

Poverty is Bad for your Health

Ruth Barrington



DISCUSSION PAPER

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Poverty is Bad for your Health

1. Why Public Health Matters

'Health, wealth and happiness' is a common toast to young people starting married life together. It reflects the collective wisdom of the generations as to the most important ingredients of a long and fruitful life.¹ An association that people have understood for centuries has been underpinned by recent research into the association between health and wealth. That research has consistently shown a strong association between poor health and low income on the one hand and higher income and better health on the other. This is most obviously the case for developing countries where the income of so many people is too low to guarantee access to even the basic necessities for a healthy life, such as clean water or adequate food. What was surprising was that a strong link between income and health is also found in developed countries, some of which have mature welfare states and health services that are accessible to all on the basis of need. The seminal *Black Report* in 1980 found that in the United Kingdom people on low incomes had death rates two or three times greater than those of the better off classes and that the gap was widening.² Similar differences in death rates between the lowest and highest socio-economic groups have been found in the 1990s in Ireland.³ Why in wealthy societies, with the safety net provided by the welfare state and a health system responsive to people's needs, are poor people experiencing health risks so much greater than their richer fellow citizens?

The search for answers to this question has absorbed the energies of many researchers interested in public health for the past decade. There is continuing debate on the possible explanations of the phenomenon. Is it linked with the unequal way modern societies are organised and the exclusion and lack of respect people on low incomes experience? Or is it to do with an accumulation of life-time negative influences on health experienced by people on low incomes? Or is it because the kinds

of employment that people on low incomes tend to work in are associated with higher levels of morbidity and mortality? Whatever the explanation, there is agreement among the researchers about the strength of the relationship between income and health. There is also agreement that people in poor areas have worse health outcomes than those living in wealthier areas. Furthermore, there is agreement that in developed countries with reasonably comprehensive medical services, the contribution of medical care to explaining differences in mortality between different income groups is relatively small.⁴ It seems that the contribution of medical care, while of vital importance to those who are ill, is too often to ameliorate the impact of diseases whose roots lie deep in the social and economic fabric of our society. The impact of other policies that affect those on low incomes in developed countries appears to be much greater on health than that of the health services.

The business of public health is to prevent unnecessary illness and death. Traditionally, this has involved protecting health by controlling infectious diseases and hazards in the environment. This remains an important part of the role of public health practitioners but increasingly, the challenge is to go beyond the traditional focus of public health and address the main causes of preventable illness and death deeply embedded in our society. The corollary of this challenge for those interested in public health is that success requires a collaborative approach with other partners sharing complementary objectives of eliminating poverty, reducing inequalities, building an inclusive society, improving public services and enhancing the quality of life. Within the health system, those involved in public health have a particular responsibility to ensure that the way in which medical services are organised does not contribute to the inequalities experienced by those on the lowest incomes and that access to care is on the basis of need, not ability to pay.

Does public health matter? Irish society values health and life. The enjoyment of good health is increasingly seen as a human right. Society is critical of avoidable death and injury on the roads; of the avoidable harm caused by street violence, passive smoking or

inaccessible medical care. Yet the toll of preventable death on the island of Ireland is staggering. It has been estimated that 5,400 fewer people would die prematurely each year if death rates were reduced to match those in Europe by tackling social deprivation and inequalities.⁵ The saving in lives would be even greater, if we attained the lowest rates achieved by some countries.

The current social partnership agreement, *Sustaining Progress*, commits government and the social partners to ‘the building of a fair and inclusive society and to ensure that people have the resources and opportunities to live life with dignity and have access to quality public services that underpin life chances and experiences.’⁶ There is a specific reference to addressing health inequalities. But there is a paradox. If, at one level, we do care about building an inclusive society and reducing health inequalities, others detect a willingness to tolerate high levels of inequality. Maev-Ann Wren in her insightful analysis of the problems of the health system has remarked:

Irish people die younger because they tolerate an inequality between them that breeds ill-health, and they accept a health care system and a view of health care which implicitly places lesser value on the lives of those with lesser means.⁷

Even where there is a commitment to reducing health inequalities as in *Sustaining Progress* and the National Anti-Poverty Strategy (see below) the manner in which that commitment is formulated suggests that we are not very clear or consistent about what is required to achieve this objective. If one adds into the equation our relatively low level of social expenditure by European standards, one of the lowest burdens of taxation in any EU country and a public that favours reductions in government services rather than an increase in taxes, one could be pessimistic that progress in tackling health inequalities can be made.

