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## foreword

This document brings together information and evidence from a wide variety of sources to highlight health inequalities in Ireland. It demonstrates how health inequalities are inextricably linked to socio-economic inequalities. It illustrates how poorer people have poorer health and die younger than the rest of the population. In the Alliance we believe that health does not have to be so unequal. We believe that those who are less well off can experience better health. To bring about change it is important to have relevant information, know what we want to change, why we want to change and to act.

This document with its portrayal of the facts illustrates what needs changing and why. It also shows that responsibility for improved health crosses many boundaries. A healthy society is a wealthy society and in the 21st Century there is an obligation on us to address health inequalities and make progress towards a situation where all have the highest possible standard of health. This aspiration, when realised bestows enormous economic and social benefits but it is an aspiration that can only be realised with commitment across sectors, disciplines and in the political arena. I know that in the Alliance this document will stimulate debate on how change can be achieved and on what actions are required. It is our hope that this debate will extend well beyond the Alliance and many will reflect on what is required of them and act accordingly to tackle health inequalities and bring about improved health.

Thank you to the very many people who contributed to this paper in a variety of different ways - by carrying out research, giving us comments and feedback, making information available and accessible to us and drafting sections. Council members Sara Burke, Celia Keenaghan, Diarmuid O'Donovan and Brigid Quirke wrote the paper. Thank you to this group for the time, energy and commitment given to its production. Thanks also to other members of the Council for their input on many versions of this paper and to Vincent Browne who wrote the summary. We are indebted to Ruth Barrington and Cecily Kelleher for reading the penultimate draft and giving helpful commentary and advice.

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**Owen Metcalfe**  
*Chairperson, Public Health Alliance Ireland*

# mission, aims, objectives and values of the alliance

The mission of the PHAI is to work for a healthier society by improving health and challenging health inequalities.

## aims

The aims of the Alliance are to:

### (a) Advocate for health

The Alliance will advocate for sustainable policies and actions that improve the health of all groups in the Irish population

### (b) Build capacity

The Alliance will facilitate multi-disciplinary and multi-sectoral working which enables individuals and communities to participate in improving health and challenging health inequalities.

## objectives

The aims of the Alliance may be pursued by the following objectives:

- Being an independent voice and lobbying force for health improvement and tackling health inequalities in Ireland
- Building alliances and partnerships amongst members, sectors and disciplines, based on agreed ethical principles, mutual understanding and respect
- Building the capacity and facilitating participation of individuals, communities, organisations and sectors, who are concerned with public health
- Enhancing the capacity of the health system to respond to national and local priorities
- Putting health on the agendas of governments, inter-governmental organisations, non-governmental organisations, the private sector, professionals, communities, consumers/clients/patients and facilitating mutual dialogue between all stakeholders
- Undertaking activities that contribute to the development of knowledge, experience and practice and providing mechanisms for the exchange of ideas that further the field of public health
- Influencing public policies in favour of health
- Providing a national forum for support and development of member organisations
- Promoting cooperation with Northern Ireland for a healthier island.

## values

### 1. Health is a basic human right

This implies a rights based approach to health. This approach is supported by Ireland's signatory to (i) the Universal Declaration of Human Rights: Article 25 describes everyone's right to a standard of living adequate for the health and well-being of themselves and their family, including medical care, social services and security in the event of sickness, disability and old age, (ii) the UN Convention on Economic, Social and Cultural Rights: Article 12 sets out everyone's right to the enjoyment of the highest attainable standard of physical and mental health

### 2. Equality

There is a need to reduce inequalities in health and to ensure equality of access to, participation in and outcomes in health and health services

### 3. Democracy

There is a commitment to inclusive partnership working with people and communities to empower people to take control of their health and to participate in decisions which impact upon health (Public Health Alliance Ireland, 2003).



*part one*  
*health inequalities - an introduction*

## Introduction

The Public Health Alliance Ireland understands public health to be concerned with all the factors which shape and influence the health of individuals, communities and society. A commitment to public health is therefore about creating the conditions in society, which enable people to be well and healthy. It seeks to promote, protect and improve the public's health within the overall social, economic and political context. It looks for solutions in environmental and social action, individual empowerment and community development, as well as in clinical interventions.

Action on public health is underpinned by the premise that a wide range of factors influence health. It takes a multi-disciplinary, multi-sectoral, partnership approach to improve health and to narrow the health gap between rich and poor and between different sections of the population.

Public health tackles inequalities, injustices and denials of human rights which are some of the key causes of differences in health locally, nationally and globally. It proactively seeks the participation of the people who are themselves the subject of policy and action.

Some groups in our society have better health than others. People who are poor and those who are socially excluded are more likely to be unwell throughout their lives and to die younger than people who are not (Balanda and Wilde, 2001; Balanda and Wilde, 2003; Barry et al, 2001). The health status of Irish people is below European averages on many indicators, and within Ireland there are significant inequalities in health that relate to income, education, age, ethnicity, gender and geography, among other factors (Balanda and Wilde, 2001; Balanda and Wilde, 2003; Barry et al, 2001).

Conditions that foster health include peace, social justice, secure employment, an adequate income, education, social, economic and political participation, safe accommodation and local environments that promote health, nutritious food, and ready access to appropriate, affordable healthcare (Wilkinson and Marmot, 2003).

## Role of the Public Health Alliance Ireland

The Public Health Alliance Ireland seeks to promote awareness of and action on health inequalities. The Alliance will promote policies to reduce current inequalities and contribute to a general improvement in health and a greater equality in health care provision (Public Health Alliance Ireland, 2003).

## Health Inequalities paper

This paper aims to bring together baseline information on health inequalities in Ireland, to inform members of the Alliance and to create greater public awareness of the levels and impacts of health inequalities in Ireland. It is hoped that this information will mobilise action so that the mission, aims and objectives of the Alliance can be achieved. Part one gives some stark examples of health inequalities, introduces the determinants of health and inequalities in health. Part two presents some of the facts on health inequalities in Ireland. Part three suggests areas for action.

## Methodology

This document was written by a subgroup of the Council of the Public Health Alliance Ireland, with assistance from people in a wide range of organisations who were consulted in the preparation stage. Several hundred documents and research reports were trawled for relevant information. Many of those consulted for this paper highlighted problems relating to a lack of accessible, systematically collected information on health. A draft of this paper was presented to the members of the Public Health Alliance Ireland and other interested people in October 2003. This paper was redrafted many times taking on board comments and feedback. The Council is very grateful to everyone who has contributed to this paper and looks forward to the dialogue and action which will follow. While this document is the product of many people, responsibility for the report rests with the authors.

# examples of health i

- Children born in less well off areas are more likely to die before the age of one year than those born in more advantaged areas (Ryan et al, 2000).
- Nearly one in ten Irish children live in consistent poverty, while one in four live in relative poverty. Poverty damages children's health and can have detrimental, lifelong effects (Barnardos, 2003; Daly and Leonard, 2002).
- In 1999, the perinatal mortality rate (based on father's occupation) was three times higher for children of unskilled manual workers than for those born in the higher professional category (Cullen, 2002).
- Accidents are the major cause of death in children. Children from lower income groups are most likely to have accidents in the home (Laffoy, 1997).
- At age 65 Irish men have the lowest life expectancy in the European Union (Eurostat, 2004).
- Irish women have almost twice the rate of death from heart disease as the European Union average (Eurostat, 2003).
- Thirty eight percent of pensioners live in the lowest 20% of households in terms of income (Equality Authority, 2002). Poverty has detrimental impacts on the health of older people.
- In 1997 people living in the Dublin region were 2.5 times more likely to have had cardiac surgery than residents of County Mayo (Barry et al, 2001).
- Women in the unemployed socio-economic group are more than twice as likely to give birth to low birth weight babies as women in the higher professional group (Barry et al, 2001).
- Women, on average, live longer than men (life expectancy for women is 78.6 and for men is 73 years). But both women and men on lower incomes are more likely to die at a younger age than those in better off groups (Barry et al, 2001).
- In 1996, men in unskilled jobs were twice as likely to die as higher professional men (Barry et al, 2001).



# inequalities in ireland

- In 1996, men in unskilled jobs were eight times more likely to die from an accidental cause than men in the higher professions (Barry et al, 2001).
- Men in unskilled jobs were four times more likely to be admitted to hospital for schizophrenia than higher professional workers (Barry et al, 2001).
- Between 1989 and 1998 the death rates for all causes of death in the lowest occupational class were more than three times those of the highest occupational class (Balanda and Wilde, 2001).
- 33% of men and 45% of women identified financial problems as the greatest factor preventing them improving their health (Kelleher et al, 2003).
- 37% of medical card holders smoke compared to 24% of those without a medical card (Kelleher et al, 2003).
- Travellers live on average 11 years less than settled people (Barry et al, 1987). The number of Traveller families living on the road is the same as it was in the 1960s.
- While smoking prevalence has decreased overall in recent years, smoking among young women has increased: rates are now similar to those among young men. The rate of smoking for less well off 15-17 year old girls increased between 1998 and 2002 (Friel et al, 1999; Kelleher et al, 2003).
- The 2002 national census found that only 3% of all Travellers were aged over 65 years of age compared to 11% of the settled population (CSO, 2003).
- The referral rate of Travellers by GP's to hospital inpatient and outpatient care was very low when compared to the settled population (ie 17% versus 70%) (Travellers Health Unit, Eastern Region, 2004).
- The Irish Sudden Infant Death Association in their Annual Report 1999, found that the rates of Sudden Infant Deaths among Travellers over a five year period was 12 times the rate among the settled population (Irish Sudden Infant Death Association, 1999).
- The self reported quality of life of asylum seekers is much poorer than that reported by the general population. In one study only 22% of asylum seekers rate their quality of life as good or very good (Foley Nolan et al, 2002).

## Definitions

### What is health?

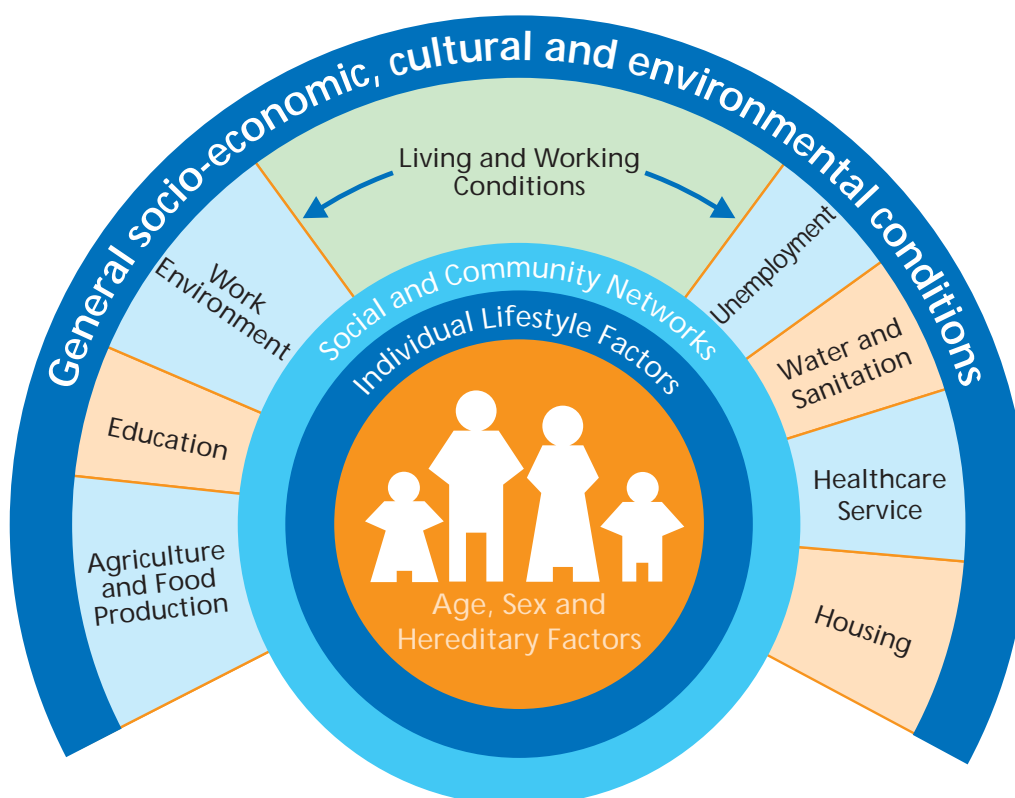
The World Health Organisation has defined “health” as “a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity”. Other definitions of health include health as strength or ability and as the foundation for achievement of human potential.

### What is public health?

Definitions of public health include “the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society” (Acheson, 1998), and “what we as a society do collectively to ensure the conditions in which people can be healthy” (Institute of Medicine, 1988). The practice of public health agencies includes identifying and assessing health needs and problems, developing policies to address these issues, and assuring services to address health problems.

# DETERMINANTS OF HEALTH

Many economic, social, political and environmental factors influence levels of health, preventable disease, disability and premature death. These factors have been described as “layers of influence” (see below, Dahlgren & Whitehead, 1992). Experiences in early life, food and nutrition, work, unemployment, stress, social support and social exclusion have been identified as major determinants of health (Wilkinson and Marmot, 2003). Poverty is central to these determinants: reducing poverty will improve health outcomes (Benzeval, Judge & Whitehead, 1995).



“Socio-economic inequalities in health reflect differential exposure from before birth and across the life span, to risk associated with socio-economic position” (Acheson, 1998).

We have understood for years that the great improvements in health in developed countries over the last 150 years are mainly due to improvements in living conditions and the ways in which society has been organised, rather than to advances in medicine. An example of this is the reduction in deaths from tuberculosis in England and Wales before the discovery of specific drugs for the disease (McKeown, 1976a, 1976b). However despite improvements in life expectancy and other health indicators, the gap between the health of the most advantaged groups and the most disadvantaged continues to grow (Wilkinson,

1996). Health care provision alone will not address the problem and it has even been described as one of the least fundamental approaches to tackling inequalities in health (Mackenbach et al, 2002b).

Human rights are important and health and human rights are inextricably linked.

The right to health is expressed in the International Bill of Human Rights as “the right to the highest attainable standard of physical and mental health” (United Nations, 2000a). This places a responsibility on governments to promote and protect the health of individuals and communities, including ensuring access to high quality health care. As economic, social, cultural and civil rights are interrelated, the state is responsible for correcting conditions that prevent people realising their right to health as well as the related rights to education, safe living and working conditions, and freedom from discrimination (Mann et al, 1999).

In addition to the above, globalisation, the increasing interconnectedness of people through communication, economic integration and cultural diffusion, has both positive and negative implications for health and inequality. Many improvements in disease prevention, treatment and surveillance have been organised on a global scale. Concerns about health impacts include escalating global economic and health inequalities between North and South (Labonte et al, 2004), environmental damage leading to climate change (McMicheal and Beaglehole, 2000), the global pandemic of obesity related to changing global food consumption patterns (Lang, 1998), and the growing international trend towards privatisation of healthcare (McMicheal and Beaglehole, 2000).

