Socioeconomic Inequality and Social Exclusion in Health: A Review

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Abstract

This paper examines the impact of social inequality and social exclusion on health. Social exclusion in health can be explained by socioeconomic inequality in health as socioeconomic position mediates access to resources including health services. Moreover, the impact of socioeconomic position on health is mediated by people's differential exposures to a very broad range of physical, chemical, biological, social, psychological and behavioral risk factors to health. People belong to upper strata of society in developed and developing countries have been experiencing higher level of life expectancy and better health status than those who are at the bottom of the society. There is evidence that societies that are more economically equal and socially cohesive have lower overall mortality than those that are more unequal. Interventions focusing on improving socioeconomic condition and increasing social inclusion and equity in social, economic and political dimensions can contribute to reduce inequities and social exclusion in health.

Keywords: Social inequality, social exclusion, socioeconomic position, social class, poverty, health status, illness, mortality

1. Introduction

This paper examines the impact of social inequality and social exclusion on health based on review of literature and secondary data. Health is multi-dimensional entity determined by the interplay of social, cultural, economic, biological, physical and political factors. Commission on the Social Determinants of Health (CSDH) states that people's health largely depends on the social conditions in which they live and work – the social determinants of health (CSDH, 2006: 3). It is obvious that socioeconomic conditions are fundamental factors influencing health and illness. In a stratified society, where resources are limited, groups of people who are at the bottom of the hierarchy have the least access to all kinds of resources including health services and are deprived of health as they are more exposed to disease in their unhealthy environment (Qadeer, 1991). Inequalities in resources and income distributions aggravate health situation and lead to disparity in health status, which is highlighted by the Black Report and the Health Divide (Townsend, P and N. Davidson, 1988). Empirical examinations of the linkages between socio-economic factors such as poverty, income, occupation, class, *etc*. have a long history. William Petty (1623-1687) anatomist turned economist and author of "Political anatomy of Ireland" provided numerical data to show the influence of societal resources on health status. Friedrich Engels and Rudolf Virchow made major early contributions to the understanding of social origins of illness. Engels argued that British capitalism in nineteen century forced working-class people to live and work under circumstances that inevitably caused sickness (Engels, 1945). He showed that mortality rates were inversely related to social class, not only for entire cities but also within specific geographic districts of cities of the Great Britain. In the analysis of multi-factorial etiology, Virchow claimed that the most important causative factors of disease were material conditions of people's everyday lives (Waitkin, 1978). Chadwick's pioneering work on the sanitary condition of laboring population in Great Britain indicated that non-biomedical factors such as housing and living conditions are responsible for the occurrence of disease and pestilence in the 19th century. Socioeconomic position of individual and population is positively associated with their health

status, socioeconomically better doing better on most measures of health status (Lynch & Kaplan, 2000).

Marginalization of certain groups of people occurs in most societies including developed countries, and perhaps it is more pronounced in underdeveloped countries. There is already evidence that poverty, social exclusion and deprivation have a major impact on health, including a higher risk for diseases as well as higher probability from being excluded from the health and other basic services (Nayar, 2007).Poverty and social exclusion are driving forces of health inequities for people across world. There is a link between poverty, social exclusion and poor health as health outcomes of poor and socially excluded peoples such as ethnic minority, unemployed, homeless, refugees and poor migrants were worse than general population (Shaw et al., 1999). Such linkages need to be contextualized and discussed within social inclusion approach to health and development in Nepal. A social exclusion approach to health takes into account the wider determinants of health disadvantage and links this to broader social and political processes (Marmot & Wilkinson, 2006). This paper shows a relationship among socioeconomic inequality, social exclusion and health, and then discusses briefly how social exclusion affect health based on review of relevant literature and facts.

