

# Social Determinants of Health

## An Improved Understanding of Health in New Mexico

The Social Determinants of Health Workgroup  
2005

NEW MEXICO  
DEPARTMENT OF  
**HEALTH**

**The New Mexico  
Public Health  
Association**

## Introduction - Social Determinants of Health in New Mexico

Health is substantially determined by social and economic factors such as poverty, income inequality, education, employment and racism. People have been aware of the important relationship between social determinants and health for many years, as can be seen from this speech written by Johann Peter Frank, a German physician, in 1790:

Let the rulers, if they can, keep away from the borders the deadly contagion of threatening diseases! Let them place all over the provinces men distinguished in the science of medicine and surgery! Let them build hospitals and administer them more auspiciously! Let them pass regulations for the inspection of pharmacies and let them apply many other measures for the citizens' health - but let them overlook only one thing, namely, the necessity of removing or of making more tolerable the richest source of diseases, *the extreme misery of the people*, and you will hardly see any benefits from public health legislation. There is in every state a necessary social order among the citizens, inseparable from any form of government. The inequality in the distribution of wealth determines the different social classes.

Frank gives us the outline of social determinants of health; little more needs saying. Poverty contributes to illness and undermines health. The determinants of a population's health are socioeconomic in nature: a strong economy, stable and meaningful jobs, decent salaries, and a good level of education.

The link between poverty and social relations and health was observed in feudal times, but, as can be seen from

the Annual Public Health Report from Montreal, Canada for 1998, even modern, first world countries observe the relationship:

What impact does poverty have on health? The poor die earlier and are in poorer health than the rich. Poverty is a complex, multifaceted phenomenon, a set of cumulatively interactive material and social shortfalls: low schooling, poor housing, poor working conditions, economic inactivity, exclusion from the decision-making process—which pushed the extreme, lead to social exclusion (<http://www.santepub-mtl.qc.ca>, Montreal, 1998 Annual Report on the Health of the Population: Social Inequalities in Health, p. 15).

The Social Determinants of Health perspective directs our attention away from seeing health as the result of good or bad, informed or uninformed, personal decisions, but rather as a result of *macro* or societal factors. This perspective reverses the magnifying glass. Instead of the micro—the bacteria—one must look at society at large. The perspective tells us that if we observe disparities in income we should expect to find disparities in health. For example, in a 1997 study among middle-aged adults, the odds that those with incomes under \$15,000 were likely to die of any cause during the subsequent five-year period were 3.9 times as great as for those with incomes over \$70,000 (Williams, D. How Income, Race and Other Factors Influence Health. n.d. Robert Woods Johnson). In addition, Williams urges us when we find links like this between poverty and health, to refocus on who is poor and why.

Discrimination by race contributes to poverty that in turn contributes to poor health. How? Poverty itself induces stress, as does the experience of powerlessness associated with racism. Stress is itself unhealthy and contributes to behaviors such as violence that have fatal consequences. The debate continues as to which comes first. Williams comes to a conclusion similar to Frank's:

The researchers concluded that although reducing the prevalence of health-risk behaviors in low-income populations is an important public health goal, socioeconomic differences in mortality are due to a wider array of factors and therefore would persist even with improved health behaviors among the disadvantaged  
(<http://www.rwjf.org/reports/grr/026422.htm#RESULTS%20AND%20FINDINGS>).

Medicine, nursing, and health insurance do not affect racism, poverty, despair, and powerlessness. The social determinants of health leave us with the uneasy feeling that even if we prevent disease and educate on how to be safe and reduce risks, it will remain unhealthy for the poorest in society.

Some evidence shows that relative poverty or income inequality, the size of the gap or disparity between rich and poor, is as important in predicting the health of a society as the absolute level of poverty.

This Social Determinants of Health in New Mexico Report was produced by the Social Determinants of Health Workgroup in order to heighten awareness about the important relationship between social determinants and health. This report presents NM case studies of work that will impact the relationship between social determinants and health. This report also presents definitions and county-level indicators relevant to social determinants of health. The Social Determinants Workgroup is a key collaboration between the New Mexico Public Health Association ([www.nmph.org](http://www.nmph.org)) and the New Mexico Department of Health ([www.health.state.nm.us](http://www.health.state.nm.us)) and is open to everyone. To participate in this important work, please contact Tom Scharmen at 505-897-5700 or David Broudy at 505-841-4145 ([Thomas.Scharmen@doh.state.nm.us](mailto:Thomas.Scharmen@doh.state.nm.us) or [David.Broudy@doh.state.nm.us](mailto:David.Broudy@doh.state.nm.us)) and visit our website at [www.nmph.org/soc-dets.htm](http://www.nmph.org/soc-dets.htm).

## **Addressing Social Determinants Internationally and in the United States**

Social determinants of health are the social and economic conditions that affect health status. Therefore, the ability of a community to achieve and maintain good health may involve reducing its levels of job insecurity, poverty, and income inequality. It may also involve raising its standards to improve education, employment and housing. This responsibility lies with all individuals and governing bodies that have the ability to change or create policies to improve the social and economic conditions of a community.

### ***International Approaches***

Societies across the globe have adopted the concept of social determinants of health and use it as the basis of their approach to health promotion and practice. England has long been a world leader in the research of interactions between social factors and health outcomes. This research is being transformed into policy as demonstrated by the United Kingdom's current National Action Plan to combat poverty and social exclusion for the years 2003-2005. This plan outlines policy measures to address the social determinants of health and to reach the national goal of halving child poverty by 2010.

Canada is another example of a country that approaches health from both a medical and social perspective. The Canadian Public Health Initiative (CPHI) was created in 1999 to help promote a better understanding of how factors including poor education and low-quality housing affect the health of individuals and communities. One of the many responsibilities of the CPHI is to use international and national data to research the social determinants of health in Canada and to make policy recommendations. Policymakers in countries like the United Kingdom and

Canada are using available research to implement social and economic policies designed to improve population health.

