevo Lugar. Although the objective of this chapter is not to expand on the particularities of needs theories, it should be pointed out that an approach such as the one followed here depicts the realm of “wanted needs” (Gasper, 2005), which are felt and valued by participants. Following Hamilton’s (2003) argument about needs as drives and goals, it allows for the identification of satisfiers which target locally valued needs that have been internalised by people and are thus motivating their consumption.

Finally, it is worth noting that there are usually numerous motivations linked to the same expenditure. As Maslow (1970) posited, all human actions are multi-motivated. The open discussion on motives that took place during the focus groups and some interviews and informal conversations made it possible to capture the interplay between different reasons people have to consume a specific good or service. This was expected to contribute to the understanding of the impact of consumption on basic needs satisfaction.

### *Third Step: Goods and Services as Satisfiers*

Consuming food in order to be nourished and valuing being physically healthy as a requirement for a “good life” does not tell much about how individuals would go about meeting those needs; what they would consume to satisfy them. The third step goes in depth into that question by exploring the case of expenditure on health care. The objective is to illustrate, through the case of Nuevo Lugar, how consumption, even for poor urban households who target at felt basic needs, is undertaken for an array of different motives and under cultural and structural circumstances that might impede their satisfaction. This does not imply that it might not fulfil other goals, such as avoiding feelings of helplessness, increasing one’s pride and keeping or improving one’s status.

In order to structure the discussion, this step compares the characteristics of what people consume under the “health care” category to the universal features of the THN basic needs satisfiers and Max-Neef’s classification. The THN describes basic needs satisfiers as “those goods and services which satisfy substantive individual needs within any particular economic

structure” (Doyal & Gough, 1991, p. 233). Goods and services might have different effects on individuals’ basic needs not only depending on their intrinsic characteristics, but also on the economic and social context within which they are consumed. That in Nuevo Lugar someone shifts from a public to a private practice does not necessarily imply their basic need for health is going to be increasingly fulfilled. They will be spending more on health care and medicines, but they still might not finish the course of treatment due to a lack of understanding of their medical condition.

The fact that consumption of *basic needs satisfiers* might not be effective was approached by Max-Neef (1991) who classified them in five types: synergic, singular, inhibiting, pseudo-satisfiers and violators or destroyers.<sup>7</sup> Table 1 reproduces Max-Neef’s categorisation of satisfiers. He claimed that not all goods, services and institutional settings result in increased needs satisfaction and that often satisfiers are not successful in contributing to the need that triggered their consumption. He pointed at violators, pseudo- and inhibiting satisfiers as the most harmful. If these are increasingly consumed by families or societies, their wellbeing in terms of basic needs might be seriously threatened. Thus, wealth in terms of total level of consumption might not equal wellbeing regarding satisfaction of basic needs.

The concept of satisfiers and the categories identified by Max-Neef offer a useful reference framework to the study of consumption and basic needs. As was already pointed out in the introduction, there is a case for arguing that people in Lima are increasingly consuming goods and services related to satisfiers of the harmful type. Schuldt (2004) and Guillen-Royo (2007) hypothesised respectively that this could explain some of the frustration of the *Limeños* and of the people living in the urban communities of the WeD Peruvian corridor.

**Table 1.** Max-Neef’s Classification of Satisfiers.

Synergic satisfiers	Satisfy simultaneously different kind of needs
Singular satisfiers	Satisfy the need they are meant to satisfy
Inhibiting satisfiers	Over-satisfy a given need so they curtail the possibility of satisfying other needs. They originated in customs, habits and rituals
Pseudo-satisfiers	Give a false sense of satisfaction of a given need. They are induced through propaganda, advertising and other means of persuasion like for instance status symbols
Violators or destroyers	Annihilate the satisfaction overtime of the need they aim at and they impair the satisfaction of other needs (all the ones related to protection, like censorship, exile ...)

Source: Max-Neef (1991).

## THE SELF-MANAGED COMMUNITY OF NUEVO LUGAR

Nuevo Lugar is a partly self-managed community located by the central road linking Lima and the Peruvian highlands. This is a relatively new settlement created in 1984 by non-violent invasion of a bald, sandy and hilly area outside Lima. Most of the early settlers were migrants from the *sierra sur* and *sierra central* (Peruvian highlands) who had arrived in the other shanty towns of Lima searching for land on which to build their houses. The invasion had an organised character since incomers followed plans already made by the Metropolitan Municipality of Lima in terms of the geographical distribution of the dwellings and of the shared and individual services that would be provided. Basic services such as electricity, water and sewerage were installed during the settlement period and until 1987, supported by the Municipality of Lima. There was also an important presence of external aid through international non-government organizations (NGOs). During the 1990s, the area suffered from a significant presence of members of the *Sendero Luminoso* (Shining Path) which had very negative consequences for the community in terms of destroying the social capital and diminishing the support from external agents (Manrique, 2002).

Currently, the slum has 83,000 inhabitants living in 13,860 dwellings distributed in 23 zones and 239 *Unidad Comunal de Vivienda* (UCV) (Yamamoto, Feijoo, Altamirano, Alvarez, & Arroyo, 2004). Every UCV covers approximately one hectare and has 60 members (either individuals or households) each owning on average 90m<sup>2</sup> of land. There are clear differences between the lower and the higher zones of the community with regards to access to basic services, mobility, housing and public services. All the dwellings located in the lower parts have access to water and electricity, sewerage and telephone connections. Houses are mainly built of brick and cement blocks, unlike most dwellings in the hills which are largely made of scrap wood, plastic and thatch. Initially some of the hills were thought to be unsuitable for urban development and no infrastructure works were planned there. Settlers moved in during the early 1990s; they were much poorer than the initial incomers and in most cases are not yet officially registered. This fosters an already traditional divide within the slum, not only in terms of access to facilities but also of social status, as the higher zones are commonly believed to be a hub of delinquency and violence.

Since the creation of the slum, national agencies have organised soup kitchens, mothers' clubs and "glass of milk" committees (Arevalo, 1997). With the aid of religious organisations and government agencies, the settlers have been able to establish health centres and schools in the area. Nowadays, the provision of medical care is done through public and private institutions. Within the public health services there are two hospitals, one health centre, five primary care surgeries, one comprehensive health centre from the local Parish and two dispensaries (Alvarez & Arroyo, 2005). In 2002, the slum also had 7 private clinics and 21 private surgeries (Manrique, 2002). Most of the treatments offered in Nuevo Lugar are modern and some institutions offer alternative or holistic medicine such as reflexology, naturopathy, etc. Education facilities are also modern and sufficient although some of them are of very low quality. There are primary, secondary and higher education public and private institutions. Alvarez and Arroyo report that the illiteracy rate is low (5%) and the majority of children of school age are in education.

Most people in the slum are Spanish speakers although some of the elderly migrants are primarily Quechua speaking and not literate in Spanish. There is also a minority of Aymara speaking migrants from the Peruvian jungle. A great variety of activities are carried out by the dwellers; the most common is some kind of petty trade or business, craftsmanship, drivers of local public transport or factory workers. Seasonal migration to the nearby Andean mines is not uncommon. In terms of traditions, the fact that the slum is a destination for migrants that have settled in subsequent waves results in people being more family oriented. Thus, celebrations primarily involve weddings, birthday parties, christenings and Christmas. People who can afford the expense travel to their village of origin for the annual festivities.

Finally, the political context in which the main qualitative fieldwork of this research took place (July–August 2005) was one of turmoil. The popularity of president Toledo had plummeted. In June and July there were marches in Lima and other cities to protest against corruption, reflecting widespread disillusionment in the society. Despite a GDP growth rate around 4% during 2005 (4.8% in 2004), charges of corruption against the incumbent president and the perception that anti-poverty measures were not sufficient had led the country to lose faith in the government and its engagement with poverty reduction. The situation did not improve much after the sixth cabinet reshuffle in four years in August 2005 (Peru Support Group, 2005).

## DEFINING BASIC NEEDS IN THE SLUM THROUGH PEOPLE'S VISIONS OF THE "GOOD LIFE"

People's basic needs were discussed with interview participants through an open-ended question, without prompting about specific aspects of the "good life". The topic was raised towards the end of the interview which helped to counter-balance the traditional *desconfianza* (mistrust) of the Peruvian population (Wright, 2004). Discussion was encouraged through either of the following questions:

- *Cuales son las cosas (materiales o inmateriales) que usted considera importantes para tener una buena vida?* (What are the things – material or other – that you consider to be important in order to have a good life?)
- *Que es para usted tener una buena vida?* (What does it mean to have a good life for you?)

Table 2 shows the 10 most important components of the "good life" ranked by the frequency they were mentioned. These are compared to the basic and

**Table 2.** The THN and the "Good Life" in Nuevo Lugar.

Ranking	Nuevo Lugar (2005)	THN Basic and Intermediate Needs
1	Good health (staying healthy, having access to medicines and health care)	Good health Appropriate health care Safe birth control and childbearing
2	Good and peaceful relationships with family	Significant primary relationships Security in childhood
3	Enough and nutritional food	Adequate nutritional food and water
4	Business, job	Economic security
5	Proper education for children	Literacy Appropriate cognitive skills Appropriate basic and cross-cultural education
6	Money	Economic security
7	Proper house	Adequate protective housing
8	Tranquillity and emotionally balanced life	
9	Convenience goods	
10 <sup>a</sup>	Religion, helping others, not drunkard, government intervention, having fun	

Source: Doyal and Gough (1991) and fieldwork data (2005).

<sup>a</sup>Items mentioned only by one participant.

intermediate needs of the THN. Arguably, health and autonomy, the two universal goals of the THN, might be underlying the local concepts of the “good life”. This was also the case in two previous studies undertaken using similar questions,<sup>8</sup> by Clark in two South African communities and by WeD (2003) in twenty Ethiopian sites. All the items reported in Nuevo Lugar that are related to intermediate needs were also mentioned by the Ethiopian and South African participants among their 10 most valued functionings. These results provide empirical support for the THN claims of universality of basic and intermediate needs. Nevertheless, as will be discussed below, they question the THN’s neglect of affiliation, belongingness and relating, as cornerstones of people’s basic needs.

Table 2 showed that being in good health was the most important requirement for a “good life”. Slum dwellers considered that staying healthy, having access to medicines and health care, to sufficient and good quality food and to a proper house were essential. As expected, people’s stress on health and food was paramount in the poorest households. Younger headed households would highlight the importance of a well-balanced diet in order to be in good health. Older participants were more preoccupied with having access to treatments and medicines in order to regain health and be able to work and carry out their usual daily activities:

Carola (51): To have a good life I need health together with money, in order to be healthy, being properly fed to be healthy.

Laura (69): I would think health is important for a good life, having access to medicines in order to be healthy in old age.

Having a job or running a business, having access to good quality education, some money and above all having good and peaceful relationships with one’s closest family were aspects of the “good life” that the THN associates with the basic need of autonomy. Participants who considered that tranquillity and an emotionally balanced life were basic requirements for a “good life” also linked them to family unity.

In general, good communication amongst family members was deemed essential by households of all ages although lack of it had the most impairing effects as people grow old. Begoña (66) constantly made mention of her concerns about the continuous rows she was having with her daughter. Although her daughter was supporting her financially, they were not in good terms and this conditioned her approach to needs and the other



topics discussed during the interview:

I would like to live in peace with my daughter [...] I do not want to be disrespected by my own daughter; I want love, conversation, laughter [...] If I were healthy and she was kind we would go out together. But now I cry and cry; my heart is sore.

Sol (36), a housewife in a household of seven, living in the most deprived area of Nuevo Lugar, showed her concern about the consequences of a non-united family:

It is necessary that all the family members are speaking with each other. If the family is not united, if we quarrel there is no strength to *sobresalir* (stand up) and everyone ends up going their own way.

People in Nuevo Lugar seemed to agree that stable close family relations were the pillars of their wellbeing. Most participants commented on the financial support they received from or gave to close relatives. It was usually perceived as indispensable, as people in Nuevo Lugar could hardly get by without assistance of some sort: borrowing one's relative's dwelling, sending periodical transfers to elder parents, cooking a hot meal a day for one's grandchildren, etc. However, good family relations not only have financial implications, but they also enhance people's self-confidence and strength to go ahead with one's life in a harsh environment. They give people the emotional balance required to engage in social, productive and caring activities and to look after themselves and provide for their own survival. In Nuevo Lugar, unlike in the THN, the role of family seems to have pre-eminence over other intermediate needs in terms of how it is perceived as supporting people's functionings.

Furthermore, the THN did not incorporate happiness or positive emotions as a component of the basic or intermediate needs. Doyal and Gough addressed positive emotions and their relationship with psychological health only in the context of the intermediate need *significant primary relationships*. They posited that the unhappiness derived from the loss of family or friends could potentially lead to mental breakdown and depression. They also maintained that isolation could harm individuals' self-esteem and thus deplete their autonomy (Doyal & Gough, 1991, pp. 207–208). However, as with family relations, they did not give a happy or emotionally balanced life a central position in the theory as a universal basic need or goal. Only recently Gough (2003) recognised that *mental wellbeing* and *affiliation* should be incorporated in the THN alongside *health* and *autonomy*.

Conversely, it is relevant to note that although participants' accounts of the "good life" tackled almost all the intermediate needs of the THN,

*non-hazardous work and physical environment* were not explicitly mentioned. They were implicit when people referred to a proper and stable job, to comforts and proper housing, and to government intervention. These issues cannot be solved by single individuals; rather, they require public action. The long history of government corruption and unaccomplished promises to the poorest population in Peru might have resulted in disappointment and people not contemplating issues of working conditions and security as potential components of the “good life”.

Not only might the political situation affect the apparent disregard of broader requirements of safety and security as basic needs, but also the fact that people feel it was their choice to have migrated to Nuevo Lugar appears to have prevented them from publicly acknowledging some of the risks attached to the decision (Akerlof & Dickens, 1990). Moreover, the lack of success of collective actions directed to non-physiological needs in the shanty towns of Lima (Almirall, 2006) might have contributed to feelings of helplessness and reinforced neglect among the population.

Arguably, the exploratory work presented so far supports the view that in Nuevo Lugar the valued components of a “good life” share common characteristics with the basic and intermediate needs of the THN. Moreover, empirical evidence shows that good close family relationships have a pre-eminent role and are strongly felt as a basic requirement since surviving is largely depending on the economic and emotional support that family members give to each other.

## BASIC NEEDS SATISFIERS IN NUEVO LUGAR

Satisfiers are not only expenditure or consumption related; they are expressions of a need which can result in institutional or political arrangements (Max-Neef, 1991). As this research focuses on private consumption, only the role of goods and services that people view as satisfiers is investigated. In order to identify satisfiers of the valued basic needs in Nuevo Lugar, interview and focus group participants were asked about their motives for consumption.

Clark's (2002) methodology for investigating people's preferences focusing on consumption priorities was used to guide the interviews. The latter revolved around the following question: *Cuales son los cinco productos o gastos mas importantes comprados por los miembros del hogar? Por favor explique sus razones.* (What are the five most important items or expenses purchased by the household? Please explain the reasons why). Focus groups

went beyond mere explanations of reasons to consume and participants engaged in deep discussions about the different motivations that one has to spend on specific categories. Thus, initial motivations were challenged and how people juggled them in everyday life was brought to the centre ground.

Table 3 links the components of the “good life” in Nuevo Lugar with the priority expenditure reported to be largely driven by felt basic needs. It shows that most goods and services that were reported to be motivated by felt basic needs could be easily taken as satisfiers of the local concepts of the “good life”. Thus, building materials, utilities, food, medicines, consultations, vitamin supplements, etc. are goods and services, the consumption of which is triggered by the satisfaction of needs (proper house, enough and nutritional food, good health) that are valued in the community.

As depicted in the preceding section, *physical health* was the most important component of a good life in Nuevo Lugar. When people

**Table 3.** Visions of the “Good Life” and Felt-Needs Satisfiers in Nuevo Lugar.

Visions of the “Good Life”	Felt-Needs Satisfiers
Item	Item
Good health (staying healthy, having access to medicines and health care)	Medicines, vitamin supplements and consultations Clothes and shoes Toiletries and detergents
Good and peaceful relationships with family	Leisure Electric appliances Transfers or donations
Enough and nutritional food	Food
Business, job	Public transport Car
Proper education for children	Education
Money	
Proper house	Water and electricity Building materials Electric appliances Furniture
Tranquillity and emotionally balanced life	
Convenience goods	
Religion, helping others, not drunkard, government intervention, having fun	Leisure

Source: THN and fieldwork data (2005).

discussed the reasons why they spent on treatments, medicines, soaps, housing services, food, clothes, etc., they highlighted how those items contributed at different levels to keep them in good health. WeD data from the Resources and Needs Questionnaire (RANQ) showed that in 2004 this expenditure was not sufficient. In Nuevo Lugar 26% of participants were ill and not seeking treatment; of these 43% declared this as due to its high cost. More than half the population reported to have suffered from a food shortage of some sort and half of them did not have a good source of drinking water. Moreover, most of the houses in the high areas were unsafe as they were made of wooden panels and had plastic sheeted or thatched roofs. Only 58% had a flush toilet or an improved pit latrine.

With regard to *autonomy*, expenditure on education, transport and communication, clothes and shoes and even electric appliances was driven by valued functionings that the THN relates to autonomy. RANQ data showed that the Nuevo Lugar sample has a lower rate of illiteracy (4%) than the country average (12%) (UNDP, 2006), that most people (62%) had completed primary education and that education facilities were easily accessible (91% have an educational facility within less than 30 minutes from home). However, data on quality of education and prospects of finding a job was not available.

In Nuevo Lugar *good family* relations appeared as a salient feature of the “good life” – they were a crucial element for people’s wellbeing. This prominence could not be directly associated to one specific expenditure although leisure activities, electric appliances and transfers or donations to relatives were usually talked about as being motivated by maintaining or strengthening family ties. Moreover, most basic needs-led consumption was done with or for the sake of children or other relatives living in the household. Family concerns were also behind most expenditure motivated by basic needs as the following quotes show:

Ines (35): I pay the electricity bills so my children are able to do their homework. It also gives us the opportunity to spend some time together, not to be in the dark.

Enrique (48): I have bought three TV sets lately, one for each of my children because they do not want to use their money for those things. They work but they do not spend, they do not spend on electric appliances, they do not help to buy what they require, I provide for their needs, they do not.

RANQ does not inquire into the quality and meaning of people’s relationships but it provides an indicator of how often people relate with close relatives other than household members. Fifty-seven per cent of RANQ participants from Nuevo Lugar reported having spent time with their

relatives during the week of the interview (75% on average in the other WeD communities). However, this does not imply that family networks are not active in the slum, as most people have close relatives in the area and in some cases they were the ones who informed them about the possibility of settling in the slum, buying a plot there, finding a job and a school for their children.

Finally, the WeD I&E<sup>9</sup> survey showed that in the Nuevo Lugar sample most people were in poverty (85%) or in extreme poverty (64%) taking as reference the national poverty line (Copestake, Guillen-Royo, Chou, Hinks, & Velazco, 2007). Thus it would be expected that lack of money can be the main reason for households not to be able to meet their valued needs. Nevertheless, an investigation of specific satisfiers might shed light on the risks and challenges that everyday consumption in Nuevo Lugar poses to their population. The next section explores satisfiers initially aiming at contributing to the valued need of physical health.

## **EXPENDITURE ON HEALTH CARE IN NUEVO LUGAR: A SINGULAR SATISFIER?**

In Nuevo Lugar, being physically healthy is the most valued functioning, and most expenditure is undertaken with the aim of contributing to keeping one's family free of illnesses and able to study or work. Around 46% of household expenditure is on food, 13% on housing, 3.3% on toiletries and personal care, 3.2% on clothes and shoes, and 3.5% is directed towards health care (Guillen-Royo, 2007). The latter is the focus of this section that presents people's narratives on the satisfiers used to target physical health. These are mainly consultations, treatments, medicines and vitamin supplements.

In the slum the most common illnesses are respiratory related, diarrhoea, urinary tract illnesses, dehydration and tuberculosis. It is believed that most health conditions could be avoided if a health prevention strategy was applied starting with a proper refuse collection system. At present the situation is chaotic and most infectious illnesses are consequence of the lack of public hygiene as is shown by the fact that between 10% and 20% of solid waste produced daily is left uncollected (Manrique, 2002).

Following the THN, a universal satisfier for health care should be related to the provision of the best techniques for preventing, curing and palliating illnesses. Doyal and Gough (1991) suggest two types of indicators to assess the appropriateness of health services: the provision of medical inputs and

people's level of access to those services. In Nuevo Lugar, *provision of medical inputs* is done through public and private institutions. Most of them offer modern treatments and some provide alternative or holistic therapies such as reflexology and naturopathy. However, not everybody has access to all types of treatment. Health care in Peru is organised in a three tiers system that results in the poor largely being treated by the centres of the *Ministerio de Salud* (Health Ministry) (39% of treatments), the salaried by the social security system (22% of treatments) and the richer in private centres (37% of treatments).<sup>10</sup> Nevertheless, this traditional divide is increasingly blurred as private surgeries and hospitals are opening in the most deprived areas (Francke, 1998).

