Health and social exclusion

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Poverty and health

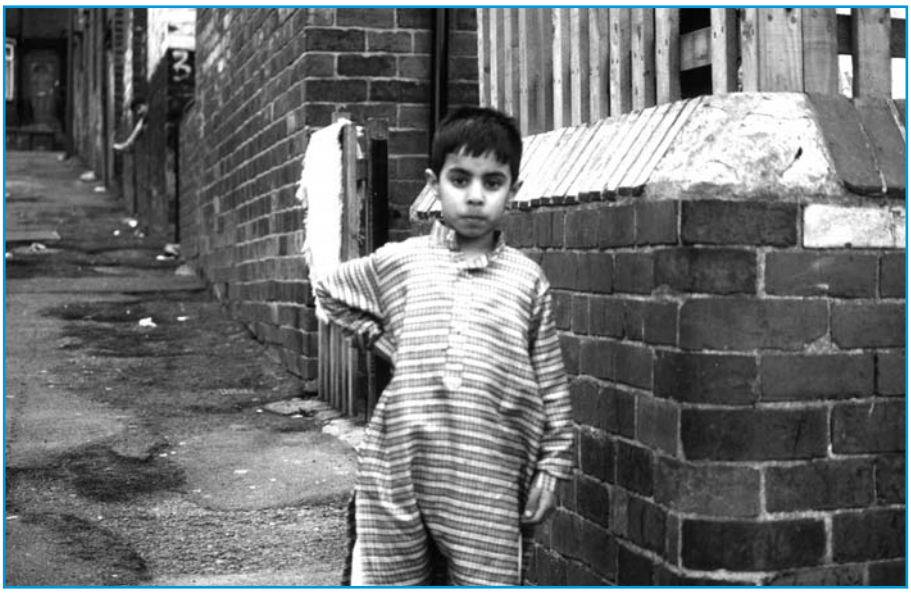

Figure 4. Leeds, 2000

IN BRITAIN THE ASSOCIATION between poverty and health has a long history. In the mid-19th century Edwin Chadwick's report to the Poor Law Commission showed that there were noticeable differences in mortality between the 'social orders'. In Manchester, for example, the average 'gentry and professional' could expect to live for 38 years, whereas 'farmers and tradesmen' lived for only 20 years and 'labourers and artisans' for 17 years (*Chadwick, 1842*). Despite the fact that there have been great improvements in absolute terms in health over the past two centuries, with life expectancy rising from around 40 in the 1840s to now being around 75 for men and 80 for women, inequalities in health persist (*Charlton and Murphy, 1997*). Moreover, differences in life expectancy by occupational social class have been widening in the past two decades; the life expectancy gap between professionals and unskilled manual workers is now 9.5 years for men, and 6.4 years for women (see Figure 1) (*Hattersley, 1999*).

LOCAL WORK

No 32 June 2001

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Photography by Mary Shaw

Local Work is published by the Centre for Local Economic Strategies, Ground Floor, Barclay House, 35 Whitworth Street West, Manchester M1 5NG

Tel: 0161 236 7036
Fax: 0161 236 1891
Email: info@cles.org.uk
Web: www.cles.org.uk
ISSN: 09503080

Editor: Pauline Sturges
Tel: 020 8761 1974
Email: paulinesturges@onetel.net.uk

Printed by Russell Press, Nottingham

Figure 1. Life expectancy from birth by occupational social class, men and women, 1992–96

Source: Adapted from Hattersley (1999)

Wealth, health and homelessness

FIGURE 1 SHOWS THE CLEAR social class differences (and also the stark gender pattern) to mortality in contemporary Britain. There is a social gradient to health: those in social class I (professionals) fare better than those in social class II (semi-professionals) who in turn fare better than those in social class IIIN (skilled non-manual workers), and so on. The worst health outcomes are consistently found in the poorest, most disadvantaged and socially excluded groups in society. Compounding on this the effects of social disadvantage accumulate over the lifecourse – the longer an individual lives in conditions of poverty and social exclusion, the more likely it is that there will be a detrimental effect on their health (*Shaw et al., 1999a*).

The health of the homeless is a prime example of how socio-economic disadvantage is 'written on the body'. In terms of morbidity, the homeless are far more likely to experience respiratory disease, alcohol and drug dependence, mental health problems and suicide, accidents and violence than the housed population. Research based on data from the mid-1990s estimated the average age of death of rough sleepers in London at 42; higher than the average life expectancy in only three of the world's poorest countries: Malawi, Uganda and Sierra Leone (*Shaw et al.,1999b*). Even in one of the richest countries of the world, social exclusion can have a grave effect on health.

Unemployment

UNEMPLOYMENT IS ANOTHER form of social exclusion which is 'bad for health'. Those who are unemployed have, in the main, low incomes, but unemployment also has effects on health independent of income. There is evidence that people who experience unemployment for more than a short period of time have an increased risk of adverse health outcomes. For example, Morris et al. (1994) found that compared to those who had been in continuous employment, those who had been unemployed at some point over the past five years were almost twice as likely to die in any year; this effect was found when factors such as social class and health-related behaviours (smoking, alcohol consumption and body weight) and also health status at the beginning of the five years had been taken into account. Those who experienced unemployment were thus not more likely to die just because they smoked more, nor because they were more likely to be in an unskilled job or because they were ill at the start of the five-year period. Instead, it appears that unemployment itself has a detrimental effect upon health.