The eight Millennium Development Goals agreed by the United Nations General Assembly in September 2000 all include elements that address global health inequalities (United Nations 2000b). Achieving the main development goal (to half, between 1990 and 2015, the proportion of people whose income is less than one dollar a day) would have more impact on reducing health inequalities and improving global health status than any other measure.

## Socio-economic inequalities in health

“In recent years, research on health inequalities has developed in other countries, particularly the industrialised nations of the EU and the US ... Here in Ireland however, we have been hampered by a lack of data at individual, ecological and health service utilisation level. This has contributed to official inertia in dealing with both the causes and consequences of health inequalities” (O’Shea and Kelleher 2001).

Within Ireland poorer people in the population experience poorer health and have less access to health services. While research on health inequalities has been lacking until recently, this paper outlines the extent and impact of these inequalities by drawing on available evidence and case studies.

Socio-economic inequalities in health are usually measured by comparing rates of illness and death experienced by people in different socio-economic groups. Individuals are assigned to different socio-economic groups or classes on the basis of their occupation and/or work status. Other indicators of socio-economic status include income, level of education, medical card possession and housing tenure. Researchers often measure the socio-economic status of a geographical area by assessing the population within it, along a number of these indicators.

Research evidence from around the world, including Ireland (Balanda and Wilde, 2001; Balanda and Wilde, 2003; Barry et al, 2001; Kelleher et al, 2003a) has recognised socio-economic and geographic gradients in indicators of health and disease. In general as socio-economic status improves, health improves.

Many reasons have been put forward to explain inequalities in health. These include:

- Material and structural explanations which identify the problem as inequality in access to material resources in society (Shaw et al 1999)
- Behavioural explanations which focus on the roles and responsibilities of individuals and societies in ensuring their health and welfare (Bartley, 2004)
- Psycho-social and social cohesion explanations which concentrate on the effects of social cohesion on the health of different groups (Kawachi and Kennedy, 2002).

These explanations are not necessarily mutually exclusive. There is evidence for instance, that the impact of psychosocial circumstances on health is related to material circumstances (Marmot and Siergrist, 2004) and that health behaviours may be influenced by material conditions (Graham, 1993). There is broad agreement in the research that the best approaches to tackling health inequalities focus on addressing the underlying structural determinants of social and economic inequalities in society (Mackenbach et al, 2002b). There is also increasing emphasis on the lifecourse perspective to health inequalities and disadvantage meaning that investment in health of mothers and children has a double advantage in improving early life status and influencing life trajectory opportunities (Seigrist, 2004).

Research has shown that poverty directly harms the health of those on low incomes (Daly and Leonard, 2002; St Vincent De Paul, 2001). Research also shows that there is a relationship between economic inequality, poverty and health. Societies that are economically unequal have higher levels of poverty; and a strong relationship has been found between the degree of income inequality in a country and poor health outcomes (Kawachi & Kennedy, 2002; Wilkinson, 1996). In Ireland, recent analysis of the health and lifestyle survey highlights the impact of income inequalities on health. This work shows that GMS status is an independent predictor not just of lifestyle factors and morbidity but also a powerful proxy for real disadvantage as it continues to be a powerful predictor of poor health even when other social factors are taken into account (Kelleher et al, 2002a: 2003b).

Ireland has the highest level of income inequality in Europe, and the second highest level of income inequality in OECD countries after the US (United Nations, 2002).

“It is striking to note that despite the remarkable performance of the economy, a measure of income inequality, calculated as the ratio of the share of wealth owned by the richest 20 per cent divided by that owned by the poorest 20 per cent, shows Ireland to have one of the worst income inequality ratios in the EU. In Ireland, the richest 20 per cent enjoy six times as much income as the poorest 20 per cent; only Portugal and Greece have worse records in this regard. In the best performing country, Finland, the ratio is only 3-1” (Forfas, 2000).

The 1999 Annual Report of the Chief Medical Officer suggests there is a need to address health inequalities in more radical ways than in the past. The report points out that little has been achieved in the implementation of policies that might address the serious equity problems that exist in both health status in itself and healthcare provision in Ireland, and warns that this must change if unnecessary deaths are to be avoided in the future (Department of Health and Children, 2000).

## Social and environmental factors

A wide range of social and environmental factors has been found to influence levels of health and well-being. A full discussion of these factors is beyond the scope of this document but some key issues are presented below.

### Education

The influence of early development and education on health outcomes is demonstrated by birth cohort studies. A study of children born in 1958 in Britain shows clear socio-economic gradients (Power et al, 1999). By age 33 lower social class at birth was associated with higher levels of obesity, limiting illness, respiratory illness and fair or poor self-rated health. However, educational qualifications had an even stronger connection between these factors and health. International evidence demonstrates that improving education for girls improves the health outcomes of their children. UNICEF stresses the importance of education in women in improving health in the general population (Cleland, 1988).

### Accommodation

There is clear evidence that poor accommodation, such as cold, damp or poorly designed homes has adverse effects on the health of people living in these conditions. Cold ambient temperature with inadequate heating and insulation, dampness with condensation, and mould all contribute to illness and deaths from hypothermia, respiratory illness and ischaemic heart disease (Keating, 1989). Travellers and homeless people living on the street, in caravans, hostels or temporary accommodation have poor health status (Barry, 1989; Holohan, 1997). Older people living in poor quality homes are more likely to experience ill health and to seek the use of health services (Stratton, 2003). Children living in damp

accommodation are likely to suffer from asthma and other respiratory illnesses. Poor quality accommodation increases risks of accidents and injuries (Laffoy, 1997).

## **Work**

Employment gives people status and social approval, both of which influence mental, physical and social health. People employed in high demand, low control jobs have poorer health than those who have high levels of control over their work (Siegrist et al, 1990). A study of more than 10,000 British civil servants found that their health status improved with their occupational grade, from lowest to highest (Marmot et al, 1991). Unemployed people have more physical and mental ill health than employed people. They have more stress and insecurity. Their children have poorer health than the children of employed people (Siegrist et al 1990).

## **Nutrition**

Good nutrition is vital for good health. Dietary issues are major risk factors for high blood pressure, coronary heart disease, stroke, diabetes, and cancers (World Health Organisation, 2002b, 2002c). The diet of many people on low incomes provides low cost energy from foods that are high in fat and refined sugars, and low in vegetables and fruit. Significant improvements in health are likely if a diet rich in vegetables, fruit, fish and unrefined cereals was accessible to poorer people.

Ireland has one of the lowest rates of breastfeeding in the world: the women who are most likely to breastfeed are the better off (Department of Health and Children, 2001a: Kelleher et al, 2003). Children of breastfed women have fewer infections and are less likely to be obese when older (Department of Health and Children, 2001a). In addition women who breastfeed are less at risk of contracting breast cancer, ovarian cancer or osteoporosis than those who do not breastfeed ([www.healthpromotion.ie/breastfeeding](http://www.healthpromotion.ie/breastfeeding)).

## **Environment**

There is a direct link between socio-economic status and safety both at home and in the workplace. More injuries occur in homes of lower socio-economic groups (Laffoy 1997). The most common workplace fatal accidents in 2003 were falls from height, transport and contact with moving machine parts mainly occurring in the agriculture and construction sectors (Health and Safety Authority, 2004).

Transport policies can affect health in many ways. Promoting walking and cycling increases physical activity, which has beneficial effects in preventing heart disease, cancer and depression. Better public transport can improve access to health services. Injury and death rates from crashes can be reduced by traffic calming and by speed legislation. Pedestrian child deaths and injury have a steep poverty gradient in countries where this has been measured. Noise pollution, particularly from transport and construction affects people living in urban areas disproportionately (McCarthy, 1999).

While air quality in Ireland has improved over the last decade, poorer children and adults are more likely to be exposed to indoor environmental tobacco smoke and to inner city transport-related air pollution. Radon levels in some Irish homes grossly exceed international guidelines (Radiological Protection Institute of Ireland, 2004). Drinking water quality is an issue particularly in rural Ireland where many people have a water supply that does not meet international safety standards (Environmental Protection Agency, 2001). Waste is a growing problem. The health hazards of landfills and incinerators are not clearly understood (Crowley et al, 2003).

## Discrimination and health inequalities

Vulnerable and marginalised groups in society bear an undue proportion of health problems. Many health disparities are rooted in socio-economic inequalities, which can be independent to or exacerbated by racism and other forms of discrimination in society.

Overt or implicit discrimination violates one of the fundamental principles of human rights and often lies at the root of poor health status. Discrimination against women, the elderly, ethnic, religious and linguistic minorities, persons with disabilities, indigenous populations and other marginalised groups in society both causes and magnifies poverty and ill-health (WHO, 2002b).

A general comment on the right to the highest attainable standards of health, recently adopted by the committee which monitors the International Covenant on Economic, Social and Cultural Rights, enumerates the grounds for non-discrimination in health by proscribing “any discrimination in access to health care and the underlying determinants of health, as well as to means and entitlements for their procurement on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health” (United Nations, 2000a).

Discrimination may be direct or indirect. Direct discrimination occurs where a person experiences exclusion or is treated less favourably than another on grounds of their membership of a particular group. This form of discrimination is relatively overt and usually involves intent.

Indirect discrimination is less visible and does not always involve intent. It is most visible in terms of the outcomes for particular groups in relation to services. Indirect discrimination occurs where policies, practices, terms or conditions apply which are unnecessary and which have a significantly adverse impact on a particular group. In this scenario, it must be demonstrated that the particular group fares worse under the policies, practices, terms or conditions than other groups, and that these policies, practices, terms or conditions cannot be shown to be necessary. Indirect discrimination refers, therefore, to the differential impact of the same treatment where the differential is not justified (NESF, 1996).



The grounds on which direct and indirect discrimination are outlawed in Ireland are listed under the Equal Status Act, 2000, as gender, marital or parental status, sexual orientation, religion, age, disability, race, colour, nationality, national or ethnic origins including membership of the Travelling community. Indirect discrimination consists of pursuing policies or practices, which although applied equally to all persons, are such that they produce outcomes that adversely affect a significantly higher proportion of marginalised groups. In this way treating everyone the same may in itself be discriminatory. Indirect discrimination is complex. It involves treatment that seems on the surface to be fair, but where the effect or result is unequal. Possible examples of indirect discrimination are policies and procedures of relevance to ethnic minorities that do not acknowledge and respond appropriately to their distinct culture, identity and way of life.

Research has shown that inequalities in the health and health care of ethnic and racial groups are evident and that racism is the most disturbing of the explanations for these inequalities. It has thus been suggested that attention be devoted to gender, ethnicity, socio-economic status, disability and rural living affecting health as well as the health effects that institutions, laws, policies and programmes may have on ethnic and racial groups.

Northern Ireland's definition of racism is useful to consider - "the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people" (Commission for Racial Equality for Northern Ireland, 1999).

## Participation of Individuals and Communities

"The most important tool in tackling inequality is to enable those experiencing it to remedy the power relationship, to take some control. This is a concept of rights that requires that those who are the furthest from the cabinet table to own the right that inheres to them by virtue solely of their humanity. Ownership of this kind enables them to describe their condition, then to challenge it, and then to ensure that any decisions taken in the organisation and the ordering of their lives are "by and with" them not "about and for" them" (Mary Robinson, WHO, 2002b).

Participation and involvement are recurrent themes in community development and they are concerned with the collective and active involvement of people in issues that affect their lives. Community participation in health is viewed as a process through which the community will gain greater control over the social, political, economic and environmental factors that determine their health status.

The World Health Organisation promotes community participation in health. In Ireland there is an increasing acknowledgement and focus on the role of "community

involvement” in health. This is reflected in the Health Strategy “Quality and Fairness: A Health System for You”, which includes people-centredness as one of its four key principles. Community participation is an essential component of a more responsive and appropriate system of care, which is truly people-centred (Department of Health and Children, 2001b). Community participation is important for a number of different reasons and offers a range of benefits to individuals, communities, organisations and society as a whole. Community participation can achieve a more democratic solution, develop a culture of participation, empower people, mobilise resources and energy, result in the development of holistic and integrated approaches and services, ensure the ownership and sustainability of programmes, result in better decisions and more effective and efficient services and improve health outcomes (Health Boards Executive, 2002).

“Community participation is a programmatic necessity. Without the close involvement of the community, and its families and individuals in health promotion, disease prevention and care of the sick, there is little likelihood that health services will have a durable impact on the health of the community” (WHO, 1990).

## Inequalities in Health Services

Health services can play an essential role in reducing health inequalities by providing a more equitable service that addresses the needs of every citizen, in particular those who need services most. Health inequalities can be worsened by inequalities in access to, participation in, use of, and outcomes from health services provision. The Inverse Care Law which describes how health services are of poorer quality and less accessible in disadvantaged populations needs to be specifically addressed (Hart, 1971).

The potential barriers that restrict access to healthcare services include financial, geographic and cultural barriers. International evidence shows that charging people on low incomes for health services discourages their use of services, sometimes to the extent that when they do present, their illness may be more serious and more difficult to treat than if they had presented earlier. Services may be located in places that service users have difficulty in getting to because of physical distance, poor roads, lack of public transport and cost. Cultural barriers such as language difficulties may mean that people who are disadvantaged because of lack of translation services are not managed appropriately.

In Ireland, the unique unequal mix of public and private care, means those who can afford to, get quicker access to better resourced services.

“There is a shocking division in this country between the richer, better educated people who can afford decent healthcare and those who cannot. The latter group is struggling with a lack of information about health as well as a basic inability to afford it. If money is not ploughed into the system now the vision of Ireland’s future is a terrifying one” (Female, 39, rural, Health Strategy Public Consultation, Colgan, 2001).

# ADDRESSING HEALTH INEQUALITIES

The literature on interventions to address health inequalities can be broadly divided into actions and policies that:

- Identify inequalities
- Encourage macro-economic, social, environmental, cultural and political change
- Strengthen individuals and communities through community development and public participation in decisions and debates about health and the determinants of health
- Improve access to services.

## Identifying inequalities in health

Research and data collection are fundamental to understanding health inequalities, and how they might be overcome. Improving the collection and dissemination of health information and knowledge is therefore essential. This will allow comparisons to be made with the health status of other populations, and between population groups in Ireland. It will also provide baselines from which targets can be set and progress can be measured. Developing information systems, policies and structures that promote the best possible health for the population is a key priority for action to address health inequalities.

## Macro-economic, social, environmental, cultural and political change

Socio-economic inequalities in health reflect wider inequalities in material conditions and access to resources in society. If these health inequalities are to be reduced, the factors which influence them must be addressed through:

- More equitable public policies
- Reducing income inequality
- Developing educational and employment policies which are inclusive of those most marginalised and excluded
- Investing in adequate and equitable public services which foster better health.

