

## **10 Poverty, social exclusion, and minorities**

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### **10.1 Introduction**

Poverty, the extent of relative deprivation, and the processes of social exclusion in a society have a major impact on the health of its population. All over Europe, in richer countries as well as poorer ones, those people who are worse off in socio-economic terms have worse health outcomes and higher death rates than those who are better off. Particular ‘minority’ ethnic groups are often in poor socio-economic positions within particular countries and hence often experience poor health, which can be exacerbated by the additional effects of prejudice and racism. The harm to health comes not only from material deprivation but also from the social and psychological problems resulting from living in relative poverty.

This chapter first presents a small sample of the vast body of available evidence that shows a clear relationship between poverty, deprivation, and health, and then discusses briefly how and why poverty affects health. Evidence of the persisting incidence of poverty and social exclusion in western and deepening poverty in eastern Europe, and the implications of this for health, are then presented. Following this, attention turns to the concept of ‘social exclusion’ in Europe and focuses on the evidence of the detrimental effect on health for particular ‘minority’ groups: the unemployed, refugees, poorer migrants, ethnic minorities, and homeless people. The chapter closes by offering short- and long-term policy suggestions for the reduction of health problems resulting from poverty, relative deprivation, and social exclusion.

### **10.2 Poverty and health**

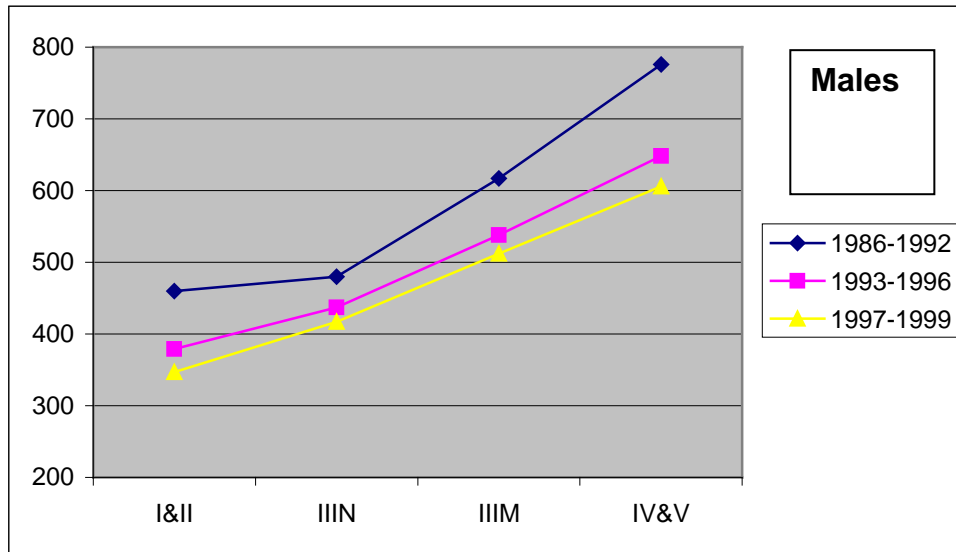
Whether we refer to mortality, morbidity, or self-reported health, and whichever indicator of socio-economic position we employ – income, class, housing tenure, deprivation, or education – we find that those who are worse off socio-economically have worse health. It is not only the case that the poorest in society have poor health, but a gradient of ill health and mortality spans all socio-economic strata. This gradient can be found across the industrialized world, although the strength of the relationship varies somewhat between different countries, for different age groups, by the health measures used, and for men and women (Kunst et al. 1995; Mackenbach et al. 2004).

Recent evidence from Britain, where there is a long tradition of research into inequalities in health (Davey Smith et al. 2001), shows that variations in life expectancy by social class continue to be found. Table 10.1 shows inequalities in all-cause mortality by social class in England, for males and females separately, for the period 1986 to 1999. Figures 10.1 and 10.2 show this in graphical form – the same scale is used for both males and females to emphasize the absolute differences in their respective death rates. These data show that while all-cause mortality fell in all classes over the study period, a consistent class gradient is apparent for both males and females. For males, the social class gap in mortality widened (see ratios in Table 10.1) whereas for females the social class gradient narrowed slightly. Occupational groups I and II include professionals, such as doctors and lawyers, as well as managerial occupations. Occupational groups IV and V include semi-skilled manual occupations, such as some coal miners and machine operators, and unskilled manual occupations,

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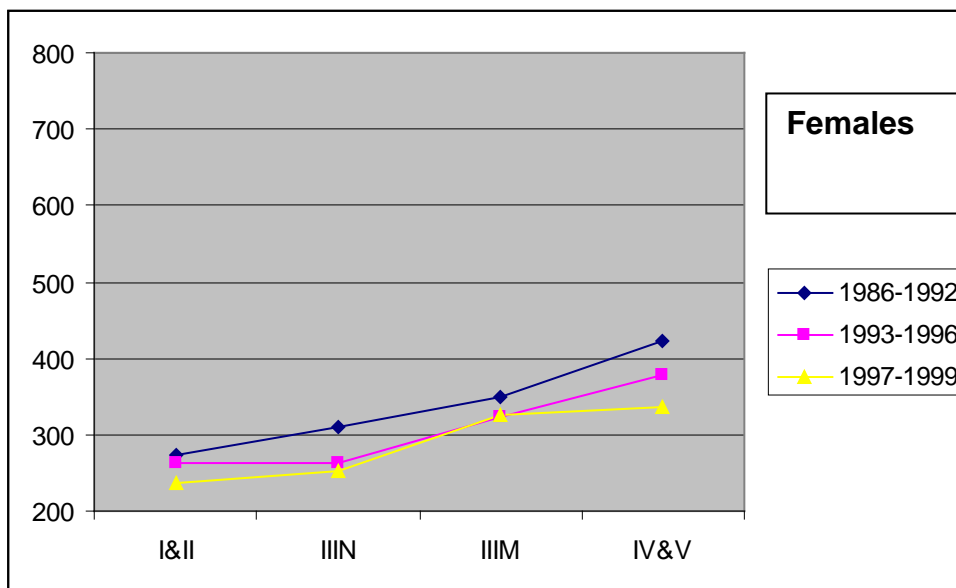
such as cleaners and labourers.

**Fig. 10.1** Directly age-standardised all-cause mortality rates per 100,000 person years, England and Wales, males aged 35-64, 1986-1999.



Source: adapted from White et al., 2003.

**Fig. 10.2** Directly age-standardised all-cause mortality rates per 100,000 person years, England and Wales, females aged 35-64, 1986-1999.



Source: adapted from White et al., 2003.

