

Joining Together to Combat Poverty

Iona Heath¹, Andy Haines², Zoran Malenica³, Judith A. Oulton⁴, Zorayda Leopando⁵, Dan Kaseje⁶, Whitney W. Addington⁷, Olivier Giscard d'Estaing⁸, James K. Tumwine⁹, Meri Koivusalo¹⁰, Gillian Biscoe¹¹, Pat Nickson¹², Matko Marušić¹³, Stanimir Vuk Pavlović¹⁴

¹Intercollegiate Forum on Poverty and Health, London; ²Department of Primary Care and Population Sciences, Royal Free and University College Medical School, London, United Kingdom; ³University of Split Law School, Split, Croatia; ⁴The International Council of Nurses, Geneva, Switzerland; ⁵Asia-Pacific, World Alliance of National Colleges and Academies of Family Medicine and Family Practice (WONCA), Manila, The Philippines; ⁶Africa Community Action Network for Health (AFRI-CAN), Nairobi, Kenya; ⁷The American College of Physicians, The American Society of Internal Medicine, Chicago, Ill, USA; ⁸BUSCO, Business Council to the UN, Paris, France; ⁹Department of Paediatrics and Child Health, Makerere University Medical School, Kampala, Uganda; ¹⁰Globalism and Social Policy Programme, National Research and Development Centre for Welfare and Health, Helsinki, Finland; ¹¹The Bellettes Bay Company Inc., Hobart, Tasmania, Australia; ¹²Institut Pan Africain de Santé Communautaire, Nyankunde, Democratic Republic of Congo, and Abidjan, Côte d'Ivoire; ¹³Croatian Medical Journal, Zagreb University School of Medicine, Zagreb, Croatia; and ¹⁴Mayo Clinic Cancer Center, Mayo Clinic, Rochester, Minn, USA

The International Poverty and Health Network (IPHN) was created in December 1997 following a series of conferences organized by the World Health Organization, with the aim of integrating health into plans to eradicate poverty. Around 1.3 billion people live on less than US\$1 per day. Of the 4.4 billion people in developing countries nearly 60% lack access to sanitation, 30% do not have clean water, 20% have no health care, and 20% do not have enough dietary energy and protein. Even among rich nations there are gross socioeconomic inequalities. Many children are robbed of their physical and mental potential through poverty. Expressed in constant 1963 US dollars, an average Croatian family needed the annual income of US\$894 to meet the poverty line in 1960 and US\$9,027 in 1995. Accordingly, 9-25% of Croatian households were below the poverty line between 1960 and 1995. The increase in the poverty rate after 1991 was compounded by the war that destroyed almost a third of industrial capacity and infrastructure. Dissipation of the communist economy and inadequate privatization have contributed to the increase in unemployment rate, corruption, and other social ills. IPHN invited Croatian Medical Journal to publish this editorial to help push the issue of poverty up political and medical agendas on a global level. We argue that a factor contributing to the failure of most large-scale programs against poverty to date is the excessive emphasis on material and infrastructure assistance at the expense of spiritual, moral, and intellectual development.

Key words: child welfare; Croatia; cultural deprivation; health campaigns; indigency; life expectancy; low income population; medically underserved area; poverty; socioeconomic factors

The International Poverty and Health Network 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 plans to eradicate poverty. Its formation was a response to the evidence of the persistent and growing burden of human suffering due to poverty. Now it invites others to join the endeavor. It asked medical journals to publish the invitation in their first 2000 issues.

The Growing Poverty

Around 1.3 billion people live in absolute, grinding poverty on less than \$1 per day (1), despite the overall substantial growth of the world economy, which doubled in the 25 years before 1998 to reach US\$24 trillion. Of the 4.4 billion people in developing countries, nearly 60% lack access to sanitation, more than 30% do not have clean water, about 20% have no health care, and another 20% do not have enough 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 ago (2). By 1995, the richest fifth of the world's population had 82 times the income of the poorest fifth. The world's 225 richest people have combined wealth equivalent to the annual income of the poorest 2.5 billion (nearly half of the world's population) (1). At the same time the world faces a growing scarcity of renewable resources from deforestation, soil erosion, water depletion, declining fish stocks, and lost biodiversity. The poor will be hit hardest by these problems.

Despite overall dramatic increases in life expectancy in the past century, health professionals should be concerned about growing inequalities in health and wealth (3). The precipitous decline in life expectancy 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 for men between selected western European countries and Russia has widened from about three years in 1970 to around 15 in 1995; the figures for women show a widening from 4 to 10 years over the same period (4).