In some societies, the belief that the surrounding social and economic environment affects community health is driving national and regional health policy agendas. For example, Sweden's National Public Health Committee, a parliamentary commission, enacted the New Public Health Policy in April 2003. The policy outlines national public health objectives organized around health determinants instead of just disease categories, and directs Swedish governmental policy toward improving public health as an explicit national goal. Elements of these international models should be considered in the development of strategic policies designed to address the social determinants of health in New Mexico and the United States as a whole.

### ***Action in the United States***

In the United States, studies have explored the social determinants of health at both national and state levels. However, addressing the effects of social factors on health historically has happened at the local level, where disease prevention is best achieved through coordinated action. One example of this approach is an organized effort in a depressed San Francisco neighborhood that brought together local leaders and community groups to decrease health inequities. A neighborhood forum identified major chronic health issues, including exposures to chemicals and indoor mold, lack of access to affordable and healthy foods, and violence. To deal with some of these issues, the local transit authority created a shuttle bus between the neighborhood and grocery stores; the parks department published a guide to

recreational services specifically oriented to the neighborhood; and the city improved key services such as street lighting, city-sponsored check cashing, areas for community gardens and “green” school yards.

Public health and area partners in Seattle/King County developed a document called “Communities Count” which measured the health of local communities based on defined health

indicators. Along with these indicators of general health, markers of income and social capital were tracked to better assess the changing picture of county residents’ health.

These are just two examples of the work that is being done in counties and states across the country to incorporate aspects of the social environment when developing strategic health plans.

## **How Social Determinants Are Being Addressed in New Mexico**

In New Mexico, several organizations have adopted missions to influence health policy using social justice and social determinants perspectives. Ranging from non-profit and community-based groups to governmental agencies, these organizations focus on issues of childhood poverty, universal access to healthcare, social and environmental justice, and income inequality. In particular one non-profit organization, 1,000 Friends of New Mexico, works to promote “Smart Growth” in New Mexico. This organization defines “Smart Growth” as the responsible use of natural resources, providing adequate infrastructure for all new building developments, revitalizing communities and ensuring that all new expansion strengthens the economy. Another organization, the New Mexico Center on Law and Poverty, works to ensure that all policies, laws and practices are designed with the best interests of those living at state poverty levels.

Many of these organizations do not explicitly identify themselves as *health* organizations, even though their work has a direct impact on health outcomes. An important initial phase of addressing social determinants in New Mexico is to build connections between these

organizations and those entities that create health policy at the state, city and community levels.

### ***Real Issues, Real Solutions***

Interventions to improve health can happen at different levels and in many different venues (community, school-based, clinical, family or individual). The ultimate goal is to develop policies that will improve the social conditions that affect the health of the citizens of New Mexico. Below, are some examples of specific social determinants of health and the work of several groups in New Mexico that addresses them. Specific measures of some of these determinants can be found in Appendices A and B.

### **Poverty**

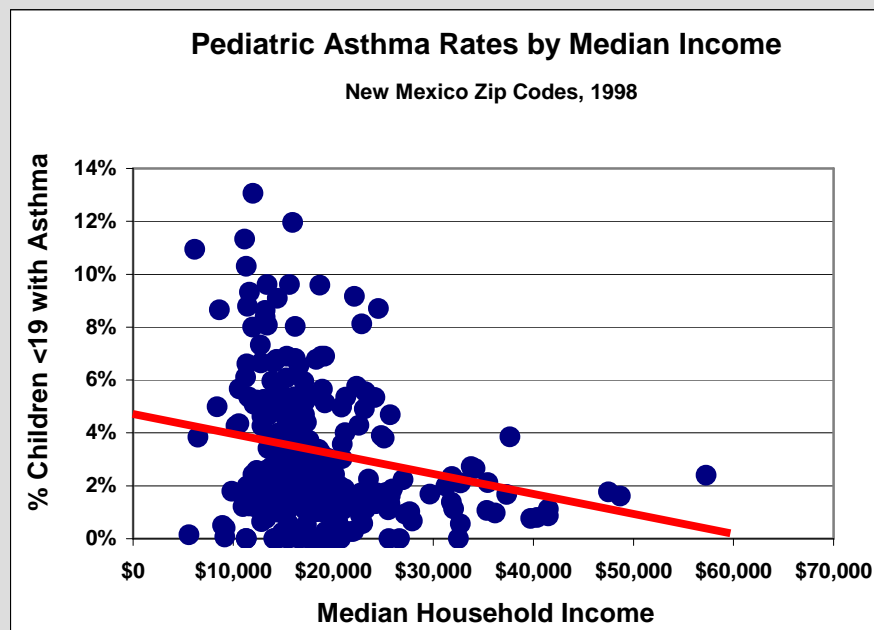
Poorer health outcomes among those in lower socioeconomic classes have long been observed. Studies – mostly conducted in Western Europe – demonstrate that affluent social classes enjoy increased longevity. The connection between poverty and health is a complex one. Material deprivation leads to poor living and working conditions, and poverty is often accompanied by increased behavioral risks, such as higher tobacco use, alcoholism and poor nutrition.

In 2000, epidemiologists with the Social Determinants of Health Working Group partnered with economists from New Mexico Advocates for Children and Families (now known as NM Voices for Children) to create a database measuring income and poverty in New Mexico.

The NM Tax and Revenue Department allowed analysts to aggregate the 1998 state tax returns by the 300-plus zip codes in the state. In addition, variables were created that calculated the number of children and adults at different levels of poverty, the median household income, the number of single parent families, the population of children, and income quintiles for each zip code.

The innovation and usefulness of this database, the NM Income Poverty Tool, was revealed in multiple ways. For example, for the first time, public health workers in New Mexico could calculate in small geographic areas the number of children eligible to be enrolled in Medicaid who were NOT receiving this benefit (estimated at approximately 30,000 children in Bernalillo County alone). The tool could also be applied to ecological correlation analysis to answer questions such as “Is childhood asthma related to poverty and income?” The chart below, illustrating the association between childhood asthma rates and median household income in NM zip codes, answers the question with a resounding “Yes.”

The New Mexico Income Poverty Tool has been used by many researchers in the state and is available at <http://www.nmpha.org/soc-dets.htm>.



### **Racial/Ethnic Health Disparities**

People of color experience much higher death rates from homicide, HIV infection, cancer, heart disease and unintentional injury than whites. These disparities hold true even when controlling for income and insurance status, suggesting that racism may be an important determinant of health.