**Table 10.1**

**Trends in all cause mortality in England and Wales by social class 1986-1999, males and females aged 35-64, directly age-standardised death rates (DSR) per 100,000 person years, with 95% confidence intervals**

	<b>Males</b>					
	DSR (95% CI)			% Change		
	1986-92	1993-96	1997-99	1986-92 to 1993-96	1993-96 to 1997-99	1998-92 to 1997-99
I&II	460 (427-494)	379 (338-426)	347 (302-399)	-17	-8	-24
IIIN	480 (431-533)	437 (377-506)	417 (352-494)	-9	-5	-13
IIIM	617 (587-649)	538 (502-577)	512 (472-556)	-13	-5	-17
IV&V	776 (731-823)	648 (593-707)	606 (546-672)	-16	-6	-21
Ratio IV&V: I&II	1.69	1.71	1.75			
Non-manual	466 (439-494)	396 (363-433)	371 (334-413)	-15	-6	-20
Manual	674 (649-700)	577 (546-610)	546 (512-582)	-14	-5	-19
	<b>Females</b>					
	DSR (95% CI)			% Change		
	1986-92	1993-96	1997-99	1986-92 to 1993-96	1993-96 to 1997-99	1998-92 to 1997-99
I&II	274 (249-302)	262 (226-303)	237 (201-281)	-5	-9	-13
IIIN	310 (276-347)	262 (223-307)	253 (211-304)	-15	-3	-18
IIIM	350 (325-377)	324 (291-361)	327 (290-369)	-7	1	-7
IV&V	422 (388-459)	378 (335-427)	335 (289-388)	-10	-11	-21
Ratio IV&V: I&II	1.54	1.44	1.41			
Non-manual	289 (268-310)	257 (232-284)	246 (219-278)	-11	-4	-15
Manual	379 (358-401)	344 (317-373)	330 (301-362)	-9	-4	-13

Source: adapted from White et al., 2003.

Similar findings of differences in mortality and life expectancy by social and occupational classes are reported for other European countries. For example, Kunst and Mackenbach (1992) compared mortality by occupational social class in six European countries (Denmark, England and Wales, Finland, France, Norway, and Sweden) and found that socio-economic gradients in mortality varied in each country and in different age groups, but that there were, nonetheless, gradients in each of these countries.

Kunst (1997) reports findings of socio-economic differences in mortality for a number of eastern and western European countries, in terms of occupational class and educational groups. Table 10.2 shows death rate ratios in the 1980s for males in manual versus non-manual occupational classes for various countries. Differences are

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particularly large for the former communist countries of the Czech Republic and Hungary, showing that socio-economic gradients in mortality were not the preserve of the capitalist countries of the West.

**Table 10.2**

**Death rate ratios for males in manual versus non-manual occupational classes in the 1980s (adapted from Kunst, 1997)**

Country	Death rate ratio	
	30–44 years	45–59 years
Czech Republic	2.25	1.83
Denmark	1.53	1.33
England and Wales	1.46	1.44
Finland	1.76	1.53
France	*	1.71
Hungary	2.89	2.65
Ireland	1.43	1.38
Italy	1.35	1.35
Norway	1.65	1.34
Portugal	1.5	1.36
Spain	*	1.37
Sweden	1.66	1.41
Switzerland	1.45	1.35

\* Data not reported for this age group.

In Britain, alternative socio-economic measures, such as housing tenure and access to a car, are often used as indicators of social position; Table 10.3 presents data for England and Wales for the 1980s. Compared to owner occupiers, those who rented their home from a public or private landlord had increasingly higher death rates; similarly, compared to those who had access to one or more cars, those who did not have access to a car had increasingly higher death rates. Similar findings have been reported when education is used as the social indicator.

**Table 10.3**

**Direct age-standardized rate ratios for deaths under 65 by housing tenure and car access: 1971 and 1981 census cohorts (Longitudinal Study data) (adapted from Filakti and Fox 1995)**

	Males		Females	
	1971–81	1981–89	1971–81	1981–89
Housing tenure				
Owner occupiers	1	1	1	1
Private renters	1.32	1.38	1.32	1.38
Social housing	1.35	1.62	1.42	1.44
Car access				
1+cars	1	1	1	1
No cars	1.44	1.57	1.40	1.56

Some researchers have looked more specifically at the health effects of relative deprivation, a concept that refers to the disadvantaged position of an individual,

family, or group relative to the society to which they belong, and focuses on the condition of deprivation as well as the lack of resources (Townsend et al. 1988). Using the Townsend index of deprivation, a composite indicator for areas (which includes unemployment, percentage of households with no car, the extent of overcrowding, and housing tenure), Eames et al. (1993) found that higher deprivation was associated with higher rates of premature death in every region in England and Wales, although the association was stronger in some regions than others.

There is also some evidence that living in a relatively deprived area can have a detrimental effect on an individual's health, even when the individual level of deprivation has been taken into account, i.e. that there is an area health effect over and above the effect of individual deprivation. This has been found in the USA (Haan et al. 1987) and in British studies of both mortality and morbidity (Langford and Bentham 1996; Shouls et al. 1996; Davey Smith 2003). However, when such area effects are found to exist, they tend to be small. CROSS REFERENCE CHAPTER BY STAFFORD

Suicide rates, in particular, have been found to be associated with deprivation (Hawton et al. 2001; Bartlett et al. 2004); Gunnell et al. (1995) report that socio-economic deprivation is an indicator and possible determinant of psychiatric morbidity and suicide. McLoone (1996) reported that the greatest rates of increase in suicide rates in Scotland between 1981 and 1993 were for deprived young people – their suicide rates being approximately twice those of young people in affluent areas. Similarly, in an ecological analysis Crawford and Prince (1999) found increasing suicide rates among young men in Britain to be associated with social deprivation, unemployment and living alone.

### **10.2.1 Why poverty is bad for health: the material, social, and psychological consequences of living in poverty**

An understanding of why those who live in conditions of poverty and relative deprivation have poorer health is necessary in order to begin effectively to redress the issue. A number of different explanations for this relationship have been suggested, including living and working conditions, limitations on resources, and the subsequent effect on social relationships. Individual life-style factors, such as smoking, alcohol consumption, exercise, and diet, have been suggested by some as the main underlying causes. However, while such factors may indeed form a part of the explanation for inequalities in health, they should not be considered the exclusive cause, nor viewed as being distinct from the socio-economic environment.

The majority of the evidence suggests that material conditions are the underlying root of ill health, which includes being the determining factor for health-related behaviours (Davey Smith et al. 1994; Shaw et al. 1999). Poverty imposes constraints on the material conditions of everyday life – by limiting access to the fundamental building blocks of health such as adequate housing, good nutrition, and opportunities to participate in society (Black and Laughlin 1996). The concomitants of poverty are often poor nutrition; overcrowded, damp, and inadequately heated housing; increased risk of infections; and inability to maintain optimal hygiene practices (Davey Smith 2003). Poor housing, for example, can be damp, cold, and contain mould, conditions which are associated with wheezing, breathlessness, cough, phlegm, meningococcal infection, and respiratory diseases and asthma (Ineichen 1993; Shaw 2004). Poor housing conditions can also bring a risk of fire and accidents, and overcrowded

housing not only increases the risk of infection but impacts upon mental health through factors such as high noise levels and lack of privacy (Shaw, 2004).

