TASC

Eliminating Health Inequalities

A Matter of Life and Death

Sara Burke and Sinéad Pentony

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Preface

The World Health Organization's Commission on Social Determinants of Health has spearheaded a renewed global concern with the social and economic factors that determine health status. Health status and inequalities in health between and within countries are primarily influenced by these factors.

This report from TASC critiques these socio-economic factors from an Irish perspective and illustrates how responses to the current economic crisis are having a disproportionate impact on low-income and vulnerable groups. This will have a direct impact on their health status and exacerbate health inequalities in the years ahead.

Even in the midst of crisis opportunities exist. This report identifies a wide ranging and comprehensive set of measures that can be used as a blueprint by the new Government to improve the health of the population as a whole and to put public policy on the path to eliminating health inequalities.

However, these policy choices need advocates across a wide spectrum of stakeholders and they need to be prioritised and resourced. Our response to health inequalities and indeed health status for all has tended to be dominated by rhetoric rather than action. This report should therefore be used as a resource to wider civil society to make demands for action on health inequalities.

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Executive Summary

INTRODUCTION

There is now evidence to show that more equal societies do better across a range of outcomes, including health. Equality is good for everyone in society.

TASC is publishing this report because of the interrelationship between economic and health inequalities. Higher levels of economic inequality result in poorer health for everyone, but especially for those on the lowest incomes.

Eliminating health inequalities is, as the title of this report says, a matter of life and death. TASC argues that we have the means and opportunity to achieve a more equal – and thus healthier – society.

THE HUMAN COST OF HEALTH INEQUALITIES

"Social injustice is killing people on a grand scale", WHO 2008 (p. 26).

Despite an overall improvement in the health of the Irish population, very little has been done to address inequalities in health between high-income and low-income groups.

Where you live and what you work at has an impact on your health. If you work at an unskilled job and live in a deprived area, you are more likely to die earlier than a professional worker living in an affluent area.

New research from the Institute of Public Health – published for the first time in this report – estimates that eliminating socio-economic mortality differentials in Ireland would mean over 13.5 million extra years of life for Irish people. These extra years would be added to the end of people's lives, and the benefits would be realised over an extended period of time. The equality foundations we lay now will be reaping benefits for our children, grandchildren and great grandchildren. The calculation is explained in detail later in the text – but what it means is that inequality is a preventable cause of death.

Prevention requires policymakers to focus on reducing the gaps between the highest and lowest occupational classes, and between the wealthiest and most deprived areas, in order to eliminate health inequalities.

Achieving this goal would mean that everyone living in Ireland, no matter what their income or social status, could expect to live a longer, healthier and more productive life. It is an ambitious goal, but an achievable one if there is political will and concerted action.

FISCAL POLICY, PUBLIC SPENDING AND HEALTH INEQUALITIES

Regressive budgetary measures over the last three years have had a disproportionate impact on low-income groups. These measures will contribute directly to higher levels of poverty and deprivation – and thus to increased health inequalities.

International comparisons of government healthcare expenditure show that public spending on health services in Ireland has risen quite rapidly compared with other EU and OECD states. However, increases in health spending started from a low base in the 1990s following the severe cutbacks in the 1980s.

By the end of the economic boom, Ireland was one of the lowest taxing and spending economies in the EU 27 (measured as a proportion of GDP), having maintained the third-lowest average level of public spending in the OECD as a proportion of GDP over the period from 1995-2008.

Levels of social spending directly impact on health and wellbeing.

When combined with regressive economic policies, and their negative impact on social policies, Ireland's low level of public spending has led to poorer health status and high levels of health inequalities for disadvantaged groups.

If Ireland wants to achieve EU levels of social protection, as well as the quality public services essential to addressing health inequalities, it will need to achieve EU levels of tax and social expenditure.

The tax revenue (including social contributions) funding our public services must be stable, sustainable and sufficient. The structure of the tax system should also be broadly based so that it can better withstand recessions and global financial turmoil. Ireland's tax policy did not conform to these criteria in recent years.

We need to develop a different economic model in order to eliminate health inequalities – a model which provides the levels of social spending required to protect the health and wellbeing of the poorest in particular, and of society in general, through high-quality universal public services.

HEALTH SERVICES AND HEALTH INEQUALITIES

Low-income groups are particularly dependent on the public health system – and are most affected by failure to invest in it. Investment alone, however, is not sufficient unless it is specifically designed to eliminate inequalities.

The Irish health system is a complicated mix of public, private and voluntary care providers, with unfair and unclear routes in and through the system for patients and users of health services.

A number of key concerns need to be tackled as part of the Government's commitment to a single-tier health service based on need rather than ability to pay. Issues highlighted in this report include:

- The role of primary care and mental health services in embedding preventative initiatives in the healthcare system;
- The dearth of specific policy measures aimed at addressing health inequalities;
- The shortcomings at political and institutional level that have resulted in failure to implement many health policy measures;
- The impact of policy measures aimed at promoting privatised healthcare on health inequalities;
- The impact of private health insurance on health inequalities.

