

# Setting health targets for poverty strategies

A background research paper

Prepared By  
Sara Burke  
for

The Institute of Public Health in Ireland

January 2001

Published by The Institute of Public Health in Ireland

© The Institute of Public Health in Ireland, 2001.  
Reproduction authorised for non-commercial purposes provided the source is acknowledged.

ISBN 0-9540010-1-X

For further copies of the framework please contact:

The Institute of Public Health  
6 Kildare Street  
Dublin 2

Tel: 00 353 1 662 9287

Fax: 00 353 1 662 9286

Email: [iph@RCPI.ie](mailto:iph@RCPI.ie)

Also contactable at Belfast: 00 44 28 9079 3050

# CONTENTS

Introduction .....	
Background and policy context .....	
Exploration of the concepts of poverty and social exclusion.....	
Health, inequalities in health and their determinants .....	
Appendix A.....	
Bibliography .....	

# Introduction

## Purpose of paper

The Institute of Public Health in Ireland was asked to prepare a background research paper to provide the context and relevant information for the Working Group on the National Anti-Poverty Strategy (NAPS) and Health<sup>1</sup>.

## This paper shall:

- 1 State the policy context and background to the establishment of the Working Groups
- 2 Explore the concepts of poverty and social exclusion and outline the differences between them
- 3 Provide an overview of the relevant issues in relation to health, inequalities in health and the social determinants of health<sup>2</sup>
- 4 Outline the national and international experience of setting targets

## 1 Background and policy context

The NAPS was published in 1997. It originated from a government commitment to the development of an anti-poverty strategy at the UN World Summit in Copenhagen in 1995. The NAPS set a ten year programme for poverty reduction and outlined five areas of focus. These areas were income adequacy, unemployment, educational disadvantage, urban concentrations of poverty and rural poverty. The NAPS set an overall global poverty reduction target, alongside five other targets in the above areas (Government of Ireland, 1997).

While health issues were outlined in the NAPS, no specific health targets were set. However, the NAPS did oblige all government departments to take the reduction of poverty into account in their strategic planning process and poverty proofing was introduced across all government policies. Under the Programme for Prosperity and Fairness (PPF), the NAPS will be updated and new targets will be set in 'health' and 'housing/accommodation', while targets in the other areas are being revised (Government of Ireland, 2000a). Poverty proofing is to be extended in a phased manner at local level through Local Authorities and Health Boards. These developments are taking place in the context of the National Development Plan 2000-2006 (Government of Ireland, 1999).

---

<sup>1</sup> See appendix A for the role, composition and terms of reference of the Working Group.

<sup>2</sup> It is technically more accurate to refer to the major factors influencing health although the term 'determinants' is now commonly used.

As the current National Health Strategy is being reviewed and a new one developed in 2001, it is an appropriate time to address inequalities in health and access to healthcare through the development of health targets for NAPS and a NAPS framework for the health sector.

The aim of NAPS health targets is to lead to a reduction in poverty and inequalities in health. Targets are being set in particular areas, in this instance health, in order to add value to the global poverty reduction target and to the poverty proofing process.

Short, medium and long term targets are to be set/revised and indicators identified so as to ensure that these targets can be measured, monitored and reviewed.

In order to develop health targets for NAPS, it is necessary to understand what determines poverty, health and inequalities in health. It is also necessary to have knowledge of and to develop feasible and effective policies and programmes that can address these complex issues.

## **2 Exploration of the concepts of poverty and social exclusion**

### **2.1 Poverty**

Opinions vary as to what poverty is and the extent of it in any country, therefore efforts to clearly define it and measure its extent are a very important contribution towards developing policies and strategies to prevent and ameliorate the causes and consequences of poverty. Townsend's definition, from his seminal work on poverty in the 1970s, has played a critical role in defining poverty:

"Individuals, families and groups in the population can be said to be in poverty when they lack the resources to obtain the type of diet, participate in the activities and have the living conditions and amenities which are customary, or at least widely encouraged, or approved of in societies to which they belong. Their resources are so seriously below those commanded by the average individual or family that they are in effect, excluded from ordinary living patterns, customs and activities." (Townsend, 1979: 31)

Using this definition, poverty is defined in relation to the prevailing societal norms and therefore is relative rather than absolute. One of the difficulties with such a definition is that societal norms vary within and between societies and over time.

Since Townsend's work, there has been much discussion as to the meaning of poverty, but there seems to be general acceptance of Piachaud's view that, "close to subsistence level there is indeed some absolute minimum necessary for

survival, but apart from this, any poverty standard must reflect prevailing social standards: it must be a relative standard." (Piachaud, 1987: 147)

The NAPS uses the following definition of poverty which reflects this relative approach to understanding 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."

(Ireland, 1997: 3)

## 2.2 Measuring Poverty

There are many different ways of measuring poverty and many different issues that need to be taken into account when doing so, such as the household size, income versus expenditure, before or after housing costs, the accounting period used.

Measuring poverty involves two separate elements: deciding on the indicator and deciding a standard to apply to that indicator. Sen has outlined the importance of differentiating between approaches which identify those whose actual consumption levels do not meet the minimum accepted level and those who do not have the ability to reach such levels (Sen, 1983). Atkinson makes a similar distinction between a concern with the accomplishment of a minimum standard of living and the rights of citizens to a minimum level of resources (Atkinson, 1987). Ringen has also made a distinction between poverty as deprivation and poverty as lack of resources (Ringen, 1988). Such differences are often confused in both the research and the literature on poverty, for example, poverty is often defined in terms of living standards but measured in terms of income or expenditure, each of which can be measured in different ways and therefore can produce different results.

Poverty in Ireland is currently measured by combining relative income measurements with non-monetary deprivation indicators<sup>3</sup>. When the NAPS was initiated, the baseline data utilised for target setting on the extent of poverty, came from the 1994 Living in Ireland Survey<sup>4</sup>.

---

<sup>3</sup> Non monetary deprivation indicators have been developed to identify households whose resources are limited so as to prevent them from having certain goods or participating in certain activities, e.g. a good winter coat, household durables or having a telephone.

<sup>4</sup> The Living in Ireland Survey surveys people who are in private household and therefore does not include people who do not live in private households such as hospitals, hostels or some members of the travelling community. There is a commitment in the PPF to improving the collection of data sources on excluded groups. (Ireland, 2000a)

The global poverty target set in the NAPS, in 1997, aimed at

**considerably reducing the numbers of those who are consistently poor from 9%-15% to less than 5%-10% by 2007.**

Data gathered in 1997, which became available in 1999, demonstrated that the original global target had been almost achieved even before it was set. During this time there was significant reductions in the levels of deprivation. There were also reductions in the combined measurement of those experiencing basic deprivation and the percentage of those below the 60% poverty line, from 15% to 10%, and for those experiencing basic deprivation and below the 50% line, from 9% to 7%. However, poverty measures taking into account how far incomes fell below the poverty line rose sharply, demonstrating an increase in the extent of poverty for those below the poverty line. And while deprivation levels fell overall, they fell much more rapidly for non-poor households, therefore the disparity between poor and non-poor households increased dramatically (Callan, 1999).

## 2.3 Social Exclusion

"Social exclusion is a broader concept than poverty, encompassing not only low material means, but the ability to participate effectively in economic, social, political and cultural life and in some characterisations, alienation and distance from mainstream society." (Duffy, 1995: 8)

The term 'les exclus' is thought to have originated in France in the 1960s and was used to refer to those who fell through the social welfare net. Since then it has entered the European and national policy and political landscape (Room, 1995).