On the *utilisation* side, Manrique (2002) reported that in the year 2000, 34% of the slum's population used the local public health services. This does not mean that the rest of the slum dwellers did not need treatment. As Francke indicates, poor Peruvians attend surgeries fewer times although have higher incidence of illnesses than their richer counterparts. As mentioned before, in Nuevo Lugar, among the 26% who were sick and did not seek treatment 28% did not do so due to lack of access to health care facilities, money, time or information and 43% due to its high cost (data from the WeD RANQ). The latter applies even to public provision as people have to pay a fee for registering, being seen by a doctor and for the medicines or treatments prescribed to them. Poor people might be exonerated from paying for medicines and treatments but the criteria applied to define their eligibility has been shown to be unclear and unsystematic, hence not decreasing significantly the number of people untreated (Francke, 1998).

### *Consultation Fees*

Regarding satisfiers, people reported that consultation fees, medicines, treatments and vitamin supplements were priority expenditures. Most people that claimed health related expenses to be among the five most important priorities were women. They were more sensitive to issues surrounding health care as they present higher morbidity levels (Valdivia, 1999) and are the carers for the ill children and elderly in the household. In general, ill people in the slum would attend public health care facilities. Participants did not usually report the cost of consultations as a deterrent. This was usually S./2 (two *nuevo sol*, or around \$ 0.61 US) which in principle everybody could afford. Women living in the poorest conditions

were sometimes offered health services for them or their children by the Municipality or the local Christian nurses for free. The long waiting time and the low quality of the consultations in the public surgeries were often referred to as the main problem regarding health care. Some said that since they knew doctors in public institutions would only prescribe drugs and would not examine them properly, they preferred to look for private alternatives.

Private health care was becoming popular in Nuevo Lugar like in other deprived areas of Lima. Francke (1998) showed that 31% of the sick in the lowest quintile of expenditure in Peru used private health care, giving evidence of the spread of private alternatives. The latter were not only used by the relatively wealthy in the slum, but also by lowly educated immigrants searching for the certainty of a cure.

Two elderly participants living in the poorest zones declared to have recently consulted private surgeries on a regular basis. Laura and Manuela's testimonies pointed out how lack of trust in public health services, of information about health conditions and of knowledge about illnesses and cures have resulted in a shift towards the more expensive private health care.

Laura (69), illiterate, was attending a doctor's private surgery once a week in order to be treated of her rheumatic disease, lung and kidney problems. Each time, the treatment was costing her S./20 – about 10% of her monthly available income. She explained that she had switched to the private surgery because she knew the doctor working there. She met him at the local public hospital where he had successfully treated her for a previous heart condition. He then advised Laura to continue treatment for her other illnesses at his private surgery which she agreed to because she trusted the competence of the doctor. Since she was too weak to work and could not afford to pay the doctor by herself she asked her children to cover the costs, which they were still doing at the time of the interview.

Manuela (75), illiterate and financially dependant on her daughter was regularly attending a private Chinese doctor's surgery in central Lima. She recalled to have recently spent S./414 on consultation fees and S./170 on a three-month dose of medicines bought at the surgery. Manuela showed us the medicines prescribed by the doctor and we could see they were vitamin supplements with a high percentage of calcium, a very common drug for osteoporosis available in any chemist of the slum. She was aware the consultation and the medicines were more expensive than the ones prescribed by public sector doctors. However, she still preferred the Chinese doctor as he was keeping her well informed about her condition and

treatment. He had also assured Manuela that he would cure her osteoporosis; contrary to the public health doctor she had previously attended who had claimed that there was no cure. She said,

The medicine that he (the Chinese doctor) has prescribed is twice as expensive as the one I used to take before ... but the one prescribed by the public health doctor did not work. He did not examine me, only prescribed drugs ... he did not say until when I had to take them.

Unlike Laura, who switched to private health care on the advice of her doctor in the public surgery, Manuela found the Chinese doctor through a neighbour. She had come across the sales representative of Chinese medicines in the Mercado Central (central market) of Nuevo Lugar. The salesman had given her information about Chinese medicines, the doctor and his practice. She attended the surgery for a consultation and since she was satisfied with the treatment she recommended him to Manuela.

In general, people were searching for alternatives to the low quality care in the public practices. In Nuevo Lugar substitutes were not commonly sought in traditional Andean medicine but in private surgeries using modern or alternative medicine. This might increase the chances of expenditure on health care becoming a Max-Neef *singular satisfier* (meeting the need they are targeting) although it will depend on the extent to which attending private surgeries has an effect on people's understanding of their illnesses and their capacity to complete a given treatment.

### *Medicines and Vitamin Supplements*

Consultation fees for public health care seemed not to be a deterrent even for the most materially deprived in the slum and some of them were even attending relatively expensive private surgeries. However, problems came up when people had to pay for their medicines or treatments. They complained that medicines were very expensive and they would rarely complete any given treatment. This is in line with Francke's (*ibid.*) assessment of the Peruvian health care system. He sustains that the mass commercialisation of generics has not made them more affordable since even buying medicines at the production cost is expensive for the large majority of Peruvians. As with consultation fees, not only lack of money troubled the sick but also lack of information about medicines, their effects and the length and characteristics of the treatment.



Fear of illnesses and lack of information sometimes resulted in an endless search for medical advice and cures. As seen in the previous section, people in Nuevo Lugar did not generally trust the public health care system which, together with their lack of knowledge about the symptoms and characteristics of common illnesses and their cure, sometimes resulted in unsuccessful spending. The case of Jacinta, a 19-year-old mother to a 5-month-old daughter, illustrates how increase in health care expenditure does not always associate to better treatments.

Jacinta had flu symptoms and had been feeling anaemic since giving birth. After receiving S./300 (roughly her usual monthly income) from a donor, she rushed into a private medical centre to see a general practitioner, a private surgery to see an obstetrician, and a public hospital to have her and her baby's health condition reassessed. She spent a total of S./27 in consultation fees, S./10 on a blood test and S./224 in medicines, S./76 of which were used to pay for nose drops and two types of syrups prescribed by two different doctors for her baby's flu. In three days she had spent the donated money in treating a minor health condition. Although she was recovering, her "swinging" strategy had left her without money to follow the recommended treatment for her anaemia.

Jacinta's behaviour, shifting between practitioners and health care centres, was very common among the sick in Nuevo Lugar. It was usually justified in terms of trust, price and often as a consequence of previous inefficient treatments derived from not completing the course. In most cases it revealed a lack of understanding of health conditions and of human physiology. Jacinta explained her visit to the second general practitioner and her blood test at the gynaecologist as follows:

Dr. Almeida gave me the same diagnosis as the previous GP but this time he said that my baby had bronchitis, he put a stick in her mouth and told me that it was very much inflamed and prescribed two syrups which cost S./25. I went back to Nuevo Lugar and straight to Dra. Juana and she took blood from my arm. It was very slow because there was not much blood but it ended up coming out. She asked me not to breastfeed my baby since my milk was transparent and it should be white.

In addition, expensive prevention measures such as taking vitamin supplements were becoming fashionable in Nuevo Lugar. The relatively wealthy – which as Copestake and colleagues (2007) reported were quite close to the poverty line – were increasingly buying vitamin supplements as complements to medicines when there was ill health in the family, especially affecting children. Some were systematically taking them to complement their poor diet.

Mexican pharmaceutical companies had penetrated the richest areas of Nuevo Lugar by hiring local grocery owners as agents. The companies would distribute informative leaflets and hold seminars about the lack of nutriment in food and the consequences of malnutrition. They publicised their products as a necessary complement to food in an area where malnourishment is endemic. Lucio, a doctor in the local Policlinico, showed his concern about this upcoming trend:

What we really miss is a good educational program targeted at families because they think that with a good vitamin supplement they are giving everything they can to their children but it is not like this. It is much better to give more nutritious food and the true love that mothers should give their children. They would need a talk by a nutritionist so they know how to prepare suitable food for every age. With regard to doctors, the Colegio de Medicos or the Ministry of Health should ask doctors not to prescribe multivitamin supplements. There should be a law on that or an open dialogue and a call for suggestions.

Hence, in Nuevo Lugar, lack of money is only partially explaining people's use of health care. This research illustrates how, even the ones that are currently spending on consultations and medicines, might not be effectively treated due to the difficulties people have to understand their health condition and follow the course of treatment. The latter is not only due to the high costs of medicines; not trusting doctors in the public sector together with lack of understandable information about illnesses and cures arise as key explanatory factors for people's choices of health care in the slum.

Drawing on Max-Neef's terminology there is a risk in Nuevo Lugar of health care expenditure not performing as *singular satisfier*; the one that meet the needs that is deemed to target. First, even if consultations and treatments are the right ones and can be afforded, illnesses related to poor public hygiene and waste disposal would still be recurrent. Second, people do not trust the public health care and even some of the poorest end up going private, which does not necessarily increase the likelihood of treatment completion. People leave most treatments unfinished or engage in health care shifting strategies due to insufficient information. Moreover, the use of vitamin supplements is spreading in Nuevo Lugar. These vitamins are more expensive than the basic brands in local chemists and often crowd out spending on better and more nutritious food.

All those aspects result in health expenditure often becoming *pseudo-satisfiers*: the ones that are perceived by people as *singular* but are not effectively meeting the targeted need. This calls for caution when associating increases of health care utilisation and expenditure with higher level of basic needs satisfaction. As the case of Nuevo Lugar shows, more money devoted

to health care might be indicating the inefficiency of the relatively affordable public health care and the progression of private alternatives. These might offer more information and emotional support to the ill but might not contribute to treatment completion due to the high costs of going for control checks and buying the prescribed medicines.

## CONCLUSIONS

This chapter has introduced a methodological approach for the analysis of consumption from a basic needs perspective drawing on a three-step strategy. It has proven useful to bring out local concepts of basic needs and the goods and services used to achieve them. The first step has explored people's visions of the good life, confronting them with the universalist approach to basic needs of the THN. This has led to a claim that, besides physical health and autonomy, family relations should be taken to the foreground if one is to understand what is valued as basic needs in Nuevo Lugar.

In the slum, physical health is, as in the THN, a principal goal. People put being physically healthy above other functionings and devote most of their income to maintaining or improving their health. The research has investigated health care expenditure as a basic need satisfier. It has gone beyond quantitative indicators of health care utilisation and provision, focusing on the actual use that people make of the system through their expenditure. This has led to a preliminary assessment of its effectiveness in contributing to people's health drawing on Max-Neef's classification of satisfiers.

In Nuevo Lugar, even materially poor people were attending private surgeries and the relatively better-off were increasingly consuming vitamin supplements. This resulted in a relatively high level of expenditure on health care which veiled the reality of uncompleted treatments and extended health conditions. Limited financial resources were important but not always the main reason for not pursuing treatment. Lack of trust of the public health care system together with lack of understanding of health conditions, and causes and functioning of treatments seemed to impede the efficiency of satisfiers.

Expenditures on consultations and medicines were not necessarily contributing to better health. In some cases they were *pseudo-satisfiers*; people would feel they would get better by attending the private doctor's surgery even if the prescribed treatment was the same they would have got in the public sector doctor only more expensive. The same would happen with expenditures on vitamin supplements that could even become *violators* if

people were taking them to substitute a long-term strategy of improving the quality or quantity of their food.

Finally, the research suggests that studying consumption from a basic needs perspective contributes to the understanding of its effects on human wellbeing. This work has followed a three-step approach; a potential fourth step might entail confronting the exploratory findings with the local population. It could well be the case, for instance, that given the structural constraints to disseminate reliable information about treatment and illnesses, people still choose to spend on private surgeries (as they feel emotionally supported) than on public health care and a complete course of medicines.

## NOTES

1. This chapter investigates consumption through expenditure. However, it goes beyond expenditure to get at things that people use which in some cases are donated or include durables.

2. Nuevo Lugar is an anonymised site name following WeD policy.

3. The first phase of the fieldwork consisted of 27 in-depth interviews conducted with a sub-sample of household heads and spouses who had participated in at least two of the previous instruments implemented in Nuevo Lugar by WeD. Only household heads or spouses who had declared their willingness to participate in my research were interviewed. The average age of the participants was 37, the eldest was 75 and the youngest 26. Most of the interviewees were women (58%) and catholic (70%). In general, interviews lasted approximately 45 minutes and were done in collaboration with the WeD fieldworker based in Nuevo Lugar. The second phase concerned three focus groups with household heads and spouses. Participants were selected through the snow-balling technique and people were gathered mainly from the lowest and richest zones. The first focus group comprised men aged 48–51, the second women aged 27–74 and the third women aged 20–30. Additional information has been obtained from the WeD's Resources and Needs Questionnaire (RANQ), community profiles, and Income and Expenditure Survey (I&E). Secondary data from other studies or data bases (World Bank, Instituto Cuanto, etc.) together with information from informal conversations with relevant actors (shop keeper, pharmacist, doctor, relatives, WeD fieldworker, etc.) has also been utilised.

4. Des Gasper (1996, p. 80) classifies theories of needs in three categories: “positive theories for driving behaviour which posit forces called needs which drive our actions; positive work analysing satisfactions, as in the psychology of happiness literature, that tries to identify what makes people fulfilled, happy or content and; normative/ethical needs theories and arguments about which prerequisites carry a priority status”.

5. It is important to note that the THN does not take as granted that people are aware of their universal basic needs. As Doyal and Gough (1991, p. 36) posit, “one can have a drive to consume something, like lots of alcohol, which one does not need and at the same time have a need for something, like exercise or to diet, which one is

in no way driven to seek". Basic needs in the THN are requisites for social participation and might not be felt by participants. Unlike the THN this research enquires into people's "basic needs" assuming they are felt and valued following Hamilton's approach (2003).

6. WeD has undertaken research in seven Peruvian communities: two of them urban (including Nuevo Lugar), three rural sites (two in the Central Andes and one in the cloudy forest), and two peri-urban communities in the Central Andes. The characteristics of the sites running from the Central highlands to Lima have justified considering the sample as a "corridor" (Copestake, 2006).

7. Max-Neef's typology was linked to his taxonomy of human needs. He developed a matrix where the axiological categories (subsistence, protection, affection, understanding, participation, idleness, creation, identity and freedom) were crossed with the essential categories of being, having, doing and interacting, resulting in different satisfiers.

8. The Wellbeing and Illbeing Dynamics in Ethiopia (WeD, 2003) survey asked: "Think about the most basic aspects of life. These are the bare essentials without which a person cannot cope or manage at all, and without which life is unbearable. These can be aspects of life that people have, or don't have and need. What are the most basic aspects of life"? Clark (2002) used an untutored and a tutored question. The untutored question was: "Think about the things that make a good life. These items could be things that you already have, or things that you need, want or desire: what are the five most important aspects of a good life"? The closed-ended question went through 38 items in the following way: "I will read you a list of things which might or may not improve life. Are they essential, valuable, unimportant or undesirable"?

9. The WeD I&E survey was implemented in the seven communities of the corridor to a sub-sample of 254 RANQ households during July 2005. The I&E survey was designed to capture data on the different categories of incomes (from self-employment, wage income, and income in kind), expenditure (production costs, food and non-food items), credit and saving behaviour as well as data on global happiness and life domain satisfaction.

10. Two percent of the population is treated in the hospitals of the armed forces.

## ACKNOWLEDGMENTS

The support of the UK Economic and Social Research Council (ESRC) is gratefully acknowledged. The work has partially drawn on data from the programme of the ESRC Research Group on Wellbeing in Developing Countries.

## REFERENCES

- Akerlof, A. G., & Dickens, W. T. (1990). The economic consequences of cognitive dissonance. In: A. G. Akerlof (Ed.), *An economic theorist's book of tales* (pp. 123–144). Cambridge: Cambridge University Press.

- Almirall, C. (2006). *Collective action for public goods provision in low-income groups: a model and evidence from Peru*. Working Paper no. 245. Lima: PUPC Economía.
- Alvarez, J. L., & Arroyo, M. (2005). *Perfil de la Comunidad Autogestionada de Huaycan*. WeD Internal document.
- Arevalo, P. (1997). Huaycán self-managing urban community: May hope be realized. *Environment and Urbanization*, 9(1), 59–80.
- Clark, D. A. (2002). *Visions of development: A study of human value*. Chentelham: Edward Elgar.
- Copestake, J. (2006). *Wellbeing and development in Peru. Draft book introduction*. Unpublished WeD paper presented at the Peru workshop in Huancayo, July 2006.
- Copestake, J., Guillen-Royo, M., Chou, W.-J., Hinks, T., & Velazco, J. (2007). *Economic and subjective wellbeing: Four tiers of analysis* (28–30 June). Bath, UK: Paper for the WeD International Conference.
- Doyal, L., & Gough, I. (1991). *A theory of human need*. London: Macmillan.
- Francke, P. (1998). *Focalizacion del gasto publico en salud en el peru: Situacion y alternativas*. Working Paper no. 155. PUPC Departamento de Economía, Lima.
- Gaspar, D. (1996). Needs and basic needs. In: G. Kohler & C. Gore, et al. (Eds), *Questioning development*. Marburg, Germany: Metropolis-Verlag.
- Gaspar, D. (2005). Human well-being: Concepts, puzzles and paradoxes. Paper for Gough, I. (2003) Rethinking human needs and wellbeing. *WeD Newsletter*, 1(2), 1–2, University of Bath, Bath. WeD, November 2005.
- Guillen-Royo, M. (2007). *Consumption and wellbeing: Motives for consumption and needs satisfiers in Peru*. Ph.D. Thesis, University of Bath, Bath, UK.
- Hamilton, L. (2003). *The political philosophy of needs*. Cambridge: Cambridge University Press.
- INEI. (2001). *Condiciones de vida en los departamentos del Peru*. Lima: INEI.
- INEI. (2006). *Condiciones de vida en el Peru: Evolucion 1997–2004*. Lima: INEI.
- Manrique, A. (2002). *Diagnostico situacional de la comunidad urbana autogestionaria de Huaycan*. Lima: ADEC-ATC.
- Maslow, A. H. (1970). *Motivation and personality* (2nd ed.). New York: Harper and Row.
- Max-Neef, M. (1991). *Human-scale development: Conception, application and further reflection*. London: Apex Press.
- Nussbaum, M. C. (1995). Human capabilities, female human beings. In: M. C. Nussbaum & J. Glover (Eds), *Women, culture and development: A study of human capabilities* (pp. 242–269). Oxford: Clarendon Press.
- Nussbaum, M. C. (2000). *Women and human development: The capabilities approach*. Cambridge: Cambridge University Press.
- Peru Support Group. (2005). *Bulletin, June–July 2005*. Retrieved January 20, 2007, from [http://www.perusupportgroup.org.uk/archive/news\\_110.html](http://www.perusupportgroup.org.uk/archive/news_110.html)
- Schuldt, J. (2004). *Bonanza macroeconomica y malestar microeconomico*. Lima: Universidad del Pacifico.
- Sen, A. (1992). *Inequality re-examined*. Oxford: Clarendon.
- Sen, A. (1999). *Development as freedom*. Oxford: Oxford University Press.
- UNDP. (2006). *Human development report 2006*. New York: Oxford University Press.
- Valdivia, M. (1999). *Planification familiar y salud materno-infantil en el Perú: Una cuestion de numero o de momento?* Available from <http://www.cies.org.pe/files/active/0/Pm0124.pdf>

- WeD. (2003). *The wellbeing and illbeing dynamics in Ethiopia (WIDE) survey*. Accessed from [www.wed-ethiopia.org/](http://www.wed-ethiopia.org/)
- Wright, K. (2004). *Qualitative data collection for impact assessment: Getting the questions right*. Unpublished Work.
- Yamamoto, J., Feijoo, A. R., Altamirano, R., Alvarez, J. L., & Arroyo, M. (2004). *The urban community of Huaycan*. WeD Internal Document.

# POLITICAL ECONOMY AND THE HEALTH AND VULNERABILITY OF BATTERED WOMEN IN NORTHERN VIETNAM

Lynn Kwiatkowski

## ABSTRACT

*Wife battering has important impacts on the health of battered women, both in the short and long term. This form of gendered violence has been a significant problem in Vietnam. Recent economic, social, and cultural changes occurring in Vietnam, with a transformation toward a socialist-oriented market economy through the state's doi moi political program, have influenced multiple aspects of wife battering. These include perspectives of wife battering, battered women's access to health care, conceptualizations of the household, and the emergence of new international health programs for battered women. Women's health problems derived from wife battering must be understood as processes that are informed by cultural, political, and economic change, on both a societal level and in the lives of individual women experiencing this form of gendered violence.*

---

The Economics of Health and Wellness: Anthropological Perspectives

Research in Economic Anthropology, Volume 26, 199–226

Copyright © 2008 by Elsevier Ltd.

All rights of reproduction in any form reserved

ISSN: 0190-1281/doi:10.1016/S0190-1281(07)26009-3



## INTRODUCTION

Wife battering has significant impacts on the physical and emotional health of battered women, both in the short and long term. In recent years, Vietnamese scholars, state leaders, and local non-government organization (NGO) personnel, as well as international health and development organization personnel, have engaged in discussions and debates about how the needs of individuals involved in the problem can be met, particularly those of battered women, but also of men. This has recently included addressing the health problems that battered women face, in the context of broader economic and political reforms occurring in Vietnam.