The impact of all public policies on the health of the population and in particular of the most vulnerable groups in society needs to be assessed and monitored carefully.

## Strengthening individuals and communities

Poverty, income inequality and poor health result from unequal social, health and economic policy decisions. Poverty, inequality and social exclusion directly damage the health of people with lower incomes and income inequality affects the health of everyone in our

society. Reducing poverty, income inequality and social exclusion, and improving health must be achieved by supporting individuals and communities and involving people in decision making.

## Improving access to facilities and services

Improving the standards of living of the poorest, by improving access to adequate housing, education, nutritious uncontaminated food, safer workplaces and health and welfare services will benefit the health of everyone in the population.



*part two*  
*health inequalities in ireland- the facts*

## 2.1 Socio-economic health inequalities

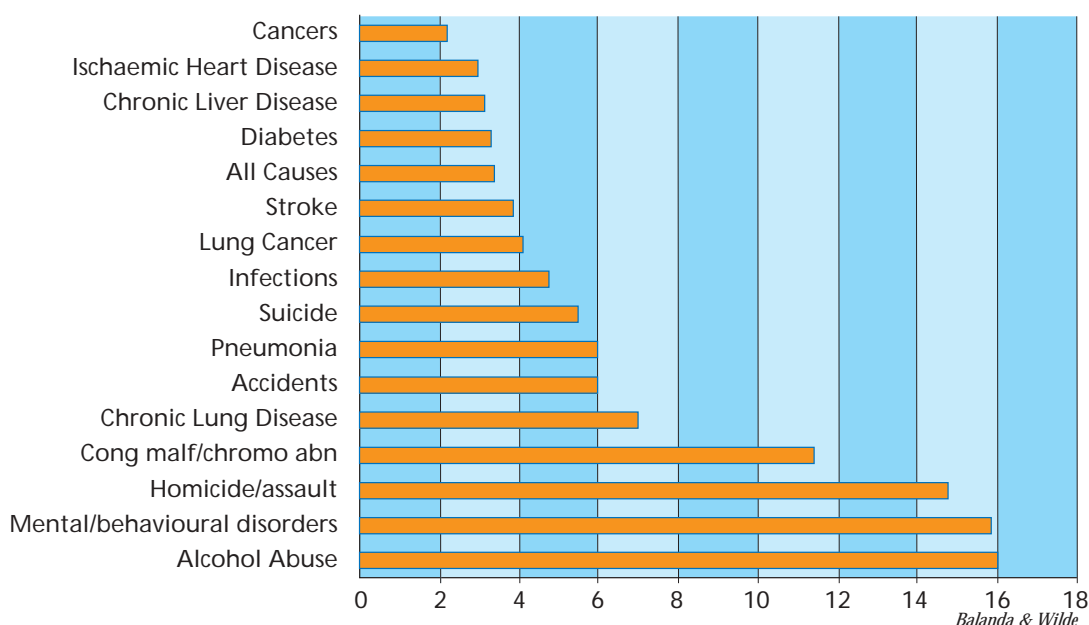
“Poverty leads to ill-health and ill-health breeds poverty. Where there is structural poverty and ill-health there will be poor development - and poor human rights”  
(Dr Gro Harlem Brundtland, WHO 1998).

In Ireland, people who are poor and excluded get sick more often and die younger than people who are better off (Nolan, 1994; Balanda and Wilde, 2001; Barry et al 2001). Health inequalities are shown to exist when any measurement of income or wealth is used i.e. socio-economic status, social class, poverty lines, deprivation, income and wealth indices, and levels of education. Health inequalities between rich and poor are clearly evident in the research literature. Research confirms inequalities across the income scale: in general, as one's income increases one's health improves (Marmot, 1991). This is known as the social gradient in health (Wilkinson and Marmot, 2003).

Differences in death rates (mortality) between lower and higher socio-economic groups in Ireland are striking. Between 1989 and 1998 the death rates for all causes of death in the lowest occupational class were more than three times those of the highest occupational class (Balanda and Wilde, 2001).

Some of the remarkable differences in life expectancy and premature death experienced by various socio-economic groups are detailed in the figure below.

### Relative rates of dying from various causes, comparing highest occupational group with lowest occupational group (Balanda and Wilde, 2001)



**Increased risk of dying for people in lowest socio-economic group compared to highest socio-economic group**

This figure illustrates the increased risks attached to dying from a range of causes for people in the lowest occupational group compared to the highest. So for example, people in the lowest occupational group (semi-skilled manual workers, unskilled manual workers and farm labourers) are six times more likely to die from accidents than people in the highest occupational group (higher professionals and lower professionals).

Research by Barry et al reported similar health differences between social classes. In 1996 they found that men in unskilled jobs were:

- Twice as likely to die as higher professional men
- Eight times more likely to die from accidents than professional men
- Four times more likely to be admitted to hospital for schizophrenia than higher professional workers (Barry et al, 2001).

They also found that in the early 1990s women in the unemployed socio-economic group were over twice as likely to give birth to low birth weight babies as women in the higher professional group (Barry et al, 2001).

These inequalities in life expectancy and premature death between lower and higher socio-economic groups are also found in many measurements of morbidity (illness); self-reported health status; and health lifestyle (Nolan, 1994; Friel et al, 1999; Kelleher et al, 2003). For example:

- The 1994 ESRI study found that the percentage of people reporting chronic physical illness increased steadily across occupational groups from 10% for higher professional class to 25% of the unskilled manual class (Nolan et al, 1994)
- In 1999, the perinatal mortality rate (based on fathers occupation) was three times higher for children of unskilled manual workers than those born in the higher professional category (Cullen, 2002).
- In 2002, 33% of men and 45% of women identified financial problems as the greatest factor from preventing them improving their health (Kelleher et al, 2003a)
- The 1998 and 2002 National Health and Lifestyle Surveys found that those with less education and who are eligible for the General Medical Scheme (GMS) were more likely to smoke, drink more alcohol than recommended, eat less fruit and vegetables and take less exercise (Kelleher et al, 2003a, Friel et al, 1999)
- While smoking prevalence has decreased overall, smoking among young women has increased in recent years and rates are now similar to those among young men. There is an increased social gradient for 15-17 year old girls between 1998 and 2002 (Friel et al, 1999; Kelleher et al, 2003a).

In understanding the differences in health behaviour, it is important to acknowledge that behavioural differences are influenced by a variety of factors, and opportunities for pursuing healthy lifestyles are often restricted by the pressure of ones material circumstances and the everyday socio-economic realities and pressures of living in poverty or on a low income (Graham, 1993; 2000; Wilkinson and Marmot, 2003).

“Poverty can affect health in a number of ways. Income provides the prerequisites for health, such as shelter, food, warmth and the ability to participate in society; living in poverty can cause stress and anxiety which can damage people’s health; and low income limits peoples’ choices and militates against desirable changes in behaviour” (Benzeval, Judge and Whitehead 1995).

In the absence of explanatory data, it is difficult to assess the nature of health inequalities between men and women. In 2001, the leading causes of death among men on the island of Ireland were circulatory deaths (40%), cancers (27%) and respiratory diseases (13%). In spite of recent increases in life expectancy, men have higher death rates at all ages and for all the leading causes of death than women. Differences in mortality figures for men and women are particularly pronounced in the case of road traffic accidents and suicide. However, Barry et al (2001) found that while women tend to live longer than men, (life expectancy in Ireland for men is 73 and 79 years for women, CSO, 2003), women on lower incomes remain more likely to die at a younger age than those in better off groups. Gender issues in health are linked to broader questions of gender, power and inequality.

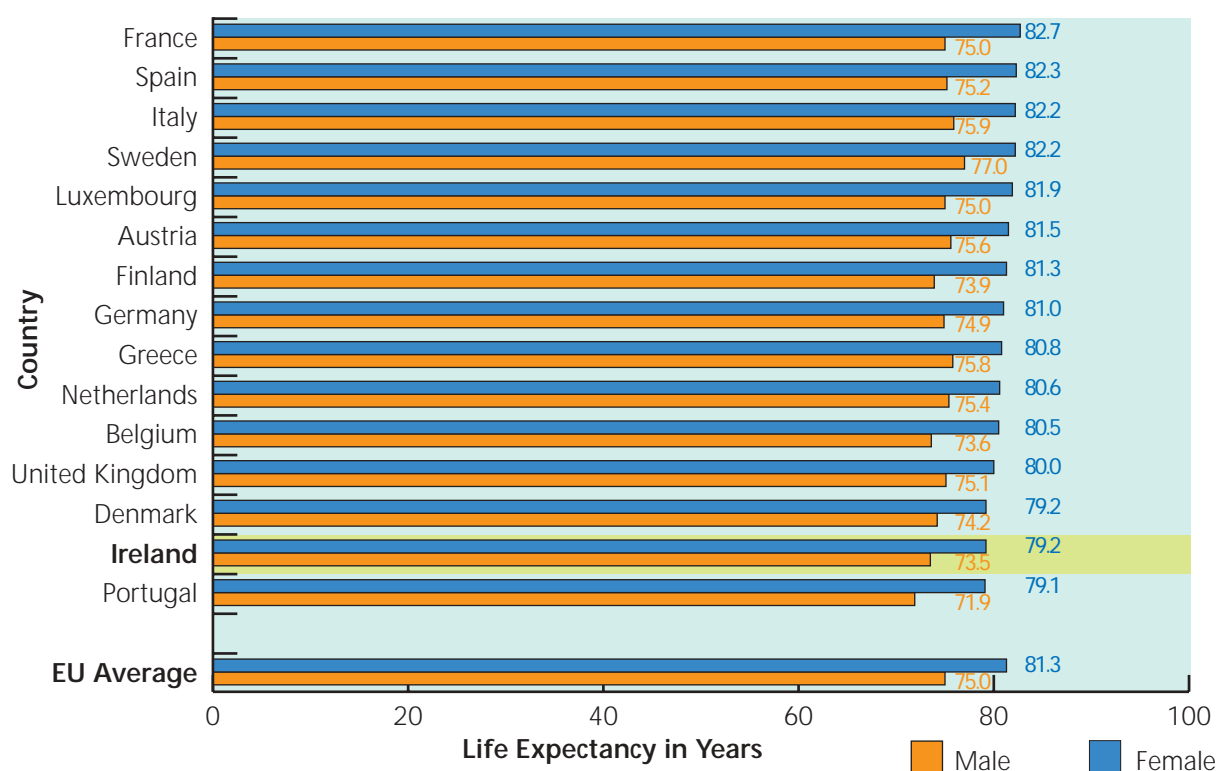
“While women do live longer they also have a poorer quality of life as they age than men, bear the inequalities found in every society in the world more than men, carry the hidden un-prestigious and extensive responsibility for the iceberg of health need in every country, and strive throughout to bear and rear new generations of people in a complex and unjust world” (Kelleher 1997, p.vii in Tovey and Share 2000).

The differing health experiences of men and women are not yet fully understood. Some work indicates the impact of work and home environments are different for men and women, suggesting that job insecurity and unemployment have a greater impact on health among men, whilst for women family structure is important. There is increasing evidence of the importance of maternal and child health, in particular the impact of stress during pregnancy and its impact on later life (Wilkinson and Marmot, 2003). We need better systems for data collection and analysis in order to improve our understanding of the complexity of the relationships between gender and socio-economic inequalities in health.



## Ireland compared to Europe

Despite national increases in wealth and income, people in Ireland live shorter lives compared to those in many other pre enlargement EU countries (Department of Health and Children 2002c):



Mortality rates in Ireland are higher than the EU average on a range of illnesses, particularly diseases of the circulatory system, breast cancer and death from smoking related illnesses. Life expectancy for males at 40 is the fourth lowest in the European Union and the lowest of all EU countries at age 65. Life expectancy for males at 65 is 13.7 years compared to a European average of 15 for men and 18.8 for women.

Despite the fact that Irish women live longer than Irish men they have a relatively lower life expectancy than their European counterparts. Maternal mortality in Ireland is below the EU average. Other examples of the experience of Irish women in an EU context include:

- In 1997, the incidence of lung cancer in females in Ireland was the sixth highest out of 23 European countries and twice the EU average
- The Standardised Death Rate (SDR) for Irish women aged between 0 and 64 of diseases of the circulatory system is 42.4 per 100,000, compared to an EU average of 33.1
- The Standardised Death Rate for ischaemic heart disease for Irish women is 20.8, compared to an EU average of 12.7
- Cerebrovascular diseases (including stroke) account for 10.6 deaths per 100,000 Irish women aged between 0 and 64, compared to an EU average of 9.1.

Cancer is the second principal cause of death for Irish women and accounts for one fifth of deaths in Ireland. While mortality has decreased in general, cancer mortality has increased, with breast cancer being the most common cause of mortality. Irish women have rates of certain cancers (colon, breast, larynx and oesophagus) and ischaemic heart disease that are among the highest in the EU, and high rates of pulmonary conditions such as bronchitis, emphysema and asthma.

### Age-Standardised Mortality Rates per 100,000 Population by Principal Causes for EU Countries

	Year of Data	All Causes	Diseases of the Circulatory System			Cancer			External Causes of Injury and Poisoning		
			All Circulatory System Diseases	Ischaemic Heart Diseases	Stroke	All Malignant Neoplasms	Cancer of the Trachea, Bronchus and Lung	Cancer of the Female Breast	All Deaths from External Causes	Motor Vehicle Traffic Accidents	Suicide
Austria	2000	658.5	315.3	132.2	67.8	174.2	32.7	27.6	47.6	10.0	17.5
Belgium	1995	744.8	258.9	86.3	60.8	213.4	53.3	37.7	56.7	15.1	19.7
Denmark	1998	781.1	262.8	125.6	60.7	221.7	50.2	37.4	51.0	8.6	13.2
Finland	1999	717.7	298.5	180.5	68.0	154.3	27.9	23.9	72.4	7.7	22.4
France	1998	636.0	178.2	52.0	42.6	191.8	36.5	27.5	60.9	13.4	16.5
Germany	1999	693.3	307.2	135.4	63.4	185.0	34.8	28.5	35.1	8.9	11.9
Greece	1998	675.4	328.2	83.8	114.4	157.3	39.0	20.8	39.1	20.1	3.5
<b>Ireland*</b>	<b>2001</b>	<b>734.3</b>	<b>286.8</b>	<b>160.2</b>	<b>60.9</b>	<b>197.2</b>	<b>39.4</b>	<b>35.2</b>	<b>40.9</b>	<b>9.0</b>	<b>11.5</b>
Italy	1998	633.9	256.8	82.9	70.2	183.4	39.0	25.9	36.8	12.7	6.6
Luxembourg	2000	659.0	240.6	80.9	70.3	185.3	39.4	30.6	59.7	18.4	13.5
Netherlands	1999	703.8	239.9	91.3	58.0	203.9	48.3	36.6	28.8	6.5	9.0
Portugal	1999	878.0	329.0	72.5	167.7	171.5	22.7	23.1	45.4	14.7	4.7
Spain	1998	652.7	228.9	71.3	63.1	175.5	35.2	22.2	37.5	14.4	7.2
Sweden	1998	620.7	272.7	135.9	61.5	159.2	24.0	24.3	38.8	5.2	12.7
United Kingdom	1999	725.5	274.8	150.0	66.6	192.8	44.0	31.8	28.4	5.5	7.2
<b>EU Average</b>	<b>1998</b>	<b>687.0</b>	<b>266.82</b>	<b>107.6</b>	<b>67.2</b>	<b>187.6</b>	<b>38.5</b>	<b>28.2</b>	<b>40.6</b>	<b>10.7</b>	<b>10.7</b>

Source: European health for all database, WHO Regional Office for Europe, Copenhagen, Denmark

\* Provisional figures based on year of registration.