In Ireland, the term has become widely used since the late 1990s. The increase of its use in the Irish national policy arena can be demonstrated by a comparison of the two most recent national development plans. The 1994 National Development Plan has few mentions of the term social inclusion or exclusion, whereas the most recent plan, 2000- 2006, has a whole chapter dedicated to social inclusion. The Programme for Prosperity and Fairness goes a step further by dedicating an entire framework to social inclusion and equality (Government of Ireland, 1993, 1999, 2000a).

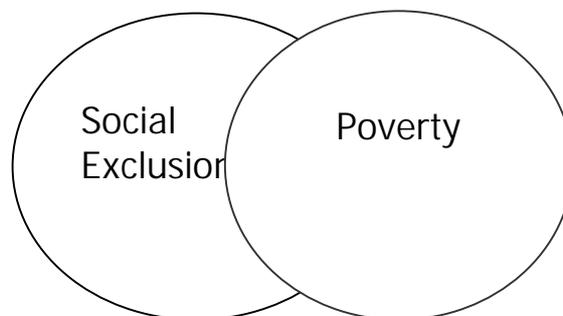
Both use the Partnership 2000 definition of social exclusion which is "social exclusion as cumulative marginalisation from production (unemployment), from consumption (poverty), from social networks (community, family and neighbours), from decision making and from an adequate quality of life." (Government of Ireland, 1996: 187)

The Department of Social, Community and Family Affairs is the lead government department in relation to NAPS and policies to combat social exclusion in Ireland. However, responsibility for the NAPS and social exclusion ultimately lies with the Cabinet Sub-Committee on Social Inclusion.

## 2.4 What is the difference between poverty and social exclusion?

The concepts of poverty and social exclusion differ in their intellectual and cultural heritages. Poverty is rooted in the liberal tradition of Anglo-Saxon societies, that material resources are necessary to participate in society while social exclusion reflects the social democratic legacies of continental Europe, the denial of the civil, political and social rights of citizenship (Room, 1995).

There is also a difference in their meaning. One can be poor without being socially excluded and one can be socially excluded without being poor, e.g. one can be poor and still be included in society and one can be wealthy but experiencing exclusion due to one's sexuality, race, health status or geographical location (Atkinson, 1998). The concept of social exclusion has also introduced the idea of agency, that it is necessary to identify who is doing the excluding in order to promote inclusion (Atkinson, 1998).



Bergham suggests that the new concept seemed to refer to a more dynamic aspect of poverty and less to the pure income dimension of poverty, "social exclusion has two distinct connotations: its comprehensiveness and its dynamic character, which make it difficult but useful." (Bergham in Room 1995: 16)

Poverty is often characterised as a state and social exclusion as a process. Gordon makes a useful contribution to the debate outlining how poverty can lead to deprivation which has an expanded range of outcomes and how deprivation can lead to social exclusion which also has an expanded range of outcomes, which can

be not just material based, but instead based on discrimination. (Gordon in Room, 1995)

Hills in an attempt to apply the European concept of social exclusion to Northern Ireland agrees that it provides us with a wider focus and a more dynamic framework (Hills, 1999).

This implies that in order to understand the experience and impact of exclusion, one must look at the breadth of the reasons for exclusion, the length of time experiencing it and the frequency of those experiences<sup>5</sup>.

While acknowledging a difference in origin and definition of these two terms, a look at their utilisation in the policy and political context in Ireland reveals these terms are often used interchangeably.

### **3 Health, inequalities in health and their determinants**

#### **3.1 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, 2000a:5)

Health is one of the most important of all our natural resources. The priority given to health was outlined in the health strategy ‘Shaping a Healthier Future’ (Department of Health and Children, 1994) which committed to improving the health of the population and increasing social equity in health. One of the difficulties with such commitments is that achievement of one does not necessarily lead to the achievement of the other (Klein, 2000).

A wide range of qualitative and quantitative methodologies have been developed to measure health including mortality and morbidity data, patterns of lifestyle and behaviour, self reported illnesses, Disability Adjusted Life Years, etc.

---

<sup>5</sup> Hobcraft, using the National Child Development Study 1958 cohort in the UK, carefully controlled for a broad range of factors which influence the relationship between childhood experience, adult outcomes and the intergenerational transmission of social exclusion, found that experience of social exclusion can continue long into the future, thus supporting the dynamic nature of social exclusion. He also found that short term improvements can have long term effects and while many people continue to experience social exclusion, many do not and move on.

Measurements of health are much contested in relation to what they are actually measuring. They are often measurements of sickness or death. The issue is further complicated by the fact that notions of what is health and good health vary within and between societies.

Many of these measurements demonstrate a persistent social gradient for numerous health and lifestyle measures. The social gradient describes a continuous decline in health as one moves down the socio-economic scale and vice versa. Marmot's famous study of Whitehall civil servants showed how more junior staff experienced more disease and earlier death than more senior staff and that this persisted across the occupational hierarchy, i.e. the higher the occupational status of the men, the better their health and vice versa. This had been shown to be true in many national and international studies (Marmot, 1984, Davey Smith et al, 1996, 1997, O'Shea, 1997, Institute of Public Health, 2001).

### **3.2 Inequalities in health**

Inequalities in health can exist for a whole range of reasons such as geographical location, sex and gender<sup>6</sup>, age, ethnicity, hereditary factors and socio-economic status. Much of the focus on inequalities in health is on disparities in health which originate from socio-economic factors.

The issues of socio-economic inequalities in health came to international prominence in Britain in 1980 with the publication of The Black Report, which outlined the growing divergence in health status between different socio-economic groups. Irish analysis of data shows similar trends, with those in higher socio-economic groups experiencing better health and longer life expectancy. Poor people are more likely to experience ill health and to die younger (Nolan, 2000). Some of these differences are outlined below in sections 3.4, 3.5, 3.6 and 3.7.

As the Chief Medical Officer commented in his 1999 Annual report, "inequalities in health status between socio-economic groups have been demonstrated in this country and are persisting. The factors involved in the relationship between ill health and socio-economic background are very complex and hard to unravel." (Department of health and Children, 2000a: 30)

As outlined in the next section, inequalities in health occur for a whole range of reasons. What is of most concern are inequalities in health status and access to health services which are unjust and unnecessary. These are usually referred to as inequities in health, that is inequalities in health that can be remedied. The challenge for public policy and health policy makers is to develop public policies which positively impact on health and more equitable access to health services.

