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Health, Poverty and Social Inclusion in Europe:
literature review on concepts, relations and solutions
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EuroHealthNet, September 2003

HEALTH, POVERTY AND SOCIAL INCLUSION IN EUROPE
Literature review on concepts, relations and solutions

CONTENTS

EXECUTIVE SUMMARY

Health, Poverty and Social Exclusion in Europe

Health, Poverty and Social Exclusion are strongly inter-related concepts. The health field, in its efforts to tackle health inequalities, and the social sector share important objectives: to increase quality of life and to create a more inclusive and thereby just and productive society. Work in the two areas overlaps, and there are numerous ways in which closer collaboration between the health and social sector can strengthen and reinforce efforts being taken in this area. This literature review investigates how the health field can contribute to efforts to reduce social exclusion. In this way, it provides the theoretical background to a complementary report that analysis health issues in National Action Plans (NAPs) on Poverty and Social Exclusion and formulates recommendations for policy review. These reports are the result of a European project on tackling health inequalities and social exclusion that was funded by the European Commission.

Concepts

The review begins with a discussion on key concepts such as health inequalities, poverty, social exclusion and related terms. The EC Joint Report on Social Exclusion (2000) for example, defines it as "circumstances where people are prevented from participating fully in economic, social and civil life." The concept of social exclusion is broader than poverty, since it moves beyond the notion of poverty as a lack of cash income. Socio-economic inequalities health in turn, refer to a broad range of differences in both health experience and health status between socio-economic groups that are avoidable, unnecessary and unfair. The conditions that lead to social exclusion and socio-economic inequalities in health are complex and these issues can only be addressed through multi-sectoral and integrated approaches.

Relations

Exploring how the health sector can help address social exclusion requires an understanding of the ways that health, poverty and social exclusion are interrelated. The second part of this review therefore isolates and discusses these relations. Central to these relations are the determinants that influence health status, which can be grouped into material, behavioural or psychosocial factors. The latter determinants are clearly important to understanding the mechanisms that lead from social exclusion to ill health, while social environment plays an important role with respect to health-related behaviour. This section also discusses the situation of specific groups that face social exclusion, namely the elderly, the disabled, the mentally ill, refugees and immigrants and lone mothers, and illustrates the ways in which ill health can lead to social exclusion and how the experience of being excluded can lead to or compound ill health.

Solutions

The final part of the literature review introduces how the health field can contribute to efforts to reduce social exclusion. While the health field may not have a great deal of influence with respect to addressing the underlying structural causes of health inequalities and social exclusion, it can establish useful relationships and collaborate with other policy areas (education, employment, housing etc.) to improve people's health status. The section also includes a discussion on the current situation with respect to access to health care in the EU and improvements that can be made in this area. In addition, it provides examples of interventions being taken by the public health and health promotion field, such as the implementation of Health Action Zones in England, which include many projects that contribute to reducing social exclusion. Since greater awareness of complementary activities amongst the health and social sectors can help generate new ideas and maximize resources, a more systematic and sustainable exchange of information amongst EU Member States in this area is recommended.

INTRODUCTION

This literature review will analyse the complex ways in which poverty, social exclusion and health are interrelated. The analysis will serve to reflect how the public health sector, in its efforts to tackle health inequalities, and the social policy sector can join forces in their common effort to achieve what is, in essence, a common objective: to create a more inclusive and thereby just and productive society.

This review is part of a European Union (EU) project on "tackling health inequalities and social exclusion" health inequalities and social exclusion (December 2002 – August 2003), funded by the European Commission (EC) (DG Employment and Social Affairs) under its Action Programme to Combat Social Exclusion. EuroHealthNet, in collaboration with the Netherlands Institute for Health Promotion and Disease Prevention (NIGZ) coordinated this project. The objectives of this project are (1) to contribute to the European Open Method of Coordination on social inclusion, from a public health and health promotion perspective and (2) to exchange information on public health-related measures to tackle health inequalities and social exclusion between EU countries and regions. Project partners are national public health institutes or health promotion institutes in Austria, Belgium, England, Estonia, Germany, Italy, Malta, the Netherlands, Scotland, Spain and Sweden.

This literature review provides the theoretical foundations for a report that analyses health issues in National Action Plans (NAPs) on Poverty and Social Exclusion and formulates recommendations for a policy review[1], and is complimentary to this report. The review is based on literature recommended by project partners and other public health professionals as well as documents found through an Internet search using key terms. It is also based on relevant publications by EU Institutions and Agencies as well as on the work of European networks active in the field of Social Policy and Health. The review represents the results of an initial exploration into key concepts, relations and solutions. It is hoped that this information can be applied, further developed and consolidated in a following phase of this project.

The review is divided into three sections. The first section will provide definitions of the key concepts that will be addressed. The second section will analyse the relations between poverty, social exclusion and health, focussing in particular, on the relationship between health and social exclusion. The final section, which includes a discussion on access to health care, provides some examples of ways in which the health field can contribute to reducing levels of social exclusion and highlights where the social sector and the health field can work together to achieve common objectives.

[1] Health, Poverty and Social Inclusion in Europe: Health analysis of national action plans on social inclusion. EuroHealthNet, C.Costongs and I.Stegeman, September 2003.

SECTION I: LEADING CONCEPTS

The following are definitions of the key concepts that will be analysed in this report.
While poverty, social exclusion and socio-economic health inequalities have only recently been identified as problems in Europe, interest and knowledge in these areas are rapidly expanding. There is however no clear consensus regarding the meaning of these, and associated terms, and they are a source of constant debate, since definitions can have important political implications. The following concepts and definitions should therefore not be regarded as authoritative; they provide an indication of current ways of thinking in this area.

1.1 Health

Health is an elusive concept that is hard to define and ways of thinking about it have evolved over the years. Two important approaches include the 'medical model' and the 'holistic model'. A medical definition of health sees it as being the absence of disease, or as "the state of being whole and free from physical and mental disease or pain, so that all parts of the body carry on their proper function." In its extreme form this model views the body as a machine, to be fixed when broken and emphasizes treating specific physical diseases. The advantage of this medical model is that disease represents a crucial issue facing society, and disease states are readily diagnosed and counted. The disadvantage, however, is that it is a negative and quite narrow conception of health, which implies that health is only about physical and mental disease and mortality and that, for example, people with disabilities are 'unhealthy'.

A more positive conception of health is the WHO definition that was adopted in 1947 which sees it as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This conception of health is much broader than the medical model perspective, since it also emphasises people's personal and social resources and ability to make choices in life, identify and realise aspirations, satisfy needs and change and cope with their environment. The 1986 Ottowa Charter for Health Promotion, in this light, moved away from the original WHO definition, which regards health as a state, towards viewing it as a dynamic process or a force. It defines health as "a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life." This definition also holds that "health is a resource for everyday life, not the object of living". The disadvantage of these conceptions is that they run the risk of excessive breadth. They have therefore been criticised for not being measurable and too vague (Individual and Population Health website of the University of Ottowa). The WHO definition of health is nevertheless widely accepted by the health community.

1.2 Health promotion

The Ottowa Charter for Health Promotion (1986) defines health promotion as the process of enabling people to increase control over, and to improve their health. It represents a comprehensive social and political process it not only entails actions directed at strengthening the skills and capabilities of individuals but also involves action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. Participation is essential to sustain health promotion action (WHO, 1998).

This definition reveals that health promotion differs from prevention or risk reduction interventions by being broader and non-specific. Health promotion does not target a single factor or disease, but instead tries to establish the person's own ability to improve their health. It seeks to create a context in which health can evolve spontaneously. If diseases are also prevented so much the better, but this is a by-product rather than the principal goal (Individual and Population Health website of the University of Ottowa).

1.3 Socio-economic inequalities in health

Socio-economic inequalities in health refer to a broad range of differences in both health experience and health status between countries, regions and socio-economic groups. In many European countries, for example, people in higher socio-economic groups can expect to live 15 years longer in good health than people in lower socio-economic groups. Almost all important health problems are more prevalent among people with a low education, professional status and income. Several factors cause these inequalities in health: life style, housing, income and economic situation, social conditions and access to appropriate care. These factors are closely connected.

Whitehead (1990) defines inequitable distributions of health as those that are '**avoidable, unnecessary and unfair**'. Differences in health resulting from health damaging behaviour not freely chosen or from exposure to health hazards in the environment or from impaired access to healthcare services will be perceived as 'unfair' and also potentially avoidable (Whitehead in Machenback and Bakker eds., 2002).The fact that there are systematic differences in smoking, drinking, nutritional and exercise patterns between people with higher and lower social-economic status reveals that these aren't the result of individual choice. These behavioural patterns are influenced by factors that individuals can't control (low incomes, unemployment, shared perceptions). Policy in this area should therefore focus on ensuring that individuals are truly able to take responsibility for their own health (ZorgOnderzoek Nederland, 2001).

1.4 Poverty

Poverty refers to a lack of resources needed to maintain an acceptable standard of living. There is much discussion around how poverty should be conceptualised ('absolute' or 'relative') and on how it can best be measured (on the basis of income, on the basis of a lack of socially perceived necessities, or on the basis of subjective feelings of need).

Poverty is most commonly defined and measured by means of a monetary approach, which identifies it as a shortfall of consumption (or income) from a defined poverty line. The European Commission defines the relative poverty rate as persons living below a threshold of 60% of median national income.

