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The role of ethics and ideology in our contribution to global health

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What drives public health professionals in their daily work? Presumably it is the appeal of working, either locally or globally, to alleviate the suffering caused by (preventable) ill-health. This article explores the political awareness of health professionals, the political implications of their daily activities and suggests an enhanced role for them in the battle against preventable ill-health worldwide. The starting point for this article is the motivating principles behind these professionals as individuals. It challenges established paradigms in health, medicine, development and academia with a focus on health professionals' political, ethical and ideological motivations and awareness plus the implications of their actions in the realm of global health in the future. It further has implications for the everyday practice of health care providers, public health practitioners, epidemiologists and social scientists in academia.

Keywords: *ethics*; *ideology*; *politics*; *public health*; *global health*

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How relevant is our work?

A lot of semantic nuances hide ideological differences in everyday discussions between public health professionals. If we are to fulfil our potential role as agents of change in trying to solve the problem of preventable ill-health, we will need to pool together our (assumed) genuine and honest predisposition to action in public health – no matter whether we are ethically or politically motivated. Such a pooling together has to begin by launching a process of critical analysis of our respective professional motivations and goals (including their frequently overlooked contradictions). This very process should, hopefully, show to what extent our actions in public health can be made to converge to achieve a real, final impact in ameliorating preventable ill-health anywhere, on a reasonable time horizon. Basically, public health professionals should be searching for a new shared ethos – a professional, and at the same time, political ethos.

Of course, there are those who argue: 'Why don't we just forget about the conservative public health professionals in our guild and focus our efforts more on helping to change things for poor people directly (the slum dwellers, the poor peasants and the unemployed) since they will ultimately be the ones called upon to bring about lasting social changes anyway?' The answer to this question can be ambivalent since these activities are not mutually exclusive: it is mostly a question of what percentage of effort to devote to each of them.

In the long run, there will have to be moral changes on the part of those of us who enjoy the luxuries of affluence. The question is, will these lead to ideological changes in some (1)? We have already passed the era when we asked public health to become more applied and involved in participatory research; now, already since Alma Ata in 1978 (2), we are asking its practitioners to become more socially conscious and more committed as real change-agents, leaving behind a lot of epidemiological preciousness. Depoliticised public health is not a discipline in the real service of man (Franz Fannon). There is indeed a heavy burden put on the shoulders of health care practitioners if they are to 'fit into Fannon's shoes' and implement social policies and/or fight to change them as they try to comprehensively care for their patients (3). We cannot assume that all providers have the exposure or

The topic of this article has vividly interested the author for many years. It is fascinating to him that the issues at stake have not changed for the last 30 years or so. As proof of this – and on purpose – references quoted are both those published before 1985 and after 1995 (Table 1). Considerable material on this topic was already available from the mid 1970s on. The end result has been the (re)construction of a scenario that has been stubborn to change and that looks into most of the, still highly relevant, burning questions of then and now on the issues pertaining to the title of this contribution for debate. It will be of interest to the reader to see how we often need to be reminded of the things our peers had evidence of and wrote about long before us – as the examples of Dr. Virchov and of the Alma Ata Declaration, for instance, show.

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expertise to use a more political language and approach in their practice. So, it is key to ask how providers will get this political education to move to a new consciousness regarding social issues as the underlying determinants of health. A good part of it is covered elsewhere (4) and some of it below.

Political naïveté?

Many among us still think that politics is not a 'virtuous' activity. That is probably why they embark in (only) quixotic actions against the injustices of the prevalent social system – which they also, more often than not, condemn – without realising that, in the end, they are being instrumental to its maintenance. They assume decision-makers in the administration are rational and righteous and will bend in front of hard scientific and/or epidemiological evidence or will react to outrageous injustice. The more liberal among us, on the other hand, pay lip-service to needed changes, even applauding interventions by the more radical among us; but they lack, perhaps as much as the mainly moralist, the political education about what is really needed to overcome preventable ill-health in our consumer societies. The fight against preventable ill-health and malnutrition is eminently a political and not a technical struggle. Technology is hardly the adequate point of departure to achieve the deep structural changes needed to drastically reduce preventable ill-health and deaths even to the timid levels called-for by the Millennium Development Goals (MDGs) (5); the right political approach is the better point of departure. Health professionals are rarely trained in the social sciences and, therefore, use social theory implicitly rather than explicitly (6). This is where the challenge lies in searching for the missing ideological link.[1]

Social consciousness

Does all this mean that the more radical public health professionals or researchers have a higher level of social consciousness than their non-radical peers? What is clear is that once a certain level of political consciousness is attained (is there a threshold?...) a more bottom-centred action-oriented attitude usually follows.[2] At that point, there is a convergence of ideology and action which makes the difference between taking an observer's as opposed to a protagonist's role. Knowing about injustices does not move us. Becoming conscious about them generates a creative anger that calls for involvement in corrective actions. The latter can only happen within the framework of an ideology consciously acquired.

