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ACTION TOWARDS HEALTHY LIVING – FOR ALL

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► **To cite this version:**

Christopher Deeming. ACTION TOWARDS HEALTHY LIVING – FOR ALL. International Journal of Epidemiology, 2010, 39 (1), pp.266. 10.1093/ije/DYP403 . hal-00563515

HAL Id: hal-00563515

<https://hal.science/hal-00563515>

Submitted on 6 Feb 2011

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Journal:	<i>International Journal of Epidemiology</i>
Manuscript ID:	IJE-2009-12-1092.R1
Manuscript Type:	Original Article
Date Submitted by the Author:	21-Dec-2009
Complete List of Authors:	Deeming, Christopher; London School of Hygiene & Tropical Medicine, Department of Public Health and Policy
Key Words:	Public Health, Health Determinants, Social Protection

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ACTION TOWARDS HEALTHY LIVING – FOR ALL

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Words	3,100 (body of text) 100 (key messages)
References	52
Tables	5

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9 Worldwide biomedical and social research has been establishing knowledge on
10 key essentials of health and well-being.(1) (2) (3) In general, this knowledge is
11 inadequately applied in public policies, resulting in avoidable health deficits,
12 waste of human potential and costs to society. Remedial measures plainly are
13 required to improve living and working conditions and create social protection
14 policy supportive of all. Formulation of the evidence into practicable ways of
15 living and the minimal costing of these to society and to the individual is
16 relatively straightforward, and we have so far assembled data on healthy living
17 for two UK population groups: adults of working age and older people. We have
18 then ascertained the minimal personal costs these currently would entail,
19 allowing for certain social provisions. This yielded our evidence-based
20 *Minimum personal Income adequate for Healthy Living (MIHL)* that may now be
21 accepted as a definable social determinant of health and, when deficient, ill-
22 health.(4)
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42 National statistics indicate that 3.6 million adults in the UK are below this
43 defined MIHL. We submit that a national minimum to increase equality of
44 opportunity for health via such a defined MIHL would be a practicable and
45 readily comprehensible step to improving public health and hopefully reducing
46 prevalent inequalities. MIHL would also provide a benchmark for health in
47 public policy generally on criteria of poverty and safe minimal standards of
48 living.
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9 We suggest practical measures in response to today's challenge that arises
10 from the knowledge on personal essentials for health that is accruing from the
11 phenomenal modern research effort. How can we better apply this knowledge
12 to our populations and all in them? The response at present is unarguably
13 inadequate.
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24 *MIHL: principles and methods*
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27 Article 25 of the UN Universal Declaration on Human Rights is relevant to our
28 argument for minimum income standards – informed by public health evidence.
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31 Article 25 states:
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38 Everyone has the right to a standard of living adequate for the health and
39 well-being of himself and of his family, including food, clothing, housing
40 and medical care and necessary social services, and the right to security
41 in the event of unemployment, sickness, disability, widowhood, old age or
42 other lack of livelihood in circumstances beyond his control.(5)
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53 There are a number of key steps in our approach to MIHL that can be
54 specified.(6) (7) (8) (9)
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58 (1) We formulate our assessment of current best evidence on personal
59 needs in key areas of health for particular population groups.
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- (2) This evidence is then translated into ways of living which we postulate will be acceptable to them, exploiting available lifestyle surveys and other information.(10)
 - (3) Next, we cost these lifestyles minimally in prevalent real-life conditions and allowing for public provisions (e.g. for older people these include free medical prescriptions, government winter fuel allowances and travel passes for example). Minimum personal costs of all of this are determined from low price retailers in the high street and where we are unable to do so from the actual expenditure of low-income households.(11)
 - (4) Finally, the minimal costs that currently would be entailed to each individual and household unit are assessed, allowing for these social provisions.