Yet if public opinion was fully aware of the burden of preventable illness and premature death borne disproportionately by those on low incomes in our society and if there were a

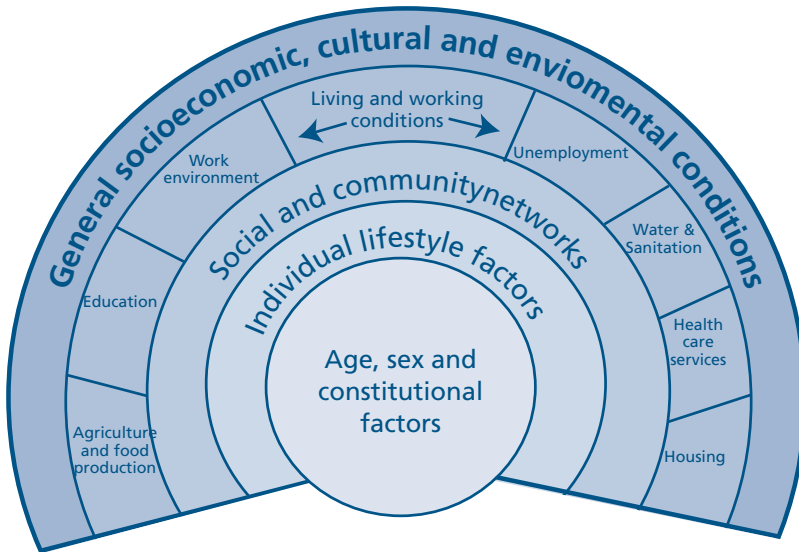
coherent set of initiatives to address the problem, it is hard to believe that it would not motivate sufficient people to want to do something about it.⁹ It is the responsibility of people working in public health to present the evidence, suggest the shared agenda for action and build the partnership to address the issues. Fortunately, there are signs of movement under each of these headings that will be referred to later in this paper.

2. Determinants of Poor Health

What determines health? What determines that your health will be good and that mine will be poor? Some factors that influence health are outside the direct control of individuals or society, for example age. The older one is, the more likely one is to be ill. Each individual's genetic profile, inherited from parents, will influence the chances of a healthy life, particularly if one inherits a disability or a high risk of developing a particular disease. Gender may also increase the risks to health. Women may experience increased risk during child-birth. However, the level of health that a society enjoys has much more to do with other factors such as the level of socio-economic development, the degree of inequality, the rate of employment, levels of education, the quality of housing, the safety of the environment, the priority attached to protecting health and the kind of social and community networks that support people. The 'rainbow' of factors that impact on the health of a society is illustrated in the diagram below. The reasons why, if you are poor, you are likely to have worse health than someone on a high income lie mainly within these wider social factors such as the quality of social and community networks, access to and the quality of employment, level of disposable income, access to education, availability of housing and the safety of the environment.

It has been argued that the reasons why poor people have worse health is because people with poor health are likely to earn less and are therefore more likely to have low incomes.

However, the research findings on this issue suggest that the downward mobility of people with poor health only accounts for a small amount of excess illness among those on low incomes.⁹



Source: Dahlgren G. Whitehead, M. *Policies and Strategies to Promote Social Equity in Health*. Stockholm, Institute of Future Studies; 1991

Death rates by age and disease are frequently used as a measure of health outcomes, in the absence of other sources of information. The difference in the death rates from the main causes of death between those in the highest and lowest socio-economic groups in Ireland are stark. For the purposes of the findings reported below, the 'highest socio-economic group' comprises higher and lower professionals. The 'lowest' socio-economic group comprises farm labourers, semi-skilled and unskilled workers.¹⁰ The mortality rate for all causes of death in the period 1989 –1998 was almost two and a half times greater for the lowest socio-group than the highest group.¹¹ This figure can be further broken down by disease. Table 1 illustrates the scale of the difference in deaths from certain diseases between the lowest and highest socio-economic groups. The five fold differences in death rates for respiratory disease and injury/poisoning between the lowest and highest groups are extraordinarily high.