Many African countries have total external debts that are more than 100% of their gross national product. Although there has been progress in canceling debt, only 22 of the 52 countries needing substantial or total debt reduction will actually see their annual payments reduced after the agreements made at the Cologne summit (5). Therefore, much remains to be done, including monitoring how the World Bank and International Monetary Fund implement debt reduction program and ensuring that the economic reforms they recommend are focused on reducing poverty. Even amongst rich nations in industrialized countries there are many examples of growing socioeconomic inequalities in health over the past 20 years (4). Of particular concern is the fact that so many children are robbed of their physical and mental potential through poverty (6). Even in the US more than one in four children aged under 12 have difficulty obtaining all the food they need.

Poverty and Health

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 sometimes to loss of employment. When it affects the principal earner in poor families it has severe implications for economically dependent family members, particularly children. By definition, poor people have 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, and in greater danger 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 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 showed that income improvement caused about a fifth of the decline in mortality between 1960 and 1990 (7). However, the researcher pointed out that education of women and the generation and use of new knowledge were more important factors.

Poverty is a social construction with many dimensions: lack of education, inadequate housing, social exclusion, unemployment, environmental degradation, and low income. Each of these diminishes opportunity, limits choices, undermines hope, and threatens 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 failure of development policies in the next century.

Health professionals strive to understand their patients' experience of illness and distress. As we share the frustration and anger of those whose health is undermined by poverty this understanding becomes part of a process of developing solidarity with disadvantaged individuals and communities. Once suffering is expressed, it becomes tangible and demands redress. This is fundamental to medicine and healing; it applies no less to social injustice. If we hear of suffering but do not work alongside the sufferer for redress, we abandon our task.

Poverty in Croatia

Under communism, objective studies of poverty in Croatia were ideologically disfavored. The official statistics were based on subjective criteria and are thus not reliable. Hence, an assessment of the situation must start with the current socioeconomic circumstances. These circumstances are still strongly impacted by the war of 1991-1995, by the incomplete transition from planned economy to market economy, and by the de facto isolation of the country by the international "community" until the parliamentary elections of January 3, 2000.

The transition to market economy started immediately after the democratic elections of 1990, but it has been only partially completed. The dislocations of war prevented the establishment of checks and balances in the redistribution of national wealth, particularly the accumulation by the nouveau riche. The consequences have been a low confidence in the institutions of the government and corruption. An additional outcome has been the decline of the gross domestic product per capita from US\$5,195 in 1990 to US\$4,028 in 1995, but with a recovery to 4,832 in 1998 (8). In 1999, some local media estimated that about 80% of individuals and households Croatian thought of themselves as poor; they claimed that their living standards in 1999 were worse than before 1991. In the summer of 1999, the Association of the Independent Workers' Unions of Croatia publicly argued that as much as 40% of the Croatian population could be considered poor. The poverty line was set at the monthly per capita

income of HRK841 (Croatian kuna, approximately US\$113), a relative criterion defined as inability to meet the needs generally perceived as basic. These claims have not been supported scientifically. In 1999, Škare published the only scientific study of poverty in Croatia (9). He set the poverty line as the income meeting the minimum individual daily nutritional needs of 2,900 calories for a family of four. Expressed in constant 1963 US dollars, the average Croatian family needed the annual income of US\$894 to meet the poverty line in 1960 and US\$9,027 in 1995. (For comparison, these figures for the USA are US\$3,022 and US\$15,569, respectively.) Accordingly, from 9% to 25% of Croatian households were below the poverty line between 1960 and 1995. The worst years were 1972, 1992, and 1993, while the best was 1968. The rather large increase in the poverty rate after 1991 was compounded by the war that destroyed almost a third of industrial capacity and infrastructure and held 24% of the national territory under occupation for four years. Dissipation of the communist economy and inadequate privatization have also contributed to the sudden increase in unemployment rate, corruption, and other social ills.

To assess the real situation, Croatia needs further in-depth studies of poverty. The census, scheduled for 2001, will greatly assist in these efforts. However, even without a definitive study it is manifest that the living standards in Croatia are grossly inadequate for a large number of citizens and that the situation has worsened over the last decade. Some estimates indicate that the unemployment rate, presently estimated at between 17% and 23%, can be substantially reduced only by economic growth at the annual rate between 7% and 10%. This rate of growth can be achieved only through a sustained process of integration of Croatian economy into developed industrial economies of the world.

What Can Croatia Contribute to the Global Combat against Poverty?

Clearly, developed economies do not lack resources to raise the worldwide levels of health care, shelter, nutrition, and education. The economic consequences of the nascent global market on developed economies, at least on that in the United States, indicate that redistribution of global wealth in favor of the poor would benefit the wealthy as well. Yet, the gap between the rich and the poor continues increasing. Why?

