The Role of Social Determinants in Tackling Health Objectives in a Context of Economic Crisis

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ABSTRACT

The impact of the economic crisis on health through its social determinants has the greatest effect on disadvantaged, low income households as they are more vulnerable to falls in income and are more likely to suffer the employment effects of an economic crisis. They are subject to exclusionary processes that lead to worse health both in the short and long term.

The health impacts of an economic crisis include an increase in suicides, homicides and cardiovascular mortality, a fall in road traffic accidents, and worse infectious disease and mental health outcomes. Those who become unemployed have a greater risk of poor health than the employed, while employees may be affected by the rise in insecure and temporary work and a greater effort-reward imbalance. As the cost of living rises faster than incomes, more households fall below a minimum income necessary to live a healthy life. There are higher levels of poverty, greater income inequalities and more households with debt problems or other financial difficulties. Lower incomes lead to more homelessness and fuel poverty. All of these factors are associated with worse physical and mental health.

Health inequalities are likely to widen following an economic crisis, though policy responses can help to mitigate the impacts. Higher levels of social spending are associated with better health outcomes and reduced inequalities, whereas research suggests that austerity measures do not have positive health effects. Health equity impact assessments should be carried out on all policies. Specific policy areas covered in the recommendations include universal health coverage, active labour market programmes, a fairer tax system, homelessness prevention, house-building, debt relief and fuel poverty measures. Local interventions can also do much to improve daily living conditions, through improving public services and resilience to financial and other shocks.

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INTRODUCTION

Health inequalities arise because of inequalities in society: "in the conditions in which people are born, grow, live, work and age"[1]; and in the structural drivers of those conditions, the unfair distribution of power, money and resources.[1] Improving healthcare and preventive public health actions have increased life expectancy and improved health outcomes across the globe, yet it is only when all of the social determinants of health are addressed that there is a chance of reducing the substantial inequalities in health that exist, on a gradient, between the most and least deprived parts of society.

The World Health Organization Commission on Social Determinants of Health conceptual framework (Figure 1) shows the causal pathways through which social factors influence health. These start with the wider societal level processes, which influence and are influenced by differential exposures and vulnerabilities in terms of social position, gender and other factors.[1] Material circumstances, social cohesion, psychosocial factors, behaviours, biological factors and the health care system all contribute to the positive and negative effects on health and well-being that accumulate over the life course.[1] All of these factors contribute to the distribution of health and well-being and should be acted upon in order to improve health and reduce inequalities.

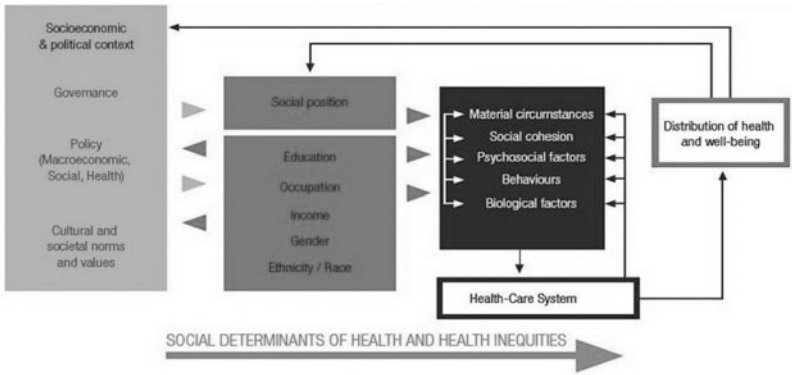

Fig. 1. Commission on Social Determinants of Health conceptual framework.

Source: Commission on social determinants of health.[1]

Efforts to improve health and reduce health inequalities should not be dependent on macroeconomic conditions or restricted to times of economic boom. In fact, economic downturns should be a time of more, not less action. During an economic crisis, many health outcomes are likely to deteriorate and there is a differential impact across the population, with those directly affected by unemployment, poor working conditions, a loss of income, financial difficulties or housing problems suffering the worst effects. The fact that there is less money does not alter the significant costs—both human and financial—of doing nothing to reduce health inequalities, as calculated for England in Fair Society, Healthy Lives, see Box 1.[2]

Box 1

Estimated Costs of Doing Nothing to Reduce Health Inequalities in England

- 1.3 to 2.5 million lost years of life
- 2.8 million years of limiting illness or disability
- GBP £31-33 billion per year in productivity losses
- GBP £20-32 billion per year in lost taxes and higher welfare payments
- GBP £5.5 billion NHS healthcare costs

Source: The Marmot Review Team. Fair society, healthy lives: Strategic review of health inequalities in England post-2010. The Marmot Review; 2010.[2]

This article discusses the impact of an economic downturn on the social determinants of health and health outcomes, emphasising the greater proportional impact on low income and deprived households and those who face additional barriers to participating fully in society. It is not intended to be a systematic review as the range of social determinants of health is too large to cover in a single paper—rather it aims to summarise the key issues. It makes recommendations on what can be done—through action on the social determinants of health—to mitigate these proportionately greater negative health impacts on the more disadvantaged.

