

## Poverty and Health

It is now widely accepted that socio-economic factors, including poverty, are key in determining health status. People experiencing poverty become sick more often and die younger than those who are better off. Measures of health inequalities, including mortality rates, low birth rates and poor nutritional status, are linked to deprivation measures such as income poverty, unemployment, inadequate housing and accommodation and poor quality built and work environments.

### Key Facts

- Households headed by an ill/disabled person have a very high risk of poverty. In 2001, two-thirds of households headed by such a person fell below the 60 per cent median income line.<sup>1</sup> For a single person the 60 per cent median income line was approximately €164 per week.
- Between 1989 and 1998 the total death rate of the lowest occupational group was 100 to 200 per cent higher than in the highest occupational groups.<sup>2</sup>
- The death rate from circulatory diseases among working-age men in the unskilled manual groups is more than three times that of working-age men from the professional categories. The death rate from cancers is over twice as high among men from the unskilled manual groups, and the death rate from injuries and poisonings is over six times higher. (See Table 1 on page 4.)
- The proportion of babies of low birth weight (below 2,500 grams) increased from 4.2 per cent to 5 per cent over the 1990s.<sup>3</sup> The rate of low birth weight among unskilled manual groups is twice that of the professional groups.<sup>4</sup>
- Irish women have significantly higher death rates from cancers and circulatory disease than their EU counterparts. In 1998 the death rate for Irish women from circulatory system diseases was 257 per 100,000 compared to 214.1 for the EU.

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1 Government of Ireland (2003) *National Action Plan against Poverty and Social Exclusion 2003-2005*, Dublin: The Stationery Office

2 The Institute of Public Health in Ireland (2001) *Inequalities in Mortality 1989-1998: A Report on All-Ireland Mortality Data*, Dublin: The Institute of Public Health in Ireland, p. 11.

3 Cullen, G. (2002) *Report on Perinatal Statistics 1999*, Dublin, ESRI and the Department of Health and Children

4 Barry, J. et al. (2001) *Inequalities in Health in Ireland – Hard Facts*, Dublin: Department of Community Health and General Practice, Trinity College Dublin

- 37 per cent of boys and 36 per cent of girls aged 15 to 17 years in the lower social classes smoke compared to 23 per cent of boys and 26 per cent of girls in the highest social classes. Over four in ten men (44%) aged 18 to 34 years with the lowest levels of education consume more than the recommended weekly alcohol limits compared to 35% of their counterparts with at least some third level education<sup>5</sup>
- One sixth of girls aged between 10 and 11 from the lower social classes report never having breakfast during the week. In the highest social classes this falls to one in twenty.<sup>6</sup>
- GP services are unevenly distributed and are particularly scarce in disadvantaged urban and rural areas.

## What do we mean by health and health inequalities?

The definition of health from the World Health Organisation (WHO) is widely used: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' In 1986 this definition was reformulated as 'a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and physical resources as well as physical and mental capacity'.<sup>7</sup> Closely related to these definitions of health are the concepts of health gain and social gain.

*Health gain* is concerned with improving life expectancy and quality of life through the cure or alleviation of illness or disability. *Social gain* is concerned with the broader aspect of quality of life primarily through the provision of social and support services.

Health inequalities arise when lower socio-economic groups experience a higher prevalence or incidence of health problems than those of higher socio-economic status. Health inequities are inequalities that are considered to be avoidable, unnecessary and unfair.

## What are the determinants of health status?

A range of factors influence people's health. Some of these are fixed, including age, sex and genetic make-up. Individual behaviour and lifestyle choices, including smoking, diet and exercise, many of which are informed by socio-economic circumstances, also impact on health.

There is now a growing acceptance that a wide range of social, economic, cultural and environmental factors, including poverty, also impact on health. These relate to living and working conditions and include experience of unemployment, quality of accommodation, level of education, social and community networks and supports, the built environment and work environments as well as access to health care services.

5 Kelleher, C. et al. (2003) *The National Health and Lifestyle Surveys Survey of Lifestyle, Attitudes and Nutrition (SLÁN) and the Irish Health Behaviour in School-Aged Children Survey (HSBC)*, Dublin: Department of Health and Children Health Promotion Unit, Galway: Centre for Health Promotion Studies, National University of Ireland, Galway

6 *Ibid*

7 WHO Regional Office for Europe (1986) *Ottawa Charter for Health Promotion 1986*. Copenhagen: WHO Regional Office for Europe

## Factors associated with Health & ill-Health



### What is the relationship between poverty and ill health?

Poor people experience ill health more than others. They are more likely to be unemployed or be occupied in low quality employment, to have low levels of education, to live in unsanitary, damp or poor quality accommodation and physical environments and have restricted access to health services. They are more likely to smoke, have poor or inadequate diets and exercise less. Being poor makes it more difficult to access health care and can reduce the opportunity or motivation to adopt a healthy lifestyle.