---

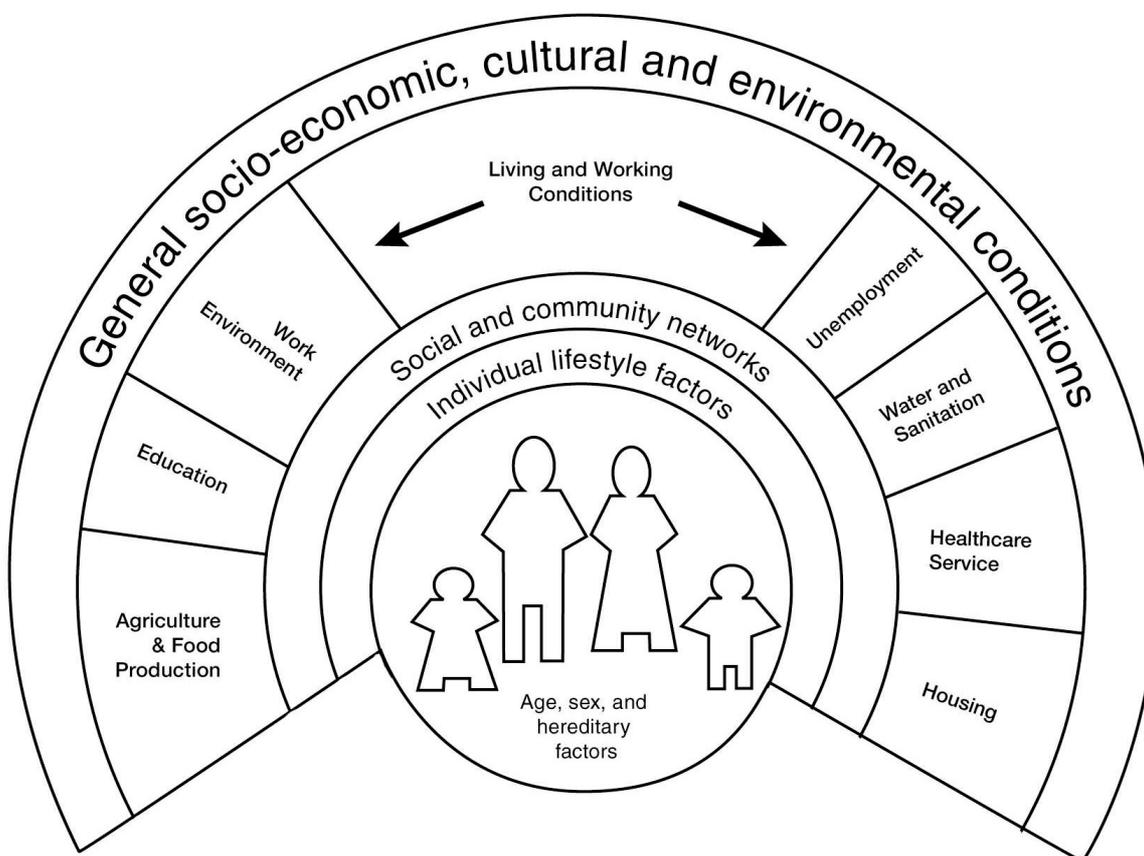
<sup>6</sup> For example, in Ireland, in 1995, life expectancy at birth for men was 73 years and for women was 78.6 years.

### 3.3 Factors determining health and inequalities in health

There is a growing body of knowledge, as to what determines health and inequalities in health and how these determinants can be impacted upon so as to improve health.

Many models of what determines health and inequalities in health have been developed. Different models can have different uses. The research community continues to develop models to help define the complex pathways by which different factors influence health. The model below by Dahlgren and Whitehead is one such model (1991).

#### Model of determinants of health



One of the most acknowledged factors affecting health and inequalities in health is socio-economic factors. There is also a growing body of international evidence in relation to the healthiest nations not being the richest nations but the nations where there is the smallest gap between the rich and the poor (Wilkinson, 1996). Such evidence is particularly relevant in Ireland given our recent economic growth and evidence of an escalating gap between the rich and the poor. See section 2.1. There is also an increasing interest in the influence of social supports on health (Kawachi, 1996).

Pinpointing the pathways which determine health and inequalities in health has proved a very challenging undertaking globally. In Ireland, the scarcity of data on these issues makes this task even more difficult. Nolan, who has done analysis in the Irish context on this matter, acknowledges the complex and dynamic causal processes which are at work, with health affecting socio-economic status as well as vice versa, but concludes the relationship between material deprivation and health outcomes appears to be crucial (Nolan, 1997).

The 1999 report of the Chief Medical Officer outlines some of these complex factors involved in the relationship between socio-economic status and ill-health as:

- health related behaviour and biological risk factors
- material conditions such as unemployment, lack of access to adequate housing, poor transport
- low educational attainment
- factors operating in early life: genetic, biological, early life experiences
- psycho-social factors such as poor support networks, lack of control over working lives
- inadequate medical care

It concludes that such inequalities result from an interplay of genetic, biological, social, environmental, cultural and behavioural factors (Department of Health and Children, 2000a).

The Institute of Public Health comments that socio-economic inequalities are a serious barrier to improving health in Ireland. Not only is there a wide gap between the rich and poor, but a gradient in health runs across the social spectrum. Increasingly research suggests people's social and psychosocial circumstances impact on health in the long term. Research in Ireland has shown that health inequalities are linked to deprivation. (Institute of Public Health, 1999)

The breadth and complexities of factors which determine health and inequalities in health illustrate the multitude of sectors with whom it is necessary to work if these issues are to be addressed. Two recent reports<sup>7</sup> from the DHC have advocated the introduction of Health Impact Assessment (HIA). HIA is a way of assessing the impact of significant policies on health and can be used as a mechanism of ensuring the policies lead to a reduction of inequalities in health. The proposed new European Public Health Programme recommends the development of mechanisms to assess the health impact of policies and activities. (European Commission, 2000)

### 3.4 Mortality

---

<sup>7</sup> The 1999 Report of the Chief Medical Officer and the National Health Promotion Strategy 2000.

In Ireland, there has been a steady reduction in mortality rates over the past 50 years. From 1950 to 1995, life expectancy at birth for men increased by 8.5 years and for women by 11.5 years. However, in 1995, Ireland still had one of the lowest life expectancies of all fifteen EU countries at the age of 65 for both men and women. Ireland also has a premature death rate (0-64 years) amongst the highest in Europe. Premature death rates are considered one of the more effective measures of inequalities in health between countries (Department of Health and Children, 1999c, 2000a).

Comparisons across countries are fraught with difficulty due to differences in classifications of occupations and socio-economic positions, however the patterns in Ireland broadly reflect those in England and Wales, with if anything a wider differential between professional/managerial and unskilled manual socio-economic groups emerging in Ireland (Nolan, 1994a).

There is little information on differences in mortality by socio-economic group in Ireland, however the analysis that has been carried out consistently shows that men in lower socio-economic groups have higher mortality rates than men in higher socio-economic groups<sup>8</sup> (O'Shea, 1997).

Figures for the period 1989-1998, show that the age standardised death rates for men in the lowest socio-economic grouping was 792.4 per 100,000, per year compared to 232.2 per 100,000, per year for men in the highest socio-economic grouping, a 3.4 fold difference (Institute of Public Health, 2001).

Infant mortality rates are also often used as an indicator of health inequalities within and between countries. Data from the perinatal reporting system for the years 1984-88, showed significant effects of socio-economic background, as well as mother's age and previous number of births, on both the risk of perinatal mortality and low birth weight. The risk of these was found to be highest when the father is an unskilled manual worker or unemployed (Nolan, 1994b).

A number of groups experience particular disadvantage in health, for example, the Travellers Health Status Study found that life expectancy for traveller men at birth was 9.9 years less than for settled men and 11.9 years less for traveller women than for settled women. Perinatal mortality among unhoused Dublin travellers was three times the national average (Barry et al, 1989).

Research carried out in the Eastern Regional Health Authority shows the health status of the adult homeless population to be well below the population average and they experience huge difficulty in accessing the health services they require (Holohan, 2000).