Source: Central Statistics Office

In general Irish mortality rates from a range of causes are worse than the EU average. When socio-economic differences are taken into account, a particularly worrying picture emerges for the health of poorer people in Ireland. Research on health and illness has consistently indicated that in countries like Ireland, poor health status is associated with social class particularly in relation to overall mortality, infant mortality, disability and morbidity.

The following eight sub-sections of this report outline health inequalities for a range of groups and issues. Neither the groups nor issues considered are exhaustive but reflect key interest areas of the Alliance and areas where supporting information is available. For many of these, health inequalities are the manifestation of poverty and income inequality e.g. homeless, drug users, lone parents, children and older people. For others e.g. people with disabilities, disadvantaged minority ethnic groups, Travellers and sexual orientation, their health inequalities may be a combined manifestation of poverty and discrimination.

## 2.II. AGE

### 2.II.a Children

Children are more affected by socio-economic circumstances than any other age group in society (Blair et al 2003, McCain and Mustard 1999). Many of the socio-economic impacts on children's health have been outlined in section 2.I.

*“Inequalities in child health arise from socio-economic and environmental factors, as well as from ethnicity, disability and geography. Poverty is the most important social factor associated with ill-health in children” (Department of Health and Children, 2001a: 7).*

The most recent statistics from the ESRI highlight a significant child poverty problem in Ireland. Children in Ireland are almost twice as likely as adults to experience poverty. In 2001, 6.5% of Irish children were living in “consistent poverty” and 23.4% were living in “relative poverty”. While the percentage of children in relative poverty has remained comparatively static since 1987, the degree or depth of relative poverty experienced by children appears to have increased. The longer a child is poor, the greater the impact on the life chances of the child and subsequent deprivation in later life. Children living in poverty are more likely to experience ill health and to die younger in later life (Spencer 2000).

*“Poverty and low socio-economic status have been linked with child health in all settings and all historical periods” (Spencer 2000: 333).*

Evidence of health differentials between social groups in Ireland can be dated back to a study of maternity hospital records between 1801 and 1841, which showed much higher death rates among children born in poorer districts compared to wealthy districts (Spencer 2000).

Perinatal and infant mortality rates are higher in lower socio-economic families and communities. For four consecutive years (1992 - 1995), parental smoking, unemployment and medical card status were evident in greater proportions among families experiencing a Sudden Infant Death than national average figures (McDonnell, et al 2002). Children in lower socio-economic circumstances are exposed to a range of risk factors including low income, poor educational, recreational and life opportunities, poorer housing and maternal nutrition, parental smoking, stress and emotional disturbance, all of which can lead to serious long-term health consequences. One in twenty births each year are to teenage mothers (Department of Health and Children, CMO 2000). While not all children born to teenagers are disadvantaged, teenage pregnancy for many is associated with an increased risk of poor social, economic and health outcomes for both child and mother (Blair et al 2003).

In addition, parental disadvantage can start a chain of social risk that puts children at further risk of ill health in the future. Poor children are more likely to have a low birth weight, to leave school early and to have less healthy lifestyles. Low birth weight not only increases the risk of ill health or death in the first year of life but is also associated with the development of heart disease, diabetes and high blood pressure in later life. Malnutrition and infection are major risk factors in early life and both are associated with poor social circumstances. A healthy diet for pregnant mothers and adequate nutrition for children are adversely affected by lack of income (Spencer 2000). Research shows that mothers often forgo their own nutrition needs for the needs of the children (Department of Health and Children, 2001a). Ireland has one of the lowest breastfeeding rates in the world and this is even lower in lower socio-economic groups (Department of Health and Children, 2001a). Concern is increasing in relation to other lifestyle related health issues for children particularly, obesity, diabetes and dental health (National Conjoint Child Health Committee 2000).

Many of the causes of morbidity and mortality in children relate to preventable causes such as infectious diseases, certain congenital abnormalities (e.g. neural tube defects) and injuries and poisonings. Immunisation uptake is considered to be a good morbidity proxy – yet immunisation uptake in Ireland is well below target rates and a social class gradient is clear (Kelleher et al, 2003). Injuries are the main cause of death in children over the age of one and have been identified as the single greatest threat to children in Ireland today (Department of Health and Children, 2001a). Risk factors for childhood injury include developmental stage, male sex, family stress, social disadvantage, poor supervision, history of previous injury, overcrowded housing conditions and rented tenure. Young children are most at risk of unintentional injury at home especially from falling, burns and poisoning, while older children are at greater risk on the road and during sports activities (Scallan et al 2001). Children of parents with medical cards have been found to have less sealant on their teeth (important in terms of prevention and an indicator of service usage) and higher decay levels than children whose parents do not have a medical card (Whelton et al 2003).

Mental health disorders in childhood and adolescence are common and disabling (National Conjoint Child Health Committee, 2000). It has been estimated that 1 in 10 children (over age 5) and adolescents have a mental illness serious enough to cause some level of impairment in any given year (Department of Health and Children, 1999). Reasons for increases in mental health disorders in children include the increasing gap between rich and poor, changing parenting styles and more single parenthood (Blair et al 2003).

The interconnectedness of ill health and poverty and how families experience this has been clearly expressed by families themselves in a recent study on family life on a low income in Ireland. The authors point out that:

“While almost all of the families in our study fell below one poverty threshold or another, their members led impoverished lives not just because of financial shortages but also because of an insufficiency of services and of the capacities and resources needed to change their situation” (Daly and Leonard 2002: 205).

Positively impacting on children's lives (particularly in the early years), their standards of living, family circumstances, educational and recreational opportunities and levels of support, provide opportunities for significantly impacting upon health inequalities.

*“As young mothers of children under seven, we are worried about what the future holds for our kids. For example, they want to go out to play but there is nothing to let them out to. You are either letting them out to busy roads, dirty flat complexes, broken houses or older kids that lead them astray. One child has to play in an alleyway behind her house beside a busy road. Others can only play in the rubbish chutes or beside a dirty pool that has been in the flats for years” (National Children's Office, 2000).*

## 2.II.b Older people

*“ The elderly are treated as though they should be grateful for any treatment given to them even when this undermines their dignity and privacy. At times the elderly are treated like they are intellectually impaired...only some health professionals will actually talk to the elderly” (Garavan et al, 2001).*

All recent demographic projections anticipate a significant growth in the number of older people in Ireland in the coming years, a period in which overall population size is expected to remain stable. In 2002, the census recorded 436,001 persons aged 65 and over living in the Republic of Ireland, representing just over 11% of the total population (Central Statistics Office, 2003).

Income levels greatly impact on the health status of older people. Income adequacy needs to be prioritised. Low income over the lifecourse is shown to have detrimental health effects (Siegrist, 2004).

- The current level of social welfare pension is equivalent to approximately 31% of the gross average industrial earnings (Fahy and Russell, 2001)
- Thirty eight percent of pensioners live in the lowest 20% of households in terms of income (Equality Authority, 2002).

Another significant factor in health or well-being for older people is their participation in the decisions that affect their lives. The dignity and autonomy of older people can be undermined in the health care system, when health professionals hold stereotypical, negative attitudes towards them. Poor attitudes in acute in-patient care were mentioned repeatedly in research conducted for the National Health Strategy – “Quality and Fairness – A Health System for You”. Where older people and their carers are given adequate information and support to make informed choices about care, their autonomy is increased. Much of the poor health and poor quality of life experienced by older people is preventable (Garavan et al, 2001).

In a 1996 study carried out on behalf of the National Council for the Elderly, it was estimated that 20–25% of older Irish people have a mental disorder of some severity at any one time. Roughly 5% of people over 65 years suffer from some form of dementia and a further 15–20% suffer from other mental problems such as depression and anxiety (Keogh and Roche, 1996). In 1998, there was a total of 6,738 admissions of persons aged 65 and over to psychiatric units in Ireland (Office for Health Gain, 1998).

The 1996 review found that the level of suicide in older males had increased significantly over the period 1977 to 1992 from just over 9 to almost 18 per 100,000 of the population. This matched the increases observed in males aged 15–24 years, the group traditionally seen as at highest risk (Keogh and Roche, 1996). The factors associated with suicide by older people include declining physical health, chronic pain, loss of independence, bereavement, alcohol and drug abuse, and loneliness (Garavan et al, 2001).

It is important in the promotion of older people's health that they are able to remain in their own home as long as possible. The extent to which the aim of enabling older people to remain at home is achievable depends on the availability of a comprehensive system of effective home and community based support services that assist older people to carry out activities of daily living. These services include home help, respite care, meals on wheels, social work services, chiropody and day care. Unfortunately the provision of these services is discretionary. This means that health boards are not obliged to provide them. A recent report indicated that only 5% or less of older people living in the community had used one of those services in the previous year (Garavan et al, 2001). An older person's access to service depends very much on his or her address. People in isolated areas are often the most disadvantaged but even urban dwellers suffer from unequal treatment across the health board areas.

In view of rising costs, older people are now being seen as a liability and a burden on society. Challenging the poor societal perception of older people is one of the greatest obstacles to future planning and one which has yet to be met by politicians, economists and by society at large. Treating older people with dignity and recognising and respecting diversity is also important if we are to adequately respond to the challenge of providing appropriate, accessible and affordable health care to the older population. By improving the quality of life of the older population, increased longevity need not be viewed as a burden to society but an undervalued asset.

Some important realities:

- Those over 65 contribute significantly to the economy
- This age group makes valuable contributions as carers
- Not all those over 65 years will be economically dependent or reliant on health services
- Many older women had to give up working when they married and devoted themselves to childcare in the home (Age Action Ireland, 2001).

### Case study of an older person living in a rural area 2003

Maureen is a seventy-year old widow who lives alone in a rural part of Leinster, some five miles or so from her nearest town. Her husband died seven years ago having worked for the County Council for over forty years. Maureen's only source of income is her Contributory Widow's Pension of €155.80 per week (2003 rate) but she is also in receipt of the new Household Benefits Package (introduced in May 2002) which entitled her to an electricity allowance, telephone allowance and free TV licence. As she lives alone she also qualifies for the €9 per week fuel allowance (from October-April). She says that her pension is only just adequate to buy essential foodstuffs and some small luxuries from time to time. In recent years she has found the cost of groceries increasing steadily and this eats into the annual increase to her Contributory Widow's Pension. She has a Medical Card - which is fortunate, because in recent months she has had to visit her GP more often due to an arthritis-related complaint. She is becoming more and more anxious that her mobility will be impaired or that she might fall and break her hip as several older neighbours have done in recent years. This fear of becoming ill through sickness or a fall has prompted her to get a personal alarm which she can use by pressing a button on a pendant which she keeps around her neck.

She also has a free-travel pass but that is of no benefit to her because there is no bus service near her home. She had a car but the introduction of the compulsory testing of vehicles two years ago meant that she was forced to give up her car when it failed the NCT test. She has no children and relies on a cousin who lives some miles away to bring her to the local town to collect her pension and do some weekly shopping. The same person also brings her to mass on Sundays. However, her cousin is getting older and more frail and she too is faced with giving up her car if she does not pass the annual eye test for her driving licence application. Maureen's neighbours include a young family with whom she used to have quite a bit of contact but whom she now sees less frequently because the female partner has recently taken a job in the town and is away for most of the day. The children of that family have come into their teens and have less time to visit than before due to examination pressures (or lack of interest) or both. As a result, she says she finds the days longer and is aware of feeling lonely more often of late. Apart from her cousin, the only person who now calls to her home with any kind of regularity is the local postman but Maureen is aware that An Post have plans to have a post box placed at her gateway. If that happens, she will rarely have an opportunity to speak with the postman.

The house, which she owns outright, is a Land Commission house built some seventy years ago. It does not have central heating and the windows and doors are beginning to deteriorate. The knowledge that they will need replacement in the near future is a great source of anxiety for Maureen. She has applied to her local authority for the Essential Repairs Grant but was informed that no further grants would be made until next year. She is extremely worried that she will have to use her savings to have her windows and door replaced if the County Council grant does not come through in 2004. In the meantime, her house has become increasingly difficult to heat and she is considering moving her bed into the kitchen over the winter. She is reasonably self-sufficient, likes to read and to keep up



with the news on the TV and radio. However, she dreads the dark nights of winter and sometimes lies awake worrying about her personal security, especially if she reads or hears of break-ins in the neighbourhood or when such happenings are reported in the media. Despite her difficulties, she acknowledges that she is generally happy and contented with her lot. Nevertheless, she worries about what the future will bring and how she will cope, given that she has no close relatives living nearby. She would dearly love to find some kind of sheltered housing in the local town, close to shops and church and where she could feel secure. Regrettably, the only such scheme has a long-waiting list and there is little chance of finding any form of alternative accommodation due to the demand on housing generally in recent years.

*Thanks to the National Council on Ageing and Older People who provided this case study.*

## 2.III ETHNICITY

### 2.III a. Travellers

Irish Travellers are “a uniquely disadvantaged group; impoverished, undereducated, often despised and ostracised, they live on the margins of Irish society” (Rottman et al, 1986).

Travellers experience of racism and discrimination can lead to low self-esteem, lack of pride in ethnic identity, coupled with anxiety about losing identity, feelings of inferiority and of being a social outcast. This experience of low social status and exclusion is mostly due to the hostility and prejudice Travellers experience from the settled community, and all aspects of their lives are affected by this discrimination. Many Travellers experience discrimination on a daily basis from verbal and physical abuse, being followed around shops and excluded from particular services. This level of discrimination is illustrated by findings from a Citizen Traveller survey (2000), which showed that:

“In terms of accepting or including Travellers socially or into the community,

- 36% of Irish people would avoid Travellers
- 97% would not accept Travellers as a member of their family
- 80% said they would not accept a Traveller as a friend
- 44% would not want Travellers as community members.

The main reasons for excluding Travellers are perceptions of their way of life/lifestyle and a feeling that Travellers are in some way not socially acceptable (27%)” (Citizen Traveller, 2000).

