

**The Social and Economic Determinants of Health**  
**For discussion at Health and Human Rights: Setting the Priorities**

The conditions in which people live and work can help create or destroy their health – lack of income, inappropriate housing, unsafe workplaces, and lack of access to health systems are some of the social determinants of health leading to inequalities within and between countries.

*WHO Commission on Social Determinants of Health (2006)*

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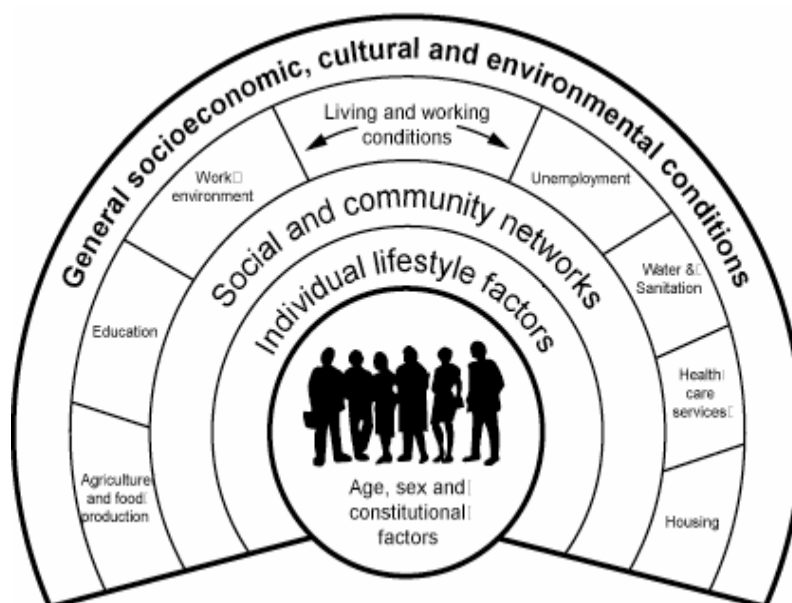


The purpose of this paper is to describe some of the issues relating to the social and economic determinants of health, highlight growing concern about health inequalities and draw attention to the common ground between human rights and public health.

## Background

Whether in rich or poor countries social conditions influence people's health. As well as age, sex and biological characteristics that are largely fixed, individuals are embedded in society and debates about health need to acknowledge the influence of personal lifestyle as well as interactions with family, friends, neighbours and communities. Good health is also shaped by the type and quality of housing, employment, the physical and social infrastructure of communities, the quality of services and amenities, income and access as well as environmental factors such as pollution or traffic congestion. It is also highly dependent on general socio-economic and cultural factors in society.

The determinants of the general health of the population can be conceptualised as rainbow-like layers of influence as shown below.



G Dahlgren and M Whitehead (1991)

The term social determinants arose in the 1970s out of concern that much of the effort to improve health focused on the acute health care system in spite of research which consistently demonstrated the huge impact on health of social circumstances and preventive services. Since then a body of public health research has increasingly demonstrated that people's health is remarkably sensitive to the wider social environment in which they live and work – the social determinants of health.

The focus of this paper is on the socio-economic determinants of health including public policies and services and lifestyle rather than determinants such as age, sex, and genetic factors.

## Health in Northern Ireland

Health has continued to improve in Northern Ireland with some remarkable successes. Life expectancy continues to rise with death rates falling from chronic diseases such as cancers and heart disease. But many challenges remain including high levels of diabetes and obesity. The health of children is threatened by poor diet, high levels of smoking, and alcohol use. About 1 in 10 adults suffers from mental health problems and there is growing concern about levels of suicide.

### **Health Inequalities**

The chances of a long and healthy life are not the same for everyone. Those who are poorer are much more likely to die younger and face more illness during their lifetime than those who are better off. This creates a steep social gradient in health whereby health tends to increase with wealth. This gradient runs across all social groups and is present for all the main causes of death.

Although this is an international finding, inequalities in health are particularly high in Northern Ireland as has been shown in several studies. For example a review of all deaths occurring between 1989 and 1998 showed that:

- the death rate for “all causes” of death in the lowest occupational class was over three times higher than in the highest occupational class
- those in the lowest occupational class were more than twice as likely to die from cancers, more than three times as likely to die from circulatory diseases, and more than six times as likely to die from respiratory disorders or injuries than those in the highest group.