There is a clear social gradient where health status continuously improves as one moves up the socio-economic ladder, and declines as one moves down it. Income inequality may also have a significant impact on health status. Some research suggests that it is not the poorest societies that experience the greatest health inequalities, but societies in which the gap between rich and poor is widest.<sup>8</sup>

Many minority groups that experience poverty and exclusion also experience particular health inequalities. For example, in a study of 100 homeless women in Dublin, 82 per cent had physical health problems and 72 per cent had psychological problems. Almost half of the 55 children living with these homeless women had not received childhood vaccinations against infectious disease.<sup>9</sup>

Only 1 per cent of Travellers live beyond 65 years of age. The life expectancy of Traveller men is 10 years shorter than for settled men. Traveller women have a life expectancy of 12 years less than settled women. Infant mortality among Travellers is two-and-a-half times higher than in the settled population.

Research on refugees and asylum seekers has found malnutrition among pregnant women, diet-related ill health in young babies and weight loss among children.<sup>10</sup>

8 O'Shea, E. and Kelleher, C. 'Health Inequalities in Ireland' in Cantillon, S. et al. (2001) *Rich and Poor: Perspectives on tackling inequality in Ireland*, Dublin: Oak Tree Press and Combat Poverty Agency

9 Smith, M., McGee, H.M., Holohan, T. and Shannon, W. (2001) *One Hundred Homeless Women: Health Status and Health Service Use of Homeless Women and their Children in Dublin*. Dublin: Royal College of Surgeons in Ireland and the Children's Research Centre, Trinity College Dublin

10 Fanning, B. et al. (2001) *Beyond the Pale: Asylum seeking children and social exclusion in Ireland*, Dublin: Irish Refugee Council

## What is the impact of ill health on poverty?

While poverty is one of the major determinants of health status, poor health is often an indicator and cause of poverty. In 2001, two thirds of households headed by an ill or disabled person fell below the 60 per cent poverty line. Many of those experiencing serious illness and disability are unable to work and have to depend on welfare payments. The financial burden of their unemployment as well as their medical and other related costs often become a family issue and can contribute to intergenerational poverty. Their situation is exacerbated by insufficient financial resources, insufficient capacity to improve their circumstances, as well as insufficient and inaccessible services.<sup>11</sup>

## How is ill health measured?

There are a number of ways of measuring health and ill health including mortality (death rates) and morbidity (illness) rates, lifestyle, disability adjusted life expectancy (DALE) and self-reported or self-assessed health status. In Ireland, little routinely collected information on broader measures of health and well-being has resulted in a reliance on morbidity and more particularly mortality rates as a measure of health or ill health. Poor people experience more sickness and die younger than the better off. In Ireland this is true for deaths from all causes as well as for deaths from major illness.

**Table 1: Percentage difference in the directly standardised death rates among working-age men between the lowest and the highest occupational classes for selected diseases, 1989-1998**

Disease	% of all deaths	Percentage difference in the death rate between the lowest and highest occupational classes
All causes of death	100	341
Diseases of the circulatory system	45	312
Cancers (malignant neoplasms)	23	223
Diseases of the respiratory system	16	619
Injuries/poisonings	5	614

Source: The Institute of Public Health in Ireland (2001) *Inequalities in Mortality 1989-1998: A Report on All-Ireland Mortality Data*, Dublin: The Institute of Public Health in Ireland, Tables 1.4.1 and 1.4.2

## What about mental health and psychological well-being?

People experiencing poverty report higher levels of mental illness and stress. The relationship between basic deprivation and psychological well-being is particularly

strong. People experiencing poverty also report higher levels of fatalism and lack of control over their circumstances and lower levels of satisfaction with life than the better off.<sup>12</sup>

<sup>11</sup> Burke, S. (2001) *Setting Health Targets for the National Anti-Poverty Strategy: A Background Research Paper*, Dublin: Institute of Public Health

<sup>12</sup> Nolan, B. and Whelan, C.T. (1999) *Loading the Dice: A Study of Cumulative Disadvantage*. Dublin: Oak Tree Press with the Combat Poverty Agency

As with mortality and morbidity rates, there is evidence of a socio-economic gradient from professional to unskilled manual occupation groups across all psychiatric illnesses. Between 1989 and 1999 deaths from mental and behavioural disorders were almost 16 times higher in the lowest occupational groups than in the highest groups.<sup>13</sup>

## What do we mean by equitable health services?

The equitable delivery of health services plays a critical role in addressing health inequalities. Equity is one of the underlying principles of the National Health Strategy, *Quality and Fairness – A Health System for You*, and encompasses

- the right of people to access services on the basis of medical need rather than the ability to pay or geographic location
- making treatment available within a reasonable period of time
- addressing variations in the health status of different groups.