Blackburn (1991) asserted that poverty affects health through not only nutrition and housing, but also in terms of the effect on mental health and caring for children. Income levels affect the way parents are able to care for their own and their children's health. As well as affecting other aspects of their lives – where they live, where their children go to school – living on a low income makes it difficult to exercise control over family health, and as a result the health needs of parents, particularly women, are often compromised for those of children. For example, Graham (1995) found that smoking rates in young women in manual households were related to the strains of caring responsibilities as well as to greater material disadvantages – it was a combination of the psychological and material difficulties of life that led to their greater smoking prevalence. By compromising their own health women thus felt better equipped to cope with the care of their children and families. It is thus necessary to understand how material restrictions operate through a number of processes – ‘unhealthy’ behaviours need to be understood in the context of the constraints on everyday life which accompany them.

It is important to recognize the processual nature of poverty, but also that it has a cumulative effect. A body of evidence is now emerging which shows that health outcomes in adulthood reflect the accumulating influence of poor socio-economic circumstances throughout life (Davey Smith, 2003). Adverse socio-economic conditions in early life can produce lasting increases in the risk of cardiovascular disease, respiratory disease, and some cancers late in life. Adverse socio-economic conditions in adulthood compound these earlier-life influences, resulting in health differentials in adulthood which reflect the social patterning of exposure acting across the life course (Davey Smith 2003). The particular influence of deprivation in childhood should focus attention on social policies concerned with reducing poverty in households with young children.

### **10.2.2 Increasing poverty, unemployment, and inequality**

What we know about the relationship between poverty and health should be cause for great concern, given that the proportion of people living in relative poverty has increased in many European countries in recent years in both western and eastern Europe.

The extent of poverty and relative deprivation increased in European countries in the 1980s and 1990s; while the incomes of the richest groups rose significantly, the incomes of the poor have hardly grown in real terms, or have even fallen (Gordon and Townsend, 2000). Between 1980 and 1988 poverty rates increased in all European Community countries, with the exceptions of the Netherlands, Portugal, and Spain (Oppenheim and Harker 1996). The sharpest rises were seen in Italy, Germany, and the UK. In terms of income inequality, the UK, Sweden, Denmark, Norway, the Netherlands, and Belgium have all experienced increases over the time period 1967–92; the UK, Norway, the Netherlands, Belgium, and Germany all experienced increases in child poverty (Goodman et al. 1997).

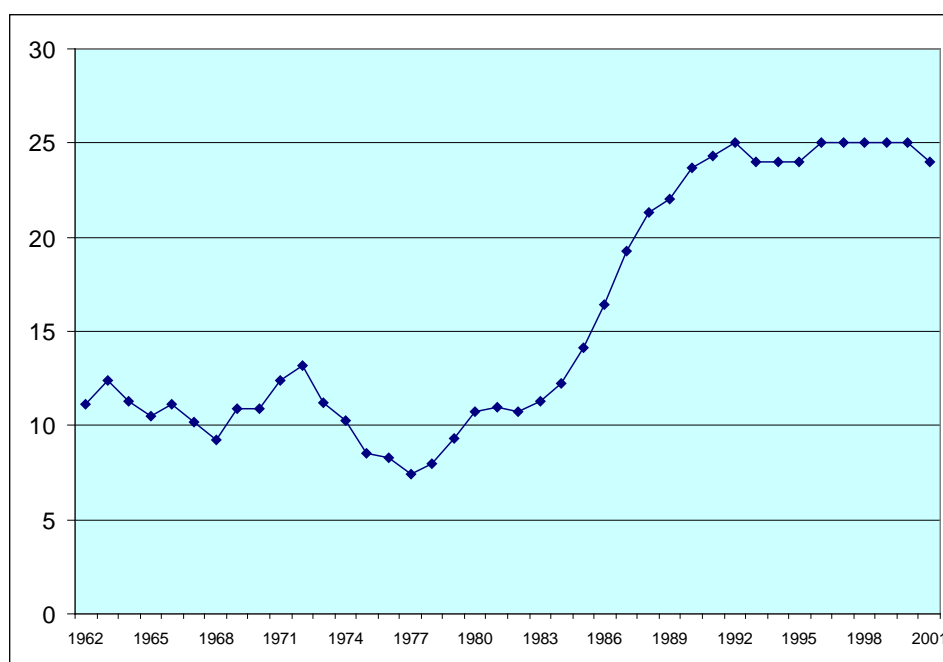
Vogel (1997) points to economic developments underlying these increases in poverty and inequality which can be seen across the European Union: mass unemployment, reductions in welfare transfer systems, and cuts in public services. Socio-demographic changes, ageing populations, increasing divorce rates, and increasing numbers of lone parents also contribute to the increased proportion of

people living in poverty. Vogel reported a clear tendency towards growing poverty rates in 9 of the 12 European countries he considered (increased poverty in the Netherlands, Denmark, Belgium, Luxembourg, Spain, Ireland, UK, Greece, and Portugal).

Although there is wide variation in the unemployment rates of European countries and methodological problems of comparing rates (Green 1998), most countries experienced mass unemployment in the 1980s and 1990s. Approximately half of the unemployment rate consists of long-term unemployed (those unemployed for more than 12 months), and the youth unemployment rate is higher than the general rate (Vogel 1997). This growth in unemployment and insecure employment, as well as rises in the numbers on welfare, rising debts and arrears, increase in the number of lone parents, and increasing numbers of homeless people is referred to by Room (1991) as the 'new poverty' of the European Community. This is in addition to, and not replacing, older forms of poverty among the elderly, sick, and children.

Examining the case in Britain, where much data is available, in the post-war period there have been considerable improvements in terms of living standards, and this has been reflected in falling overall mortality rates. However, despite this overall growth in prosperity, there has also been an increase in relative poverty and inequality. The case of housing provides an example. Home ownership in Britain increased from 57 per cent in 1981 to 68 per cent in 1991 (Dorling 1995) to 71 per cent in 2001 (Dorling and Thomas, 2004). The proportion of households with central heating increased from 37 per cent in 1972 to 83 per cent in 1992 (Wadsworth 1996) and over 90 per cent in 2001 (Census, 2001); the proportion of households with more than one car from 9 per cent in 1972 to 24 per cent in 1992 (Wadsworth 1996) and 29 per cent in 2001 (Census 2001). However, the number of households in insecure housing tenures rose during the 1980s and 1990s, reflected in increases in the number of mortgage reposessions and households in temporary accommodation – the number of which rose from over 10 000 in 1982 to over 67 000 in 1992 (Wadsworth 1996). While the number of households in temporary accommodation fell in the early to mid-1990s, it subsequently rose steadily and in 2002 stood at 85,000 (Social Trends 34). Thus in the context of increased overall prosperity, relative poverty has been on the increase.