In recent years, anthropological research on wife battering has focused on women's experiences of and responses to historical change occurring in societies, and resulting changes in cultural conceptions and practices relating to wife battering (Alonso, 2002; Cameron & Frazer, 1994; Dobash & Dobash, 1992; Gutmann, 1996; Lancaster, 1992; McClusky, 2001; Merry, 2000, 2006; Mrsevic, 2000; Plesset, 2006). This chapter draws from Cameron and Frazer's argument that definitions, interpretations, and representations of gender and violence shift over time. Experiences of and responses to violence, including health experiences, can be added as well. Cameron and Frazer also asserted that at any one time there is a range of possibilities for gender identity, as well as a contested set of meanings available to deal with violence: "Tracing the complex interrelations of these multiple and shifting possibilities is ... a crucial dimension of any satisfactory analysis of any particular social practice" (Cameron & Frazer, 1994). Likewise, in reference to gendered violence, Moore writes, "It is not possible to analyze discourses on gender [or gendered violence], wherever they occur, without recognizing the ways in which they are implicated in larger processes of economic and political change well beyond the control of local communities" (Moore, 1994).

Following these conceptions of gender and violence, in this chapter I will be addressing the perceptions and experience of wife battering of men and women living in three communities in northern Vietnam, and the health of battered women in these communities in the context of social and economic reforms that have been occurring in Vietnam with *doi moi*, or renovation policies. I will suggest that in order to understand wife battering, its health impacts on women, and battered women's attempts to seek health care and avenues to end the violence, it is important to understand the intersection of cultural, political, and economic shifts occurring in particular societies.

As part of her ethnographic research, Maria Tapias addressed emotional and embodied experiences associated with domestic violence in Bolivia in the context of economic reform during the 1990s and early 2000s. She asserted that “[t]he economic and political reforms operating at the level of the nation state come to be experienced in very localized ways and present women with difficult predicaments” (Tapias, 2006, p. 407). Vietnamese battered women face similar difficult predicaments in the context of intersecting global and local economic and cultural changes, as they attempt to preserve their own and their children’s emotional and physical well-being. Sonja Plesset argued that an anthropological study of violence against women “can offer ... an in-depth look at how people talk about and make sense of violence in everyday life” (Plesset, 2006, p. 15). Vietnamese community members’ perspectives and battered women’s experiences of the violence, and their related health struggles, can be understood as being significantly shaped by dynamic and intersecting global and local economic, political, and cultural forces.

Taking a political economy of health approach in critical medical anthropology in this chapter, I specifically assess perceptions and experiences of wife battering in the context of economic restructuring in Vietnam, and economic concerns and issues affecting the health, safety, and vulnerability of battered women. A political economy of health perspective in medical anthropology is useful for understanding health problems such as the emotional and physical suffering derived from wife battering, the sources of which clearly stem from the historically specific cultural ideologies and social structures of societies. The political economy of health is a perspective that emphasizes the social relations of sickness and healing, and the social production of health and illness (Morsy, 1990). This approach allows us to understand the intersecting economic, political, cultural, and social forces, including power relations, which play an integral role in the emergence of individuals’ health status over time (Baer & Singer, 1997; Singer & Baer, 1995; Morsy, 1990). This theoretical perspective also provides us with insight into the consequences of articulating local and global political economies and power relations for the health and vulnerability of individuals cross-culturally. Linda Whiteford argued that through the political economy of health perspective “more work needs to be conducted using the three conceptual tools of political economy, gender, and the social production of health” (Whiteford, 1996, p. 243). The political economy of health recognizes the social production of health and illness by focusing not only on individuals, but also on relations between social categories, such as classes or gender groups, and social institutions, such as the state (*ibid.*).

There is much literature in diverse disciplines regarding battered women's economic status in relation to their husbands, their ability to be economically independent and to escape the battering, and other factors influencing their power to end or reduce the violence (Basu & Famoye, 2004; Bowlus & Seitz, 2006; Farmer & Tiefenthaler, 1997; London, 1997). This literature does not generally address economic issues associated with wife battering in relation to battered women's health, although there are some exceptions (Tapias, 2006). In addition, some of the economic research on wife battering does not recognize the need for culturally specific understandings of the intersection of economic issues with social and cultural forces in a diverse range of societies, or the cross-cultural applicability of their economic theories. The economic analyses tend to address a specific set of variables in addition to working or economic status of the wife, such as education of the wife, and experiences of domestic violence in the husband's natal family, yet they neglect broader cultural ideologies and global processes that inform conceptions of violence, family, gender, and marriage. This chapter attempts to analyze wife battering in the context of the intersection of health, culture, and political economy, framing this intersection as a global, dynamic, and continually changing process.

More specifically, this chapter attempts to situate wife battering and battered women's health within the context of an emergent socialist-oriented market economy within Vietnam, which began in 1986 with *doi moi* policy. A process of modernization in Vietnam began during the period of French colonial capitalism, and was replaced by the socialist model and a politically independent state during the 20th century. The new market economy continues the modernization process. This recent state policy change has been influenced by globalization, as it further integrates the Vietnam economy into the capitalist world order (Tran & Le, 1997; Werner, 2002). Werner writes that "[g]lobalization in the late twentieth and early twenty-first centuries exerts inexorable pressure on post-socialist states to 'restructure' internally" (2002, p. 30). In this regard, *doi moi* has recognized three economic sectors: the state sector, the private sector, and the household sector, or family economy. This neoliberal reform policy has allowed for more private forms of ownership in the economic arena, with the private household economy serving as the basis for the market economy. It has also led to the restructuring of internal institutions to conform to the market economy. Government financial reforms, parallel to World Bank structural adjustment reforms, have included cuts in public spending and the creation of public revenue through requiring fees for social services, including health services (Ladinsky, Nguyen, & Volk, 2000).

In Vietnam, battered women's health is influenced not only by the immediate impact of their husbands' battering and their social relationship, but also by changing broader economic and political forces such as these. I suggest that it is important to understand not only the cultural ideological sources of Vietnamese women's bodily and emotional suffering through wife battering, but also the political and economic influences on this suffering. Married couples are currently negotiating economic and cultural changes occurring in Vietnam society, due to the state's economic reforms and social changes under *doi moi* policies. These changes are influencing perceptions of wife battering as well. To address these, I will look at generational differences in perceptions and understandings of the phenomenon. Additionally, I will discuss how, as economic differences among families emerge, battered women from poor families and those who may become impoverished in relation to the violence will be at greatest risk of poor health due to institutional changes that have been implemented in the health care arena. To address the multiple health concerns of battered women, health problems derived from wife battering must be understood as processes that are informed by cultural, political, and economic change, on both a societal level and in the lives of individual women experiencing this form of gendered violence.

In this chapter, I will look at changes battered women face due to state economic reform, as well as new approaches to wife battering that are being implemented in Vietnam in relation to greater political openness, which is also associated with *doi moi*. In so doing, I draw upon Gillian Walker's approach to the interaction between the state and women's movements, in this case both national and transnational women's movements. She argues that one-dimensional views of the state as a monolith, with either benign or negative intentions toward women, are inadequate (Walker, 2003). Instead, in the case of Vietnam, we must address the multilayered state approaches to violence against women and health care being implemented and negotiated during a period of significant, ongoing social transformation.

## METHODOLOGY

This chapter is based on research that I conducted in northern Vietnam during three short-term visits, primarily in three communities in northern Vietnam.<sup>1</sup> One community is located in a rural district of Ha Noi. Another is situated in a mostly agricultural, but also semi-industrial, town located in Ha Tay Province, which borders Ha Noi. A drive from this town to the

center of Ha Noi takes about one hour. The third community is found in a mixed agricultural and commercial district close to the center of Hanoi. I also conducted research in the center of Hanoi, interviewing especially Women's Union members at the national level, scholars conducting research on domestic violence, and local NGO and international development personnel, both foreign and Vietnamese, who were addressing domestic violence through their programs.

In the rural district of Hanoi, I formally interviewed a set of 24 people, including 12 men and 12 women, about their lives, and perceptions and personal experiences of gender relations and wife battering. This area was mostly agricultural, but there were also some businesses and services in the district, and some people engaged in craft production. There was little industry there because the area was limited in resources and skilled labor. In the town in Ha Tay Province, I formally interviewed a set of 41 people, including 21 women and 19 men. In these interviews I focused on gender relations within the family, with a particular emphasis on cultural conceptions of masculinity, and their perceptions, practices, and experiences of wife battering. This area was also largely agricultural, but the center of town also had several businesses, some industry, and government offices. In the third community near Hanoi center, I interviewed 10 battered women who were visiting a recently established counseling center for women at a public hospital, some of whom also visited a commune health center that had links to the counseling center. I visited the counseling center, commune health center, and two hospitals. I also participated in community meetings in the communities.

Among the individuals I formally interviewed in all of these communities, 18 women said they had been battered by their husbands and 9 men were known to have battered their wives. The battered women all identified with the Kinh ethnic group, and their ages ranged from the twenties to sixties, with most women being within the age range of twenties to forties. Thirteen of the women were being battered during the time I spoke with them, and five had been battered in the past. Ten of the women identified their families as being poor, four as average, and three as average or a bit above average, and one was uncertain of how to categorize her economic status. Eight of the battered women identified their work as farming, while other occupations identified were: professional in the area of finance (1), restaurant manager (1), seller of food or goods (3), wage worker (3), and motorcycle taxi driver (1), and one was unemployed (1).

In each of the three communities, I also interviewed some local government leaders and professionals, including health professionals, members of

the Vietnam Women's Union, local government officials, and others. In addition, I conducted a few formal and informal interviews with other Hanoi residents about their perceptions of gender and marriage, and experiences with wife battering. I also conducted some limited research in Ho Chi Minh City, with scholars and a local NGO concerned with wife battering.

The community members I spoke with identified with the Kinh ethnic group, which is the majority ethnic group in Vietnam. There was some representation of individuals from different socio-economic groups, age groups, and religions among the community members I interviewed. In regard to socio-economic activities and status, though, most were families engaged in agricultural activities, along with other economic activities as well. Fewer individuals were professionals, businesspersons, full-time wage laborers, and craftspersons. In each of these communities, most of the women and men worked outside of their homes, particularly in their agricultural fields. As is typical of families in northern Vietnam, kinship was based on patrilineal descent in these communities, and residence was largely patrilocal. This pattern has been changing in Vietnam, however.

Since there may be differences in understandings of and approaches to wife battering based on regional and ethnic variations among members of the Vietnamese population, my analysis cannot be generalized to all other areas of Vietnam. This chapter provides a glimpse of ways in which economic and political relations can impact understandings and experiences of wife battering, including women's health, in the communities in which I conducted research.

## **WIFE BATTERING IN VIETNAM**

There have been no national surveys conducted in Vietnam to estimate the prevalence of wife battering in the country. Therefore, it is not possible to present an accurate assessment of the extent of the problem there. However, numerous Vietnamese and other scholars have pointed to the seriousness of the problem in Vietnam, and individuals I interviewed acknowledged that wife battering is commonly found in their own and other Vietnamese communities.<sup>2</sup> While not the norm among married couples, the majority of individuals I interviewed knew of at least one family or community member who had been involved in wife battering.

From the perspectives of some professionals in Vietnam, violence against women, including wife battering, generally involved both physical

and emotional abuse of women, within and outside of the home, and including sexual abuse and men committing adultery (Le, 1998). This perspective has been influenced by internationally promoted, largely Western, conceptions of wife battering, or domestic violence, as an aspect of globalization and the transnational circulation of feminist and human rights ideologies (Merry, 2006). National level officials of the Vietnam state's Women's Union asserted versions of this definition. The Women's Union is a government mass organization that is supported by and tied to the state and Communist Party.<sup>3</sup> It is also considered to be one of the primary government-related organizations assisting battered women. In contrast, people whom I interviewed in the three communities generally thought of husbands' violent maltreatment of their wives as referring primarily to physical violence, or hitting their wives. The extent of the impacts of this violence on women's bodies and health influenced community members' interpretations of the battering. For many community members, wife battering was considered a minor problem and somewhat acceptable if it resulted in minimal injury to women's bodies. It was conceived of as a more serious problem if it resulted in severe injury. Thus, there are multiple and changing interpretations of wife battering in Vietnam. This diversity of interpretations can impact social responses to wife battering, including the kinds of economic commitments national and local level government officials are willing to make to alleviate the problem and assist battered women. The diversity of interpretations of what constitutes wife battering also makes it difficult to estimate the prevalence of wife battering in Vietnam (Vu, Vu, Nguyen, & Clement, 1999).

As demonstrated later in this chapter, the idea of violence in the home is somewhat acceptable among Vietnamese individuals, despite the outlawing of violence against family members by the contemporary socialist state. Vietnamese community members' perspectives of wife battering are largely influenced by cultural conceptions of gender, including the naturalization of men's violence, marital and family relationships, and the relationship of the family to the larger society in Vietnam. Women are vulnerable to violence in part due to continuing historical ideas of gender inequality, influenced by Confucian philosophy, in the context of broader state and international ideals of gender equality. Through my interviews, I found that conceptions of gender inequality, especially within the family between husband and wife, persist among both younger and older Vietnamese individuals in the face of state discourse which asserts equal rights for men and women.



## **WIFE BATTERING, AGE, AND GENDER**

Vietnamese women and men's perceptions and experiences of wife battering have developed in the context of economic reform. In the following, I will briefly discuss perceptions of wife battering expressed to me by men and women of different age groups. This approach can help to inform us, to some extent, of the influence of the current political and economic context within Vietnam on the perspectives of wife battering that have emerged among people of varying ages and social experiences.

A Vietnamese sociologist with whom I spoke expressed her view that there is a difference between the perceptions of older and younger women. She said this is due to women learning different ideas about women's roles and status within different cultural environments and time periods. Generally, she continued, women of her generation, or women approximately aged 40 or older, "suffer violence as their fate. They think it is normal to suffer throughout their lives." Younger women, in her view, "have more consciousness about gender equality and have more chances to learn about the laws emphasizing gender equality." While the younger generation does not necessarily participate directly in gender-oriented classes, she said they have been influenced by the political revolution of 1945. Women now participate more in social life, working outside of their homes, earning incomes, and generally have a higher status than women did prior to 1945. She also mentioned that international influences from French and American cultures have supported the ideology of gender equality.

Her continuing discourse, however, exemplified ambivalence about the differences that she asserted. Sometime later in our conversation, she said that, with renovation, patriarchal ideas have reemerged.<sup>4</sup> She argued that with renovation the government is trying to strengthen Vietnamese culture, and government officials think that modernization redevelops traditional values, such as the idea that men must govern women. Young men, she observed, want to marry women who have educational and professional levels lower than their own, so they can be the head of the family.<sup>5</sup> Also, popular government discourse emphasizes the ideal of a happy family, and she said young women themselves think they must return to the family, and keep the family together.

This sociologist's complex view of generational differences in perceptions of marriage, family, and gender reflects the kinds of ambivalences individuals I spoke with held regarding their views of domestic violence. For example, among 15 women in the younger generation of women that



I interviewed in the research communities, between the ages of 21 and 39, 8 of the women expressed definitively the view that domestic violence is always wrong. A few of these women, however, said they managed their husbands' potential violence toward themselves by remaining "silent" when their husband became angry with them.

Five women in the younger generation held ambivalent views about domestic violence, while two asserted that wife beating was acceptable. One woman said that "domestic violence is not acceptable in society in general ... but if the wife makes a mistake and the husband beats her to some extent, that is acceptable, like a slap when she is nearby, or throwing something at her if she is far from him." Also, like many men and women I interviewed, she said, "It is not acceptable for a woman to beat her husband." Another woman, who has negotiated with couples who were experiencing domestic violence, said,

Violence is unacceptable, but in some light cases, if the man just slaps his wife, that is just normal. But if I think of it again, even that is unacceptable. [But,] I think that woman must be a very talkative woman, and she says so many bad words to him and his family. So, that is a good reason for him to beat his wife.

Wife battering is commonly perceived by these young women, as well as other women and men, to be caused by women and a result of men's lack of control over their anger (see also Rydstrom, 2003). For instance, a woman, who had once been slapped by her husband, said "sometimes when my husband gets angry I have to withdraw my decision in order to avoid making the problem more serious." She further said,

... most of the women who are beaten by their husbands are the women who often make a mistake with the husband, which leads to the beating. I saw many cases of women nearby beaten by their husbands. Some of my neighbors complain too much about their husbands, so their husbands got angry and beat them.

She believes that men are quite different from women because "they cannot control themselves when angry."

Among 22 women of the older generation, aged 40 and older, 13 expressed clearly their view of the inappropriateness of domestic violence. Nine of the older women were ambivalent, as they expressed the view that women could in some cases be at fault and deserving of the beatings. Among the battered women I interviewed who addressed this issue, younger women had more divergent views than older women. Among six younger women, two asserted that wife battering was unacceptable, two expressed ambivalence about the violence, and two found it to be acceptable under any

circumstances. Among five older women, four asserted that wife battering was unacceptable, and only one was ambivalent about it.

These women's responses demonstrate that there is some difference in views of domestic violence between women of the younger and older generations, although not a great difference. These women's responses also depict the variability within generation groups. Some of the women's ambivalent views about the appropriateness of gender violence may reflect the contradictory relationship of resistance and accommodation women may be experiencing, discussed by Kondo and Lewin (Kondo, 1990; Lewin, 1995) as they try to integrate conflicting discourses of womanhood emerging from their families and from the changing Vietnamese society. These women may be trying to integrate the different meanings attributed to their roles, in order to construct a satisfying definition of the self (Lewin, 1995), although these meanings may at times conflict, such as their roles as women deserving of respect, as good and proper wives, as good mothers, and as good daughters.

Changing ideologies may also occur over a person's lifetime, depending on their life stage status and the broader social and cultural context of their lives at any one time. For example, in Vietnam, as well as in other societies, women may be entering a position of greater power, status, and independence as they age (Wolf, 1972). They may be able to afford to be more outspoken in their condemnation of domestic violence. Also, some of the older women may have developed intolerance for the practice over time. Given the structural constraints that younger women face, including the problem of providing adequate material support for their young children, they may attempt to convince themselves that they caused the violence, or that the violence is a part of suffering that they must endure as wives and mothers.

Additionally, many older- and middle-aged women discussed how domestic violence was considered to be more of a problem shared by the community approximately 20–30 years ago, whereas now it is considered to be a problem of individual families. One older woman said that there was more “traditional village” punishment and more public sanctioning of batterers by community members, and criticism of both husband and wife for their fighting. They were made to prepare a village feast, entailing spending much of their time and resources, to make up for their problem. She said that people were taught that if they were angry they had to keep their anger inside of themselves. Another middle-aged Vietnamese scholar expressed her view that before renovation, local government officials took domestic violence more seriously, and there was a greater sense of the family

being one unit of a larger cooperative, and country. Now there is greater focus on the family as an individual unit. With production processes having changed from a system of collectivized agriculture to the assignment of land use rights to households in rural areas with *doi moi*, greater emphasis on the household and family has led to a shift toward greater community recognition of family privacy. According to this scholar, this change has resulted in women experiencing less support and protection from wife battering from other community members than they had prior to *doi moi*, due to greater emphasis being placed on the idea of wife battering being a private family matter. Currently, men who are batterers are sometimes given advice or are scolded by concerned neighbors, members of the local Women's Union, or other government leaders, but usually on a more private level. Men today also face the possibility of being visited and/or arrested by the police, but this is infrequent, and often carried out only in the most severe cases of battering. Therefore, according to some people's perceptions, public sanctioning of batterers has been minimized in recent years. Women of the older generation may have been more greatly influenced in earlier years by societal and government discourses and practices that were less ambivalent regarding the inappropriateness of domestic violence. Even though contemporary government discourse condemns wife battering, its practices tend to favor men's authority within their families and provide little support for battered women.

Among the men I interviewed there was also variation of perspectives between and within generation groups, as well as ambivalence of position. Among 10 men of the younger generation interviewed, between the ages of 20 and 39, 3 asserted that wife battering is inappropriate, and did not blame women for the violence. Six younger men were more ambivalent in their views, stating that while generally wife battering was not a good practice, there were times when the situation warranted hitting a wife. One younger man said that wife battering was acceptable. One of the men said he had slapped his wife when she had not listened to him and he had become angry. Another man said if a wife uses bad words toward her husband, then he is justified in beating her.

Among the older generation of 20 men, aged 40 and older, 11 unequivocally stated that wife battering was not acceptable behavior, and 9 were more willing to blame the wife for making a mistake, indicating that would be an acceptable situation for battering one's wife. One older man said that most wives understand that their husbands hit them as a psychological reaction to their anger, implying that it really was not his fault. He said a wife has to learn how to avoid making her husband angry.

We see a similar situation of intragenerational variation, and ambivalent views among men regarding wife battering. But we can also observe less equally divergent views of wife battering among younger men, with a higher percentage of younger men viewing the violence as appropriate behavior in some cases compared to older men. These men also may have been trying to integrate sometimes conflicting, sometimes coherent, identities, as family authorities, benevolent husbands, and men deserving of respect.

While this sample is quite small, and the findings thereby limited, looking at these generational understandings and meanings of the legitimacy of wife battering in relation to a changing political, economic, and cultural environment is relevant to women's health. As young women and men are generally more likely to excuse husbands' violence toward wives than older men and women in a context of emerging individualism and reemerging patriarchal views, women become more vulnerable to wife battering and poor health.