---

<sup>8</sup> There are still many difficulties in estimating women's socio-economic status as they are usually categorised according to their husbands status, which is an increasingly unreliable indicator. Due to the limited information on women and older people, it is often only data on men of working age that is analysed for such purposes.

Areas with very high levels of deprivation have been identified using deprivation indices. These areas contain residents with higher mortality rates and incidences of low birth weight babies than residents living in other areas (Kelly, 1997).

### **3.5 Morbidity**

While we are living longer, many of our extra years are not healthy (Department of Health and Children, 2000a: 18). Information about non-fatal but chronic disabling illnesses can be gained from a variety of sources; hospital admissions; disease notifications; special registers of illness and disability, and health and lifestyle surveys. All of these, apart from the latter depend on contact with the health service and are therefore often more of an indicator of health service utilisation rather than the degree of sickness.

People from lower socio-economic groups are likely to experience poorer health. The percentage of adults reporting a long standing illness in 1987 was twice as high for the unskilled manual as for the professional and managerial classes (Nolan, 1994a). More recently, in 1999, another ESRI study showed once again that different aspects of health status vary across occupational groups (Nolan, 2000b).

There is increasingly an emphasis on health and public health data sources which should lead to a more effective analysis of variations in health status and risk factors. The Public Health Information Systems in each health board area and the forthcoming Health Information Strategy should greatly enhance such developments.

Internationally, many methods have been developed to measure the quality of life of additional years gained through increases in life expectancy, even if they are not healthy years. Work is ongoing at the WHO and OECD on the development of measurements such as Disability Adjusted Life Years (DALYs) and Health Adjusted Life Expectancy (HALEs). While there has been much controversy in relation to their development and use, such types of measures can be useful in comparing health and social gain between and within populations. The development of new methods is in progress in the health and economic research communities.

### **3.6 Health behaviour**

The findings from the first National Health and Lifestyle Survey, SLAN, 1999<sup>9</sup>, show those in lower socio-economic groups have significantly less healthy

---

<sup>9</sup> A detailed analysis of the results is in The National Health and Lifestyle Survey, SLAN, 1999. Some relevant facts include: 4 out of 20 adults engage in regular physical exercise on a weekly basis; 3 in 10 people are regular or occasional smokers with slightly more males than females smoking; 27% of males and 21% of

lifestyles than those in higher socio-economic groups. These figures greatly enhance our ability to monitor patterns of lifestyle and behaviour. As many of the main causes of premature death are now preventable through changes in lifestyle and behaviour, this information is particularly valuable. There is a growing body of knowledge on how health behaviour is directly enhanced and inhibited by social and economic circumstances. Such evidence highlights the need to address the underlying socio-economic and environmental factors which directly impact on lifestyle and behavioural patterns (Marmot, 1999).

37% of unskilled manual workers are smokers compared to 24% of non-manual workers. 70% of those in Social Class (SC) 1&2 consumed the recommended daily intake of four or more fruit and vegetables per day compared to 59% in SC5&6. Body Mass Index was lower in professional and non-manual classes than in manual classes. Prevalence of raised blood pressure was lowest in SC1 and highest in SC6.

### **3.7 Impact of ill health on poverty**

People who experience ill health and disability are more at risk of poverty and social exclusion. As outlined in the Operational Plan for the National Development Plan, 2000.

“Apart from unemployment, illness is one of the major contributory factors to poverty. In the case of serious illness, a person’s ability to maximise his or her employment opportunities and to be financially independent can be severely affected. In less severe cases, the significant cost of obtaining treatment for illness can reduce the standard of living in a household. The economic costs of illness cannot be measured alone at household level, where an entire family can bear the consequences of the illness of a single person, but at macro economic level where illness curtails overall economic potential.” (Government of Ireland, 2001:111)

Recent evidence shows that people with a disability/illness have a 56.5% risk of falling below the 50% relative income poverty line. Only the unemployed have a higher risk of poverty (Callan et al. 1999).

While evidence is lacking to demonstrate a direct chain of causation between ill health and poverty, there is an increasing awareness of the negative impact of ill health and disability on participation in society and of associated policies and programmes to address such exclusion.

Although access to health services is not a primary determinant of inequalities in health, it may be a component of these determinants, particularly for those who experience this double disadvantage in health. For example, if someone is

---

females consume more than the recommended weekly intake for alcohol; 58% of respondents classified themselves as overweight and 10% as obese.

experiencing ill health and is denied access to the services they need, it is likely that their position will deteriorate or certainly not improve and could lead to further exclusion in social and economic terms.

It is also pertinent given recent advances in disease treatment for some of the major causes of death in men (coronary heart disease) and women (breast cancer) which have contributed to declining levels of mortality from such diseases. The inequitable delivery of health care for these and other conditions could contribute importantly to socio-economic differentials and a widening mortality gap between socio-economic groups (Davey Smith et al, 2000).

### **3.8 Access to health care services**

Equity of access to services encompasses a range of issues, e.g. geographical access, barriers to access including charges, rural and urban issues, experiences of particular populations e.g. travellers, ethnic minorities, the elderly, the homeless etc., quality of service and outcomes. There is a growing body of knowledge demonstrating inequality of access to health care services in Ireland. Inequalities in access can range across the health spectrum, from access to primary care and preventative services to access to hospital beds and long term care.

Recent evidence shows variations in the provision of diagnostic, therapeutic and rehabilitation services for coronary heart disease in favour of the better off (Department of Health and Children, 1999a). A recent study which looked at the experience of waiting times for hospital services, found variations depending on whether people had private insurance or not. These results demonstrate how complex the situation is. For example, of those interviewed who had an inpatient stay, 58% of those with private insurance did not have to wait for an admission while 69% of those without insurance did not have to wait<sup>10</sup>. With regard to day surgery, 33% of the insured compared to 43% of the uninsured had to go on a waiting list. There are variations between waiting times for different types of treatment, which are not always consistent with insurance status (Nolan et al., 2000b). For some types of treatment those with insurance had to wait longer, while for other types, the uninsured had to wait longer.

Reliable anecdotal evidence also suggests that in some cases public patients have longer waiting times for some hospital services than those with health insurance. As outlined in sections 3.4, 3.5 and 3.6, those from lower socio-economic groups have poorer health and, as detailed above, can experience poorer access to health services, thus experiencing a double disadvantage in health. Despite current policy in relation to equity of access on the basis of need, inequalities in access remain and persist and are one of the greatest challenges to be addressed within the health system.

---

<sup>10</sup> This may reflect a greater probability of being admitted through A&E for the latter on the basis of their older age profile and morbidity levels.

The structure and design of the health services must take into account the marked differences across socio-economic groups in health status and life expectancy and target care where it is most needed. However, as health inequalities reflect wider inequalities in material circumstances, alleviating poverty and reducing inequalities in income, wealth and education may be the most effective way of narrowing the gap in health and life expectancy (Nolan, 1997).

## **4 The national and international experience of setting targets**

“There is an art as well as a science to target setting” (Whitehead et al., 1998:1279)

### **4.1 Target setting and the NAPS**

“Target setting...is arguably the single most important element of the NAPS, as in aiming to meet these targets, the Government ensures that the policy framework and the specific policies are adapted accordingly” (Government of Ireland, 2000b: 62)

Target setting, achieving and revising is one of the main achievements of the NAPS. NAPS is to be reviewed and updated in 2001. The target setting exercises currently underway will feed into this review. The global target has been reset, the other five original targets are being revised and new targets are being set in the areas of health and housing/ accommodation (Combat Poverty Agency, 2000, National Economic and Social Forum, 2000).