THE HEALTH IMPACTS OF ECONOMIC CRISIS

There are physical and mental health impacts of an economic crisis and these are felt both in the short- and long-term. Results of research into the immediate impact of an economic crisis on the physical health of a population have found different results depending on whether they study

the whole population, those most severely affected or particular health outcomes. The earliest signs that a recession may be associated with a fall in mortality were reports following the 1929 depression in the United States that showed a reduction in overall mortality rates by about ten per cent across American cities. However, more recent research has shown that there were increases in certain causes of death such as suicides, particularly in those states that had more bank failures.[3] Further, other intervening factors such as prohibition and New Deal policies influenced the reductions in total mortality.[3,4] There is comparatively little research into the longer-term impacts of an economic crisis, though it appears that being born in a recession is associated with increased mortality rates in adulthood.[5]

Studies into specific causes of mortality have allowed us to see more clearly the impact of recession on health. In the short-term, suicides and homicides tend to increase with a rise in the unemployment rate, while road traffic accidents fall, as people have less disposable income to spend on using their cars.[6] For example, suicides across European Union countries rose between 2007-2009, by 17 and 13 per cent in Greece and Ireland, two countries facing the most severe economic crises.[7]

A recent systematic review of infectious disease transmission and control during economic downturns found evidence of increased risks, both immediately (mainly from increased contact rates) and with a delay of several years (in terms of indirect transmission through infrastructure deterioration or reduced health system capacity to provide effective treatment), resulting in longer infectious periods.[8] The authors also noted that economic downturns could exacerbate socio-economic inequalities while increasing certain susceptible populations and high-risk spreader groups, such as prisoners, migrants, and the homeless. Lower living standards may also lead to over-crowding and poorer nutrition while environmental exposures to pathogens may be altered, creating new opportunities for the spread of vector-borne disease. Recovery rates may be similarly affected, with less funding available for healthcare provision, and susceptible groups less able to access healthcare, particularly in health systems that do not offer universal coverage.[8]

Non-communicable diseases may also increase following an economic crisis, both in the short- and long-term. Cardiovascular mortality has been shown to rise after a system-wide banking crisis in high-income countries,[9] as well as increasing two to three years after heightened unemployment, with the effect persisting for 10-15 years.[10]

Mental health and well-being deteriorate more immediately and perhaps more severely than physical health during an economic downturn.[11] The two are linked, with increased stress and anxiety in those most affected leading to rises in suicides, cardiovascular disease and overall mortality. A comparison

of the frequency of mental disorders in primary care in Spain in 2010 and 2006 (pre-recession), showed substantial increases in the proportion of patients with mental health disorders, particularly among families experiencing unemployment and mortgage payment problems.[12] Further, Eurobarometer data from 27 EU countries has shown that recession may intensify social exclusion for people with mental health problems.[13]

Some causes of injury and death decline during a recession—for example road traffic accidents, due to a reduction in the amount of travel undertaken.[3]

EXPERIENCES AND MECHANISMS THAT LEAD TO POOR HEALTH

Some people are worse affected than others by the economic crisis, such as those in the most disadvantaged social groups. People in these groups are more likely to experience unemployment, fall into financial difficulties, become impoverished and move into poor quality housing or become homeless. Those in the most disadvantaged groups are subject to multiple exclusionary processes.

Unemployment and Youth Unemployment

Recorded unemployment rose by 28 million people globally between 2007-2012, an increase in the unemployment rate from 5.4 per cent to 5.9 per cent.[14] This masks huge variation in different countries and regions, both in terms of recorded levels and the extent to which work is undertaken on an informal basis by those who cannot get formal employment. About half of the recorded increase in unemployment since 2007 has been in the advanced economies, though the highest rates of recorded unemployment remain elsewhere, particularly in the Middle East and North Africa.[14]

Unemployed people—particularly those suffering long term unemployment—have a greater risk of poor health than those in employment.[2] Reasons for this include fewer financial resources to live a healthy life, stress associated with job loss and financial difficulty, and a lack of control and the sense of a role in life. We can learn from previous experiences of recession, as it will be some years before comparable prospective evidence is available for the recent economic crisis. People who were unemployed during the early 1980s recession had a 20-25 per cent higher mortality rate than employed people in the equivalent socio-economic group,[15] as shown in Figure 2. They were more than twice as likely to develop a limiting illness compared to those in employment and 60 per cent less likely to recover from it.[16]

Fig. 2. Mortality of men in England and Wales in 1981-92 by social class and employment status at the 1981 Census.