The situation regarding the distribution of wealth and income in Britain was been examined in detail by Hills (1995*a,b*, 1998). He reported (Hills 1995*a*) that income inequality grew between 1970 and 1990, and that while income inequality also grew in a number of other advanced industrialized countries, the rate of increase in Britain was faster than in any other country except New Zealand. Using the series of data on 'households below half average income' for Britain also shows this trend and takes it into the twenty first century (see Figure 10.3). From this it can be seen that the proportion of the population with less than half the average income rose from 7% in the 1970s to 24% in the 1990s, and that this high level has since been sustained (DWP, 2003). The extent of inequality is thus such that the lowest-income groups have not benefited from economic growth. As a result of high unemployment and economic activity (such as early retirement and invalidity), more people became dependent on state benefits. Those particularly vulnerable to low income are pensioners, lone parents, households with no earners, and families with children.

**Figure 10.3. Percentage of the population with below half average incomes after housing costs, Britain, 1961-2001**

Source: Households below average income series (DWP)

At the same time that economic inequality has increased in Britain, so too has the gap between the death rates of the better off and the deprived (McLoone and Boddy 1994; Phillimore et al. 1994; Shaw et al. 1999; Davey Smith et al. 2002). For example, Raleigh and Kiri (1997) looked at life expectancy and deprivation in district health authorities in England and Wales between 1984 and 1994. Those areas with the greatest gains in prosperity had the greatest gains in life expectancy, whereas in deprived areas improvements in life expectancy were negligible. They report a difference in life expectancy of 6.7 years for men and 4.7 years for women between the most and least deprived areas. Davey Smith et al. (2002) looked at age-sex standardized mortality ratios for deaths under the age of 75 for poverty deciles in Britain for the period 1990-99. They found that inequality increased steadily across the decade - the chance of premature mortality polarized between richer and poorer areas of Britain over this decade.

Blane and Drever (1998) have calculated this widening gap of health in terms of years of potential life lost. While standardized mortality ratios have the advantage of taking into account the different age structures of the social class groups, they are heavily influenced by the number of deaths occurring in the oldest age category. However, the largest relative class differences in absolute mortality are at younger ages, and so it is also worth considering the relative number of years of productive life which are lost through premature mortality (Davey Smith et al. 1994). As Table 10.4 shows, the ratio of years of life lost for social class V as compared to social class I between the early 1970s and early 1990s rose from 2.1 to 3.3. Thus increasing poverty and income inequality are mirrored by increasing health inequalities.



**Table 10.4**

**Annual age-adjusted rate of years of potential life lost per 1000 population for all causes of death in men aged 20–64 in England and Wales for 1970–72, 1979–80 and 1982–83, and 1991–93 (standardized to population of England and Wales 1981) (from Blane and Drever 1998)**

<b>Social class</b>	<b>1970–2</b>	<b>1979–80, 1982–83</b>	<b>1991–93</b>
I	48.7	36.5	28.0
II	51.9	42.2	31.6
III non-manual	65.0	53.9	45.7
III manual	66.0	58.0	50.5
IV	75.6	67.7	52.8
V	103.0	105.8	93.3
Ratio V: I	2.1	2.9	3.3

Similar polarization can be seen on a larger scale. Shaw et al. (1998) have analysed changing all-cause standardized mortality ratios (SMRs) for deaths under the age of 65 for 160 regions of the European Union. Data were analysed at the NUTS 2 (Nomenclature of Statistical Territorial Units) level, which are generally provinces, *Regierungsbezirke* (German regions), or groups of counties (for example, Herefordshire and Worcester and Warwickshire in the UK). Regions were amalgamated into population deciles according to their SMRs in 1990.

Table 10.5 indicates that while a number of the deciles had decreasing SMRs, including those that already had relatively low SMRs in 1990, deciles 5, 6, 7, and 10 have experienced increasing SMRs over the study period. Most notably, the SMR of the population decile with the highest death rates was 130.1 in 1990 but by 1994 the SMR of this population decile was 134.9. Thus the difference between the regions with the highest and the lowest SMRs is becoming greater. A cursory inspection of the geographical patterning of this polarization of mortality across Europe suggests that it reflects, to a large extent, the European geography of polarizing wealth and employment.

As further evidence of this trend of growing socio-economic and health inequality, a specific disease which traditionally has been associated with poverty, tuberculosis, rose in eastern Europe in the 1990s. Raviglione et al. (1994) reported increases in Romania, Armenia, Kyrgystan, Latvia, Lithuania, Moldova, and Turkmenistan and no further decline in other countries. Likewise, recent rises in Britain have been linked with increased poverty, deprivation, and unemployment (Darbyshire 1995; Kumar et al. 1995) and incidence has become increasingly concentrated among non-white groups (Regan et al. 2003).

**Table 10.5**

**SMRs (all cause, under 65) by population deciles, 1990 and 1994 (standardized to the European average) (from Shaw et al. 1998)**

<b>Decile</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
1990	75.0	85.1	90.6	94.6	97.4	100.6	105.1	109.0	116.3	130.1
1994	73.5	84.0	89.4	94.4	97.8	102.2	105.9	108.7	113.7	134.9
Change	-1.5	-1.1	-1.2	-0.2	+0.4	+1.6	+0.8	-0.3	-2.6	+4.8

### 10.3 Central and Eastern Europe

Increases in inequalities in health can thus be interpreted as a result of increases in poverty and inequality, and this phenomenon can be also seen in the former communist countries of eastern and central Europe. While overall death rates fell throughout the twentieth century in western Europe, in eastern and central Europe mortality has been rising since the mid 1960s (Shkolnikov et al. 1998). In the years after the collapse of communism, death rates rose sharply. Between 1989 and 1994 life expectancy in Russia fell by 6.5 years for men and 3.5 years for women (Shkolnikov et al. 1998); similar changes have been seen in other former Soviet countries (Dennis et al. 1993). By 1993, death rates had risen substantially in all of the former Warsaw Pact countries with the exception of Hungary (UNICEF 1993). These changes have not been spread evenly throughout the population, for example in Russia, death rates have risen fastest among those with lower levels of education (Shkolnikov et al. 1998).

As well as increasing rates of tuberculosis, Davis (1993) has noted that in eastern Europe morbidity as a result of diseases such as diphtheria, measles, whooping cough, and syphilis has also increased; nutritional, infectious, and degenerative diseases have all become more widespread. In terms of mortality, a great proportion of the increase is due to male deaths from accidents and homicide, and many of these deaths are alcohol related (Ellman 1994; Leon et al. 1997; Shkolnikov 2001). For example, Ellman states that for males aged 15–59, between 1987 and 1991, 77 per cent of the total increase in mortality was accounted for by accidents and homicide. These increases in morbidity and mortality are all occurred within the context of a ravaged healthcare system:

Medical facilities are underfunded and afflicted by shortages of all categories of supplies . . .  
The quality of medical care in state facilities has almost certainly fallen. These negative trends have not been offset by the increase in sophisticated treatment in private facilities, which only a small minority can afford . . .