The role of the NAPS targets is to have focus for action in some key priority areas, which lead to a reduction in poverty and to add value to the poverty proofing process. Short, medium and long term targets are to be set/revised and indicators identified so as to ensure that these targets can be measured, monitored, reviewed and achieved. Particular attention needs to be paid to child poverty, women's poverty and older people.

Health targets for the NAPS specifically aim to achieve a reduction in poverty and inequalities in health. In order to develop targets to reduce poverty and inequalities in health, it is desirable to consider what determines poverty, health and the growing inequalities between sections of the population. (See Terms of Reference in Appendix A.)

## 4.2 What happened to the original NAPS targets and what can be learnt from them?

An initial assessment of the NAPS up to 1999 was carried out by the Combat Poverty Agency. The following achievements and lessons were outlined:

- The global target has been achieved and re-set to reduce by half the numbers experiencing consistent poverty from 10% in 1997 to 5% in 2004.
- The unemployment target has been achieved and re-set to be below 5% by 2002 and long term unemployment to be 2.5% by 2002.
- The educational target which was set in relation to the junior and leaving certificate achievements needs to be reviewed and to take into account other forms of training and the concept of life long learning. New ones are to be developed.
- The income adequacy target restated the global target and made some recommendations in relation to minimum standards as set out in the Commission on Social Welfare. Issues in relation to low pay and linking social welfare rates to earnings rather than prices are to be explored. The “increase in inequalities in income would suggest the need for a stand alone relative income poverty target in addition to the global target”. (Combat Poverty Agency, 2000: 61) The bench marking and indexation Working Group is dealing with these issues.
- The urban disadvantage and rural poverty targets are to be revised and re-set.
- New targets are to be set in the areas of health and housing/accommodation.
- Special attention is to be paid to child poverty, women’s poverty, older people, asylum seekers and refugees.
- The process by which targets are set or reviewed is crucial.
- Government departments need to be central to the target setting process, as it is they who will “ultimately deliver measures by which to achieve targets” (Combat Poverty Agency, 2000: 61).
- “Thought needs to be given as to which policies require to be put in place to work towards the achievement of targets and what barriers need to be overcome. Cross-departmental working would seem to be important in this regard.” (Combat Poverty Agency, 2000:61).
- The timeframe within which targets are set needs to be considered. Originally, it was set within a ten year frame, which is a logical timeframe in relation to a complex issue like poverty. However, this cannot take into consideration rapid economic and social progress, like that recently experienced by Ireland and therefore the 3 to 7 year time frameworks may be more appropriate.
- Progress in meeting targets needs to be monitored on a regular basis. Therefore a system of indicators is needed to assess such progress. Such monitoring requires good quality data and analysis on an ongoing basis. Exploitation of secondary sources needs to take place.
- “There is a need to ensure that the achievement of targets will lead to poverty reduction, therefore all subsidiary targets must be linked to the global targets” (Combat Poverty Agency, 2000: 62).

- “There needs to be a more systematic review of the application of the principles” which underlie the targets and NAPS. (Combat Poverty Agency, 2000: 62).

### 4.3 The experience of setting health targets

A review of the literature on the international and national experience of setting targets for health yielded a variety of results, with three main types of targets emerging:

- global aspirational targets, e.g. World Health Organisation Health For All targets
- national and regional targets which are disease or area specific, e.g. reduction in the number of smokers, increase in the rates of breast feeding or uptake of screening and immunisation services
- targets which aim to improve the health of the worst off and narrow the health gap, e.g. the Swedish Public Health Policy.

The first Irish Health Promotion Strategy outlined the key components of target setting. “Targets are specific..... Targets assume the availability of reliable basic data, effective strategies to achieve change and means of measuring that change. Setting targets makes it possible to identify and quantify progress towards the achievement of goals. Targets need not be numerous nor elaborate to begin with but need to reflect key national priorities for a stated time period whose attainment is as measurable as available indicators permit.” (Department of Health, 1995: 17)

A review of health targets in Europe identified three levels of implementation:

- intentions are articulated at the political level
- a plan is developed at the political level
- the plan is implemented at a practical level

A widespread agreement emerged from the European review:

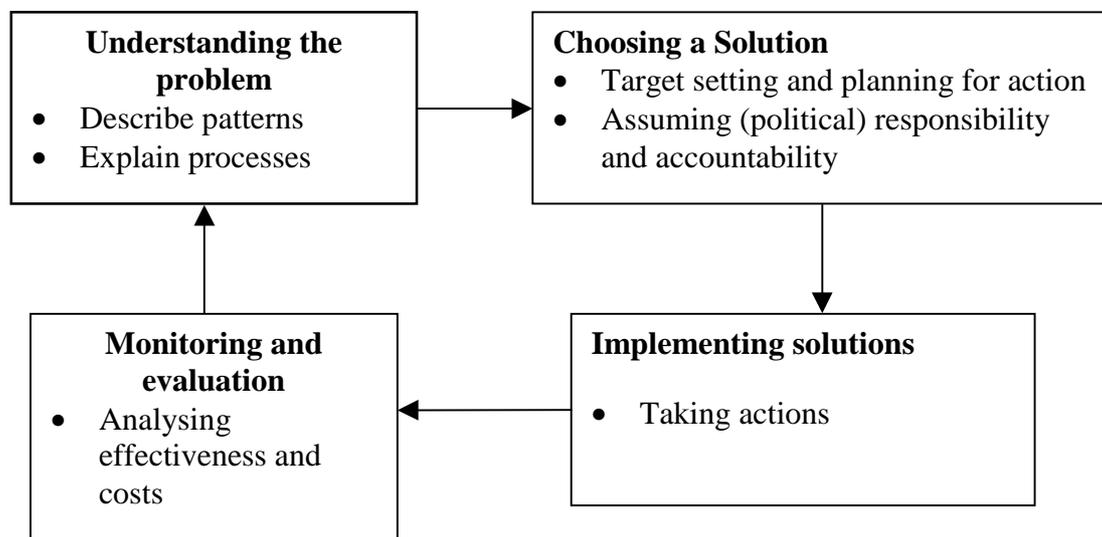
- a broad consensus needs to be developed among stakeholders
- targets need to be limited to a manageable number (the World Health Organisation's 21 is too big, most regional and national ones focus on 5 or 10)
- any plan should be based on evidence of effectiveness
- targets need to be linked to resources.

“Once a target based strategy is agreed, technical challenges remain. Target setting requires an understanding of the current pattern of health in a population. Designing and implementing policies to meet targets requires a high level of public health management skills. Monitoring progress requires knowledge of the natural history of diseases. A key question is how long it will take for new policies to take effect. For some risk factors changes now will affect disease only many

years later, as with smoking and lung cancer. Here process measures are more appropriate, such as changes in attitudes or behaviour. For others such as injuries the outcome is more immediate. The most important question is if target setting actually makes a difference to health. The answer seems to be “it depends”. There is no set model of a health policy based on targets, but if a country takes into account these processes of target setting, it can provide a more rational basis for health policy and begin to address problems that might otherwise be ignored.” (McKee, M. et al., 2000: 327)

#### 4.4 The Targeting cycle

Similar to any policy development process, target setting can be seen as a cyclical process.