Summary of recommendations

EVIDENCE-BASED POLICYMAKING APPROACHES TO ADDRESSING HEALTH INEQUALITIES.

- TASC recommends that an Independent Review of Health Inequalities be undertaken.
- The Independent Review should be modelled on the approach adopted in England, which resulted in the publication of the Marmot Review - *Fair Society, Healthy Lives.*
- The Independent Review of Health Inequalities should report within 12 months, and the recommendations should be used to form the basis of a new population health policy in Ireland.
- The Central Statistics Office (CSO) should be given responsibility for monitoring the implementation of policy measures and strategies aimed at eliminating health inequalities.

A crucial step towards eliminating health inequalities is to ensure that policymaking is evidence-based.

REDISTRIBUTING FOR BETTER HEALTH

- Increases in taxation should be used to provide higher levels of social spending in the areas of health and education.

Investment in public health services, together with investment in pre-school, primary and secondary education, has been found to have the biggest impact on income distribution over time.

- Increased investment should be particularly targeted in the area of early childhood care and education.

Investment in this area has been identified as playing a critical role in addressing health inequalities, especially where policy measures are designed to break the links between early disadvantage and poor outcomes in later life.

FUNDING HEALTH ON THE BASIS OF SOLIDARITY

- Health-related commitments can only be fully funded through a model of universal social health insurance combined with general taxation.
- A social-insurance model should be funded through increased employer and employee social insurance contributions.

When combined with revenue from general taxation, social health insurance benefits can be extended to cover everyone living in Ireland, in order to provide equal access to the health system.

- There are many variations of universal health insurance and TASC recommends that the merits of a **single social health insurance fund** be evaluated alongside the option of competing public and private insurers in the forthcoming White Paper on Financing Universal Health Insurance.

MAKING IRELAND HEALTHIER: REALIGNMENT OF PRIORITIES THROUGH POLITICAL LEADERSHIP

- TASC recommends the creation of a Cabinet Sub-Committee on Population Health whose role should be to drive the process of inter-departmental co-ordination of health, and the addressing of health inequalities, across all relevant government departments.
- This Committee should be chaired by the Minister for Health.
- A Joint Oireachtas Committee on Population Health should be established as one of the fewer but stronger committees with appropriate resources.
- TASC recommends that a Population Health Division (within the Department of Health) be established with the necessary expertise, headed at Chief Medical Officer / Assistant Secretary level.

Improved health and the prevention of health inequalities must be put at the heart of public policy. For this to be achieved, a series of changes is required to put the necessary institutional framework in place to ensure that all draft legislation and government policies are assessed for their impact on health and health inequalities.

1. Introduction

OBJECTIVE OF TASC REPORT ON HEALTH INEQUALITIES

1.1 TASC is an independent think-tank dedicated to ensuring that public policy has equality at its core. TASC develops policy alternatives based on the values of equality, sustainability, accountability and democracy.

1.2 The aim of this report is to shift the public discourse on health so that:

- The benefits of improved health status and reducing health inequalities are better understood;
- Actions which can improve health and reduce health inequalities are clearly articulated;
- Political and policy actors, as well as the public at large, are motivated to improve health and reduce health inequalities.

1.3 This is TASC's first publication on health. TASC is publishing this report because of the connection between economic inequality and health inequalities. Economic inequality is not confined to income inequality, but exists across many areas of the economy. Examples include asset ownership, wealth, taxation, access to health, housing and education. Higher levels of economic inequality result in poorer health for everyone, especially for those on the lowest incomes. Poorer people have poorer health and live shorter lives than those on higher incomes.[1][2]

1.4 Much of the Irish public and policy discourse on health focuses on health services. This reflects the public awareness that access to high quality health services is essential if one is sick. And, although most of the factors which determine health are external to the health system, health inequalities are exacerbated by Ireland's two-tier health system whereby public patients often have to wait longer for treatment than those who can afford to pay privately.

1.5 This report demonstrates that the policies needed to address health inequalities are not confined to health, because the causes of health inequalities are complex and encompass lifestyle factors as well as wider determinants such as poverty, housing, education and income.

1.6 TASC contends that Irish people should have the best health status in Europe and that the difference in health outcomes between those on high and low incomes should be no greater than the difference achieved by the most socially inclusive countries in Europe.

1.7 Specifically, Irish public policy should aim to improve the health status of the lowest occupational classes to the level enjoyed by the highest occupational class, and of those living in the most deprived areas to the standard of health enjoyed by those living in the wealthiest areas.