(Davis 1993, p. 34)

Severe environmental pollution has also been suggested as a possible contributory factor (Feshbach and Friendly 1992; Antunes et al. 2003). However, as increases in mortality rates have particularly affected certain groups – young men of working age in particular – it has been argued that this is unlikely to be a predominant cause of the overall increases (Watson 1995). Similarly, Hertzman (1995) argues that pockets of pollution tend to affect health at the local level and this effect is not enough to influence significantly national mortality rates.

Others point to behavioural changes as a major factor in these poorer health outcomes, particularly increased alcohol consumption. For example, Cockerham (1997) argues that life-style factors – alcohol consumption, smoking, poor diet, and lack of exercise – account for this increase in mortality. Bobak and Marmot (1996) also point to the role of unhealthy behaviours and life styles, arguing that smoking has probably had the largest impact; Leon et al. (1997) highlight alcohol consumption. However, these authors also emphasize that individual behaviours need to be understood in their broader social context, we must look to the far-reaching changes in socio-economic conditions for explanations as to why large groups of people behave as they do. Local considerations may also need to be borne in mind. For example, in a paper reporting mortality in a cohort of the Nova Huta steelworkers in Poland, Watson (1998) suggested that the results needed to be understood not only in

the context of broader political and economic circumstances, but also regarding the history and experience of employment at that particular steelworks. Similarly, Phillimore and Morris (1991) have argued that in order to understand geographical patterns in mortality we need an understanding of what constitutes a 'place', and this may include looking not only at levels of deprivation but also examining closely the social and economic histories of particular localities, such as the provision of housing and the pattern of deprivation over a number of decades. Others have also addressed the issue of *how* places affect health (Macintyre et al. 2002; Tunstall et al. 2004).

An understanding of place-specific factors, cultures, and societies is also needed at the international level. In virtually all states of central and eastern Europe and the former Soviet Union political and economic changes were accompanied by drastic reductions in production output and in real wages, and living standards fell (Davis 1993). As a consequence, many people found themselves in a condition of sudden impoverishment (Cornia and Panizza 1995); income inequalities widened. Many people took on two jobs and worked very long hours in order to provide for themselves and their families. For example, Ellman (1994) reported that, in Russia in 1992, 37 per cent of the Russian population were below the poverty line (defined in this study as an income which would allow a level of food consumption adequate to maintain a normal body weight at an average level of activity), and 47 per cent of children below the age of 15 were living below the poverty line. Such conditions have direct effects, such as on food consumption (due to both lack of availability and lack of purchasing power), and also lead to social stress (Shapiro 1995). During the same period marriage rates also declined and crime rates soared. People lost not only their incomes, but also a sense of pride, power, and participation, in relation to both work and national identity. Watson (1995) argued that it is likely that rising mortality rates in eastern European countries were not only associated with falling absolute standards of living for the majority of the population, but were also related to increased social and economic inequalities, a sense of hopelessness and disenfranchisement with the political process, and higher levels of insecurity and uncertainty, particularly in employment.

There are thus psychosocial implications (Davey Smith and Egger 1996) of social and economic stress, which may influence rates of murder, depression, suicide, and alcohol consumption. As Ellman says:

. . . someone whose job is insecure and who may become unemployed (or who has actually become unemployed), who is living on a low and uncertain income (which may frequently not be paid when due) under conditions of very high inflation and very high crime, and whose access to meat, vegetables, fruit and medical care has sharply worsened, may die in a brawl, car crash or of alcohol poisoning.

(Ellman 1994, p. 343)

Economic conditions thus have a knock-on effect. Increased poverty and the difficulties that accompany it affect health in terms of morbidity and mortality, and it is those who are worse off whose health suffers most. This is the case in established market economies as well as societies in the process of transition.

## 10.4 Social exclusion

In many areas the terminology of social exclusion is superseding poverty or deprivation in popularity. 'Poverty' emphasizes lack of economic resources, and the

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term 'relative deprivation' stresses the conditions of living. 'Social exclusion' refers not only to the economic hardship of relative economic poverty, but also incorporates the notion of the *process* of marginalization – how individuals come, through their lives, to be excluded and marginalized from various aspects of social and community life.

There is no European-wide definition of social exclusion, but it is generally considered to include a number of dimensions:

Exclusion processes are dynamic and multidimensional in nature. They are linked not only to unemployment and/or to low income, but also to housing conditions, levels of education and opportunities, health, discrimination, citizenship and integration in the local community

(European Social Policy White Paper (1994), cited in Oppenheim and Harker 1996, p. 156).

As the 'Social Exclusion Unit' in England has stated, the term is:

...a shorthand label for what can happen when individuals or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdowns.

(Social Exclusion Unit, 1997, cited in Levitas, 2000)

The term 'social exclusion' also relates to cultural aspects of exclusion and discrimination and refers to the relationship between the included and excluded, the meaning and identity of the excluded. Social exclusion is about multidimensional disadvantage – there is not one 'social exclusion' but many 'social exclusions' (Room 1995) and, as with social class and relative economic deprivation, there are degrees of exclusion. The term 'socially excluded' can refer to those who may be stigmatized and marginalized, such as people with HIV/AIDS, who might not be considered in traditional analyses of economic deprivation. Those who are more socially included have greater access to resources, not only in economic terms but also resources which come from living within a society – such as educational opportunities, social networks, and support; those who are excluded are denied these (see Chapter 8). As Wilkinson has powerfully said:

To feel depressed, cheated, bitter, desperate, vulnerable, frightened, angry, worried about debts or job and housing insecurity; to feel devalued, useless, helpless, uncared for, hopeless, isolated, anxious and a failure: these feelings can dominate people's whole experience of life . . . The material environment is merely the indelible mark and constant reminder of the oppressive fact of one's failure, of the atrophy of any sense of having a place in a community, and of one's social exclusion and devaluation as a human being

(Wilkinson 1996, p. 215)

The processes leading to social exclusion in Europe include economic change (increased unemployment and widespread job insecurity), demographic change (increased proportions of single households, lone parents, and elderly), changes to welfare regimes (cuts and withdrawal), and specific spatial processes of segregation and separation (stigmatization and marginalization of certain groups, often leading to spatial segregation of minorities) (White 1998). White (1998) refers to four aspects of social exclusion (Fig. 10.4). First there is exclusion from civil society through legal constraint or regulation. This is particularly relevant to migrants, for example the children born to foreign immigrants (with no German ancestry) in Germany, who remain foreigners in legal terms. Secondly, there is the failure to supply social goods

to a group with particular needs; for example, facilities for the disabled, language services, or accommodation for the homeless. Thirdly, there is exclusion from social production, not being able to be an active contributor to society; certain groups may be labelled as undesirable, unacceptable, or in need of control, for example gypsies and travellers. Finally, there is economic exclusion from normal social consumption – not having access to the normal perquisites, routines, and experiences of everyday life.