This discrimination, often combined with poor accommodation and living conditions, has a detrimental effect on the health status of Travellers. Pavee Point conducted a national survey on the Health of Traveller women in 1997. This found that 71% of the women had experienced verbal abuse because they were Travellers, 25% of these included physical violence. It also indicated that 34% of Traveller women interviewed suffered from long term depression (compared to approximately 9% among settled women).

The Traveller accommodation crisis has been highlighted in Government and other reports over the years. Despite this, many Travellers (1,100 families, approx 25% of the population) still live on the roadside in appalling conditions without access to basic services including water, electricity or sanitation. Many other Travellers live in official accommodation that is poorly serviced and maintained and often situated in unhealthy or dangerous locations.

In 1983, the Travelling People Review Body proposed the regular and systematic collection of data on the health status of Irish Travellers. The publication of the “Travellers Health Status Study - Census of Travelling People 1986”, (Barry et al, 1989) and “The Travellers Health Status Study - Vital Statistics of the Travelling People 1987”, (Barry et al, 1989) gave

rise to considerable concern about the health status of the Traveller community. These reports found that:

- The fertility rate of Travellers in 1987 was 34.9 per 1,000 - more than double the national average and the highest in the European Union
- Travellers have more than double the national rate of still births
- Infant mortality rates are 3 times higher than the national rate
- Traveller men live on average 10 years less than settled men
- Travellers are only now reaching the life expectancy that settled people reached in the 1940s
- Travellers of all ages have very high mortality rates compared to the Irish population
- Traveller women live on average 12 years less than their settled peers
- Travellers have higher rates of morbidity for all main diseases.

Traveller health issues are linked to issues regarding accommodation provision and further, to the social and economic exclusion of this community within contemporary Irish society. The circumstance of Travellers lives includes poor living conditions and stress generated by living in a hostile society. This is compounded by frequently enforced changes in their way of life. These factors impact adversely on Travellers health and negatively affect their access to and experience of health services.

Since 1987, no national studies have been conducted on Traveller health, but some subsequent research suggests that the health of Travellers has not improved, and more alarmingly, may have deteriorated. What we do know for certain is that the gap between the health status of Travellers and settled people has widened. This is borne out by the following statistics:

- The 2002 national census found that only 3% of all Travellers were aged over 65 years of age, compared to 11% of the settled population
- A study of Travellers using Tallaght hospital, found that only 2% of all hospital patients were Travellers aged over 65 years, compared to 34% of hospital patients who were settled people aged over 65
- In the same study, the referral rate of Travellers by GP's to hospital inpatient and outpatient care was negligible
- The Irish Sudden Infant Death Association in their Annual Report 1999, found that the rates of Sudden Infant Deaths among Travellers over a five year period was 12 times the rate among the settled population.

## Traveller case study

Mary is a Traveller, married for twenty years to Johnny. She is thirty-nine years of age and they have six children. She and her family moved from Westmeath a year ago after being evicted from the side of the road. She doesn't understand why exactly. Somebody told her there was some new law that came in that meant that Travellers could be moved on. She had lived in the same place for ten years and never had much trouble before. She had thought she belonged there. It was hard to go but there was no choice really. The hardest thing was leaving the town where her mother was buried. Her mother died of breast cancer at fifty-three years of age and her father went back to England and lives with her brother in Manchester.

They came to Dublin because her husband's extended family lived there, but when they arrived there was no room in the halting site. They decided to pull in, where another family left on the side of the road in west Dublin. They have no water, electricity or a toilet and no post, and she lives with the fear of being moved on again at anytime. The site is beside a dump and the trucks pass up and down all the time and she worries about her kids being knocked down, as well as the rats that are as big as houses. She is on a list for an official halting site but nothing has happened despite all the meetings about it.

Sometimes she gets depressed thinking about it all but has to snap out of it because two of her children have developed asthma since she came to Dublin and are very bad with it. She still travels to the midlands to see her Doctor, because when she moved to Dublin, she tried three local GPs who all refused to take her. The receptionists said their lists were full, but she didn't really believe them. Mary knows what that look means, she has felt it everyday of her life from when she went to school for a while, to when she goes shopping and the security man follows her around, to when she tried to get a hotel for her first daughter's wedding last year and the only place that would have them was 60 miles away from home.

Mary felt it would be better to stay with the GP she knew, anyway, rather than have anymore hassle. She thinks the asthma is from living beside the dump, but she is afraid to say that to her Doctor, in case he thinks she is being smart. She just drives back to Westmeath every month and gets her prescription and says nothing – it is faster that way. The Doctor is nice but he always seems busy and God love him he is getting on. She worries about what will happen when he retires.

Mary has had a lump on her breast for the past year. She is very worried about the lump, but is ashamed to mention it to her husband or her doctor. In fact, she really only uses her GP for her children's health problems. The last time she visited the surgery, with her children, she noticed what she thought were women's health leaflets, but was unable to read them. She thinks there may be women's clinics with women doctors, who she could talk to, but doesn't know where or who to ask for the information. She decides she will try to put it out of her head, say a few prayers and maybe things will get better for the family, maybe they will get a decent place to live and when they do, that will be time enough to get herself seen to.

*Thanks to Pavee Point who provided this case study.*

## 2.III Ethnicity

### 2.III b. Disadvantaged minority ethnic groups

Disadvantaged Ethnic Minorities is the term used in this report to describe asylum seekers, refugees, low-income migrant workers and undocumented ethnic minorities.

“Asylum seekers potentially experience greater degrees of social exclusion than many other vulnerable groups in Irish society because of language difficulties, racism and institutional barriers caused by having fewer rights and entitlements. In particular, the absence of a right to work and barriers to training and support were factors in the social exclusion of asylum seekers and their children. These in turn impact upon the mental and physical health and well being of asylum seekers” (Fanning et al, 2001: 5).

Recent demographic changes in Ireland present challenges to policy makers in meeting the needs of a more diverse society and designing and delivering health services to these groups within Irish society. In recent years, the circumstances of disadvantaged minority ethnic communities have come to the fore, and experience indicates that disadvantaged minority ethnic communities have particular health needs.

There is limited research in Ireland on the health status of disadvantaged ethnic minorities, and on the effectiveness of the existing service provision (Fanning et al, 2001; Cairde, 2003). International research suggests that most asylum seekers arrive in apparent good health, expecting to find security, however, many experience deterioration in their health after arrival. A significant minority arrive in considerable distress, following experiences of conflict, victimisation, and torture. Asylum, accommodation, food and warmth are the priorities on arrival (British Medical Association, 2002).

The current system allows for the dispersal of refugees and asylum seekers to sites around the country. This system removes them from places where they may have established links and social supports with other asylum seekers from their home country. This takes away people’s control over their lives, increases isolation and may discourage some people from applying for asylum (Fanning et al, 2001; Cairde, 2003).

Existing research suggests that an insecure legal status in the host society, forced inactivity, lack of adequate and suitable financial resources and living conditions, and lack of family and communal support structures, constitute some of the more significant causes of stress, anxiety and depression among ethnic minorities (Cairde, 2003). Recent research shows:

- That over 80% of ethnic minorities interviewed suffered from stress, worry and symptoms of depression (Cairde, 2003)
- Experiences of hostility and racism from the local population, the trauma of the legal process and delays, cause high levels of stress on these communities (Cairde, 2003)
- Minority ethnic communities experience isolation. Dependency on direct provision causes particularly high levels of isolation and stress (Delaney and McGee, 2001)

- Needs related to post traumatic stress disorder (PTSD) following torture and conflict include highly specialised services (Cairde, 2003)
- Living in overcrowded hostels presents problems in maintaining acceptable levels of personal hygiene (Cairde, 2003)
- Voluntary screening for infectious diseases may suggest to some people that their asylum application may depend on the results, and discourage them from being screened (Cairde, 2003)
- Many migrant workers are just outside of medical card eligibility and are therefore not accessing health services and not always entitled to sick leave.

The physical health of asylum seekers is reported by GPs to be generally good, although a quarter of this young group take medication daily. Their self reported quality of life is much poorer than that reported by the general population and only 22% rate their quality of life as good or very good (Foley Nolan et al. 2002).

Recent research has found that Irish health services are generally not prepared to deal with the specific needs of ethnic minorities (Cairde, 2003). There is a lack of information on the part of both health service providers and refugees and asylum seekers. Many ethnic minorities have problems registering with a GP and language difficulties present enormous barriers to healthcare. Interpretation services need to be improved. Misdiagnosis may be a serious consequence of a lack of understanding of culture and language.

A range of health issues was identified in research of asylum seekers in direct provision. These included:

Food issues where food in hostels was found to be inadequate and unsuitable, with a lack of choice in the preparation of food and no catering for special dietary needs. "Some respondents reported experiences of extreme deprivation. These included malnutrition amongst expectant mothers, ill-health related to diet amongst babies, weight loss amongst children, worries about health of children, hunger amongst adults as a result of "within household rationing" of available resources in an effort to provide for the needs of children and babies and the inadequacy of hostel food to meet the needs of respondents, especially pregnant women and babies".

Overcrowding occurred in hostels with many families sharing a single room. This led to health and safety risks to parents and children and a range of day-to-day tensions and pressures that affected the psychological well being of parents and children in hostels. Children living in "direct provision" experienced stress related illnesses. Health problems for children included asthma, stomach problems, constipation, eye problems and babies ill health (Fanning et al, 2001).

## Case studies on disadvantaged ethnic minorities

Names are changed to protect identity of the women.

1. **Anita** is from Africa. She came to Ireland as an asylum seeker. Since she came to Ireland, she went through a health screening and was diagnosed HIV positive. She is on a regime of medication, which she sometimes finds difficult. Sometimes it makes her feel sick, other times she gets really sleepy and needs to just lie down and sleep. She lives in a hostel and she is given €19.10 per week. Everyone in the hostel is fed at 8am, 1pm and 6pm. She is not allowed to prepare food for herself. She does not want other people in the hostel to know that she is HIV positive. Anita has seen in her own country how people with HIV are treated. She doesn't want anyone to think she is "dirty". Some of her medication has to be refrigerated. After a few months of requests she was given a small fridge for her room. The other women in the hostel want to know why she was entitled to get a fridge. She does not have much privacy in her hostel. Sometimes people from a HIV support group call and other women in the hostel always ask her why is she getting extra support. Sometimes when it is time to take her medication, there are other women in her room. She does not want to ask them to leave and so sometimes she doesn't take her medication. The women often ask her why she has to go to the hospital so often. Occasionally when she goes to St. James she tells the consultant that she couldn't take some of her medication. Sometimes the consultant gets fed up and Anita feels it is written in her file that she doesn't comply with the drug regime and so is a poor patient. What Anita really needs is private accommodation where anyone she wants can come to her home without having to hide the reasons for her visitors, hide the contents of her fridge or not take medication because there are people in her room.
2. **Marie Claire** is a programme refugee which means she does not have to go through the asylum process as the Irish government invited her and her husband to come to Ireland from Africa. Marie Claire is 22 years old and her husband is 52 years old. It was an arranged marriage against her will. Marie Claire did not want to come to Ireland with her husband. He is abusive. On her fifth day in Ireland she made contact with a support group. On that day the support group helped her to be accommodated in a separate hostel away from her husband. She does not speak English, only speaks Arabic, and does not have any money or clothes other than those she is wearing. She has chronic piles and cannot sit for long periods. She was told that she could go to a GP that day between 3pm and 6pm to have them checked out. However, when she arrived at the GP office at 4pm it was closed. She then went to the Emergency department. She does not understand the difference between the services offered at the GP and at the hospital. She was told that the piles are a minor problem and that she cannot see a doctor. She did not fully understand why this is so. They gave her ointment and told her to go to a GP the following day. She went back to the hostel to discover that she has to share a room with another woman and her small baby. Marie Claire is terrified. She is lonely, scared and doesn't know what the future holds for her.

*Thanks to Cairde who provided the case studies.*

## 2.IV Sexual orientation

It is estimated that at least 10% of the Irish population is lesbian, gay or bisexual (LGB). There is an absence of national data on the health of lesbians, gays and bisexuals (Equality Authority, 2002). Lesbian, gay and bisexual people are known to experience greater levels of discrimination and exclusion than the heterosexual population (Equality Authority, 2002; GLEN Nexus, 1995). Being lesbian, gay or bisexual (LGB) can exacerbate vulnerability to poverty because of homophobia that may result in problems in education or employment (GLEN Nexus, 1995). Discrimination impacts on all aspects of affected people's lives including employment, training and education, relationships with family and friends, access and use of services, access to resources such as benefits and housing, experience of violence and harassment and lack of legal recognition of partnerships (Equality Authority, 2002). In health services, staff may often lack the knowledge, skills and capacity to understand and address the health needs of lesbians, gays and bisexuals (Galway Lesbian Line, 1999).

There is a particular lack of research on lesbian health when compared to the material available on gay men which has developed as a consequence of HIV/AIDS and other sexual health concerns (Galway Lesbian Line, 1999). Research into the health of lesbians, gays and bisexuals is notably absent from any major national or regional studies on health status, behaviour and lifestyles. Sexual orientation is not a question in the National Census and it is not possible to disaggregate most other data sets by sexual orientation (Equality Authority, 2002).

The experience of marginalisation and discrimination can result in stress, mental health difficulties, drug and substance misuse and risky sexual behaviour. This is particularly the case in rural areas or where there is limited family or community support (Equality Authority, 2002). Lesbian, gay and bisexual people are also vulnerable to harassment and violence which can result in additional stress and which in turn can impact negatively on health status (Morrison and MacKay, 2000).

Mental health difficulties and the increasing incidence of suicide in Ireland is an area of increasing concern in the LGB community. A number of international surveys and analyses on the links between sexual orientation and suicide amongst young people indicate that up to 30% of completed suicides are motivated by issues and difficulties experienced by young people of differing sexual orientation (Equality Authority, 2002). The continuing prevalence of suicide amongst young men in Ireland and the high numbers of women who attempt suicide has yet to be examined with a view to determining whether sexual orientation is a factor, despite the strength of findings elsewhere.

Discrimination, denial of access to resources and full participation in society are the consequences of the exclusion and inequalities faced by lesbian, gay and bisexual people. These inequalities can reveal themselves in poorer physical and mental health – but more information is necessary in order to assess and understand the inequalities experienced by lesbian, gay and bisexual people and how these effect their health. Priority to non-



discrimination and equality measures and legislation are central to the achievement of better equality outcomes and health for lesbian, gay and bisexual people.

“I was ostracised by the majority of my family and forced to leave home because of their fear that my sexuality might lead to HIV infection”

“I was constantly harassed by students in secondary school (at one point attacked). I was also harassed by teaching staff” (GLEN Nexus 1995).

## 2.V Disability

“Disabled people have and currently experience levels of discrimination, which impact on every aspect of their participation within Irish life...(this)...requires fundamental change on the part of all institutions of the state: public and private” (Forum of People with Disabilities, 2001).