1.8 Eliminating socio-economic mortality differentials in Ireland would mean over 13.5 million extra years of life for Irish people. These extra years would be added to the end of people's lives, and the benefits would be realised over an extended period of time.[1]

1 See Appendix 2 for an explanation of how this statistic was derived.

1.9 The achievement of this goal would mean that everyone born or living in Ireland, no matter what their income or social status, could expect to live a longer, healthier and more productive life, free from preventable disease. If there is political will, together with the policy know-how, commitment and concerted action, these ambitious targets can be achieved. Persuading the public and political leaders that such action is necessary and worthwhile is one of the key objectives of TASC's work in health policy.

1.10 Although we prioritise our own health and that of our families, our collective health attracts little attention. The Department of Health has responsibility for public health.[2] The vast majority of the budget and activity is concerned with health or sickness services. Other government departments, whose work directly or indirectly impacts on the health of the nation, often see health as beyond their remit.

1.11 Nevertheless, government departments with responsibility for finance, education, environment and social protection (among many others) make policy choices that can significantly improve or worsen people's health. Currently, policies are introduced without any consideration of their impact on individual wellbeing or society's collective health [(2)].

1.12 Overall, the health of the Irish population is improving.[3] However, this report shows that very little has been done to address inequalities in health at a population level between high-income and low-income groups.

1.13 There is now ample evidence to show that more equal societies do better across a range of outcomes, including health. Equality is good for everyone in society, regardless of whether they are at the top or the bottom of the income ladder [(3)]. But, as extensive research in this area indicates, one's socio-economic position relative to others, as well as one's absolute position, impacts on one's health [(4)].

1.14 This growing body of research shows that the overall wealth in a society is less important in determining mortality and health in that society than how evenly wealth is distributed. The more equally wealth is distributed, the better the health of that society [(3)].

1.15 Simply concentrating action on those at the bottom of the social scale fails to reduce the gaps between all sections of society. The focus needs to be on the scale of social hierarchy which is key to wellbeing, and on ensuring action results in reducing the steepness of the gradient itself [(3)].

HEALTH IN A TIME OF CRISIS

1.16 Ireland, as a society and an economy, is living through extraordinary times. Ten years ago, we were the envy of the world, cited as an exemplar of a small, open and thriving economy. By 2011, three years after the economic collapse, that illusion has been well and truly shattered. In 2010, Ireland recorded the single worst annual government deficit in the history of post-war Western Europe. Economic output fell by 16 per cent from its 2007 peak.

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2 The Department of Health and Children will be separated into two new government departments in 2011; the Department of Health and the Department of Children.

3 See Appendix 1 for an overview of the health of the Irish population.

1.17 The government was pressured to negotiate a loan facility from the European Union (EU), European Central Bank (ECB) and International Monetary Fund (IMF). This loan facility may be appropriate for a country experiencing a liquidity problem but is insufficient for countries with solvency questions. There remains a significant possibility of debt restructuring by one or more peripheral Euro Area economies.

1.18 Government policy between 1997 and 2010 was an ill-advised combination of running down the tax base while increasing public spending. This pro-cyclical policy, combined with a construction bubble fuelled by easy credit, tax breaks and unregulated reckless banking practices, was the main cause of Ireland's economic collapse.

1.19 Even during the boom, while most people earned more than before and many more were in work, this was not necessarily accompanied by a corresponding improvement in people's quality of life. For example, unprecedented property prices resulted in many young families taking out large mortgages and moving to towns and suburbs with long commutes from family and friends (as well as work). The result was that they were often without social supports. Many people are now living with unsustainable debt, as earnings have dropped and jobs have been lost. This decline in income has a direct negative impact on people's health.

1.20 One million additional people were employed during the economic boom. However, just three years on from high employment, the (standardised) unemployment rate at the end of May 2011 stood at 14.8 per cent [6]. Currently, over half of all unemployed people are classified as being long-term unemployed [7]. Ten years ago, in 2001, Irish unemployment stood at four per cent of the labour force with 72,000 people unemployed, 30 per cent of whom were long-term unemployed (based on Quarterly National Household Survey).

1.21 Although many people benefited, many were left behind and – with the rising incomes of many of those working – the gap grew between high earners and those living on low incomes. [8] Those left behind experienced increased stress, poorer health and further alienation from society as old social support structures were wiped out.

1.22 Ireland in 2011 is a very different country to the Ireland of 2001. The bubble burst. The previous government ceded control over large parts of the country's economic policy due to the acceptance of the EU/IMF loan facility, and the country faces more years of austerity as articulated in the National Recovery Plan, EU/IMF deal and a series of austerity budgets.

1.23 Our political leaders past and present claim there is no alternative to the policies they have pursued and continue to pursue with vigour. Alongside this mantra, there is a growing range of voices pointing out that there is an alternative course – that a new type of politics and economics is needed to heal, reinvigorate and reimagine the type of country we want to live in.