2. Poverty, caste/ethnicity and social exclusion

Poverty, caste/ethnicity and social exclusion are important socioeconomic variables, which are often taken for granted while explaining social impact on health and illness. Poverty is defined as a "pronounced deprivation in wellbeing" (Haughton & Khandker, 2009). There are currently two main ways of setting poverty lines: relative and absolute. Relative poverty lines are defined in relation to the overall distribution of income or consumption in a country (these are more properly viewed as a crude measure of inequality). Absolute poverty lines, in contrast, are based in an absolute standard of what households should be able to count on in order to meet their basic needs. Absolute

poverty is a condition characterized by severe deprivation of basic human needs. Overall poverty can take various forms including "lack of income and productive resources to ensure sustainable livelihoods; hunger and malnutrition; ill health; limited or lack of access to education and other basic services; increased morbidity and mortality from illness; homelessness and inadequate housing; unsafe environments and social discrimination and exclusion. It is also characterized by lack of participation in decision-making and in civil, social and cultural life (UNDP, 1995). Poverty is understood to be multidimensional, encompassing not just low income, but lack of access to services, resources, vulnerability, insecurity and voicelessness and powerlessness (Maxwell, 1999).

Poverty and social exclusion are frequently used synonymous. Some consider social exclusion and poverty to be the same phenomenon (Eurostat, 2010); other see poverty as one form of social exclusion (economic exclusion) (Justin and Litchfield, 2003). In course of the last 15 years, the concept of social exclusion has been replaced the concept of poverty in many cases. Social exclusion is believed to provide new insight into social problems and to be a more appropriate concept than poverty to describe the severe disadvantage of a person or group (Flotten, 2006). Severe form of poverty can prevent persons from participating in decision-making and in various activities of social life. Poverty and social exclusion are considered two distinct phenomena; they are not two aspects of the same matter- a person may be socially excluded although he or she is not poor, and a person may be poor although he or she may not may excluded. Social exclusion is a broader perspective on social disadvantage than poverty.

The general concept of social exclusion is closely related to mechanisms of marginalization, and can be associated with a lack of access to services and of participation. It is related to an old problem in developing countries, namely: poverty, inequality, unemployment, deprivation and marginalization (Silver,2007). Economic exclusion gives rise to the issue of employment, diversity of access to goods and services, urban/rural segregation.

Economic inequality is considered here as distinct from poverty. In the context of social exclusion, the excluded can be determined by the individual's level of income or consumption, or by the position in society in relation to social membership at the group, community and/or national level; and by how this membership affects access to goals and services, employment, safety nets and entitlements (Chakravarty, 2009). Sen (2000) argues that social exclusion can be placed within the broader perspective of the poverty as capability deprivation. Access to resources and entitlements are centered in distributive powers of the political system. In this sense, poverty and social exclusion are inherently multidimensional concepts.

The term "excluded" was originally coined in France in the 1970s in reference to social assistance, describing various categories of people left out of State contributory benefits. Such people were labeled "social problems" and were not protected by social insurance, particularly the young, the elderly, the disabled and single parents (Haan, 1999). Social exclusion initially referred to a process of social disintegration, a progressive rupture of the relationship between the individual and society. It later extended to incorporate those suffering multiple deprivations in worst affected locations. Since the late 1980s, the concept has become increasingly concerned with the problem of "new poverty" associated with long-term unemployment, unskilled workers and immigrants. Following the World Summit for Social Development (Copenhagen, 5-12 March 1995), the concept of social exclusion entered the development debate by several multilateral agencies, notably the World Bank, the International Labor Organization (ILO) and the Department for International Development.