People with a disability or multiple disabilities come from all sections of the population and like all minority groups are very diverse. Disabled children, women, older people, those from minority ethnic groups and lesbian, gay, bisexual people with disabilities encounter multiple layers of discrimination, exclusion and poverty (Combat Poverty, 1995). What is most common to all people with disabilities is their experience of discrimination and prejudice. The Disability Federation of Ireland (2001) has clearly outlined the impact disability can have on health including reduced income, greater demands on that income (extra costs of disability), increased incidence of other disability/disabling condition/illness, lack of early access to acute and rehabilitative services, lack of access to personal social services, worry about the future, stress on relationships, becoming effectively locked out of normal social activities, and a sense of being on one's own.

Over 10% of the population aged 15-64 have a long-term health problem or disability (Commission on the Status of People with Disabilities, 1996). 85% of these have acquired a disability, or longstanding health problem, over the course of their lives. There is 80% unemployment amongst disabled people, as against 5% for the rest of the population (Disability Legislation Consultation Group 2003). These unemployment statistics are an indicator of the level of exclusion experienced by people with disabilities. Such employment exclusion combined with experiences of poverty and discrimination has significant implications for the health and well being of people with disabilities.

There is particular concern about those who live in residential environments as they have little opportunity to give voice to their experiences in what are often poorly resourced environments. Their right to participate in society on an equal basis is denied through low incomes, physical exclusion and the lack of access to independent advocacy (Forum of People with Disabilities, 2001; The Disability Federation of Ireland, 2001).

The poor quality or lack of public services for people with disabilities has been strongly criticised in submissions to recent health policy consultations (Forum of People with Disabilities, 2001; Disability Federation of Ireland, 2001). The Disability Legislation Consultation Group paper, *Equal Citizens*, makes proposals for progress in the following areas: independent needs assessment and service co-ordination, advocacy, mainstreaming, accessibility including physical and communications, disability awareness/equality training and public service employment.

Successive governments have ignored disability organisations' calls for a social and rights based model of responding to disability. *Equal Citizens* outlines what a human rights model means:

*“The human rights model sees people with disabilities as people with the same enforceable rights as everyone else. Instead of the disabled person being seen as a 'problem' to be cured or cared for, this approach reflects the need for the State to remove discrimination and enable people with disabilities to participate fully in society” (Disability Legislation Consultation Group: 11).*

## 2.VI Mental health

Mental health is a public health issue for the whole population, as well as being crucial to people who use mental health services. Like physical health status, people experience a wide range of mental health difficulties which range from stress or anxiety to mental illness. Examples of such symptoms include anxiety, depressed mood, obsessional thinking, delusions and hallucinations. Help may take the form of counselling or psychotherapy, drug treatment and/or lifestyle change.

Many people who experience mental health difficulties can be put under additional stresses due to the stigma associated with mental illness and societal discrimination against those with mental illnesses.

The findings of a National Disability Authority study “Public Attitudes To Disability In The Republic Of Ireland” (2002) clearly illustrate that people with mental health difficulties experience even more discriminatory attitudes than those with other types of physical or intellectual disability. The study found that:

- 30% of respondents were fully comfortable with people who have mental health difficulties living in their neighbourhood (compared to 53% for people with physical disabilities, 49% for people with intellectual disabilities)
- 32% of respondents said that people with mental health difficulties have the same right to fulfilment through relationships and sexuality as everyone else (50% for people with physical and intellectual disability)

- 40% of respondents said that people with mental health difficulties should not have children (13% for people with intellectual disability, 9% for people with physical disability)
- 55% of respondents said that people with mental health difficulties should have the same employment opportunities as everyone else (81% for people with physical disability, 75% for people with intellectual disability)
- 42% of respondents said that people with mental health difficulties were treated fairly in society (53% for people with physical and sensory disability, and 47% for people with intellectual disability).

There are very few, if any, national measures of mental health or well-being. Admission to psychiatric hospitals and usage of mental health services are used as proxies in health policy but are in fact indicators of acute mental illness rather than mental health and well-being. People with mental illness are not always in a position to assert their rights, and family members or friends are sometimes not best placed to act on their behalf. An effective complaints procedure and a comprehensive system of personal advocacy should be provided to allow this to happen. Amnesty International urges the Irish Government to acknowledge and respect the right of all people with mental illness in Ireland to the best available mental health care (Amnesty International, 2003).

In 1999, there were 25,062 admissions to Irish psychiatric hospitals of people aged 16 and over which is a rate of 930 per 100,000 (Department of Health and Children, 2001b). Utilisation of Psychiatric Hospitals demonstrates a severe social gradient with the highest rate of hospitalisation amongst the unskilled group (314.3 per 100,000 population: Daly and Walsh, 2002). This rate was more than 6 times that for the higher professional group, and more than 10 times that for employers and managers. The rate for agricultural workers was 252.8 per 100,000, nearly two and a half times that for farmers. The lowest rate was for salaried employees/own workers for whom the rate was 5.8 per 100,000 population.

Suicide is the most acute manifestation of mental illness. Ireland experiences higher rates of suicide than most of our European neighbours. It is the second most common cause of death in young men. There is a clear social class gradient in suicide for men and women of all ages with higher prevalence among people from lower socio-economic groups (National Suicide Review Group, 2001).

The physical health of users of mental health services is known to be much poorer than the general population. This has been linked to high levels of medication and associated side effects, low levels of support, the experience of discrimination and stigma e.g. people with mental illness denied employment, denial of rights of people in mental health services, barriers to participation in society and the lack of access to mainstream services such as education and health. People with mental illness tend to have poor self-care/self referral for preventative health services like dental care, eye and ear testing and medical check ups.

They also tend to engage in unhealthy behaviours, high levels of smoking and alcohol use and restricted level of activity, life routines and employment. All of these compound the poorer health status of people with mental health difficulties.

The use of mental health services, as a proxy for mental health status is not an appropriate measure of mental health. Other measurements need to be developed and used. This will be central to reducing health inequalities and eliminating discrimination against people with mental health difficulties and towards creating a society where all people are respected and valued no matter what their mental health status. Whilst it is essential that the needs of people who experience mental health difficulties and their family members/carers are addressed, there needs to be action to protect and promote the mental health of the whole population in order to address health inequalities.

Mental health and mental health services have traditionally been the Cinderella of public health and health services. People with mental health difficulties are often those more at risk of poorer health in society and therefore need to be prioritised in all public health activity.

## 2.VII Homelessness

People become homeless usually due to a combination of complex factors including poverty, loss of housing/accommodation, difficult life circumstances often related to relationship breakdown, violence, personal tragedy, drug and alcohol abuse, bereavement and lack of a safety net. People stay homeless often for different reasons, such as poverty, unemployment, low educational take up, inaccessible and unaffordable housing, inadequate and inappropriate emergency accommodation and responses, and the failure of services to adequately meet the complex needs of homeless people in crisis (Focus Ireland, 1998). Being homeless is very stressful and unhealthy and can cause extreme mental and physical ill health. People who are homeless experience much poorer health and die much younger than the general population (Holohan, 1997; Feeney et al, 2000; Costello and Howley, 1999; Focus Ireland, 2000; Smith et al, 2001; Condon 2001).

Research indicates that there are two groups of homeless people, those who are registered as homeless with a local authority and those using services for homeless people. There is little cross over between the two groups. The former group are generally families waiting for public housing but not using emergency accommodation, the latter are those staying in emergency accommodation or sleeping rough (Williams and Gorby, 2002).

People who are homeless make up a vulnerable population that has an unacceptable high risk for preventable disease, progressive morbidity, and premature death. People who are homeless experience much higher levels of mental health difficulties, poorer physical health including higher rates of Hepatitis-C, HIV, TB, poor nutrition, drug and alcohol addiction

than the general population (Holohan, 1997; Feeney et al, 2000; Costello and Howley, 1999; Focus Ireland, 2000; Smith et al, 2001, Condon 2001).

According to research from the UK, the average age of death of a homeless person sleeping rough is 42 years. From Simon's experience of working with street homeless in Cork, Dublin, Dundalk and Galway, the mortality rates of rough sleepers in Ireland are along similar lines.

Research carried out in the Dublin area found that people who are homeless have a much higher prevalence of chronic physical disease and a lower life expectancy than those of comparable age in the general population (Holohan, 1997). A report of the health status of people who are homeless in Cork has also found extreme manifestations of ill health among the homeless population there. Of those staying in the Cork Simon shelter, only 22% had a health status that would be considered normal by the general population (Cork Simon, 1998).

The report found that:

- 40% of hostel dwellers had a serious psychiatric illness (including depression)
- 42% had problems of alcohol dependency
- 18% had other physical problems
- 6% had respiratory problems
- 5% had mobility problems.

The problem of poor dental health is also exceptional among the homeless population. Recent research on hostel dwelling men found they had large unmet dental treatment needs, including extractions, fillings, gum disease, and treatment for trauma (Condon, 2001).

## 2.VIII Substance use

Irish people's use of substances both legal and illegal is higher than the European average (Kelleher et al, 2003, Brinkley et al, 1999, Cox and Lawless, 1999, 2000, [www.otc.ie](http://www.otc.ie), Department of Health and Children, 2002b). The use of tobacco, alcohol, prescription and illegal drugs has serious consequences for public health. The use of psychoactive substances has increased generally in Western societies and it is clear some people turn to addictive substances when living in difficult circumstances and without the supports, incentives and opportunities available to them to live a healthy life. There is a social gradient to most aspects of substance use, with people from lower socio-economic groups using more tobacco and illegal drugs, and having lower rates of successfully quitting (Kelleher et al, 2003).

## Tobacco

The prevalence of smoking is declining in Ireland, but continues to be higher than in most other European countries and to be highest among younger men and women (Office of Tobacco Control, 2004). Smoking has a steep social gradient evident in differences between socio-economic groups. 37% of medical card holders compared to 24% of those without a medical card (Kelleher et al, 2003). Smokers tend to rate their health slightly less well than non-smokers (Kelleher et al, 2003). While the numbers of 12-14 year olds who reported smoking dropped between 1998 and 2002, the social class gradient for 15-17 years old boys and girls widened (Kelleher et al, 2003).

There has been an increased emphasis on the critical public health implications of tobacco use and restrictions in tobacco availability and use (Office of Tobacco Control, 2004). Efforts to reduce smoking rates need to be supported by environments, programmes and services, which prevent take up and facilitate quitting. This requires a greater understanding of why people smoke in the first place and why some find it harder to quit than others (Graham, 1993).

## Alcohol

Ireland has very high use of alcohol and the highest increase in alcohol consumption in the European Union, with consumption increasing by 41% between 1989 and 1999. Ten other member states experienced decreases in usage and three countries had very moderate increases over the same period (Department of Health and Children, 2002). Between 1998 and 2002 there were slight increases in the numbers of men (30%) and women (22%) who consumed more than the weekly limits for alcohol (Kelleher et al, 2003). The higher use of alcohol by young people compared to their European counterparts is of great concern, in particular the level of binge drinking and drunkenness. One third of the 15-16 age group reported binge drinking (5 drinks or more) 3 or more times in the last month (Kelleher et al, 2003). Although it is illegal for under eighteens to purchase alcohol or consume it in a public place, this is not an apparent deterrent to drinking among young people.

There is no clear social class gradient for alcohol use, as measured in health and lifestyle surveys, although some groups like women over 55 with low educational status tend to report non-drinking more frequently (Kelleher et al, 2003). There is little class effect among girls and boys reporting being 'really drunk' – with the exception of 15-17 year old boys where a small class gradient is evident (Kelleher et al, 2003). However, there is an evident social gradient in terms of alcohol related deaths and alcohol related use of psychiatric services, with those from lower socio-economic groups carrying more of the mortality and morbidity burden than higher socio-economic groups (Barry et al, 2001).

Continual, excessive use of alcohol contributes to a variety of physical and mental health, social and financial problems. Harm resulting from alcohol use can be identified in:

- Unintentional injuries/personal harm (evident in numbers in A&E departments with alcohol related injuries)
- Personal relationships (the social consequences of alcohol resulting in relationship breakdown, or the link between alcohol use and unintentional and or unprotected sex)

- Interpersonal violence/public safety (evident in increases in alcohol related assaults and public order offences)
- Drink driving (alcohol is related to 30% of all road accidents and 40% of all fatal accidents)
- Alcohol related mortality (where alcohol is a contributory factor to accidental falls, suicide, homicide and accidents and regular consumption increases the risk of liver cirrhosis, cancers of the mouth, pharynx, larynx, oesophagus and liver)
- Mental health problems (alcohol disorders continue to be the main cause of admissions to psychiatric hospitals and alcohol abuse is a significant risk factor in suicide)
- Cost of alcohol related problems (it is estimated that alcohol related problems cost Irish society €2.4 billion per year. This includes the costs of health care, road accidents, alcohol related crime and lost productivity)

(Department of Health and Children, 2002b: 8-12)

## Illegal drugs

The nature of illegal drug use means that its measurement is difficult. People may be reluctant to admit use in general surveys and often those who are researched tend to be those with the most problematic drug use and may be atypical of the majority of users e.g. injecting drug users in prison, homeless drug users etc (Cox and Lawless, 1999 or 2000). Most drugs research in Ireland, as elsewhere apart from national prevalence estimates, has concentrated on opiate use. Looking at national prevalence estimates, Ireland is marginally above the EU average (Morgan, 2001).

Comparative data on the use of illegal drugs among young people shows Irish young people to use more than their European neighbours (EMCCDA, 1998). There is a lack of information on “soft” or “recreational” drug users who do not come to the attention of health services or the criminal justice system, despite an increase in the availability and acceptance of such drugs (Mayock, 2000). Patterns and types of reported drug use vary across geographical locations.

The majority of those who present for treatment are from the Dublin area, male, under 30 years of age, unemployed and more than three quarters have left school before the age of 16 years. Over half of those presenting for treatment inject their main drug while a third smoke it. Most of those presenting for treatment are opiate dependent, again reflecting the types of treatment services and types of research carried out, rather than the range of drug users in Ireland. There is also clear evidence of high levels of drug use in Irish prisons (O’Brien and Moran, 1997).

Responses to drug use in Ireland are evident in the development of local area task forces and investment in particular inner city and suburban communities in major urban centres. Such responses acknowledge the direct relationship between poverty, exclusion and substance use and the social, economic and environmental factors which cause problematic (and often opiate) drug use (Ministerial Task Force on Measures to Reduce the Demand for Drugs, 1996; Government of Ireland, 2001). Long-term opiate and hard drug use has long-

term physical, mental and social effects (Cox and Lawless, 1999). IV (intravenous) drug users are particularly susceptible to infectious diseases such as HIV and Hepatitis C (Smyth et al, 1995, 1998). Some drug users outside of treatment are particularly at risk and these include homeless drug users, female drug users and young drug users (Cox and Lawless, 1999; Mayock, 2000; Lawless, 2003).