**Fig. 10.4 The process and outcome of social exclusion in Europe (adapted from White 1998).**

Social exclusion can refer to individuals, but it is not just individuals who manifest conditions of exclusion and accompanying stress and insecurity. Spatial concentration and segregation can mean that areas can become deprived, disadvantaged or stigmatized, this may affect all of those in the area, and affect their potential for mobility. For instance, living in an area where factories are closing and where there are no job vacancies increases an individual's chance of unemployment. An area which has high unemployment and high levels of deprivation is also likely to have poor schools – an individual's circumstances depend very much on his or her geographical setting. The health-damaging and health-promoting features of local areas in Glasgow, Scotland's largest city, have been investigated in work by Sooman and MacIntyre (1995). They found that not only were there differences in self-reported health between local areas, with those in more advantaged areas reporting fewer health problems, but there was also an association between the respondents' perceptions of their local social and physical environment which could not be explained by social class differences. Important factors were local amenities and problems, area reputation, neighbourliness, fear of crime, and area satisfaction. Later work by these authors on a similar theme has also reported on the role of the living environment for health (Macintyre et al. 2003) and particularly the role of social cohesion (Macintyre and Ellaway, 2000). These findings highlight that social exclusion is not just about individuals, but that there is also a spatial dimension.

### 10.4.1 Unemployment

The groups of people who are socially excluded, and their characteristics, vary from state to state. They can include elderly people, people with disabilities (especially disabled children), lone parents and their children, as well as those with certain health conditions (e.g. the mentally ill and the long-term sick). However, here we concentrate on the evidence showing that unemployed people, refugees, poorer migrants and ethnic minorities, and homeless people have adverse health outcomes. As noted above, high unemployment rates (also termed mass unemployment) have become a permanent feature of developed economies, as the European postwar social contract has been reformulated (Korpi, 2003). This unemployment tends to be concentrated in certain groups – there are growing numbers of long-term unemployed and youth unemployment is also widespread – increasing numbers of young people in Europe have never worked. Unemployment is essentially a spatial process, because people are limited in how far they can travel to work in a day; they rely on the supply of work in their local area and when this supply falls, unemployment rises. Unemployment in Europe is also concentrated disproportionately among immigrants, particularly female migrants (Model, 2002). For example, in the mid 1990s in the

Netherlands unemployment was 7 per cent for the Dutch themselves, but for non-Dutch workers it was 20 per cent, for those from Turkey and Morocco it was even higher (Pinder 1998).

The research showing that unemployment carries a risk of premature mortality is discussed in Chapter 5 of this volume. The effect operates over and above pre-existing health and social class position. According to Drever and Whitehead (1997), after adjusting for social class, the excess mortality for the unemployed is 25 per cent for men and 21 per cent for women. Nor is this increased mortality due solely to behavioural factors – data from the British Regional Heart Study have shown that differences in mortality between employed and unemployed men remain after adjustment for factors including smoking and alcohol consumption (Morris et al. 1994). Furthermore, evidence suggests that the negative health effects of unemployment are cumulative – the longer someone experiences unemployment, the more likely their health will suffer as a result (Bartley and Plewis, 2002).

It is thus not just the economic hardship which accompanies unemployment which has repercussions for health, but the psychosocial condition of unemployment appears also have an effect. Consistent with this, job insecurity and the anticipation of job loss have been found to be associated with poorer health outcomes (Ferrie et al. 1995; Bartley et al. 1996). The health of temporary employees has also been found to be worse than permanent employees (Kivimaki et al. 2003) (see also Chapter 6 on work).

#### 10.4.2 Refugees, migrants, and ethnic minorities

Refugees and internationally displaced persons experience elevated risks of mortality in the period following their migration. For people fleeing from countries which have recently experienced conflict in Europe (the former Yugoslavia, Georgia, Azerbaijan, Chechnia and Kosovo), this includes not only war-related injuries but also communicable diseases, neonatal problems, and nutritional deficiencies (Toole and Waldman 1997). The stresses accompanying this process – past traumatic experiences, the loss of family and friends and disruption of social support networks, and problems of settling in a new environment – will also have an impact upon a number of dimensions of physical and mental health. Migration can also impact upon mental health due to the effect of having to renegotiate cultural identities (Bhugra, 2004) (see also Chapter 8 on Social Support).

People also migrate in order to find work, unemployment being a spatial phenomenon. Some migrants and guest workers will experience similar problems to those of refugees (although perhaps to a lesser degree). There is a range of evidence that poorer migrants and ethnic minorities have different health outcomes to those of the general population of the society in which they are living. In terms of all-cause mortality, Drever and Whitehead (1997) report raised rates for most ethnic groups in Britain (Table 10.6).

**Table 10.6 SMRs, by country of birth, for men aged 20–64, all causes (England and Wales 1991–93) (from Drever and Whitehead 1997)**

	All countries	Caribbean	West/South Africa	East Africa	Indian sub-continent	Scotland	Ireland (all parts)
SMR	100	89	126	123	107	129	135
SMR adjusted for social class	100	82	135	137	117	132	129

Table 10.6 shows that migrants from the Indian subcontinent, East, West and southern Africa, as well as from Scotland and Ireland, have significantly higher SMRs than the average population in England and Wales, and that this is the case even after social class is taken into account. Only those who were born in the Caribbean have lower SMRs. This is likely to be explained by a healthy migrant effect, with only the healthiest from the Caribbean migrating to Britain (Marmot et al. 1984), or may possibly be due to the fact that many migrants return to the Caribbean shortly before their death and thus have not been included in these mortality data.

This elevated mortality has also been found to extend to the children of migrants. Harding and Balarajan (1996) found that the mortality of second-generation Irish migrants living in England and Wales was significantly higher for most causes of death than that of all men and women, and this was only partially explained by socio-economic variables (social class, car access, and housing tenure). In the Netherlands, the mortality rate of Turkish and Moroccan children under 15 is two to three times higher than that for Dutch children – the main causes of death responsible for this elevated rate being perinatal death (including congenital malformations), accidents (including drowning), and infectious diseases (Schulpen 1996).

There is also evidence in terms of particular health outcomes. Evidence from Australia suggests that migrant workers may be more prone to work-related accidents, as Corvalan et al. (1994) found that language and duration of stay were related to occupation-related fatalities. In Canada, the stress of resettlement after migration has been linked to higher suicide rates (Trovato 1992). Harding (2003) has reported that for South Asian migrants resident in England and Wales, longer duration of residence was associated with increased cardiovascular and cancer mortality.