## **HEALTH, INJURY, AND ILLNESS**

Battered women with whom I spoke experienced a number of injuries, health problems, and emotional distress derived from their husband's battering. In discussing their own perceptions and experiences of wife battering, battered women I spoke with expressed both physical and emotional pain, sometimes emphasizing the emotional suffering they experienced more than the physical. This also involved painful social relationships and feelings of shame. The battering included slapping, kicking, punching, pushing, burning, cutting, strangling, and throwing objects at the women. For some of the women, injuries derived from wife battering resulted in short and/or long-term emotional and physical pain, and other problems. These included memory problems, headaches, nausea, depression, suicidal thoughts and attempts, bodily pain (such as back pain), broken bones, bruises, loss of or broken teeth, weight loss, and other health issues. For several of the battered women, emotional pain extended to fear, anxiety, and sadness over their husband's violence directed at their children, or the bind that they felt themselves to be in since many believed that they would lose their children if they decided to leave their husbands. A burden carried by most of these women was the internalization of the cultural discourse that women should endure suffering for their families, especially their children, and for the greater good of their family and society. In Vietnamese culture, women's needs commonly are not considered to be as

significant as those of the family, and by extension the needs of the larger society (Young, 1998).

## **PERCEPTIONS OF WIFE BATTERING AND *DOI MOI***

Vietnamese people I spoke with had given consideration to recent changes in regard to ideologies and practices surrounding wife battering. These changes transpired in the context of economic reform policies, as well as in conjunction with other changes that occurred decades earlier with the institution of communism and the Communist Party's promotion of ideologies of gender equality, and government condemnation of gender violence. There was no consensus among the people I spoke with, however, regarding whether domestic violence has increased or decreased in recent years, but the majority of individuals I interviewed perceived it to be decreasing.<sup>6</sup>

A number of people I interviewed in both the rural and urban areas asserted that greater access to education and increasing family economic status already have begun, and will continue to be important factors influencing the decrease in wife battering. While these ideas may be true to some extent, other structural and ideological factors may influence the persistence of gender violence over time and across generations, despite changes in education and economic status. One example is a lack of government or non-government material support for women who leave battering husbands. While there are some programs offered to help women raise their economic status through the Vietnam Government Women's Union and a few international development organizations, there are no widespread programs that specifically aid victims of domestic violence who decide to leave their husbands. Some new programs to assist battered women have been emerging, however, as I will discuss below. Vietnam's Communist led state promotes gender equality, yet a normalized state response to cases of wife battering is to encourage women to remain with their husbands and families. This response occurs through formal state procedures of reconciliation, involving a formal reconciliation committee, as well as through informal discussions between local government leaders, Women's Union leaders, battering men, and battered women. As I noted previously, Women's Union members are some of the most significant community level responders to incidents of wife battering. While discussing with me the process of reconciliation and responding to wife battering, one Women's Union leader said, "... the main objective is to reconcile the

couple, to help them to live together in harmony and in a good family environment.”

While divorce rates are increasing, especially in the urban areas, courtroom judges usually convince women to return to their battering husbands at least two times before divorcing, since the government is invested in promoting stable families that provide for their children. Compounding the problem is the fear many women have of losing their children to their husbands if they leave their homes, since women do not feel certain that the government will protect their right to raise their children even if their husbands are batterers. Women additionally fear that their children will be harmed emotionally if they grow up without a father’s regular presence. Also, many women’s families urge women to go back to their battering husbands because the women and their children are perceived to be a burden on their natal family. Remarriage is difficult for women, and family members fear the women will remain unmarried for the rest of their lives if they divorce.

Some people thought that as economic insecurity within the family is reduced with *doi moi*, tensions between couples will be lessened and violence against wives will be reduced. Yet, one man discussed how new conflicts have arisen between couples in recent years, due to increasing differential wealth in Vietnamese communities. Some women pressure their husbands to earn as much income as other men in their neighborhoods or families have been able to earn in the new economy. He said their wives feel that they have a difficult life and that their lives are not flexible because of their husbands. This has sometimes resulted in men beating their wives to silence their complaints and to reassert their status as respectable husbands. Also with renovation has come a relaxing of social mores, with some men spending more money on gambling and drinking than they may have in the past. Both of these activities were regularly associated with domestic violence by scholars, and by community members I talked with (Vu et al., 1999)

## **BATTERED WOMEN’S PERCEPTIONS**

Scholars of domestic violence have often reported on the problem of battered women’s economic dependency on their husbands influencing their difficulty in leaving or divorcing their battering situation, if this is their preferred response to the violence. According to London, who researched battered women in Senegal, women who are economically independent are more likely to bring criminal charges against their husbands or attempt to

acquire a divorce. He found that most Senegalese women are dependent on husbands who are the sole economic provider for the family, thereby leading to a situation of men's economic domination of the household and their ability to commit violence against their wives without fear of consequences. Yet, he also states that with Senegalese women's greater participation in work to economically support their families, due to the economic crisis of the 1980s, some husbands viewed their wives as economic competitors and blamed women who participated in economic activities for a variety of social problems. Violence is sometimes used by husbands to keep women from engaging in economic activities in order to maintain their subordination and economic dependence in the household (London, 1997). In contrast, among the battered women I spoke with in my research, there were a variety of economic situations that battered women faced, and usually not full economic dependence on their husbands. The majority of the battered women I spoke with contributed to the household economy. Still, living independently as a farmer would be quite difficult. One woman, who was divorced from her husband who had demanded their divorce, lived near members of her natal family in order to receive material and labor support. Vietnamese battered women cannot always count on their family's support, however, since a number of women expressed pressure from their families to remain with their husbands.

Some battered women were the sole providers for their families out of necessity, rather than choice. In these cases, their husbands provided little or no support. In one case, the husband had left the family, but over several years continued to take goods from his family's home, or destroyed household goods that they had during fits of anger and violence. All of these women expressed a desire for a divorce, although most had not achieved one.

Women's emotional and bodily health may be affected by the stress that arises due to family economic difficulties that commonly accompany wife battering, as can occur for women who are not battered as well (Tapias, 2006). In some cases, battered women's economic difficulty is due to the husband's lack of economic support for his family, which may be an aspect of his overall approach to his family that is centered on his own needs. In other cases, it is due to a woman's inability to perform her economic activities due to injury or illness derived from the battering, sometimes combined with her status as the sole economic provider for their family, with her husband either living or not living with her. This stress weighs heavily on battered women as they attempt to support their family, influencing a sense of despair, worry, and suffering. Some women discussed



losing considerable weight due to the stress they experienced, and being depressed and worried. At the same time, most of the battered women that I spoke with were not immobilized by these problems and their distress, but rather exhibited agency in coping with their situation. They worked very hard to the extent that they could, borrowed resources from family members or friends, and conceptualized strategies for how they might provide greater financial stability for their family. This example demonstrates that health problems deriving from wife battering do not only stem from direct physical violence against the women. Instead, social and economic stress that they experience in relation to the broader impacts of wife battering is also experienced bodily and emotionally (Scheper-Hughes, 1992; Tapias, 2006), resulting in long-term states of poor health. These states of poor health, including worry over financial problems, and suffering are expressed through the cultural theme of "sacrifice" for women, as many battered women expressed that they must sacrifice themselves for their family, and for their children in particular. This also refers to a choice made to remain with their husband, although this is often a choice made in the face of social and cultural constraints on their ability to end the violence. In addition, battered women are usually encouraged to make sacrifices for their family by local and government leaders, as a moral obligation that they have as wives and mothers. For many battered women, this involves sacrificing their economic security, which compounds their bodily and emotional health problems.

When battered women consider leaving their husband to escape the battering, one consideration, among many, is their ability to support themselves, and possibly their children, if they are mothers. The majority of Vietnamese women surveyed by scholars have reported that their incomes have increased with the implementation of *doi moi* policies (Werner, 2002). Yet, changes associated with economic reform have not improved women's economic opportunities equal to those of men's. Well-paying employment opportunities are not easily obtained by individual, unskilled women, and women have fewer employment choices and lower earning capability compared to men (Tran & Le, 1997). For battered women who desire to leave their husbands, working full-time as a single woman with young children might create a need for child care, or the woman may work part-time. Many women living in rural areas concentrate their work on their family's agricultural land, and engage in other economic activities as well (*ibid.*). Battered women living in rural areas face difficulties in regard to access to resources if they consider divorce. For instance, if a battered woman moved away from her own village into that of her husband, she may



not have easy access to land she inherited in her own village. She also may not be able to acquire land in her new village in place of her inherited land without a penalty, or at all. With divorce, a battered woman has not been legally guaranteed a portion of the land owned by her own household (Werner, 2002). With women's employment currently being primarily in the household sector (*ibid.*) and with uncertainty associated with locating well-paying employment, battered women deciding to leave their husband and household can be a difficult undertaking.

Existing state policy does not provide sufficient social assistance for poor, single women and children following a divorce, also inhibiting some women from seeking a divorce from a battering husband. For instance, Thuy, a 48-year-old woman who had divorced her husband, explained,

... I received no (economic) help.<sup>7</sup> I had to stand on my own, so many years ago. I lived in a tent (with my children) near a river, and I had to sleep on a sidewalk ... It took me so much time, labor and money to obtain this house. When I got divorced, I used to sleep in a tent in the market, where people sell things, and also on the pavement. I thought, if someone would let me sleep in their kitchen my children would be better off. If we slept in the market, when it rained we all got very wet. I had my three children with me because my husband could not take care of himself, so he could not take care of the children.

A few social programs are available for poor women, such as Women's Union programs. More financial assistance programs also are being introduced for women through local NGOs and international development organizations, some of which are implemented through Women's Union programs. These include craft or vocational training, credit programs, and job creation. Prior to 1994, a divorced woman named Huong said she had not received assistance from the state. But she said that, since 1994, the Women's Union had lent money to her from a project focusing on the elimination of poverty and hunger in Vietnam. She had received a loan of 300,000 Vietnamese *dong* (approximately 26.00 U.S. dollars at the time of the interview) each year, with a small amount of interest required with repayment. While there is limited financial assistance available for women from the Women's Union, most battered women I spoke with said they were still being advised by Women's Union leaders to practice self-denial with their husband, and to return to their husband and children. Of the battered women I spoke with, only one had both obtained a divorce and received assistance from the Women's Union. We see that there are intersecting concerns and predicaments that women face that influence them to remain with their husbands, including ideologies of womanhood, women's fear of losing their children, shame associated with the violence within their

marriage and family, economic difficulty, and pressure from family members and government officials to remain within their family. This situation makes them vulnerable to continued battering and subject to long-term emotional and physical health problems resulting from the violence.

## **MARRIAGE, KINSHIP, AND GENDER**

Some Vietnamese individuals held an ideology of marriage being an economic transaction which gives a mother-in-law rights over their daughter-in-law's body, including the right to encourage her son to beat her. While this practice is illegal in Vietnam, according to the Vietnam Law on Marriage and the Family and the Criminal Code, some mothers-in-law perceive themselves to retain the right to control their daughter-in-law's actions through their son's battering. In this way, economic transactions intersecting with kinship relationships can influence wife battering and women's health.

Chau, a 40-year-old woman who had been battered by her husband for 15 years, is the sole financial supporter for her family. Her husband has also beaten her children several times. She said that she believes that her husband beats her primarily to pressure her to earn money for him and their family. Her health has suffered as a result of the violence, as he has commonly beaten her face until it has become bruised; she has coughed up blood; she has experienced much pain in her chest and stomach, where he often hits her; he has strangled her several times with his hands and cut her; and he had punched her back when she was pregnant with her second child. During our interview, Chau said,

The first time he beat me it was because my parents gave me money to buy new clothes for our son. When I bought two items of clothing, my mother-in-law felt that I had spent too much money, then my husband beat me ... The first time he hit me was very serious. At that time I had long hair, and he tied my hair to beat me, pulling it. My mother-in-law asked him to beat me.

Chau began to cry, and later said,

... and now I remember the first time my husband beat me. My mother-in-law stood near me and said to me, "I had to spend money for your wedding, so I have the right to respond badly to you." At that time I did not understand this, and when my mother came to my house and I asked her about this, she explained the meaning to me. A mother-in-law has the right to maltreat her daughter-in-law. My mother did not agree with this, though.

The mother-in-law asserted that since she had spent money on her daughter-in-law's wedding, she had the right to do as she desires with her. In this way, women's rights over their own bodies become transformed through the financial sponsoring of a woman's wedding by her parents-in-law and the hierarchical social relationships that emerge within the traditional patrilineal families they marry into. While not all Vietnamese people ascribe to this ideology, for those who do this conception of a daughter-in-law's body may be legitimate, from their perspective, wife battering that stems not simply from a husband, but from other family members as well. Chau further said,

Then (following her husband's first aggression toward her) I decided to divorce and I called my parents to come to resolve the problem. But after that, my mother-in-law and husband asked for my forgiveness, and I thought about my child. So, I did not divorce him. If at that time I had decided to divorce him, then he would not have been able to beat me for all of this time.

While Chau's mother-in-law asked for Chau's forgiveness for asking her son to beat Chau, her mother-in-law's actions and perspective may have influenced Chau's husband to continue to beat her over the next 15 years. This example depicts the significance of the influence of intersecting cultural ideologies of marriage, kinship, gender, and mothering on wife battering.

## HEALTH AND HEALTH CARE

One significant arena of change for battered women's health has been policy changes associated with neoliberal economic restructuring in regard to the provision of health care services. There have been many improvements in the health of both women and men since the implementation of *doi moi*, and related improvements in the standard of living in Vietnam (Tran, 2004). With the privatization of health care services and continued state health care, women have more choice in accessing health care, particularly in urban areas where more private health care services are located. The range of choices may not be as readily available to women living in rural areas, and poor women, however. Women have also become more aware of health issues affecting them through increased emphasis on reproductive health and population and family planning programs, implemented by the state health service and international health organizations.<sup>8</sup>

Under the centrally planned socialist economy, prior to the implementation of *doi moi*, however, health care was provided without cost. This ideally

allowed the poor regular access to state provided health care, although these services were not of the highest quality and were limited in availability, especially for the poor (Tran, 2004; London, 2004). Today, while some basic health care and prevention programs are still provided for free in local communities, health care is not entirely without cost, such as payments needed for diagnosis and treatment through a new fee for service system, and other expenses. Also, the percentage of the state budget allotted for health care has been reduced in recent years as a feature of reform policies (Tran, 2004; Werner, 2002; Ladinsky et al., 2000).

The economic changes introduced into the health care system with *doi moi* may have reduced poor battered women's access to adequate or any treatment for their injuries, and led to the development of long-term health problems resulting from their not addressing injuries derived from the battering. Poor battered women sometimes wait until their health problems worsen before visiting a health care provider due to their poverty. Or, they may become highly indebted due to obtaining health care that was very costly. For instance, Duong, another 48-year-old woman, who had been battered for more than 17 years, said, "I went to the hospital so many times for treatment of my injuries. Because of my poverty, I had no money for treatments. I would be examined, but I would not be treated." Only recently, with the implementation of an international health and development organization program addressing wife battering, has she received treatment for her injuries. Even with this program, she also relied on private donations of funds and an additional 30% reduction of the cost of the surgery by a hospital so that she could undergo surgery to repair her severely broken leg. Her leg had been broken during an accident, but the injury was worsened by her husband's repeated kicks to her broken leg during fits of anger. Many women discussed using home remedies to treat their injuries, though the cost of health care may not have been the only reason for this practice. Many Vietnamese battered women desire to keep their experience of battering hidden from public view, due to feelings of shame and a reluctance to reveal their family's problems to other community members.

While many scholars have addressed battered women's class position and their economic status in relation to their ability to leave their husbands, they often convey a static view of women's economic situation. Health problems, and those that become long term, can also have a serious impact on women's ability to work and the economic status of their household. The problem of changing economic conditions of battered women's households must be considered, as women become injured and ill, or experience a

decline in health and strength over time, or as husbands no longer provide support for the family. For instance, one 45-year-old woman I spoke with was attacked by her husband, who seriously injured her by cutting her neck with a knife. He had battered her for 11 years by that time. She said, "It has taken me months to recover from my illness, and I am still not fully recovered. I now depend on all of my relatives for my and my (11-year-old) son's economic stability." She was a farmer, and could not work at the time of our interview due to her injuries. Another 49-year-old battered woman was hospitalized for 1 month due to severe headaches and nausea that she experienced after her husband had hit her head. In cases such as these, in which the health problems experienced by battered women significantly affects their ability to work, the economic status of the household is often compromised, even when they do receive health care. This kind of problem also needs to be recognized in considering women's economic independence relative to their ability to leave their spouse if they desire to do so, and in programs assisting battered women, since there are few social services available to aid battered women facing this type of situation.

## SHIFTING HEALTH ORIENTATIONS

The political economy of health takes into account global economic and political movements deriving from international health and development discourses and practices. With *doi moi*, a new political openness in Vietnam has allowed for the growth of international health and development programs, as well as local NGOs. In recent years, international health organizations and NGOs have introduced new programs addressing wife battering, some of which emphasized the safety of women's health over the needs of the family. One pilot program in a Hanoi district focused on training health professionals to better serve the health needs of battered women, including attempting to ensure their protection from future violence. As I noted above, this program has also aided some battered women in seeking much needed health care, and acquiring a divorce from their husbands. It has also involved the development of community level men's and women's clubs that are oriented toward preventing wife battering, and helping men to stop battering their wives. In this way, both women and men are asked to participate in this new orientation to wife battering, so that the problem is once again addressed at the community level rather than at the individual family level. The introduction of new cultural orientations to wife battering has arisen with the globalization of feminist

discourses of gender violence, and wife battering in particular, in conjunction with pressure on the Vietnam state to recognize the need to eliminate violence against women. These intersecting transnational, national, and local movements around violence against women and international health are beginning to influence individual Vietnamese battered women's lives and local communities, if only on a small scale at this time.

While this program has offered positive approaches to assisting individual battered women that influence their health status, some people were concerned about the continuation of programs such as this one. Some health officials had asserted that other health problems are priorities that need to be addressed first, and that funds would be directed toward these problems. This program has expanded to five new communes since 2004, nevertheless. Still, a problem faced by Vietnamese people who are involved with new health or social programs stemming from international health programs, including those aiming to assist battered women, is uncertainty of the long-term viability of the programs. This is due in part to a certain degree of economic dependency on international health organizations or other organizations, for new, innovative health and community programs for battered women and batterers. Health providers said that they were uncertain if the state would be able to financially support the new programs that had been implemented when international funding for these programs runs out.

## **UNEVEN EFFECTS OF ECONOMIC AND SOCIAL CHANGE**

I have discussed some difficulties experienced by battered women, particularly those who are poor and live in rural areas of Vietnam. There are, however, exceptions to the experience of health and economic difficulties among battered women in the context of *doi moi*, which I have presented. For instance, as a result of *doi moi* policies, some women's family incomes have improved, or they experience greater collaboration with their husbands and other family members, for example, as a result of the development of a family business. Some of these women will have positive or improved relationships with their husbands, given their improved relationship and a reduction in family economic stresses. In addition, there may be little, or possibly more positive, change in access to health care for more economically secure battered women, who can afford to purchase health services. Battered women who have prospered economically with

changes associated with *doi moi* may also experience greater economic security and ability to escape a battering situation. Women who achieve higher levels of education may be more financially secure and have a greater sense of independence and security that can aid them in avoiding or stopping wife battering if they are married, as other scholars have also argued. Thus, while wife battering is found to occur at all social class levels in Vietnam society, women's economic position and security may influence some battered women's ability to escape wife battering and avoid injury and other health problems when it occurs. Still, other social pressures, structural conditions, and battered women's emotions and perceptions may still influence them to stay with their husbands.

Finally, as I have previously noted, change is occurring in regard to perspectives of and approaches to wife battering in Vietnam due to international influence on local NGOs and the implementation of new programs addressing wife battering by international health and development organizations, particularly during the last decade. While state funding of new programs may be uncertain, ideologies associated with wife battering are beginning to shift due in part to the global circulation of international health programs, new cultural discourses about wife battering, and the emergence of debates about these discourses among professionals and community members in Vietnam. For instance, a new anti-domestic violence law is projected to be adopted by the Vietnam National Assembly in 2007 or 2008, the first of its kind in Vietnam. By 2004, these changes were unevenly distributed, usually as small community level projects, and there had not yet been nationwide programs implemented to protect the health and safety of battered women and to prevent future cases of wife battering.

## CONCLUSION

In order to comprehend the health problems of battered women and the sources of the battering and its perpetuation, it is important to understand the intersection of global and local economic, political, and cultural forces (Whiteford, 1996). In Vietnam, social and cultural changes that have arisen with the emergence of a socialist-oriented market economy, globalization, and neoliberal economic reforms have influenced both women's ability to protect themselves and access health care, and new conceptions of and institutional approaches to wife battering in Vietnam. These include new approaches in health care institutions. Also, as young women and men are generally more tolerant of wife battering than older men and women,

women become more vulnerable to the violence and poor health. Additionally, increasing economic differentiation among families may result in poor battered women having greater difficulty than more wealthy women in protecting themselves from violence, maintaining good health, or recovering from injuries and illness derived from their husbands' violence. This form of structural violence is added to the physical and emotional violence the women are already exposed to. Thus, in order to address the multiple health concerns of battered women, health problems derived from wife battering must be understood as processes that are informed by cultural, political, and economic change, on both a societal level and in the lives of individual women experiencing this form of gendered violence.

## NOTES

1. I conducted research in Vietnam in 1997, 2000, and 2004.
2. For instance, see Rydstrom (2003), Hoang (2002), Le (2002), Nguyen et al. (2001), Le Thi Quy (1992, 1995, 2000), Vu et al. (1999), Le (1998), Johnson (1996), Thai Thi Ngoc Du (1996), and Tran (1995).
3. The Women's Union has networks of women throughout the country who strive to attain gender equality and teach women to participate in the development of society.
4. This is a view held by other scholars as well (see, e.g., Drummond, 2004).
5. While I found that some educated young men preferred their wives to be subordinate to them, they did not always require her educational level to be lower than their own.
6. It is possible that this perception was conveyed to me because of a desire to present the problem as improving.
7. All names used in this article are pseudonyms.
8. See Tine Gammeltoft (1999), for an excellent ethnographic study of health and family planning in a rural community in Vietnam.