This definition and measure of poverty has, however, been criticised for being too limited. It confines poverty to material aspects of life and excludes social, cultural and political aspects that also determine individual living standards. Sen (2001) for example, believes that income

is not the only measure of well-being, and that indicators of poverty should focus on freedom of individuals to live lives that are valued (termed the capability of the individual) i.e. the realisation of human potential. Sen, therefore, defines poverty as the failure to achieve certain minimal or basic capabilities, which are defined as the ability to satisfy fundamental needs and desires. Monetary resources may not be a reliable indicator of capability outcomes because of differences individuals face in transforming those resources into valuable achievements – differences that depend on different individual characteristics (including age, gender, physical capacities, etc). In addition, besides private monetary income, publicly provided goods and services, as well as the individual's personal characteristics and the general environmental context help determine an individual's capabilities and their ability to employ them. Monetary resources, therefore, remain instrumentally related to the achievement of well-being (or conversely, of poverty) but are not the only influencing factor. Sen's framework emphasises the adequacy of monetary and other resources for the achievement of certain capabilities rather than their sufficiency (Sen in Ruggeri *et al*., 2003).

An individual or family's **socio economic status (SES)** reflects their relative position in society. This relative position is operationally defined by indicators such as educational attainment, occupation, income and house or car ownership. These variables are therefore considered to provide a good indication of the likelihood that they will be exposed to health damaging factors or possess particular health enhancing resources (Lynch and Kaplan, 2000). This paper will therefore use the terms poverty and a low socio economic status interchangeably.

1.5 Social exclusion and social inclusion

The concept of social exclusion was developed in industrialised countries to describe the processes of marginalisation and deprivation that can arise even within rich countries with comprehensive welfare provisions. The first use of the term has been attributed to Lenoir, the French Secretary of State for Social Action in Government in 1974. He used the term to refer to people who did not fit into the norms of industrial societies, were not protected by social insurance, and were considered social misfits. This included groups such as the elderly, the disabled, drug users and delinquents, and was estimated to account for one-tenth of the French population. The concept now forms a central aspect of EU social policy; several European Council decisions (starting with the Lisbon Council of March 2000) have adopted strategic goals and political processes aimed at countering the risk of poverty and social exclusion. Social exclusion is defined in the EC Joint Report on Social Inclusion (2001) as 'circumstances where people are prevented from participating fully in economic, social and civil life'. It also refers to individuals 'whose income and other resources (personal, family, social and cultural) is so inadequate as to exclude them from enjoying a standard of living and quality of life that is regarded as acceptable by the society in which they live. Thus, a person is considered excluded if he or she is a resident of a society, but for reasons beyond his/her control cannot participate in normal activities of citizens in that society. There is some question as to whether those who choose to be excluded should fall under this category (Le Grand in Ruggeri Laderchi *et al*., 2003).

Atkinson (1998) has identified three main characteristics of social exclusion: relativity (i.e. exclusion is relative to a particular society); agency (i.e. are excluded as a result of the attitudes and actions of others); and dynamics (i.e. future prospects are relevant as well as current circumstances) (Atkinson in C. Ruggeri Laderchi *et al*., 2003). This latter characteristic also reflects that the consequences of social exclusion compound one another. As stated in a Eurostat Task Force document (1998) "some disadvantages lead to some exclusion, which in turn leads to more disadvantages and more exclusion and ends up with persistent multiple (deprivation) disadvantages."

Changes in the political and economic contexts in which countries function today have expanded the groups of people defined as 'socially excluded'. A report on the Europromed Project (1999) identifies three very broad categories of people at risk of exclusion: those 'without' (papers, permanent housing, rights, etc.) the 'outlaws' (drug abusers, prisoners, sex workers) and the 'un-categorised; those whose situation does not fit into the framework of social protection and care systems, such as migrants, refugees, asylum seekers and the Roma. Today, the concept of exclusion is more widespread than ever, since it incorporates economic exclusion and the process of alienation it engenders. The term 'excluded' now refers primarily to those suffering extreme poverty, those on state income support, the long-term unemployed, young people, etc., in short, to all the new categories of society that are experiencing difficulties due to the sweeping economic and social changes that have taken place since the 1980s (Serge Ebersold, 2003).

The exact ways in which countries define and address social exclusion differ, and depend on the prevailing political views regarding the nature of the state's responsibility to the individual (D'Ambrosio *et al.*, 2002). Nevertheless, EU Member States agreed, during the Laeken European Council in 2001, on 18 common indicators for social inclusion to allow progress in this area to be monitored and compared. These indicators cover four important dimensions of social inclusion (income poverty, employment, health and education) which reflect the dynamic and multidimensional aspects of social exclusion. They are grouped into ten primary indicators to cover the most important elements identified as leading to social exclusion, and eight secondary indicators to describe other dimensions of the problem (Dennis and Guio, 2003).

Social Inclusion concerns the ways in which social exclusion can be overcome. These can include changes in law, changes in the policies and practices of organisations and institutions, support for communities, provisions and appropriate or improved services, increasing employment and educational or training opportunities and improvements in access to services (Lothian Anti Poverty Alliance, 2001).
Sen (2001) writes that "(social) inclusion is characterised by a society's widely shared social experience and active participation, by a broad equality of opportunities and life chances for individuals and by the achievement of a basic level of well-being for all citizens."

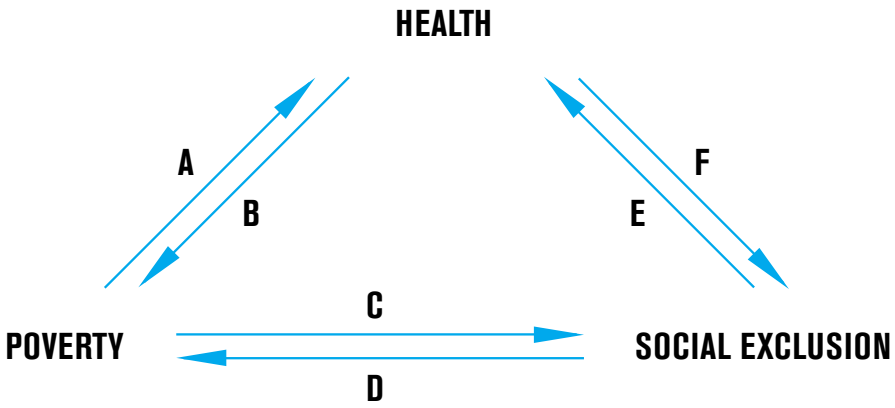
[2] Social Policy Agenda COM(2000) 379 final of 28.6.2000

[3] Mid-term review of the Social Policy Agenda, COM(2003) 312 final of 2.6.2003

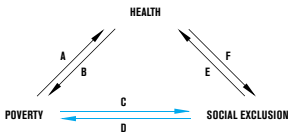
[4] The term social exclusion refers to circumstances where people are prevented from participating fully in economic, social and civil life and / or when their access to income and other resources (personal, family, social and cultural) is so inadequate as to exclude them from enjoying a standard of living and quality of life that is regarded as acceptable by the society in which they live (EC Joint Report on Social Inclusion 2001).

[5] Strenghtening the social dimension of the Lisbon Strategy: Streamlining open coordination in the field of social protection. COM (2003) yyy final.

SECTION II: RELATIONS



Poverty, social exclusion and health are tightly inter-related. The conditions reflected by the different corners of the diagram above can be a cause or a consequence of the others and the relations amongst the three can be cyclical. Thus, for example, many of the mechanisms leading to and perpetuating poverty and social exclusion are related to health. This section will outline and elaborate upon the nature of these relations. The analysis will serve in particular, to develop a better understanding of the relation between social exclusion and health.



2.1 Poverty and Social Exclusion (links C and D)

As noted in the first section, the concept of social exclusion is broader than poverty. It takes a more relativistic view of poverty and relates it to unfavourable living conditions and to multidimensional deprivation, thereby moving beyond the narrow notion of poverty as a lack of cash income. Empirical work points to causal connections between different dimensions of exclusion, e.g. between employment and income, housing and employment, formal sector employment and insurance. Therefore multidimensionality, or being deprived in more than one, and perhaps many, dimensions is an intrinsic feature of social exclusion. Many pathways can therefore be outlined that lead from poverty to social exclusion and vice-versa.

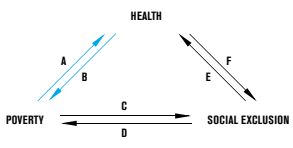
Poverty, defined as a lack of monetary income, can be a cause of social exclusion, as income poor people may become increasingly excluded due to a lack of resources or due to shame. Therefore, persons in a low-income household appear to be much more frequently

disadvantaged in non-monetary terms than the rest of the population (EC Joint Report on Social Inclusion, 2001).
Yet poverty is not the only indicator of social exclusion. There are people who are not poor, who receive social benefits, or who own assets that place them above the relative poverty line, but who can still be considered socially excluded. However factors such as health conditions, level of security at work, the need for extra care for elderly or disabled members of the household, etc, may lead to not being able to satisfy at least one of the needs identified as basic. Thus, there are groups of people who may not be income poor, but may be socially excluded.

Social exclusion can, in turn, lead to poverty. People who are discriminated on the basis of disability, race, gender, or age may not be able to or may not get the opportunity to engage in economic activities and, as such, may fall into income poverty (Ruggeri Laderchi *et al*., 2003). Exclusion from labour market activities therefore, to a large extent, leads to social exclusion since this limits income as well as social contact. This is verified by a report on Social Exclusion in the EU. (D'Ambrosio *et al*., 2002) The report found that the looser the links of the individual household with the labour market, in the form of unemployment, precarious employment or the existence of various barriers to labour market participation, the higher the risk of social exclusion in comparison to the rest of the population. Three groups that were found to face a high risk of social exclusion in comparison to the rest of the population in almost all EU countries are immigrants, the elderly, and members of lone parent households, although this varied considerably from country to country. These groups all, for different reasons, have limited access to labour market activities.