We have retained the distinction regarding poverty as lack of the resources, especially income necessary to participate in the society and social exclusion as a more comprehensive concept which refers to the dynamic process of being shut out or fully or partially, from any of the social, economic, political or cultural systems which determine the social integration of a person in society (Walker and Walker 1997, as cited in Byrne, 2009). It is a process

and a state that prevents individuals or groups from full participation in social, economic and political life and from asserting their rights. It derives from exclusionary relationships based on power (Beal and Piron, 2005). It is opposite to the social integration and multi-dimensional in nature, which can be understood in terms of the complex dynamic life trajectories and the significance spatial separation within particular societies (Byrne, 2005). Exclusion is founded on social relations. It is concerned with the excluded as well as with the excluder, thereby putting power at the centre of analysis (Silver, 2007). It is a feature of social structure of societies in which recurrent patterns of social relationships deny individuals and groups access to goods, services activities and resources which are associated with citizenship, social disadvantage that lead to the inability of individuals to create livelihoods or claim their rights owing to, for instance, racial discrimination, religious intolerance, gender inequalities impinging on access to education and/or to the labor market. Exclusion is a multidimensional process where aspects of social disadvantages intersect, e.g. poverty and gender. It refers to both individual and societies, and to disadvantage, alienation and lack of freedom (Bhalla & Lapeyre, 1997).

In Nepal, discourse on social exclusion and inclusion originated in 14th century when King Jayasthiti Malla restructured the Newar society and divided people into several occupational caste groups following Hindu caste hierarchy system (Bhattachan, 2008). King Prithvi Narayan Shah, who wanted to see Nepal as *Asali Hindustan*, discriminated against indigenous peoples, Dalits, women, *Madhesi*, Muslims, speakers of the mother tongue and non-Hindu religious groups through expansion and promotion of Hind caste system throughout the country. The MulukiAin (National Legal Code) of 1854 was instrumental in implementation of social exclusion practices imposing Hindu caste rules on various ethnic groups of Nepal (Hofer, 1979). It classified the Nepalese society into the four-tier caste hierarchy, i.e. *Tagadhari* (sacred thread wearing), *Matawali* (liquor drinking), *Pani nachalne chhoiee chito halnunaparne* (water unacceptable but no purification required) and *Pani nachaln echhoieehito halnuparne* (water unacceptable and purification required). Indigenous peoples

who did not belong to Hindu Verna were categorized as Matawali and further divided into *masine* (slavable) and *na-masine* (unslavable). It imposed negative impact on non-Hindu groups mainly Mongoloid stocks Partyless Panchayat System (1960-1990) introduced by King Mahendra in 2017 BS denied the existence of indigenous peoples' culture and language in the name "one King, one country, one language, one costume". The recognition of a multi-ethnic society since 1990 is a major departure from the past and step for ethnic discourse in Nepal. Even after restoration of so-called democracy, rulers continued more or less exclusionary practices. It is obvious that state policy and practices were less inclusionary and more exclusionary against indigenous peoples, Dalit, Madhesi and religious minority until people's movement of 2006. Even after promulgation of Interim Constitution and Policy Plan of the country, vestiges of the exclusionary practices are widely prevalent in social, cultural and political system.

The process of marginalization and exclusion in the country has compelled the indigenous peoples, ethnic/religious minorities and *Dalits* to live in extreme poverty and social deprivation.The feudal and semi-feudal systems that have been existed in for centuries together with the prevalent of the patriarchal social systems and Hindu caste hierarchy have created socio-economic inequality among different groups of people. The feudal socio-economic and political structures have excluded the general masses of *Dalits*, indigenous nationalities, *Madhesis*, women and religious minorities from the development mainstream. They are underrepresented in decision-making processes at all levels and lack proper access to justice and the State's resources. The feudal sociopolitical structures espoused by Hindu social system have created opportunities and spaces for so called high caste Hindu, Brahman/Chhetri and Thakuri and they are considered as most advantaged groups of Nepal. Dalit, Muslim, *Janajati* and Terai/Madhesi castes belong to the excluded groups of Nepal. The Newars and Thakalis, have had advantage over other ethnic communities by being city dwellers and being involved in trade and commerce. These caste and ethnic groups have stratified Nepalese society into different strata in hierarchical order and one broad group is equivalent social to one social class.

Brahman/Chhetri group occupies the top position and Dalit bottom in social hierarchy.