There has been a major increase in financial investment in the health services in recent years and improvements in services targeted at disadvantaged groups. Despite this, inequities in access to health services in Ireland remain.<sup>14</sup>

Approximately one-third of the population is eligible for means-tested medical cards and entitled to free dental, aural, optical and GP services, prescription medication and public hospital services. Eligibility for a medical card does not guarantee access to services and those with low incomes frequently face long

waiting lists for treatment. Almost half of the population pay for private health insurance that gives them access to both public and private health services and frequently results in shorter waiting times and greater choice of when, where and by whom they are treated.

## How are health inequalities being addressed?

The National Anti-Poverty Strategy (NAPS) and the National Health Strategy adopt a population health approach that recognises, among other factors, the role that government policies and strategies play in improving the health of the population. Relevant policy areas include income maintenance, education, housing and the environment. Key mechanisms to obtain these targets include poverty proofing and health impact assessments.<sup>15</sup>

## The National Anti-Poverty Strategy

The NAPS health targets are to:

- make health and health inequalities central to public policy
- act on the social factors influencing health
- improve access to health and personal social services for people who are poor or socially excluded
- improve the information and research base on health status and service access for these groups.

## The National Health Strategy

The National Health Strategy is committed to meeting the NAPS targets and to developing new targets for Travellers, asylum seekers and refugees. The Strategy also aims to improve the health of particularly vulnerable groups and improve our knowledge of

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13 The Institute of Public Health in Ireland, *op. cit.*, p.30

14 Harkin, A.M. (2001) *Equity of Access to Health Services: Some Relevant Issues in an Irish Context*, Dublin: The Institute of Public Health in Ireland

15 The existing system of *poverty proofing* requires government departments and local authorities to look at how policy or work practices, including those relating to health and the health services, impact on the lives of those who are poor. The proposed system of *health impact assessments* would require all government departments and agencies to assess the impact of their policies and programmes on health inequalities.

## NAPS health targets

### Key target

- To reduce the gap in premature mortality between the lowest and the highest socio-economic groups by at least 10 per cent for circulatory diseases, cancers and injuries and poisoning by 2007

### Associated targets

- To reduce the gap in low birth weight rates for children from the lowest and highest socio-economic group by 10 per cent by 2007
- To reduce the gap in life expectancy between the Traveller community and

the whole population by at least 10 per cent by 2007

- To increase access to orthopaedic services so that no one is waiting longer than 12 months for a hip replacement
- To ensure that the basic needs of all families, especially young parents, lone parents, older people and ethnic minorities are met through enhanced and better co-ordinated State support services
- To improve access to employment, health, education and housing services for rural dwellers

health inequalities and health status by developing new initiatives and delivering existing national strategies including

- the National Traveller Health Strategy
- the National Drug Strategy
- the National Youth Homelessness Strategy
- the Health Promotion Strategy
- the Health Information Strategy.

### How can community development approaches help address health inequalities?

Community development approaches focus on empowerment and collective action for change and are a key tool in developing healthier citizens and communities.

Community development has a particular role in supporting the participation of those experiencing poverty and disadvantage in the development and improvement of health services. For example, primary care services are

most often the first point of contact with the health services and include services provided by GPs, dentists, community welfare officers and public health nurses among others.<sup>16</sup> The Primary Health Strategy recognises limited opportunities for user involvement as one of the key weaknesses in current primary care provision. It points to the need for user participation in the design and delivery of services and for the need for these to link in with community development projects.

Existing community development initiatives addressing poverty and disadvantage could play a significant role in promoting health and well-being and in working in partnership with service providers.<sup>17</sup> Community development approaches can also help identify health needs and develop innovative responses and models of best practice in addressing health inequalities in disadvantaged communities.

<sup>16</sup> See Department of Health and Children (2001) *Primary Care: A New Direction*, Dublin: The Stationery Office, p.15

<sup>17</sup> Combat Poverty Agency Submission to the National Anti-Poverty Strategy and Health Working Group, May 2001