Involvement in the labour market activities does not however, automatically infer social inclusion. The extent to which secure and uninterrupted employment provides a shield against poverty and social exclusion has been found to vary a lot across countries. McKnight (in CASEbrief 23, 2002) notes that in the UK, for example, work in 1996 was less likely to protect a household from poverty than in 1968. Part of this is due to an increase in the share of households solely dependent on a low-paid employee and an increase in the likelihood of poverty in such households. Educational qualifications seem to be a better guarantee against social exclusion than employment: the higher the educational qualifications of the individual or the household's reference person, the lower the risk of social exclusion This has been found to be true for all EU Member-States (D'Ambrosio *et al*., 2002).

Although there is a close relation between poverty and social exclusion, this does not mean that one has to lead automatically to the other. While poverty can lead to and is often paired with social exclusion, the poor are not by definition socially excluded. There are, for example, people who are income poor but who are not necessarily socially excluded and who participate actively in their community. Bradshaw et al (2002) have accordingly made a distinction between four dimensions of social exclusion: impoverishment or exclusion from adequate income or resources labour market exclusion service exclusion (lack of basic services in the home and outside of it); and exclusion from social relations, which can be examined through non-participation in social activities with family and friends, isolation and lack of support, civic disengagement and confinement. Similarly, empirical work in the UK indicated that relatively low proportions of people excluded on one dimension were also excluded on another dimension. Of those who were not engaged in the labour market, almost 40% also had a low income, but less than a fifth were politically disengaged or socially isolated (Burchardt *et al*. in Ruggeri Laderchi *et al*., 2003).



2.2 Poverty and Health (links A and B)

Health plays an important role in the pathways that lead from poverty to social exclusion and

vice versa. There is a very strong association between poverty and health that is evident from the results of a great deal of research that has been conducted over the past 15 years, which reflects a marked correlation between socio-economic status (SES) and health. This research has revealed a graded association SES is important to health not only for those in poverty, but at all levels of SES. On average, the more advantaged the individuals, the better their health – whether measured in terms of disease and mortality or in terms of self-assessed physical and psycho-social health (Power *et al*., in Graham, 2000).

A wide range of research verifies these findings. Some examples of research conducted and the results are as follows:

- In France, at the age of 35, there is nearly 10 years difference in life expectancy between engineers and labourers (Europromed Project, 1999).

- In Sweden, the mortality risk of the homeless under 40 years of age is 9 times higher than among the general population (Europromed Project, 1999).

- In Ireland, mortality rates in the lowest socio-economic groups are over 100% higher than in the highest socio-economic groups for all major causes of death (Institute of Public Health, 2001).

- Among men in the UK, death rates from Coronary Heart Disease (CHD), which is the leading single cause of death in the UK, are about 40% higher among manual workers than among non-manual workers. The death rate for wives of manual workers is about twice the rate for wives of non-manual workers. Like mortality, morbidity from CHD also displays a socio-economic gradient, with angina and heart attacks more common among manual than non-manual groups. (Graham, 2000).

- A recent study in Denmark revealed that social position and educational levels have a profound impact on the chance of dying from lung disease. Researchers found that men and women who spent the fewest years in education ran the highest risk of lung problems. Those who finished secondary school saw their risk of dying from lung disease fall by almost 90 per cent for women and 70 per cent for men, even when other factors were taken into account. For men, economic factors are important too, with blue-collar workers being twice as likely to die from lung disease as white-collar workers. This link was not simply related to higher levels of smoking among people with a lower socio-economic status, since the relationship persists even when smoking is accounted for. The study found that smoking and low socio-economic status compound one another - with a heavy smoker who left school at the earliest opportunity being 15 times more likely to die of lung disease than a non-smoker who finished secondary school (Prescott, 2003).

- The risk of becoming disabled is much higher among people who are poorer, less educated and of lower social status (Deaton, 2002).

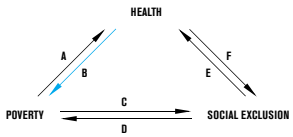
- The association between socio-economic status and rates of morbidity and mortality exist among all ages. A table showing 'social class inequalities in symptoms among children in Germany, ages 11-15 indicates a very clear correlation between incidences of headache, backache, poor sleep, helplessness and loneliness and social class gradient (Lynch, 2002).

- People from lower socio-economic groups are less likely to act to prevent or detect disease at an a-symptomatic state. Disparities in risks for chronic diseases and injuries are therefore evident across social groupings or among racial groups within countries (Bennett, 2003).

A relation between low SES and health is therefore clearly apparent. The EC Joint Report on Social Inclusion (2002) states, for example, that: there is a widespread understanding that poor health is both a cause and a consequence of wider socio-economic difficulties. The

overall health status of the population tends to be weaker in lower income groups. The percentage of people claiming their health to be (very) bad was significantly higher for those below the poverty line than for those above it in the EU as a whole (13% and 9% respectively) as well as in all Member States.

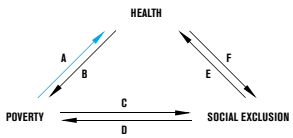
While a great deal of research has been undertaken that identifies the relationship between health and socio-economic status, it is much more difficult to find evidence of measures which reduces socio-economic health inequalities. This requires an understanding of the mechanisms that are generating these health differences.



2.2.1 Health Selection (link B)

One way to explain the relationship between health and low socio-economic status is referred to as the selection theory, which holds that a person's socio-economic status is determined by their health (health selection). Health selection is generally regarded as playing a more modest role in contributing to the socio-economic gradient than 'health causation'. This finding is supported by research that was recently conducted into the relation between health status and social mobility. People born in 1958 were followed at different stages of their lives (16, 23, 33 years). Individuals with poor health were more likely to move down and less likely to move up the social scale. Yet the paper concluded that the effect of health selection on the social gradient was variable, of modest size and cannot be regarded as a major explanation for inequalities in health in early adulthood (O Manor *et al*., 2003).

Other authors note, however, that the importance of health selection is undervalued. Deaton (2000) for example, writes that "it is unfortunate and divisive that much of the public health literature on the [health inequalities] gradient takes the position that the effects of health on socio-economic status … are negligible." He states that economists and others have documented the effects of health on earnings in many contexts. One example of this is a study that explores whether the financial burden off ill health leads to poverty. The study sketches theoretical reasons why health may alter household savings and provides evidence of the effects of long and short-term illness and disability on household wealth. The impacts on saving are quantitatively large and are only partly explained by increased out-of-pocket medical expenses. Reduced earnings due to inability to work or care-taking duties and a change in life expectancy also play a role in pathways that lead from ill health to poverty (Smith, 1999).



2.2.2 Health Causation (link A)

The second way to explain the relation between health and poverty is that the conditions of poverty result in poor health and premature death (health causation). In other words, those with a higher socio-economic status are more likely to have better health and to move up the occupational ladder, amplifying the health advantages associated with higher socio-economic status. On the other hand, the circumstances of living in poverty compound one another and are likely to increase the rates of morbidity and mortality in lower socio-economic groups (Graham, 2000).

The causation theory necessitates an understanding of the factors that influence health and the ways in which they promote or break down health.

It is widely recognised that there are many different determinants that interact in a complex fashion to affect health. A comprehensive analysis of these determinants and pathways include macroeconomic contexts and social factors as well as more immediate social environments (Alder and Ostrove, 1999). Graham groups them under three broad headings: material, behavioural and psychosocial factors, although she notes that many health determinants fall between and across these categories.

Material factors. An individual's health is in large part determined by the conditions of their physical environment, home, neighbourhood, work and living standards secured through earnings (income). Areas populated by poorer people score higher on material hazards like environmental pollution, traffic volume and rates of road traffic accidents. In addition, the housing conditions of the poor are more likely to be bad with respect to damp, temperature, ventilation, crowding and access to amenities, and there are fewer resources such as shops, recreational facilities, public transport and primary healthcare services. Those on low incomes can afford less of the more appealing forms of healthy food and are often employed in the most heavy and hazardous industries (Berney *et al*., in Graham ed., 2000). Such conditions are likely to have a negative influence on their health, as physical and social environmental conditions may promote or damage residents' physical health directly or affect their psychological well-being.

A study by Macintyre *et al*. (1998) for example, confirms that people who rent homes are both poorer and in poorer health than home owners. This may be because renters tend to live in homes and neighbourhoods that contain more health hazards (noise, disrepair) and fewer health resources (gardens, safe play spaces). Research has also revealed that whether or not an individual rents his/her house is more strongly predictive of mortality than social class. Even individuals of higher SES living in lower SES areas were more at risk of mortality than those living in more well-to-do areas (Macintyre *et al*., in Graham ed., 2000). One of the key findings of a comprehensive longitudinal study conducted in Britain was that the impact of multiple housing deprivation would appear to be in the same order of magnitude as addressing the issue of smoking and the risk seems greater, on average, than that posed by excessive alcohol consumption (Macintyre *et al*., in Graham ed., 2000).

Behavioural factors. Health related routines and behaviours also determine an individual's health. Thus, poor people have been found to have less healthy diets and they are more likely to smoke and to engage less in physical activity. In addition, poor people who are ill find it more difficult to conform to complicated and time-intensive regimes, such as for diabetes, HIV, or multi-drug-resistant tuberculosis (Deaton, 2000).

There are many explanations why poorer people are less likely to adopt healthy lifestyles, many of which point to psycho-social mechanisms that will be discussed further below. A study in the Netherlands attributes a lack of health enhancing behaviours, such as engaging in physical exercise to 'parochial', or traditional and irrational attitudes. This entails that people with low socio-economic status have less confidence in the effect of their own behaviour on health and in their ability to influence their health or life, which can lead to passiveness. In addition there is evidence that stress and a perceived lack of future prospects associated with income deprivation lead people to engage in harmful behaviours.