## ACKNOWLEDGMENTS

I would like to express my deep appreciation to Dr. Le Thi Quy, Director of the Research Center for Gender and Development, at the Hanoi University for Social Science and Humanities, and Dr. Le Thi Nham Tuyet, former Director of the Research Centre for Gender, Family and Environment in Development (CGFED) in Hanoi, each of whom provided me affiliation with their institutions and invaluable assistance for my research. I am also sincerely grateful to the many Women's Union members who helped me



to conduct my research within their communities, and to the Vietnamese people who participated in my research. I am highly thankful for the generous funding of my research by the Office of the Vice President for Research and Information Technology, at Colorado State University, and the University of South Alabama Research Council. I am also grateful for the very helpful and astute comments of the reviewers of my chapter.

## REFERENCES

- Alonso, A. M. (2002). "What the strong owe to the weak": Rationality, domestic violence, and governmentality in nineteenth century Mexico. In: R. Montoya, L. J. Frazier & J. Hurtig (Eds), *Gender's place: Feminist anthropologies of Latin America* (pp. 115–134). New York: Palgrave Macmillan.
- Baer, H., & Singer, M. (1997). *Medical anthropology and the world system*. Westport, CT: Bergin and Garvey.
- Basu, B., & Famoye, F. (2004). Domestic violence against women, and their economic dependence: A count data analysis. *Review of Political Economy*, 16(4), 457–472.
- Bowlus, A. J., & Seitz, S. (2006). Domestic violence, employment, and divorce. *International Economic Review*, 47(4), 1113–1149.
- Cameron, D., & Frazer, E. (1994). Cultural difference and the lust to kill. In: P. Harvey & P. Gow (Eds), *Sex and violence: Issues in representation and experience* (pp. 156–171). London and New York: Routledge.
- Dobash, R. E., & Dobash, R. P. (Eds). (1992). *Women, violence and social change*. London and New York: Routledge.
- Drummond, L. (2004). The modern "Vietnamese woman": Socialization and women's magazines. In: L. Drummond & H. Rydstrom (Eds), *Gender practices in contemporary Vietnam* (pp. 158–178). Singapore: Singapore University Press.
- Farmer, A., & Tiefenthaler, J. (1997). An economic analysis of domestic violence. *Review of Social Economy*, 55(3), 337–358.
- Gammeltoft, T. (1999). *Women's bodies, women's worries: Health and family planning in a Vietnamese rural community*. Richmond, Surrey, England: Curzon Press.
- Gutmann, M. C. (1996). *The meanings of macho: Being a man in Mexico City*. Berkeley, CA: University of California Press.
- Huang, B. T. (2002). Relationship between family members. In: T. N. T Le (Ed.), *Images of the Vietnamese woman in the new millennium* (pp. 142–144). Hanoi: The Gioi Publishers.
- Johnson, M. P. (1996). Violence against women in the family: The United States and Vietnam. In: K. Barry (Ed.), *Vietnam's women in transition* (pp. 287–296). New York: St. Martin's Press.
- Kondo, D. (1990). *Crafting selves: Power, gender, and discourses of identity in a Japanese workplace*. Chicago, IL: University of Chicago Press.
- Ladinsky, J. L., Nguyen, H. T., & Volk, N. D. (2000). Changes in the health care system of Vietnam in response to the emerging market economy. *Journal of Public Health Policy*, 21(1), 82–98.

- Lancaster, N. (1992). *Life is hard: Machismo, danger, and the intimacy of power in Nicaragua*. Berkeley, CA: University of California Press.
- Le, T. N. T. (Ed.) (2002). *Images of the Vietnamese woman in the new millennium* (pp. 142–144). Hanoi: The Gioi Publishers.
- Le, T. P. M. (1998). Violence and its consequences for reproductive health: The Vietnam case. *South and Southeast Asia regional working papers*, 12(15), 34–42. Hanoi: The Population Council.
- Le, T. Q. (1992). Some views on family violence. *Vietnam Social Sciences*, 4, 80–87.
- Le, T. Q. (1995). Domestic violence in Vietnam and efforts to curb it. In: K. Barry (Ed.), *Vietnam's women in transition* (pp. 263–274). New York: St. Martin's Press, Inc.
- Le, T. Q. (2000). *Domestic violence in Vietnam: Context, forms, causes, and recommendations for action*. Chiangmai, Thailand: Asia Pacific Forum on Women, Law and Development.
- Lewin, E. (1995). On the outside looking in: The politics of lesbian motherhood. In: F. D. Ginsburg & R. Rapp (Eds), *Conceiving the new world order: The global politics of reproduction* (pp. 103–121). Berkeley, CA and Los Angeles, CA: University of California Press.
- London, J. (2004). Rethinking Vietnam's mass education and health systems. In: D. McCargo (Ed.), *Rethinking Vietnam* (pp. 127–142). London and New York: RoutledgeCurzon.
- London, S. (1997). Conciliation and domestic violence in Senegal, West Africa. *Political and Legal Anthropology Review*, 20(2), 83–91.
- McClusky, L. J. (2001). *"Here, our culture is hard": Stories of domestic violence from a Mayan community in Belize*. Austin, TX: University of Texas Press.
- Merry, S. E. (2000). *Colonizing Hawai'i: The cultural power of law*. Princeton, NJ: Princeton University Press.
- Merry, S. E. (2006). *Human rights and gender violence: Translating international law into local justice*. Chicago, IL and London: The University of Chicago Press.
- Moore, H. (1994). The problem of explaining violence in the social sciences. In: P. Harvey & P. Gow (Eds), *Sex and violence: Issues in representation and experience* (pp. 138–155). London and New York: Routledge.
- Morsy, S. (1990). Political economy in medical anthropology. In: T. M. Johnson & C. F. Sargent (Eds), *Medical anthropology: Contemporary theory and method* (pp. 26–46). New York: Praeger Publishers.
- Mrsevic, Z. (2000). Belgrade's SOS hotline for women and children victims of violence: A report. In: S. Gal & G. Kligman (Eds), *Reproducing gender: Politics, publics, and everyday life after socialism* (pp. 370–392). Princeton, NJ: Princeton University Press.
- Nguyen, T. H. D., Vu, P. N. T., & The Centre for Reproductive and Family Health Project Officers. (2001). *Domestic violence against women and attitudes, practices of health workers (case studies in Hanoi and Ninh Binh provinces)*. Hanoi: The Centre for Reproductive and Family Health (RaFH) and the New Zealand Embassy.
- Plesset, S. (2006). *Sheltering women: Negotiating gender and violence in Northern Italy*. Stanford, CA: Stanford University Press.
- Rydstrom, H. (2003). Encountering 'hot' anger: Domestic violence in contemporary Vietnam. *Violence Against Women*, 9(6), 676–697.
- Scheper-Hughes, N. (1992). *Death without weeping: The violence of everyday life in Brazil*. Berkeley, CA: University of California Press.

- Singer, M., & Baer, H. (1995). *Critical medical anthropology*. Amityville, NY: Baywood Publishing Company, Inc.
- Tapias, M. (2006). Emotions and the intergenerational embodiment of social suffering in rural Bolivia. *Medical Anthropology Quarterly*, 20(3), 399–415.
- Thai, T. N. D. (1996). Divorce and its impact on women and families in Ho Chi Minh City. In: K. Barry (Ed.), *Vietnam's women in transition* (pp. 74–86). New York: St. Martin's Press.
- Tran, H. G. (2004). Impact of renovation policies on women in education, healthcare and social welfare. In: L. Drummond & H. Rydstrom (Eds), *Gender practices in contemporary Vietnam* (pp. 137–157). Singapore: Singapore University Press.
- Tran, T. Q. (1995). Gender issues in Vietnam's development. In: I. Norlund, C. L. Gates & C. D. Vu (Eds), *Vietnam in a changing world* (pp. 187–206). Surrey: Curzon Press.
- Tran, T. V. A., & Le, N. H. (1997). *Women and doi moi in Vietnam*. Hanoi: Woman Publishing House.
- Vu, M. L., Vu, T. H., Nguyen, H. M., & Clement, J. (1999). *Gender-based violence: The case of Vietnam*. Hanoi: The World Bank in Vietnam.
- Walker, G. (2003). The conceptual politics of struggle: Wife battering, the women's movement and the state. In: C. Andrew, P. Armstrong, H. Armstrong, W. Clement & L. F. Vosko (Eds), *Studies in political economy: Developments in feminism* (pp. 253–277). Toronto, ON: Women's Press.
- Werner, J. (2002). Gender, household, and state: Renovation (*doi moi*) as social process in Viet Nam. In: J. Werner & D. Belanger (Eds), *Gender, household, state: Doi moi in Viet Nam* (pp. 29–47). Ithaca, NY: Cornell Southeast Asia Program Publications.
- Whiteford, L. (1996). Political economy, gender, and the social production of health and illness. In: C. F. Sargent & C. B. Brettell (Eds), *Gender and health: An international perspective* (pp. 242–259). Upper Saddle River, NJ: Prentice Hall.
- Wolf, M. (1972). *Women and the family in rural Taiwan*. Stanford, CA: Stanford University Press.
- Young, S. B. (1998). The orthodox Chinese Confucian social paradigm versus Vietnamese individualism. In: W. H. Slote & G. A. De Vos (Eds), *Confucianism and the family* (pp. 137–161). Albany, NY: State University of New York Press.

# THE ECONOMIES OF HEALTH IN WESTERN BUDDHISM: A CASE STUDY OF A TIBETAN BUDDHIST GROUP IN FRANCE

Lionel Obadia

## ABSTRACT

*Based on ethnographic data and a textual analysis, this chapter highlights the process of “therapization” of Buddhism in Western countries, with a specific emphasis on Tibetan Buddhism in France. Referring to the paradigm of “political economy of health”, as developed in recent medical anthropology, it attempts to explore the relationships between two concepts – economics and health – that had previously been considered separately, in the context of Western Buddhism. Further, this chapter’s aim is to expose a potential application of theoretical economic models in an anthropological approach of Buddhist diffusion and appropriation in the West.*

*Be well, be better, practice the Dharma*

*–Tibetan monks’ motto in France*

---

The Economics of Health and Wellness: Anthropological Perspectives

Research in Economic Anthropology, Volume 26, 227–259

Copyright © 2008 by Elsevier Ltd.

All rights of reproduction in any form reserved

ISSN: 0190-1281/doi:10.1016/S0190-1281(07)26010-X

## WELL-BEING: WESTERN NEEDS, ASIAN SUPPLIES

It is common wisdom to recall that “well-being” has been – and still is – considered as a universal value for mankind insofar it is related to the issue of health and existential meaning. Virtually all human societies have endorsed systems of meanings and practices to cope with suffering. But can the historical deepness and cultural recurrence of such a representation explain the present-day vogue for “happiness”? Indeed, the diversity of forms and tonalities in societies and history counterbalances the aspiration to entrench the contemporary infatuation of healthiness and well-being themes and practices in Western countries in the narrative of an unvarying universal human aspiration. Well-being is rather modulated by particular cultural and historical conditions. A brief look on Western Europe’s recent history is indeed edifying: countless reports and essays have pointed out the emergence of an ideology of well-being and its spreading out since the end of the Second World War. The 20th century’s outbreak of health and happiness issues gave rise to new cultural and “therapeutic” institutions in the Western landscapes and the development of specialized economies and markets. Among the many new therapeutic forms and trends in the West, some are genuinely “indigenous”, but many are imported or exported from (culturally and geographically) distant countries. The proliferation of Asian-based and therapeutically oriented themes and techniques in Western countries (borrowed from or embedded in Indian Ayurveda, Chinese “traditional” medicines, T’ai chi, Qi cong, Japanese reflexology or Reiki, and so on) is thus understandable in terms of Western “needs” satisfied by Asian “supplies”. But how and why *Asian* traditions or techniques happened to incarnate therapeutic responses to *Western* troubles is a first question whose answer lies in the orientalist Western imagination. The second – and foremost – question that will be addressed in this chapter is why Buddhism, a religious tradition, turned out to embody a therapeutic alternative while settling in certain Western contexts. Yet, all the great and local religions, from universalist monotheisms to very specific forms of shamanism or “animism”, include a set of therapeutic doctrines and practices, and many anthropologists used to depict “primitive religions” as “primitive medicines” (see Radin, 1942), or located the roots of medicine in ancient magic (Rivers, 1924). But the case of Buddhism illustrates other – and more recent – processes of “therapization” of religion, i.e. the totalizing interpretation of religious traditions in medical terms, and the inflection of religious practices (rites, prayers and cultic activities) towards therapeutic aims.

In his critical article on the relationships between Buddhism and Science, Martin Verhoeven (2001) mentions “today’s near-obsession with therapy in the West” and its impact on the comprehension of Buddhism. Verhoeven’s accurate assertion can even be extended to a wider scale: in recent years, large portions of Western views and discourses on Buddhism have literally been colonized by the ideologies of hygienism and well-being.

### **BUDDHISM IN THE WEST AND THE LACK OF ECONOMIC PERSPECTIVE**

In the last four decades, Buddhism – or more accurately, Buddhist traditions – has indeed gained a striking visibility in Western societies. The relentless media coverage of Buddhism made it a fashionable topic and an object of much discussion (Obadia, 2007; Prebish & Tanaka, 1998). In “the West” (a controversial concept whose extension and content will not be discussed here), Buddhism has assumed different colours, meanings and forms ranging from utterly “religious” adherence to more “scientific” examination. But one of the latest and most striking forms it has taken is the therapeutic inflection (in the wider meaning of the word) of its doctrines and techniques. Surfacing in the 1960s, this phenomenon became very strong in the 1980s and still continues today. Perpetually interpreted in Buddhist terms, it has received few inventive sociological or anthropological explanations. The spread and rooting of Buddhism in the West has captured the interest of sociology, history and political sciences – as well as anthropology, but only to a certain extent. As an “emerging genre” in religious sciences (Spuler, 2000), the newly founded “Buddhism in the West studies” have not yet covered all relevant topics nor examined all the aspects of this complex and multifaceted phenomenon. So far, the academic literature has been mainly concerned with the earliest-noticed themes: historical reconstitutions (Batchelor, 1994; Fields, 1992; de Lubac, 1952), the causes and forms of Asian migrations (McLellan, 1999) the sociology of Western conversions (Coleman, 2001), and the study of acculturative processes within these two trends and populations (Baumann & Prebish, 2002; Prebish & Tanaka, 1998; Williams & Queen, 1999). Economic themes have consequently received little attention, with the exception of the reconstitution of “ethnic” markets within Asian overseas communities (Senryo & Williams, 1999), the sources and modes of funding of temples (Numrich, 1996) or the commodification of religious objects (Padgett, 2000).

Unconnected to these, the “therapeutic” issue has been considered in quite a different framework, explained below, that deserves a specific economic-inspired perspective, germinal in the economic perspectives on Buddhism. After Max Weber’s (1958, 1968) classical approach of religions and capitalism, and also Buddhism, Ernst Schumacher (1973), indeed coined the expression “Buddhist economics”, and was instrumental in paving the way towards an examination of the transposition of (in his view, “humanistic”) Buddhist ethics within (“destructive”) Western capitalism. In 1982, Serge-Christophe Kolm believed, in a much more positive way, that Buddhism, on the contrary, perfectly fitted the values of modern economics (individualism and rationality), and depicted Buddhism as a modern “happiness-liberty” (*bonheur-liberté*). Schumacher and Kolm have thus been instrumental – in rather opposite directions – in drawing lines of convergence between economic conditions and collective feelings and health balance in the interpretation of Buddhism’s success in the West. Since Buddhism has become established in both the religious and the therapeutic landscapes of Western (and capitalist) societies, another interesting approach that still has not been examined could be inspired by the “political economy” of medicine. Focusing on the interaction between (economic and political) macroscopic conditions (of medical ideologies, powers and structures) and local processes (of sickness and curing – Singer, 1986), this political economy not only deals with therapeutic topics, but also meets, at least methodologically, the “local-global” articulation of anthropology: two reasons to probe its relevance in the case study presented here. The main argument of this chapter is indeed that “therapeutic trends” in Western Buddhism – and their observable expressions in the community context – are accountable for changes in Western representations of Buddhism.

## THE WESTERN CONSTRUCTION OF BUDDHISM AS A “THERAPY”

In France, and also elsewhere in highly developed and industrialized countries, the press and other mass media recurrently associate Buddhism with a series of other topics related to psychological fulfilment and social comfort. Almost every month, French women’s magazines, popular journals, and loads of easy-reading books refer to topics such as “Zen and beauty”, “yoga and fitness”, or “meditation and fulfilled sexuality”.

All these references mention, explicitly or not, that the Buddhist techniques have the ability to fit the contemporary zeal to build a healthy body and a balanced mind, and to respond accurately to this need. Has Buddhism degenerated into an insipid and disposable product, to be used like cosmetics, vitamins or gymnastics? The frontier between Buddhism – as an Asian set of ethno-religious traditions – and the stream of Western technologies of well-being is blurred by the active participation of Buddhist leading figures in this *métissage*. For example, the Dalai Lama has authored (or co-authored) dozens of books with titles that are often right in line with the well-being terminology – *Healing Anger* (1997), *The Art of Happiness* (1998), *The Art of Happiness at Work* (2003) – and other Tibetan masters such as Geshe Doga, author of *Inner Peace and Happiness* (2005), and also Western Buddhist masters and apologists like Matthieu Ricard and Daniel Goleman, who wrote *Happiness: A Guide to Developing Life's Most Important Skill* (2007), have also put their own advice on paper as well. All these volumes have one point in common: they publicize indisputably the fundamental principles of Buddhist doctrines (the sutras) but dye them in a trendy terminology. The convergence between Buddhism and fashionable hygienist, healthful and aesthetic modern ideals – seen as culturally prominent and socially determinant in Western “late modernity” (Dziuban, 2007) – is the result of a particular trajectory of the Asian tradition in Western ideologies: the one that starts with a “psychologization” of Buddhist ideas and practices, and concludes in their dissemination in the modern technologies of the self and the body.

## BUDDHISM: FROM “RELIGION” TO “PSYCHIATRY”

While tracing back the reception and the translation of Buddhist ideas in Western Europe since the 19th century, Roger-Pol Droit (1997, pp. 11–12) introduces his opus maintaining that:

For us, at present, Buddhism is above all a therapy. Curing suffering, it has nothing to do with nihilism. It epitomizes, more than a religion or a philosophy, a doctrine-medicine. [...] The nirvana is the cure of all afflictions created by desire – without the need to distinguish, as the Western philosophical tradition traced, between corporal desires on the one hand, and rational desire on another hand, the one that inspires the construction of conceptual systems – metaphysics and sciences.

Such a view, fairly flirting with the apology of Buddhism, reminds us that the therapeutic emphasis – even crucial to Buddhist doctrines – is just



the last of the many cultural translations to which Buddhism has been subjected while disseminating in the West. The therapeutic emphasis on Buddhism is quite recent in the history of Buddhist ideas and practices in Western countries. The Buddhist path to Western countries indeed traces back to the 19th century. It was first discovered in the early decades (1820–1830) and soon became a major topic for Oriental Studies – when Eugène Burnouf founded, quite unintentionally, Buddhist Studies in 1830 with the first publication devoted to Buddhism. Since its discovery, Buddhism has continuously been reinterpreted in Western terms, in different ideological and imaginary frameworks (Almond, 1988). It was first interpreted in religious terms – as the opposite of a religion – before being later subjected to many other ideological frameworks: philosophy, esotericism, positivism, scientism, psychology, humanism, modernism, post-modernism, ecology and lastly social activism. But there are few references to the “healing powers” of Buddhism before the 1960s and 1970s – with the notable exception of psychologically inspired interpretations of Buddhism. (South Asian) Buddhism was rather a “science” according to the theosophist Henry Olcott (1881, reprinted 1905) or a “philosophy” for all the European (Droit, 1997), American (Tweed, 1992) and South-African (Clasquin & Krüger, 1999) intellectuals. Only Alexandra David-Néel, in the early 1930s, granted (Tibetan) Buddhists magical powers and depicted Buddhist traditions (in their Tibetan versions) as “mystic”. In the French explorer’s views, inspired by the Orientalism of Theosophical society, the lamas of Tibet were both ascetics and magicians, owners of supernatural and thaumaturgic knowledge and skills (David-Néel, 1931). David-Néel’s romantic conceptions later fertilized the New Age imagination on Tibet and the Tibetans, and had a major influence in the construction of Buddhism and Asian religions as therapies for the modern West. Since the geographic location of Tibet has been, since the 19th century, a powerful source for the Western esoteric and romantic Orientalism and the topographic location of the imagined Otherness, the cultural and religious traditions of the high plateaux of the Himalayas are encapsulated in a “magical” fantasy: Tibetan traditions, whether cultural, religious (Bishop, 1989, 1993; Lopez, 1998; Schell, 2000) or medical (Clifford, 1994; Dummer, 1988), are thus credited of “supernatural powers”.