Institutionalized racism can have a great effect on health. Socially excluding minorities denies them equal access to quality education, employment, healthcare and preventive services, and political participation.

These disparities can be approached in many ways. For example, improving environmental conditions and increasing access to healthcare may alleviate the

burden of a disease such as asthma. Although many of these conditions can be addressed locally, well-founded universal policies can be very effective at reducing health disparities, particularly among infectious diseases. One example involves *Streptococcus pneumoniae*, a bacteria that has traditionally resulted in a higher disease incidence among blacks than whites. Following the implementation of a new vaccine to treat the disease in 2000, the gap between the races closed considerably. Before this vaccination became available, black children under two years of age contracted the disease at a rate 3.3 times higher than that of white children the same age. After the vaccination that disparity was cut by more than half.

Many western states historically have had some of the highest rates of hepatitis A disease in the nation. Hepatitis A rates in New Mexico have been as high as 71.3 cases/100,000 population in 1990 and 66.5/100,000 in 1994 compared with the national rates of 12.5/100,000 and 10.2/100,000, respectively. During 1996-1997, the New Mexico Department of Health collaborated with medical providers throughout the state, including the Indian Health Service and Vaccine for Children providers, to run a targeted campaign to vaccinate children. The campaign targeted the areas of the state considered at high-risk for hepatitis A infection demonstrated by high rates of reported disease in those counties. Since the targeted campaign began in 1996-1997, hepatitis A rates across the state have decreased dramatically and remain low. Prior to the targeted vaccination campaign, Native Americans in New Mexico had the highest rate of hepatitis A and after the campaign they had the lowest rate among racial/ethnic groups.

Many conditions, such as disenfranchisement, lack of accessible transportation and high-quality housing, and limited culturally proficient services can isolate a specific population and

create a higher disease burden within it. These health disparities are often addressed through the directed efforts of local health collaborations.

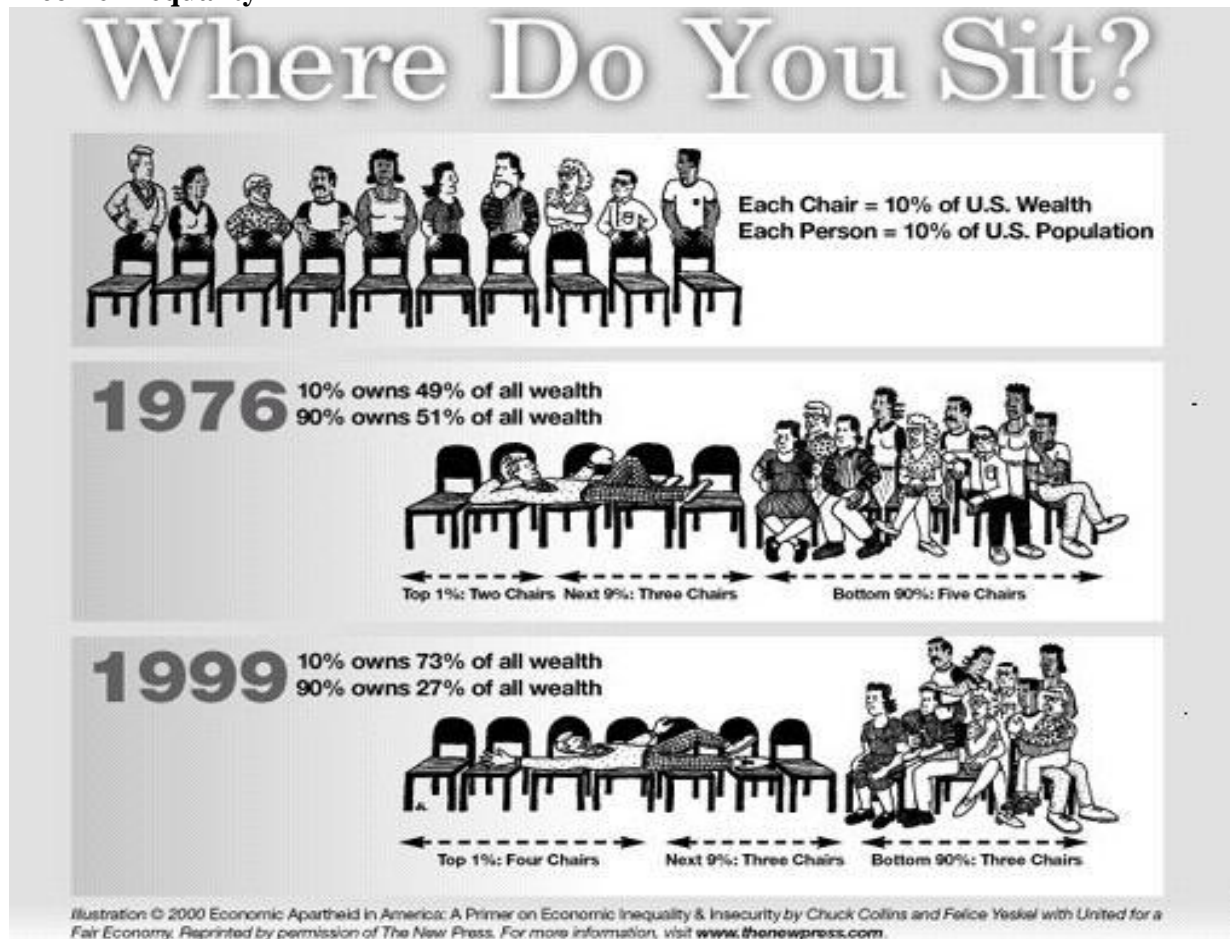
The TOTAH Behavioral Health Authority (TBHA) is a collaboration that works to address the issue of alcoholism among American Indians. It's collaborating partners include the Navajo Nation, San Juan County, the city of Farmington, San Juan Regional

Medical Center, the Farmington Intertribal Indian Organization, the Four Winds Recovery Center, Presbyterian Medical Services, the New Mexico Department of Health, and Indian Health Services.