Adapted by Layte from Van Herten, 2000

#### 4.5 Lessons from target setting

Despite the different types of targets set nationally and internationally, many commonalities in the analysis of target setting are evident. The criteria below were obtained from a variety of sources<sup>11</sup>. Some of these criteria may not necessarily be compatible with each other. However, the analysis of them can be divided into three sets of criteria necessary to ensure effective target setting:

- 1 General target setting criteria**
- 2 Criteria necessary for the process of target setting**
- 3 Criteria necessary for the achievement of targets**

<sup>11</sup> New Zealand Government, 1989; Benezeval, M. et al, 1994; Campbell, H. et al, 1994; Ireland, 1997; Cheng et al, 1997; Hoddinott, P, 1997; WHO, 1985, 1998; Whitehead, M. et al, 1998; Acheson et al, 1998; Van Herten et al, 1998, 1999; Social Exclusion Unit, 1999; Davis, R. 2000; Ireland, 2000a, CPA, 2000, McKee, M. et al, 2000; Middleton, J. 2000, Mendez, et al, 2000, Swedish Ministry for Health and Social Affairs, 2000; US Department of Health and Human Services, 2000.

### **General target setting criteria**

- target setting, implementing, monitoring, achieving, reviewing and revising are all part of the target setting process
- there needs to be greater involvement of the community and voluntary sector in target setting, achieving and revising
- there needs to be an appropriate consultation in target setting, achieving and revising
- there should be a greater emphasis on the link between poverty and inequality
- there is a need to ensure that the achievement of targets will lead to poverty reduction, therefore all auxiliary targets must be linked to the global targets
- few rather than many targets should be set
- aspirational targets are not necessarily measurable but can have great symbolic significance by enabling issues to gain recognition and legitimacy

### **Targets should be**

- specific, measurable, achievable, realistic and time bound (SMART)
- reviewed and if necessary reset regularly
- formulated in terms of the determinants of health
- based on historical trend data
- influencing policies not the outcomes of policies
- specify a levelling up not a levelling down, in order to avoid narrowing the health gap by bringing the health of the healthiest group down

### **Criteria necessary to the process of target setting**

- the process by which targets are set or reviewed is crucial
- government departments need to be central to the target setting process, as it is they who will ultimately lead on and/or deliver measures by which to achieve targets. They are also responsible for the resources allocated to achieve them.

### **Targets should be**

- established with public consultation
- developed by a broad consensus among stakeholders
- action and process oriented

### **Criteria necessary for the achievement of targets**

- institutions need to be designated responsibility for carrying out actions which shall lead to the achievement of specific targets

### **Targets should be**

- linked to resources
- related to actions known to be effective
- realistic but challenging/ambitious
- introduced at the right level
- politically supported and driven
- amenable to action that is largely under political control
- relevant to other policies and strategic objectives, so that their achievement does not become a diversion
- able to take account of differential cause and effect among various sections of society.

## 4.6 Conclusion

Developing health targets and an associated monitoring and implementation framework for the NAPS is both a challenge and an opportunity. In order to carry out this difficult task, many actions need to happen concurrently:

- learning from the national and international arena on the experience of setting targets
- developing a greater understanding of the multi-causal nature of and precise pathways leading to poverty and inequalities in health
- utilising a social model of health
- consultation and consensus building with stakeholders and citizens
- integrating action oriented equity targets into current public policy and strategic developments
- linking targets to resource allocation
- ensuring that measuring, monitoring and reviewing of targets is integral to the target setting process
- developing appropriate, motivating targets which will provide genuine help in achieving the desired objectives
- providing a vision of what needs to happen in order to achieve a reduction in poverty and inequalities in health.

The challenge and opportunity for the Working Group on NAPS and Health is to assist this process by identifying research and information deficits in Ireland, devising ways of overcoming these deficits and applying the existing knowledge to the development of health targets for the NAPS which will lead to a reduction in poverty and inequalities in health.

## Appendix A

### **The role of the WG is to:**

- 1 Develop health targets for the NAPS and a NAPS monitoring and implementation framework for the health sector
- 2 Make recommendations on these to the Department of Health and Children.

The Department of Health and Children will in turn put recommendations to the Inter Departmental Policy Committee, which feeds in to the Cabinet Sub-Committee on Social Inclusion. (See over for organigram of the process.) The Working Group is comprised of representatives from the Social Partners; Farmers, Unions, Community/Voluntary, Industry/Business; Government Departments; Health and Children, Finance, Education and Science, Social, Community and Family Affairs, Environment and Local Government, Trade, Enterprise and Employment, Justice, Equality and Law Reform, Taoiseach; health boards and health service providers; the Combat Poverty Agency and the Institute of Public Health in Ireland.

The Working Group is chaired by the Chief Medical Officer of the Department of Health and Children, Dr Jim Kiely. It was set up in Autumn 2000 and is due to complete its work by June 2001.

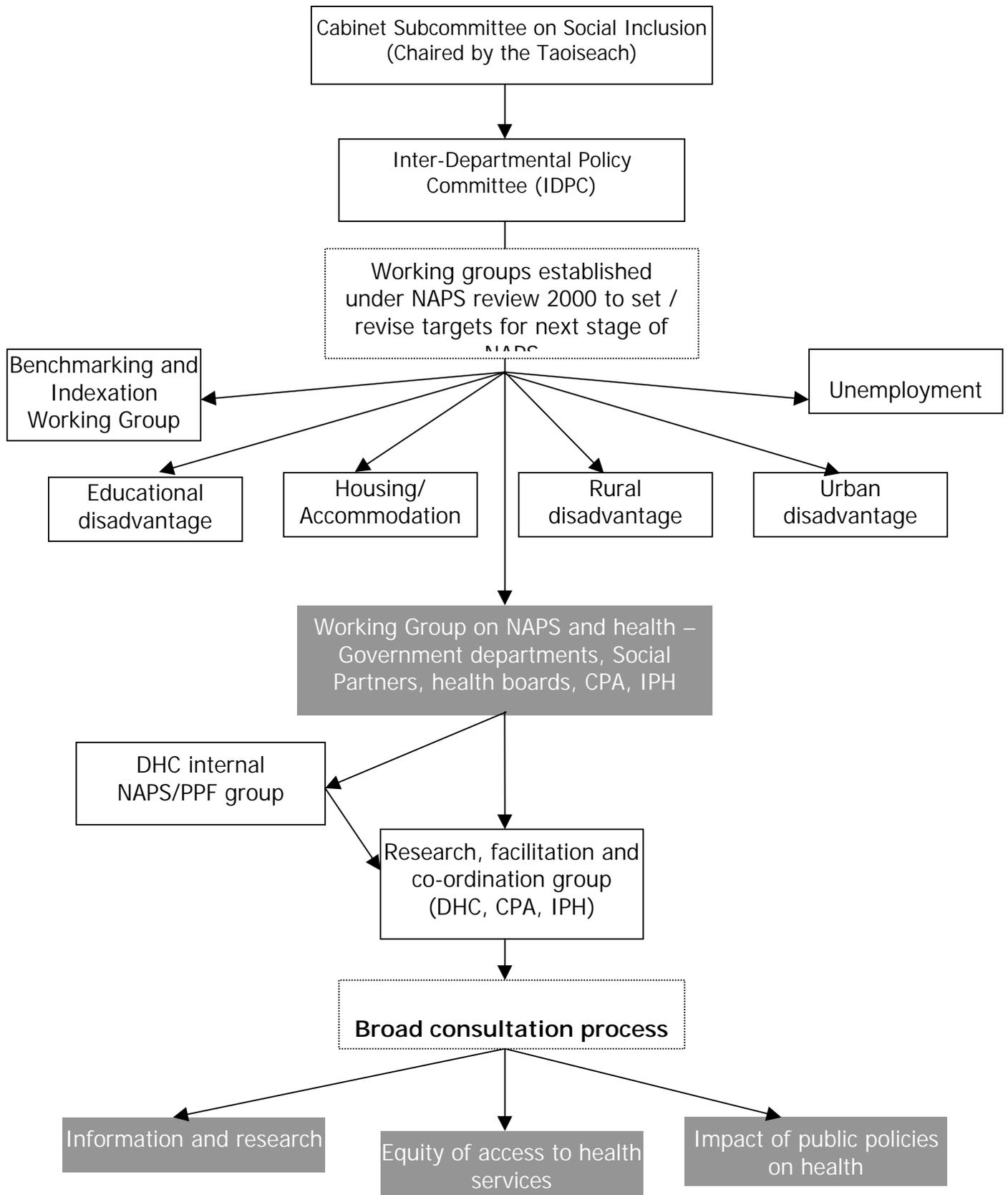
### **Terms of Reference for Working Group on NAPS and Health**