IPH, 2001

As well as the marked differences in mortality from the top to bottom of the occupational hierarchy similar differences are found when looking at the effect of socio-economic circumstances such as income, education, and housing on health. For example a report on different measures of health including aspects of social capital showed significant demographic and socio-economic inequalities. For example:

- people with no formal educational qualifications were half as likely as those with third level education to have excellent/very good health
- people who are unemployed were a third less likely than those in employment to have a high general mental health score
- people with the lowest income were half as likely as those with the highest income to be very satisfied with their health or have a very good quality of life
- people who rent in the public sector were nearly half as likely as those who own their home to have a very good quality of life.

IPH, 2003

Inequities in health which are caused by the unequal distribution of social and economic public policies are both unfair and avoidable. They represent an

unacceptable social injustice. They also contradict the basic Human Rights principle of achieving the highest standards of health and health care.

### **Cause of Inequalities**

The causes of health inequalities are multi-faceted, but three sets of factors emerge from the research field as important:

- socio-economic or material factors like income, employment, housing, and the environment as well as the distribution of income and resources in society
- psychosocial factors like stress, isolation, social exclusion and lack of social support
- behavioural or lifestyle factors, such as smoking, poor diet and lack of exercise.

These factors are closely inter-related and underpinned by the social environment or context in which people live. Social exclusion for instance is often inextricably linked to the impact of poverty or inequality. Behavioural factors such as poor diet or substance abuse are also linked to social contexts with a nutritious diet difficult to achieve in the context of a low income and ready availability of cheaper processed food.

Health research has recently become more interested in how accumulated disadvantage or advantage over the life course influences health. The influence of wider social conditions on health may differ at different points in the life cycle particularly when people are most dependent or vulnerable, e.g. childhood, pregnancy and older age, is understood to be very important.

Many researchers consider that social position is a fundamental determinant of health as it is a pivotal link in a chain through which social determinants connect to influence health.

### **Summary of Social Determinants**

A brief summary of the main social and economic determinants is provided to set a context for discussion.

#### **Poverty**

Poverty is both a cause and a consequence of poor health. It affects health directly and indirectly. Income poverty rates have been declining but the risk of poverty for some groups such as one parent households or households headed by someone who was unemployed, ill or disabled is still particularly high. Children are particularly vulnerable to poverty. When income poverty is combined with deprivation (enforced lack of certain items) this produces a poverty measure called 'consistent' poverty.

Recent research on poverty and social exclusion in Northern Ireland in 2003 estimated that one quarter of households, representing over half a million people in Northern Ireland lived in poor households.

### **Income Inequality**

International evidence also shows a link between income inequality and health. It is suggested that the most egalitarian countries (where the income gap between rich and poor is smaller) enjoy better health overall and less significant health inequalities than less egalitarian countries. Income inequality in Northern Ireland is comparatively high. Those in the top income quintile have almost 5 times the income of those in the bottom quintile and inequality may be rising.

### **Public Policy and Services**

Public policy and services can exert a powerful influence and play an important role in creating a social environment which acts as a barrier or an opportunity for health.

At a structural level public policy can reduce poverty, provide equitable distribution of resources, strengthen educational opportunities and create the conditions for employment and life-long learning. At the micro level policy can enhance the conditions that enable and empower individuals to lead healthier lives particularly in relation to issues such as access to nutritious affordable food, access to physical activity and the prevention of substance abuse.

Adequate, accessible and equitable health and social care services are a key determinant. Access to appropriate care and treatment, on the basis of need rather than ability to pay, is fundamental. Inequities can result in lengthy waits for treatments or care. But the matter goes well beyond health services. A wide range of other public policies and services in particular employment, education, housing and transport influence the protection and generation of health.

### **Employment**

There are two main ways in which work is fundamentally linked to health. First, being in work is better for health than being out of work. Unemployment for instance is a major cause of poverty and material hardship, and is also associated with stress. People who are unemployed are more likely to die at a younger age than the general population. Being at work on the other hand provides not only an income, but also access to social networks, a sense of identity and opportunities for development or progression.

But working conditions, particularly for those in manual or unskilled jobs, or in less secure or low paid employments may have adverse effects on health. These can be direct hazards that arise from the physical environment, such as poor health and safety protection; or indirect hazards associated with job insecurity, low pay or limited access to pensions or career progression. The psychosocial environment at work is also influential, and health suffers when people have little opportunity to use their skills and limited decision making authority.

Issues of discrimination and racism also arise in relation to work. Racism for instance may be a feature of the workplace for migrants, and this can negatively affect their mental health and well-being.