Source: Office for National Statistics Longitudinal Study.[15]

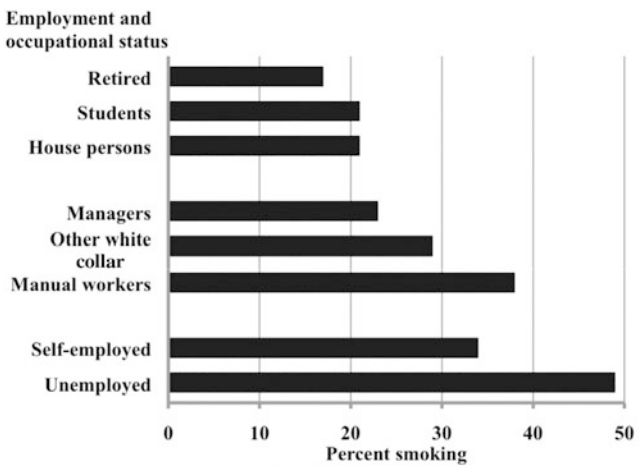

Fig. 3. Current smoking prevalence in EU27 countries, by occupational category, 2012.

Source: Attitudes of Europeans towards tobacco. European Commission, Special Eurobarometer 385; 2010.[19]

Unemployment, particularly long-term unemployment, is associated with poor mental health, including depression, anxiety, psychosomatic symptoms, low subjective well-being and poor self-esteem.[17] Long-term unemployment is associated with a greater incidence of suicide. The risk has been shown to be highest in the first five years, yet it persists at a lower but elevated level for up to 16 years.[18] Unemployed people are more likely to adopt health-damaging behaviours. For example, Figure 3 shows that almost half of unemployed people smoke—more than the proportion in any other occupational class.[19]

Economic crisis causes particular types of unemployment: involuntary job loss, often due to redundancy or workplace closure or downsizing. Studies that looked at these factors specifically identified associations such as a higher risk of overall mortality, heart attack incidence and alcohol-related hospitalization.[20-23] Unemployment is most common among the least well educated, as shown in Figure 4.

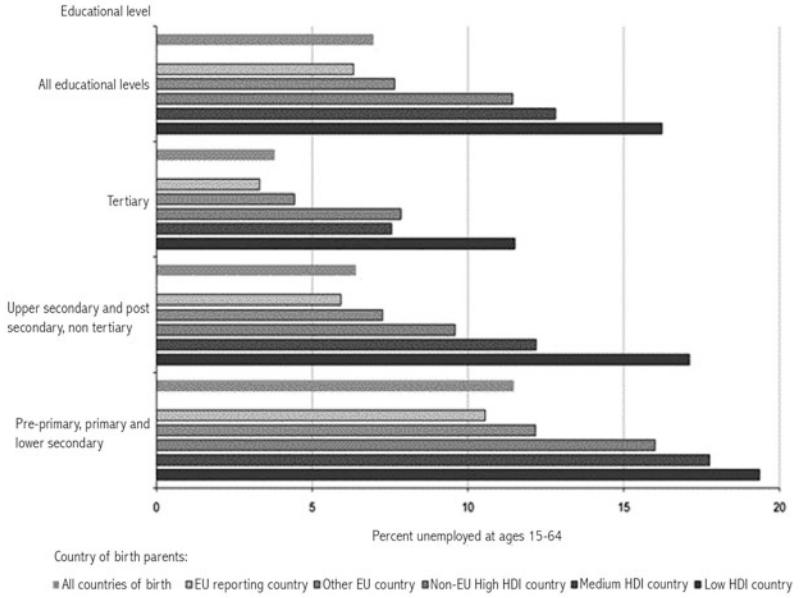

Fig. 4. Unemployment rates by education and country of origin in selected countries, WHO European Region 2009.

Source: Eurostat 2010.[64]

Young adults are particularly vulnerable to unemployment during tough economic times. Globally, this group is suffering worst from the effects of unemployment, with an estimated 73.4 million aged 15-24 (12.6%) recorded as unemployed in 2013, an increase of 3.5 million since 2007.[24] The International Labour Organization (ILO) warned recently of a particularly long-term effect of this crisis on young people, with the global unemployment rate projected to rise to 12.8 per cent in 2018.[24] The effects are also uneven, with Developed Economies and the EU (18.1% in 2012), the Middle East (28.3% in 2012) and North Africa (23.7% in 2012) faring worst, and regional disparities expected to increase.[24]

Aside from the health effects of unemployment and job loss identified above, young people experiencing unemployment early in their career will face a detrimental effect on future employment prospects and earning power. Research has indicated that they are more likely to experience unemployment and low wages up to ten years later, indicating that the recession may have a disproportionately severe and long-term impact on the health of the generation most affected.[25]

Conditions of Employment

There are also health impacts for those in employment during an economic crisis. Where employment is available, it is often only part time work, reducing living standards (while having the apparently perverse effect of reducing national productivity indicators such as GDP per employed person) or insecure employment. Additionally, skilled or more experienced employees may also be retained on a temporary basis in non-productive jobs by employers wishing to retain their skill/experience base in the hope of a return to "better times"—but leading to stress in those concerned and a reduction in the profitability and productivity of the employing organization. Among those who are employed in productive jobs, there is a greater effort-reward imbalance, as employees are expected to put in more effort (whether in terms of workload or hours) for the same reward (money or job security).