This question is as philosophical as it is pressing. It probes the very definition of poverty to identify its root causes and identify its remedies. We argue that a factor contributing to the failure of most large-scale programs against poverty to date is the excessive emphasis on material and infrastructure assistance at the expense of spiritual, moral, and intellectual development. Paradoxically, spiritual and moral development are needed both in the world that gives and in the world that receives; only a global awareness of the intrinsic dignity and transcendental value of every human being – a spiritual category – can provide a universal platform for the overcoming of the political and economic divides. Such divides are inherent in every global effort that by necessity cuts across cultures and civilizations. We argue that the small countries, themselves maybe in need of assistance, can meaningfully contribute to the global goal of eradicating poverty. The success of Israeli agricultural and community development programs in sub-Saharan Africa before the Six-Day War of 1967 supports this argument most eloquently.

The relative failure of the United States and other New World countries in eradicating poverty in the inner cities and native communities is an example of welfare not accompanied by sufficient assistance to the family and to the broader community. This mode of assistance should focus on building the spiritual, educational, and cultural, not just economic leadership. In fact, the success of different immigrant groups in the United States and other countries of immigration appears directly linked to their spiritual values and maintenance of social cohesion. The success of Jewish and Chinese Americans in the first half of the 20th century is a case in point. Strong sense of community and common values – hard work, focus on education, spiritual link with the previous and incoming generations, work on behalf of descendants – allowed these groups to secure a socioeconomic impact well above their strength in numbers. While economically poor, they were rich in heritage and values that redeemed them from poverty.

Admittedly, assimilation into the societies of the “First World” is hardly paradigmatic of the solutions needed in the “Third World”. However, these examples do emphasize that any economic assistance must be accompanied by a true commitment of donor nations and groups to sustained human interaction with the receivers. This interaction should mediate a gradual integration of the poorest societies into the community of nations that equal each other not only in the per capita national product, but also in education, health, strength of family, and cohesion of community. Small nations of the “Second World”, such as Croatia, can provide these essential non-economic components of assistance. Arguably, medical, educational and other professionals from small transitional countries could be particularly sensitive to the spirituality and dignity of societies and groups under duress, an essential requirement for success of any human interaction. Such sensitivity has not always been

indigenous to the rich and the powerful, often self-declared as the "international community". Many Croatians perceive their current political difficulties and the de facto international isolation of the country as caused by such a lack of sensitivity. If this belief has some basis in facts, many a transitional country is an untapped resource of meaningful contributions to humanity.

Invitation

The International Poverty and Health Network is a worldwide network of people and organizations from health, business, non-governmental organizations, and government who seek to influence policy to protect and improve the health of the world's poor, particularly the poorest in all countries. The network urges that a balance must be struck between social development and growth in income; between the human and financial dimensions of poverty; and between redistribution and market reforms. Its aspiration is to achieve a balance between biomedical and social approaches; between community based health development and a response to individuals; between prevention of disease, promotion of health, and treatment; and between physical and mental health.

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

1. Engaging in strategic discussions with the International Monetary Fund, the World Bank, the World Health Organization, and national governments to ensure that health is put at the center of development. We urge health impact assessments of all policies.
2. Promoting action for health locally, regionally, and nationally by working with sectors such as education, business, agriculture, and transport.
3. Building the evidence base on effective interventions to reduce inequalities in health and how improved health can reduce poverty.
4. Facilitating exchange among health professionals in north and south about effective ways of working.
5. Ensuring that education programs for health professionals include information on the impact of socioeconomic inequalities on health and what they can do to reduce such inequalities.
6. Encouraging health professionals to work with local communities to improve the health of the poorest.
7. Monitoring trends in health inequalities and using the data to influence policy.

We invite others to join the IPHN in this endeavor.

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References

- 1 United Nations Development Programme. Human development report 1998. New York (NY): Oxford University Press; 1998.
- 2 United Nations Development Programme. Human development report 1996-7. New York (NY): Oxford University Press; 1997.
- 3 McCally M, Haines A, Fein O, Addington W, Lawrence R, Cassel C. Poverty and ill health: physicians can and should make a difference. *Ann Intern Med* 1998;129:726-33.
- 4 Whitehead M, Diderichsen F. International evidence on social inequalities in health. In: Drever F, Whitehead M, editors. *Health inequalities*. London: Office for National Statistics; 1996.
- 5 Jubilee 2000 Coalition. *Unfinished business. The world's leaders and the millennium debt challenge*. London: Jubilee 2000 Coalition; 1999.
- 6 UNICEF. *The state of the world's children 1998*. New York (NY): Oxford University Press; 1998.
- 7 Wang J, Jamison D, Bos E, Preker A, Peabody J. *Measuring country performance on health: selected indicators for 115 countries*. Washington, DC: World Bank; 1999.
- 8 Republika Hrvatska. *Statistički ljetopis*. Zagreb: Državni zavod za statistiku; 1999.
- 9 Škare M. Indicators of poverty in the Republic of Croatia [in Croatian]. *Revija za socijalnu politiku* 1999;6(3-4):279-90.

Correspondence to:

Roger Drew
Healthlink Worldwide
Cityside, 40 Adler Street

London E1 1EE, United Kingdom
drew.r@healthlink.org.uk

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