Today, we are in a position to formulate and offer an objective epistemologically grounded concept of needs for health which captures the available biomedical and social research evidence. The basic premise of MIHL is that modern research is providing us with solid knowledge of basic needs for personal healthy living, in nutrition, physical activity, housing, psychosocial relations and social inclusion. The health science is, of course, incomplete. Household expenditure data taken from national social surveys can also be used to define

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9 popular consensus on other basic essentials in the absence of formal health
10 science. Because we are interested in establishing a minimum income for
11 healthy living, we select, when necessary, relevant study population households
12 toward the bottom of the income distribution. Our proposition is that the health
13 knowledge base is sufficient to form a constructive definition of MIHL today.
14 Table 1 describes the basic methodological principles. Following these
15 sequential steps will yield a minimum disposable income required for healthy
16 living; i.e. an MIHL. This, we submit, should be a benchmark for Public Health
17 and for its stance in the formulation of public policy.
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33 *The evidence on essentials for health*

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35 We trawl the scattered modern literature for international and national expert
36 reviews, for the findings of randomized control trials and other research, and
37 where necessary, depend on our own study of the evidence with wide
38 consultation.
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47 The evidence is strong for application in public policy in many critical areas of
48 human need including diet and nutrition, (12) (13) (14) (15) (16) (17) on physical
49 activity,(18) (19) (20) and medical care. It is sufficient to allow informed
50 judgement in relation to psycho-social relations,(21) (22) hygiene and personal
51 care.(9) There are particular problems in housing.(23) (24)
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In setting the context for MIHL we may be over-simplifying concepts and issues in the research literature that are heavily contested. Two key observations on the literature are critical for our argument. First, there is general agreement that there are basic major human needs for health and well-being. These “needs” in health terms capture elements of cognate approaches to conditions of health in the social sciences – the ‘primary goods’,(25) ‘necessary capabilities’, (26) (27) ‘resources for equality’,(28) and ‘basic goods’.(29) Any such theory of human needs rests on evidence that if needs are not met significant loss will result.(30) The loss of life due to starvation and malnutrition during a famine serves to illustrate. Three million people died in the Bengal famine of 1943, which has often been described as being ‘man made’. Workers and the poor were unable to secure sufficient food due to social and economic factors, such as declining wages, rising food prices and poor food-distribution systems due to conflict and war.(31) (32) The current knowledge-base underpinning human needs can be further illustrated by the vast international literature on inequalities in health in which low income features prominently.(4) (33) (34) (35) (36) (37) (38)

Universal basic human needs can be distinguished from ‘wants’ that derive from an individual’s particular preferences and cultural environment. Objective harm, both physical and social, usually marks the distinction between needs and mere ‘wants’.(30) We acknowledge this and will not consider ‘wants’ further as we have discussed this at more length elsewhere.(7) Our contribution to this debate will be to argue for a new formulation of health needs for public policy today:

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9 needs for healthy living that can be objectively determined and priced.

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11 Consideration of need satisfaction leads to a second proposition about how they
12 are met. It is clear that basic human needs can be and are being met in different
13 ways. There is a substantial literature that discusses the satisfaction of human
14 needs within various economic and political systems; the level of welfare that is
15 produced between state, market, NGOs and family.(39) (40) What is required
16 now is an evidence-based approach to the field of needs, to set the foundations
17 for improved working conditions and systems of social protection around the
18 world.
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34 *MIHL in practice*