People's behaviour can also, to an important degree, be influenced by their social environment, as people with comparable incomes may come to adopt the same patterns of beliefs, values and leisure activities as a way of acquiring or maintaining acceptance within a status group. Those with more disposable income may, for example, use it to engage in 'conspicuous consumption' to advertise their privilege. Social groups, including people with lower income, may also adopt symbolically significant activities or forms of consumption, in some cases perhaps enabling them to display their rejection of the lifestyle of those who are better off. This helps to understand the importance of financial and non-financial factors in

enabling people to adopt 'healthy behaviour'. It costs nothing to follow a diet or exercise regime at home, suggesting that income alone does not explain social differences in leisure preferences. These practices seem to be undertaken in part as a way of expressing or seeking membership of certain social groups and social distance or differentiation from others (Bartley *et al*., in Graham ed. 2000). Material conditions are therefore interpreted (given a social meaning) by groups of individuals who form 'counter cultures' or networks of solidarity as a way of enhancing their self-esteem and buffering against stress.
Deaton (2000) notes that health-related behaviours only comprise 10-30% of the causes of health inequalities, suggesting that material and psychosocial factors play a more important role. There is also a widespread belief that policies and interventions that aim to change behaviour should be paired with policies and interventions that also change the overall structural characteristics in which people live (Stronk 2000) (Deaton 2000).

Psychosocial factors. The ways in which behaviours lead to bad health are very closely associated with psychosocial determinants - or by the individual's sense of self-perception, which is influenced by their environment as well as their sense of control over their work and lives. Material deprivation may also lead to ill health through psychosocial pathways, with inequity causing social exclusion, loss of control and low self-esteem, which can in turn, as will be discussed below, lead to biological problems such as raised cortisol, altered blood-pressure responses, and decreased immunity (Moris,1997).

There is much evidence to support that health can be significantly impacted through such psychosocial pathways, particularly by way of self-perceived social status. This has been indicated by laboratory experiments with monkeys, which revealed that an individual's social rank could act as protection against experimentally induced infection. Animals that were lower in the social hierarchy secreted higher levels of cortisol, had higher blood pressure and lower immunity and more commonly had central obesity. In addition their ratios of high-density lipoproteins and low-density lipoproteins were less good, even when they were fed the same diet. There is also evidence that the manipulation of socio-economic status has biological consequences. When the same monkey experienced a different rank, when the monkey groups were shuffled, the monkey's rank, not its identity, predicted the protection it received. In experiments in which social status was manipulated, subordinate monkeys "received more aggression, engaged in less affiliation, and spent more time alone than dominants … they spent more time fearfully scanning the social environment and displayed more behavioural depression than dominants." Loss of social status that resulted from being moved to a place with more dominant animals was associated with fivefold increases in coronary artery sclerosis (Wilkinson, 1997).

This association between social status and psychological and physiological well being also holds true for humans. Longtitudinal studies amongst British civil servants, (Whitehall I and II studies) reflect similar conclusions: the Whitehall II study revealed that the most powerful predictor of good health was not necessarily income, but position in the occupational hierarchy. Having a lower social status was found to adverse physiological affects, and has been associated with lower rations of high to low-density lipoproteins, obesity and higher fibrinogen concentrations (Wilkinson, 1997). Such findings lead to the conclusion that, as Brunner (in Graham ed., 2000) states, "to perceive oneself as 'inferior' or subservient activates biological responses that, over the long term, increase vulnerability to heart disease and other serious illnesses." The psychological effects of perceived social status and also helps explain why, during the 1980s, when Britain had greater increase in inequality than other developed market economies, deaths among young men due to suicide, AIDS, violence and cirrhosis (liver disease) increased (Wilkinson, 1997).

Self-efficacy

The term *self-efficacy* means the degree to which a person feels in control over important aspects of his or her life. Many studies have revealed that there are links between levels of self-efficacy and health. People who have a low socio-economic status also have less sense of control over their lives and their work. This affects the likelihood that they will engage in health-enhancing behaviour: the greater one's sense of perceived control, the more likely one is to engage in behaviours that are beneficial to health. In addition, low levels of perceived self-efficacy may lead to anxiety and stress, and have an impact on health through a range of health damaging stress-related behaviours and biological processes (Campbell *et al*., 1999).

In this context, Bartley *et al*., (in Graham ed., 2000) cite a number of studies that indicate that conditions and relationships at work can cause psychological ill health and that these factors can also lead to heart disease. Central to this relationship is sense of 'work control', or the degree of power that other people have over the conduct of an individual's working day. The studies found that the poorer health of those who had a low sense of work control could not be explained by factors such as different lifestyles in terms of diet, leisure or smoking. This suggests that individuals were not themselves responsible for the effects of low work control on health. It implies, instead, that the effect may be produced by bio-psychosocial process in which stress caused by low control and monotony at work induces changes both in mood and in blood chemistry (Bartley *et al*., in Graham ed., 2000). In addition, people who reported feelings of low control at home and over life circumstances in general had an increased risk of depression. This has been shown to be particularly apparent in women in low status jobs (Marmot, 2001).

There is also evidence to suggest that work that is insufficiently credited can lead to ill health. The so-called 'effort-reward imbalance model' holds that high efforts at work that are not adequately remunerated in terms of finances, peer gratitude and respect, or promotion can lead to stress. Many studies have indicated that this type of stress is associated with adverse physical and mental health (Siegrist, 2002). It is likely that working hard without being offered an adequate salary promotion, job security and prospects of a promotion is more frequent among lower socio-economic groups.

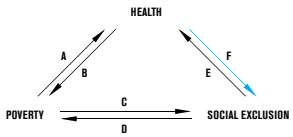
Studies have also indicated that individual's ability to manage stressful environments may also vary between socio economic groups. People with lower SES have been found to have more immediate adverse physiological reactions to stressful situations (Steptoe et al, 2002) and to have fewer resources to cope psychologically (Kristenson et al, 2003). This could be due to the fact that people with lower SES are confronted more often with stressful situations.

The findings that sense of status, sense of control and 'effort-reward' imbalances may be more important than actual material conditions in determining health outcomes can explain why there is little relationship between average income and life expectancy between rich countries, while there is a close relationship amongst these factors within countries. Wilkinson (2002) concludes that this is because income is a measure of status -or relative position- within a country, which is in turn related to mortality. It also helps explain why, as Bennett (2003) notes, as economies grow, benchmarking levels of absolute poverty are often surpassed while the health effects of poverty remain. The evidence that suggests that inequity in health and relative deprivation is more important than absolute deprivation may shed light on why inequalities in health persist, despite an overall increase in income levels.

Conclusion

There are many determinants of health, grouped here under the headings of material, behavioural and psychosocial factors, which indicate how poverty can lead to ill health, and ill health to poverty. These determinants do not work in isolation of one another – and often, in fact, compound one another. Psychosocial determinants, which can lead to physiological

responses, are clearly important in understanding and accounting for the health differences that exist between individuals of different socio-economic status in relatively wealthy societies.



2.3 Impact of Health on Social Exclusion (Link F)

The mechanisms described above which lead to the associations between poverty and ill health are, in many cases, similar to those that link social exclusion to ill health. As discussed in section one, social exclusion is socially defined, and is often a characteristic of groups – the elderly, disabled, racial or ethnic categories. Often, social exclusion occurs as a direct result of health problems or physical limitations. This section will therefore explore how ill health can lead to and intensify the isolation of specific groups.

Elderly

One group of people amongst whom ill health can lead to social exclusion is the elderly. According to Eurostat's "The Social Situation in the European Union 2002" 20% of people over 65 in the 15 Member States of the EU are at risk of poverty: in one country more than 40% are at risk, and in two others over 30% (Age Platform, 2003). D'Ambrosio *et al*. (2002) have found that there are considerable cross-country differences with respect to the relative risk of social exclusion of older persons in the EU. While the elderly in most EU countries face a risk of social exclusion that is average or below average, the elderly in a number of southern countries face a risk of exclusion that is substantially higher than average. This is perhaps because northern countries were the first to face the profound social transformations taking place throughout EU, which have altered family structures and care-taking roles, and have adapted more quickly to accommodate these changes.

The elderly are prone to social exclusion for a number of interrelated reasons. Health tends to deteriorate with age older people therefore face a greater risk of becoming marginalized, since public life is not suited to the needs of the elderly and the sick. The elderly are often confronted by 'ageism', a particular form of social prejudice that excludes the old from social activities. In addition, elderly people loose their social role, since they no longer have professional or parental duties, while their social circle diminishes due to sickness or death of spouses, friends and relatives. As a result they may feel useless and unimportant. In addition, the material resources of people may diminish following retirement, which can also affect their ability to engage in social involvements and activities. Due to the gender income gap, elderly women run a greater risk of becoming socially excluded than men (MEPESE, 2003).

Socio economic inequalities by education and income have been found to exist among the elderly in countries in eleven European countries (Huisman *et al*., 2003). In this regard, Deaton (2000) notes that ill health is often the hidden cause of early retirement, which, in turn, leads to a loss of material resources and increases the chances of social exclusion. In many such cases 'life course' influences (discussed below) are clearly apparent, since the illnesses that provoke early retirement are much less likely amongst the rich and well educated.

Chronically ill and disabled

Another important group of people for whom ill health can clearly lead to poverty and social exclusion are the chronically ill and disabled. According to a recent fact sheet produced by the European Foundation for the Improvement of Living and Working Conditions (OSHA, 2003) chronic illness or disability affects 17% of Europe's general population and about 15% of the working age population. Six per cent of the working age population claim disability benefits. The OSHA publication notes that people with chronic illness and disabilities are

frequently regarded solely as objects of care, and that they are often segregated from mainstream society at an early stage.