Table 1: Deaths for selected diseases by lowest and highest socio-economic groups (SEGs) 1989-1998 (working age males)

| Selected Disease | % of all deaths | Ratio of death rate in lowest SEG to death rate in highest SEGs (base 100) |
|---------------------|-----------------|--|
| Malignant Neoplasms | 23 | 223 |
| Circulatory | 45 | 312 |
| Respiratory | 16 | 619 |
| Injury/Poisoning | 5 | 614 |

Source: Inequalities in Mortality, The Institute of Public Health, 2001

Nor is it just the poorest who suffer excess mortality from these diseases and disorders. There is a gradient of increased mortality for the conditions in table 1 across all socio-economic groups from the highest to the lowest, suggesting the scope for reducing premature death across most socio-economic groups.

The scale of the differences in death rates between those in the lowest and highest socio-economic groups appears to be greater in Ireland than in other European countries. Even on the island of Ireland, the difference in mortality rates between the groups at each end of the social spectrum appears to be greater in the South than in the North.¹²

3. How does Living in Poverty Affect People's Health?

The figures illustrate the extent to which people on low incomes in this country have poor health outcomes. But what is it about living in poverty that affects people's health? If one could define it, the definition might hold the key to interventions to protect

health and reduce premature death. There is much information available about the experience of living in poverty in Ireland that is relevant to health.

Those on low incomes, for example, tend to have lower levels of education than those with higher incomes. Many receive little more than primary education. Those who only have primary education have much fewer job opportunities than those with secondary or tertiary education. Those from disadvantaged backgrounds are more likely to be unemployed or to have experienced unemployment in the past. If they are working, they tend to work in jobs that are less secure and that offer little control or reward for effort. They in turn are more dependent on income support and public services for everyday necessities.

Low income is also associated with less control over individual lifestyle factors that affect health. The diet of those in the lowest socio-economic groups is likely to include insufficient fruit and vegetables. They are more likely to smoke and less likely to exercise regularly than people with higher incomes.¹³ They are more likely to be single parents, and if women, to have had a child during their teenage years. They are more likely to be exposed to environmental pollutants, both at work and where they live.

In relation to housing, they are more likely to experience overcrowding and to have to live with the insecurity of private rented accommodation rather than the security of being owner-occupiers. And they are at higher risk of dying during the winter as a result of inadequate heating in their homes and difficulties in accessing health services.¹⁴

Those on low incomes experience more exclusion or alienation from society than those who are better off. They are less likely to vote or take part in community or voluntary activities. If they are members of ethnic minorities, they may experience discrimination and aggression. They are more likely to be the victims of crime and intimidation.¹⁵ They are less likely to see a medical specialist when ill and have to wait longer for hospital treatment.¹⁶

What is increasingly being recognised is the cumulative impact of the stress associated with living on low incomes for individuals, either simultaneously or sequentially. There is increasing evidence that the strain of living on a low income manifests itself in biological changes in the body. In emergencies our bodies respond by activating a cascade of stress hormones that affect the cardiovascular and immune systems. This enables the body to deal with an immediate physical threat by raising the heart rate, diverting blood to muscles and increasing anxiety and alertness. While this response to stress is natural, it seems that if it happens too often and for too long, it damages health. Symptoms include depression, increased susceptibility to infection, diabetes and a harmful pattern of cholesterol and fats in the blood, high blood pressure and the attendant risks of heart attack and stroke.¹⁷ If the stress associated with living on a low income is added to the damage caused by high levels of smoking and poor diet, it is not too difficult to explain why poor people experience more ill health and die younger than the better off.

One of the consequences of the struggle with life that people on low incomes experience is that they do not attach as high a priority to good health as those who are better off. This may explain why the issue has not come to the top of the political agenda sooner. The question for those who wish to see those on low incomes enjoy the maximum level of good health is: What is the most effective way of intervening to achieve that aim?

4. Initiatives to Create Economic and Social Change in Favour of Greater Public Health

It is common among those who work in public health in this country to look at health inequalities by gender, across the life span and by those categories protected by equality legislation. While these approaches throw valuable light on the health experiences by gender, age or other status, there is a danger that such analysis can lose sight of the sheer scale of the excess burden

of mortality when the population is categorised by income and social class. For example, the death rate of men in Ireland is high by European standards but it is likely that the excess is largely the result of the very high rates among those on low incomes. On the other hand, public health specialists often focus on one issue that affects the health of the population such as smoking, alcohol abuse, excess salt, poor nutrition or inadequate exercise. They pursue interventions that assume a high level of education, presume that people can exercise choice to change their lifestyles or that health is the most important priority for the audience to which their messages are addressed. In the case of people on low incomes, none of these assumptions may be true. Others focus on reducing ill-health and premature death from one disease, such as cardiovascular disease or cancer, without an explicit focus on the socio-economic circumstances that are a major part of the explanation of the high incidence of the diseases on this island.