But at the same time, the prominent rationalist and scientist interpretative framework rooted the examination of Buddhist in a philosophy of “depth” and the emphasis on mental processes in a comparison between Buddhist

doctrines of the mind and Western psychology. Paradoxically, this trend, antithetical to the romantic fascination of Orientalism, has been as powerful as the previous, but in a quite different way, in the “therapization” of Buddhism in the West. Whilst Sigmund Freud and Carl G. Jung were instrumental in the exploration of Buddhist doctrines and themes, they were reluctant to classify them within the category of “psychology”. The gap was overstepped by D. T. Suzuki in his 1949 “Introduction to Zen Buddhism” (reprinted 1991), and later in his collaboration with Erich Fromm (1957, reprinted 1960). Allan Watts’ “Psychotherapy East and West” (1961) carried on in this way and, since then, a substantial increase in the number of books, articles, conferences and investigations on “Buddhism and psychology” and “Buddhism and psychotherapy” (too long to be discussed here – see Obadia, *forthcoming*) have appeared, and Buddhism finally came to exemplify, in the 1990s and 2000s, the paragon of these modern “spiritual therapies” in Western countries. C. G. Jung’s influence in this process is noteworthy; he translated Asian religions and Buddhism into psychological and psychiatric terms, while asserting that “religions are systems of healing for psychic illness” (quoted in Gomez, 1995, p. 200). And John Snelling has also drawn attention to the fact that “in the Freudian view, the psychoanalyst was a sort of medical doctor. In Jungian terms, he was that and more as well – a kind of priest” (Snelling, 1987, p. 292). In the West, the psychologization of Buddhism corresponds to a psychologization of religion, and more generally of Western cultures, colonized by psychological themes and practices (as suggested by Peter Berger, 1977). Buddhism is nowadays not only considered a “psychiatry” (of a certain kind), but also a potential cure for moral and social troubles, i.e. as a “sociotherapy”, in the Socially Engaged Buddhism movement, that was born in Asian countries as a response to social suffering of whole populations affected by the violence of political changes and wars (Queen & King, 1996). Yet it has been transposed in the West for the same symptoms but not for the same causes (Queen, 2000).

On a broader level, and as early as the 1930s to the 1950s, health was used as a metaphor to explain the condition of Western “civilization” and its first attempts to “turn East”. Oswald Spengler’s *Decline of the West* (1919, reprinted 1927) theory was nourished by René Guénon’s “sickness of the Western civilization” and the urge to turn to Asian traditional societies (1946, English version 1962). For Edward Conze (1951), the “decay of Western civilization” was accountable for the Western appeal to “ancient wisdoms”, especially Buddhism and Henri de Lubac (1952), the

first to trace the history of Buddhism in the West, arrived to the same conclusion. If Buddhism represented in the early 20th century a *traditional* response to a *modern* malaise or predicament, it now epitomizes a *modern* response to a *modern* aspiration for “happiness”.

## A MODERN APPROACH OF BUDDHISM

Why has Buddhism been consecrated as a provider of such “good feelings” or psychological tools for the modern West? A possible first answer can be found in the examination of religious principles – or the kinds of effects and sensations that religious systems can provide by themselves: a psychological questionnaire-based inquiry among Western practitioners of Tibetan Buddhism in Belgium recently illuminated the valence of items associated with “agreeableness” for this population (Saroglou & Dupuis, 2006) and the singularity of Buddhist “ideal affects” (calm, quietness and happiness) has been confirmed by the cross-national and comparative psychological study of Tsai, Miao, and Seppala (2007). In Weberian terms, Buddhism is much more a soteriology than a theodicy. Indeed, the key concept of Buddhism’s ontology is *dukkha*, often translated as “suffering”. (even if other translations are conceivable). While tracing the dawn and the expansion of Buddhism in Asia, Mircéa Eliade (1959, p. 182), an historian of religions, recalled that the Buddhist stress upon *dukkha* was a common feature of the whole Indian religiosity at the time. But two millennia and a half after its formulation, Buddhist’s *dukkha* today assumes highly modern meanings: it is a solution for the stress of the “Modern Man” (Kolm, 1982) and the promise of a better world (Snelling, 1987). Buddhologists with an orthodox conception of Buddhism should certainly eschew such a translation, since the *dukkha* is the main ethical principle of Buddhism and is (in this perspective) per se ontological and religious, rather than socially or psychologically therapeutic – or, at least, can be conferred therapeutic aims *metaphorically*.

Consequently, Buddhism cannot be labelled *as* a therapy, but reversely, it is incorrect to state that Buddhism *is not* a therapy. The inclusion of Buddhism (a Western term, see Droit, 1997) within one of these two categories is a challenge for the ethnographer. Empirically speaking, there are therapeutic features in Buddhism, but Buddhist schools coexist in Asia with medical traditions, and therefore Buddhism and Asian medical traditions represent autonomous systems of ideas and practices. But the

choice of one category against another (medicine *or* religion) is not only a matter of empirical classification: it is also an epistemological problem since the distinction between the two is rooted in the political and medical history of the West, and especially the laicization of medicine. The essential point to mention here, is the totalization of Buddhism and Asian medicines in the encompassing ideology of well-being, and the way it is therefore supposed to “reconcile” what the West has separated since Descartes, the body and the mind, the material and the spiritual. The translation of major medical texts of Buddhist traditions, such as that which Terry Clifford prepared for Tibetan Medicine (1994), play a key role in this amalgamation of Buddhism (the doctrines and the rituals of an organized monasticism in a community of monks and a lay society) and medicine, i.e. their fusion into the same spiritual totality, and in the nursing American milieu, there is no difference between Tibetan *Buddhism* and Tibetan *medicine* (Begley, 1994). The meaning of a religious concept such as *dukkha* thus depends dramatically on the contexts of use and the ideological framework in which it makes sense. And in the West, the therapeutic emphasis on *dukkha* is connected with the ideological shift towards a quest for “well-being”, a word that has almost become synonymous for “health” (Leininger, quoted in Begley, 1994, p. 324). For someone who knows at least a little about the basic concepts of Buddhism, the prominence of *dukkha* in this translation of Buddhism in psychiatric terms and practices, or “psychiatrization” of Buddhism, is consistent with orthodox Buddhist views (according to the textual exegesis of the *sutrapitaka*, the Buddha’s teachings), and therefore can be seen as a rather “literary” translation of Buddhist ethics. But since Buddhism has been subjected to a wide range of interpretations in the last century, many other alternative views on Buddhism have been framed, putting emphasis upon economic (Kolm, 1982), sociological (Lenoir, 1999) or psychological (Varela & Hayward, 1992) “rationality”, but also “experience” in psychological terms (Watts, 1961), moral “ethics” (Droit, 1997), political “altruism” (Queen, 2000), and ecological “inter-connectedness” (Batchelor & Brown, 1992) among many others.

Sukkha or “happiness”, another Buddhist key notion, also belongs in this list – as mentioned before – conjointly with *dukkha*: an instructive clue to bring to light the complex and dual global self-representation of the West (as afflicted by an acute predicament but also in search of prosperity and happiness) and the “responses” it found in its own cultural matrixes, or that it imported from distant cultures.

## **NEW RELIGIOUS MOVEMENTS, MODERNITY AND THE NEW CONCEPTIONS OF HEALTH**

The path of Buddhism in Western countries is indeed understandable with reference to the ideological, sociological and cultural changes in the religious landscape. The reception and settling of Buddhist traditions in the West is concomitant with the rise of the “New Religious Movements” (NRMs). Historically, it is more accurate to speak of their “increase in numbers” or “expansion”, since they emerged as early as the universal religions did. These non-orthodox and alternative forms of spiritual beliefs and practices have grown in the shadow of powerful churches or institutions, but were socially dominated during past centuries. Their emancipation from the official churches is related to the emergence of scientific ideologies – rationalism, positivism and scientism – in the 19th century and rapid social change thereafter (Beckford, 1986). The post-WWII period offers a political and economic context propitious for the growth and increasing visibility of the NRMs in the landscape of Western societies, and is concomitant with the rise of the New Age and the counterculture movements, i.e. ideological frames for a cultural transition in the West (Dawson, 2003). The flourishing of NRMs in the 1960s and 1970s clearly occurred simultaneously with a specific sequence of the history of Buddhism in Western countries: its massive expansion (i.e. large increase in number of followers and temples), after slow beginnings in the late 19th century and early 20th century (Baumann, 2001).

In highly developed countries, many NRMs offer “self-development”, “improvement of health”, “longevity”, “success in careers”, i.e. a wide range of “solutions” for potential adherents (Barker, 1995). Some of them are consequently labelled “healing religions” or call for a (re)conciliation of psychotherapy and medicine, on the one side, and religious traditions, on the other side, maintaining that there are religious aspects in therapy and therapeutic aspects in religion (de Groot, 1998). The New Age movement was above all a powerful historical and cultural force for the reception and the assimilation of Asian traditions (Buddhism, Hinduism, Taoism, etc.) and especially medical ones like acupuncture, Reiki or Ayurveda (in the United States, see Reddy, 2002; in Germany, see Frank & Stollberg, 2004), among many others. If these traditions rely upon a symbolic dimension to legitimize the efficiency of their techniques, Western scholarship and administrations hardly consider them as “religions”, since they only share few features of the model of religion (beliefs, but not gods,

techniques, but not cults). However, their inclusion in the category of “medical practices” is not challenging the Western division between religion and medicine, and the “sect” or “cult” controversies in France and in Europe have especially relied upon the illegal exercise of medicine to stop the activity of such groups.<sup>1</sup> The issue of their real effects on individuals and societies is, however, much more controversial. Yet meditation (in its Buddhist form), as a “therapeutic” tool, is now used both in medical and in religious contexts, an increasing phenomenon linked to the late developments of a “humanistic” (holistic and spiritualist) psychology that is inclined to receive Asian spiritual influences (Aanstoos, 2003, p. 125), or the application of Buddhist techniques (such as meditation) in health-care practices within Western medical institutions, for instance in Hospice Care (Bruce & Davies, 2005). In this context, Buddhism has thus been constructed as a “remedy” for “modern age ailments” or “modern societies’ illnesses”, on the organic, the psychological and the social levels.

### *The Ethnography of Buddhist Practices*

The analysis of these macroscopic ideological frames is informative, but remains of little scientific value for the anthropologist if they are not related to an examination of their real (or fictitious) impact in local contexts – i.e. in the observation of practices. In other words, it is time to turn to what really happens in the context of Buddhism in practice. If the application of (selected) Buddhist techniques, mainly meditation, in medical and para-medical organizations (especially psychiatric) are more and more documented (see Obadia, forthcoming), few works have been devoted to the examination of the meaning of health and the “therapization” of religious acts in non-medical milieux where Buddhist themes and techniques are adopted. The appropriation of Buddhism undertakes a wide variety of modes and is dependent on sociological and contextual features: it ranges from purely “intellectual” and heterodox modes (among the sympathizers described by Thomas Tweed as “Night-Stand Buddhists”, 1999) to community integration and orthodox training (as studied by most of the scholars among the temples in the West). Faithful to this community-based approach, this section is devoted to the issues of health in a Tibetan-oriented French group of Buddhist followers.

*Case Study: A Tibetan-Oriented Community in France*

Buddhism has been widely discussed and studied in France since the middle of the past century. While it settled in other countries (such as Switzerland and Germany) as early as the 1910s and 1920s, Buddhism did not establish itself in France before the late 1960s. Yet, today France is one of the Western countries with the highest number of temples and adherents (Baumann, 2002). Faithful to the ethnographic method, the fieldwork for the present study was conducted within communities of practitioners of Buddhism, in a direct and quotidian observation of their life. The French Buddhist landscape is quite heterogeneous; just as in other Western countries (e.g. North America, Germany, Great Britain and Australia) it is a compound of “Asian” (migrant or of migrant-extraction) and “white” traditions and groups. Tibetan Buddhism belongs to the second category since it is mainly practised by Westerners. When I embarked on this ethnographic fieldwork in the early 1990s, I first joined one of the many small Buddhist communities (*sangha*) of the Tibetan tradition of the Drukpa Kagyu, a branch of the great Kagyu-pa tradition, in a “meditation centre” named Drougkon Djang Tchoup Ling, located in the southeast of France, that was founded in the early 1980s by a Ladhaki master Thoukse Rinpoché. This centre is quite like many others in France (Obadia, 1999) but also in other countries (for the United states, see Prebish, 1999). It consists of a small cluster of less than 20 persons, all “Westerners”,<sup>2</sup> and key members of a larger network (adding up to an audience of 150 persons when a special event is organized). Ages range from about 30 to around 50 years, and many members have quite ordinary social and economic lives (employed, with family and children), and they gather regularly in a central place (a *gompa*), but do not have full-time religious personnel to train them. Contrary to other Tibetan groups in France and in other Western countries, the Drukpa Kagyu lineage remains attached to a long and arduous tradition of training to achieve a complete monkhood, and, therefore, is not aiming at the recruitment of new masters, but the transmission of this branch’s specific teachings to a lay audience.

The rhythm of the activities is dependent on the teachings or the rituals that can be organized in the presence of travelling Tibetan lamas, but also on weekly lay collective activities (mantra recitation and meditation), dharma-talks or workshops. Sharing the ordinary life of lay adherents and monks, I was involved – as an ethnographer and as a member of the group – in meditative and ritual practices (for five years), and largely achieved the “insider” position, involving complete engagement in the community and its



“practices” (a term widely used by the French practitioners, whose meaning is wide and ranges from individual and private meditation, to large collective rituals), experiencing in everyday life the modes and dynamics of Buddhist transmission and training – on the lamas’ side – and the modes of appropriation and translation of religious skills and knowledge – on the followers’ side. I converted to Buddhism “officially” by taking refuge, by accepting the three jewels of Buddhism (Buddha, the founder, Dharma, the doctrine, and Sangha, the community), observing the religious precepts, and following a master’s teachings, but it was only for ethnographic purposes, and I did not pursue the training to the monk degree. By assuming an effective and durable presence as a lay follower (of a specific kind – the “researcher” – who is supposed to be a sympathizer as well), I had the chance to observe in different contexts – in the cultic site of the *gompa*, but also as a guest, in the lay private homes of the members of the centre – the nature and the depth of the appropriation of Buddhist techniques and values. The fieldwork later extended to other Buddhist groups, Tibetan but also from other traditions (Gelugpa and Sakyapa), or from other monastic traditions (Japanese Zen, for instance), and finally non-monastic groups (such as Sōka Gakkai, where I only made a short field study). This increase in numbers (in Tibetan Buddhism) and diversification (in other schools of Buddhism) of the empirical sites allowed me to make local observations of a comparative and more generalist scope, and also allowed me to better question the issue of “health” (its expressions, forms and meanings) in the Western Buddhist context.

*The Transient “Therapeutic” Aspects of Tibetan Practices: Where is “Health”?*

Ryo Imamura (1998, p. 229) ironically asserted that American practitioners of Buddhism “regard the temple to be a kind of therapy centre and the Buddhist priest to be a type of psychotherapist”. This description, pertaining to the specific context of Japanese Jodo-Shin Buddhism in the United States, is not compatible with my own observations of Tibetan Buddhism in France. Yet, themes related to “health” and “therapy” were very common in the lamas’ teachings and in the practitioners’ discourses as well. The walls of the temple were ornamented with Tibetan paintings (*thangka*) and, among them, a large picture of Bhaisajyaguru, the Medicine Buddha (*sman-bla* or *sam gyi bla* in Tibetan). In the practitioners’ houses, the book collections inevitably contained at least one or two opuses on



spiritual healing. A large number of my informants (at least two-thirds, or around 50 people), had already tried “alternative medicines” (spiritual, herbal) for prophylactic aims (the majority) or curative ones. In their teachings, as well as in private master-to-disciple appointments, the lamas insisted on the “four pure notions” (in Tibetan doctrines: *dag pa'i 'du shes bzhi*) and the correlative need to consider oneself as a “sick person”, the doctrine as a “remedy” and the master as a “healer”. Altogether, these empirical data suggest undoubtedly that health matters for people within this community. However, the question is *how* health matters and what it means for Western adherents of Buddhism.

The student eager to discover the secrets and effects of “healing” powers and therapeutic practices of the Tibetans would nevertheless be very disappointed. I was not, however, because, I did not start this research with such a perspective. Yet, the “therapization” of Buddhism is a totalizing process, and Buddhism as a whole has been constructed as a “therapy”. But each Buddhist tradition has a specific relationship with the issue of health; for instance, the Western medical institutions have mainly been interested in Japanese Zen techniques, while Tibetan ones still remain located in the New Age topography of spiritual healing. And Tibetan Buddhism is not like the Sōka Gakkai, a Japanese NRM whose therapeutic emphasis is observable through the “healing powers” of chanting (the Lotus Sutra and the famous mantra *nam-yoho renge kyo*) in front of an altar or gohonzon (Hammond & Machacek, 1999; Hourmant, 1990; Wilson & Dobbeleare, 1994). In Tibetan Buddhism, the practices were – and still are – presented as centred upon the inner discovery of self-awareness and the “transformation” of the mind, and consequently they can have therapeutic aims. Seated and quiet meditation is a pivotal technique. Religious activities, however, also encompass texts exegesis, training in chants, and participation in rituals – often accompanied with prostrations and sometimes circambulations around a votive monument named *chörten*. In one way or another, all of these activities are linked to a corporeal activeness and meaning: the body is supposed to “vibrate” in chants and mantra praying, it is “explored” (in its organic and psychic processes) in meditation, and is in motion in prostrations and circambulations. Not all of these practices are clearly related to “health” in a Western conception of the term (i.e. protective and curative practices for the body). But actually they are, in a certain way and under certain conditions.

Inside the community practices, and as far as the Tibetan masters could regulate them, “damaging” habits – such as smoking, drinking alcohol and using drugs – were prohibited since they were “impure” activities and led to

the deterioration of the body. Empirically speaking, Buddhism can thus have an indirect but effective impact on organic health. Nevertheless, as I observed, these religious restrictions only apply in the context of collective gatherings in the *gompa*: “Let’s smoke a cigarette!” some of the practitioners regularly said as soon as the teaching had ended and when we were leaving the temple. In the private situations (house reunions), it was not uncommon to talk about the teachings and the practices in front of a beer or some wine – the use of it was justified by the fact that “the lamas also drink wine for tantric purposes: it commutes into pure energy in their body” (by transmutation techniques). In addition, some practitioners still enjoy the counter-culture inherited habits of drug consumption – and even justify them in spiritual words (“to open the mind” or “to explore the limits of consciousness”), just as Myron J. Stolaroff (1999) has attempted to do, while asserting that a reasonable use of cannabis could be useful for a better concentration in Buddhist meditation.

But the effects of the Western emphasis on health are observable on an ideological level, and are expressed on both in the Asian masters’ discursive rationalization of their teachings for a Western audience,<sup>3</sup> and also in Buddhist followers’ practices. For the practitioners, the masters (lamas) were supposed to have spiritual powers, and especially healing powers – even if they did not have the legacy of a Tibetan medical training. They were revered and respected consequently as figures of charisma and authority, owners of magical skills they “are supposed to use in secret, since it’s forbidden to expose them publicly”, reported a 45-year-old practitioner, who had converted to Buddhism five years earlier: They can “exorcise”, “tell what’s wrong with someone’s head”, or “have a penetrative vision through the body” (and therefore spot possible ailments). All of these projections are quite understandable with regard to Buddhist and Western representations of the guru, and generate the (expected) associated attitudes on the both sides. The lamas responded to the “therapeutic” expectations of their audiences while accentuating the issues of psychic and organic balance the followers can achieve through a regular and rigorous practice. Still, in between the rituals and teachings, the lamas held private appointments with their disciples or any other person who asked for one. As the *gompa* was opened to anybody who was interested in meeting a Tibetan lama or to participate in rituals or meditations, a permanent flow of newcomers to the *gompa* carried with it many different people, with quite dissimilar demands. Some of them were therapeutically oriented, especially for people working in nursing or health sectors, interested in what Tibetan Buddhism offered concerning organic and mental suffering (Obadia, 1999). During these

meetings, which were free of charge (whilst participating in teachings and rituals required a “gift” or *dana*, as a financial contribution) the lamas established a kind of client–supplier relationship. But, as I asked for appointments and observed a series of them, I observed that the lamas do not *cure* but rather respond in religious terms to different kinds of sufferings. It would be incorrect to assume that the whole population of Buddhist temples or those who participate (even sporadically) in their religious life is healthy and socially privileged – and this is one reason why “health”, in its pathological expressions, assumes so many empirical occurrences. Whatever kind of suffering occurs, Tibetan Buddhism can offer a “solution”. The first case I will mention here is Dorjee (meaning “thunder” – the Tibetan name of a French native convert), a 50-year-old Buddhist practitioner. A lower-class intermittent worker, he used to change jobs regularly and did not lead a usual life. He had “experienced” a wide range of other Asian and non-Asian spiritualities, but was satisfied by Tibetan Buddhism, and he was a devoted follower. In the mid-1990s, at the time I was in the field and intimate with the community, Dorjee told me that he had been diagnosed with cancer. He was not convinced that the medical diagnosis was correct, but he was sure he had a health problem that he attributed to the excesses of a rather unbalanced lifestyle: he had drunk and smoked quite a lot.