### **Education**

It has been well established that the foundations for life long health are set down in childhood. Yet the education system is failing a significant proportion of children

living in poverty who are leaving school early or without qualifications. Public policy interventions, which address educational disadvantage, therefore have a significant part to play. International evidence also demonstrates that early interventions at pre school age are particularly important in breaking the cycle of poverty and educational disadvantage.

Education and training are important pathways to employment. Adult education and access to training in the workplace equip people with additional qualifications and skills. Addressing adult education and training needs is particularly important in the current context, given growing concerns about the 'working poor'. Tackling educational disadvantage is vital to breaking the cycle of poverty, and poverty is widely considered an important risk factor for health.

### **Housing**

International research shows a relationship between the neighbourhood environment, housing quality and health. Poor people for example, are more likely to live in poor quality built environments and this contributes to poorer health.

Housing and neighbourhood quality have both direct and indirect effects on health. For example overcrowding, dampness and inefficient or inadequate heating have direct consequences for health. Dampness has been associated with respiratory problems and a research review in Northern Ireland has documented the link between damp and mould growth and poorer health in both adults and children.

EU research has found that people in Ireland and the UK experienced the highest rates of seasonal mortality in Northern Europe, at least partly because of thermally inefficient housing stocks.

Poor perceptions of neighbourhood quality or local services are also associated with poorer health. For some, the health problems that arise from housing, accommodation and neighbourhood environments are particularly severe. Travellers for instance often live in poorly serviced accommodation without adequate access to sanitation or other utilities. Homeless people face considerable health risk and refugees and asylum seekers also experience accommodation problems, which give rise to health issues.

City, town and neighbourhood design have important implications for safety, access to physical activity and social connectedness. A recent IPH report on the health impacts of the built environment noted that public spaces and networks influence health in a number of ways including access to good quality well maintained public spaces, efficient, modern public transport systems and 'walkable' neighbourhoods.

### **Transport**

Lack of adequate or effective public transport systems can isolate people without cars, often the least well off, the young, the old and those in rural locations. This isolation can be social, especially for the young and the old. But it can also make it difficult for people reliant on public transport to access employment and a wide array of other services and amenities.

## **Social Exclusion and Discrimination**

**‘Life is short where its quality is poor. By causing hardship and resentment, poverty, social exclusion and discrimination cost lives’**

Social exclusion is a term that is used to describe the process by which groups and individuals can be pushed to the margins and prevented from participating fully in society. It is now widely accepted that a range of what have become known as ‘psychosocial’ factors have a powerful effect on health. These factors include anxiety, insecurity, low self-esteem, social isolation and lack of control over work and home life. Lack of social support or social isolation are also key sources of stress.

Social exclusion is often compounded by discrimination, for example from gender, disability, ethnicity, sexual orientation or membership of other minority groups. Social exclusion therefore is about more than income poverty as it isolates people from everyday participation in social life, and from power and decision making. It is harmful to the individuals and communities affected, it is harmful to society as a whole and it is linked with poorer health outcomes.

In recent years there has been a growth in research into the impact of social status and social connections on health. In more unequal societies people’s subjective experience of exclusion or of being at the lower end of the social hierarchy has been shown to have important health effects, principally through the stress mechanism. In addition, it is suggested that social affiliations, involvement in community life and access to social support are beneficial to health.

### **Asylum Seekers, Refugees and Ethnic Groups**

Minority ethnic groups make up a growing proportion of the population. Accessing services, including health, social and educational services, can be difficult for members of these groups. Research indicates high levels of stress, worry and depression among ethnic minorities and documents isolation, stress, nutrition problems and health and safety issues among those immigrant groups dependent on the system of direct provision.

### **Disability**

Unemployment and poverty rates are high among people with disabilities. In Northern Ireland 33 per cent of people with disabilities are in employment compared to 75 per cent of non-disabled people. This socio-economic exclusion of people with disabilities results in lower incomes and combines with lack of access to transport and services and many other aspects of everyday participation in community life. This leads to a particularly acute form of marginalisation.

### **Lifestyle**

Individual health practices have an obvious impact on their health. However, wider social, economic and environmental conditions that are beyond the control of individuals can influence and shape people’s lifestyles and the range of choices they can make. Research has found that poor diet for instance can be a consequence of affordability and availability; and that smoking is often related to stress and coping in particular situations. This is why public policies which facilitate healthy lifestyles and which tackle the obstacles to healthy lifestyles are so important.

