INTRODUCTION

The most recent World Health Organization (WHO) International Conference on Health Promotion in Jakarta, Indonesia, identified poverty as the greatest threat to health. Indeed, in advanced industrial countries, including Australia, the overall level of illness is much higher among the poor compared to their more affluent counterparts. Generally speaking, poor people are sick more often than wealthier people, and poor people die younger due to poorer economic, social, political and physical conditions (Short, Sharman & Speedy 1998).

This article will discuss and explain the relationship between poverty and health, and demonstrate how poverty contributes to ill health. To begin with, a brief descriptive section defines relative poverty and reviews the relationship between socioeconomic status and morbidity, before continuing on to outline two aspects of poverty that have a negative effect on individuals’ lives. Firstly, the effect of low income on health will be examined, followed by the poor health behaviours of individuals living in poverty. The last section of the article looks at a specific example of an individual health behaviour, cigarette smoking, and delves into various explanations as to why poor people may be more susceptible to partake in such health-damaging behaviours. Finally, the article closes with a brief comment about the role of...
primary care health professionals in relation to people living in poverty.

**Poverty and its effects on health**

Internationally, people who lack food and shelter for minimal needs are said to be living in absolute poverty. Comparatively, poverty in Australia is referred to as ‘relative poverty’ (Healey, Brotherhood of St Laurence 2002). The concept of relative poverty asserts that the poor are not defined as those who fall below a fixed subsistence level but those whose incomes are considered too far removed from the rest of the society in which they live (Holman 1978). In short, the poor are identified in relation, or relative, to other people (Holman 1978). It is well documented that relative poverty is a significant determinant of ill health (Wass 2000). It is also well documented that poverty and the extent of relative deprivation have a major impact on the health of a society’s population (Marmot & Wilkinson, Shaw, Dorling & Davey Smith 1999).

Recent studies have identified that countries with higher levels of equality in income distribution have higher life expectancy and this is the case both in countries that are relatively poor and in those that are well off (Wass 2000). In Australia there are clear patterns in the distribution of morbidity and mortality across social groups with the general pattern being that the lower the social class the worse the mortality and morbidity (Short, Sharman and Speedy 1998).

Importantly the strength of the link between socioeconomic status and health varies according to the degree of differences in income between people of differing socioeconomic status (Wass 2000). Cross-national research shows that the greater the degree of socioeconomic inequality within a society, the steeper the gradient of health inequalities (Schrader 2004). The fact that class differences in health are smaller in Sweden than the United Kingdom and the USA has been attributed to Sweden’s more even distribution of income (Schrader 2004). To determine the aetiology of the inverse relationship between health and socioeconomic status of populations, it is practical to consider socioeconomic status at an individual level.

**Material resources**

When poor socioeconomic status of individuals is examined by literature, a focus is frequently placed on the lack of income and material resources available to these individuals. Defining the link between health and poverty is more complex than simply a lack of money (Marmot 2001). Shaw, Dorling and Davey Smith (1999) emphasise that the harm to health comes not only from material deprivation but also from the psychological and social problems resulting from living in relative poverty. That said, the majority of the research related to poverty and health suggests that material conditions are the underlying root of ill health. That is, poverty is considered principally in terms of lack of economic resources and how that prevents people from attaining a decent standard of living and from participating in society (Taylor & McClelland 1994).

The level of economic resources, usually measured by income, can contribute to health inequalities directly and indirectly (National Health Strategy 1992). Directly, low income can contribute to ill health through the inability to purchase nutritious food and quality housing. The diets of low-income groups are likely to be inadequate, and such diets are characterised by low fruit, vegetable and fish consumption (Robertson, Brunner & Sheiham 1999). As a consequence, nutrient intake is low in dietary fibre, antioxidant and other vitamins, folate, iron, and essential fatty acids (Dowler & Dobson 1997, cited in: Robertson, Brunner and Sheiham 1999: 200).

Low income can also contribute to a lack of quality housing. Poor housing can be damp, cold and contain mould, conditions which are associated with wheezing, breathlessness, cough, phlegm, meningococcal infection, and respirato-
ry diseases and asthma (Ineichen 1993, cited in: Shaw, Dorling & Davey Smith 1999: 216). In addition to these issues, poor housing conditions can also bring a risk of fire and accidents, and overcrowded housing not only increases the risk of infection but impacts on mental health through factors such as lack of privacy and high noise levels (Shaw, Dorling & Davey Smith 1999). Indirectly, low income may contribute to ill health through, for example, reduced participation in society.

There is now considerable evidence showing that social support is beneficial to health and that social isolation leads to ill health (Stansfeld 1999). Burdess (2004) suggests that less socially integrated individuals – those with few friends or family support, those with low levels of community participation and those not in a stable relationship – can have significantly higher rates of illness than those with close social ties. Poverty and low income can also affect mental health. Financial hardship, for example, has been associated with both the onset of depression as well as chronic episodes among single mothers and this places them at high risk for poor mental health, particularly for subclinical depressive symptoms (Peden et al. 2004).

All of these examples demonstrate how low income can have a negative effect on how an individual may access the fundamental building blocks of health, such as good nutrition, adequate housing, and opportunities to participate in society. Low income, however, is not the only significant link between health and poverty. The influence that poverty has on an individual’s behaviour, and their capacity to make healthy choices, is another important aspect of the health and poverty relationship.

**Heath Behaviours**

An individual’s behaviour is influenced by the environment in which they live, and therefore healthy responses of individuals require an environment in which they can make healthy decisions (Schrader 2004). Ogden (2001) suggests that 50% of mortality from the 10 leading causes of death results from individual behaviour or lifestyle choices. However, the individual cannot be held completely responsible for the decisions they make that affect their health negatively. Sociologists of health argue that individual’s health and longevity are dependent on the political and social context and levels of inequality in which they live (White 2002). This argument suggests that social divisions and material differences are significant factors of lifestyle and behaviour. When social and economic circumstances are poor and there is lack of hope for the future, people are less empowered to make healthy decisions on such things as smoking, drugs, alcohol, diet or exercise (Schrader 2004).