THBA's target population is: male, approximately 42 years of age; Navajo (93%); found in an incapacitated, inebriated state; retained in protective custody up to five times within a year; in immediate danger of hurting themselves or others; separated from relationships with family and clan; unemployed (79%); homeless (86%); low income and uninsured (95%); exhibiting a need for access to mental health, primary medical and other human services.

Through its efforts, TBHA has contacted 621 individuals; 88% of the estimated 700 chronic public inebriates in the region. Employing outreach and facilitated case management models, TBHA serves an average caseload of 104 clients and has referred 15% of its target population to inpatient treatment for alcoholism.

### Income Inequality



Income inequality occurs when social classes disproportionately benefit from economic growth. When the rich become richer and the poor become relatively

poorer, social exclusion increases. This results in more conflict as lower social classes are denied access to the same services as higher classes. Several U.S.



studies have shown a relationship between high-income inequality and increased levels of mortality. In New Mexico, a study showed that in the late 1990s, the average income of the richest fifth of families was more than eleven

times greater than the average income of the bottom fifth of families. Income inequality has increased in New Mexico since the late 1970s, and should be a focus for future health policy.

The Senior Life Cycle Group of the Grant County Community Health Council developed and staffed a Medication Assistance Program (MAP). The MAP was developed because there was no such program in Grant County and the Senior Life Cycle Group could identify no providers that offered this type of service. A needs assessment survey done as part of the assessment for the 1999 Grant County Community Health Plan had a substantial number of respondents state that access to health care was compromised by lack of insurance and lack of ability to pay for medications. MAP has been in existence over 4 years now and is managed by Hidalgo Medical Services (HMS). The program remains staffed by volunteers and a few paid Community Health Workers. Through a partnership with Gila Regional Medical Center the volunteers are trained and covered for liability issues. There are now five sites in Grant County and additional sites in Hidalgo County. Two Silver City sites alone, located in physician offices, assisted 5,413 patients and processed 9,340 medication assistance applications between 2003 and the end of 2004. This is a major accomplishment in the challenge of providing medications equally across income classes.

## Conclusion

Recognizing and addressing the social determinants discussed in this report is a complex and important challenge for all of those interested in improving the population's health. Many countries have made great advances in this field, but there is much work to be done here in the United States and in New Mexico. Reducing poverty and income inequality, and the negative affects they have on health, will not happen overnight but can be achieved through the coordinated efforts of those working to improve health in New Mexico. An important first step, and a goal of the Social Determinants Workgroup, is to initiate more research that will help explain the relationships between our social environment and health. Understanding how transportation

affects exercise levels and how poverty affects access to healthy foods, are two elements of analyzing the issue of obesity in New Mexico. Learning the ways that unemployment and social exclusion can alter behavioral risks such as alcohol abuse and smoking, is an important step in fighting chronic disease in New Mexico. Identifying and addressing health disparities and inequitable healthcare access will give every New Mexican the same opportunity to live a longer and healthier life. As the correlations between social factors and health are better defined, policymakers will gain information necessary to generate policies that address them. The social determinants of health in New Mexico are critical pieces in efforts to improve the health of all New Mexicans.

APPENDIX A

**Table 1. Social Indicators of Health and Total Mortality by New Mexico County**

County	Child Poverty (2000) *	Education (2000) †	Unemployment (2000) §	Robin-Hood Index (2000) **	Total Mortality (2000-2002) ††
<i>Bernalillo</i>	17.9	84.0	3.20	32.04%	797.1
<i>Catron</i>	39.6	78.0	8.10	32.31%	736.1
<i>Chaves</i>	29.1	73.0	6.30	33.81%	880
<i>Cibola</i>	32	75.0	7.00	30.52%	912.4
<i>Colfax</i>	21.2	81.0	5.10	30.54%	761.9
<i>Curry</i>	25.1	78.0	3.90	32.77%	887.1
<i>De Baca</i>	23.3	72.0	4.50	31.04%	768
<i>Dona Ana</i>	34.4	70.0	7.10	33.34%	753
<i>Eddy</i>	21.5	75.0	6.70	32.41%	942.5
<i>Grant</i>	25.9	79.0	6.10	30.84%	851.7
<i>Guadalupe</i>	24.1	68.0	8.40	31.00%	916.9
<i>Harding</i>	31.3	72.0	3.50	32.11%	694.7
<i>Hidalgo</i>	38.9	69.0	10.90	33.97%	828
<i>Lea</i>	28	67.0	4.90	32.51%	927.9
<i>Lincoln</i>	24.7	85.0	4.10	32.12%	681.4
<i>Los Alamos</i>	1.8	96.0	2.10	24.69%	647
<i>Luna</i>	46.8	60.0	23.40	33.67%	805.2
<i>McKinley</i>	42.3	65.0	7.20	34.95%	930.4
<i>Mora</i>	25.9	70.0	15.40	33.46%	818.2
<i>Otero</i>	27.9	81.0	5.50	29.27%	814
<i>Quay</i>	25.5	74.0	4.30	35.42%	855.7
<i>Rio Arriba</i>	23.3	73.0	7.00	32.44%	903.5
<i>Roosevelt</i>	25.1	75.0	3.40	35.69%	845.5
<i>San Juan</i>	26.6	86.0	7.20	31.39%	849.8
<i>San Miguel</i>	27.8	77.0	6.20	32.82%	921.7
<i>Sandoval</i>	15.6	74.0	3.50	28.35%	711.3
<i>Santa Fe</i>	15.2	84.0	2.70	32.55%	670.1
<i>Sierra</i>	31.5	76.0	2.80	32.69%	909
<i>Socorro</i>	43.6	72.0	5.50	35.85%	835.1
<i>Taos</i>	24.6	79.0	10.4	34.74%	743.3
<i>Torrance</i>	24.5	77.0	5.70	31.20%	835.8
<i>Union</i>	31.4	80.0	3.20	29.66%	1037.5
<i>Valencia</i>	22.3	76.0	4.10	29.22%	851
New Mexico	24.6	78.9	5.00	32.72%	
<b>Correlation With Total Mortality</b>	0.336	-0.373	0.052	0.223	