1.24 *Eliminating Health Inequalities – A Matter of Life and Death* is a contribution to this broader discussion of a new and better Ireland: one where the disparities between the rich and poor are reduced, one which sees a significant reduction in health inequalities, where everyone can have the best possible health and where health services are accessed on the basis of need rather than ability to pay.

2. Social Determinants of Health

2.1 There is a complex web of factors influencing individual and population health. An emerging body of evidence driven by the World Health Organisation (WHO) supports the premise that factors influencing health include the conditions in which we are born, grow, live, work and age [9].

2.2 This means that our income, wealth, education, environment, work and life opportunities all impact upon our health. Psychosocial factors such as stress, isolation, friendships, happiness and social support also play a pivotal role. In addition, lifestyle factors such as our eating, drinking, exercise and smoking habits are important. Although genetics and hereditary conditions are also very significant, they are less amenable to public policy interventions.

2.3 All of these above factors are interconnected, and many of them are socially, politically and economically influenced. Government economic and social policies have a direct impact on people's lives, with the distribution of income, wealth and social protection being vital to societal and individual wellbeing.

2.4 Health services matter because the prevention and treatment facilities provided can mitigate some health inequalities, as long as those services are accessible, universal and free at the point of delivery. However, if as in Ireland there are inequalities in access to public health services, existing health inequalities will be exacerbated. This increases the burden of illness on those with low incomes.

2.5 The health status and life expectancy of the Irish population has improved dramatically over the past century because of improved living conditions underpinned by investment in sanitation, housing, education, social protection and health services, as well as increased employment. As national income rises, so too does health status. However, at a certain point national income becomes less relevant and it is instead the distribution of wealth, combined with economic and social policies, that determines population health and the level of health inequalities [10].

2.6 Among rich countries there is little correlation between per capita Gross National Product (GNP) and life expectancy. For example, in 2008 New Zealand's GNP was half that of the USA, yet its average life expectancy was one-and-a-half years higher than that of the USA. According to Wilkinson and Pickett (p.29), *"having come to the end of what higher material living standards can offer us, we are the first generation to have to find other ways of improving the real quality of life. The evidence shows that reducing inequality is the best way of improving the quality of the social environment and so the real quality of life, for all of us."* [3]

PUBLIC POLICY APPROACHES TO REDUCING HEALTH INEQUALITIES

2.7 The WHO Commission on the Social Determinants of Health found that social inequalities in health arise out of inequalities in conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources. It concluded that *"social injustice is killing people on a grand scale"* and that *"the toxic combination of bad policies, economics and politics is, in large measure, responsible for the*

fact that a majority of people in the world do not enjoy the good health that is biologically possible" p.26 [9].

2.8 The WHO Commission also specifically made the case for investment in universal health care systems, especially primary care. It warned against the increased commercialisation of healthcare, since this can undermine comprehensive primary care systems which are the most effective way of addressing inequalities in health and in disease.

2.9 Detailed research led by Michael Marmot – ***'Fair Society, Healthy Lives'*** – shows how investments in a variety of social policies benefit health [4]. Children who live in good quality housing, with safe neighbourhoods to play in and good quality schools to attend, are much more likely to grow up healthy and live longer lives than those who do not. Likewise, adults who have a decent wage and safe and secure employment are significantly less likely to adopt unhealthy lifestyles such as poor diets, smoking and drinking [2].

2.10 The Marmot Review (p. 15) argues that, in order to reduce the steep social gradient in health, ***"...actions must be universal but with a scale and intensity that is proportionate to the level of disadvantage."*** [2]. Marmot outlines how actions taken to reduce health inequalities benefit society in many ways. It details how a healthier work force is economically beneficial, as there are fewer productivity losses, increased tax revenue, lower welfare payments and treatment costs.