Table 1: Poverty Incidence, Per Capita Income and HDI by Social Groups

Caste /Ethnicity	Poverty incidence	Per capita income in Rs.	Human Development index
Brahman/Chhetri	18.4	18,400	0.552
Newar	14.0	26,100	0.616
Hill Janajati	44.0	13,500	0.507
TaraiJanajati	35.4	12,700	0.470
Tarai/Madhesi castes	21.3	11,300	0.450
Muslim	41.3	10,200	0.401
Dalits	45.5	10,000	0.424
All Nepal	30.8	15,000	0.509

Source: CBS 2005 and Nepal Human Development Report 2009

Incidence of poverty is highest among Dalits, followed by Hill *Janajati*, Muslim, Tarai *Janajati* and *Madhesi* caste (Table 1). There is a wide gap between the advantaged and excluded groups in terms of level of poverty and income. It indicates that poverty, caste/ethnic groups and social exclusion are correlated. Excluded and discriminated groups are poorer and more vulnerable to ill health compared to the advantaged and included group in the society.

3. Socioeconomic inequality and health

In health research, concepts and measures of socio-economic status or position are used to determine the association between people's unequal lives and their unequal health. Social class and socioeconomic status are described as measures of socioeconomic inequality. These two measures of inequality are derived from two different theoretical traditions in sociology associated with the work of Karl Marx and Marx Weber. In a classical Marxist sense, classes are interdependent economic relationship, formed around the interplay of property, ownership and labor. Class is large groups of people differing from each other by the place they occupy in a historically determined system of social production, by their relation to the means of production (Zotov, 1985). Classes reciprocally define each other: the working class exists in relationship to the ruling class. People who belong to working class sell their labor power to the owner of the means of production to survive. Class analysis provides a unitary theoretical explanation of inequality being produced around the ownership and non-ownership of private property (White, 2002). According to Max Weber, an individual' position in society can be captured in 'socioeconomic status' (life chances), which is measured in terms of education, income or occupational prestige. Gender and ethnicity tend to be treated in the same way, as personal characteristics and individual variables. Socio-economic position, like other social positions, are therefore regarded less as stable attributes of individuals and more as dynamic elements of social structures. 'social class' and 'class inequality' tend to be preferred to 'socio-economic position' and 'socio-economic inequality'. Class is a characteristic not of people but of locations within the division of labor. An individual's socio-economic position is shaped by unequal structures which exist outside their lives. Social inequality is a product of the social organization of society. Socioeconomic inequality is produced and sustained by the interplay of social structure and individual agency which is particularly important for understanding health inequalities.

Inequality in health can be described by socioeconomic status which varies within a group and between groups in unequal society. Socioeconomic status is positively associated with health status and negatively associated with diseases and mortality. The Black Report assessed inequalities in health on the basis of a classification of the British population in to six social classes: class I (professionals: doctors, lawyers, scientists and professionals), class II (Intermediate: managers, nurse, school teachers etc.), class IIIN (skilled non-manual: clerical worker, secretary, shop assistants), class IIIM (skilled manual: carpenter, butcher, driver), Class IV (partly skilled: agriculture workers, factory process workers, forestry workers), and class V (Unskilled workers: laborers, cleaners), which were classified according to the status of occupation in the society. This study has found marked differences in health status between social classes, for men and women, and for all ages. The basic finding of the Black Report is that the people at the bottom of the social system have a much higher mortality rate than those at the top. Inequality in mortality rates in the United Kingdom in 1971 among the persons aged 15-64 is presented in Table 2. Mortality was highest in unskilled class and lowest in professional class showing wide gap in health between high and low social classes. It also indicates that the risk of death for men in each occupational class is almost twice that of women, the cumulative product of health inequalities between the sexes during the whole lifetime. Trend in infant mortality in England and Wales over 30 years (1942-1972) was declining in all classes, but infant mortality rates continued to remain highest among class IV (20/1000) and V (32/1000) compared to those of class I (12/1000) and class II (14/1000). This is not restricted to mortality due to specific diseases, but applies to the majority of diseases. Death rates from diarrhea and pneumonia have been five times higher in class IV and class V than in class I. Furthermore, people in the lower classes suffer from more chronic illness, their children weight less at birth and they are shorter. There are marked inequalities in access to health services, and particularly to preventive services (Townsend and Davison, 1988).