\* Percent of Children at or Below Poverty Level- US Census Bureau, 2000

† Percent of Adults With a High School Degree or Graduate Equivalent Degree-U S Census Bureau, 2000

§ Civilian Labor Force Unemployment Rate - New Mexico Department of Labor, 2000

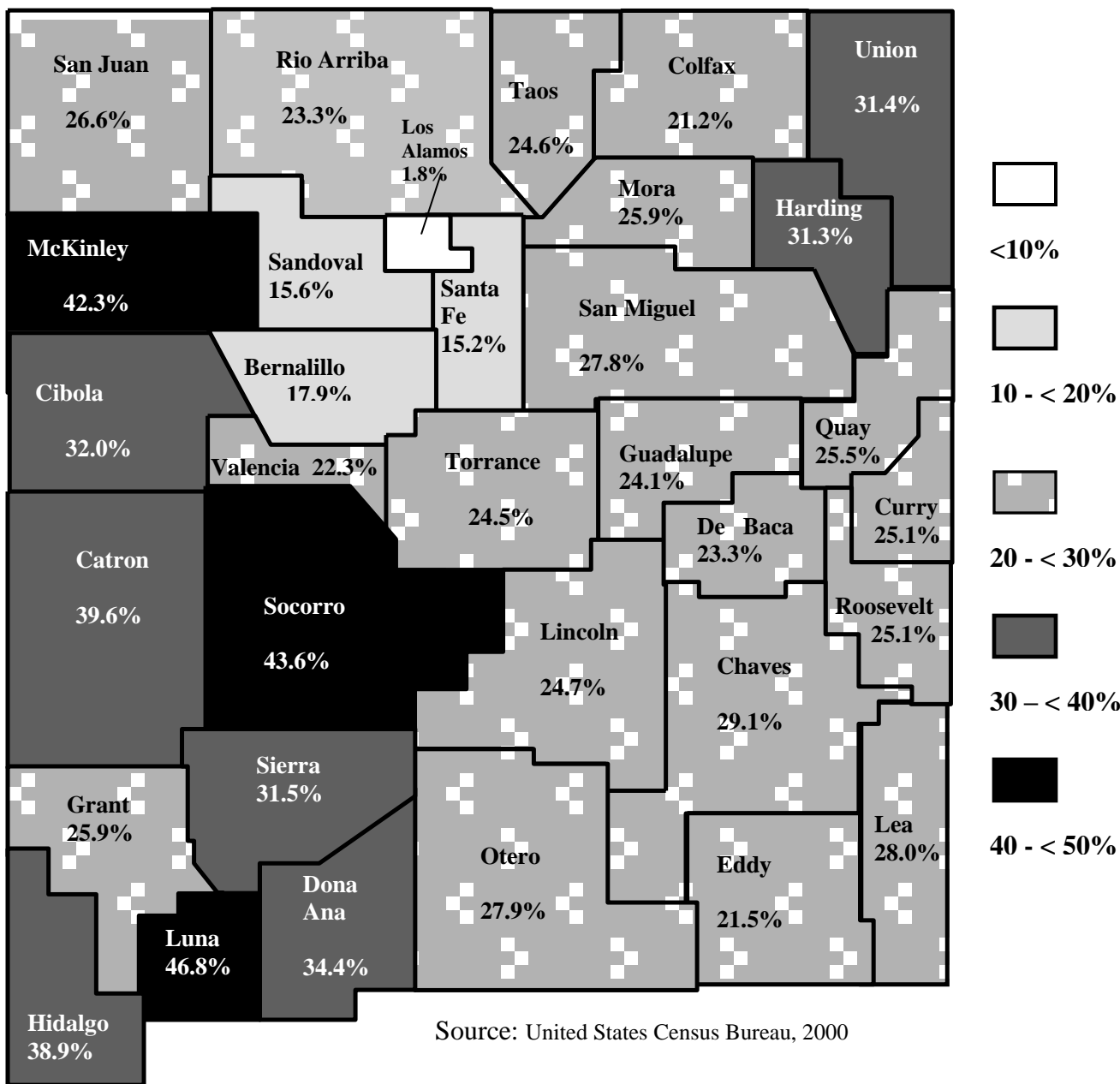
\*\* Income Inequality Measure Calculated by the Bureau of Business and Economic Research (University of New Mexico) Based on US Census Bureau 2000 Figures

†† Total Mortality, Bureau of Vital Records and Health Statistics, NMDOH, 2000-2002

The social indicators in Table 1 were chosen because they represent social conditions that have documented associations with health outcomes. High educational attainment, stable employment, financial prosperity and social and economic equality are all conditions that support the achievement and maintenance of good health. Pearson correlation coefficients were calculated to measure the correlation between each indicator measure and the total mortality measure for the thirty-three New Mexico Counties.