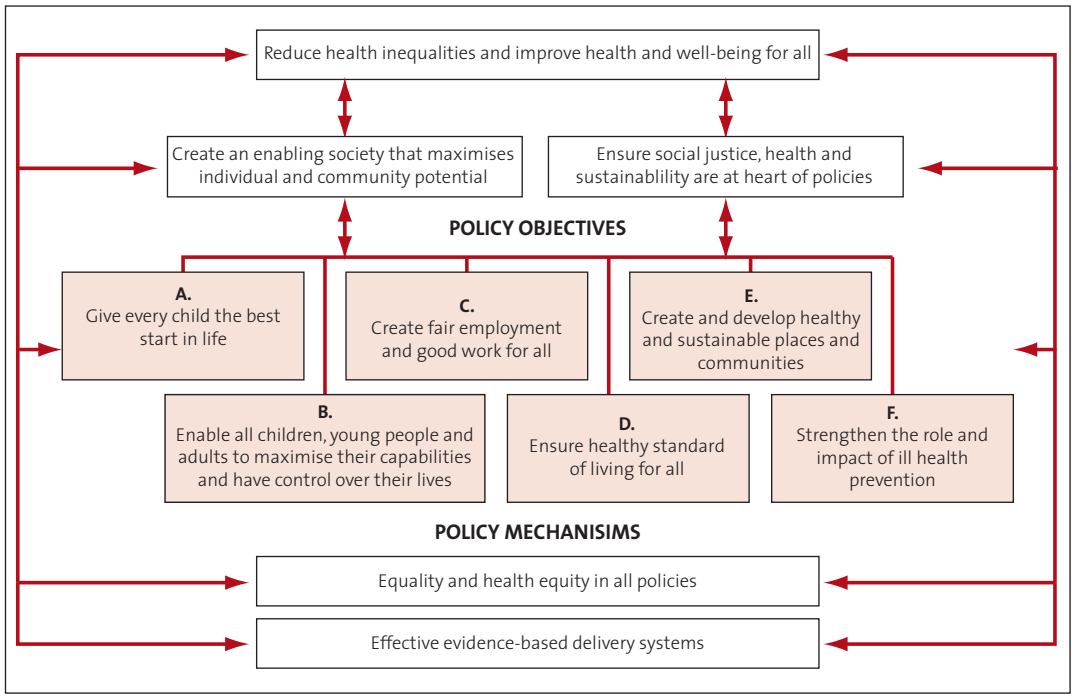
2.11 It also argues that economic growth is not the most important measure of a country's success: ***"the fair distribution of health, wellbeing and sustainability are important social goals***[2]. The Marmot Review (p.15) took a life course approach to tackling inequalities, as disadvantage can start before birth and accumulates over a lifetime. The Review prioritised the first of their six policy actions – give every child the best start in life – as the most important. The other five are:

- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standards of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention [2].

The Marmot Review (p.19) developed a framework for action (Figure 1) which sets out the overall aim of the Review – to reduce health inequalities and improve health and wellbeing for all.

4 This research is commonly referred to as The Marmot Review.

Figure 1: A path to health equality



Source: Marmot M. Fair Society, Healthy Lives. The Marmot Review. Strategic Review of Health Inequalities in England post-2010. London. 2010.

2.12 The findings in the Marmot Review are reinforced by the work of the Commission on the Measurement of Economic Performance and Social Progress, chaired by Joseph Stiglitz, Amartya Sen and Jean Paul Fitoussi, which emphasised that wellbeing should be a more important societal goal than continuous economic growth, and that the levels of inequalities in health should be used as a measure of wellbeing [11]. The 2010 UN Human Development Report, which reviewed twenty years of human development, found that *"human development is different from economic growth and that great achievements are possible even without fast growth"* p.49 [10].

2.13 This growing body of international work clearly demonstrates the need for a multi-faceted approach to tackling these intractable – but not insurmountable – societal inequalities. In Part 5 of this report, TASC sets out a series of actions associated with developing the evidence-based approach to policymaking needed in order to eliminate health inequalities.

HEALTH INEQUALITIES IN IRELAND

2.14 The international evidence on the social determinants of health clearly demonstrates that our income, wealth, education, environment, work and life opportunities all impact upon our health. This part of the report provides an overview of the extent of health inequalities in Ireland, with a particular focus on the relationship between income distribution, associated social indicators and health inequalities.

2.15 The enjoyment of good health is unevenly distributed across Irish society, with people on low incomes experiencing poorer health and living shorter lives. The difference in the

experience of health among different sections of the populations is described as 'health inequalities'. Although some people will live longer, healthier lives due to genetic or hereditary factors, 'health inequities' refer to inequalities which are unnecessary, unjust and avoidable, and can be addressed through public policies.

2.16 *The Spirit Level* by Wilkinson and Pickett uses nine indicators to show that unequal societies are worse for all who live in them – not just for those on low incomes. This work finds lower life expectancy rates, poorer mental health and lower levels of trust, alongside higher rates of infant mortality, imprisonment, obesity and poor educational performance in more unequal societies [3].