The political forces behind timid sectoral health reforms are to be fought with political actions, not with morals, or with yet more technological fixes. This does not mean that strong ethical principles cannot be used as a political weapon in our work in global health, but this usually fails if not placed in a structural political context: without trying to caricaturise things, 'offering the other cheek' is not enough. It is because of an ideological and political lack of clarity that many a public health professional who has occasionally jumped into the political arena in the North or in the South has so often failed. Health care providers do have values – let us be clear – but I am afraid the same are heavily influenced by the reductionist biomedical model of health we are indoctrinated into from day one. I contend that the latter prevents practitioners from adopting a more socially conscious approach in their practice; it also centres their accountability first and foremost on their technical medical and public health performance with their social accountability falling through the cracks.

Are we afraid of speaking-up in political terms?

Many health professionals feel that their positions in academia, government or international or private organisations may be jeopardised if they 'come out of the closet' with more radical positions. I acknowledge repressive situations in some, but not all, countries; but even under more liberal circumstances, these professionals too often take a survivor's attitude. The result of such a position is yet more palliative interventions that do not do much to eradicate preventable ill-health and malnutrition. But there are certain actions that can be implemented in any system that will have a lasting effect in addressing preventable ill-health and malnutrition. We seldom see agencies or concerned public health professionals primarily pushing those actions, because they are mostly non-health, at least at the outset (4). If we could at least begin giving priority to some of these interventions, i.e. employment generation and income redistribution measures, we would be contributing more to solving the health problems of the deprived sectors of the population than by only implementing specific public health interventions.

Health professionals have to stop thinking that they cannot contribute much to the selection and implementation of non-health interventions, because the latter are outside their immediate field of expertise. These professionals are champions in denouncing transgressions to the principles of the biological and medical sciences, but they are not half as active, and much less effective, in

[1]The mainstream applied social scientist probably does not spend much time either in screening or purposely studying the structural elements of capitalist ideology to come up with the long-term workable structural solutions so elusive in our interventions up to now. Only the more radical among them will go through this exercise to better adjust their strategies and tactics.

[2]This refers to people exercising direct democracy in decision-making – as opposed to representative democracy in which people vote only occasionally and have no control over decisions taken by those they elect.

denouncing transgressions to principles of the social sciences.

Lastly here, I do recognise there is varying political awareness of public health professionals working on global health in different countries; a few of them have successfully engaged in political processes and have played or are playing a valuable public health leadership and political advocacy role. But they are a distinct minority: does the exception confirm the rule?

Health problems in poor countries

So, what are internationally funded health programmes in poor countries really contributing to? How much responsibility are health professionals working in those projects taking for their failure or their success? Who do they see really benefiting from these programmes? How do they see these programmes impact in the long run? A good number of these programmes only scratch the surface of the local problems and, therefore, contribute to the *status-quo* in these countries.[3] Every donor brings its own ideas of the 'best' health development strategy and its programmes will reflect that ideology. The influx of foreign experts tends to mystify the planning process and to reinforce people's feelings of inadequacy about their own capabilities (7–9).

Professionals working in these projects should take part of the blame for failures. They should fight for changes in direction if programmes are not bringing about the anticipated and expected results. Here, a new role for them becomes more evident: the public health professional as a denouncer of non-realistic goals or processes of achieving them – this, especially because there are still some interventions that will just partly contribute to decreasing preventable ill-health in a given population even within the constraints of the unfair prevailing system. It is true that these colleagues, in most cases, did not participate in the programmes design, but it should never be too late to change direction. Therefore, for these workers everything said about speaking up in political terms is doubly important, be they ethically or politically motivated.

Some possible new directions

Yes, but what can I do?

For those accustomed to solving problems and putting them aside, grasping a problem as intractable as the worldwide high prevalence of preventable ill-health and malnutrition guarantees frustration. The flaw in our thinking is that the solution to the preventable ill-health problem is not in nature, but in ourselves – in our approach to the fundamental social relationships among people (10). Preventable ill-health should not be combated because this brings mankind utility, but because it is morally necessary (Emmanuel Kant). What we need to fight for is equity not utility.