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37 We have assessed an MIHL for adults (6) (41) and for older people aged 65+
38 years.(8) (9) Our initial focus on adults of working age was prompted by the
39 UK governments' institution in 1999 of a statutory National Minimum Wage. We
40 were dismayed by the absence of consideration of such a wage's capacity to
41 meet obvious and basic needs for health and well-being.(42) (43) There was
42 little if any mention of these in Parliament, the health and public policy
43 community generally, or the media. The findings in this test case demonstrated
44 that the wage introduced by Government (since substantially increased) was
45 incapable of meeting the cost of our MIHL, i.e. minimally assessed essentials
46 for healthy living (Table 2). Figures from the national survey of earnings suggest
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9 that 800,000 workers in the UK had incomes below our conservative MIHL
10 benchmark (Table 3). A further 1.6 million people who are unemployed and
11 claiming Job Seekers Allowance are living on incomes well below the MIHL
12 (Table 3).
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20 Providing a healthy living wage requires supportive economic and public policy
21 that is based on the costs of meeting health needs and is reviewed on a regular
22 basis. Governments, NGOs and research centres should estimate the cost of
23 healthy living for workers in order to calculate healthy living wage levels in each
24 country; including low and middle income countries where low labour costs
25 often provides a competitive advantage. Educational attainment is linked to
26 improved health outcomes, partly through its effects on adult income and
27 employment. Public policy initiatives may be required to help the unemployed to
28 gain the education, training and skills that will help them to participate in the
29 workforce. Training opportunities are required that suit the needs of older
30 people who wish to continue in employment.
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47 The second case study deals with older people, living independently in the
48 community in England, and free of defined disability, i.e. covering some 60% of
49 the total population aged 65 years or more.(8) (9) This found again that our
50 deliberately economical MIHL (Table 2), allowing of course for the important
51 public provisions was greater than the national Old Age Pension and greater
52 also than the means-tested Government's official safety net for older people,
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9 the Pension Credit Guarantee (which of course may also have to cover the
10 costs of disability). Neither the Old Age Pension nor the PCG are discernibly
11 based on any assessment of health needs – the prevalent international
12 situation. The MIHL for younger adults is greater than that for older adults
13 (Table 2). In part this may be explained by the public provisions that are
14 available to adults over 60 in the UK. Older people are entitled to a free bus
15 travel pass but such travel costs are included in the MIHL for younger adults. A
16 free TV licence and winter fuel payments are available to older people in the UK
17 and such provisions have been factored into our MIHL calculations. There are
18 also differences in housing costs to consider. The MIHL for older people does
19 not include allowances for rent and local government council tax but the MIHL
20 for working adults does. Older people in receipt of the PCG may have their
21 rents and local government council tax payments met by local government after
22 means-testing. Figures from Government's main UK-wide general household
23 survey show that about 1.2 million pensioners over 65 years of age had
24 incomes below our conservative MIHL benchmark (Table 3). On this reckoning,
25 they were below a basic minimum to live healthily and therefore liable to ill-
26 health, disability, waste of human potential, with manifest social costs too.
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28 People aged 85 years *plus*, our most rapidly growing age group, are a particular
29 concern.

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58 Universal social protection systems are an important component of public
59 policies that seek to enable healthy living. In low income countries developing
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9 and expanding social protection systems can be a challenge. We welcome the
10 UN proposal for a universal pension fund. This would guarantee at least a
11 minimum payment to all older people around the world equivalent to the
12 international extreme dollar a day poverty line. The UN report suggests that:
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20 In most contexts, basic non-contributory pension schemes seem
21 affordable, even in low-income countries. A simple numerical exercise
22 under reasonable assumptions suggests that abolishing extreme poverty
23 in old age by providing a basic universal pension equivalent to \$1 per day
24 to all over age 60 would cost less than 1 per cent of gross domestic
25 product (GDP) per annum in 66 out of 100 developing countries ... The
26 costs of a basic pension scheme for such countries, despite rapidly ageing
27 populations, are projected to be relatively modest by 2050.(44)
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42 *Determining essential human needs and costs*

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45 Each of the major health needs presented its own complexities in translating the
46 plethora of literature into a practical evidence-based specification that would
47 appeal to policy-makers and the general public and satisfy the scientific
48 community. We illustrate the most difficult technical problems from the issues
49 that arise in housing.
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57 Because of years of too little research, decisions here presented the greatest
58 challenge. The evidence is limited and not well-focused on relevant aspects of
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physical, psychological and social well-being, yet decisions are crucial. The long-established Public Health tradition on housing focused on *infection*, *sanitary issues*, *damp* and *space/crowding* – overcrowding for long was a common proxy for poverty.(45) We take these aspects for granted.