These work conditions can be detrimental to health, partly because of insufficient income to maintain a healthy life, or due to stress, frustration, and lack of self-esteem and control. Female part-time and casual retail workers were found to have a higher risk of stress, leading to repetitive strain injuries, migraine headaches, feelings of low self-esteem, low motivation and job dissatisfaction.[26] Temporary workers who were dissatisfied with the insecure work situation or who took on temporary work involuntarily were found to have a much higher risk of mortality compared to permanent employees.[27] Further, temporary workers have a greater risk of alcohol-related deaths

among men and women, and smoking deaths among men.[28] Downsizing of an organization is associated with lower well-being and an excess risk of cardiovascular and all-cause mortality among all employees, compared to those working in stable organisations.[29-31] Figure 5 shows that there is a strong association between the security of contracts and mental health among manual workers in Spain, with those on less secure contracts suffering worse mental health.[32,cited in 1]

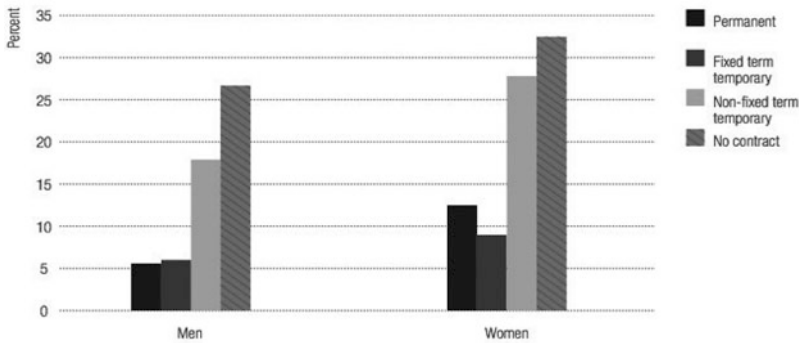

Fig. 5. Prevalence of poor mental health among manual workers in Spain by type of contract.

Source: Artacoz 2005,[32] cited in CSDH 2008.[1]

In developing countries, there is a slowing of "structural change", which has provided opportunities for workers to move from poor quality, informal, subsistence farming into better-paid jobs, because of a lack of investment in high productivity sectors.[11] This is an adverse impact on some of the world's poorest workers, denied the opportunity to raise themselves out of poverty and achieve an income closer to the amount necessary to live a healthy life.

Reduced Income and Poverty

As the cost of living increases faster than incomes, households will be finding it harder to make ends meet, and more will be falling below a minimum income necessary to live a healthy life. A healthy standard of living was emphasized by the WHO Commission on Social Determinants of Health as necessary for improving health and reducing health inequalities.[1]

Economic crises often increase the numbers in absolute poverty, or poverty "anchored" to a pre-recession benchmark of median income.[33] Relative poverty is more variable, as median incomes fall during a recession.

Patterns differ across population groups: in general, relative poverty* across OECD countries increased considerably among children and youth, while incomes among the elderly were relatively immune.[33] Poverty is associated with poor mental health, including a greater risk of mental disorders, sleep deprivation, and depression in new mothers.[34] Child poverty is associated with a greater risk of mortality in early and later life.[35] Children who live in poverty are more likely to be born early and small[35] and suffer chronic illnesses such as asthma.[36] Children's mental ill-health is associated with a reduction in disposable family income, which is occurring in many households across the world as a result of the economic crisis.[37]

Child poverty rates are, to a considerable extent, a reflection of government policy. Figure 6 shows the impact of social transfers on child poverty rates in EU countries. Many countries with high levels of child poverty, before taking account of social transfers, perform better than others with lower levels once these transfers are included in the comparison. Austerity measures lead to a reduction in government transfers to keep children out of poverty, discussed further in the next section.

Evidence suggests that remittances to Africa and the Commonwealth of Independent States (CIS) region 2008/2009 have fallen during the economic crisis, as a result of the reduced ability of those in the diaspora to send money home and the increased number of migrants returning home after losing their jobs.[38,39] This trend will exacerbate existing problems of low income in developing countries, given the significant impact of remittances on raising incomes in poor households in receiving countries.

