# Open invitation from the International Poverty and Health Network to all health professionals

Always and everywhere, the challenge for all health professionals 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.[1] Understanding, once even partially achieved, creates empathy and a responsibility to advocate for redress.

The International Poverty and Health Network (IPHN) was created in December 1997, following a series of conferences organised by the World Health Organisation. The aim of the network is to "integrate health into poverty eradication policies and strategies, promoting community partnership and intersectoral action, as a means 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 endeavour.

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 before 1998 to reach $24 trillion.[2] 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.

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.[3] By 1995 the richest 20% of the world's population had 82 times the income of the poorest 20%. The world's 225 richest people have the combined wealth equivalent to the annual income of the poorest 2.5 billion people in the world (47% of the world's population).[2] 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 past century, health professionals should be concerned about growing inequalities in health and wealth.[4] 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 between selected Western European countries and Russia has widened from about 3 years for men in 1970 to around 15 years in 1995; the figures for women show a widening from 4 to 10 years over the same period.[5] This health crisis is centred 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 progress in cancelling 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.[6] Therefore, much still remains to be done, including monitoring how the World Bank and IMF propose to implement the debt reduction programme and ensuring that the economic policy reforms they recommend are focused on reducing poverty.

Even among generally prosperous, industrialised nations, in countries including Spain, Finland, Sweden, Denmark, and the USA, there are many examples of growing socioeconomic inequalities in health over the past 20 years or so.[5] In the UK, there has been a widening of the differential in all-cause mortality between social class V (unskilled) and social class I (professional) from a twofold difference in 1970–2 to almost a threefold difference in 1991–3.[7]

It is a matter of particular concern that the lives of so many children are blighted by poverty and robbed of their physical and mental potential[8]; even in the USA more than one in four 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 affects 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 crisis precipitated by illness. Each option leaves them more vulnerable, less able to recover their former condition, and in greater danger of moving down the poverty spiral. In contrast, effective and accessible health services can protect the poor from spiralling 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 automatic. A recent World Bank study of the causes of declines in mortality between 1960 and 1990 suggested that gains in income contributed around 20% to male and female adult mortality and under 5 mortality reductions.[9] The researchers indicated that educational level among women and the generation and utilisation 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 hope, 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 pre-eminent measure of the success or otherwise of development policies in the next century. It is health, rather than economic, indicators that will demonstrate the importance of implementing policies across a range of sectors to slow the rate of depletion of renewable resources and, through the securing of human rights,[10] to capitalise 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 understanding becomes, as we share our patients' frustration and anger, part of a process of developing solidarity with 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.

The IPHN is a worldwide network of people and organisations from the fields of health, business, non-governmental organisations, 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 poorest 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, promotive, and 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 caused by poverty in the following ways:

- Engaging in strategic discussions with international institutions such as the IMF, the World Bank, the WHO, and national governments to ensure that health is placed at the centre 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 of working.
- Ensuring that education programmes 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 the data to influence policy.

We invite others to join us in this endeavour.

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