### **Links between Health and Human Rights: Creating Common Ground**

The Northern Ireland Human Rights Commission's Economic, Social and Cultural Rights Committee has identified 10 international standards it considers to be fundamental in the area of health and human rights. It is beyond the scope of this paper to review these or provide more than a brief note on the developing links between human rights and health. The following areas are highlighted for discussion.

#### **Maximising Potential of International Initiatives**

About twenty UN reports on the right to the highest attainable standard of health have now been published. Some of these reports are on general themes and others are on the right to health in specific countries. They illustrate the common ground between public health and human rights and show how human rights can help to reinforce *existing*, good, health programmes. They also show how human rights can sometimes help to identify *new*, equitable, health policies. These reports could be systematically studied to identify learning for Northern Ireland.

Initiatives such as the World Health Organization (WHO) Commission on Social Determinants of Health launched in 2005 are drawing attention to the social factors that influence health and the opportunities for policy interventions to address these factors.

The WHO Commission has recently published a review of actions to tackle inequalities. The report stresses that responsibility lies across government and across many aspects of public policy and planning. It also lies across society, as sectors including the community and voluntary sector, employers and trade unions have vital contributions to make to the creation of social conditions conducive to health. The report makes the important point that it is critical to distinguish between the social determinants of health for the general population and the social determinants of inequities in health.

Consideration of this review would provide a benchmark against which to develop and strengthen human rights in public health strategies and programmes in Northern Ireland. The WHO review also calls for a stronger emphasis on health impact assessments (HIA) of government policies, and stresses the importance of equity impact. Government departments could also be asked to strengthen their commitment to HIA.

#### **Strengthening Links in Northern Ireland**

In Northern Ireland the publication of the Strategy and Action Plan to Promote Equality, Good Relations and Human Rights sets the scene for greater efforts to improve people's experience and access to information and services, mainstream equality and human rights, and promote an equality and rights culture across the health and care system. It acknowledges that applying the right to health to national health policies and programmes is likely to make them more equitable, inclusive, and participatory.

The Strategy highlights the importance of making links between different government policies and outlines what these are. International level work to develop tools such as indicators and benchmarks will enable the right to health to contribute to policy-making and accountability processes. Learning from this, Northern Ireland is in a

good position to develop its own indicators and benchmarks which could be applied to all relevant policies and serve to develop more integrated approaches.

### **Support for Community Based Work**

Many organisations and individuals are now working to help make the content of the right to health clearer, and thinking how the right can be put into practice. From the right to health perspective, one of the first steps towards tackling these problems is to establish genuine community based participatory processes. The Participation and the Practice of Rights Project is supporting communities in using a rights based approach in addressing the social and economic inequalities they face. This and other community based programmes which build on people's experience of human rights and health in communities needs to be supported to help inform action in Northern Ireland.

### **Developing a Shared Research Agenda**

A literature review carried out for the DHSSPSNI Strategy stated that "during the course of the review it became noticeably difficult to locate Northern Ireland specific research which made specific connections between health and social services provision and human rights. However research is beginning to emerge, particularly from the Northern Ireland Human Rights Commission."

A shared research agenda might be developed between human rights and health organisations. For example we need to know why health outcomes for certain groups are not improving so we can adjust the relevant policies and programmes. The kinds of questions we might ask could include;

Why is heart disease in Northern Ireland amongst the highest in Western Europe?  
Why is infant mortality for poor children fifty per cent higher than that for rich children? In Northern Ireland how many men and women in prison suffer from mental disorders? How is it that obesity rates for adults almost doubled between 1980 and 1999? How much human rights education and training is provided to public health professionals?

### **Summary**

Paul Hunt, UN Special Rapporteur on the right to the highest attainable standard of health said "Public health and human rights have reached a major crossroads. The relationship between public health and human rights is so close that it would be absurd if we fail to do all we can to make it prosper. It is clear as crystal that the right to the highest attainable standard of health - or 'the right to health' - depends upon the interventions and insights of public health."

In Paul Hunt's view "*for the first time*, the key pieces are now in place for public health and human rights, including the right to health, to invigorate and enrich each other in an operational, systematic and sustained way. Classic, long-established public health objectives can benefit from the newer, dynamic discipline of human rights."

However, there remains a disturbing failure in debates about health to consider the importance of the social determinants of health. This often blinds us to the fact that socio-economic inequality is a source of inequity and denies people the right to the realisation of the highest standard of health.

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