Income Inequality

Income inequality across the OECD countries rose more between 2007-2010 than in the previous twelve years, excluding the mitigating effects of the welfare state, via taxes and transfers on income. Further, the OECD predicts that "as the economic and especially the jobs crisis persists and fiscal consolidation takes hold, there is a growing risk that the most vulnerable in society will be hit harder as the cost of the crisis increases".[33] Income inequality *per se* in developed countries is associated with a variety of social outcomes including levels of trust in the population, physical and mental health.[40]

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* This refers to the share of people having less income than half the national median income.

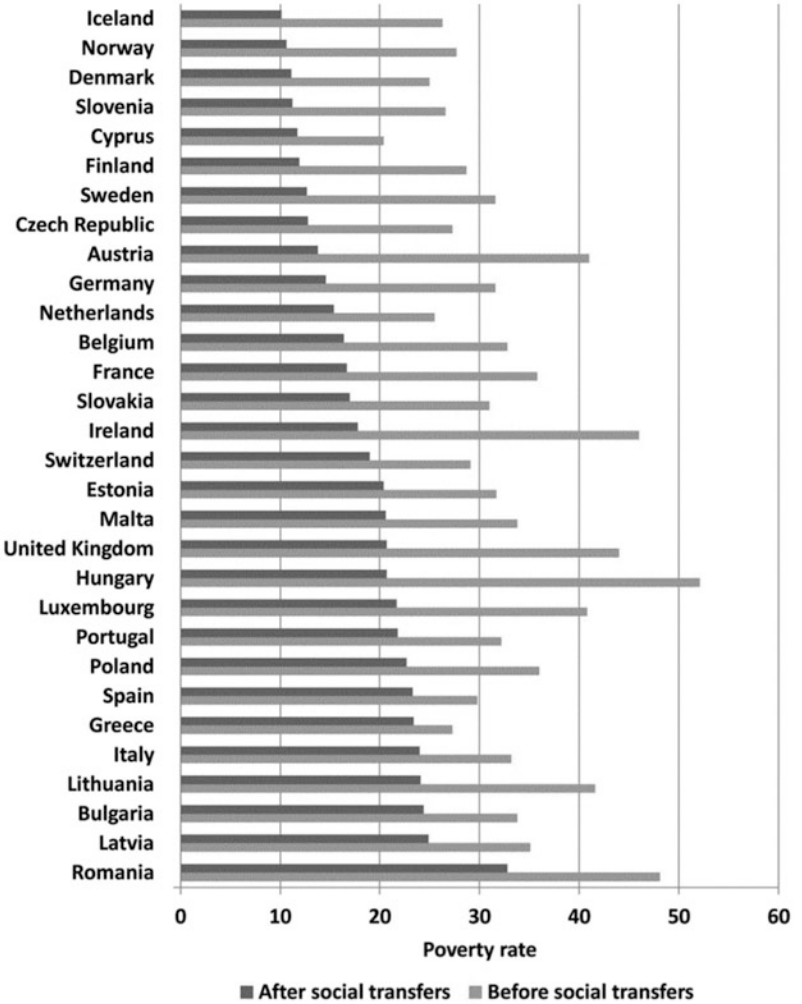

Fig. 6. Child poverty rates (per cent of children under 18 in households with equivalent income less than 60 per cent of median income) before and after transfers ranked by after transfer rate EU Statistics on Income Living Conditions 2009.

Note: Data for EU SILC 2009 were collected in 2008.

Source: Bradshaw et al.[65]

Debt

There has been much concern that households will find it more difficult to pay their debts as they lose income. Households with debt problems or other financial difficulties have been associated with worse mental health including increased likelihood of mental disorders, relationship problems and stress.[2,34,41-43] Those with multiple sources of debt who had to obtain money from pawnbrokers and moneylenders have been found to have the highest rates of common mental disorders, suggesting that the relationship may vary according to type of debt.[44] Debt is associated with a greater likelihood of health-damaging behaviours. Amongst EU countries, those who perceive themselves as having more difficulty in paying bills are more likely to smoke, as shown in Figure 7.

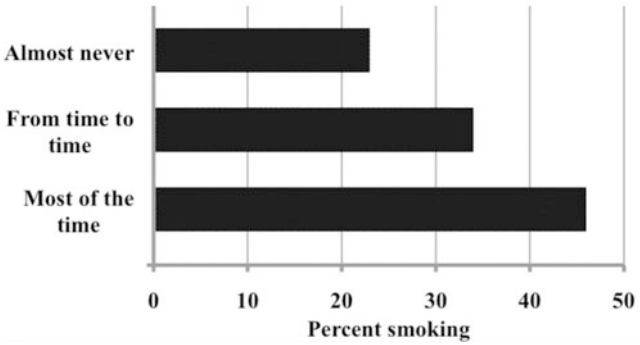

Fig. 7. Current smoking prevalence in EU27 countries, by difficulty in paying bills, 2012.