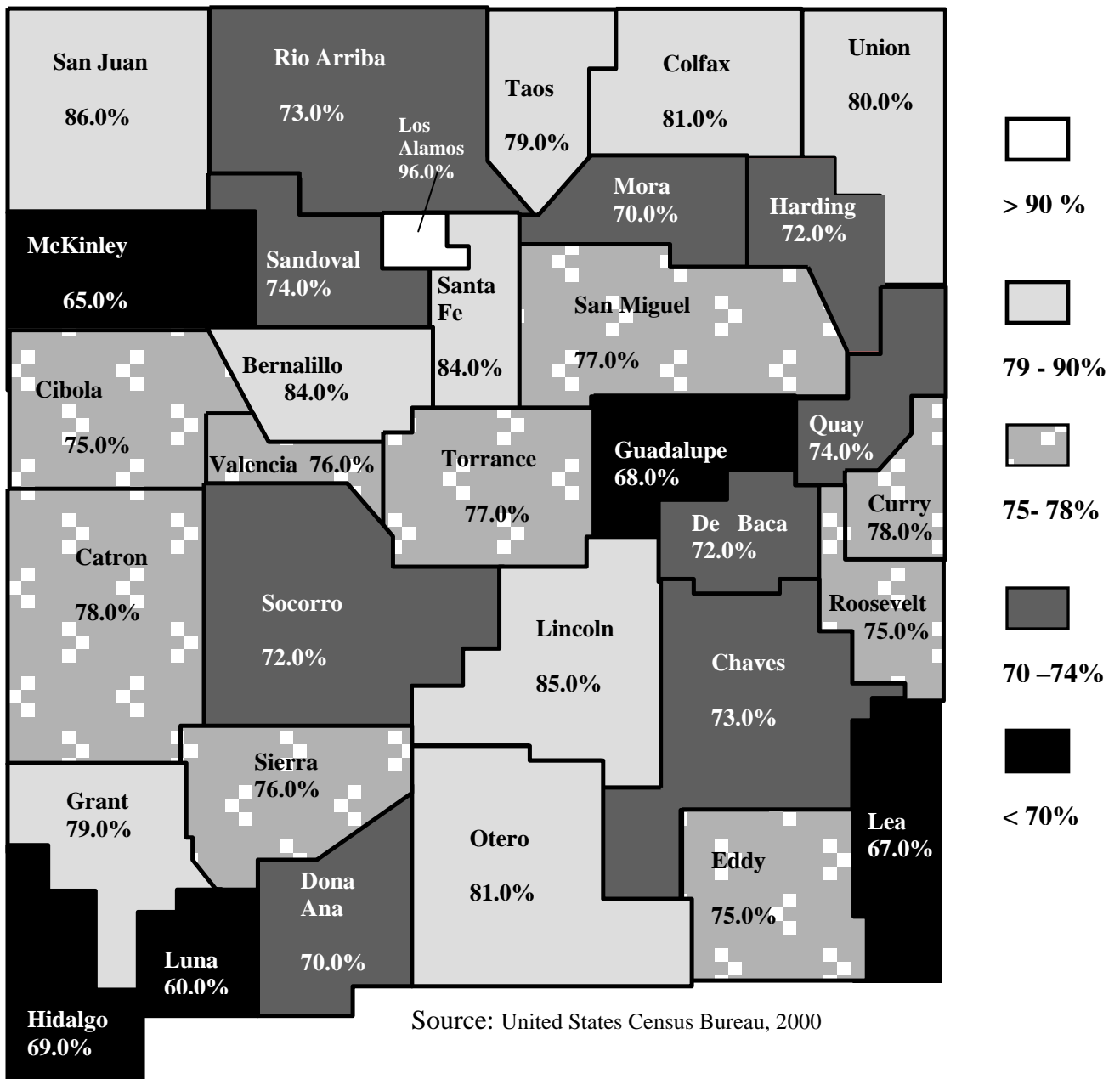
Total mortality was aggregated for the years 2000-2002 to avoid small numbers in less populous counties. According to these data, the highest correlated indicator was education status, followed by child poverty. Neither income inequality nor unemployment significantly correlated with total mortality ( $\alpha=0.1$ ).

Percent of Child Poverty by County, New Mexico, 2000



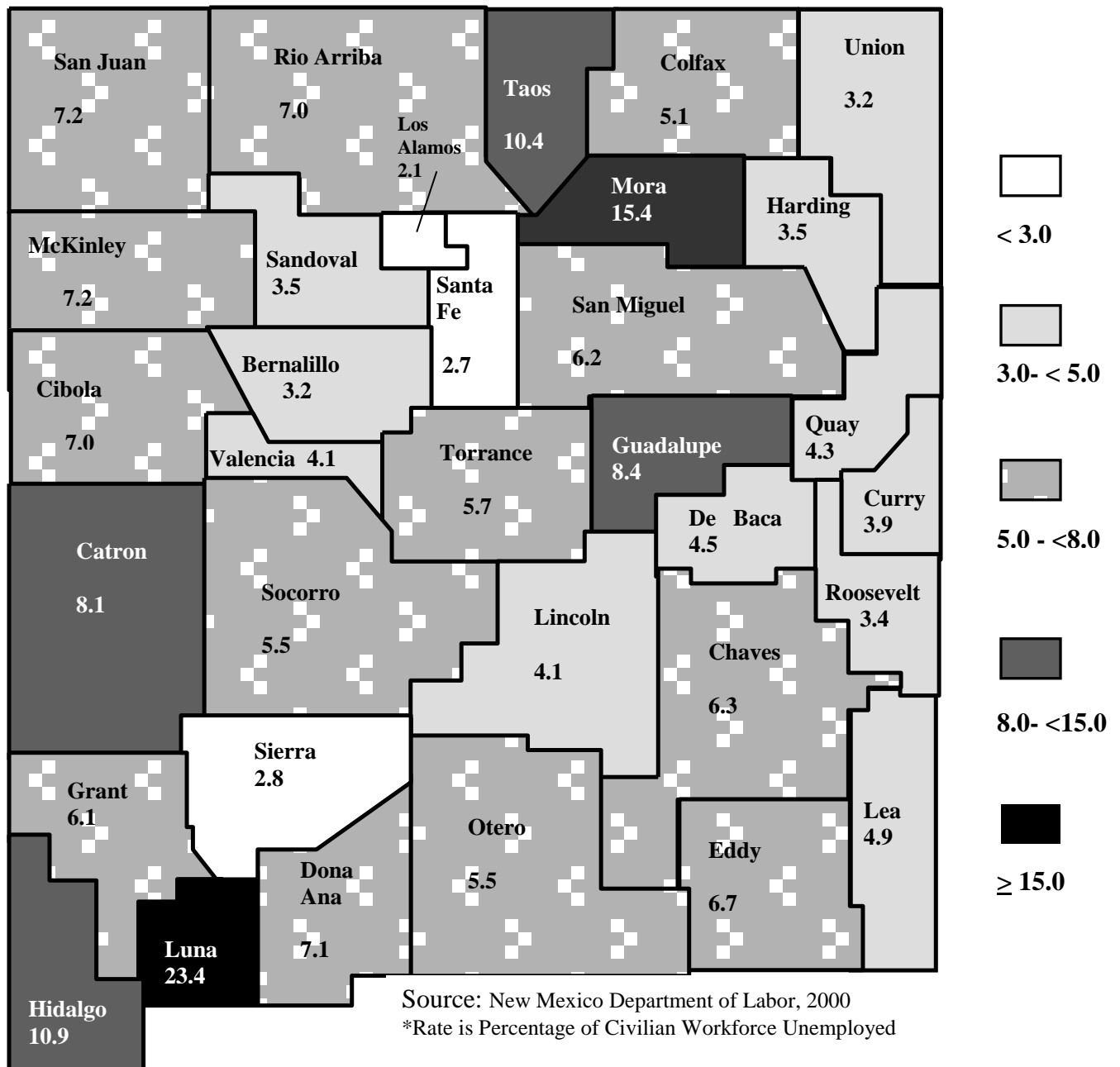
Poverty, particularly among children, can be associated with limited healthcare access, inadequate nutrition and poor growth and development. These problems in early life can result in later social exclusion, disease and premature mortality. In New Mexico child poverty was lowest in Los Alamos, Santa Fe, Bernalillo and Sandoval counties. Stretching diagonally from San Juan County in the Northwest to Lea County in the Southeast, 20-30% of children are living in poverty. The highest percentages of children living in poverty were found in Luna, Socorro and McKinley counties. In the year 2000, nearly half of all children living in Luna County were born into and living in poverty.

