More than 300 million Indigenous Peoples around the world experience systematic racism and oppression including Europe’s Roma people. Millions of people including asylum seekers in the UK are ‘Citizens of Nowhere, forgotten by governments, ignored by census takers, amongst the World’s poorest and most disenfranchised.’ (Mydans, 2007). In 2001, 1% of the World’s population owned 40% of the World’s wealth whilst 50% of the population owned 1% of the wealth. Globally, around a billion people are living on less than US$1 a day including half of the population of Sub-Saharan Africa. In the UK in 2004/5, 3.4 million children were living in relative poverty. Are these the contours of social exclusion? Disadvantaged groups are an important part of the problem but this approach to understanding may be a significant barrier to effective action to address social exclusion. The concept of social exclusion was originally developed in Europe. Despite resistance in places such as Sub-Saharan Africa, where concepts such as human rights, sustainable development, poverty and basic needs have greater salience, the concept has spread rapidly around the world partly due to its adoption by powerful organisations such as the World Bank.

There are two broad approaches to defining social exclusion and different actions flow from each. The most common is the shopping list approach in which exclusion describes a ‘state’ experienced by particular groups, for example, indigenous peoples, the poor, the homeless, the mentally ill, people with disabilities, who are excluded from a never-ending shopping list of things including:

‘a livelihood; secure, permanent employment; earnings; property, credit, or land; housing; minimal or prevailing consumption levels; education, skills, and cultural capital; the welfare state; citizenship and legal equality; democratic participation; public goods; the nation or the dominant race; family and sociability; humanity, respect, fulfilment and understanding…….’

(Silver, 1994: 541)

This approach has advantages. It moves the focus away from understanding poverty as simply the shortage of money highlighting the profound consequences on psychological, social and cultural levels. It has also re-energised action for greater equity. But there are significant disadvantages and limitations. Arguably, this use of social exclusion is just
another way of labelling disadvantaged groups and can be stigmatising. It presents the ‘problem’ as a dichotomy: people are either included or excluded rendering unequal inclusion invisible. But perhaps most importantly the shopping list approach to defining social exclusion fails to illuminate the causes.

The alternative approach to defining social exclusion is relational. This focuses attention onto exclusionary processes that are driven by unequal power relationships operating across four dimensions, economic, political, social and cultural, and at different levels, individual, households, country and global regions. These exclusionary processes create a continuum of inclusion/exclusion characterised by unjust distributions of resources, capabilities and rights, i.e. socio-economic inequalities that in turn generate health inequalities.

The main advantage of this relational approach to understanding social exclusion is that it emphasises the drivers of inequality rather the conditions experienced by particular ‘entrenched excluded’ groups. By doing this it reveals the actors driving these exclusionary processes. Governments must take primary responsibility for reversing exclusionary processes by ensuring that human rights and basic needs of all citizens are met and protected, providing accountable/transparent political and legal systems, promoting and supporting civil society action and community empowerment and setting and enforcing standards for others including the private sector.

The evidence is overwhelming: a pre-requisite if exclusionary processes are to be reversed is universal publicly funded provision of high-quality essential services including healthcare, education, water, sanitation and social protection. These have had significant positive impacts on social cohesion and population health in OECD countries whilst means-tested selective services are associated with high costs, low uptake and undermine social cohesion. (Townsend, 2007) Despite this evidence state policies around the World have moved from universalism, through targeting to conditional cash transfers: paying poor people to behave properly (as defined by middle-class professionals). These are the opposite of inclusive services.

Another key to reversing exclusionary processes is the genuine delegation of power to ordinary people. But real community empowerment is a major challenge to professional power and is consistently resisted, albeit not always consciously. People experiencing poverty and disadvantage are routinely stereotyped and disrespected by health professionals and researchers. Do we really think people like being labelled as excluded and/or vulnerable, being told they are health ‘illiterate’ or having their children described as stunted? This type of language reflects and reinforces deep-seated prejudices about the undeserving poor.

Compared with words such as inequality and powerlessness, the phrase social exclusion may have a ‘feel good’ flavour but it is important to recognise that meanings drive action and restrictive meanings drive restrictive action. The shopping list approach to social exclusion is stigmatising and supports conditional inclusion: action that is both ineffective and divisive. If health professionals are to use the concept of social exclusion to inform their practice then they need to define it in ways that provide investigative advantage and promote action for social justice (Sen, 2000: 8) or find another concept.

Acknowledgements

The author wishes to acknowledge the coauthors on this report: Sarah Escorel, Mario Hernandez, Jane Mathieson and Laetitia Rispel. This editorial is based on the final report of the WHO Social Exclusion Knowledge Network (SEKN) one of nine knowledge networks established to support the work of the WHO Commission on the Social Determinants of Health (Popay et al., 2008).
References


