

Workshop "Re-defining our Role in Global Health"

Aachen, 21<sup>st</sup> November 2008

### **Nina Urwanzoff: Poverty and Health**

The latest "World Health Report", apart from focussing on a specific issue, shows through its statistics how clear and obvious the connection between development and health really is. Mortality and life expectancy rates, or numbers and percentages of professionals or medical expenditure correlate perfectly with the levels of economic and social development of the various countries and regions. Leaving aside some particular cases, the distribution across the world of what we might call acceptable or reasonable health situations of populations or countries clearly corresponds to the distribution of industrial and financial power.

That poverty and health are simultaneously causes and effects is so evident that it does not require any major theoretical explanations. It is obvious that, generally speaking, those who are sick will become poor, and that the poor are much more likely to fall ill. This, however, presents us with a practical dilemma: how is it possible to break this vicious circle of poverty and bad health? The question is where to begin - by fighting poverty or by promoting health?

In a very summarized way it is possible to say that development theories have offered two alternative answers to this problem: first, a "social" one according to which, by fighting the structural shortcomings within a society, the health of the population can be improved.

Then, later on, another answer appeared - one that we might call "health-focused". For this model that began to spread in the seventies there was no social progress without health: therefore, it was necessary to educate before preventing; to prevent before treating and to treat including rehabilitation.

Briefly, health was the guarantee for social integration of the poor. This "health-focused" answer also presupposed a critical attitude towards mainstream economic models of development.

Unfortunately the so-called "underdeveloped" countries - and partly also many of the highly industrialized ones - looked for a simpler, but – in my view – rather scandalous synthesis between these two models. Since it was not possible to distribute wealth otherwise, there seemed to be no other possibility than to divide the health system in itself: to ensure one type of health care for the “rich“, and - - to support another type of health care for the “poor“. A solution that is unacceptable not only from a moral, but also from an economic and a health-care point of view. The differentiation of health systems into social hierarchies does not contribute to social development. Unfortunately, this is the most widely used model: a private medicine for the upper class, and a so-called “community“ or state medicine for the poor.

MISEREOR’s health work is rooted in the Christian solidarity principle of ‘caritas’. We understand our help as an ethical responsibility in front of the marginalised. But our holistic community-based health care approach aims at the well-being of the *whole* community.

In this sense, the Alma-Ata declaration, for whose core values - I believe - MISEREOR and all Medicus Mundi members have been working for decades and to which they remain faithful - conceives health action from an integral point of view. The central criterion is that health projects are part of programs with social components: production, education, human rights and environmental protection. The strategy of Primary Health Care is not a medicine for poor people for us; it is a form of social growth. Not only poor people should benefit from Primary Health Care; the middle and upper classes must benefit too. The aim is that health systems become more equitable, inclusive and fair.

This relation between poverty and health is quite delicate because politics come in between the two of them. Poverty and health are the objects of economic and social policies and of health programmes. Under these circumstances, our work is always faced with the danger that our support could be seen as not only “technical“, and our solidarity as not only "disinterested"; our help could be interpreted as “political intervention“. A situation that becomes even more uncomfortable when we think that the

separation between donors and recipients shows once again the worldwide division in wealth between the "North" and the "South".

Of course no NGO would want to appear like a political actor. We all know that our possibilities of action depend on our political neutrality.

However, does that mean that we have no other possibility than to limit our work to a hybrid combination of limited technical help, hope for social change and scepticism on the future? Although I can offer no recipe, I do believe nevertheless that our work is not useless, and that the possibilities of health progress in the poor countries are real. Our experience over many years has shown that health work in the communities does contribute to channeling and multiplying the participation of civil society in society as a whole and in the sociopolitical life of the country concerned. We have seen in Africa, Asia and Latin America how health initiatives among extremely marginalized people and communities without any form of economic or political power can become the entry point for positive change in social issues.

In the current state of world economic turbulences, I fear that the most vulnerable will once again be the marginalized populations. It would be one of the biggest possible errors to hope to solve the world crisis by concentrating the economic effort on the first world and ignoring the rest. More than ever before, the first world has to multiply its aid efforts. It would mean a big step forward if we managed to convince those who take financial decisions that there is no long-term better investment than to fight poverty in all parts of the world, and indeed that there will never be, so to speak, a "stock-exchange transaction" more profitable than promoting people's health!

I would like therefore to propose today to the members of this network to express our worries about a possible decrease in development aid and to stress the crucial importance of increasing and strengthening health networks in the so-called Third World and in the Northern countries too.