As a result, disability and chronic (long term) illness is a major cause of low income and poverty. Several studies conducted in Europe and elsewhere have concluded that disabled people are particularly vulnerable to social exclusion and that the average family income is substantially lower for a household with a disabled person. This is because disabled and chronically ill people have lower levels of income and education, while they often have to pay high medical costs. The OSHA publication notes that disabled people have twice the rate of non-participation in the labour force than people without disabilities of working age. In addition, the unemployment rate of persons with a disability is about three times the level of non-disabled persons, while people with an illness or disability receive a lower wage than the non-disabled. The report also notes that disability is more common among blue-collar workers, since they have more exposure to conditions that have adverse health effects.

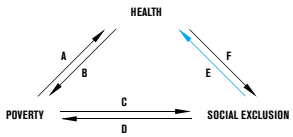
The results of a report by the European Disability Forum (2002), based on a survey on disability conducted throughout Europe, reinforce that disability is one of the factors leading to poverty and social exclusion. The report underscores the multidimensional nature of poverty and social exclusion affecting disabled people and highlights that the main factors of exclusion for disabled people are linked to unemployment and barriers to the social environment, stigmatisation, lack or limited access to goods and services and inadequate education and training. This is followed by lack of economic policies to compensate for the extra cost of disability, the structure of the benefit system and finally living in an institution. The report also notes that a clear correlation exists between the severity of the impairment and the degree of poverty and exclusion. While disabled people living in institutions do not generally encounter extreme financial poverty, they do, in many cases, experience extreme social exclusion.

Mental health problems

Mental health problems are a form of disability prevalent amongst a number of socially excluded groups. According to the results of the Eurobarometer report (2003) on Mental Health and the European Population, 25% of Europeans suffer from mental health problems (depression, schizophrenia, etc). Once mental health problems develop, they can have a negative impact on employability, housing, household income, opportunities to access services and social networks - potentially leading to economic deprivation and social exclusion. This is evidenced by the fact that eight out of ten homeless people, for example, suffer from schizophrenia (Bourin in Van Remoortel, 2003). There is little knowledge of mental health issues in schools and universities, and early detection and support mechanisms are almost non-existent. As a result, many people with mental illness do not complete their studies and 15% are illiterate. Unemployment is common amongst people with mental health problems since people are not offered jobs despite their proven ability to do them, because of a psychiatric past. There has for example been very little increase, over the past 10 years, in the proportion of adults with neurotic or psychotic disorders participating in the workforce, while there has been an increase in the employment rate for the general population and for people with disabilities. Over half of the adults with mental health problems that are in employment are on a low income (Van Reemortel, 2003) (Mental Health Europe, 2003).

The multidimensional nature of exclusion is highly apparent amongst adults with mental health problems, since they experience different types of exclusion. They face high levels of stigmatization and discrimination and are less likely to access everyday goods and basic services such as health and banking services or to take part in leisure, arts and community activities. Over one fourth of people with mental health problems, for example, report having to move out of their home because of harassment, while 57% felt afraid of attacks in their immediate neighbourhood. More than 50% complain of being unfairly treated in general health care because

of their psychiatric problems, while almost 50% of people with mental health problems have been harassed or abused in public because of these problems (Van Reemortel, 2003). In addition, people with mental health problems have trouble living in appropriate or private housing and in having strong family networks. They are four times less likely to have someone to talk to about their problems, compared to the general population. They are also three times as likely to be separated or divorced and over twice as likely to be living on their own as those without mental health problems (Mental Health Europe, 2003). Excluding mental health service users thus leads to difficulties in establishing contacts, social networks and access to basic goods and services. Low levels of social participation, in turn, affect the individual's quality of life, increasing their social exclusion and aggravating their problems.
A common difficulty with respect to the elderly, the chronically ill and disabled and people with mental problems is that the focus is often placed on what they can't, rather than on what they can do. Creating opportunities that enable these people to participate in society will reduce their isolation and can thereby improve their health and increase their quality of life.



2.4 The Impact of Social Exclusion on Health (link E)

The pathways by which the experience of being socially excluded can lead to bad health are described in the section on poverty and health causation above. Socially excluded people often live in poverty, with the ensuing material and behavioural consequences. The Scoping Note on by Mental Health Europe (2003) lists a number of risk factors that are directly associated with social exclusion that can influence the development of mental health problems. These include socio-economic disadvantage, neighbourhood violence and crime, unemployment, poor educational achievement, being a member of a minority group and being a lone parent or teenage mother.

Refugees and Immigrants

Amongst the groups most adversely affected by social exclusion and its consequences on mental and physical health are refugee and immigrant groups in Europe. These groups are excluded by nature of being foreigners who are not, in most cases, warmly welcomed by their host country. Many refugees and immigrants who obtain legal status become part of the poorer classes in their new country of residence – and thereby loose the status they had in their country of origin. Illegal immigrants have no status at all.

Many refugee adults and children arrive in their host countries with physical and psychological problems. They may have experienced persecution, imprisonment, separation from family and friends or uncertainty about their future. Such feelings lead to anxiety and mental stress. These conditions are compounded by the experience of culture shock: not knowing the food, the customs, and the language of their new place of residence leads to social exclusion and to depression and disorientation. There is therefore a high level of psychological, post-traumatic stress disorder and psychiatric illness among refugees. The long waiting time to process asylum applications is harmful for health – as they become passive and loose self-esteem. Living in a centre for a long time increases social isolation and inactivity. Unemployment causes deprivation of financial and material resources, which can in turn lead to bad health and chronic illness. In some countries such as Italy and Greece, refugees cannot always get accommodation and sleep in parks. According to Spinnewijn (Feantsa, 2003) there has, over the past ten years, been an enormous increase in the number of (recent arrival, illegal) immigrants in homeless shelters; the problems of immigration and homelessness are therefore closely related. Cultural differences also make it very difficult for refugees and immigrants to access and receive effective medical and psychological treatment (Report of the Refugee Panel, 1999). The experiences of refugees and immigrants therefore, in many cases, provide extreme and poignant examples of how social exclusion can lead to, and exacerbate health problems.

2.4.1 Social capital and health

Just as there is a great of deal evidence available that social exclusion has a negative affect on health, there are also indications that social inclusion benefits health. Since 1990s there has been a focus on studies that look at the ways in which the immediate social environment, family and friends, social networks and civic participation affect health. This concept is defined as 'social capital', and embraces the notion that strong community ties, community participation and social trust are beneficial for individual health and behaviour (Putnam in van Kemenade, 2003).

The concept of social capital was popularised by Putnam, who sought to establish a positive correlation between high levels of involvement in voluntary associations and social networks on the one hand and more effective local government on the other. While this correlation has been difficult to explicate in the field of political science, it has given rise to a large body of work regarding the relation between social cohesion and health. (Cambell *et al*., 1999) Putnam maintains that social capital is as important an indicator of a country's health as the unemployment rate, the gross domestic product or environmental conditions (Putnam in van Kemenade, 2003).

There is much evidence that social integration benefits health. Hyyppä and Mäki (2001), for example, conclude that the higher life expectancy of Swedish-speaking Finns seems to be associated with the social networks they establish (in van Kemenade, 2003). Numerous other studies have highlighted the close relationship between social networks and mortality rates, and indicated that the risk of death was two to three times higher for persons lacking social support than for those who were well integrated into social networks. Studies in the UK, for instance, have found that there is a strong relationship between perceived social support from friends and relatives and psychosocial health. They have also found that men and women from all ethnic groups are more likely to have poor health if they report a severe lack of social support from these groups (McCulloch, 2002) (Campbell *et al*.,1999). It is interesting to note that while these studies have traditionally focused on the health benefits of receiving social support, there is also growing interest in the health enhancing benefits of giving social support (Cambell *et al*.,1999).

Although there is much evidence of a strong correlation between social capital and health, the underlying causal mechanisms remain unclear. Not all socially deprived areas, for example, lack social capital. In the study by Macintyre (in Graham ed., 2000) poorer neighbourhoods were found to have as much access to those facilities and amenities associated with a high level of social capital as wealthier ones (although the quality of these facilities and amenities was not assessed, which may be an issue). Residents of poorer neighbourhoods felt part of a reciprocal community at least as often as those living in wealthier areas. Therefore, while having features that may be damaging to health, poor neighbourhoods may also have social characteristics that might mitigate these effects.

In addition, a high degree social capital does not necessarily promote health-enhancing behaviour. A study conducted in the UK concluded that in some cases strong support networks and identity seem to encourage rather than to challenge smoking. Another report concluded that while low social capital and a lack of social support were related to higher levels of smoking amongst whites, smoking among many minority ethnic adults was more commonly reported amongst those who had most social contact and friends. In this case, therefore, high social capital and social support from friends and relatives was not consistently related to better general health for specific minority ethnic groups (Campbell, 1999) (Cooper, 2000). This indicates, as noted in the section above on poverty and health, that individuals are part of an interdependent and dynamic system, and that their health depends not only on their behaviour and social situation, but on the interlocking behaviours and social situation of others in their social network. (Berkman, 1995 in Cambell *et al*., 1999)

Social Capital in EU Member States

A Eurostat analysis of income poverty and deprivation among the poor (2000) reflects some of these mixed findings regarding the correlation between social capital and health. It fails to find clear associations between countries in the EU with respect to socio-economic status, levels of social capital and health when looked at in terms of frequency of social contact, although quality of contact differs significantly. According to the Eurostat report, there are no large differences between the poor and non-poor regarding social contact. Lack of contact was always higher for the poor but the differences were not necessarily significant. As far as differences across countries are concerned, social networks appeared, in fact, to be stronger in countries with higher poverty rates. Only three percent or less of people in Ireland, Spain and Greece reported meeting friends or relatives less than once a month, compared to between 12 and 14 per cent in France, Austria and Luxembourg. Portugal was exceptional: one in eight Portuguese claimed to go for one month without meeting friends and relatives, separating them from the norm of Southern Europe. In the Southern countries, with the exception of Portugal, sociability tended to be higher for those with low incomes, while the inverse was the case in the northern counties. The report therefore indicates that there was no systematic relationship between poverty and the frequency of social contacts.