Table 2: Inequalities in Mortality (Rates per 1000 population) in the United Kingdom in 1971 among Persons aged 15-64

Social (Occupational) class	Males	Females	Ratio M/F
I (Professionals)	3.98	2.15	1.85
II (Intermediate)	5.54	2.85	1.95
IIIN (Skilled non-manual)	5.80	2.76	1.96
IIIM (Skilled manual)	6.08	3.41	1.78
IV (Partly skilled)	7.96	4.27	1.87
V (Unskilled)	9.88	5.31	1.86

Source: Towsend, Davidson and Whitehead (1988), Inequalities in Health.

Substantial inequalities in mortality were seen in the United States and other countries of Europe. Nearly all causes of deaths have higher rates of mortality in the lower socio-economic groups (Mackenbach, 2002). In Western Europe the risk of ill health is 1.5 to 2.5 times higher in the lower half of the socio-economic distribution than the upper half. A study from Canada showed higher mortality among men with less income, less education, and lower occupational status for a variety of causes of death, all of which were amenable to medical treatment (Wood et al, 1999).

People belong to the lower socio-economic live shorter lives and spend a large portion of their live in health. Barriers or lack of access to effective medical care is likely to lead unnecessary morbidity and suffering among poor and disadvantaged groups (Marmot &Wilkinson, 1999). The socioeconomic status of people shapes their experiences of health and diseases, largely determines the length of their life.

This socioeconomic gradient is evident in the patterning of health across rich and poorer countries. Table 3 shows wide differences between some developed, developing and least developed countries

in health outcomes. There are considerable disparities in life expectancy, infant mortality, child mortality, maternal mortality and prevalence of tuberculosis. Life expectancy at birth is above 80 years in developed and rich countries like, Japan, Australia, Norway, Sweden, Canada, France etc. and lowest in poor countries like Sierra Leone, Burkino Faso and Ethiopia. A girl born in Japan will live 36 years longer than a girl born in Sierra Leone. Quoting from the report of WHO's Commission on Social Determinants of Health, "In Glasgow, an unskilled, working-class person will have a lifespan28 years shorter than a businessman in the top income bracket in Scotland."As indicated in Table, there is a 23 year difference in life expectancy between low-income countries (57 years) and high income countries (80 years).

Table 3: Health status, mortality and prevalence of tuberculosis

Countries	Life expectancy at birth			Infant mortality rate per 1000 live births	Under five mortality rate per 1000 live births	Maternal morality ratio per 100,000 live births	Adult Mortality rate probability of dying between 15 and 60 years per 1000 population	Prevalence of TB/100000 population
	M	F	Both sex					
Japan	80	86	83	2	3	6	64	26
Australia	80	84	82	4	5	5	76	7.8
Switzerland	80	84	82	4	4	10	58	6
Norway	79	83	81	3	4	7	67	7.3
Sweden	79	83	81	2	3	5	61	8.1
UK	78	82	80	5	5	12	77	15
Canada	79	83	81	5	6	12	70	5.8
German	78	83	80	3	4	7	76	5.9
France	78	85	81	3	4	8	85	7.3
The US	76	81	79	7	8	24	106	4.5
China	72	76	74	17	19	38	116	138
Hungary	70	78	74	5	6	13	164	20