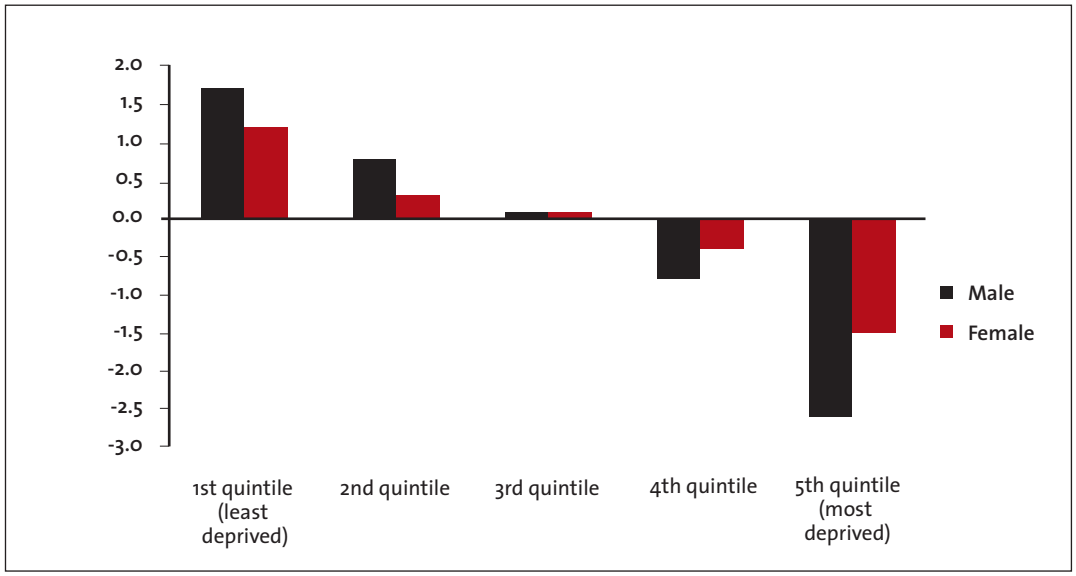
2.17 People who live on lower incomes tend to have poorer health because they are more likely

- to be 'at risk of' or live in poverty;
- to have poor educational attainment;
- to have fewer job opportunities.

This inequality is evident in death as in life.

2.18 Recent data published by the Central Statistics Office demonstrates the link between deprivation and life expectancy (Figure 2)[12]. It found the affluence of the area of residence to be the strongest predictor of shorter life expectancy for both men and women in the 2006 Census. Men living in the poorest areas lived four-and-a-half years less (73.5 years) than men who lived in the most affluent areas (78 years). Women living in the poorest areas had a life expectancy of 80, and those in the wealthiest had a life expectancy of 82.7 years.

Figure 2: Deviation of life expectancy at birth from average life expectancy by deprivation ranking



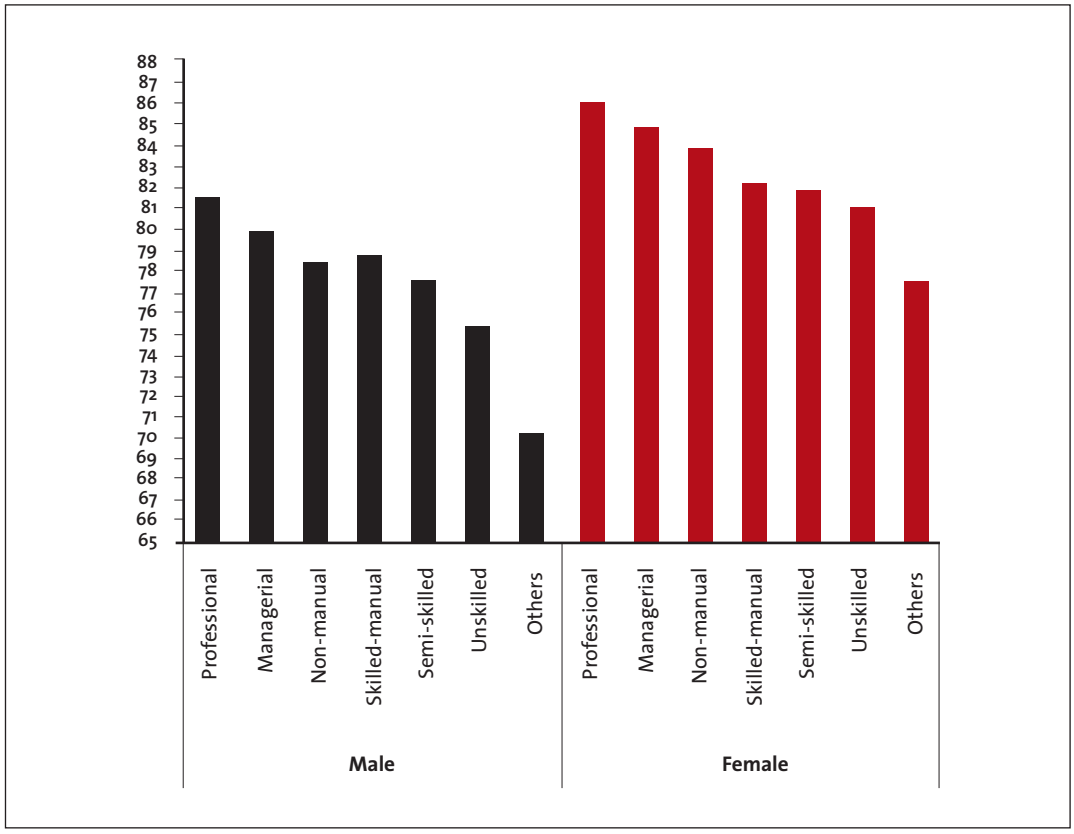
Source: Central Statistics Office (2010A, p3) Mortality Differentials in Ireland [online]. Available at: http://www.cso.ie/census/documents/Mortality_Differentials_in_Ireland.pdf [20 January 2010].