On the other hand, the analysis reflects that subjective social isolation is greater for the poor in all countries, indicating that the measures of social isolation fail to capture important qualitative differences in the character of networks. Those in the lowest quartile income group were also more likely to feel that others do not value them. In addition, while the unemployed did not have lower levels of sociability than those in work, they felt significantly more isolated. This was the case even when income has been controlled. Social isolation was also greater in cities and large towns.

The view that the poor have qualitatively different networks was reinforced by the fact that a much higher proportion of friends were unemployed (and therefore poorly placed to offer significant support). The polarisation of networks between those in the lowest income quartiles and others was particularly marked in Belgium, West Germany, Great Britain, Ireland, Finland and Austria. These effects were evident for unemployment, low income, social isolation, poor quality of local neighbourhood environments, high levels of work pressure, job insecurity and poor quality work tasks. Those in more precarious life situations were significantly more dissatisfied with society. Satisfaction with family life was significantly higher among the general population than among those in the lowest income quartile. In addition, the unemployed were more dissatisfied with both their family and social lives than those in other employment statuses (Social Precarity and Social Integration, 2002).

Conclusion

The above-mentioned studies and reports indicate that a high level of social capital, or living in a socially inclusive environment, can have a positive impact on health. There are, however, many different ways in which the social environment and different types of social networks can influence individuals and affect health. The findings again reflect the multidimensional nature of social exclusion: deprivation in one area leads to deprivation in many areas and can lead to a loss of self-esteem and of quality social support. The socially excluded tend to see the world around them more negatively and to loose access and the desire to seek out effective role models and assistance. Psycho-social mechanisms thereby leave the socially excluded more vulnerable to ill health. It is therefore important to find ways to break through these cycles of deprivation, which affect individuals as well as society as a whole.

2.5 Gender and cultural differences

In the discussions above – reference has been made to the fact that certain groups in society are more prone to poverty and social exclusion than others, and individuals may react differently to similar circumstances. Graham (2000) notes that more is known about health

determinants than about the lives and lifestyles of individuals. In other words it is very difficult to understand how determinants work together, and which have the greatest impact on different individual's lives. This underscores the importance of taking into account issues of gender and ethnic differences when considering relations between health and social exclusion.

That economic and political power in society tends to be in the hands of white males means that many 'standards' with respect to behaviour, correlations and symptoms which are projected on society as a whole are actually based on male experiences. Wamala and Lynch (2002), for example, refer to a case in Sweden where the symptoms of a heart attack in a woman were not recognized, since they did not correspond onto the symptoms generally displayed by men. In fact, many health problems manifest themselves differently in women and men. The dominant position of white males also means that large gender gaps with respect to income and positions of power remain, and that care- taking duties tend to be de-valued. As a result, societal structures in many countries make it difficult for women to combine care-taking duties with work, while this combination, according to many studies, optimises women's health (Mackenback and Bakker eds., 2002).

Families today are more isolated than ever. Amongst the groups most disadvantaged and therefore highly prone to poverty and social exclusion, are lone mothers. Since many single mothers are unable to work, this reduces their income and also narrows their social network, which can have adverse health implications. A study by the Heath Development Agency, for example, has found that 50% of lone mothers smoke and that 75% of the most disadvantaged lone mothers smoke, compared to 25% of other women. Amongst the conclusions of the research are that lone parents are less likely to stop smoking since they have low morale and self-esteem and see their prospects as bleak (HEA, 1998).

While prevailing social structures tend to favour men, this does not mean that all men benefit from these norms and standards. Men facing unemployment and poverty often unleash the stress and the frustrations that result from these experiences in the form of violence against each other, as well as against the women and children in their lives (Williams, 1999). One of the manifestations of this is the growing number of women and children who are seeking refuge in shelters, in many cases because they are fleeing situations of domestic violence. According to Spinnewijn single women now make up the majority of homeless families in Europe (Feantsea, 2003).

Indeed, men and women react differently to similar socio-economic circumstances. Young men who are unemployed are, for instance, more likely to externalise their concern and frustrations and to engage in aggressive behaviours, such as speeding, which can lead to accidents and disability. Women, on the other hand, tend to internalise their concerns and frustration, which can lead to depression.

Just as social structures generally benefit men more than women, the same holds true for the white population in relation to ethnic minorities. The results of a study conducted in the UK, for instance, show substantially poorer health among all minority ethnic groups compared to whites of working age (Campbell, 2003). This is also reflected by the fact that the determinants of socio-economic-status tend to be developed for the white population and may therefore not predict the same outcomes for people of other ethnic groups. Minority ethnic groups face higher rates of unemployment and of employment in low skilled jobs than equally qualified white males. This is because their qualifications may be unrecognised and they may face discrimination or lack the networks and connections needed to get a job (Smith *et al*., in Graham, 2000). In addition current income is related to wealth, or to real purchasing power, in a different manner for different ethnic groups, since some immigrants may send a relatively large proportion of their income to their extended families in their countries of origin (Karlsen *et al*. in Graham ed., 2000).

Ethnic minority women are, perhaps, most disadvantaged of all by prevailing social structures. In addition to the fact that they have a lower health status than the white population for socio-economic reasons, they also face gender inequalities, as the health status of ethnic minority women is even lower than that of ethnic minority men (Cooper, 2002). It is important to note however, that the term 'ethnic minority' does not represent a homogeneous group, and that the ways in which different determinants interact and affect the health of people varies within and amongst these groups.

These examples indicate that it is important to look at and take into account individual circumstances and characteristics when addressing poverty and social exclusion, since all lives are shaped by a wide variety of different influences. It is in addition, important to look at how broader structural social process shape and constrain individual lives and affect behaviour. This has implications for the ways in which polices and interventions that aim to reduce social exclusion and to increase the quality of individual's lives should be designed.

2.6 Life course perspective

A consistent theme, throughout the discussions above, is that the problems of ill health, poverty and social exclusion compound one another. In this sense, these accumulated problems can be exacerbated in the course of an individual's life and may be passed on across generations. This is reflected in the life course concept, which draws attention to how social inequality influences the paths we track through childhood, across adulthood and into old age, paths which shape our access to health promoting resources and our exposure to health damaging risks. The concept helps to understand how disadvantages in infancy, adolescence and adulthood all play a part in the socio-economic gradient in adult health (Graham ed., 2000).

Childhood is a particularly important life stage since it can establish the foundations of future well-being or malaise. Numerous studies have shown that childhood circumstances have long-term affects on both adult health and socio-economic circumstances. Hobcraft (1998) presents a number of practical illustrations, using data on a group of people born in 1958, of how experiences in childhood can lead to social exclusion in adulthood. He found that social housing is more common if parents lived in local authority housing and that poor children have lower income as adults. He also found that parental interest in schooling is a powerful predictor of educational success. In addition, anxious children face a higher risk of depression as adults, while low educational test scores correlated powerfully with, amongst other things, a doubling of the risk of depression (Casebrief 8, 1998).

Well-being in adulthood is not solely, of course, determined during childhood. Living and working conditions in adult life can also influence health. (Berney *et al*., in Graham ed., 2000). Thus, no stage of the life course is particularly privileged, and interventions that improve living and working conditions will help no matter what stage of the life course they target.

SECTION III: SOLUTIONS

There are numerous pathways by which the experience of poverty and social exclusion can lead to ill health, while ill health can in many cases lead to and compound poverty and social exclusion. Addressing the interrelated problems of social exclusion and health inequalities requires an integrated approach that involves a broad range of policy sectors. The extent of the contributions that the health field – particularly the public health and health promotion field- can make to reducing poverty and social exclusion has become more apparent as a result of the growing concern about the issue of health inequalities. This has raised awareness about the need for, and the potential of greater co-operation between the health and social field. Many initiatives are currently being taken to address this issue of health inequalities, which also have the indirect objective of reducing poverty and social exclusion. Work in the two fields therefore overlaps, and there are numerous ways in which closer collaboration can strengthen and reinforce efforts being taken in each area. This section will provide some initial examples of how the health sector can contribute to reducing levels of social exclusion. An important aspect of this is achieving equal access to health care. It will also highlight some of the ways in which the social sector and the health sector can work together to achieve their common objectives.

3.1 Initiatives from the health sector to reduce social exclusion

Initiatives that are being taken from the health sector to address health inequalities, and thereby to reduce poverty and social exclusion, can be categorized as 'upstream' 'midstream' and 'downstream' interventions (Mackenbach and Bakker eds., 2002):

'Upstream' interventions and policies are those that target socio-economic disadvantage and thereby address the root causes of inequalities in health. These interventions involve improving living standards through the social security system as well as education policy, employment policy and housing policy. While poverty and social exclusion can only be tackled by addressing the root, structural causes that lead to these conditions, health policy-makers do not usually make decisions about basic socio-economic distributions. They must therefore liaise with other policy areas to ensure effective action in this area. As discussed further below, important partnerships can be developed between national ministries to achieve common objectives with respect to targeting the factors that lead to poverty, social exclusion and health inequalities.

'Midstream' interventions involve public health and health promotion sector. Addressing the root causes of social inequalities will not in itself improve the health status of the poor and those experiencing social exclusion. This is because improving health status implies changing day-to-day behaviours, which have often been passed on over generations and developed across a lifespan, and breaking habits with a negative impact on health. Midstream interventions and policies therefore aim to reduce exposure to, and the effects of unfavourable

specific material conditions, psychosocial factors and behavioural risk factors in the lower socio-economic groups. Such interventions help prevent and alleviate adverse conditions for those living in poverty and experiencing social exclusion.

