There is an argument that poverty no longer exists in Britain today. Many people would say that the days when people died from lack of food, shelter or clean water ended, in this country, with the introduction of the welfare state (Chinn, 1995). Poverty, however, can be defined in two ways and depending on which definition one chooses to employ, it can be contested whether the balance of evidence shows that poverty actually does exist or not. In this piece of work it will be argued that poverty does affect many people in our society and the lack of resources of poorer people in society is at the root of inequalities in health. Furthermore it will be shown that the discrepancy between the standards of living that better off people in society enjoy and the standards of living that poorer people endure can be something that is very difficult to alter. In conclusion there will be a discussion on the role that social care professionals may play in trying to reduce the negative effects suffered by some people as a result of poverty.

The first of the two identified forms of poverty is absolute or "subsistence level poverty" (Thompson and Priestly, 1996: 207). Income falls below a set level so that a person does not have the means to be able to secure the basic necessities for living, in terms of food, drink, shelter and clothing. Stephens et al (1998) argue that for some people in society, like rough

sleepers, poverty in absolute terms is very real and that when older people die from hypothermia because they can't afford to heat their homes adequately it is as a result of absolute poverty. Poverty in this sense however has certainly diminished since the advent of the Welfare State.

The second definition of poverty, relative poverty, is defined in terms of a 'reasonable' standard of living generally expected by the society in which a person lives. It identifies 'needs' as more than basic biological requirements, taking into account social and emotional needs. It is also about being excluded from taking part in activities which are widely undertaken by the rest of society. In terms of resources, relative poverty is a higher standard of living than absolute poverty but it could be argued that many things that are not strictly essential for life nevertheless could be deemed as necessities by society in general. Thus whether you adhere to an absolutist or relativist definition of it, it is clear that there are certain people in society who suffer from poverty. Modern research into poverty combines both classifications. Stevens et al (1988: 266) maintain: "it's important to capitalise on the advantages of both definitions".

There have been several pieces of well-documented research into health inequalities, both by successive governments and independent bodies, for

example, The Black Report in 1980; Margaret Whitehead's 'The health divide' in 1987 (Stephens et al, 1998) and most recently the Acheson Report in 1998. This research underlines the correlation between poverty and ill health and the disparity that exists, depending on social class. Measurements and comparisons are made in terms of morbidity and in terms of mortality. Research shows that if a person is born into poverty his/her chances of suffering ill health and a shortened life span are greater than if he/she was born into prosperity. Some of the most recent research has shown, for example that children in social class five (where five represents the least well off and one represents the most well off) are five times as likely to suffer accidental death than their peers from social class one (Roberts I. & Power C, 1996). Further studies show that a baby boy from social class one can be expected to live for more than nine years longer than a baby boy from social class five (Office for National Statistics, 1998).

The British Medical Journal (1999) states "Social class differences in health are seen at all ages, with lower socio-economic groups having the greater incidence of heart disease, stroke and some cancers". The rate of pre-natal mortality is higher for women from lower socio-economic groups. A poorer person is more likely to die in infancy, more likely to suffer ill

health, as a child and as an adult, and more likely to die prematurely than someone who has greater access to resources. It has been stated that “the most significant factor [affecting health] in poverty is… the fact that poor people are denied access to possessions and services that are available to their better-off peers" (Moore, 1997). This could include: preventative medicine, early treatment when sick, a healthy diet, access to ‘keep fit’ leisure activities. Other factors which could have a detrimental effect on poorer people could include things like poorly maintained housing, stress related illness and smoking, which is more prevalent among lower income groups (Office for National Statistics, 1998).

Explanations for poverty tend to fall into two categories. There are individualistic explanations for poverty. That people who are in relative poverty are so because they are in some way lazy, irresponsible or ‘feckless’ and they could help themselves to escape poverty if they really wanted to. Some people vocalise this way of thinking by, for example, telling the unemployed to ‘get on their bikes’ and find work. This type of argument can, and often is, applied to any ‘inappropriate’ or ‘wasteful’ use of resources for example, by criticising people for wanting to dress their children in more expensive clothes, or by condemning women for the number of children they choose to have. Another common reaction when

confronted with arguments about poverty is to be reproachful when someone chooses to smoke instead of 'spending their money wisely'. These arguments however fail to take into account the way that society is structured and the effects that this has on people's life chances. There is an element of victim blaming and consideration is not given to the fact that some people have far more power than others to alter aspects of their lives.

Structural, as opposed to individualistic, explanations focus on "the political, economic and material environment in which people find themselves" (Howe, 1997: 173). A person who is born into poverty is more likely to stay poor and their children are likely to be poor. In this way a life or poverty can be a self-perpetuating cycle of deprivation which people have very little power to change. This deprivation is exacerbated by the fact that it can be combined with other inequalities, such as those based on gender, ethnicity, and age. The fact that some people suffer from multiple disadvantages is attributable to structural inequality, which is inherent in our society. Anatole France wrote: "The law, in its majestic equality, forbids the rich as well as the poor to sleep under bridges, to beg in the streets, and to steal bread." France (1894). Clearly there is no need for wealthier people 'to sleep under bridges' whereas there may be a justification or even a necessity for a homeless person to do it. The concept

of a society where everyone has the same opportunities and all are equal is a fallacy when viewed from a structural perspective.

This does not however mean that people are absolutely powerless to help themselves and assumptions should not be made that because someone is in poverty they will necessarily need the help of social care professionals. People can often make changes to make their lives better, to suggest otherwise would be to disempower people. Social care professionals should be aware of the effects of poverty and the relative powerlessness of some people but not to such an extent that the power imbalance is made greater by the workers inability to treat the client as an individual. Anti-oppressive practice is "a form of social work that addresses social divisions and structural inequalities … by responding to people's needs regardless of their social states" Dominelli (1993). This argument is further developed by Dalrymple and Burke (1995) when they talk about giving the client access to records so that any information is shared. Ensuring inclusion and consultation can lessen the power imbalance between social care worker and client.

Government policy is geared to combating inequalities, in light of the findings of the Acheson Report. In particular it recognises the needs of

those who may have multiple disadvantages, for example women, children, people with disabilities, older people and people from ethnic minority groups. Social care workers should have an awareness of combined inequalities and should have a commitment to reduce them. "Many social workers invest considerable efforts to maximise the welfare benefits of their clients and search through charitable resources to alleviate some of their acute hardships" (Jones, 1997: 121). Social care workers can work in partnership with other agencies to ensure that they refer people to organisations who are able to help, when it is not within the social carer's remit. For example, referrals could be made to: agencies who advise on health matters, or work to increase benefits, or help people back into work, or give advice on housing matters. "The best way to get rid of poverty – absolute or relative – is to forge a more genuinely equal society" Stephens et al (1998: 258). This is something that is beyond the capabilities of any one profession. In conclusion, social care workers can help to reduce the negative effects of poverty to a certain extent but, for any major improvements to be made, there needs to be a radical change (through governmental policy) in the distribution of both power and wealth.

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