We considered the evidence sufficient to specify a standard *heating regimen* as a minimum to protect against winter cold.(46) Yet for householders over 75 years, who are particularly vulnerable to cold and likely to spend much of their time at home, this is probably too conservative. Initiatives to help improve home *energy efficiency* with Local Authority support may be expected to achieve a number of important health benefits and to reduce fuel costs for low income families(24) (as well as helping to achieve *greenhouse gas reduction* targets). But recent fuel price volatility has emphasized how sensitive and unpredictable fuel expenditure is as a key element of household budgets.

We also considered it important to ensure good *maintenance and repair*, to help protect against risk of falls, fire,(24) carbon monoxide exposure,(47) and of heating system failure during the critical periods of cold. This means unavoidable provision for repair work and periodic capital expenditure, and also, in the case of older people, a protective insurance *maintenance contract* that we regarded as essential to cover central heating, other gas and key electrical appliances, and plumbing and drains – and thus hopefully to allay anxieties and the familiar crises! Essential adaptations (grab rails, non-slip floors, and the like) were not included on the assumption that they would be provided with the

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9 support of the Local Authority grants available in the UK. The cost of such
10 provision is difficult to assess: there is little research, the actual experience of
11 pensioners themselves is limited, and expenditure on important items (including
12 building insurance) are often neglected or deferred by families on low income,
13 so that their recorded expenditure is likely to be insufficient. In general
14 experience of low income pensioners is too limited to be of help in assessing
15 demonstrable needs for healthy living and inevitably little guide to the costs of
16 maintenance and repair.
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28 The implications are more research, and that our assessment of costs is surely
29 too low (Table 4 summarise specific issues relating to housing in later life).
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31 Even though the evidence is imperfect, we believe the uncertainties on housing
32 are not so large to preclude attempts at quantified assessment in the areas we
33 have addressed. The MIHL principle is, we submit, an advance on existing
34 policies – or lack of them – and sufficiently grounded in evidence to support
35 interim specific policy conclusions.
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51 *What could be achieved?*
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54 Assessment of the MIHL has several potential uses:
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57 (1) As an evidence-based standard of health for public policies aimed at
58 yielding an adequate minimal disposable income and thereby an
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9 operational criterion of poverty and a basic minimum living standard
10 for all.

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14 (2) As a marker for monitoring a critical driver of inequalities in health
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17 (3) To stimulate research on areas where more information on essential
18 needs for healthy living manifestly are required – e.g. in housing, as
19 above, in mental health and of course the clinical/social biomedical of
20 the large numbers with disability in our ageing populations.
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27 (4) To focus policy development on particular aspects of social need
28 debates about components of the MIHL formulation, as illustrated
29 above for housing and by what are acceptable and welcome ways of
30 living, and considering also our diverse populations.
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37 (5) To provide society and the public with a possible strategy for coping
38 with the mounting research evidence on determinants of health.
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42 (6) To provide a bridge between the Public Health and the Social
43 Science community. Collaboration at present is weak, to their mutual
44 disadvantage.
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50 Being below an MIHL threshold cannot but be a barrier to health, and it is
51 reasonable to claim that if a concept such as the MIHL is not adopted, those
52 below its threshold will be deprived. MIHL would therefore literally be an
53 empowering policy, an upstream measure increasing equality of opportunity for
54 healthy living. Introduction of such an initiative would be unfamiliar, possibly
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9 unique,(4) and monitoring of direct and indirect population responses would be
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11 vital.
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15 The enabling conditions of healthy living relate to much more than just income
16 of course; crucial also are education, attitudes and habits from childhood.(48)
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18 The MIHL policy framework is a necessary but not sufficient condition to
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20 promote as well as enable healthy living.(49) The national debate that inevitably
21
22 would precede such a shift in public policy towards health can be expected to
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24 have powerful cultural and personal resonance, hopefully raising peoples'
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26 motivation and surely providing multiple opportunities for national, communal
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28 and personal education. The policy would be timely in context of rising living
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30 costs.
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42 *Where can an MIHL be applied?*
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45 In low income settings, markers of health disadvantage such as lack of access
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47 to clean water and sanitation, and lack of clean household fuels are often
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49 transparent. The formulation and costing of minimum essentials for healthy
50
51 living could therefore be argued to add little to what may already be ample
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53 evidence of health disadvantage. However, even in these circumstances,
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55 where many are likely to live on incomes below a level necessary for health, an
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57 appropriately constructed summative measure of health needs and required
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9 income could provide a useful benchmark.(34) (35) The WHO commission
10 endorses MIHL: “such a methodology or similar could be adapted in all
11 countries and used to inform minimum-wage and social-benefit levels...” and
12 further that “there are strong arguments for setting up universal protection
13 systems, even in poor countries.”(4)
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21 In higher income populations the evidence is more straightforward to derive and
22 apply. But in all settings, the real-life challenge is also to embed the results of
23 an MIHL formulation into population-level social and economic policies. These
24 have also to give consideration to issues of affordability and how particular
25 policies affect the distribution of tax burdens and competing benefits in the
26 population. The specification of minimum income needs *for health* would
27 therefore be a step in addressing important social and ethical goals.
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45 *The task ahead*