'Downstream' interventions, at the other end of the spectrum, involve the healthcare sector. Healthcare (medical) interventions are expensive and will never totally eliminate the problems of people facing poverty and social exclusion, because people have to fall ill before medical care can repair the damage. Healthcare nevertheless plays an important role in improving certain aspects of the lives of socially excluded people and in generating an overall improvement in their health and quality of life.

An integrated approach, and a combination of upstream, midstream and downstream solutions are all required in efforts to address health inequalities. While the health field has limited control over 'upstream' interventions and can only try to exert influence over policy sectors that determine relevant measures, it can play an important role with respect to mid-stream and downstream measures. Public health professionals can, for example, introduce initiatives to reduce the effects of bad health on socio-economic position by adapting the working conditions for chronically ill and disabled people to increase work participation. They can also take initiatives that involve improving workplace conditions or introducing school health promotion programs, to reduce the effects of exposure to the adverse conditions that are often related to low socio-economic status. Public health professionals can, in addition, initiate school health promotion programs that provide poor children with opportunities to get a healthy school lunch or to engage in sports. Finally, health professionals can reduce the health effects (including the consequences of illness) of being in a lower socio-economic position through improved access to healthcare. This can occur by reinforcing primary health care in disadvantaged areas through the employment of more practice assistance, nurse practitioners and peer educators (Mackenbach and Bakker eds., 2002).

3.2 Access to Health Care

Generally, when one thinks of solutions in the health sector to tackle social exclusion and poverty, the focus tends to be on improving access to health care. As revealed in the discussions above, health, to a large extent, is determined by broader socio-economic determinants. The danger of focussing only on access to health care interventions is that they, as 'downstream' interventions, only address symptoms and thereby draw attention away from preventative actions that can be taken to break the links between poverty, social exclusion and ill health. Nevertheless, access issues are very important to consider, since failure to get necessary and adequate care, or the inability to pay for medical treatment can exacerbate poverty and social exclusion. In addition, health care services are an important point of intervention to improve individual's well-being. While access to health care in EU Member States is relatively good, there are still a number of problems in this area – as reflected by the results of a study conducted in Belgium that was based on consultations with the poor that will be discussed further below.

3.2.1 Positive developments in access to health care

Health care systems amongst the Member States of the European Union tend to be based on taxation or social insurance systems or on a combination of these. These systems generally perform well when it comes to accessibility. Van Doorslaer *et al.*'s (2000) cross-European study of equality in access indicates that there is little evidence of an inequitable overall health-care. The study found that the actual distribution of General Pracitioner (GP) and hospital care across income groups was very close to the needs-expected distribution – in fact utilization was much higher among lower-income groups in all countries. Thus, all of the universal health-care systems in the European countries that were studied performed reasonably well in terms of equality in access to and utilization of healthcare in the late 1980s and early 1990s.

Positive developments with respect to access to health care have taken place in countries like Belgium and France, which have introduced new laws to improve accessibility. France introduced a universal health insurance (*Couverture maladie universele*) in early 2000. The new laws, amongst other things, automatically affiliate all persons who are residents of France to the social security system, regardless of employment status and enables people below a certain income ceiling to obtain supplementary insurance free of charge to cover some costs. It also eliminates advance payments, as insurance funds and supplementary bodies pay medical fees (WHO, 2002). In Belgium, a measure called the Maximum Health Bill was introduced in 1994 to make health care more affordable and accessible to socially vulnerable people. Once a maximum out of pocket payment for medical care is reached, all other payments are fully refunded by sickness funds. In addition, out-of-pocket payments by socially vulnerable categories for most medical services, some types of medicines and hospital admissions have, in recent years, been lowered.

3.2.2 Problems with access to health care

Despite such positive developments, Paterson and Judge (2002) note that the overall picture in relation to equality of access to primary care across Western Europe is complex and varied and that, at best, there are no grounds for complacency. In many countries, health care reforms have been threatening health care equity. In Austria for instance, all patients, regardless of socio-economic status, must pay the same fixed fee at the time of their medical consultation– a policy that falls heavily on the poor. In addition, health care policies in most Member States only cover legal residents and citizens. In Greece, for example, it is against the law for doctors to treat illegal immigrants (Feantsea, 2003).

Paterson and Judge also cite a number of studies in countries throughout the EU showing that people in the most disadvantaged circumstances often (but not always) benefit less from what their health services have to offer. While, for example, people with a low socio-economic status have been found to make more use of medical services and demonstrated as a higher average number of visits to a doctor, this is not necessarily enough to compensate for their higher needs. In addition, those in higher educational groups were more likely to consult a doctor than those of low educational or income groups as health status becomes worse, again reflecting that use does not reflect needs. Thus, while access to general services in European hospitals appears largely equitable, this might not be true of access to and quality of care in specialist or intensive services. The risk continues in many healthcare systems that the most disadvantaged do not receive the services they require in relation to their needs. In addition, socially deprived groups may receive care that is of lower quality. Williams (1999) notes that with respect to psychiatric care, people from oppressed social groups (women, elderly, people from black or minority ethnic groups) are more likely to receive forcible treatment, treatment with drugs and electro-convulsive therapy, while there is evidence that access to the more valued talking treatments is affected by race, ethnicity and social class.

Study on access to health care from the perspective of people living in poverty

The Belgian health care system can be considered one of the better ones in Europe. It provides a high quality care, which as the recent health care reforms noted above indicate, is relatively accessible. The Department of Primary Care at the University of Gent in Belgium recently conducted a study on access to health care from the perspective of people living in poverty (Logo Vakgroup, 2003). The aim of the study was to gain insight into the different factors that determine whether someone makes use of the health care system. Researchers worked together with a Belgian umbrella organisation that serves the needs and promotes the interests of poor and socially excluded people. Seven members of this organisation, such as homeless shelters and community centres, took part in a working group and developed a common research framework. Each of these organisations held focus group discussions based on this framework, which provided people living in poverty the opportunity to share their experiences and visions about specific themes relating to access to health care. The study

reports on the findings of these focal groups and provides insight into the difficulties faced by the poor and those experiencing social exclusion when it comes to access issues. While the report focuses on Belgium, the experiences of those consulted undoubtedly reflect those of poor and socially excluded people throughout the EU. A consultation exercise that was conducted in Ireland on health in the anti poverty strategy, for example, reports similar findings with respect to access to health care (Burke, 2002).

The results of the Belgian study indicate that many poor and socially excluded people continue to experience barriers to access at many levels – financial access, administrative access, cultural access and psychological access – and therefore don't receive the necessary treatment. The problems people faced with respect to these barriers were broadly divided into problems regarding the provision of health services and with the demand for services.

Concerning **provision** of health services, problems were encountered with the means of payment and the complexity of health care regulations in stipulating eligibility for special assistance and how to claim this. The fact that insurance schemes require payment in advance, which is reimbursed later, poses a big problem for people with financial constraints. Similar arrangements made it difficult to pay for prescribed medications. Problems with payment are aggravated by the fact that people may be asked to return for additional or more specialised treatments and additional consultations, which they are unable to afford. Some people who failed to pay their insurance contributions were denied care altogether.

While special schemes have been introduced to alleviate the financial burdens of seeking care, these tend to be very complex administratively. Those who are most eligible for these schemes are also those who have the most difficulty gaining information about them or applying for them. This finding is supported by a study in Blackpool in the UK that found that millions of pounds of social security benefits go unclaimed annually, since people perceive the procedures to obtain the benefits that they are entitled to as being too difficult. Elderly patients, for example, do not like to ask for what they see as 'charity', even though they are entitled to the benefits under the law. Unclaimed benefits include, amongst other things, income support, disability and invalidity allowances, and payments for caretakers who look after patients at home (WHO, 2002). Other categories of socially vulnerable people, particularly the homeless, may not be covered by such schemes at all, since they lack legal status or a home address. In addition, the regulations determining who is and who is not eligible for benefits are often arbitrary. Therefore, borderline cases who do not meet the criteria struggle to pay – and may decide not to seek medical care. In addition, many benefits, such as a minimum payment, are based on official income, which does not always reflect available income due to for example, high fixed costs or the payment of loans.

Problems with provision of services do not only have to do with financial barriers. Those questioned also complained about the type and quality of treatment they received. Services were sometimes hard to reach, and transport costs high. People often faced long waiting times, in part due to a lack of personnel. In addition there were complaints that the quality of care was often poor, and there were frequent changes with respect to health service providers, which not only undermined the development of a relationship of trust, but also led to a lack of consistency in treatment.

As a result of these difficulties, many people fail to make a **demand** on health services. Failure to seek out necessary treatment can also stem from the very nature of being socially excluded and therefore isolated. People's social environments influence their conception of what is healthy and how to engage in healthy behaviour. Social networks often provide encouragement to seek medical treatment when required and support when medical care is needed. Many poor and socially excluded people do not have such a network to provide advice and support. In addition, those who are poor and in need of treatment may be responsible for the care of others, and may not have family or friends to take over care taking

duties while seeking treatment. In addition, many poor and socially excluded people fail to seek medical treatment because they are ashamed to ask for help and feel stigmatised by having to ask for special assistance. They may therefore feel hostile towards or suspicious of health care service providers.

3.3 Improving access to health care

Failure to seek out and get appropriate medical treatment when it is needed can exacerbate problems of poverty and social exclusion. Improving access to health care requires a multi-dimensional approach, with attention to financial, administrative, cultural, and psychological aspects of access. The following are some recommendations that arose from the consultation processes in Belgium and in Ireland on how to improve access to health care (Logo Vakgroup, 2003) (Burke, 2002):

- Measures that alleviate financial burdens are essential to improving access. People in the lowest socio-economic categories shouldn't have to pay – or only pay a minimal amount - at the point of service.