These traditional public health approaches might be more effective if they were informed by a model of health inequalities that recognised the influence of social and economic determinants on health. Health inequalities are integrated problems that require integrated solutions. If health inequalities are to be reduced and the health of the population enhanced, interventions must go beyond the traditional boundaries of the health system. They require a concerted approach by those working to improve health, ameliorate low income, increase participation in education, supply adequate housing, enhance employment opportunities and improve the quality of social and community networks.

Is there any template that we could use for interventions that would address the 'rainbow' of factors that determine the health of our society? A foundation for action is being laid through research and information. The Institute of Public Health has led the way with its pioneering study of *Inequalities in Mortality on the Island of Ireland*.¹⁸ It has maintained a clear focus on the reduction in health inequalities since its establishment and, in taking the initiative to establish a multi disciplinary Public Health Alliance provided a forum in which discussion and debate on health equalities can be taken forward in this jurisdiction. The

Health Research Board (HRB) funds a research programme on health and social gain under the directorship of Professor Cecily Kelleher, of University College Dublin. This programme is assessing, for the first time in Ireland, the determinants of health status over time, using a model that includes the insights of biology, psychology and sociology as to what constitutes a healthy life. The programme is assembling a cohort of 1,000 infants, 1,000 other children and 3,000 adults to explore the inter-relationship between socio-economic status, family lifestyle and health outcomes, including use of health services. The team has also published secondary analysis of existing data.¹⁹ The research programme is linked to a European Science Foundation initiative to explain social variations in health expectancy in Europe.

At a policy level there is a commitment to tackling health inequalities in the health strategy – ***Quality and Fairness- A Health System for You***, and a recognition that the task needs the commitment of many government agencies whose policies and services affect health. There is a commitment in ***Quality and Fairness*** that:

'equity will be central in developing policies (i) to reduce the difference in health status currently running across the social spectrum in Ireland; and (ii) to ensure equitable access to services based on need.'²⁰

Fair access to services is to be based on need, in order to ensure that financial barriers do not preclude people from achieving their health potential and that the 'two-tier' element of hospital treatment that puts public patients at a disadvantage in accessing elective treatment will be addressed. However, the Strategy does not outline how the policies and actions of government agencies will be co-ordinated to tackle the problem of health inequalities in a coherent, 'joined-up' way.

It is encouraging that for the first time, the ***National Anti-Poverty Strategy 2002-7*** (NAPS) includes a health dimension, in recognition of the inequalities in health that people in poverty face. However, the health targets set in the NAPS are not well

formulated since some could be achieved by reducing the rates experienced by those in the highest socio-economic groups rather than by increasing the rates of those in the lowest groups.²¹ Nor is it clear which agency is responsible for achieving most of the targets. In the absence of good information systems, the progress towards achieving the targets may be difficult to measure.

The agreement between the social partners, *Sustaining Progress* includes a commitment to addressing health inequalities. However, the commitments under the heading of 'Health and Addressing Health Inequalities' suggest that the social partners have not understood the impact of socio-economic forces on health outcomes. In the document, the social partners agree that health inequalities are to be overcome through: the implementation of the primary care strategy; structural reform of the health services; additional rehabilitation facilities; improved information systems that achieve value for money and quality outcomes; health promotion activities that address the whole population with a commitment to 'strategic' initiatives targeting workplace health; mental health and men's health. These are all initiatives that are within the responsibility of the health system to deliver and represent no advance in thinking about the need for government agencies to work together to tackle health inequalities. It is clear from this short overview of *Quality and Fairness*, the NAPS programme and *Sustaining Progress* that there is no agreed understanding of the challenge posed by health inequalities in our society, let alone agreement on a framework for effective intervention to redress them.

How do we stand compared to other European countries? Since 1990, there has been a growing awareness of the challenge of health inequalities in European countries, with a number developing innovative approaches and a few adopting comprehensive strategies.²² In Finland, France, Greece, Italy, Lithuania, the Netherlands, Spain, Sweden and the United Kingdom, health inequalities have reached the political agenda. Governments have typically commissioned reports on the scale of the challenge of health inequalities, developed research programmes, established advisory committees to recommend

policy initiatives and adopted co-ordinated policy interventions. Innovative approaches include policy steering mechanisms such as quantitative targets to reduce health inequalities and health inequalities, impact assessment (Netherlands), interventions in the labour market (Sweden and France) and health interventions to improve nutrition (Finland). In three countries – the Netherlands, Sweden and the United Kingdom - governments have adopted co-ordinated strategies to reduce health inequalities and increase the health of their populations. The approach of the UK is the most comprehensive.