## Percent of Adults Over 25 Years of Age With a High School Diploma or GED by County, New Mexico, 2000



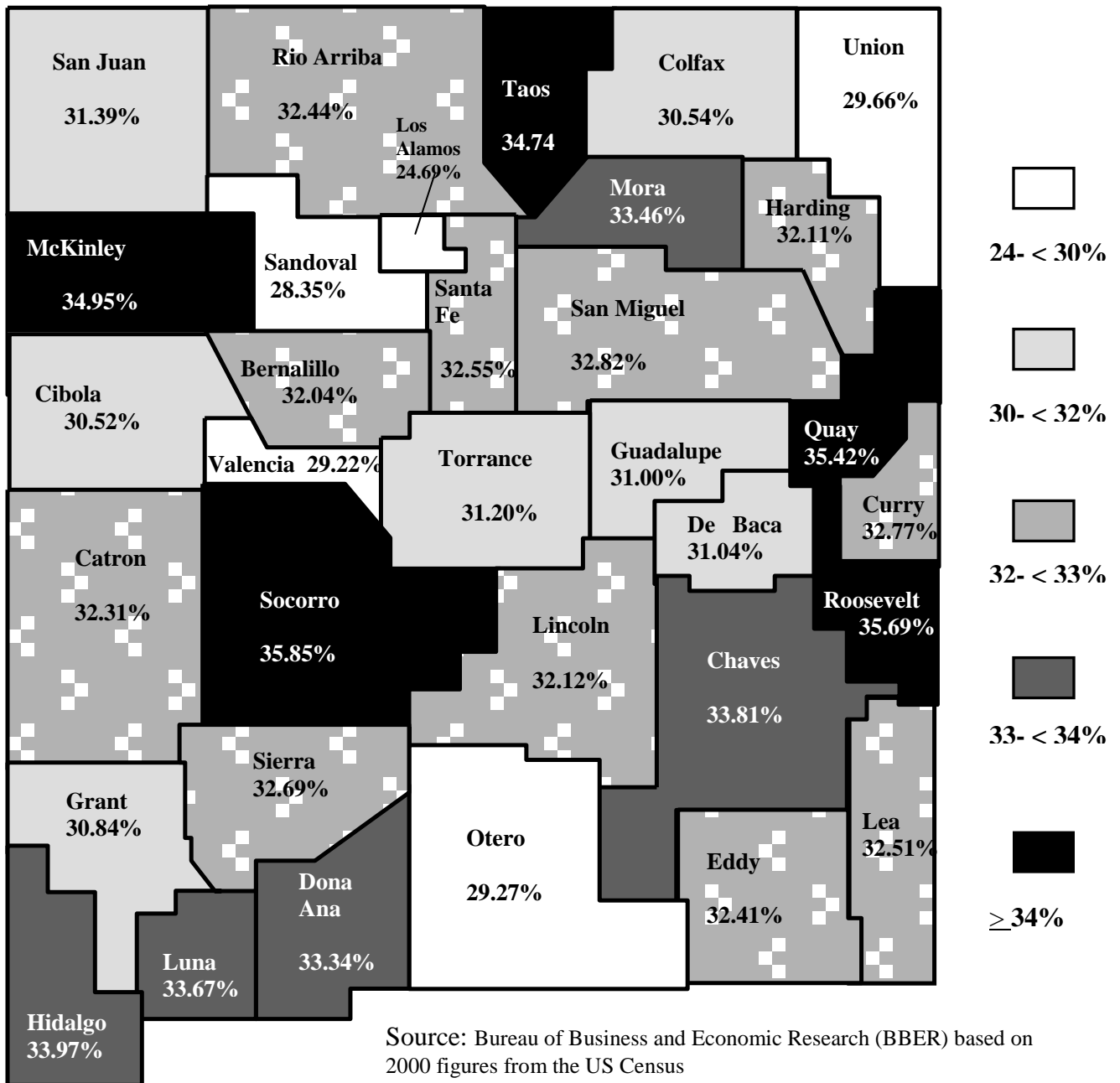
There has been a demonstrated association between limited education and increased mortality. This may involve the phenomenon that low education attainment can often lead to poorer working conditions and jobs that involve more intense manual labor. In the state of New Mexico, the percentage of adults over 25 years of age with a high school diploma is significantly correlated with total mortality. Counties with the lowest percentage of adults with higher education (i.e. Luna, McKinley, and Guadalupe) also have some of the highest total mortality rates. There is not a clear pattern of education status across the state although the lowest percentages of adults with a high school education are in more rural areas of the state along the borders.

## Civilian Workforce Unemployment Rate\*, by County, New Mexico, 2000



Unemployment can affect one's health psychologically, mentally, and physically. An association has been demonstrated between unemployment and self-reported poor or fair health in national and international studies. As the association is a complex one, the effects of unemployment on health are optimally measured over a long period of time. In many cases, poor health may precede and lead to unemployment, causing a false relationship to appear. This false relationship can be evaluated and disproved over a longer period of time. Using 2000 Census data, unemployment rates in the state of New Mexico are not heavily correlated with county mortality figures. Perhaps this is the case because snapshot data are used for comparison instead of longitudinal data. There exists a large unemployment disparity among counties in New Mexico, with the lowest unemployment rate in Los Alamos County and the highest rate in Luna County (a 23 fold difference).