Why is unemployment detrimental to health? Unemployment usually brings financial hardship, itself associated with poorer health; but it can also lead to social isolation and

Figure 2. Begging in London, 2000

loss of self-esteem. There are a number of benefits which people derive from work in addition to the financial reward: having a structure and purpose to the day, self-respect, the respect of others, physical and mental activity, use of skills, interpersonal contact and social status (*Bartley, 1994*). Crucially, it has also been found that the anticipation of job loss or job insecurity affects health (*Ferrie et al., 1998*).

Recent research conducted for the Joseph Rowntree Foundation has estimated that if full employment were attained in Britain, then 2,500 premature deaths would be avoided each year (see Table 1) (*Mitchell et al., 2000*). A mild redistribution of income and wealth would affect a greater proportion of the population, however, and prevent over 7,500 premature deaths annually.

Table 1. Potential lives that could be saved by successful implementation of three government policies in Britain (for ages less than 65)

	Total number of lives saved annually	Proportion of deaths <65
Mild redistribution of wealth	7,597	7%
Full employment achieved	2,504	2%
Child poverty eradicated (ages 0-14)	1,407	21%*
Total	11,509	10%

*Note these proportions refer only to deaths of children aged 0–14.

Source: Mitchell, et al. (2000)

Social exclusion, poverty and child health

The effects of social exclusion and poverty are particularly discernible when considering the health outcomes of children. Poverty, poor housing and unemployment all have an effect on maternal health, which in turn affects foetal health. Babies born to poorer families are more likely to be born prematurely and to be of low birth weight – this has a number of important implications, including a greater likelihood of impaired development, cerebral palsy, and of certain chronic diseases – including coronary heart disease, hypertension and diabetes – in later life (*Shaw et al., 2001*).

The children of poorer families are more likely to experience illness. There is evidence of a socio-economic gradient for the following conditions: infant and childhood respiratory infections, gastroenteritis, *helicobacter pylori* infection (an infection acquired in early life which is associated with increased risk of peptic ulcers and stomach cancer in later life), dental caries, tuberculosis and HIV (*Shaw et al., 2001*).

Injury and poisoning is now the major category of cause of death for children. Although the overall rates of death from these causes have been falling in the past couple of decades children whose parents do unskilled manual work are now five times more likely to die from injury or poisoning than children whose parents have professional occupations (*Roberts and Power, 1996*). Accidents in aggregate are not a matter of fate, but like other forms of morbidity and mortality are strongly related to factors of social organisation – children from poorer backgrounds are more likely to be injured and to die in road traffic accidents, even though their own parents are less likely to have a car.

Changes in the socio-economic profile of Britain in the past two decades have had a particular impact on households with children. In the past two decades the proportion of lone parent households, children in families with no earner and the proportion of households with children living in poverty have all increased (*Shaw et al., 1999a*). The recent Poverty and Social Exclusion Survey of Britain showed that 18 per cent of British children in 1999 were suffering from multiple deprivation, even after the sacrifices made by their parents.

What would be the health effect on Britain's burden of mortality of the eradication of child poverty – a policy goal which the current government aims to achieve by 2020? It has been estimate that if this goal were reached then 1,400 premature deaths would be avoided annually (see Table 1) (*Mitchell et al., 2000*).

Figure 3. Job centre

"18 per cent of British children in 1999 were suffering from multiple deprivation ... "

Health and social exclusion: recent policy developments

There are many encouraging signs that the current Labour government is serious about tackling social exclusion and its consequent health effects. For example, the Minister of Health, Alan Milburn, has stated that 'our ambition is to do something that no government – Tory or Labour – has ever done. Not only to improve the health of the nation, but also to improve the health of the worst off at a faster rate' (*Milburn, 1999*). Importantly, for the first time targets for the reduction of health inequalities were set in February 2001.

A tranche of policy initiatives have been aimed at tackling health inequalities and child poverty. Child Benefit has been raised from £11.05 to £15.50 (in April 2001) for the first child and changes in the child allowances for Income Related Benefits have also benefited households with children. Working Families Tax Credit has now been introduced and has had a great effect on improving the standards of living of children who are poor in families where an adult has work. However, the poorest children in our society and those most likely to suffer adverse health in the future are not growing up in families where an adult has work. There has been more progress on the first part of the slogan 'Work for those who can and security for those who can't' than on the second part.

By the time of the election there had been a substantial reduction in poverty, especially child poverty, reversing the trend of the 1980s and 1990s. By the end of its first term in office the Labour administration had lifted 1.23 million children out of poverty, mostly due to increases in child benefit and social assistance. These changes are partly a consequence of the buoyant economy and falling unemployment but also due to redistributive social policies.

> *"Our ambition is to do something that no government – Tory or Labour – has ever done. Not only to improve the health of the nation, but also to improve the health of the worst off at a faster rate."*
>
> *Alan Milburn*
> *Minister of Health*

However, these moves towards a fairer society, where fewer people live in poverty and social exclusion, could have been sooner, and faster. After five years in office, child poverty will have halved, but it will still be higher than when Labour last left office. If income tax had not been cut by 1p then a further 695,000 children could have been lifted out of poverty. The improved state of public finances allows greater latitude for anti-poverty measures. As Jonathan Bradshaw clearly states:

'In order to abolish child poverty, income support is going to need to rise faster than the rate of inflation, faster than the increase in earnings and include increases for older children. To avoid incentive problems child benefit would need to grow by the same amount. That means increases in taxation on those who can afford to pay.' (*Bradshaw, 2001:25*)

There is still much to be done.

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