In accordance with a commitment given in the Programme for Prosperity and Fairness 2000, a Working Group on NAPS and Health has been established by the Department of Health and Children. Its remit is to develop health targets and an associated implementation and monitoring framework for the Department of Health and Children to submit to Government as part of the NAPS review. This exercise will be carried out within the general framework of the NAPS principles by:

- outlining the context of the relationship between poverty, social exclusion and health and the rationale for setting health targets that will lead to a reduction in poverty and health inequalities
- consultation and participation of the relevant sectors in the target setting process
- recommending short, medium and long term targets that are measurable and that can be incorporated into the next set of NAPS targets
- identifying strategies and actions/measures that contribute to the achievement of the targets
- identifying indicators that can be used to measure the progress and monitor the performance towards meeting the targets and recommending mechanisms for periodic review of the targets.

Particular attention will be paid to child poverty, women's poverty and older people.

## Organigram of the Working Group on NAPS and Health



## Bibliography

- Acheson, D. et al. *Independent Inquiry into Inequalities in Health Report*. London, The Stationary Office; 1998.
- Atkinson. A. *On the Measurement of Poverty*. Econometrica; 1987 55 (4), pp. 749-64.
- Atkinson. A. and Hills, J. *Exclusion, Employment and Opportunity*. CASEpaper/5. London. LSE; 1987.
- Barry, J., Herity, B, Solan, J. *The Travellers Health Status Study*. Dublin, Health Research Board; 1989.
- Benezeval, M., Judge, K, Whitehead, M. *Tackling Inequalities in Health: An Agenda for Action*. London, Kings Fund; 1994.
- Black, D. *Inequalities in health: The Black Report*. London, Penguin; 1982.
- Burchardt, T., Le Grand, J, Piachaud, D. *Social Exclusion In Britain, 1991-95*. Social Policy and Administration 1999 33(3): 227-244.
- Callan, T., Nolan, B. *Income Inequality and Poverty in Ireland*. In: J. H. Goldthorpe, Whelan,C.T. Cambridge, editors. *Changing Patterns in the Distribution of Economic Welfare: An International Perspective*.Cambridge University Press;1997.
- Callan, T., Nolan, B., Whelan, C.T. et al *Poverty in the 1990s*. Dublin, Oak Tree Press;1996.
- Callan, T., Layte, R et al. *Monitoring Poverty Trends*. Dublin, Stationary Office/ESRI; 1999.
- Campbell, H., Gibson, A. *Health targets in the NHS: lessons from experience with breast feeding targets in Scotland*. British Medical Journal 1997;314; 1030.
- Cheung, et al. *Are the Health of the Nation's targets attainable? Postal survey of general practitioners' views*, British Medical Journal 1997:314:1250.
- Central Statistics Office. *Population Census, 1996*. Dublin. Stationary Office; 1998
- Central Statistics Office. *That was then, this is now: Change in Ireland, 1949 - 1999*. Dublin, Stationary Office; 2000.
- Centre for Health Promotion Studies. *The National Health and Lifestyle Surveys (SLAN and HBSC)* National University of Ireland, Galway; 1999.
- Combat Poverty Agency (Ire). *Planning For a More Inclusive Society: An Initial Assessment of the National Anti-Poverty Strategy*. Dublin. CPA; 2000.
- Dahlgren G. Whitehad, M. *Policies and strategies to promote social equity in health*. Stockholm. Institute of Future Studies; 1991.
- Davey-Smith, G. *Income inequality and mortality*. British Medical Journal 1996 (312): 987- 988.

**Davey-Smith, G. et al.** *Lifetime socio-economic position and mortality: prospective observational study.* British Medical Journal 1997 314: 547-552.

**Davey-Smith, G.** *Rationing for health equity: is it necessary?* Health Economics 2000 (9) 575-579.

**Davis, R.,** *Healthy People 2010: objectives for the United States:* British Medical Journal 2000;320:818-819.

**Department of Health.** *Shaping a Healthier Future.* Dublin, Stationary Office; 1994.

**Department of Health.** *A Health Promotion Strategy...Making the healthier choice the easier choice.* Dublin, Hawkins House; 1995.

**Department of Health and Children.** *Building Healthier Hearts.* Dublin, Stationary Office; 1999a.

**Department of Health and Children.** *White Paper on Private Health Insurance.* Dublin, Stationary Office; 1999b.

**Department of Health and Children.** *Health Statistics 1999.* Dublin, Hawkins House; 1999c

**Department of Health and Children.** *Annual Report of the Chief Medical Officer, 1999.* Dublin, Hawkins House; 2000a.

**Department of Health and Children.** *The National Health Promotion Strategy 2000-2005.* Dublin, Hawkins House; 2000b.

**Department of Health, UK.** *Saving lives: our healthier nation.* London; 1999.

**Doorley, P.** *Measuring health. A Healthier Future.* E. McAuliffe, Joyce, L. Dublin, IPA; 1998.

**Duffy, K.** *Social exclusion and human dignity in Europe.* Strasbourg, Council of Europe.; 1995.

**Economic and Social Research Institute (ESRI).** *Living In Ireland Survey, 1997.* Dublin, Stationary Office; 1999.

**European Commission.** *On the State of Health in the European Union.* Brussels, European Commission; 1995.

**European Commission.** *Programme for Community Action in the field of Public Health (2001-2006)* Brussels, European Commission; 2000.

**Fahey, T.** *Social Inequities in health.* The Journal of Health Gain 1997 1(2): 9-10.

**Feinstein, J.** *The relationship between socio-economic status and health: a review of the literature.* The Millbank Quaterly 1993 71: 279- 321.