## Income Inequality (Robin Hood Index) by County, New Mexico, Census 2000-Based



The Robin Hood Index is an income inequality measure that describes relative deprivation and equates with the percentage of income earned by the bottom 50% of a population. It has shown stronger correlations with all-cause mortality than other inequality measures (i.e. Gini coefficient). It is widely known that income inequality has an inverse relationship with life expectancy and additional studies should be planned to evaluate the effect of income inequality on the lives of New Mexicans. Using Robin Hood Indices calculated with Census 2000 figures, income inequality is not highly correlated with total mortality across New Mexico's counties. Nevertheless, income inequality is an important social determinant of health and all efforts should be made to minimize it. This map shows a scattered pattern of income inequality with the lowest measure in Los Alamos County and the highest measure in Socorro County.

## **DEFINITIONS AND KEY TERMS**

### ***Advocacy***

Advocacy is a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or program.

### ***Capacity building***

Capacity building is... "The development of sustainable skills, organizational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over". (P. Hawe et al, 1999)

The five key elements of capacity building are:

- \* Organizational development
- \* Workforce development
- \* Resource allocation
- \* Partnerships
- \* Leadership

### ***Collaboration/Partnering***

Collaboration/Partnering is a recognized relationship between different sectors of society that has been formed to take action on an issue to achieve improvements in health in a way that is more effective, efficient or sustainable than might be achieved by the health sector acting alone.

### ***Community development***

Community development is a range of activities dedicated to: \* increasing the strength and effectiveness of communities; \* improving local conditions (especially for people in disadvantaged situations); and \* enabling people to participate in public decision-making to achieve greater long-term control over their circumstances.

### ***Discrimination***

The process by which a member, or members of a socially defined group is, or are, treated differently (especially unfairly) because of his/her/their membership of that group.

### ***Economic, regulatory and policy initiatives***

Economic, regulatory and policy initiatives involve putting in place incentives and/or disincentives to encourage individuals, groups or organizations to adopt healthier practices or make healthier choices. Examples include restrictions on the sale of alcohol, food safety requirements and restrictions on tobacco advertising.

### ***Health***

Health is defined in the World Health Organization (WHO) constitution as: "a dynamic state of complete physical, mental, spiritual and social well-being, and not merely the absence of disease or infirmity."

Health promotion defines health as a resource, which allows people to lead an individually, socially and economically productive life. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities.



### ***Health promotion***

Health promotion represents a comprehensive social and political process. It not only embraces actions directed at strengthening the skills and capabilities of individuals, but also 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.

### ***Heterosexism***

Institutional and interpersonal practice whereby heterosexuals accrue privileges and discriminate against people who have or desire same sex sexual partners, and justify these practices via ideologies of innate superiority, difference, or deviance.

### ***Human Rights***

Presumes that all people are born free and equal in dignity and rights and provides a universal frame of reference for deciding questions of equity and social justice.

### ***Poverty***

#### **Human poverty**

Impoverishment in multiple dimensions--deprivations in a long and healthy life, in knowledge, in a decent standard of living, in participation.

#### **Income poverty**

Deprivation in a single dimension--income.

#### **Social exclusion**

Focuses not only on the impact, but the process of marginalization.

### ***Primary Health Care***

The Declaration of Alma Ata defines primary health care as being "essential care made universally accessible at a cost a country and community can afford, using methods that are practical, scientifically sound and socially acceptable".

Primary Health Care is seen as a solution to the inadequate illness management system by providing a balanced system of treatment and disease prevention that is affordable, appropriate and accessible.

Principles of advancing health through primary health care include:

- \* consumer / community participation and responsiveness
- \* self management and reliance
- \* intersectoral collaboration and partnerships
- \* prevention, health promotion and integrated care
- \* social justice and equity

These principles require the search for a balance between big picture and local needs and short and longer-term gains in health, recognition of the inequalities in health between groups and greater access to policy development and resource allocation processes.

### ***Public health***

Public health is the organized response by society to protect and promote health and to prevent illness, injury and disability. Public health seeks to improve health and wellbeing using approaches that focus on whole populations. It aims to reduce inequalities in health status between social groups and to influence the underlying social, economic, physical and biological determinants of health.

### ***Racism***

Institutional and individual practices that create and reinforce oppressive systems of race relations.

### ***Sexism***

Inequitable gender relationships and refers to institutional and interpersonal practices whereby members of dominant gender groups (typically men) accrue privileges by subordination of other gender groups (typically women) and justify these practices via ideologies of innate superiority or difference.

### ***Social capital***

Social capital is a term used to describe the contribution that social relationships make towards the health and wellbeing of our society. It refers to the bond of trust and relationships that communities build and renew when people interact with each other in families, workplaces, neighborhoods, local associations and a range of informal and formal meeting places and situations.

The elements that make up social capital include:

- \* Social networks and support structures
- \* Community participation
- \* Civic and political environment
- \* Trust in people and social situations
- \* Tolerance of diversity
- \* Altruism and
- \* Philanthropy

### ***Social determinants***

Even in the richest countries, wealthier people live longer and have fewer illnesses than the poor. These differences in health are an important social injustice, and reflect some of the most powerful influences on health in the modern world.

The WHO in its document *The Solid Facts* refers to these social influences as the 'social determinants of health'. People's lifestyles and the conditions in which they live and work strongly influence their health, wellbeing and longevity. Poor conditions lead to poorer health. An unhealthy environment and unhealthy behavior have direct harmful effects, but the worries and insecurities of daily life and the lack of supportive environments also have an influence.

Examples of social determinants are:

- \* income
- \* education
- \* occupation
- \* family structure

- \* access to transport
- \* stress
- \* sanitation
- \* exposure to hazards
- \* social support
- \* racial discrimination
- \* access to resources linked to health.

**Stress**

Environmental demands tax or exceed the adaptive capacity of an organism, resulting in psychological or biological changes that may place persons at risk for disease.