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47 The immediate task for Public Health and the health community in general is to
48 lead in advocating that society seeks to adopt modern knowledge about health
49 needs as a base for the living standard of the population, all of it. Hopefully
50 there will be many allies in this enterprise.
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ACKNOWLEDGEMENTS

We are grateful to our colleagues for information and advice and we are greatly obliged to Jo Semence, Department for Work and Pensions, for the figures for pensioners in Table 3 and for generous guidance and support in the task of reconciling the disparate datasets.

GUARANTOR OF PAPER

Dr Christopher Deeming

CONFLICTS OF INTEREST

None

FUNDING SOURCE

None

ETHICS COMMITTEE APPROVAL

None required

CONTRIBUTIONS

Jerry Morris wrote the first draft of this paper. All authors contributed substantially to the study and text.

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12 KEY MESSAGES
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- 14 • Modern research provides consensual evidence for defining
15 the major personal requirements for health and wellbeing in
16 nutrition, physical activity, housing, psychosocial relations and
17 social inclusion.
18
- 19 • Minimal costs of these can be assessed to produce an MIHL
20 for specific population groups in different countries and
21 regions.
22
- 23 • Numbers living below MIHL can be estimated using national
24 survey data and official government statistics.
25
- 26 • Public Health, as social medicine, has to engage in such
27 application of knowledge to improve living and working
28 conditions and create social protection policy supportive of all.
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Table 1. Methodological principles of MIHL

- Science-evidence base on key essential personal needs for health and wellbeing.
- Current consensual best evidence on other necessities for healthy decent participatory living.
- Translation of (1) and (2) into presumptively acceptable ways of for specific populations in England.
- Assessment of minimal personal costs these would tail.
- Their total is proposed as Minimum personal Income required for Healthy Living (MIHL) by the specific population.
- MIHL is postulated as a benchmark for health community, and its message for public policy, as a safe minimum standard of living.
- Practical issues that arise, e.g. obtaining survey data and estimates from government departments relating to the number of people and household with incomes below MIHL.

Table 2. Minimum Income for Healthy Living (MIHL), components and aggregate costs (6) (8) (9) (41)

	Weekly cost (£s)		
	Adults (2009 prices) [€]	Older Adults (2007 prices) [¥]	Older couple (2007 prices) [¥]
Diet/nutrition	36.00	34.50	68.90
Physical activity: health, fitness	3.90	2.30	4.40
Housing, a home	64.80	39.10	42.80
Psychosocial relations, social participation	24.00	23.00	33.70
Getting about (personal transport)*	12.70	3.40	6.80
Health care ^{\$}	5.40	2.10	4.40
Hygiene, personal, domestic [†]	1.90	5.10	8.50
Other costs of healthy social living [#]	14.90	12.60	25.20
Contingencies, inefficiencies, emergencies	16.40	8.90	13.30
Total MIHL	190.00	131.00	208.00

[€]Calculations *include* housing cost such as rent and local government council tax payments. Original MIHL estimates have been updated for the movement in prices using the UK Consumer and Retail Price Index.