It seems that our uncompromising devotion to science is not enough; we need to use science to follow our conscience. We need to think about ourselves as political human beings working as technicians in health remembering that global change does not begin at the global level, but starts with individuals (11). Many health professionals have initially been motivated to simply transfer knowledge to the people; the need is now to start focusing more on the social determinants of the problems of mass poverty and preventable ill-health (4, 12). They need to act as humanists before acting as health professionals. An important requirement for this is to seek knowledge about the real world and not only about the world we would like to see (13). One cannot build on wishful thinking. It is precisely a misunderstanding of reality [or a partial, possibly biomedical, understanding] that often reinforces the apolitical (or politically ambivalent) position of some health professionals.[4] The social reality is not like a laboratory; many variables in it are unknown and unforeseen and when we look at them it is often in the wrong way, searching for the statistical 'whats' instead of analysing the human 'whys' (14).

Health a vehicle?

Public health seems to be as good (or bad) an entry point as any other (nutrition, employment, education, energy, natural resources, the environment, etc.) to get involved in questions of equity and the human right to health in our societies (15, 16). Since the hurdles in the road to equity and the right to health are structural in nature, criticising them from any angle, initially, should lead us invariably to the core of the underlying social structural problems (4, 17, 18). Health can lead to global considerations only if it is not made a 'single-issue' goal. Advocates of a more limited approach to health often look at constraints from a quite narrow perspective – a fact that seldom leads to more equity. There are too many substitutes for in-depth political action in 'single-issue-politics' that lead nowhere. The worst is that many people do not see this difference and a lot of political motivation and sometimes talent among scientists, health professionals or lay people is lost, because of an apolitical approach to global issues. Single-issue politics approaches suffer from a lack of global vision of society and, in

[3]We must be aware, though, that most poor countries' governments would not accept foreign aid programmes at all if otherwise.

[4]Or, some of them may not really want to understand; they have, all too often and for all the wrong reasons, already made up their minds about one reality.

particular, a lack of will to make systemic historical changes (19).[5]

What is needed is more time specifically dedicated to work directly with poor communities so they themselves can tackle the social and political causes of their poverty, ill-health and malnutrition. This calls for public health professionals to go, as much as possible, back to field work and out of their offices or laboratories. Only out there, can the strengths needed for a change in direction and perspective be found. Knowledge and scientific power created in institutions away from the people are returning to the people and affecting them negatively. The gap between those who have social power over thinking – an important form of capital – and those who have not, has reached dimensions no less formidable than the gap in access to economic assets (12, 21, 22).

Establishing the needed links

Public health professionals need to learn from the people, as well as from their perceptions of the problems. They need to establish links with local mass movements and participate in their consciousness raising. The socioeconomic contradictions present locally need to be highlighted and sharpened to give priority to political action over, say, technological actions that will only superficially and in the short-term benefit poor people and marginalised groups of society. The choice is, essentially, between leading poor people towards changes based on an external consciousness, and raising mass consciousness and their capability to make the changes themselves. It is important to demonstrate to them that it is in their power, not only to change social reality, but the physical reality that surrounds them as well (12, 23, 24).

The bottom line

Public health professionals go to the field either as researchers or as persons in charge of certain interventions or projects. As such, they should always participate, as well as intervene. They should enter into a dialogue with the community which will more likely direct their action also towards the social determinants of health that, in community members' eyes, are relevant for solving their health problems. It is probably because this is not done that quick in-and-out field research or projects create more frustration than motivation, both for their implementers and in the community.

That said, the desirable role of public health professionals doing field work should be more one of a listener that does not allow interventions to proceed unchanged if they are culturally or politically neutral or even biased against the interests of the beneficiaries.

This leads us to the concept of accountability mentioned earlier; to whom should these professionals in the field be accountable for their work, besides themselves? Traditionally, they have been accountable to their peers and to funding agencies. Too often they have neglected their accountability to the beneficiaries (25–27).[6]

At this point, we are back full circle then to the question: 'What can I do?' All that has been said here just stresses the fact that the battle against preventable ill-health, preventable malnutrition and preventable deaths can be won, if only public health professionals play their role ultimately addressing the real *causes of the causes* as WHO's Social Determinants of Health Report calls for.

[5]Mention has to be made here that, already long ago, there was a call for a new ethic as the paradigm to replace the present neoliberal ethic of constant growth (11, 20). This new, 'desirable' ethic was called the 'ethics of accommodation.' It has called for simpler patterns of living, more in balance with nature. One might agree with such an approach only in what pertains to the finite availability of natural resources in our planet but, in what relates to social and economic determinants of the ills of our world, this new ethic seems to be a typical example of a partial focus on global realities and a selective choice of action priorities that condones social *status-quo* and thus poverty.

[6]In the case of research, we seldom see researchers communicating their findings directly to the people being served or studied, in an understandable language. Here, then, is another urgent area in need of improvement.

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Table 1. This is a review of old and new evidence

Post-1995	Pre-1995
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Table 1 (*Continued*)

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