Source: Attitudes of Europeans towards tobacco. European Commission, Special Eurobarometer 385, 2010.[19]

Homelessness

A rise in job loss and inability to make rent and mortgage payments has led to an increase in homelessness. Though it is difficult to find comparable data in terms of the numbers of homeless people, survey data have shown that almost three quarters of people in the EU believe that homelessness has risen in their country since 2007.[45] The characteristics of the homeless population have changed, to include more people who have suffered job loss or a sudden fall in income, with migrants (often working in sectors worse hit by recession), young adults (more affected by unemployment) and children (reflecting more families made homeless following relationship breakdown) featuring disproportionately in the rising homeless population.[45]

Homeless people are far more vulnerable to a variety of physical and mental health outcomes. Rough sleepers have been shown to be 35 times more likely than the general population to commit suicide (though some of this may be due predisposing factors, for example mentally ill people being more likely to become homeless) and twice as likely to die of cancer.[46] Homeless people exhibit worse health behaviours, including alcohol and substance misuse and smoking.[47,48]

Fuel Poverty

Reduced incomes because of the economic downturn combined with rapidly rising fuel prices means that fuel poverty is likely to have been exacerbated by the economic crisis. Living in a cold, damp home is associated with poor health outcomes including cardiovascular and respiratory disease, excess winter mortality, depression among children and adults and colds and flu.[49]

Health Inequalities

Research from Japan, the US and the United Kingdom suggests that health inequalities according to socioeconomic status, level of education and geographical area are likely to widen following an economic crisis.[50-52]

There is good reason to anticipate that the health of the most vulnerable groups in society will be disproportionately impacted by the crisis, given that they are more likely to suffer unemployment, rely on welfare and public services, and face other barriers to health and well-being that may be compromised by a reduced income.

Whether through job loss, reductions in the disposable income which previously allowed households to participate in social activities, or housing payment problems necessitating moving home away from friends, family and networks to a cheaper property, we should expect to see an increase in the exclusion of particular groups of people from engaging fully in community and social life, particularly among those groups already likely to face exclusionary processes prior to the economic crisis.

It is also these people who are likely to have least resilience to cope with economic shocks. Those higher on the income scale may rely on their savings to carry them through a period of unemployment, whereas others might fall into debt, rent arrears and even homelessness. Those lower on the socioeconomic scale are least likely to have strong social networks and support that can help them both financially and in terms of coping with additional stresses they are under.

POLICY CONTEXT

Austerity Policies and Social Spending

In response to the economic crisis, economists and politicians have mainly taken a variation of one of two positions. Either, countries should impose policies of austerity, restricting spending in order to reduce their deficits and pay down national debt, or they should spend to stimulate the economy and encourage investment. Proponents of both positions believe that their method will lead to both a reduction in national debt and economic recovery.[53-56]

On the whole, the debate views the main criterion of success of any policy response to the economic crisis to be economic growth. However, evidence suggests that stimulus policies are more likely to reduce the negative social and health impacts of economic crisis, suggesting that views may not be as divided if the criteria for success included health and health equity. David Stuckler and Sanjay Basu have used examples from across the globe and throughout history to show that, while stimulus policies improve health outcomes during a period of economic crisis, austerity policies worsen health significantly.[3] It is the policy response, as opposed to the impact of an economic crisis in itself, that is the most significant in terms of health impact. These economic and policy response decisions have the potential to exacerbate or mitigate the impacts of the economic crisis on health and should be evaluated for their impacts on health and health equity.

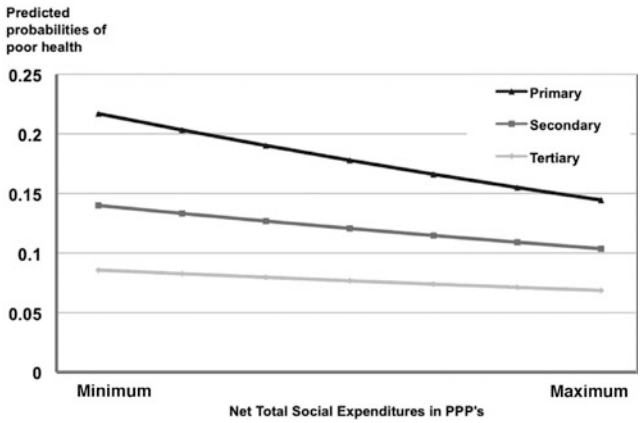

Fig. 8. Associations between social expenditure and poor self reported health by educational group for men.

Note: Predicted probabilities estimated from Model 2, Table 3 in Dahl & van der Wel for Net Total Social Expenditure (PPP).