2.19 Social class was also a strong predictor of life expectancy (Figure 3) with a six-year gap between the life expectancy of professional workers and their unskilled counterparts, ranging from 75.3 years for unskilled men to 81.4 years for male professional workers [12].

Unskilled women had a life expectancy of 81.8 years, while their professional counterparts could expect to live to 86 years. Education was also a strong predictor of length of life, as was place of residence.

2.20 Analysis of this data by the Institute of Public Health shows that eliminating socio-economic mortality differentials in Ireland would mean over 13.5 million extra years of life for Irish people. These extra years would be added to the end of people's lives, and the benefits would be realised over an extended period of time.

Figure 3: Life expectancy at birth by social class

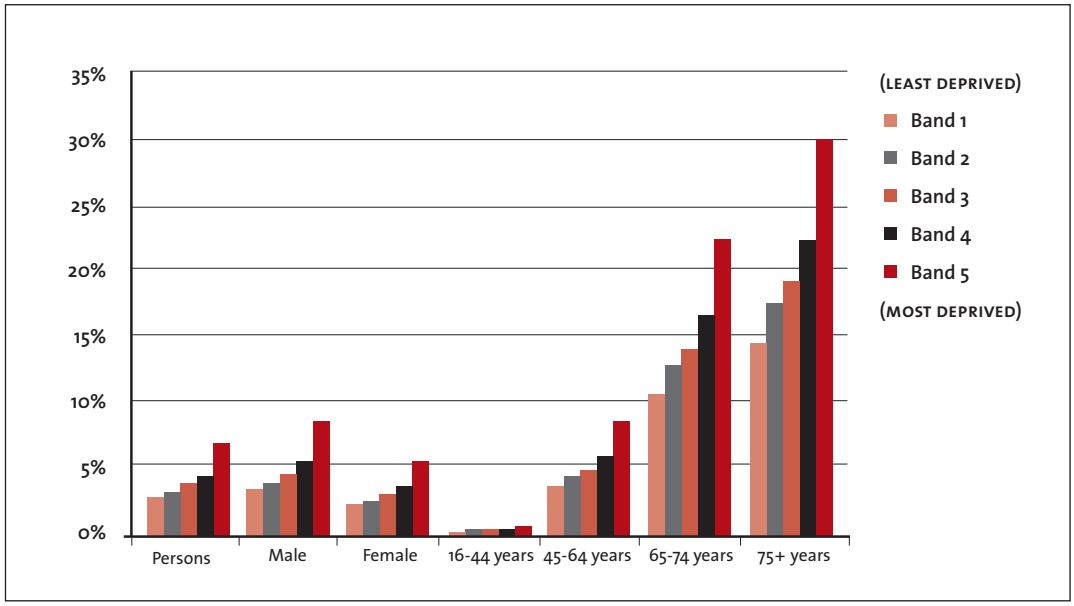


Source: Central Statistics Office (2010B, p3) Mortality Differentials in Ireland [online]. Available at: http://www.cso.ie/census/documents/Mortality_Differentials_in_Ireland.pdf [20 January 2010].

2.21 There is a social gradient across health inequalities, with health improving and life expectancy increasing in line with social class, income and educational attainment. The social gradient is apparent across the majority of health and sickness measurements. The link between areas of residence and poor health is also evident in data showing that those who live in the most deprived areas have significantly higher rates of coronary heart disease than those in less deprived areas [13].

2.22 The Institute of Public Health's work on chronic diseases shows higher rates of both coronary heart disease (CHD) and diabetes in the most deprived fifth of the population compared to the rest, with rates decreasing gradually as deprivation decreases (Figure 4)[13]. Those who were least deprived were also least likely to have CHD or diabetes. The older the age, the greater the increase in illness between those from the least deprived areas and those from the most deprived [13].

Figure 4: Population prevalence rates of angina and heart attack (CHD) amongst adults across the deprivation bands in the Republic of Ireland within each sex and age group (2007)[13]



2.23 Risk factors such as body mass index, cholesterol and blood pressure are also persistently higher amongst low-income social classes [14]. The social gradient is also evident in mental health scores. People from higher social classes tend to experience better mental health. Levels of depression and admissions to psychiatric hospital are also socially patterned, with higher prevalence among less affluent socio-economic groups [15].

2.24 People from less affluent socio-economic groups are less likely to participate in moderate-to-high levels of physical exercise, and are more likely to eat fried foods, and to smoke. Smoking rates are highest (56 per cent) amongst women aged 18 to 29 years from the less affluent socio-economic class, compared to 28 per cent of young women from the highest social classes [16]. There are also social class differences in male smoking, although not to the same extent as amongst women.