[¥]Calculations relate to older people (65+) living in the community without defined significant disability; they *exclude* housing cost such as rent and local government council tax payments may be met by local government after means-testing.

*Occasional taxi, train fair.

^{\$}The few residuals in England, dental care.

[†]Including personal hygiene, household cleaning, laundry and dry cleaning.

[#]Clothing and household goods.

Table 3. Adults living below the Minimum Income for Healthy Living (MIHL), UK[§]

	No. below MIHL	Population totals	Per cent below MIHL
Job seekers (unemployed)*			
18-24 years	470,000	-	-
25-49 years	850,000	-	-
50+ years	240,000	-	-
Total	1,560,000	-	-
Jobs held by people[#]			
16-17 years	230,000	340,000	68
18-21 years	370,000	1,700,000	22
22+ years	180,000	23,670,000	1
Total	780,000	25,700,000	3
Single pensioners[†]			
65-84 years	510,000	2,710,000	19
85+ years	150,000	610,000	24
Total	650,000	3,330,000	20
Pensioner couples[†]			
65-84 years	480,000	4,000,000	12
85+ years	60,000	250,000	24
Total	540,000	4,250,000	13

[§]All numbers have been rounded to the nearest 10,000.

*Estimates relating to the number of job seekers (unemployed) with income below MIHL are based on the number of people claiming Job Seeker's Allowance during November 2009.(50) For an adult aged 25 without dependants the allowance was £64.30 a week £50.95 for adults aged 16-25. Rent and local government council tax may be paid by local government after means testing.

[#]Estimates relating to the number of workers with income below MIHL are derived from the 2009 national survey of earnings.(51) Our MIHL for adults in work includes allowances for rent and local government council tax.

[†]Estimates for the number of pensioners below MIHL relate to national household survey data from 2007.(52) For pensioners MIHL excludes rent and local government council tax payments as these costs may be met by local government after means-testing.

Table 4. Housing, a home: older people. Requirements in the assessment of MIHL costs

FACTOR	BASIS FOR INCLUSION AND COSTING
Fuel costs for heating, lighting, cooking, etc.	Home heating to an adequate level is important to protect against winter/cold-related mortality and morbidity, indoor mould, and to address important aspects of psychosocial needs. Many other forms of fuel use are essential (for cooking, washing, refrigeration, food hygiene, lighting). Calculations were based on a standardized heating regimen to maintain minimum acceptable indoor temperatures.
Water supply and sewerage etc.	Essential services with (relatively) fixed cost. Assessment of cost based on actual expenditure by low income pensioner families.
Service contract for maintenance, breakdown and emergency repairs of heating system, etc.	Included to ensure cover for heating system failure during the critical periods of cold, other important household services, and to allay anxieties. Costing based on a maintenance contract offered by major national suppliers for central heating, other gas and key electrical appliances, plumbing and drains.
Basic repair costs to assure dwelling fit for a home, to maintain the dwelling fabric and, of course, security	Maintenance and repair are important to protect against failures of structural integrity (rain, damp, structural collapse etc), risks of falls and other forms of injury risk, fire and electrical accident, exposure to combustion products from poorly maintained combustion appliances. Costings were based on actual expenditure by low income pensioner families. But because repairs may often be neglected, two components were also included: (i) actual expenditure on maintenance/repair and (ii) an estimate (from the English House Condition Survey) of the estimated minimal expenditure needed to restore fitness, distributed over a period of ten years.
Insurance (dwelling structural and contents)	An item considered essential to protect against major insurable risks. Based on low cost policies.