Lower expectations of health, plus a general feeling of lack of control among poorer class groups, help to generate a more fatalistic attitude to health (Burdess 2004). These factors can lead to higher levels of risk taking and lower participation in preventative health services (Burdess 2004). It has been shown that programs aimed at behaviour change often fail to reach lower socioeconomic groups (Schrader 2004). The Queensland Government Public Health Services Branch (n.d.) suggest that men and women with lower socioeconomic status are less likely to act to prevent disease and also to seek early detection of disease tests. Schrader’s (2004) research reveals that women of lower-socioeconomic status are less likely to have Pap tests, breast checks or mammograms independent of age, health status or frequency of doctor visits. Beck (1992 cited in: Hardey 1998: 143) acknowledges that health risks are increased with poverty: ‘Like wealth, risks adhere to the class pattern, only inversely: wealth accumulates at the top, risks at the bottom … Poverty attracts an unfortunate abundance of risks.’

The association between poverty and behaviour may be due to a variety of factors, including poorer access to education and information (Jarvis & Wardle 1999). Limited or no access to
health education, information and support will effect individual behavioural or lifestyle factors (Fincher & Nieuwenhuysen 1998) and health behaviours in terms of smoking, drinking alcohol, diet and exercise seem to be important in predicting the mortality and morbidity of individuals (Ogden 2001). Jarvis and Wardle (1999) suggest that poor people in a country such as the United Kingdom are less likely than those who are well off to eat a good diet, more likely to have a sedentary lifestyle, more likely to be obese, and more likely to be regularly drunk. Furthermore, Jarvis and Wardle (1999) found that the links between deprivation and health behaviours are strongest in the case of drug use, both legal and illegal. Of the many poor health behaviours people have, none are more detrimental to individuals than cigarette smoking.

**Health behaviour: smoking**

There are clear socioeconomic differences in smoking and other unhealthy behaviours that are risk factors for ill health (Marmot 2001). Cigarette smoking is the individual health behaviour with the single largest impact on health inequalities (Jarvis & Wardle 1999). Ironically, it is the poorer groups within Australian society who are worst effected by smoking, with one of the ironies being that the expense of cigarette smoking further limits or restricts individual’s financial situation. It appears those who can least afford to smoke, smoke the most and suffer most from it (Jarvis & Wardle 1999).

There are varying explanations as to why it is that poor people are particularly drawn to this habit. Jarvis and Wardle (1999) suggest that the association could be mediated by higher rates of smoking initiation, stronger perceived rewarding effects (either positive or negative) leading to higher levels of dependence, or to greater difficulties in cessation through lower motivation, higher dependence, or fewer available coping resources. In her study of lone mothers, Graham (1987a, cited in Hardey 1998: 144) explained the lifestyle of parents in terms of their smoking behaviour; ‘in a lifestyle stripped of new clothes, make-up, hairdressing, travel by bus and evenings out, smoking can become an important symbol of one’s participation in an adult centred world’. Jarvis and Wardle (1999) propose an alternative functional view of smoking is that it is self-medication. Cigarette smoking is perceived as a means of managing stress, of regulating mood, and of coping with all the hassles and strain resulting from material deprivation (Graham 1987b; Smith & Morris 1994, cited in Jarvis & Wardle 1999: 250). Overall, there is a widening social class gap between the middle and poorer classes with an inverse relationship between income and smoking becoming increasingly evident (Hardey 1998).

**Conclusion**

In modern western societies, including Australia, there is a clear inverse relationship between poverty and health. People living in poverty suffer higher morbidity and mortality rates than people in wealthier lifestyles. This paper focused on relative poverty in Australia and recognised two key factors associated with the effects that poverty can have on health. Firstly, material deprivation was outlined, and used to explain that the lack of access to economic resources has a significant impact on individual’s health. Further illustrating the effect of poverty on health, the behaviour of individuals living in poverty was outlined, highlighting that individuals’ choices and decisions regarding health are greatly influenced by their societal environment. Being the health behaviour with the single largest impact on health inequalities, cigarette smoking was used as a specific example of a health behaviour that has a significant negative impact on people living in poverty.

In closing, there is no question that people living in poverty are more susceptible to poor health and higher rates of morbidity and mortality than other people in their society. As primary care health professionals, we have a responsibility to be mindful of this when assessing and iden-
Students’ corner: Living in poverty and its effects on health

Identifying people’s health needs, to treat people respectfully and in a non-judgmental manner, and to promote and provide good health information when and where it is possible.

Acknowledgements
My sister, Lorna Bagworth, for assistance with editing and my lecturer, Sandi Mackey, for assistance with publishing.

References
Robertson A, Brunner E and Sheiham A (1999) ‘Food is a practical issue’ in Marmot M and Wilkinson R (Eds) Social Determinants of
Sally Swinnerton


ANNOUNCING

HEALTH SOCIOLOGY REVIEW

SOCIAL EQUITY AND HEALTH

Edited by Olle Lundberg, CHESS, Karolinska Institute, Sweden
ISBN 0-9757422-8-0; iv + 124 pages; softcover

Course Coordinators are invited to contact the Publisher: subscriptions@e-contentmanagement.com for an adoption evaluation copy.

EXEMPLAR

Would you like to share an experience that you believe has made a difference to a patient and/or their family?
If so, write to the EXEMPLAR section of Contemporary Nurse.
See the Author Guidelines on www.contemporarynurse.com for more information about this section and how to submit your work.