Setting the agenda for change in the New Millenium: An Open Invitation from the International Poverty and Health Network to all Health Professionals

lona Heath (General Practitioner, Chairman of the Intercollegiate Forum on Poverty and Health, London, UK.)
Andy Haines (Department of Priniarv Care mind population Sciences, Royal Free Society and University College Medical School, London, UK.)
S. N. Bazmi lnam (Associate Professor and Chairman, Department of Community Health Sciences, Ziauddin Medical University, Karachi.)

Around 1.3 billion people live in absolute, grinding poverty on less than $1 per day despite the overall substantial growth of the world economy which doubled over the 25 years prior to 1998 to reach $24trillion[1]. Of the 4.4 billion people in developing countries nearly 60% lack access to sanitation, a third have no access to clean water and about 20% lack access to health care of any kind, a similar proportion do not have sufficient dietary energy and protein.

South Asia has a population of 515 million. Forty three percent of the total population live in absolute poverty (below $1 a day). There are more people living in poverty here than in Sub-Saharan Africa. East Asia (excluding China), the Arab states, and Latin America and the Caribbean region, all taken together. The bulk of South Asian poverty is concentrated in Bangladesh, Pakistan, Eastern and Central Indian States and Nepal. It is also the most illiterate regions of the world with 395 million illiterate adults, nearly half of worlds total, and 50 million out of school children which is two-fifths of world's total[2].

Pakistan is a country with a population of 130 million[3] and a GNP per capita of' $400". It has a high infant mortality rate (95 per 1000 live births) [4], high maternal mortality rate (340 per 100,000 live births)[5], high crude birth rate (36 per 1000 population)[4] and a low contraceptive prevalence rate (1 7%)[6]. The population growth rate of 2.6% is among the highest in the region'. Malnutrition in children under five years of age is unacceptably high (40%)[4]. Twenty four percent of children born are of low birth weight or less than 2.5kg[4]. Nearly half of women of childbearing age suffer from nutritional anemia[6]. Almost half the population does not have access to safe water and sanitation. More than 40% of children under one year remain unimmunized[4].

The overall literacy rate of Pakistan is 38% with a female literacy of only 24%[2]. The mean years of schooling for male and female are merely 2.9 and 0.7 respectively as compared to 8 and 6.3 years in Sri Lanka. The mean years of schooling in India are also no better than Pakistan (males 3.5 and females 1.2)[2].

Cross-country research has shown that 1 to 3 years of mothers schooling is associated with a 20% decline in risk of childhood mortality[7]. A World Bank simulation study demonstrates a reduction of IMR by 64% over a period of 20 years by doubling the female secondary level school enrollment[2]. Whereas, doubling the numbers of doctors would have reduced the IMR by 5 % and doubling the per capita income by only 6%[8].

Education also pays rich dividends in population control. In Bangladesh, the Contraceptive Prevalence Rate increased from 27% in women with no education to 66% in women with more than secondary education[9]. In India, according to the 1980 census total fertility rate was 5.lin women with no education as compared to 3.1 in women with secondary education and 2.1 in those with more than secondary education[10]. Cost-benefit ratio is also high with investment in education. In Pakistan, it was estimated that a $40,000 investment in educating 1000 women would have averted 660 births and thus would

have saved over $250,000 needed to sustain the new babies at the level of average income per capita. Thus yielding a cost-benefit ratio of 6:1.[11]

Always and everywhere, the challenge for all health professional is to understand, from a position of relative comfort, the nature and extent of the problems faced by the poor the marginalised and the vulnerable[12]. Understanding, once even partially achieved, creates empathy and a responsibility to advocate for redress.

Economic disparities both within and between countries have grown and in about 100 countries incomes are lower in real terms than they were a decade or more ago[13]. By 1995 the richest 20% of the world's population had 82 times the income of the poorest 20%. The world's richest 225 people combined wealth equivalent to the annual income of the poorest 2.5 billion people in the world (47% of the world's population)[14]. At the same time the world is facing a growing scarcity of essential renewable resources from deforestation, soil erosion, water depletion, declining fish stocks, lost biodiversity and challenges such as climate change which are likely to impact particularly on poor, vulnerable populations.

Despite the overall dramatic increases in life expectancy which have occurred over the last century, health professionals should he concerned about growing inequalities in health and wealth[15]. The precipitous decline in life expectancy in Eastern Europe, particularly in Russia, is a graphic example of how health may deteriorate as societies face sudden social and economic change accompanied by growing poverty. The gap in life expectancy in selected Western European countries and Russia has widened from 4 to 10 years over the same period[16]. T'his health crisis is centered particularly on adult mortality from chronic diseases and external causes, principally violence. The East Asian recession has been deep and severe, resulting in substantial falls in average per capita income in five countries, most notably in Indonesia, with likely effects on poverty and ill health.