The UK approach was strongly influenced by the Acheson Report of 1998 which recommended action to reduce health inequalities under seven policy areas: taxation and social security; education; employment; housing and environment; mobility, transport and pollution; nutrition and the health service.²³ In Northern Ireland, the Executive, established following the Belfast Agreement, was influenced by this agenda and identified ‘working for a healthier people’ as one of its five overarching priorities. It gave expression to this priority by developing, following consultation, a strategy for action to improve health and well-being and reduce health inequalities involving most government departments, public bodies, local communities, voluntary bodies, district councils and the social partners. The strategy, known as *Investing for Health*, was adopted in March 2002. Although the lead role in developing *Investing for Health* was taken by the Department of Health, Social Services and Public Safety, it represents a remarkable consensus across government and the community and voluntary sector about what is required to improve health and reduce health inequalities in Northern Ireland. The implementation of *Investing for Health* is overseen by a ministerial group on public health, chaired by the Minister for Health, Social Services and Public Safety, and at local level by Investing for Health Partnerships, led by the four health and social services boards. The multi-disciplinary Northern Ireland Public Health Alliance is to play a role as an independent forum on health improvement.

Northern Ireland is clearly some way ahead of the south in its approach to tackling health inequalities. What is still missing here is a shared understanding of what is required to improve health and to tackle health inequalities, the prioritisation by government of action to tackle health inequalities and a co-ordinated plan of action led by government with the support of the social partners and community and voluntary sectors.

How can a shared understanding of what is required to improve health and tackle health inequalities be developed and made a priority issue for government? People who care about public health can make a unique contribution to building a shared understanding of how health in our society is determined, by undertaking the research and refining the information that underpin action and convincing decision makers of the need for prioritisation. The Institute for Public Health and the newly formed Public Health Alliance, with its multidisciplinary membership drawn from statutory, community and voluntary bodies, are major resources for this work.

5. An Action Plan to Improve Health and Reduce Health Inequalities

What would a co-ordinated action plan on health improvement and reducing health inequalities consist of? It would make common cause with the NAPS in relation to the reduction and eventual elimination of poverty, given the overwhelming association between low income and poor health. On the basis that the effects of early development last a lifetime, the priority would be to ensure that all children get the best possible start in life. “Tús maith is leath na hoibre” as the Irish saying goes – a good start is half the work. In particular it would address the protection and promotion of the health of the estimated 70,000 children experiencing a combination of income poverty and deprivation of basic necessities and of the estimated 300,000 children in income poor households.²⁴ However, it would go beyond the minimalist health targets in the NAPS to outline

interventions under each of the determinants of health to improve health and reduce health inequalities. It would look at income support, education, employment, transport and environment policies from a health perspective and lay the foundations for impact assessments of government policies to assess their contribution to improving health and reducing health inequalities. It would look at social and community networks and how they could be strengthened to promote healthier lives. It would address the issue of how to create a more egalitarian society, one which more closely reflected the republican ideals on which the state was founded and one in which citizenship, rather than ability to pay, was the criterion for access to essential services such as medical care.²⁵

The lead role in preparing the action plan should be taken by the Department of Health and Children on behalf of the health system but it would involve all government agencies whose policies or actions impact on health, on the model of Northern Ireland's *Investing for Health*. A key challenge of the action plan for those in public health would be to integrate the traditional approaches to population, disease or substance specific interventions in the light of the linked goal of improving health and reducing inequalities. This is not a question of abandoning valuable health interventions but of reappraising them in the light of their contribution to reducing health inequalities linked to socio-economic factors and working in a more integrated way with those responsible for shaping the social and economic determinants of health.

Two neglected areas that impact on the health of those on low incomes are security and civic involvement. Those who live in deprived communities experience a disproportionate level of crime compared to those who do not.²⁶ Fear associated with intimidation or personal insecurity is a major stressor and can contribute to poor health outcomes. Low levels of civic involvement, illustrated by low turnout in elections and participation in community activities are also features of deprived communities that weaken their collective power to improve their situation. Initiatives that would improve security through better

policing and greater civic involvement are issues that might form part of an action plan to reduce health inequalities.