During an appointment with his Tibetan master, he was informed that he had a very unclean *karma* and that the improvement of his life practice (especially through engaging in “purifying practices” such as prostrations, offerings and meditation) would be the best way to recover. As a Buddhist devotee, he already knew that. And his involvement in Buddhism restricted the use of other “alternative therapies”: the only two legitimate discourses he heard were those of the Buddhist masters and the hospital doctors. Shifting from a place to another, from one therapeutic relationship to another, he attempted to mix the two in his own way: the Masters had a “solution” and the doctors could state the acuteness of his ailment. Both had (conflicting) etiologies for the “origin” of Dorjee’s illness – he smoked too much (external – environmental cause) or he had gotten involved in “magical” practices that damaged his body from the inside (internal cause). When I left the community, Dorjee was still not reassured: the diagnosis of cancer was still not ratified by the doctors, but he observed Buddhist precepts and carried on the liturgy and the meditation the best he could, saying that, “It might work it out, if I follow the master’s advice. But, I might recover for other reasons. I have nothing to loose trying, anyway”. Later, I was informed that the diagnosis of cancer may have been a medical

misinterpretation of his X-ray photography. But Dorjee was still a faithful follower and planned to fly to Ladakh in order to complete his training.

Organic troubles are not the only ones to be potentially “treated” or “explained” in Buddhist terms: psychological and social ones are much more frequent. Nathalie (a pseudonym) is another case. She was in her thirties and in good health, but was facing a series of difficult social problems (with her boyfriend and family), and she was also unemployed and experiencing financial difficulties as well: “all goes the wrong way since years” she said “and this is getting worse”. The repetition of her troubles, and her incapacity to return to a better balanced life led her to think of a problem with her fortune – she, as Dorjee did, interpreted in terms of “karma”. She was invited to recite the mantras she had been initiated to in her training, and to meditate “with faith” in order to transform her own vision of her world, and to transform her environment. “It is a hard way but the master is certainly right”, she said when leaving the appointment. She was not as pious as Dorjee was, and soon dropped out of the practices. Echoing the “exploration of the Buddhist concept of health” in Tibetan Buddhism that Christina Deck (2002) exposes in her report, such Tibetan “therapeutic” responses are firmly embedded in the normative and codified “religious” doctrines.

In addition, in this Tibetan-oriented community, the “healing” or “therapeutic” practices did not lie exactly where one might expect, according to the predominant projective ideologies of well-being on Buddhism: they indeed lay *figuratively* in the heart of Buddhist practices, but *accurately* at its margins. Training in Tibetan Buddhism can indeed be considered as self-sufficient in its prophylactic effects – due to the diet, respiratory exercises and mental control involved in regular practice. The lay leaders of the community – with the agreement of their Tibetan hierarchy – nevertheless organize workshops and formations about sophrology, Reiki, acupuncture, macrobiotics, transactional psychology and gestalt-therapy, and other health-oriented practices. Tibetan medicine (or “science of healing” *soba rig-pa*), it is worth mentioning, takes place in such workshops and not in the standard ritual practices. These health-oriented manifestations take place in other times than meditation or rituals, but for the same audience, officially to “increase its healthiness”. The temporal dislocation between medicine, even sacred (*smam grub*), and religion (*chos*), or rather, between a medicine of remedies and a medicine of dharma (*chos la smam gyi ‘du shes*), maintain therefore a clear distinction between the Tibetan liturgy (in its orthodox form) and the associated practices (that can be labelled here as “heterodox”), just as if there was a peaceful tolerance of Tibetan authorities towards such practices, despite a

strict focus upon the orthopraxis (i.e. a defense of the normative system of beliefs and practices) – at least, in the context of religious training under the guidance of masters with a traditional curriculum.

## THE PRAGMATICS OF “WELL-BEING”: THE BODY AND THE DISCOURSES

The discourses on “therapy” have a direct impact on the way the Western followers of Buddhism rationalize their engagement. At first, the motivations to join a Buddhist group or to engage in Buddhist practices are not always labelled in pathological terms, and even not in a medical terminology. People attended the temples for many reasons – and in my field research the therapeutic issue (“the healing powers of Tibetan Buddhism”) often came indirectly, either as a *cause*, or as a *consequence* of Buddhism’s “therapeutic” emphasis. This conceptual opposition’s aim is to highlight the process by which, empirically speaking, the ailments of practitioners can be framed in a Buddhist register (and therefore be a “cause”), but also the adherence to Buddhist soteriology (of *dhukka*) can lead the practitioner to rationalize his/her existence in therapeutic terms, and thus “discover” inner troubles despite the seemingly lack of organic or psychological disorder (then, it is a “consequence”). As such, Buddhism can also have psychopathogenetic effects, but the empirical cases indicative of such consequences are very rare.

In the collected interviews, meditation is mainly described as the source of “well-being” for practitioners. Regular practice of meditation indeed installs a positive feeling among the practitioners that is formulated in a wide range of expressions: e.g. “a feeling of blissfulness”, “a sentiment of beatitude” and “an incredible emotion”. But what are the sources of this feeling of “well-being”? “Classical” Buddhist Studies are inclined to pinpoint that a practice like meditation, while textualized in a normative tradition, logically has the empirical expected effects: it is a source of well-being and well-being ensues logically from meditation. For psychologists, however, meditation is not psychotherapeutic per se, but its practitioners claim to obtain benefits for mental balance (Tseng, 1999, p. 141). However, if meditation is considered as both mentally and physically relaxing, it is quite difficult to assert how far religious and especially *Buddhist* meditation is concerned, or whether every kind of meditation has the same effects. From an ethnographic perspective, the situation is quite complex. There are

situations in which the practice of Buddhism is interpreted in religious terms, and in others, in secular terms. But it is the same meditation. The same practitioner can hence assign a religious (soteriological or propitiatory) meaning to his/her practice (meditation or prostrations) in one context. A 51-year-old male practitioner who had converted seven years earlier said, “The aim of seated meditation, and the visualizations of the sacred syllables (*Om, ha, Hung*) in different parts of your body is to realize the liberation of the mind – to extinguish the passion of *samsara* (the world of illusions and suffering) and to realize the *bodhi* (the Buddha’s nature) state of Buddha”. The same person can allocate to the same practice a “hygienic” rationalization in another context. Reported the same man:

When I sit and meditate, it’s a bit confusing in the first minutes – how difficult is it to free your mind from the flow of thoughts! But after a while, your body forgets the *dolour* of the lotus position, and you feel good inside. Even if you progress step by step, and the realisation of nirvana is far, how peaceful and rested you are ... in any case, it doesn’t hurt and even is good for your body and mind.

Further, this distinctive inscription of the same practice in different registers – what we can call a *disjoining* logic – can also embody an *additional* logic: in the same discourses, meditation or prostrations can be attributed both a religious and a hygienist meaning. Said one community staff member, “... in the *ngöndro* [preliminary and purifying practices], you have to prostrate 100,000 times! Your body and your karma both appreciate it! It’s a kind of sport and the hope for liberation of the mind. So it’s all benefit!” As Stacey L. Pigg (1996) suggested in the Nepalese context, religious practices are subjected to an “heteroglossia” that prevent their interpretation from an exclusive doctrinal perspective. A similar diversity of views and of practices (from “religious” to “therapeutic”) is observed in Buddhist communities of converts in France. Such a situation raises the issue of the place of Buddhism in the contemporary religious and medical pluralism.

## BUDDHISM, ASIAN TRADITIONS AND THE “MARKET”

### *Economic Concepts for Religious Fieldwork: The “Political Economy” Perspective*

While Marc Micozzi (2001, 2002) focuses on the symbolic and practical complementarities between biomedicine and Asian therapies in the Western

context, Hans A. Baer (2002, p. 403) aspires to bring the debate to what he calls a “political economy of complementary and alternative medicine”, i.e. the economy of exchanges and the nature of the relationships between “official” and “alternative” medicines, and the issue of an “integrative” (global) medicine. While Baer is stressing the proliferation of “alternative” medicines in the United States and in Western Europe, such views on “integration” are limited in France, the land of Pasteur and Bachelard, where circumstances are not so favourable for a complete integration of Asian-Based techniques in official medical institutions. The history of health representations and institutions in France has been characterized by the monopolization (borrowing from Max Weber, 1968) of the representation of health and the therapeutic practices by the powerful institutionalized organizations of medicine and psychiatry, since the early 19th century. But the conjoint progression of Buddhism and Asian-based or Asian-inspired complementary or alternative medicines epitomize what sociologists have recently coined as an “open economy” whether religious or therapeutic. Much can be said about the relationships between Asian traditions and the recent emergence of religious and medical pluralism in the West, in view of the fact that these two last features have typified Asian societies since long ago. Here, however, I will focus only on some observable “market effects” upon Buddhism, in the Western context of pluralism and competition. Some Asian “medical” traditions are embarking on a process of institutionalization and professionalization, whose consequence is to disconnect the religious and the medical dimension (Reddy, 2002) in order to align with the Western distinction between symbolic and technical dimensions of medicine. The opposite process is the hybridization with Western medical – mainly psychotherapeutic – terminology and tools as an efficient adjustment strategy, that Buddhism has recurrently adopted, similar to the one adopted by “complementary medicines” in the United States (Barnum, 1999) or in Germany (Frank & Stollberg, 2004).

### *Turning to Buddhism as “Medicine”: Sociological Dimensions*

Shifting from the institutional side of biomedical methods, to the effective appropriation of these “alternative” practices, it is important to observe that a series of variables (such as gender, social strata or ethnicity) play a major role in people’s embracing of such therapeutic options (Baer, 2001). Recent research has underlined the issue of “elective affinities” between Asian-based spiritual and therapeutic techniques, and specific social and



cultural backgrounds (for Buddhism, see Coleman, 2001). Recalling the history of Buddhism in the West, it is important to mention that it was first discovered by intellectual “elites” (from the 1830s through the 1950s), democratized by the young, counter-culture, urban middle-class (from the 1950s through the 1960s), and ultimately, widely distributed in Western societies since the 1960s and especially the 1980s (Baumann, 2001). Since then, the potential appropriation of Buddhist techniques as “tools” whether *therapeutic* or *spiritual* by sympathizers or practitioners is supposed to transcend social differences.

Sociological statistics in Western countries (in North America and in Western Europe) are decidedly few, but they are indicative of lingering strong connections between the appeal of Buddhism in the West and a bourgeois *ethos*, uncovered by the sociological features (social strata, economic status and educational level) of the population of its practitioners: urban upper middle-class, socially installed and economically stable individuals are statistically more greatly represented (for France, see Lenoir, 1999; and for the United States, see Coleman, 2001). However, the quantitative preeminence of these strata must not be allowed to overshadow the appeal of Buddhism in the lower strata, which is also noteworthy, if not substantial (Obadia, 1999). In practice, these sociological and economic differences generate a variation in the interpretations of Buddhism and in the reasons to adopt it, and here, the therapeutic theme is not just metaphorical. One of my informants, who was only indirectly involved in collective rituals, was a 40-year-old famous and wealthy entrepreneur who was active in the funding of the temples and of the lamas’ regular journeys. During the long hours of our discussions, he always underlined the “beneficial” effects of practicing meditation under the guidance of a (private) lama, and the bliss that such a regular activity added to an “already fulfilled” personal and professional life. The theme of social or psychological “suffering” was thoroughly missing in his discourse. Quite the reserve, the motif was lexically recurrent and semantically central in the discourse of people of low social and economic status, for whom Buddhism was “a solution to escape or assume the misery of life” (as a 30-year-old unemployed lay practitioner said). Leaving aside the issue of psychological personal suffering – another factor of variation – these discursive inflexions suggest that two sociologically determined and distinct modes of appropriation of “therapeutic” elements of Buddhism can be drawn: for the population of practitioners of the higher classes, who are healthy, wealthy and socially favoured, Buddhism is a religious and therapeutic option “by excess” (i.e. whose adoption only improves the sense of “well-being”). On



the other hand, for lower classes, poor and socially disadvantaged practitioners, the issue of “suffering” (*dukkha*) is more meaningful and Buddhism is an option “by default”, a pledge for better psychological and social balances (Obadia, 2000).

*“Consumption” of Therapeutic “Goods” in a “Marketplace” and  
“Market” Effects*

Beyond the issue of pluralism, another possibility for infusing economic modelizations in anthropology is the use of the “market theory” applied to the globalizing Asian traditions, whether medical or spiritual, or both. The French anthropologist Francis Zimmermann explains the appeal of Asian-inspired “soft medicines” or great Asian medical traditions by the three same causes: the “charm of ethnicity” (or “exoticism”), the “appeal of philosophy” (the call for corresponding existential meaning) and the “commodification” of Asian therapeutic products (whether they are services or drugs) (Zimmermann, 1995). The westward spread of Buddhism can be (and has been) explained in very similar terms, but the concept of “commodification” calls for a critical examination.

In the mid-1980s, the French anthropologist George Balandier depicted modern societies as characterized by both the search of “better-being” (*mieux être*) and the commodification of values. In his perspective, modern attitudes are so deeply inspired by an economy of consumption that the attitudes (especially towards religion) are “profit and loss accounting” (Balandier, 1985, p. 151). Religion – as medicine – thus “cannot preserve its monopoly as in past societies: amidst modernity, it divides, pluralizes, and is subjected to the law of market competition” (Balandier, 1988, p. 22).

Baudrillard went even further. For him, “hypermodern” societies are characterized by an uncontrolled circulation of signs whose motion is accountable for a loss of symbolic consistence: according to the French sociologist, the hypermodern economy of signs is supposed to obliterate the meaning of things (Baudrillard, 1993). Furthermore, the Belgian essayist Gilles Lipovetsky (1983, p. 133) considers that “spirituality is now at the kaleidoscopic age of supermarket and self-service”. The convergence of views on the dissolving impact of market economy upon religion and other religious-based ideas and practices – such as faith-healing – suggests that, indeed, the “modern” or “hypermodern” attitudes towards spirituality and spiritual healing are subjected to the ruling ideologies and dynamics of capitalist-like commodification.

However, in his 2000 book, *Global Culture/Individual Identity*, Gordon Mathews unambiguously depicts the contemporary world as a “cultural supermarket” opened to “consumption” but he frames different outcomes: the Buddhist “seekers” indeed portray themselves in economic terms (as “shopping around in a cultural supermarket” – p. 104), but their quest and “consumption” remain attached to existential values, and cannot be reduced to an economic instrumentalism (p. 106). Therefore, the use of concepts such as “salesmen” and “prospective consumers” (*ibid.*) for Tibetan Buddhism, “market”, “supply”, and “demand” for the Sōka Gakkai (Hammond & Machacek, 1999) or “cultural commodity” for Ayurveda (Reddy, 2002, p. 99) are descriptive concepts to understand the dynamics of diffusion and Western appropriation of Asian traditions, rather than reflections of the domination of the culture of capitalism in all the compartments of Western societies.

### *A Symbolic “Micro-Economy” of Practices*

Empirically speaking, there are nevertheless obvious “economic” processes that can be observed and analysed, at different levels. The first level is the practice itself. The Buddhist practices, in Tibetan-oriented communities, include an initial category of soteriological techniques (prostrations, chants, visualizations, meditations, collective rituals and exegesis) and propitiatory ones (burning incense, offerings, wearing amulets, etc.). All of these techniques are considered by the practitioners in the Buddhist frame of a kind of capitalization. In the Drukpa Kagyu communities of France, the practitioners can engage in “preliminary” practices (*ngöndro*) in order to “purify” themselves before being allowed to engage in “deeper” practices, like *chine* (“mental quietness”) and *lhaktong* (“penetrating vision”). Prostrations and prayers to the divinity, Dorje sempa, range among the major preliminary practices (alongside “offerings to the Mandala” and “to the master” or guru-puja). The following excerpt from a conversation illustrates this:

---

Ethnographer:	How many mantras did you recite today?
Practitioner:	Oh, just a few dozen.
Ethnographer:	We are far from nirvana, aren't we?

Practitioner:

Well, not so far ... I have gained at least a thousand rebirths prostrating and reciting mantras everyday (laughs). But you and I are still far from becoming *bodhisattvas*. Maybe in the next life? Go back to the *gompa* and pray for your guru...a hundred thousands times!

---

The practitioners “calculate” their spiritual “capital” (with a rosary or *mala*), just as in the “karma system” described by Melford Spiro (in the context of South Asian Buddhism in Burma, 1982), in which of the acts and practices (Sanskrit – *karman*) are supposed to increase the religious capital of the Buddhists practitioners, and offer a chance to have a “better” (healthy) life or a “good” rebirth. The French scholar Paul Lévy supposed that the progresses of Buddhism in Asia are owing to this “pecuniary” dimension of capitalization through the effective calculation of one’s accumulation of “merit” (Sanskrit – *puna*) for a present as well as future life (Lévy, 1987). Therefore, Buddhist principles of religious capitalization through everyday practices, and especially those associated with the body and the inner “mechanisms” of the mind, are not actually divergent from the values of so-called “postmodern” or “hypermodern” societies or “times”, Ivan Varga (2005, p. 226) typifies as the times for a new sacralization of the body. After Bourdieu, he first professes his own vision of the modern body as “...a form of physical capital (which) also has become commodified in modern societies” but has commuted in the main locus for psychological and social achievement, “symbolic capitalization”, and new forms of sacralization – and many NRMs have been instrumental in echoing, in their doctrines and practices, these contemporary trends (Dziuban, 2007). Since Tibetan Buddhism (and Buddhism in general) also locates in the body the “power” to transform – purify, cure and sanctify – oneself, the connection with Western contemporary and fashionable values are easy to draw. And two French political scientists, Bruno Etienne and Raphael Liogier, have been prompt to define Buddhism (in its Western or French forms) as a “psycho-spiritual technique” perfectly fitting the hypermodern trends, rather than as a traditional form of religion (Etienne & Liogier, 1997).

## **WESTERN NEEDS FOR WELLNESS AND ASIAN RESPONSES: AN UNDERLYING CAPITALIST IDEOLOGY?**

Has Buddhism thus turned into the new paragon of modern spiritual therapies for advanced capitalist societies? To a certain extent, the answer is yes. But ethnographic data suggest a more complex picture. “Health” is first of all at the heart of a large semantic network, the adoption of which is subjected to significant ideological, idiosyncratic, sociological and ontological fluctuations – health issues are the result of a Western “therapization” of Buddhism, vary according to personal history, needs and position in social structures, and can reside in metaphorical discourses or root themselves in concrete practices. It is thus, secondly, a set of practices, the form, the meaning and the aim of which range from trivial prophylactic “well-being” to vital curative resource. Thirdly, Buddhism is not therapeutic exclusively but is associated with non-Buddhist beliefs and practices. Fourthly, while haunting the sphere of discourses and practical uses of Buddhism, therapeutic themes arise sporadically and did not colonize Buddhism as a whole. In Western scholars’ terminology, Tibetan Buddhism remains, in this context, an ethno-religious tradition, expanded with a therapeutic coloration.

In conclusion, I would like to recall the basic theoretical issue of this chapter, i.e. the relationships between Buddhist therapization in the West and the economic conditions of the West. After having explored some observable economic factors, and some potential usages of theoretical models of economy for the understanding of this topic, it now seems appropriate to shift towards the cultural and ideological underlying dimensions of Western economy. Indeed, Buddhism has rooted itself in Western countries where capitalism and the market economy are prevalent, and are sustained by certain ideological principles and cultural values. Therefore, following Appadurai’s (2001) suggestions, modernity and globalization are not only rooted in effective cultural flows and disjunctions, but also they are redesigned by and redesigning collective imaginations, and, for Buddhism and other Asian (based) traditions, this work of imagination is embedded in an Orientalism. Colin Campbell’s (1999) thesis of the “Easternization of the West” portrayed a progressive substitution of Western religious and therapeutic values, practices and social forms by Eastern ones. In economic terms, this process can be understood as the triumph of a concurrent “Eastern” system over a previously monopolistic

“Western” system. Andrew Dawson’s crucial rejoinder has drawn attention to the opposite process: the appropriation of Eastern themes, practices and institutions comes under a process of Westernization of these Eastern forms (Dawson, 2006). As far as the empirical and documentary data presented here allows me, the same question deserves to be asked: To what degree have Buddhist and other Asian traditions partaken of an “orientalization” of the therapeutic and spiritual spheres in France and in other Western countries?