Iran	70	75	73	26	31	30	118	27
Lebanon	71	77	74	11	12	26	124	20
Venezuela	71	78	75	15	17	68	146	48
India	63	66	65	50	66	230	212	249
Indonesia	66	71	68	30	39	240	190	285
South Africa	54	55	54	43	62	410	496	808
Pakistan	62	64	63	70	87	260	208	373
Sri Lanka	65	76	71	13	16	39	182	101
Nepal	65	69	67	39	48	381	196	240
Bangladesh	64	66	65	41	52	340	234	425
Ethiopia	53	56	54	67	104	470	412	572
Burkino Faso	49	56	52	95	154	560	413	357
Sierra Leone	48	50	49	123	192	970	487	1193
Income Group								
Low income	55	59	57	75	117	580	321	444
Lower middle income	66	69	69	42	57	230	178	225
Upper middle income	68	75	71	19	22	82	184	105
High income	77	83	80	6	7	15	88	17

Source: World Health Statistics, WHO 2011

Infant rate is highest in the poorest and least developed countries like Sierra Leone (123/1000 live births and Burkino Faso (95/1000 live births) and lowest in Japan (2/1000 live births). In low-income countries, one child in nine does not live to their fifth birthday; in high-income countries, one child in 143 dies before the age of 5. Likewise, in low-income countries, one woman in 173 live births

dies due to pregnancy related complication while a woman dies in 14286 live births in high income countries. Prevalence of tuberculosis (disease of poverty) is very high in low-income countries (444/100000) compared to that of high-income countries (17/100000). These indicate that socioeconomic conditions of the country have direct impact on health outcomes. It is evident that there are great inequalities across the people of the world in standard of living and in health status. The inhabitants of poorer countries not only have lower real incomes, but they frequently suffer from various health problems and live shorter lives (Deaton, 2006).

Poverty and socioeconomic conditions can affect health in a number of ways. Income provides the prerequisites for health, such as shelter, food, warmth, and the ability to participate in society; living in poverty can cause stress and anxiety, and ill health. At its most basic material level, poverty impacts on health through absolute and relative deprivation. Being poor increases exposure to unhealthy environment and risk of diseases and injuries, it also makes health services to access. Low income or unemployment can deprive people of quality of housing, clothing and nutritional foods and it can expose people to material hazards such as high-level of contaminants and pollutants, and harmful environments such as damp and poor housing, increase risk of infections, inability of maintain standards of hygiene. At behavioral level, being poor increases propensity to high-risk activities like smoking, excessive alcohol consumption, fatty diets and sedentary lifestyles. These can increases susceptibility infection, diabetes, high blood pressure, and accumulation of cholesterol in blood vessel walls, with risk of heart attack and stroke (Brunner & Marmot, 1999).

4. Social exclusion and health

Exclusion in health is one of several dimensions of social exclusion. The relationship between social exclusion and exclusion in health could be conceived of as it appears in the following figure:

Figure 1: Relationship between social exclusion and exclusion in health

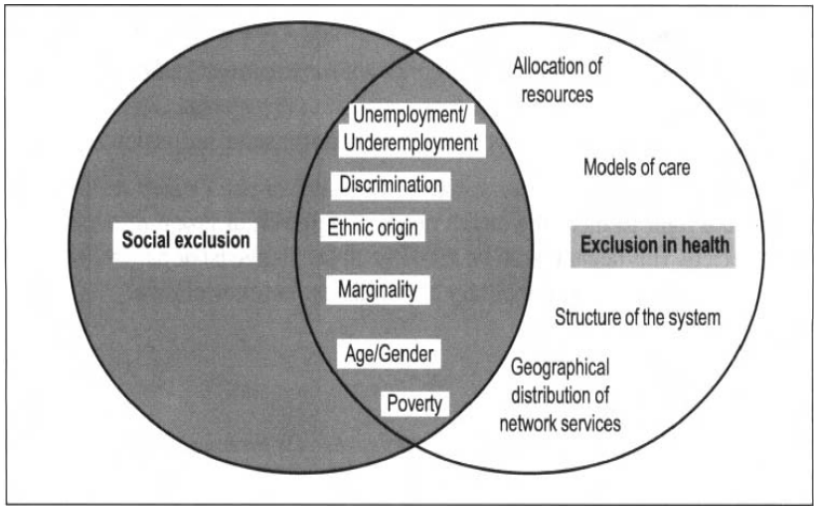

Figure adapted from exclusion in health in Latin America and the Caribbean, PAHO/WHO/SIDA 2004