6. Contribution of the Health System to Reducing Health Inequalities

The action plan would also address the extent to which the health system, in terms of policy and access to and targeting of services, is contributing to health improvement and a reduction in health inequalities. At an intellectual level, the responsibility rests with leadership in the health system to recognise and convince others of the scale of the health problems associated with low income in our society and to analyse and address these health inequalities as a priority. This may seem obvious but it is a difficult task to keep to the forefront of public attention in the day to day war of attrition in the health services as different interest groups vie with each other for funding, policy interventions or the time of key policy makers. Two years after the publication of the Health Strategy and its welcome commitments to equity, for example, there are no proposals that would translate these commitments into action. Instead, the health system is engaged in major organisational and administrative changes that are driven by different motives than that of addressing health inequalities.

To what extent is the health system contributing to the inequalities in health experienced by those on low income? The evidence suggests that it may be contributing more than is generally realised.

Access to one of the most important medical services in this country – primary care – is means tested, with applicants showing that they cannot afford to provide medical care for themselves and their dependents ‘without undue hardship’ before they are granted a medical card. The medical card guidelines have fallen so far behind increases in social welfare payments that many

families dependent on social welfare no longer qualify for a medical card. The proportion of the population that now qualifies for a medical card on income grounds has fallen to 27.7 per cent, the lowest percentage since the current scheme was introduced in 1972.²⁷ A family of four earning more than €250 a week will not qualify for a medical card under the most recent guidelines. This means that families on very low incomes must find the money to pay general practitioner fees (€30-40 per visit) and the first €78 of the pharmacist's bill every month. One visit to the general practitioner and a prescription costing €30 could cost more than one quarter of the weekly income of a family of four just above the medical card limits.

Should a person without a medical card be admitted to hospital, he or she will have to pay €40 for each night spent in hospital, a significant amount of money for the family of four referred to above. Should a person on a low income – with or without a medical card - be referred to a specialist, he or she will have a much lower chance of seeing one in our health service than those on higher incomes.²⁸ Waiting lists for elective surgery in public hospitals are believed to consist overwhelmingly of public patients who do not have health insurance or who cannot afford to pay for an operation. Under present arrangements in public hospitals, beds are designated 'public' or 'private', but all the other facilities of the hospital are shared. Private patients access both inpatient and day facilities in public hospitals faster than and in disproportionate numbers to patients who do not have insurance. In some specialities, the number of private patients treated as a proportion of the total is increasing.²⁹

If the health system is part of the problem, how should it remedy the situation? The priority should be to address the problem of those on low incomes in accessing medical care. Ireland is unusual in Europe in not providing primary care services without charge to the majority of the population. A society committed to inclusiveness would set a target for the gradual widening of entitlement to primary care. There are a number of ways this could be done – by gradually increasing the medical card income thresholds, or granting medical cards to those earning less than

the average industrial wage or to all children, as advocated by the Chief Medical Officer of the Department of Health and Children.³⁰ The Government is committed to extending the medical card scheme but as indicated above, the numbers covered are declining, not increasing.³¹

The Health Strategy undertook to increase hospital capacity by appointing more specialists and providing more beds and facilities. However, there has been little expansion in the number of specialists or facilities in the intervening period and it is not clear to what extent these commitments will be honoured. The ESRI has estimated that the cost of each private patient stay in hospital is subsidised by the taxpayer by up to 50 per cent.³² In the interest of equity of access to public hospitals on the basis of need, there is an overwhelming case for introducing common waiting lists for both public and private patients in public hospitals.

There are other effective interventions that would assist in strengthening health in low income families and communities. Vaccination is one of the most effective means of protecting the health of children but children in low-income families and communities have the lowest take up levels in Ireland. It appears that a considerable part of the reason for the low take up is poor organisation on the part of the health services rather than any particular reluctance on the part of parents to avail of the service. Similarly, a more proactive approach might be taken to providing ante-natal care for mothers, and particularly single mothers, on low incomes. It is a curious hangover of the past that public health nurses visit mothers after the birth of a child but not before. Earlier and more proactive intervention during pregnancy could have important health benefits for both mother and child. An expansion of the community mothers programme, which supports young mothers, many of them single, is another practical and effective way in which the health service could support women and children on low incomes. Greater co-operation between the education and health sectors in providing pre-schooling and school meals for children in deprived communities would contribute to their healthy growth and development.