Etienne et al. (1994) report that tuberculosis is higher in immigrants in Belgium; Elender et al. (1998) showed the same in England and Wales, noting that this was accounted for by overcrowded living conditions and poverty. Circumstances in country of origin may also play a role. In Sweden, there is evidence of elevated morbidity in labour migrants and refugees (Sundquist 1995). That research found that migrants were more likely to live in rented housing and have low material standards of living, they were also more likely not to feel secure in everyday life and to have poor leisure opportunities – being an immigrant was a risk factor for poor health of equal significance to life-style risk factors.

Nazroo (1998) has highlighted the importance of social position in determining the health of migrants. He asserts that much of the variation in health by ethnicity can be explained by standards of living. The health of ethnic minorities may also be influenced by geographical concentration in certain areas, as well as the experience of harassment and discrimination. Nazroo warns:

The ethnic classifications we use do not reflect unchangeable and natural divisions within groups. Also ethnicity does not exist in isolation, it is within a social context that ethnicity achieves its significance, and part of that social context is the ways in which those seen as members of ethnic minority groups are racialised. Indeed, one of the most important purposes for undertaking work on ethnicity and health is to extend our understanding of the nature and extent of the social disadvantage faced by ethnic minority groups. Not only is health part of the disadvantage, it is also a consequence.

(Nazroo 1998, p. 8)

Methodological issues also need to be considered when looking at the health of migrant workers. Egger et al. (1990) report on health inequalities by occupational class in Switzerland, suggesting that class differences may be understated as large

numbers of migrant workers (mostly from Yugoslavia, Italy, Spain, and Portugal), concentrated in partly skilled and unskilled manual occupations, are not routinely included in official statistics. Even within particular occupational groups there is evidence that migrant workers experience worse conditions, and hence demonstrate unfavourable health outcomes, compared to the indigenous Swiss population. Studies have attempted to address this issue by using name-based searches for identifying migrants in records (Razum et al., 2001), but such a method is far from ideal.

### 10.4.3 Homeless people

Even in developed societies with relatively high gross domestic product (GDP) and highly developed welfare systems, we see the problem of homelessness. There are many methodological problems with the definition and enumeration of homelessness (Pleace and Quilgars 1996). The European Federation of National Organisations Working with Homelessness states that “it is not possible to provide a single reliable European statistic on the extent of homelessness in Europe.” (FEANTSA, 2000: p7). However, FEANTSA say that some tentative comparisons can be made. Germany, with the largest population in the EU, also has the largest homeless population – around 390,000 (data for 2000) – of who almost a quarter of a million are homeless families. For the UK, an estimate can be derived from the figures for the number of people accepted by local authorities under the homelessness legislation, which stood at 165,000 people ‘in priority need’ in 2000/2001. Estimates for France suggest a homeless population (including people living in temporary accommodation) at around 200,000 (2001) and 70-80,000 ‘roofless’ people in Italy (2000).

In terms of trends over time, homelessness increased in Germany from the late 1980s to the mid-1990s, and has since followed a sustained reduction (FEANTSA, 2002). In the UK, the total number of people accepted by local authorities as homeless also declined over the 1990s, and the government has also claimed to have significantly reduced the number of people sleeping rough (although this is perhaps the most difficult manifestation of homelessness to enumerate). There is no reliable data to compare trends in France. In the Scandinavian countries, levels of homelessness remained steady, or fell slightly, during the 1990s. However, homelessness nonetheless remains a feature in industrialized, wealthy nations. Factors which have contributed to this are high unemployment and long-term unemployment, restrictions on emigration (due to worldwide economic trends), lack of availability of low-cost rented accommodation, and progressive disinvestment in local authority housing.

There is a great deal of evidence that homeless people have poor health outcomes, and this can be seen in terms of a range of both physical and mental health problems. A comprehensive study of the health problems of homeless people in Britain (Bines 1994) found that people using hostels, living in bed and breakfast accommodation, and those sleeping rough were not only more likely to have health problems than the general population, but were also more likely to have multiple health problems. Health data were collected from 1280 people living in hostels and bed and breakfast accommodation and 507 people sleeping rough and using day centres and soup runs. These were compared to data from the first wave of the British Household Panel Survey (BHPS), which is a representative sample of 10 264 individuals from over 5000 households (Buck et al. 1994). Bines calculated standardized *morbidity* ratios which take into account the age and sex structure of each group. This is a more accurate comparison than merely reporting rates of ill health, as the homeless group



is, on average, much younger than the general population and so should ‘expect’ good health. The standardized morbidity ratios are presented in Table 10.7. As with standardized mortality ratios, the rate of the general population is set at 100. A number higher than 100 means that the group is more likely than the general population to experience that particular health problem.

**Table 10.7**

**Standardized morbidity ratios (SMorbRs) for reported health problems for hostel users and rough sleepers compared to the general population (from Bines 1994)**

Health problem	Hostels and B&Bs	Sleeping rough	
		Day centres	Soup runs
Musculoskeletal problems	153	185	221
Wounds, skin ulcers, or other skin complaints	105	189	298
Chronic chest or other breathing problems	183	259	365
Fits or loss of consciousness	651	2109	1892
Frequent headaches	264	338	365

SmorbRs for the general population (from the BHPS) are 100.  
B&B, bed and breakfast.

We can see from this table that homeless people have higher rates of morbidity than the general population. Those in hostels have rates higher than the general population (whose rates are set equal to 100) and those sleeping rough have even higher rates. For example, those living in hostels and bed and breakfast accommodation have an SMorbR of 183 for ‘chronic chest or other breathing problems’ – meaning they are nearly twice as likely to report suffering from this health problem. Those using soup runs are almost four times as likely to report this problem, with an SMorbR of 365. Rates are highest, however, for ‘fits or loss of consciousness’, a result which is likely to be related to the high levels of drug and alcohol use amongst these groups, in conjunction with the deprivations of living on the streets.

Infectious diseases are also a problem for homeless people. Studies have found relatively high rates of tuberculosis amongst homeless people in England and Wales (Ramsden et al. 1988). In the mid-1990s, Darbyshire (1995) linked increases in tuberculosis in England and Wales with poverty, unemployment, and homelessness. Kumar et al. (1995) found that nearly one-quarter of 642 shelter users examined had abnormal chest radiographs and 5 per cent had active tuberculosis. As homelessness and injecting drug use often coincide, there are also increased risks of HIV, and Hepatitis B and C infection (Raoult et al. 2001). Skin problems such as scabies, pediculosis, tinea infections and impetigo are common reasons for homeless people to seek medical attention (Raoult et al. 2001).