Exclusion in health was defined as the situation in which an individual or group of individuals does not access the mechanisms that would make possible the satisfaction of health needs. As a result, exclusion in health is understood as the lack of access of certain groups or people to various goods, services and opportunities that improve or maintain their health status. In this context, exclusion in health can be expressed in some of the following situations:

1. Lack of access to the basic mechanisms for the satisfaction of health needs: when a minimum infrastructure that allows for provision of health services does not exist or when a group of people cannot access services due to geographical, economic, cultural or other types of barriers.

2. *Lack of access to financial protection mechanisms against the risks and results of becoming ill* when a group of people cannot access a health insurance program.

3. Lack of access to the mechanisms for the satisfaction of health needs under adequate conditions of timeliness, quality, and dignity, regardless of ability to pay: when a group people cannot access a program for social protection in health.

Table 4: Health, mortality and access to health services among castes and ethnic groups in 2006

Caste/ethnicity	Life expect-ancy	Infant Mort-ality	Under-five morta-lity	Chronic malnu-trition (stunted) among under 5 children	Receiving antenatal care from SBA	Assistance by SBA during delivery	% Delivery in a health facility
Brahman/Chhetri	68	59	76	47	57	26	24
Newar	68	36	43	33	68	50	48
Janajati excluding Newar	62	59	80	48	34	14	14
Tarai/Madhesi castes	63	64	86	52	40	16	15
Muslim	61	68	NA	58	32	13	12
Dalits	61	68	90	57	40	11	9

Source: Nepal Demographic and Health Survey 2006 and Nepal Human Development Report 2009

Data presented in Table 4 highlight the link between social exclusion and health status in Nepal. Life expectancy at birth is highest among Brahman/Chhetri and lowest among excluded groups such Muslim and Dalits. Infant and child mortality rates are highest in Dalit group across the caste/ethnic groups. Under five mortality in Dalit is 90 per thousand live births compared to Nepal's national figure (68/1000) and Newar child mortality (43/1000). Majority of children from the excluded groups suffers from chronic malnutrition. In India, infant and child mortality rates are higher in schedule caste and schedule tribes than other groups (Nayar, 2007) Likewise, disparity in utilization of maternal health services can be observed across the caste and ethnic groups.

Percentage of pregnant women receiving antenatal care is highest in Newar (57%) and Brahmin/Chhetri group (57%) and lowest in Janajati group (34%). Women from the excluded groups in Nepal are less likely to receive support from skilled birth attendants (SBA) during delivery at home, and giving birth at health institutions. Data show that socio-historically excluded and marginalized groups of people such as *Dalits*, Muslims, *Madhesi* castes and *Janajati* who are also poor in Nepal have poor health status and poor access to health services compared to those of Brahman/Chhetri and advantaged groups. Health status and health service utilization patterns of such groups give some indication of social exclusion and its impact on health. The burden of disease, disability, and death is consistently greater in indigenous than in non-indigenous people reflecting socioeconomic inequalities (Willis, Stephens & Nettleton, 2005). The poor health of indigenous people in the world is associated with poverty, malnutrition, overcrowding, poor hygiene and prevalent infections (Gracey and King, 2009). Poor and excluded groups of people are in high risk for diseases and ill health, and high probability for being excluded from health and other basic services.

Ethnic and racial disparities in health can be found in developed countries. In Baltimore state of the US, a black unemployed youth has a lifespan 32 years shorter than a white corporate lawyer, and a young African American is 1.8 times more likely than young white American to die from cardiovascular condition (Navarro, 2009). Minorities have more difficulty than the majority population in locating a usual source of medical care. African-American and Latino patients report greater difficulty than whites obtaining medical care at their regular sources (IOM, 2003). In terms of quality of care, African-American patients received poorer quality care than whites (Ayanian et al., 1999). Despite the expansion of health care services including availability of anti-retroviral therapy in federal programs in the US, there is discrepancy between white and non-white population in utilization of health services as ethnic minorities such as African, Latino and Asian face greater barriers than white to appropriate care. African Americans with HIV infection are less likely to receive antiretroviral therapy and less likely to receive protease inhibitors than non-minorities with HIV.