Source: Dahl & van der Wel 2013.[57]

The health effects of increases in social spending are greater among those people within a society with lower levels of education (Figure 8) and in those countries with less developed social protection systems.[57] Therefore, health inequities narrow both within and between countries as a result of an increase in social spending.

However, higher levels of social spending are associated with better health outcomes across the population.[58] One study of EU countries found that each additional USD $100 increase in social welfare spending was associated with a 1.19 per cent drop in all-cause mortality.[58] But, it should be noted that the health effects often depend on how the money is spent, and the type of welfare state.[59]

Social spending has such an impact on health because of the potential of social protection and public services to provide individual and collective resources to those within society who might not otherwise have access to them.[60] Both the provision of public services such as education, healthcare and public transport, and redistributing to people on low incomes, reduces inequities and increases the chances that everyone will have the minimum income necessary to live a healthy life. They further provide reassurance to those whose employment becomes less secure during a recession—by reducing the threat of an adverse social and economic impact should they become unemployed. Many developed countries have cut the aid they provide to developing countries which will have resulting effects on health among their populations, further increasing disparities between those in rich and poor countries across the world. Social spending has diminished in many countries in response to the economic crisis.

Part of the UK government's austerity package in response to the economic crisis includes significant cuts and reforms to the welfare budget, which have and will continue to reduce incomes for many benefit recipients, restrict eligibility for certain benefits and add restrictions to the previously universal Child Benefit. This is a good example of where austerity measures impact most heavily on the poor and most vulnerable (the part of society receiving means-tested benefits) and reduce incomes at a time when basic living costs are rising rapidly. Child poverty is expected to increase by six per cent Before Housing Costs (BHC) across England between 2011-2020, primarily because of the welfare reforms.[61]

POLICY RECOMMENDATIONS

Improving the social conditions in which people live, at a time when factors outside of their control risk making their lives, incomes and health worse,

necessitates ensuring that the balance between social spending and taxation is designed to provide an adequate buffer for those at risk. It is important during an economic downturn, more than ever, to encourage good employment practices, to invest in the early years and the skill development of young adults who are finding it difficult to get work, to institute a minimum income for healthy living and to ensure that people have enough food to eat and a safe place to live. Action should take place to reduce health inequities within and between countries at the international, national and local level and across all sectors.

National Approach to Austerity and Social Spending

Higher social spending has positive health effects, particularly for the most vulnerable citizens. Iceland's decision to let their banks fail and protect their strong social protection system led to a strong and rapid economic recovery and positive health and well-being scores.[3] Greece agreed to implement an austerity package as part of the conditionality of an International Monetary Fund loan, which has not led to a successful economic recovery as anticipated.[62] At the same time, Greece has seen increases in poor health outcomes such as HIV rates and suicides.[3]

The WHO Review of social determinants and the health divide in Europe recommends that the health and social consequences of austerity measures should be recognized and ministers for health and social affairs involved in negotiations shaping economic and fiscal policy.[60] If countries must reduce their spending, they should ensure that full health equity impact assessments are carried out on each policy and priority is given to those with the most positive health and equity impacts. An example of evidence-based social investment is provided by active labour market programmes (ALMPs).

Active Labour Market Programmes

ALMPs have been shown to improve health outcomes. One study found that USD $100 greater spending per capita on ALMPs appeared to lower the effect of unemployment on suicides by 0.38 per cent.[6] It is crucial that investment in these programmes focus on getting people into sustained and good quality employment, so as not to perpetuate the cycle of unemployment/employment/unemployment experienced by many on short-term, insecure temporary contracts. Precarious employment whether because of insecure contracts, dangerous working conditions or exposure to hazardous materials impacts health and has a proportionally greater impact on those lower on

the socioeconomic scale as they are more likely to work in hazardous, insecure jobs.

Quality of employment should be a priority, and engaging employers and greater regulation of working conditions can go a long way to achieving this. Addressing youth unemployment should be a further priority because of the current high rates and because of the long-term effects this will have on their future employment prospects and health. Some examples of good practice identified by the ILO, focusing on good quality work and youth unemployment include jobs guarantees in Sweden and vocational training programmes in Denmark (Box 2).

Box 2
Case Studies from the ILO

Sweden: Jobs Guarantees

Sweden has provided jobs guarantees and training for young people who are finding it difficult to gain employment. They have relied on a close collaboration between employers, unions and government. They found that the benefits of the programme far outweigh the costs, and participants found it easier to get a job than those who did not participate.

Denmark: Vocational Training

Denmark has addressed their skills mismatch by introducing vocational training programmes in a wide range of areas, linking the education sector with private companies to ensure that the skills learned are those required in the labour market. This has successfully reduced youth unemployment in the country.

Source: ILO website. Global employment trends for youth 2013.[24]

Healthcare

The health impacts of an economic crisis fall heaviest on those further down the socioeconomic scale who are least likely to be able to afford health coverage, and those who lose their jobs and therefore their health insurance. All countries should move towards universal health coverage to ensure more equitable and improved health outcomes.