**Government of Ireland.** *Ireland National Development Plan 1994 - 1999.* Dublin, Stationary Office; 1993.

- Government of Ireland.** *Partnership for Inclusion, Employment and Competitiveness.* Dublin, Stationary Office; 1996.
- Government of Ireland.** *Sharing the Progress: National Anti-Poverty Strategy.* Dublin, Stationary Office; 1997.
- Government of Ireland.** *National Development Plan.* Dublin, Stationary Office; 1999.
- Government of Ireland.** *Programmes for Prosperity and Fairness.* Dublin, Stationary Office; 2000a.
- Government of Ireland.** *Social Inclusion Strategy, Annual report of the Inter-Departmental Policy Committee 1999/2000.* Dublin, Department of Social, Community and Family Affairs.
- Government of Ireland.** *Operational Plan for National Development Plan.* Dublin, Department of Environment and Local Government; 2001 forthcoming.
- Hills, J.** *Social Exclusion, Income Dynamics and Public Policy.* Belfast, Northern Ireland Economic Council; 1999.
- Hobcraft, J.** *Intergenerational and Life-Course Transmission of Social Exclusion: Influences of Childhood Poverty, Family Disruption, and Contact with the Police.* London. CASE; 1998.
- Holohan, T., Feeney, A., Magee, H.M., Shannon, W.** *Health of Hostel Dwelling Men in Dublin - perceived health status, lifestyle and healthcare utilisation of homeless men in South inner city Dublin hostels.* Dublin, Royal College of Surgeons of Ireland and Eastern Health Board; 1998.
- Hoddinott, P.** BMJ letter, 1997, 2 August; 315:313.
- Illsley, R., Le Grand, J in Williams, A.** *The measurement of inequality in health. Health and Economics.* London, Macmillan; 1987.
- Institute of Public Health in Ireland.** *Strategic Plan 2000-2003.* Dublin, IPH; 1999
- Institute of Public Health in Ireland.** *Mortality and mortality data on the island of Ireland, 1989-1998.* Dublin, IPH; forthcoming, 2001.
- Kawachi, I et al.** *A prospective study of social networks in relation to total mortality and cardiovascular disease in men in the USA.* Journal of Epidemiology and Community Health 1996 50(3): 245-251.
- Kelly, A.** *Deprivation and Health: Identifying the Black Spots.* The Journal of Health Gain 1997 1(2): 13-15.
- Keogh, F., Walsh, D.** *Irish Psychiatric Hospitals and Units, Activities 1995.* Dublin, Health Research Board; 1996.
- Klein, R.** *Health inequalities: Bringing the hidden assumptions into the open.* Health Economics 2000 9 569-570.

- Layte, R. adapted from Van Herten.** *Proceedings of St Vincent de Paul conference.* Dublin, November 2000.
- Lynch, F. McAuliffe, E, Joyce, L.** *Health Funding and Expenditure in Ireland. A Healthier Future.* Dublin, IPA; 1998.
- McKee, M., Fulop, N.** *On target for health?* *BMJ* 2000;320: 327-328.
- Middleton, J.** *BMJ*, letter, 6 June 2000.
- Mendez and Warner.** *Smoking prevalence in 2010: why health objectives for the healthy people goal is unattainable.* *Am J of Public Health* 2000;90:401-403.
- Marmot, M., Shipley, M. and Rose, G.** *Inequalities in death specific explanations of a general pattern.* *Lancet* 1, 1984 1003-1006.
- Marmot, M., Wilkinson, R.** *Social Determinants of Health.* Oxford, Oxford University Press; 1999.
- National Economic and Social Forum (NESF).** *The National Anti-Poverty Strategy.* Forum Opinion No. 8. Dublin. NESF; 2000.
- New Zealand Government.** *A new relationship.* Wellington; 1989.
- Nolan, B., Callan, T eds.** *Poverty and Policy in Ireland.* Dublin, Gill & Macmillan; 1994a
- Nolan, B.** *Perinatal Mortality and Low Birthweight by Socio-economic Background: evidence for Ireland.* *Economic and Social Review* 1994b vol 25, 321-41.
- Nolan, B, and Whelan, C.T.** *Resources, deprivation and poverty.* Oxford. Oxford University Press; 1996.
- Nolan, B.** *Health inequalities in Ireland.* *The Journal of Health Gain* 1997 1(2): 11-12.
- Nolan, B.** *Socio-Economic Health Inequalities in Ireland.* Paper for Southern Health Board conference on Inequalities in Health May 2000. ESRI.
- Nolan, B., Wiley, M.** *Private practice in Irish Public Hospitals.* Dublin, ESRI; 2000b.
- O'Shea, E.** *Male mortality differentials by socio-economic group in Ireland.* *Social Science and Medicine* 1997 Vol 45, No 6 pp 803-809.
- Piachaud, D.** *Problems in the Definition and Measurement of Poverty.* *Journal of Social Policy* 1987 16 (2), pp 147-164.
- Quinn, S.** *Improving Health Care: Health Policy in Ireland.* In: S. Quinn, Kennedy, P, O'Donnell, A, Kiely, G. *Contemporary Irish Social Policy.* Dublin, University College Dublin Press; 1999.
- Ringen, S.** *Direct and Indirect Measures of Poverty.* *Journal of Social Policy* 1988 17, pp 351-366.
- Room, G.** *Beyond the Threshold; The measurement and Analysis of Social Exclusion.* Bristol, The Policy Press; 1995.
- Sen, A.** *Poor relatively speaking.* *Oxford Economic Papers* 1983; 32 (2):153-69.

- Swedish Ministry of Health and Social Affairs.** *The new Swedish Public Health Policy.* Stockholm; 2000 [www.fhi.ie](http://www.fhi.ie)
- Social Exclusion Unit.** *Opportunity for All - Tackling Poverty and Social Exclusion.* London, Social Exclusion Unit; 1999.
- Shaw, M., Dorling, D, Gordon, G, Davey-Smith, G.** *The Widening Gap.* Bristol, The Policy Press; 1999
- Townsend, P.** *Poverty in the United Kingdom : a survey of household resources and standards of living.* Harmondsworth. Penguin; 1979.
- US Department of Health and Human Services.** *Healthy People 2010.* Washington DC; 2000.
- Van Herten and Van de Water.** British Medical Journal, 1999; 319:700-703.
- Van Herten and Van de Water.** *Health policies on target? Review of health target and priority setting in 18 European countries.* Leiden; 1998.
- Whitehead, M.** *The health divide: Inequalities in health in the 1980s.* London, Health Education Council; 1987.
- Whitehead, M., Scott-Samuel. A., Dahlgren. G.** *Setting targets to address inequalities in health.* The Lancet. 1998 Vol 351.
- Wilkinson, R.** *Income distribution and life expectancy.* British Medical Journal 1993 (304): 165- 168.
- Wilkinson, R.** *Unhealthy societies. The Afflictions of Inequality.* London. Routledge; 1996.
- Wilkinson, R.** *Prosperity, redistribution, health and welfare. Social Determinants of Health.* M. Marmot, Wilkinson, R. Oxford, Oxford University Press; 1999.
- World Health Organisation.** *Targets for health for all.* Copenhagen, World Health Organisation; 1998.
- World Health Organisation.** *Health 21.* Copenhagen, World Health Organisation; 1998.

The Institute of Public Health  
6 Kildare Street, Dublin 2

Tel: 00 353 1 662 9287

Fax: 00 353 1 662 9286

Email: [iph@RCPI.ie](mailto:iph@RCPI.ie)

Also contactable at Belfast: 00 44 28 9079 3050