Mental health problems are also an important issue for this vulnerable group. A survey by the (then) Office of Population Censuses and Surveys of psychiatric morbidity amongst homeless people is notable for its coverage and depth. It included hostel residents, residents of private-sector leased accommodation (used as a substitute for bed and breakfast accommodation by local authorities), adults staying in night shelters, and people sleeping rough (Gill et al. 1996). The results (Table 10.8) show high rates of physical and mental illness, and many individuals reporting both. A recent systematic review of studies of schizophrenia amongst homeless people

included 33 studies from eight countries, in the ten methodologically superior studies, the weighted average prevalence of schizophrenia was 11%; rates were higher among young people, women and the 'chronically homeless' (Folsom and Jeste, 2002).

Table 10.8 also indicates high rates of alcohol and drug dependence, with half of the rough sleepers alcohol dependent, and one-quarter drug dependent. This compared to rates for the general population of about 5 per cent and 2 per cent, respectively (Meltzer et al. 1995). This can lead to cirrhosis, overdoses, and accidents. Injecting drug use also brings problems such as thrombosis, abscesses, and infected injecting sites.

**Table 10.8**  
Selected results of the OPCS survey of psychiatric morbidity (% self-reported items) (adapted from Gill et al. 1996)

	Sample size*	Physical illness only	Physical and mental illness	Mental illness only	Alcohol dependence	Drug dependence	GP registration
Hostels	530	36	6	6	16	11	92
PSLA	268	33	2	3	3	7	95
Night shelters	187	26	9	12	44	29	71
Sleeping rough	181	39	14	7	50	24	58

\*Not all respondents completed all parts of the questionnaire.  
PSLA, private-sector leased accommodation.

Another health issue associated with homelessness is suicide (Baker 1997). In a recent study (Desai et al. 2003) suicidal ideation was found to be common amongst a sample of homeless people in the US (66.2% lifetime prevalence). Half of the sample reported that they had ever attempted suicide, and 8% reported an attempt in the previous 30 days. Suicide and suicidal feelings are likely to occur at all stages of homelessness: fear of losing one's home, sudden and unprepared moves, having no settled home, seeking accommodation, waiting for a home, and settling into a new home (in some ways similar to the challenges faced by migrants). As Baker notes, various emotions are associated with homelessness:

..... a sense of isolation and loneliness, feeling worthless, a failure and uncared for, lacking hope for the future, feeling trapped and powerless to change things, despised, rejected and marginalised by society, feeling frustrated, betrayed and misunderstood.

(Baker 1997, p. 24)

In England, Keyes and Kennedy (1992) found that homeless people were 34 times more likely to kill themselves than the general population; similarly, Grenier (1997) reports that they are 35 times more likely to do so.

Violence from others is also an everyday threat faced by those without a home, especially homeless women and those sleeping on the streets. North et al. (1996), in a study of the use of accident and emergency departments by homeless people, found that their accidental injuries were four times as likely to be the result of assault as those of housed people. Keyes and Kennedy (1992) found that homeless people were 150 times more likely to be fatally assaulted and eight times more likely to die in an

accident than the general population. An Australian study also reports that homeless people are likely to witness violence against others as well as to be victims themselves, and that half of homeless women and 10% of homeless men in a study in Sydney reported being the victims of rape (Buhrich, et al. 2000).

Homeless people have also been found to have much higher overall mortality rates than the housed population. In the USA, Hwang et al. (1997) have reported the average age of death of homeless people in Boston to be 47 years. A study in Georgia reports an average age of death of 46 years; 42 per cent of deaths were from injuries, mostly accidental, nearly half of which were related to acute or chronic effects of alcohol (Hanzlick and Parrish 1993). A Danish study of two homeless hostels in Copenhagen has also reported a higher rate of mortality for homeless people, particularly young women (Nordentoft and Wandall-Holm, 2003). However, due to problems with estimating denominators – the number of homeless people in each age group – it is often difficult to compare death rates with those of the general population. In Britain, a study of deaths of rough sleepers found the average age of death to be 42 (Grenier 1997) – this has been found to translate to a standardized mortality ratio of over 2500 (Shaw and Dorling 1998) - the street homeless are thus 25 times more likely to die in any given period than the people who walk past them on the streets.

The direction of the relationship between health and homelessness, and particularly mental health, is unclear – the health problems of some homeless people may predate their homelessness (Pleace and Quilgars 1996). For example, Bines' study (1994) found that between 12 per cent and 20 per cent of homeless people had previously stayed in a psychiatric institution. However, between 9 per cent and 21 per cent had been in a young offenders' institution, and 15–24 per cent had been in a children's home; over half had been resident in some kind of institution before becoming homeless. Moreover, while some health problems may precede homelessness, it is certainly the case that the daily conditions of homelessness, both material and psychosocial, compound existing health problems, cause additional problems (such as problems with feet and respiratory illness), and make access to healthcare more problematic (Fisher and Collins 1993; Pleace and Quilgars 1996).

## **10.5 Conclusion and implications for policy**

There is a well-established link between poverty and poor health – those who are socially excluded, such as the unemployed, refugees and other poorer migrants, and homeless people, experience worse or very worse health outcomes than the general population. In the context of sustained or increasing relative poverty, inequality, and social exclusion in Europe, health inequalities are also polarizing.

In the long term, the way to address the poor health of the socially excluded is to pursue economic policies that lead to greater economic equality. A redistribution in wealth and income will have the greatest influence on improving the health of those who are worse off. There is evidence that societies that are more economically equal and socially cohesive have lower overall mortality than those that are more unequal (Wilkinson 1996).

However, in the short term, a number of specific actions can be taken to improve the health of those who are socially excluded. As social exclusion is dynamic and multidimensional, so should be the policies to combat it and its effects. Policies include:

- (1) Legislation to protect the rights of minority and migrant groups, particularly concerning citizenship and employment rights, anti-discrimination, and protection of those seeking asylum.
- (2) Income support/welfare regimes to provide an adequate standard of living for the unemployed. Adequate minimum wages to protect those on low incomes.
- (3) Policies should focus on reducing the proportion of children born into and living in poverty (which will have short-term as well as long-term effects on health).
- (4) Policies should aim to reduce inequalities in income and wealth within populations, for example, through progressive taxation of income and inherited wealth.
- (5) Policies to ensure access to educational, training, and employment opportunities, especially for those such as the long-term unemployed.
- (6) Barriers to access to health and social services should be removed, which will involve understanding where and why such barriers exist.
- (7) Adequate follow-up support is needed for those leaving institutional care.
- (8) Housing policies should aim to provide enough affordable housing of reasonable standard.
- (9) Employment policies should aim to preserve and create jobs.
- (10) Improving the health of migrants requires attention to the unfavourable socio-economic position of many migrant groups and also particular difficulties of access to health, and other care services.

Policies such as these, which are focused on the many dimensions of social exclusion and which aim to reduce inequality in a society, will have an effect on health. As Blane and colleagues have said:

A society which nurtures people's skills and abilities throughout the population, which provides economic opportunities for all, and fosters a cohesive and integrated social environment, would do more for health than curative medical services are able to.

(Blane et al. 1996, p. 12)

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