Healthcare budgets should be protected and, during bad as in good economic times, a greater proportion of the health budget should be spent on prevention. Health has a high priority among populations, though economic concerns have been highest in recent years. It should be ensured that economic concerns do not influence those decisions that should be made on the basis of improvements to health.

Homelessness and House Building

The extent of the increase in homelessness varies, seemingly according to whether or not national policies and programmes to address homelessness exist. For example, Latvia and Hungary have no strategy to reduce homelessness and they have seen dramatic increases in the number of homeless people. Conversely, Ireland's national strategy of coordinating support at a local level limited the rise in their homeless population.[45] Policies addressing housing shortages through building decent, affordable homes and attempts to drive down rents in high rent areas should be considered as part of any homelessness strategy that aims to provide a long-term solution.

Tax Regulation

Closing tax loopholes and ensuring companies pay their fair share of tax has become a priority across many countries in recent years, reflected in the discussions at the G8 summit in June 2013. Following the summit, the developed world has great potential to bring about a fairer international tax system, which considers health equity.

Reduce Fuel Poverty

Governments should think about how they can reduce the numbers of people in fuel poverty, primarily through improving the energy-efficiency of homes but also subsidising rapidly rising fuel costs of those at risk of fuel poverty. In many countries where action is taken, pensioners are prioritized as they are more vulnerable to the effects of living in a cold home. Efforts to reduce fuel poverty should extend to other groups who are also vulnerable (e.g., children in poverty) and are adversely affected by the economic downturn.

Debt Relief

Credit unions offer a sustainable, manageable option for households in need of credit and they should be encouraged. There is also scope by countries for greater regulation of lending.

Local Interventions

At a local level, much can be done to improve daily living conditions and protect against the impacts of economic downturns. Local policies and interventions can help to narrow health inequities through improving public services and individual and community resilience to financial and other shocks.

At a time when governments are spending less, building resilience within communities and ensuring that the assets within those communities are fully utilized can mitigate against the negative impacts of unemployment and lower incomes and improve health within those populations. This includes encouraging community groups, volunteering and other social activities. Communities should be engaged in the design, implementation and evaluation of interventions, and utilizing all assets within the area such as skills and networks within the population, or physical buildings. The resulting empowerment and connectedness among the population should in itself increase resilience and improve health.

Public, private, voluntary and community sectors should work together to ensure that the most effective and joined-up services are provided to improve living standards within the population, particularly for those further down the income scale or who face greater exclusionary processes. This does not necessarily mean employing targeted approaches, as universal services often have a greater impact on the more disadvantaged as they are more likely to use or gain the most from the services provided. Examples of such services, unlikely to be applicable in every context, include children's centres, food banks, breakfast clubs and advice and support services.

Advice and support on debt, employment, housing and other issues can help to prevent the worst health effects of an economic downturn. There is demand, certainly in countries following austerity programmes, for cost-neutral solutions to the social and economic problems caused by the economic crisis. Adequate public services and support cannot be provided without any funding, yet many options for cost effective interventions exist. For example, English housing charity Shelter carried out a cost-benefit analysis of homelessness prevention advice and assistance and found that at least GBP £1,286 could be saved per household prevented from becoming homeless.[63] Further, action on the social determinants of health may have other, more immediate economic benefits, such as increased employment leading to an increase in tax revenue. As discussed in the introduction, the costs of doing nothing to reduce health inequalities are significant, which puts the costs of mitigating actions into context.

CONCLUSION

Many countries have emerged from recession but consequences such as high youth unemployment and reductions in social protection and health care spending, and possible isolated large-scale redundancies and cut backs for specific industries, remain. The impact of the economic crisis on health

through its social determinants has the greatest effect on disadvantaged, low income households as they are more vulnerable to falls in income and are more likely to suffer the employment effects of an economic crisis. It is likely that this will cause health inequalities within countries to widen. The economic crisis began in the developed world but has spread to developing countries and is likely to have a substantial impact on their population health, particularly given that they start from lower baselines in health and its social determinants.

Health objectives in this context must be to improve health in both developed and developing countries, while reducing health inequalities between and within countries. Action on the social determinants of health is likely to be the most effective way to meet these objectives. This report provides some evidence-based examples of how we can mitigate the impacts of the crisis through action on the social determinants of health—income, housing and employment in particular. Social spending, on welfare and ALMPs, is central. National and local policies to address homelessness, fuel poverty, housing shortages and redistributing income through the tax system, are further examples. All policies should be assessed for their likely impact on health and health equity and those with the most favourable results should be implemented if we wish to avoid potentially disastrous health impacts.

Acronyms List:
ALMPs = active labour market programes
ILO = The International Labour Organization

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