- Improvements in the provision of information and in communication between service providers and patients are of critical importance to improving access to health care. Clear information should be provided to those who are entitled to social benefits.

- Health care providers should receive training to become more sensitised to the situation of their patients and aware of how their socio-economic situation may be related to and can influence their health status. In addition, a more holistic approach should be followed in the treatment of patients, in which not only medical conditions are treated but the circumstances that may cause and aggravate these conditions or hinder recovery are also considered.

- More attention should be given to preventative measures – and to ensuring that these are designed to reach people in socially vulnerable situations, are culturally sensitive and correspond to the realities that they face.

- People with low socio-economic status should have equal access to primary, as well as to secondary care treatments – while the quality of care should be the same for people at all socio-economic levels.

3.4 Initiatives from the public health and health promotion sector

Improving access to health care is not the only contribution that the health field can make with respect to addressing the problems of poverty and social exclusion. Numerous other initiatives can and are being taken by public health and health promotion professionals to improve the quality of life of those experiencing poverty and social exclusion. A study conducted by the Flemish Institute of Health Promotion (VIG) in association with the European Network of Health Promotion Agencies (ENHPA, now EuroHealthNet) (Jennings *et al*., 2001) provides a number of examples of such initiatives that are taking place throughout EU Member States. Many of these policies and interventions are being implemented in the context of efforts to reduce health inequalities, and therefore involve addressing poverty and social exclusion and forging partnerships with other policy areas to achieve this goal. Some of these measures are 'upstream' in the sense that they involve influencing policy at the national, regional and local level, while others are 'mid-stream' and 'downstream' measures that provide direct support to communities and individuals in need.

Development of national targets to tackle health inequalities

While the health field cannot make decisions about socio-economic distributions, the growing

interest in socio-economic inequalities has led health related bodies to become more involved, and to gain some influence in this area. This focus has led to the establishment of national targets in this field. The United Kingdom, for example, announced its first health inequality targets in February 2001, which encompassed two areas – infant mortality and life expectancy. Similarly, the Swedish government has defined national objectives for health development, such as the counteraction of the wider disparities in income and the reduction of relative poverty and devised strategies and to achieve them. The Danish Government has also set an overall target to reduce social inequalities in health – above all by strengthening efforts to improve health for the most disadvantaged groups.

Targets set a context for and therefore help support and sustain a variety of other measures that are directed at, and aim to improve some aspect of the lives of those experiencing poverty and social exclusion. Since national health inequality targets cannot be achieved without mobilizing actors in other sectors that influence the determinants of health, they stimulate co-operation across policy areas.

Development of inter-sectoral partnerships and networks

Considerable progress is being made in Ireland with respect to the establishment of good partnerships between the health and the social policy fields. The Department of Health and Children, for example, set up the National Anti-Poverty Strategy and health consultation exercise to involve people who are poor and excluded in the process of developing health targets. This was also an effort to put linked poverty and health issues on the public and political agendas in order to contribute towards the building of a more inclusive, equitable and healthy society (Burke, 2002).

Another way to develop partnerships across policy areas is through the establishment of inter-sectoral public health committees. Such committees have, for example, been set up in more than two thirds of all Swedish municipalities. The focus of public health at the municipal level has reportedly been shifting to structural determinants of health like economics, (un)employment, education, demographics and sustainable development, reflecting the inter-related nature of these fields.

Implementation of Health Impact Assessment

A policy tool that derives from the health sector, which can help in efforts to tackle poverty and social exclusion is Health Impact Assessment. HIA is defined as "a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population" (WHO, 1999) This tool has been designed to ensure that other policy sectors take into account the health implications of proposed and adopted measures. HIA can also be applied to determine the impact that measures have on different social groups, distinguished by gender, ethnic background and socio-economic status, and can therefore be of importance in efforts to tackle health inequalities and social exclusion. The National Assembly for Wales is developing HIA as a key tool to assist in the process of achieving health and well being in the country. (Welsh Assembly Government, 2003)

Introduction of community development programmes

Many initiatives at the regional and local level are based on community development approaches, which aim to improve the circumstances of people living in deprived areas. In the UK, the National Government has introduced Health Action Zones, to target funding at areas in England with the highest levels of deprivation and the poorest levels of health. They are multi-agency programmes between the National Health Service, local government, voluntary and private sectors and community groups. Their principle aim is to "tackle inequalities in health in the most deprived areas of England through health and social care service modernisation programmes with opportunities to address the wider determinants of health such as housing, education and employment." Amongst the key areas that they focus on are

the broader determinants of health and community empowerment. Amongst the key principles or values that HAZ have to sign up to are: person-centred services, engaging community, maintaining a principle of equity, partnerships/multi-agency work and a 'whole systems' approach. Each HAZ develops its own priorities and targets guided by national targets but adapted to local needs. Approaches are deliberately flexible in order to be able to change the way services were delivered, and budgets are pooled between health authorities and local authorities.

The Merseyside HAZ in England, which was launched in 1999 is the largest and most complex of the 26 Health Action Zones that have been created in the UK. Merseyside includes some of the most deprived communities in Europe. It covers four health authorities and five local authorities and has a population of 1.4 million people. The Merseyside HAZ is linked to the Sefton Health Improvement Programme and provides an opportunity to change the way that local authorities and health authorities work together with non-statuatory partners in the voluntary and business sectors to meet changing health needs and reduce health inequalities.

The Merseyside HAZ has four clear strategic goals: to modernise and improve the provision of health and social care; to promote healthy employment opportunities; to increase the proportion of elderly or disabled people who have an active independent life and to enhance peoples quality of life. Over sixty-eight local interventions, each of which relate specifically to one of these goals, have been funded under the HAZ programme to achieve these objectives. The budgets and the scope of these projects vary widely, and range from smoking cessation projects and detoxification schemes, to the promotion and implementation of cancer screening programs, to an intensive housing scheme for adults with severe and enduring mental health problems and addiction. Interventions also involve providing information about welfare rights, establishing and supporting community centres and shelters, funding research into workplace health, improving employment prospects and facilitating co-operation amongst social service providers at the local level (Hill *et al*., 2002).

Similar community development based strategies, initiated by the health field, are also taking place in other EU Member States. In Germany, 'The Social Town' project was established to integrate the health, housing, transport and economic aspects in deprived areas. The programme aims to generate employment, support and facilitate social structures within and between population groups, and provide integrated ecological (sustainable) planning. It aims to foster a greater level of community participation in the planning process combined with greater levels of ownership and responsibility. The success of the programme has been attributed in large part to the support of a number of Ministries, who provide considerable financial and legislative support (Programm Soziale Stadt, 2003) (Wagner, 2002).

Another example of a community initiative is Het Arnhemse Broek, in the Netherlands, where inhabitants of a deprived neighbourhood in Arnhem were involved in identifying their needs and developing activities to address these. The community identified three 'top priorities': safety, parenting and dealing with stress. An activity plan was developed on the basis of these priorities. An evaluation process reported significant successes in the areas of achieving consensus and co-operation between participating organisations and the community and in translating the needs of the community into measurable activities to tackle problems (Ten Dam, 2001).

Small scale initiatives

Many other initiatives have and are taking place in EU Member States, in which the public health and health promotion sector are directly involved in efforts to reduce social exclusion. One such project, for example, called 'Soares dos Reis', was initiated by a group of volunteers in Portugal who worked in co-operation with health professionals to assist older people living in isolation. The overall aim was to improve the quality of life and well-being of low-income older people who were living in poor housing conditions and who were not receiving any

family support. Work concentrated on solving daily practical problems through home visits (cleaning and basic maintenance) and ensuring that more formal services were accessed if they were required (Miranda, 2001).

Another project in Sefton, England, aims to address the fact that many people, particularly those living in deprived areas, frequently visit their general practitioners as a result of the pressure and stress they feel due to the fact that they have to manage upon a low income. The project recognises the link between social/economic circumstances and mental health and attempts to relieve some of these pressures by ensuring that patients whose circumstances entitle them to benefits actually receive their maximum entitlement and also have access to general welfare advice. It employs, in addition, three outreach workers who visit GP practices to provide consultations (Hill *et al*., 2002).

There are numerous other examples of small-scale initiatives deriving from the public health sector that contribute to improving the health of poor and socially excluded people. They include providing child care facilities to mothers to enable them to attend college, establishing sports clubs for disabled groups such as the visually impaired, and organising activity holidays for children from deprived backgrounds. In addition, there are projects that organise 'tupperware' style parties (small reunions) in people's homes, providing informal and amicable settings to discuss health related issues. Community centers can also offer active cooking courses and support groups for mothers and impart information on a wide range of health-related topics such as healthy eating, dental care and lice. While these projects are small-scale, they help diminish the isolation and increase the quality of life of those involved.

3.5 Conclusion

The above-mentioned efforts reveal that work being conducted by the social policy field and in the health field have many commonalities. While the two fields have similar goals, in Sen's words to improve the freedom and capabilities of socially vulnerable people so that they thereby improve their quality of life, their emphases often differ. The two sectors are complementary, and are both necessary to combat poverty and social exclusion. In addition, the health and social policy fields may not, on their own, have sufficient means to influence, implement and/or evaluate policies and interventions that address poverty and social exclusion. Increased co-ordination, co-operation and integration of the two areas can therefore maximise the available resources. The examples provided in this report give an initial impression of the activities that are currently taking place within the health promotion and health care sectors to combat social exclusion. The expertise and experience available in this area within EU Member States can, when shared across borders, generate new ideas and lead to more effective interventions to improve the health of those experiencing poverty and social exclusion. A more structural and sustainable exchange of best practices is therefore recommended, since it can make an important contribution to the process of creating a more inclusive European society.

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