Research has also shown that homeless drug users are more likely to engage in a range of risk behaviours than other drug users (Cox and Lawless, 1999). Homelessness among injecting drug users is associated with heavy drug use, daily administration of drugs, high incidence of both lending and receiving injecting equipment and also a greater tendency to be street or public injectors (Cox and Lawless, 1999).

## 2.IX Lone parenthood

Eight out of every hundred families in Ireland is headed by a lone parent and the vast majority of lone parents are women. Lone parent families face a high risk of poverty with 16 per cent of all children living below the poverty line coming from one parent families (Daly and Leonard, 2002). Lone parents also tend to be significantly over represented in local authority housing lists. Lack of availability and accessibility of quality childcare is an issue facing all parents but is a particular barrier to lone parents who wish to take up training or employment outside the home (One Parent Exchange Network, 2003).

Studies in other countries have shown that lone parents have poorer health status than the general population (Spencer, 2000). A study of the changes experienced by 950 lone parent families over a five-year period in the UK found that:

- There was a strong association between the experience of material hardship and the development of health problems among parents and children. The most common ailments among children were respiratory problems, such as asthma - suffered by 7 in 10 ill children
- In 1991, 15% of lone parents reported a long-term or limiting illness, but by 1995 29% said they were ill. The proportion with ill children also increased from 13% to 29%
- In four in ten households the mother and children remained free of long-term or limiting illness throughout the five years. In one in eight households both parent and child were ill. In one in twelve families, two or more children were ill
- Illness was a hidden barrier to employment, with half of those reporting a medical condition saying that it affected the kind of work they could do and where they could do it. Parents who were healthy throughout the period were three times more likely to have worked continuously than those whose health remained poor (Benzeval, 1998).

Another study based on a large national data set in the UK (three consecutive years of the British General Household Survey) found that lone parents, particularly lone mothers, have



poor health status relative to parents living as couples. The observed health differences mirrored variations in socio-economic circumstances. However, aside from socio-economic factors, lone mothers were still found to have significantly poorer health than couple mothers suggesting other possible causes such as the absence of an intimate/confiding relationship; the stress and stigma associated with becoming a lone parent and health selection, i.e. not that being a lone parent causes poor health, but that poor health increases the risk of becoming a lone parent (Benzeval, 1998).

Similar research on the health of lone parents is not available in Ireland. The absence of research and statistical data means that in many areas, policy and attitudes to lone parents are based on a mixture of anecdote and stereotype. The focus of much data collected in relation to lone parents is work and welfare and there is very little information on the health and or health needs of lone parents. More research is required, and there is a particular need for more qualitative and longitudinal data about lone parent family experiences.

### Case study of a lone parent living in poverty

Máire is a 22-year-old lone mother with three children, the eldest of whom is four years old and the youngest six months. She was taken out of school at the age of 12 to look after her younger siblings and as a result has difficulties with reading and writing. During the interview Máire made no mention of the father(s) of her children. Her house is extremely shabbily furnished; the windows were partly boarded up giving little light to the living room which was in semi-darkness when the interview was carried out. Her middle child, a boy of three, has behavioural problems and created difficulties during the interview, running around the living room, knocking into furniture, picking things up and dropping them on the floor. Hers is a daily struggle of trying to make ends meet, being in debt and rarely socialising outside the house. Despite living in the area for one and a half years, she had never spoken to any neighbours except one woman and this was only two weeks prior to the interview. When she went into labour with her youngest child, she had to bring her three-year-old son and four-year-old daughter to hospital with her since she had no one to look after them and none of the neighbours volunteered. One neighbour telephoned for an ambulance because she went into labour prematurely but this was the extent of the local help she received. Her mother who lives several miles away came later to the hospital to take the children. While she was in hospital, drug addicts broke into the house and used it as a site for injecting. In reaction to complaints from neighbours, the local authority decided to temporarily block the house up to prevent it from being used in this way. On hearing this, Máire felt compelled to sign herself out of hospital prematurely, since she was afraid of being made temporarily homeless. Upon her return home from hospital she found all the windows in the house broken and used needles scattered everywhere. Since then, her backyard is used regularly by local youths as a drinking den and a place where they can inject themselves. Máire slept downstairs because she was too frightened to sleep upstairs and lived in constant fear of the young people in her backyard breaking into her house (Daly and Leonard 2002:104).

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## 2.X Inequalities in health services

“There is evidence that the less well-off in society have poorer access to health services” (Jim Kiely, in Wren, 2003a).

The Irish health system is a “unique” unequal mix of private and public provision and funding. This mix often means that those who can afford to pay get a better service more quickly than those who cannot (St Vincent de Paul, 2001; Kiely in Wren, 2003). There are also geographical inequalities in the provision of health services (Barry, 2001).

### Developments in the health services

While there has been an increase in funding, historically the health service in Ireland has been chronically under funded. Over the last thirty years we have spent below the average proportion of GDP on health services in comparison to other developed countries (Deloitte and Touche, 2001; Wren, 2001a). Over the five years, 1998 to 2003, Ireland tripled expenditure in the health system. Since the end of 2001 extensive policy recommendations on health system reform have been made. However, neither the increased investment in the health services nor the planned system reforms have sufficiently addressed systemic inequalities in access that the Irish health system perpetuates.

The 2001 Health Strategy “Quality and Fairness - A Health System for You” acknowledges the current inequity of the Irish system. For instance, it outlines how “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”.

It also states that:

“One of the key concerns of the Health Strategy is to promote fair access to services, based on objectively assessed need, rather than on any other factor such as whether the patient is attending on a public or a private basis ...

The framework for eligibility should ensure that financial barriers do not adversely affect an individual's opportunity to reach his or her full health potential ...

The Strategy must address the “two-tier” element of hospital treatment where public patients frequently do not have fair access to elective treatment”.

However, as yet there are no concrete actions or commitments arising from this policy document which promises the provision of services actually being provided on the basis of need, nor any discussion of reform of the two-tier health system.

“From the mid 20th Century, most European states developed universal systems in which access to care was guaranteed and regarded as an expression of social solidarity. In Ireland health care and health remain residuals, luxuries which the wealthy may purchase and the masses may access when economic conditions permit.... Not only are Irish people sicker than they should be but Irish social values are unhealthy and foster

ill-health. Irish people die younger because they tolerate an inequality between them which 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" (Maev Ann Wren, 2003a: 11).

The Primary Care Strategy "Primary Care A New Direction" describes in detail the shortcomings of the current system and the need for change. In describing the current organisation of general practice it states that "the public-private mix of entitlements complicates access to services". In the list of conclusions drawn from the views expressed by the public in consultation for the strategy is ... "the need for an improvement in local access and availability of care out-of-hours, and the need for improved integration of services...". The system is described as being "oriented around the needs of providers rather than users" (Department of Health and Children, 2001c).

## **There are broadly four levels of health service user in Ireland:**

### **Medical card holders**

The General Medical Services scheme, founded in 1972 provides free medical care to those on low incomes (The Act is quite specific...medical cards will normally be granted "to those for whom the provision of medical and surgical services for themselves and their dependants would prove undue financial hardship). Eligibility is determined on the grounds of income and medical need. Those deemed eligible are entitled to free GP care, free approved, prescribed drugs and free hospital care, including consultant care in public hospitals, subject to waiting lists.

### **People with private health insurance**

Insured people pay GP fees and pay for medications up to a monthly threshold. They gain access to private care by hospital consultants through referrals from their general practitioner which is paid for by their insurance company.

### **The uninsured**

Those without insurance who are not GMS eligible pay GP fees, pay for medicines up to a monthly threshold which has recently been raised, pay daily charges for hospital care, in public hospitals, up to an annual limit. This also includes the care of a consultant, subject to waiting lists.

### **Those with no entitlements**

There are people in Ireland who are unable to pay and have difficulties in accessing some essential health services. These include people who have entered the country legally but their status may have changed e.g. students, undocumented workers, those who are applying for residency on the basis of parentage of an Irish born child, those whose legal status is called into question.

## The public-private mix

Every citizen is entitled to hospital care (those without medical cards must pay up to a limit). Despite this, nearly 50% of the population have private medical insurance. Hospital waiting lists describe the time public patients have to wait for an appointment. While there has been particular concern over the length of waiting time for public patients, recent initiatives in this area have resulted in some reductions. However, the systemic inequality in provision remains, with people who can afford to getting access to elective surgery and other specific treatments in public hospitals more quickly. There are two main differences for public patients in accessing hospital services. Firstly, it takes longer to get an outpatient appointment with a specialist. Secondly, the waiting times are longer for elective surgery and specific treatments for public patients. Inequalities in access to acute hospital care are the most visible of the systemic inequalities within Irish health services.

In public hospitals, 20% of beds and 33% of day care beds are designated as private. Hospital consultants, depending on their contract, are entitled to both on-site and off-site private practice: the “public only” consultants contract was discontinued in 1997.

In 2003, fewer than 28% of the Irish population was eligible for a medical card on income grounds, the lowest level since the GMS was introduced in 1972 (Wren, 2003c). Over the last 25 years the proportion of the population covered by the GMS on income grounds has declined from 39% to under 28%. The means tested eligibility level has not kept pace with rising incomes (Wren, 2003c).

Thus, over 70% of the population must pay for medical care including seeing a GP and attending A&E. Patients without health insurance or a medical card (over 20% of the population) must pay charges for staying in hospital at €45 per night up to a €450 maximum (2004 figures). Charges for general practice have increased more than inflation. The proportion of family income necessary to pay for healthcare in families just above the GMS eligibility level can directly influence levels of poverty in families and make it economically unviable to enter the workforce (see case study opposite).

Uniquely in Western Europe, most people in Ireland have to pay for GP services. In Ireland GPs are self-employed, and depend on a combination of private fees and income from the GMS (if they are eligible to have a list).

A consultancy report commissioned by the Department of Health and Children identifies practical ways in which the private health system negatively impacts on the public health system (Deloitte and Touche, 2001). The number of people with private health insurance has been rising, principally because of the speed and certainty of access to care which insurance provides. It highlights concerns that hospital consultants may spend more time on private healthcare than appropriate to their contracts, and that private patients do not pay a sufficiently high price for access to private beds in public hospitals. There has not been an assessment of whether the activity generated by the insured population justifies the allocation of private beds in public hospitals, as data on private hospital activity is not readily available (Deloitte and Touche, 2001).

## Case study

Patients without medical cards may pay a very significant proportion of their income in GP and hospital charges. For a single person living alone who earns just above the €138 weekly ceiling for a medical card, one €40 fee for a visit to a GP can consume 28.5% of weekly income. Add say €20 for antibiotics and the effect of an illness is to consume 43% of weekly income.

For a couple with two children earning just above the €250 weekly ceiling, one visit costs 15.6% of income, one visit plus €20 worth of medication consumes nearly a quarter of their weekly income.

For the uninsured without medical cards who must pay hospital charges of €40 per night up to a maximum of €400 per annum, a ten day hospital stay could consume 68.9% of the monthly income of a single person living alone and 36% of the monthly income of a family of four.

These figures convey the bottom line of access to health care in this state. For many people there is a significant financial barrier to access to care. When the Government failed to extend eligibility for medical cards in 2001, the year it launched its new primary care strategy, the Minister for Health Micháel Martin argued that to do so would “flood” the existing system, a tacit admission that there is huge unmet need out there. The Government did not extend eligibility for medical cards last year either with the consequence that now only some 29% of the population have cards (and this includes many over-70-year-olds on higher incomes). Twenty-five years ago nearly 39 per cent of the population had cards” (Maev Ann Wren, 2003b).

## Geographic inequalities

There is concern about the geographically inequitable provision of services. For example, for the treatment of heart disease in 1997, residents of Dublin and Cork were significantly more likely to have coronary artery bypass grafts than residents of other counties (Barry et al, 2001). Dublin residents were also significantly more likely to have had angioplasty. The six counties with the lowest rates are all in the west of Ireland. In treating cancers, between 1994 and 1998 significantly fewer lung, breast and lymphoma patients in the Western and Mid Western Health Boards received radiotherapy. These findings reflect provision of services rather than need for services. If information was available from private hospitals, it is suggested that these geographical inequalities might be even more apparent.

There are also inequities in the geographical distribution of primary care, with fewer GPs serving the most deprived communities. The fact that health services are of poorer quality and less accessible in disadvantaged populations needs to be specifically addressed. The Irish Psychiatric Association shows that clinical resources in mental health have been developed in areas of greatest affluence rather than greatest need (O’Keane et al, 2003).

## Primary care, continuing care and public health

All people, at some stage of their lives need access to primary care, continuing care and public health services. However, some groups have particular need for access. These include women of childbearing age, children, older people, people with disabilities and chronic illnesses. For example older people and people with disabilities often need ongoing care and support from health and personal social services. These services need to be provided in a holistic way with the person and their carers at the centre of the planning and delivery of their care. Both the National Council on Ageing and Older People and The Commission on the Status of People with Disabilities highlighted the inaccessibility of health services, the centralisation of key services in Dublin, the unpredictability and underfunding of community services such as home helps and respite care, as well as widespread lack of awareness and of a clearly defined complaints procedure (Commission on the Status of People with Disabilities, 1996; Garavan et al, 2001). Community based services in the areas of public health, primary and continuing care are crucial to prevention, early intervention and ongoing care and support. Investment in these greatly contributes to quality of life and can prevent the need for more costly services at a later stage.

## Inequalities in health services experienced by specific groups

While mainstream services need to adapt so that they meet the needs of groups who experience particular health inequalities, some sections of society may require additional services and supports to redress the inequalities experienced.

There are clear discrepancies in access and utilisation of health services in Ireland. For example, there are clear gender discrepancies in access to and utilisation of health services. While women are more likely to access health services, they still experience poorer health throughout their lives and are in particular need of access to them in their reproductive years. Compared to women, men have limited contact with their GPs, are reluctant to access primary care services, and often present late in the course of an illness (McEvoy and Richardson, 2004). Low income groups who do not have access to a medical card are more likely not to use services due to inability to pay.

Another example is the extreme poor health experienced by homeless people. Despite this, a significant proportion of homeless people are neither registered with a GP nor hold a medical card (Smith et al, 2001; Holohan, 1997). Dublin Simon's Outreach team found that 50% of rough sleepers they met did not have a medical card or a GP. Their sole source of medical support was A&E Departments of general hospitals. The use of A&E Departments by people who are homeless is both inefficient for the health service and inappropriate for people who are homeless. Travellers also experience difficulty in registering with a GP and use A&E Departments at a much higher level than the general population. The study on Travellers using Tallaght hospital found that 80% of Travellers accessed in patient services via Accident and Emergency compared to 35% of settled people. 70% of Travellers accessed outpatients via A&E compared to 27% of settled people (Travellers Health Unit, 2001).

## Conclusion on health services

Ireland's unequal and inequitable health system needs reform so that services are provided on the basis of need, not just ability to pay. Current provision frequently exacerbates unjust and unnecessary health inequalities.