There is also a need to experiment with innovative ways of tackling health problems in deprived areas, perhaps on the model of the health action zones in Northern Ireland that form part of the *Investing in Health* strategy.

7. Information and Research

One reason why the socio-economic dimension to health outcomes has been slow to develop in this country may be the inadequacy of information systems and the small amount of research that has been conducted on the health of people on low incomes. People only tend to collect information about things they consider important. The fact that we collect so little information about the impact of socio-economic factors on health suggests that the issue has had a low priority. The absence of high quality information “contributes to official inertia in dealing with both the causes and consequences of health inequalities”.³³ The Action Plan proposed above should address the deficit in research and information on health inequalities and outline how these will be developed to enable monitoring of progress towards the objective of promoting health and reducing health inequalities.

8. Joined up Government?

The success of public interventions on behalf of those on low incomes depends to a great extent on the ability of government agencies to work together to a common objective and agenda. Their focus and manner of intervention may differ but each should add value towards the elimination of poverty and the creation of a more inclusive society. It is precisely this kind of ‘joined up’ working that public agencies in this country find so hard to do. Government in Ireland is characterised by a multitude of specialist agencies, centralised in organisation and orientation,

without common boundaries for their operational activities. Public bodies appear to have great difficulty agreeing common objectives and agendas with other agencies in the interests of the development of a particular region, community or socio-economic group.³⁴ While the Health Strategy recognised the need for multi-agency working if the health potential of the population is to be achieved, it is disappointing that the health reform programme announced in June 2003 may make multi-agency working to reduce health inequalities at regional and local level more difficult.

9. Conclusions

The toll of premature death in Ireland is enormous and the greater part of that mortality is the result of socio-economic factors, particularly low income. Those on low incomes experience an accumulation of factors that undermine their health, reduce the priority they attach to protecting health and lessen their control over the factors that influence their health. The continuing stress associated with living on a low income manifests itself in biological changes that increase the risk of depression, infections, diabetes and cardiovascular disease.

Although there are signs that health inequalities associated with low income are becoming a political issue, there is as yet no consensus about the action required to reduce them. Although the need for an approach that involves public agencies whose policies or actions impact on health is recognised, this recognition has not found expression in an agreed action plan that has the support of government. The Northern Ireland **Investing for Health** initiative to promote health and reduce health inequalities, provides a model that this jurisdiction might follow. The priority should be a co-ordinated effort to protect and promote the health of children in poverty since the effects of early development last a lifetime. Existing public health interventions should be reappraised to ensure that there is a coherent approach within the health system and with agencies

responsible for other policies that shape the determinants of health.

The health system can have little credibility in persuading other sectors to focus on reducing health inequalities if it does not prioritise the removal of inequalities within the health system itself. The health system should ensure that there is equity of access for those on low incomes to health services, that coverage for primary care is widened and that services are targeted to support low income families with children as a priority. The quantity and quality of research and information on health inequalities should be increased to provide the evidence for action and for monitoring the effectiveness of interventions. The challenge of getting all public agencies working together to protect and enhance the health of those on low incomes may be made more difficult by the reorganisation of the health services.

Ireland, as a country with one of the highest per capita incomes in the world, can now, for the first time in its history, afford to guarantee all its citizens the opportunity of a long and healthy life. It is not a question of the feasibility of that goal. The question is whether there is the collective will to achieve it.

Endnotes

- 1 The toast is based on impeccable academic credentials. The relationship of health, wealth and happiness is discussed by Aristotle in the *Nicomachean Ethics*.
- 2 Black Report – *Inequalities in Health, Report of a Research Working Group*, HMSO, London 1980.
- 3 Balanda, Kevin P & Wilde, Jane, *Inequalities in Mortality 1989-1998, A Report on All-Ireland Mortality Data*, The Institute of Public Health, 2001.
- 4 Wilkinson, Richard G, *Unhealthy Societies – The Afflictions of Inequality*, London, 1996 pp 66-7.
- 5 Balanda and Wilde, op. cit. and *Investing For Health, Social Services and Public Safety*, Belfast, March 2002 pg 23.
- 6 Sustaining Progress – Social Partnership Agreement 2003-2005, p. 8.
- 7 Wren, Maev-Ann, *Unhealthy State – Anatomy of a Sick Society*, New Island, 2003 (p11).
- 8 Timonen, Virpi *Irish Social Expenditure in a Comparative International Context*, Combat Poverty Agency/Institute of Public Administration, 2003; Irish Times Monday 29 September 2003.
- 9 Wilkinson, Richard G, op.cit. pp 59-60.
- 10 The ‘lowest socio-economic group’ is the closest equivalent available for comparison purposes with the poorest sections of Irish society.
- 11 Balanda and Wilde, op. cit.
- 12 *ibid*.
- 13 Kelleher, Cecily, et al. *The National Health and lifestyle Surveys*, Centre for Health Promotion Studies, Galway, April 2003.
- 14 Daly, DJ *Excess Winter Mortality in Europe: A Cross Country Analysis Identifying Key Risk Factors*, Journal of Epidemiology and Community Health 2003; 57:784-789.