In parallel to Buddhism, the New Age movement injected new conceptions of illness and cure in the West: the call for being “one’s own therapist”, the exploration of the “power of the mind”, and the “awareness of oneself and one’s environment” (Ferguson, 1980). This “paradigm change” towards a new inner, individualist, intellectualist-oriented cultural model, confident in the supernatural powers of the mind (as a “potential”) is not the result of an Eastern influence but the path of Western transformations – or, at least, it can be said that the influences from “the East” did not play a key role some wanted them to have played. The French economist Serge-Christophe Kolm has depicted Buddhism as the “essence” of modernity (despite the cultural and historical distance between the birth of Buddhism in Asia and the dawn of modernity in the West) because it offers a “rational”, “psychological”, and “conscious” field of knowledge and action to tackle the condition of modern societies, and impels for a new moral economy of the self and society based on the search of happiness and the reduction of suffering (Kolm, 1982). Does Kolm’s project actually fit with Western contemporary appropriations of Buddhism? Such a view on Buddhism and modernity is above all a *utopian* translation of a Western representation of Buddhism in a modernist framework. And, before engaging in a precipitate confirmation of the “Buddhization” of Western religious and sanitary landscapes, it is indeed essential to question the structural rather than cultural frameworks by which Buddhism has been imported and adopted in the West. In French society, the cultural translation of Buddhism as “therapy” is shaped by different ideological and sociological conditions. André Comte-Sponville (2000, p. 72) considers, as a philosopher, that the search for happiness is a universal feature of human societies, and he explains in these terms the Western and recent appeal of Buddhism. However, the lack of historicization of his perspective is prejudicial to a contextualized and grounded analysis. Besides, indeed, the therapization of Buddhism reflects two opposite but complementary contemporary *Western* ideologies, *both related to economy*. The first has been labelled by the sociologist Alain Ehrenberg (1998) as the “difficulty of being oneself”, i.e. an ideology of “malaise” related to the increasing social pressure on the individuals in an economic liberal system: the compulsion of

being healthy, sexually attractive and professionally competent. Contemporary norms of the “self” are restrained by the compulsive and compulsory duty to be beautiful and self-confident in a highly competitive society and this is, according to Ehrenberg, a major factor of psychological depression and social despair. Thus, the search for happiness is a paradoxical response to the pressure of social life, while valorized by inverse cultural models of self-fulfilment. Following Ehrenberg, the proliferation of well-being ideologies unveils the incessant demands of “must-be” (happy, beautiful, balanced, healthy, etc.), and consequently psychic or social pathologies are hypertrophied: in a society where “well-being” becomes a norm, the frontiers of the salubrious plot become narrower and give place to an invasion of pathologies (imaginary or not) and increase the feeling of morbidity. Since the 1980s, as the French historian Georges Vigarello recently demonstrated, a “civilizational process” (in Norbert Elias’ perspective) has relocated the frontier between the “tolerable” and the “intolerable” in the conceptions of the self, the body and the health. Although previously endured, the feeling of “bad-being” (*mal-être*) is nowadays undesirable (Vigarello, 2006, p. 302). Therefore, he depicts the recent turn towards the ideology of sanitary prevention as the progresses of an “awareness” of potential sickness and disease, but not the increase in numbers of actual ailments. Quite the reverse, in highly developed societies the life-time expectancy is still increasing, and the global sanitary conditions have significantly improved (*ibid.*, p. 302). Further, this new sanitary “consciousness” is connected with the rise of a market of “well-being” (*ibid.*, p. 303). The French philosopher Pascal Bruckner suggests in other terms that the contemporary condition of Western societies is governed by the “compulsion to happiness”. In his views, the success of Buddhism in the West (as well as other Asian-based or Asian-inspired technologies of well-being) is nothing else than another way modern wealthy societies (in his terms: Western ones) conform to their own creed of “everlasting euphoria” (*euphorie perpétuelle*) and the “duty of happiness”, while borrowing and translating into their own Westernized terms the Asian Traditions they have imagined as the source of blissfulness (Bruckner, 2000). Summarizing these various perspectives, a transversal feature is rather informative on the role of capitalism on the reception of Buddhism in the West, and its translation in a therapeutic terminology and uses. In Ehrenberg’s views, the turn to new attitudes towards “well-being” (including Buddhist-inspired ones) is indeed something like a response to the impacts of Western economy on culture and society. In Vigarello’s terms, it can be seen as the mirror of ideological and practical shifts in Western cultural and social norms, following the historical evolution of the West towards advanced

development and massive industrialization. In Bruckner's conception, it is even a disguised self-representation of the West itself – modern societies supposedly afflicted by the ideological and economic systems for which they have nevertheless opted. In all the cases, the cultural forms in which Buddhism has been adjusted are, in a way of another, economically derived ones: modern productivism and capitalism, two ideological and sociological foundations of Western societies that had turned “somatic” according to Bryan Turner (1992).

Inspired by attempts in medical anthropology to establish the paradigm of a “political economy”, the challenge was here to bring together two yet unrelated aspects of Western Buddhism: economy and health. However, whilst a political economy of health offers stimulating outlooks on health in advanced capitalist countries, it is mainly concerned with a “political economy of illness” and, of course, a “political economy of health” (Baer, 1982). The transposition of such perspectives in the field of Buddhism in Western Studies is restricted by the specific nature of “health” for Buddhist practitioners: whether a metaphorical representation of religious goals, the principles of human balance in Buddhist ontology, the dramatization in Buddhist terms of their spiritual achievement or the interpretation of organic, psychological or social symptoms. In this context, “health” is a collective representation that is informative of the ways Buddhist values, principles and practices are shared, appropriated and reinterpreted. In such a view, shaped by the ethnographic configuration (communities, fluid networks, open “market” of Buddhist themes and techniques, etc.) the “political economy” of Western Buddhism can be seen as the politics of representation, promotion and distribution of Buddhist “goods” in a “market” of well-being, to stick to a economic modelization. But also an anthropologically oriented economy of signs and meanings by which they are appropriated and relocated in new cultural frameworks, in which they are significant.

## NOTES

1. In the French context, the “sect” controversy started in the mid-1990s with the publication of a first parliamentary report and since then, the foundation of inter-ministerial commissions whose mission is to “observe” the progresses of New Religious Movements, and to control the legality of their activities, especially the educative and therapeutic ones. If many Asian-inspired movements were categorized as “sects” (i.e. small groups of followers living apart from the rest of society because of their beliefs, and with customs divergent from the legal norms and normative



values) few Buddhist groups were considered as “dangerous” sects (see Obadia, 2001, note 33).

2. The opposition between “Westerners” and “Asians” is a prevailing but controversial tool in the studies of Buddhism in the West (see Fields, 1998), but mainly used to distinguish between Buddhist “converts” and Buddhist “natives”. Without any further discussion on the epistemological and ideological issues of such dichotomies, I simply refer to the category of “Westerners” as an equivalent of “converts” since Tibetan Buddhist traditions did not settle in France by way of migrations, and their followers are for the large majority of French origin.

3. One of the leading figures of Tibetan Masters in the West, the famous Lama Thupten Yeshe, has for instance published a book entitled (in French) *Becoming Your Own Therapist: An Introduction to Buddhist Thought* (1999) in which he emphasizes healthiness (in a prophylactic and curative ways) while another Tibetan Master, Tulku Thundup Rinpoché, is the author of *The Healing Power of Mind* (1997) focusing upon the “transformative” processes of the mind through meditation.

## REFERENCES

- Aanstoos, C. M. (2003). The relevance of humanistic psychology. *Journal of Humanistic Psychology*, 43(3), 121–132.
- Almond, P. (1988). *The British discovery of Buddhism*. New York: Cambridge University Press.
- Appadurai, A. (2001). Grassroots globalization and the research imagination. In: A. Appadurai (Ed.), *Globalization* (pp. 1–21). Durham: Duke University Press.
- Baer, H. A. (1982). On the political economy of health. *Medical Anthropology Newsletter*, 14(1), 1–2, 13–17.
- Baer, H. A. (2001). *Biomedicine and alternative healing systems in America: Issues of class, race, ethnicity, and gender*. Madison: University of Wisconsin Press.
- Baer, H. A. (2002). The growing interest of biomedicine in complementary and alternative medicine: A critical perspective. *Medical Anthropology Quarterly*, 16(4), 403–405.
- Balandier, G. (1985). *Le détour, pouvoir et modernité*. Paris: Fayard.
- Balandier, G. (1988). *Le désordre, éloge du mouvement*. Paris: Fayard.
- Barker, E. (1995). *New religious movements. A practical introduction* (5th ed.). London: HMSO.
- Barnum, B. S. (1999). Healers in complementary medicine. *Alternative Health Practitioners*, 5(3), 217–224.
- Batchelor, M., & Brown, K. (Eds). (1992). *Buddhism and ecology*. London: Cassell.
- Batchelor, S. (1994). *The awakening of the West: The encounter of Buddhism and Western culture*. London: Aquarian, Harper Collins/Berkeley, Parallax Press.
- Baudrillard, J. (1993). *Symbolic exchange and death*. London: Sage.
- Baumann, M. (2001). Global Buddhism: Developmental periods, regional histories, and a new analytical perspective. *Journal of Global Buddhism*, 2, 1–43.
- Baumann, M. (2002). Buddhism in Europe: Past, present, prospects. In: M. Baumann & C. Prebish (Eds), *Westward Dharma: Buddhism beyond Asia* (pp. 85–105). Berkeley, CA: University of California Press.
- Baumann, M., & Prebish, C. (Eds). (2002). *Westward Dharma: Buddhism beyond Asia*. Berkeley, CA: University of California Press.



- Beckford, J. A. (Ed.) (1986). *New religious movements and rapid social change*. Beverly Hills, CA: Sage.
- Begley, S. S. (1994). Tibetan Buddhist medicine: A transcultural nursing experience. *Journal of Holistic Nursing*, 12(3), 323–342.
- Berger, P. (1977). *Facing up to modernity: Excursions in society, politics, and religion*. New York: Basic Books.
- Bishop, P. (1989). *The myth of Shangri-La: Tibet, travel writing and the Western creation of sacred landscape*. London: Athlone Press.
- Bishop, P. (1993). *Dreams of power: Tibetan religion and the Western imagination*. London: Athlone Press.
- Bruce, A., & Davies, B. (2005). Mindfulness in hospice care: Practicing meditation-in-action. *Qualitative Health Research*, 15(10), 1329–1344.
- Bruckner, P. (2000). *L'euphorie perpétuelle: Essai sur le devoir de bonheur*. Paris: Grasset & Fasquelle.
- Campbell, C. (1999). The Easternization of the West. In: B. Wilson & J. Cresswell (Eds), *New religious movements: Challenge and response* (pp. 35–48). London: Routledge.
- Clasquin, M., & Krüger, J. S. (Eds). (1999). *Buddhism and Africa*. Pretoria: Unisa.
- Clifford, T. (1994). *Tibetan Buddhist medicine and psychiatry: The diamond healing*. Delhi: Motilal Banarsidass.
- Coleman, J. W. (2001). *The new Buddhism: The Western transformation of an ancient tradition*. Oxford: Oxford University Press.
- Comte-Sponville, A. (2000). *Le bonheur désespérément*. Paris: Plein Feux/Librio.
- Conze, E. (1951). *Buddhism: Its essence and development*. New York: Philosophical Library.
- David-Néel, A. (1931). *With mystics and magicians in Tibet*. London: Penguin Books.
- Dawson, A. (2006). East is east, except when it's west: The Easternization thesis and the Western habitus. *Journal of Religion and Society*, 8, 1–13.
- Dawson, L. (Ed.) (2003). *Cults and new religious movements: A reader*. Oxford: Blackwell.
- Deck, C. (2002). *Health, harma, and practice: Well-being and purification in Tibetan Buddhism*. Retrieved May 5, 2007, from <http://www.hds.harvard.edu/cswr/resources/print/rhb/reports/09.Deck.pdf>
- Doga, G. (2005). *Inner peace and happiness*. Victoria, Australia: Lothian Publishing Co.
- Droit, R.-P. (1997). *Le culte du néant: Les philosophes et le Bouddhisme*. Paris: Le Seuil.
- Dummer, T. (1988). *Tibetan medicine and other holistic health-care systems*. London: Routledge and Kegan Paul.
- Dziuban, A. (2007). Spirituality and the body in late modernity. *Religion Compass* (Online Early Articles) doi:10.1111/j.1749-8171.2007.00031.x. Retrieved May 5, 2007, from <http://www.blackwell-synergy.com/action/showPdf?submitPDF=Full+Text+PDF+%28227+KB%29&doi=10.1111%2Fj.1749-8171.2007.00031.x&cookieSet=1>
- Ehrenberg, A. (1998). *La fatigue d'être soi: Dépression et société*. Paris: Odile Jacob.
- Eliade, M. (1959). *Techniques du yoga*. Paris: Payot.
- Etienne, B., & Liogier, R. (1997). *Etre Bouddhiste en France aujourd'hui*. Paris: Albin Michel.
- Ferguson, M. (1980). *The Aquarian conspiracy*. Los Angeles, CA: J.P. Tarcher.
- Fields, R. (1992). *How the swans came to the lake: A narrative history of Buddhism in America* (3rd ed.). Boston, MA: Shambhala.
- Fields, R. (1998). Divided dharma: White Buddhists, ethnic Buddhists, and racism. In: C. Prebish & K. K. Tanaka (Eds), *The faces of Buddhism in America* (pp. 196–206). Berkeley, CA; Los Angeles, CA; and London: University of California Press.

- Frank, R., & Stollberg, G. (2004). Conceptualizing hybridization: On the diffusion of Asian medical knowledge to Germany. *International Sociology*, 19(1), 71–88.
- Fromm, E., de Martino, R., & Suzuki, D. T. (1960). *Zen Buddhism and psychoanalysis*. New York: Harper and Row.
- Gomez, L. O. (1995). Oriental wisdom and the cure of souls: Jung and the Indian East. In: D. S. Lopez, Jr. (Ed.), *Curators of the Buddha: The study of Buddhism under colonialism* (pp. 197–250). Chicago, IL: University of Chicago Press.
- de Groot, C. N. (1998). Sociology of religion looks at psychotherapy. *Recherches Sociologiques (Louvain-la-Neuve, Belgium)*, 2, 3–17.
- Guénon, R. (1962). *The crisis of the modern world*. London: Luzac.
- Hammond, P., & Machacek, D. (1999). *Sōka Gakkai in America: Accommodation and conversion*. New York: Oxford University Press.
- Hourmant, L. (1990). Une religion orientée à l'action efficace dans le monde. In: D. Hervieu & F. Champion (Eds), *De l'émotion en religion* (pp. 80–119). Paris: Le Centurion.
- Imamura, R. (1998). Buddhist and Western psychotherapies: An Asian American perspective. In: C. Prebish & K. Tanaka (Eds), *The faces of Buddhism in America* (pp. 228–237). Berkeley, CA: University of California Press.
- Kolm, S.-C. (1982). *Le bonheur-liberté, Bouddhisme profond et modernité*. Paris: Presses Universitaires de France.
- Lama, D. (1997). *Healing anger: The power of patience from a Buddhist perspective*. Ithaca, NY: Snow Lion Publications.
- Lama, D. (2003). *The art of happiness at work*. New York: Riverhead Books.
- Lama, D., & Cutler, H. C. (1998). *The art of happiness: A handbook for living*. New York: Riverhead Books.
- Lenoir, F. (1999). *Le Bouddhisme en France*. Paris: Fayard.
- Lévy, P. (1987). Avant-propos. In: de Berval (Ed.), *Présence du Bouddhisme*. Paris: Gallimard.
- Lipovetsky, G. (1983). *L'ère du vide: Essais sur l'individualisme contemporain*. Paris: Gallimard.
- Lopez, D., Jr. (1998). *Prisoners of Shangri-La: Tibetan Buddhism and the West*. Chicago, IL: University of Chicago Press.
- de Lubac, H. (1952). *La rencontre du Bouddhisme et de l'Occident*. Paris: Aubier.
- Mathews, G. (2000). *Global culture/individual identity: Searching for home in the cultural supermarket*. London: Routledge.
- McLellan, J. (1999). *Many petals of the lotus: Five Asian Buddhist communities in Toronto*. Toronto, ON: University of Toronto Press.
- Micozzi, M. (2001). *Fundamentals of complementary and alternative medicine* (2nd ed.). New York: Churchill Livingstone.
- Micozzi, M. (2002). Culture, anthropology, and the return of “complementary medicine”. *Medical Anthropology Quarterly*, 16(4), 398–403.
- Numrich, P. D. (1996). *Old wisdom in the New World: Americanization in two immigrant Theravada Buddhist temples*. Knoxville, TN: University of Tennessee Press.
- Obadia, L. (1999). *Bouddhisme et Occident. La diffusion du Bouddhisme Tibétain en France*. Paris: L'Harmattan.
- Obadia, L. (2000). L'adhésion au Bouddhisme en France. In: D. Gira & J. Scheuer (Eds), *Vivre de plusieurs religions: Promesse ou illusion?* (pp. 32–43). Paris: Editions de l'Atelier.
- Obadia, L. (2001). Tibetan Buddhism in France: A missionary religion? *Journal of Global Buddhism*, 2, 92–105. Retrieved June 21, 2007, from <http://www.globalbuddhism.org/2/obadia012.html>

- Obadia, L. (2007). *Le bouddhisme en Occident*. Paris: La Découverte.
- Obadia, L. (forthcoming). *Buddhism and modernity*. Oxford: Blackwell.
- Olcott, H. S. (1905). *Le Bouddhisme, selon le canon de l'église du sud et sous forme de catéchisme* (37th ed.). Paris: Publications Théosophiques.
- Padgett, D. M. (2000). Americans need something to sit on. *Journal of Global Buddhism*, 1, 61–81.
- Pigg, S. L. (1996). The credible and the credulous: The question of “villagers” beliefs’ in Nepal. *Cultural Anthropology*, 11(2), 160–201.
- Prebish, C. (1999). *Luminous passage: The practice and study of Buddhism in America*. Berkeley, CA: University of California Press.
- Prebish, C., & Tanaka, K. (Eds). (1998). *The faces of Buddhism in America*. Berkeley, CA: University of California Press.
- Queen, C. (Ed.) (2000). *Engaged Buddhism in the West*. Boston, MA: Wisdom Publications.
- Queen, C., & King, S. (Eds). (1996). *Engaged Buddhism: Buddhist liberation movements in Asia*. Albany, NY: State University of New York Press.
- Radin, P. (1942). *Primitive religion: Its nature and origin*. New York: Viking Press.
- Reddy, S. (2002). Asian medicine in America: The Ayurvedic case. *The Annals of the American Academy of Political and Social Science*, 583(1), 97–121.
- Ricard, M., & Goleman, D. (2007). *Happiness: A guide to developing life's most important skill*. London: Little, Brown and Company.
- Rivers, W. H. R. (1924). *Medicine, magic and religion: The FitzPatrick Lectures delivered before The Royal College of Physicians in London in 1915–1916*. New York: Harcourt Brace.
- Saroglou, V., & Dupuis, J. (2006). Being Buddhist in Western Europe: Cognitive needs, prosocial character, and values. *The International Journal for the Psychology of Religion*, 16(3), 163–179.
- Schell, O. (2000). *Virtual Tibet: Searching for Shangri-La from the Himalayas to Hollywood*. New York: Henry Holt/Metropolitan Books.
- Schumacher, E. F. (1973). *Small is beautiful: Economics as if people mattered*. New York: Harper Perennial.
- Senryo, A., & Williams, D. R. (1999). Japanese American Zen temples: Cultural identity and economics. In: D. R. Williams & C. S. Queen (Eds), *American Buddhism: Methods and findings in recent scholarship* (pp. 20–35). Richmond: Curzon Press.
- Singer, M. (1986). Developing a critical perspective in medical anthropology. *Medical Anthropology Newsletter*, 17(5), 128–129.
- Snelling, J. (1987). *The Buddhist handbook. A complete guide to Buddhist teaching and practice*. London: Rider.
- Spengler, O. (1927). *The decline of the West*. New York: A. A. Knopf.
- Spiro, M. (1982). *Buddhism and society: A great tradition and its Burmese vicissitudes*. Berkeley, CA: University of California Press.
- Spuler, M. (2000). Buddhism in the West: An emerging genre. *Religious Studies Review*, 26, 343–350.
- Stolaroff, M. J. (1999). Are psychedelics useful in the practice of Buddhism? *Journal of Humanistic Psychology*, 39(1), 60–80.
- Suzuki, D. T. (1991). *Introduction to Zen Buddhism*. New York: Grove Press.
- Tsai, J. L., Miao, F. F., & Seppala, E. (2007). Good feelings in Christianity and Buddhism: Religious differences in ideal affect. *Personality and Social Psychology Bulletin*, 33(3), 409–421.

- Tseng, W.-S. (1999). Culture and psychotherapy: Review and practical guidelines. *Transcultural Psychiatry*, 36(2), 131–179.
- Tulku Thondup Rinpoché. (1997). *L'infini pouvoir de guérison de l'esprit, selon le Bouddhisme Tibétain*. Paris: Le Courrier du Livre.
- Turner, B. (1992). *Regulating body: Essays in medical sociology*. New York: Routledge.
- Tweed, T. (1992). *The American encounter with Buddhism*. Bloomington, IN: Indiana University Press.
- Tweed, T. (1999). Night-stand Buddhists and other creatures: Sympathizers, adherents, and the study of religion. In: D. R. Williams & C. S. Queen (Eds), *American Buddhism: Methods and findings in recent scholarship* (pp. 71–90). Richmond: Curzon Press.
- Varela, F., & Hayward, J. (Eds). (1992). *Gentle bridges: Dialogues between the cognitive sciences and the Buddhist tradition*. Boston, MA: Shambhala Press.
- Varga, I. (2005). The body – the new sacred? The body in hypermodernity. *Current Sociology*, 53(2), 209–235.
- Verhoeven, M. J. (2001). Buddhism and science: Probing the boundaries of faith and reason. *Religion East and West*, 1, 77–97.
- Vigarello, G. (2006). *Histoire des pratiques de santé: Le sain et le malsain depuis le moyen âge*. Paris: Le Seuil.
- Watts, A. (1961). *Psychotherapy East and West*. New York: New American Library.
- Weber, M. (1958). *The religion of India*. New York: Free Press.
- Weber, M. (1968). *Economy and society*. New York: Bedminster Press.
- Williams, D. R., & Queen, C. S. (Eds). (1999). *American Buddhism: Methods and findings in recent scholarship*. Richmond: Curzon Press.
- Wilson, B., & Dobbeleare, K. (1994). *A time to chant: The Soka Gakkai Buddhists in Britain*. Oxford: Clarendon Press.
- Yeshe, L. T. (1999). *Devenir son propre thérapeute: Une introduction à la pensée Bouddhique*. Marzens, France: Editions Vajra Yogini.
- Zimmermann, F. (1995). *Généalogie des médecines douces: De l'Inde à l'Occident*. Paris: Presses Universitaires de France.

This page intentionally left blank