There is a range of issues which need to be addressed within the health system in the context of reducing overall health inequalities. These include:

- Deconstruction of the two tier health system so that everybody has equal access on the basis of need
- A shift in focus and resources so that all health services have a stronger emphasis on public health, early intervention and the promotion of health and well-being
- The resourcing and sustaining of community based support services
- The involvement and participation of users of services in the planning, implementation and evaluation of services and in their own care plans
- Information on services and rights in an accessible and inclusive manner
- Better co-ordination within health services and between all public services
- A balancing of targeting services between those who need them most to bending mainstream services to meet the needs of those who are excluded
- Promoting equality/diversity aware services and preventing discrimination
- Equality proofing of health sector policies and strategies
- Better monitoring, research and information on health inequalities and access to, utilisation of, participation in and outcomes from health service utilisation.

While health services alone cannot tackle health inequalities, they have a responsibility to provide leadership in this area and proactively contribute to a reduction in current levels of inequalities.

## 2.XI Common issues from Part 2

Part 2 of this paper outlines health inequalities and the impact of these inequalities on different groups in the population. Available evidence clearly indicates that poverty, social exclusion and discrimination are common factors which lead to poorer health and that their impact on health manifests itself in different ways for particular groups.

On a range of measures and indicators of health and well-being the health of Irish people is significantly worse than that of our European counterparts. This is despite recent growth in the economy. Within Ireland poorer people in the population experience poorer health and have less access to health services.

People with higher socio-economic status enjoy better health status than those who are less well off. Poverty and lack of access to resources, such as education and employment are clearly factors which influence health. Poor health status may keep people poor by restricting their opportunities to access the resources necessary to improve their economic circumstances.

Although Ireland's standard of living has increased dramatically over the past 50 years and in particular over the past ten, high levels of income inequality are still a cause for concern. Socio-economic inequalities in health reflect wider inequalities in material conditions and access to resources in society. If these health inequalities are to be reduced, the factors which influence them must be addressed through more equitable public policies. This means improving the standards of living of the poorest, tackling income inequality and developing educational and employment policies which are inclusive of those most excluded and investing in adequate and equitable public services which foster better health.

Economic policies at national and global levels have significant social and health impacts. There is growing concern about the rising number of people using private health insurance to ensure access to the health service when they need it. This is part of an international concern with the emergence of market conditions in this sector allowing higher socio-economic groups access to better health care, where health and health care are seen as traded goods as opposed to rights. Privatisation of public services tends to impact adversely and disproportionately on more vulnerable groups in society.

The development of a healthy population also requires the participation of individuals and communities. Building community capacity and empowering communities, particularly marginalised and excluded communities, have an important role to play in improving the health of the Irish population.

Ireland's unequal health system requires reform to ensure that services are provided on the basis of need. Current provisions exacerbate unjust and unnecessary health inequalities. For many individuals and groups in society their health status is directly linked to their social and economic exclusion within contemporary Irish society. An understanding of the different circumstances and complexity of experiences of different socially and economically excluded groups in society is essential to addressing health inequalities. It also highlights the need for inter-sectoral actions and responses across a range of social, environmental, economic and cultural contexts.

Limited research and statistical data on people's experiences of health and health services increases the risk that in many areas, policy, practice and attitudes are based on a mixture of anecdote and stereotype rather than evidence.

There clearly are problems in relation to research and information on health, but there is sufficient information to know that some people have poorer health status than others and that much of this poorer health is avoidable. While pursuing action to reduce avoidable poor health and deaths is a priority for the Alliance, improved information and research in some areas and for some groups is also important.

Many of the inequalities detailed in Part 2 are unjust and unnecessary. They can be tackled through economic, social and political action. Given the wide range of influences on health, action is required on many fronts, and from those involved in many sectors, for instance education, housing, health, environment and criminal justice. No one sector or discipline alone can redress the current imbalances. Through a unified voice for action and change, the Public Health Alliance Ireland can contribute to a reduction in health inequalities in Ireland.





*part three*  
*areas for action to reduce inequalities*

“And one should bear in mind that there is nothing more difficult to execute, nor more dubious of success, nor more dangerous to administer than to introduce a new order of things; for he who introduces it has all those who profit from the old order as his enemies, and he has only lukewarm allies in all those who might profit from the new. The lukewarmness partly stems from fear of their adversaries, who have the law on their side, and partly from the scepticism of men who do not truly believe in new things unless they have actually had personal experience of them” (Niccolo Machiavelli ‘The Prince’ First published in 1532).

The Public Health Alliance Ireland aims to work towards the reduction of health inequalities in Ireland and to ensure that everyone has an equal opportunity to enjoy the best possible health throughout their lifetime. This can be achieved in two main ways:

- Addressing poverty and social exclusion
- Ensuring equality of access, participation and outcome in health and health services between marginalised and non-marginalised groups.

## Areas for Action

### 1. Investing in a fairer society

The evidence is clear that social and economic disadvantage is a significant determinant of health that gives rise to lifelong health problems and premature death for many in the population. Inequalities in health reflect structural inequalities in society. In order to address health inequalities, there is an obligation on Government to fundamentally and radically address the underlying structural inequalities which give rise to them.

This implies serious investment in tackling poverty, social exclusion and the marginalisation of individuals and communities. Investing in a more just society with more equitable access to income and resources is fundamental to improving health and reducing health inequalities. The focus of this investment must include:

- A reduction in income inequality through an equitable tax and welfare system that will reduce the income gap
- Investment in early childhood and maternal well-being to address the life long consequences of child poverty
- A reduction in inequalities in access to, and participation in, education by increasing the proportion of children from lower socio-economic groups in completing second level and participating in third level education. This will only be achieved through investment in early childhood education
- Appropriate, affordable and good quality accommodation/housing for those who need it
- An end to the two-tier health system and replacement with a universal, free, appropriate and effective health service that provides care on the basis of need rather than ability to pay
- Specific action which focuses on improving the health of the most excluded groups in society for instance those on low income, lone parents, Travellers, refugees and asylum seekers, the homeless and those with mental health difficulties, among others.

### 2. Healthy public policy

Given the range of factors influencing health, public policies in many areas have a role to play in fostering better public health and reducing health inequalities. International developments in the area of tackling health inequalities show that countries which pursue a more socially democratic and equitable distribution of resources and which provide good quality public services can improve the health of the poorest and most excluded and reduce health inequalities. Many national policy documents contain commitments to greater health equality and the eradication of poverty and disadvantage, particularly the National Anti-Poverty Strategy and the National Health Strategy. These commitments must be pursued as a priority.

Action 1 of the Health Strategy 2001 states that: “Health Impact Assessment will be introduced as part of the public policy development process”. Progress must be made on ensuring that health impacts are considered in policy making to ensure healthier public policy development and implementation. The Investing for Health policy in Northern Ireland provides us with a blueprint of a comprehensive, multi-sectoral approach to tackle health inequalities.

### **3. Working against discrimination through including communities in decision making and respecting human rights**

The experience of discrimination directly impacts on health and well-being, whether this is based on socio-economic status, ethnicity, age, gender, disability, family status, geography or sexual orientation. A commitment to eliminating discrimination at all levels of society is crucial to fostering better public health and more effective and equitable health services. Monitoring and evaluation of equality legislation must be part of all public services.

Health and human rights are inextricably linked. The state must take responsibility for correcting conditions that prevent people realising their right to health as well as the related rights to education, safe living and working conditions, and freedom from discrimination.

Working for better health, and more equitable health services, must also be pursued through the involvement of individuals and communities in the development of responses appropriate to their needs; supporting frameworks that enable individuals and communities to respect each other’s rights and value the contribution made by individuals and communities, including carers, to protecting health and well being.

### **4. Improved data collection, research and knowledge of health inequalities and how they can be overcome**

While there is much evidence that demonstrates the extent and nature of health inequalities in Ireland, it is clear from this paper that there is a need for improved data collection and research. This requires a systematic, objective, co-ordinated, accessible and inclusive approach to the collection, analysis and use of health and related data. In order to evaluate changes in health inequalities and inequities it should be possible to disaggregate routinely collected data on health, healthcare, and determinants of health by factors that reflect relative social advantage and disadvantage. Support needs to be given to the development of a range of methodologies to improve our understanding of health and health issues to ensure that measures used and data collected are inclusive, appropriate and meaningful. This should be a central part of the Research and Development functions of the Department of Health and Children and the health services.

Action 18 of the Health Strategy 2001 describes: “A key deliverable is the putting in place of indicator and research data to monitor and evaluate the NAPS health targets”.

### Concluding observations

The mission of the Alliance is to work together for a healthier society by improving health and challenging health inequalities. The Council of the Public Health Alliance Ireland believes that the fact that some Irish people have fewer opportunities to live healthier and longer lives than others, is unjust and unnecessary. We hope that documenting these injustices will mobilise action and contribute to working for a fairer, healthier Ireland.

### Next Steps for the Alliance

- Publish and disseminate paper widely
- Host seminars for members and interested people on the paper
- Demonstrate ways it can be used as a tool for action on health inequalities
- Develop more specific papers on themes and necessary responses.

**“Any state that is based on economics alone is a prison house. What a state needs is imagination” (WB Yeats, 1904).**

# GLOSSARY

## Consistent poverty

Consistent poverty is defined as being below 50-60% of average disposable income and experiencing enforced basic deprivation. Basic deprivation refers to a set of eight indicators, which were regarded as necessities and possessed by a majority of those in the Living in Ireland Survey conducted by the Economic and Social Research Institute. Consistent poverty is used by government as the measurement for the global poverty target.

## Community development

Community development is about people working collectively for social change which will improve the quality of their lives, the communities in which they live or the society of which they are part. It is about enabling and empowering those who are disadvantaged to identify and articulate need, to participate in working for change and to influence decision making structures that affect them, their communities and wider society.

## Determinants of health

This is the term used to describe the major factors which influence the health of a population.

## Directly standardised rate ratio (DSRR)

Directly standardised rate ratio is a measure which allows the comparison of death rates between groups, for example between social classes or areas. The comparisons used in this report compare death rates (standardised for age) of the lowest socio-economic group with those for the highest socio-economic group.

## Equality

Equality of access, participation and outcomes refers to achieving overall equality between marginalised and non-marginalised groups in terms of access to and distribution of economic, educational, health, cultural, political and other benefits (NESF, 1996).

## Equity

The word equity relates to the concept of fairness. In WHO terms equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that none should be disadvantaged from achieving this potential, if it can be avoided. Based on this definition, the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level and quality of health but rather to reduce or eliminate those which result from factors that are considered to be both avoidable and unfair.

Whitehead (1992), an international expert on the issue, defines Equity in Health Care as:

- Equal access to available care for equal need (in the Irish system this means equal access to public services for equal need)

- Equal utilisation for equal need (in practice this would mean monitoring of uptake and supportive action where uptake is noticeably unequal)
- Equal quality of care for all (in the Irish system this means in public facilities i.e. public and private patients in public hospitals).

## Health

“Various definitions of health have been developed over the years that focus on the notion of health as a positive concept rather than merely the absence of disease. Health is now regarded as a resource to be protected and developed so as to enable people to attain their maximum physical and mental capacity” (Department of Health and Children, 2000: 5).

## Health Impact Assessment

Health Impact Assessment (HIA) is an approach by which a policy, programme or project can be judged for its impact on health. As HIA is a method for addressing inequalities in health, achieving equity is a core component of HIA.

## Health inequalities

Health inequalities are differences in health experiences and health outcomes between groups of people according to socio-economic status, geographical area, age, disability, gender and ethnic group. These inequalities may be considered as inequities if they are considered unjust: this implies they are unacceptable and potentially avoidable. Inequities describe differences in opportunity for different population groups which result in unequal life chances, and disparities in access to nutritious food, adequate housing, health services etc. Health inequities can lead to health inequalities (Department of Health, 2003).

## Health and Personal Social Services

This refers to the health and personal social services within the remit of the Department of Health and Children. Health services include those directed at health promotion, disease prevention, treatment (including of chronic conditions) and rehabilitation. Personal Social Services refer to services such as social work services, family support, home helps, meals on wheels and day care services.

## Inequality in health status

This is the term used to describe differences in health. Outcomes attributable to differences between groups in the population that are inequitable, such as differences in socio-economic status or race.

## Life expectancy

The average number of years an individual of a given age is expected to live if current mortality rates continue to apply.

## Mortality (or death) rate ratio

This is the ratio of the death rate for one group compared to the death rate for another group.

### **Multi sectoral working**

Multi sectoral working is a term used to describe working across a range of sectors and disciplines.

### **Perinatal mortality rate**

Perinatal deaths refer to stillbirths plus deaths of live born infants aged under one week.

### **Poverty**

People are living in poverty, if their income and resources (material, cultural and social) are so inadequate as to preclude them from having a standard of living that is regarded as acceptable by Irish society generally. As a result of inadequate income and resources people may be excluded and marginalised from participating in activities which are considered the norm for other people in society (Department of Social, Community and Family Affairs 2001a).

### **Poverty Line**

Usually measured by household income. Households with incomes below half the average for all households, adjusted for size and composition, are deemed to be poor. This is a relative poverty line.

### **Primary care**

Primary care is an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being.

### **Primary Health Care**

Primary health care means all the supports and health and personal social services required to promote health, prevent, diagnose and treat illness. It includes GP and public health nursing services at its core, and a range of other services - therapy services (e.g. physiotherapy, occupational, speech and language), psychology, counselling, social work, community pharmacy, drug treatment services, community drugs workers, community welfare officers, health promotion officers and community development workers. Primary health care also includes dental, aural and ophthalmic services. International evidence strongly suggests that team work among the above disciplines is the most effective way to deliver primary health care.

A distinction is sometimes made between primary health care as a community-based participatory approach and primary or medical care as a professional model. In the context of a partnership approach the term primary health care is being used here to denote an inclusive approach which encompasses both. It is recognised that community participation is key to the success of primary health care.



### **Relative Poverty**

Having an income substantially below the average for that society and too low to secure a standard of living regarded as decent and acceptable by the society in which one lives.

### **Relevant sectors**

Relevant sectors refers to all sectors whose role impacts upon health. These include all those outlined in Section 6.1. It also refers to statutory, non-statutory, community, voluntary, public and private sectors.

### **Social exclusion**

“Social exclusion is cumulative marginalisation from production (unemployment), from consumption (poverty), from social networks (community, family and neighbours), from decision making and from an adequate quality of life” (Partnership for Inclusion, Employment and Competitiveness, 1996: 187).

### **Socio-economic group**

Socio-economic groups are used to classify people according to their occupation, employment status and also their life-styles in terms of social, cultural and leisure behaviour. It is an aggregate concept based on both resources (material as well as social) and prestige.

### **Social gradient**

Social gradient is the term used to describe the fact that health improves continuously as one moves up in social status whether in terms of education, income or wealth.

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