- 15 Interdepartmental Group on Urban Crime and Disorder (Ronanstown Report) 1992 Dublin , Stationery Office; Fahey T *Social Housing in Ireland: A Study of Success, Failure and Lessons Learned*. (1999) Oak Tree Press; Sinclair, H, Connolly J, et al *Overview of the Drug Situation In Ireland*, Health Research Board, (forthcoming).
- 16 Van Doorslaer, E. 'Equity in the Use of Physician Visits in OECD Countries: Has Equal Treatment for Equal Need Been Achieved?' paper delivered at the OECD Conference 'Measuring Up – Improving Health Systems Performance in OECD Countries', Ottawa, Canada, November 2001.
- 17 Bartley, Dr Mel et al, *Social Determinants of Health: The Solid Facts*, World Health Organisation, 2003.
- 18 Balanda, Kevin P and Wilde, Jane op. cit.
- 19 see for example O'Shea, Eamon and Kelleher, Cecily op.cit.
- 20 *Quality and Fairness – A Health System for You*, Department of Health and Children, 2001
- 21 Barrington, Ruth 'Building an Inclusive Society – A Health Perspective' in *Poverty Today*, April 2002.
- 22 I am grateful to Professor Johan Mackenbach for this information presented at an European Science Foundation seminar on Social Variations in Health Expectancy, University College Dublin, Saturday 11 October 2003.
- 23 Acheson, Sir Donald, *Independent Inquiry into Inequalities in Health Report*, 1997, London, Stationery Office.
- 24 *Investing in the Future: Ending child and family poverty*, Combat Poverty Agency, Pre-budget submission, 2003.
- 25 The word 'republic' means a state in which supreme power is held be the people or their elected representatives and there is equality between people. Concise Oxford Dictionary 1976 edition.
- 26 See endnote 16 above.
- 27 Wren, Maev-Ann, *Chronic Consequences as Medical Card Safety Net Slowly Disappears* The Irish Times, Monday Novemebr 17, 2003.
- 28 Van Doorslaer op. cit.

- 29 Wiley, Miriam. 'Treatments for Female Breast Cancer in Irish Public Hospitals 1999-2002: Variations by health board and Public/Private Status' presented at All-Ireland Cancer Conference October 21, Rochestown Park Hotel, Cork.
- 30 Kiely, Dr Jim, Annual Report of the Chief Medical Officer, Department of Health and Children, 2000.
- 31 At the launch of the Health Strategy, the Minister for Health and Children said that he planned to extend medical card eligibility to 200,000 extra people. The Fianna Fáil election manifesto in 2002 promised to extend medical card eligibility to over 200,000 extra people, with priority to be given to families with children.
- 32 Nolan, Brian & Wiley, Miriam, *Private Practice in Public Hospitals*, Economic and Social Research Institute, 2000.
- 33 O'Shea, Eamon and Kelleher, Cecily '*Health Inequalities in Ireland*' in Cantillon, Sara et al. ed, *Rich and Poor – Perspectives on tackling inequality in Ireland*, Oaktree Press, 2001.
- 34 Helen Johnston, 'Elimination of Poverty finally in Sight' in *Poverty Today*, April 2002

Over 5,000 Irish lives could be saved each year if we could reduce the toll of ill-health associated with poverty to the level achieved in other European countries.

This paper describes the impact of poverty on health in Ireland and explores the ways in which health is undermined by low income. It argues for a clearer focus in public health policy on tackling health inequalities and for a national action plan to improve the health of people experiencing poverty.

The prospect of a society in which all enjoy good health is now within sight. The question is 'do we have the collective will to achieve it'?

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