Many African countries have total external debts that are more than 100% of their Gross National Product. Although there has been problem-canceling debt, only 22 of the 52 countries needing substantial or total debt reduction will actually see their annual payments reduced following the agreements made at the Cologne summit[17]. Therefore much still remains to be done, including monitoring how The World Bank and IMF propose to implement the debt reduction program and ensuring that the economic policy reforms they recommend are focused on reducing policy.

Even among generally prosperous, industrialized nations, in countries including Spain, Finland, Sweden, Denmark and the USA, there are many examples of growing socioeconomic inequalities in health over the last 20 years or so[18]. In the UK, there has been widening of the differential in all cause mortality between Social Class V (unskilled) and the Social Class I (professional) from a 2 fold difference in 1970-72 to almost a 3 fold difference in 199 1-93[19].

It is the matter of particular concern that the lives of so many children are blighted by poverty and robbed of their physical and potential[20], even in the USA more than 1 in 4 children under the age of 12 have difficulties in obtaining all the food they need.

Ill health and poverty are mutually reinforcing and can generate a vicious cycle of deterioration and suffering. Ill health contributes directly to reduced productivity and, in some cases, to loss of employment. When it effects the principal earner in poor families it frequently has severe implications for economically dependent children, and other family members, who may no longer be able to nourish themselves adequately. By definition, poor people have very few reserves and may be forced to sell what assets they have, including land and livestock, or borrow at high interest rates; in order to deal with the immediate crises precipitated by illness. Each option leaves them more vulnerable, less able to recover their former condition, and in greater condition of moving down the poverty spiral. In contrast, effective and accessible health services can protect the poor from spiraling into worsening economic problems with the onset of illness, and community based health care has the potential to make a major

contribution to the building of social capital and to the strengthening of the community's own coping mechanisms.

In the 20th century development has all-too-often been equated with economic growth, but the link between economic prosperity and health, a key component of human development, is not autonhatic. A recent World Bank study of the causes of decline in mortality between 1960 and 1990 suggested that gains in income contributed around 20% to male and female adult mortality and under 5 mortality rate reductions[21] The researches indicated that education level amongst women and the generation and utilization of new knowledge were more important factors.

Poverty is a social construction with many dimensions including lack of basic education, inadequate housing. social exclusion, lack of employment, environmental degradation and low income. Each of these diminishes opportunity, limits choices and undermines hopes, and each poses a threat to health. Economic indicators focus primarily on income poverty, whereas health indicators provide a measure of the multidimensional nature of poverty. For this reason, health should be the preeminent measure of the success or otherwise of development policies in the next century. It is health, rather than economic indicators, which will demonstrate the importance of implementing policies across a range of sectorsto slow the rate of depletion of renewable resources and, through the securing of human rights[22], to capitalize on the potential of those who are currently unable to improve their quality of life.

Health professionals strive to understand the detail of their patients' experience of illness and distress. Where health is being undermined by poverty, this misunderstanding becomes, as we share our patients' anger and frustration, part of a process of developing solidarity and disadvantaged individuals and communities. Once suffering is expressed, it becomes tangible and demands redress. This is one of the fundamental processes of medicine and healing, it applies no less to social injustice. If we simply hear the story of suffering but make no move to work alongside the sufferer for redress, we abandon our task.

It is alarming to note that based on the Human Development Index if the 1960-94 trends continues, it will take South Asia 94 years. India 90 years, Bangladesh 135 years to reach high human development category[2].

The gravity of the problems of poverty and under-development makes it imperative that policy makers and planners along with health professionals need to understand the intricate relationship of social determinants of health and the intricate relationship of development from a fresh perspective of human development. The focus and priorities need to be realigned in the light of better understanding of equitable distribution of dividends of economic growth by reducing societal disparities and increasing opportunities for participating in enhancing societal gains.

An example of misplaced priorities can no better be demonstrated by the fact that together India and Pakistan spend over $12 billion per year on defense. If defense expenditure are cut by 5 percent per year over the next five year it could release about $22 billion which is four times the amount required for the goal of universal primary education within the next five years[2].

The International Poverty and Health Network (IPHN) was created in December 1997, following a series of conferences organized by the World Health Organization. The aim of the Network is to "integrate health into poverty eradication policies and strategies. promoting community partnership and intersectoral action, as a mean to achieve effective and sustainable results." It was formed in response to the evidence of the persistent and growing burden of human suffering due to poverty and it invites others to join the endeavor.

The IPHN is a world wide network of people and organizations from the fields of health, business, NGOs, and government, who seek to influence policy to protect and improve the health of the world's poor. with particular emphasis on the poorest in all countries. The network urges that a balance must be struck between social development and growth in per capita income, between the human and income dimensions of poverty and between redistributive and market reforms. At the level of health, with

particular focus on the needs of the poor and most vulnerable, the aspiration is to achieve a balance between biomedical and social approaches, between community based health development and an appropriate response to the needs of individuals, between preventive. prom oti ye, curative health care, and between physical and mental health.