These disparities remain even after adjusting for age, gender, education, and insurance coverage (Shapiro et al., 1999).Some evidence suggests that perceptions racial and non-racial discrimination are related to health (Weinick et al., 2000). Many black African suffer from social exclusion as a direct result of the racism and xenophobia endemic within American society. Black people in the UK face a range of inequalities in employment, education and everyday life which makes sexual and reproductive health issues relatively remote (Terrance Higgins Trust, 2001). It indicates that ethnic minorities who have faced some forms of discriminations in the society are likely to have poor health status and face greater barriers to health services compared to dominant groups. It can be assumed that poverty and social exclusion have negative impact on health status and access to health care.

5. Conclusion

We know that social exclusion, socioeconomic position and health condition are interrelated. The process of marginalization and social exclusion put the certain groups of people in the bottom of social hierarchy reducing their life chances. In a stratified society, people at the top impose an array of restrictions and barriers on those at the bottom, limiting their access to resources and public services. Consequently, the excluded and marginalized people become poorer than dominant groups. Incidence of poverty is higher among the excluded groups of people such as *Dalit*, Muslim and *Janajati* in Nepal and schedule castes and schedule tribes in India, and ethnic minorities in the United States. Severe form of poverty prevents people from participating in decision making, social, political and economic dimensions of life. Social exclusion, poverty and discrimination in the society have created the socioeconomic inequality in the society.

Social exclusion in health can be explained by socioeconomic inequality in health as those who occupy advantaged positions in the society command most resources including health services. In their influential paper, Bruce Link and Jo Phelan argue that it is the

association between socio-economic position and differential command over resources which underlie the association between socio-economic position and health (Link and Phelan, 1995). There is evidence that impact of socioeconomic position on health is mediated by people's differential exposures to a very broad range of physical, chemical, biological, social, psychological and behavioral risk factors to health (Robert and House, 2000). Socioeconomic position mediates access to resource during period in which societies and major cause of death change, the association between socio-economic position and health persists over time and despite changes in risk factors and killer diseases. For this reason, social condition of individuals and groups of people can be explained as fundamental cause of health and diseases. Therefore, poor and socially excluded people are more likely to suffer from various health problems, spend a large portion of their life in ill health and live shorter than those people who have better socioeconomic condition and advantaged position (Graham, 2007). It is obvious that social exclusion and poverty have negative impact on health status of the people. But there is lack of evidence and studies establishing relationship between social exclusion and health. There is a great need for more research on how social exclusion combines with inequalities by caste and ethnicity in affecting health.

People belong to upper strata of society in developed and developing countries have been experiencing higher level of life expectancy and better health status than those who are at the bottom of the society, experiencing discrimination and deprivations. In order to reduce socioeconomic inequalities and hence improve overall population health along with ensuring equity and social justice in health and health care, it is essential to better understand the forces that generate and explain the existence and persistence of these inequalities including social exclusion. Many suggest that better understanding of the mechanism or pathways through which socioeconomic position of individuals comes to affect health. Although improving income and health insurance coverage among racial and ethnic groups can result in substantial reductions in disparities in the access to and use of health care services, it would not eliminate such disparities

altogether (IOM, 2003).There is evidence that societies that are more economically equal and socially cohesive have lower overall mortality than those that are more unequal (Wilkinson, 1996). Interventions directing to improving socioeconomic condition and increasing social inclusion and equity in social, economic and political dimensions can contribute to reduce inequities and social exclusion in health. Health policy alone cannot solve the issues of social exclusion and inequality/inequity in health. Social policy addressing social determinants of health and root cause of social exclusion in the society is equally important to improve the health of the poor and excluded group of people.

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