Over the next few years IPHN supporters will strive to reduce the burden of ill health due to poverty in following ways:

Engaging in strategic discussions with international institutions such as the IMF, The World Bank, WHO and national governments to ensure that heath is placed at the center of development and that health impact assessments of all policies are undertaken.

Promoting intersectoral action for health at the local, regional and national levels by working with sectors such as education, business, agriculture and transport to develop and implement effective policies.

• Building the evidence base on effective interventions to reduce inequalities in health and how improved health can reduce poverty.

• Facilitating exchange of knowledge between health professionals in North and South about effective ways if working.

• Ensuring that education programs for health professionals include appropriate information on the impact of socioeconomic inequalities on health and what health professionals can do to reduce such inequalities.

Encouraging health professionals to work with local communities to improve the health of the poorest.

Monitoring trends in health inequalities and using data to influence policy.

We invite others to join us in this endeavour, For more information about the IPHN, please contact:

International Poverty and Health Network(IPHN) Health Link Worldwide, Cityside, 40 Alder Street, London El lEE, UK, Tel: 0207 539 1570, Fax: 0207 539 1580,

E-mail: (Roger Drew) drew.r@healthlink.org.uk, International Poverty and Health Network (IPHN) Community Health Cell, Society for Community Health and

Awareness, Research and Action, No.326, 5th Main, 1st Block, Koramangala, Bangalore 560 634, India, **E-mail:** (Thelma Narayan) sochara@blr.vsnl.net.in at IN ET

References

1.United Nations Development Program, Human Development Report 1998, Oxford, NewYork, Oxford University Press, 1998.

2.Mahbubul Haq, Khadija Haq. Human Development in South Asia 998. Human Development Center, Karachi. Oxford University Press 1998.

3.Population Census Organization. Population and housing census 1998. Islamabad, Population Census Organization, 1998.

4.UNICEF The State of the Worlds Children 2000, New York, Oxford. Oxford University Press, 1999.

5.Government of Pakistan Integrated Ilousehold Survey: Round -2 1996-1997. islamabad, Federal Bureau of Statistics, 1997.

6.Pakistan Medical and Research Council. National Health Survey 1996, Preliminary Results Islamabad, Pakistan Medical and Research Council, 1997.

7.World Bank. 997. Primary Education in India. Washington D.C. In: Mahbub uI Haq, Khadija Haq. Human Development Center, Karachi, Pakistan. 1998.

8.Subbarao K, Raney L. 1995. Social gains from female education: a cross-national study. Economic Development and Cultural Change 44.105:105-20. in: Mahbubul Haq, Khadija Haq. H uman Development in South Asia 1998. Human Development Center, Karachi. Pakistan. Oxford University Press, 1998.

9.World Bank 1993. Staff appraisal report on Femaic' Secondary School Assistance. Report No.15496-IN. 16 February 1993. In: Mahbub uI l-laq, Khadija Haq. Human Development in South Asia 1998. 1-luman Development Center, Karachi, Pakistan Oxford University Press 1998.
10.Government of India. 1993. Education For All: A Graphic Representation. New Dcliii. NIEPA. In: Maitbub ul H aq. Khadija Ilaq. Human Development in South Asia 1998. H luman Development Center. Karachi, Pakistan. Oxford University Press 1998,
11.Summers, L. 1992. investing in All the People. Washington D.C. The World Bank. In: Mahbub ul I laq. Khadija Haq. H uman Development in South Asia 1998. Human Development Centcr, Karachi. Pakistan. Oxford University Press, 1998.
12.Nathonson V. Humanitarian Action: the duty ot' all doctors. Br. Med. J., 1997:315:1389-90.
13.United Nations Development Program Human Development Report 1996, 1997, Oxford, New York, Oxford University Press, 1997.
14.United Nations Development Program, Human Development Report 1998. Oxford, New York, Oxford University Press, 199$.
15.McCally M, Haines A. Fein 0, Addingtott W, et aal. Poverty and III health: Physicians Can and Should Make a Difference Ann. Intern. Med.. 1998:129,726-33.
16.Whitehead M, Diderichsen F, International evidence on social inequalities in health in Health Inequalities editors Drever F, Whitehead M, Office of National Statistics, London. The Stationary Office, 1996.
17.Jubilee 2000 Coalition, Untittished business, The world's leaders and the millenium debt challenge Jubilee 2000 Coalition. 999, I, Rivington St. Lotidoit EC2 A 3DT, 1999.
18.Drever F, Bunting J, Patterns and trends in nate mortality in: l-Ieaith Inequalities. Drever F, Whitchead M, Ollice for National Statistics, London, The Stationary Oftice, 1996.
19.UNICEF. The State of the World's Children 1998, New York. Oxford. Oxford University Press, 1998.
20.Wang J, Jamison D, Bos E. et al. Mcasuring Country performance on health: Selected Indicators for 115 countries. Health Nutrition atid Population Series, Washington DA, The World l3ank, 1999.
21.Bagnoud FX, Mann JM. Health atid humatt rights. Br. Med. J. 1996;3 12:924-25.