2.25 Peri-natal mortality and low birth weight are both considered good indicators of poor health status. In both of these measurements, rates are significantly higher among lower income groups. Babies born to parents who are unemployed or whose socio-economic status was unknown ran over twice the risk of having a low birth weight when compared with those whose parents were recorded as higher professionals [17].

2.26 There are significant health inequalities in Ireland. Those in the lower socio-economic groups experience poorer health and shorter lives than those in the higher socio-economic groups. Such poor health is most evident amongst the Traveller population and the street homeless in Ireland.

2.27 *The All Ireland Traveller Health Status Study* reports the poor health status of that population[18]. It found that life expectancy for Traveller men is 15 years less than for settled men, while the gap is 11.5 years for women. Although there was a slight improvement for women between 1986 and 2008, there was a serious decline in the health of Traveller men. The gap in life expectancy widened between settled men and Traveller men. Infant mortality, defined as death in the first year of life, is 3.5 times higher among Travellers, while Traveller men have a suicide rate seven times that of the general population.

2.28 On a positive note, the evidence suggests that the health of the whole population improves when income inequalities are reduced and that health inequalities can be reduced through effective government intervention in this regard [3].

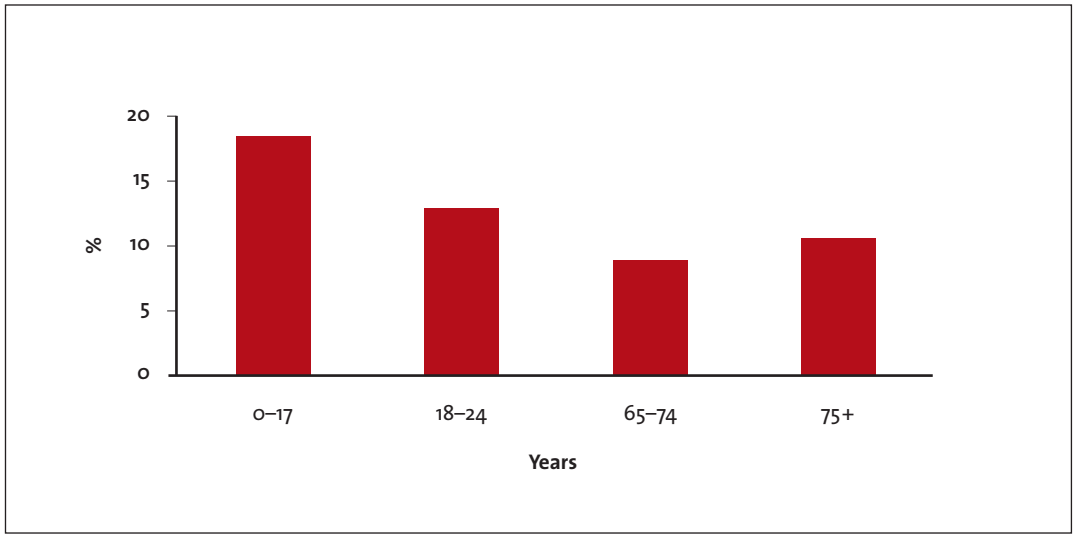
IRISH HEALTH INEQUALITIES IN CONTEXT

2.29 There is a relationship between poverty and health inequalities. Up to 2009, there was a significant decline in the at-risk-of-poverty rate, which decreased from 21.8 per cent in 2001 to 14.1 per cent in 2009. The 'at-risk' of poverty threshold in 2009 was equivalent to living on €231.36 per week for a single person (€12,064 per annum). Over 600,000 people were living on incomes at or below this level [19] .

2.30 The drop in the numbers and rates of those living in poverty was due to significantly higher numbers in work and increases in social welfare rates. It is estimated that 46 per cent of the population would have been at risk of poverty in 2009 had they not received any social transfers. This demonstrates the importance of social welfare payments in keeping people out of poverty [19].

2.31 In 2009, 23 per cent of the 'at risk of poverty' population were living in a household where the head of the household was at work. Lone parent households had the highest 'at risk of poverty' rate at 35.5 per cent [19]. Children remained the group most likely to be 'at risk of poverty', with one in six – or over 205,000 children – falling into this category in 2009 (Figure 5) [19] [20].

Figure 5: At-risk-of-poverty rate by age group



Source: Central Statistics Office (2010, p45) Survey on Income and Living Conditions 2009 [online]. Available at: http://www.cso.ie/releasespublications/documents/silc/current/silc.pdf [accessed 21 December 2010]

2.32 There is also a direct relationship between lower educational attainment and higher poverty rates. This is reflected in the 2009 EU SILC data, with just four per cent of those

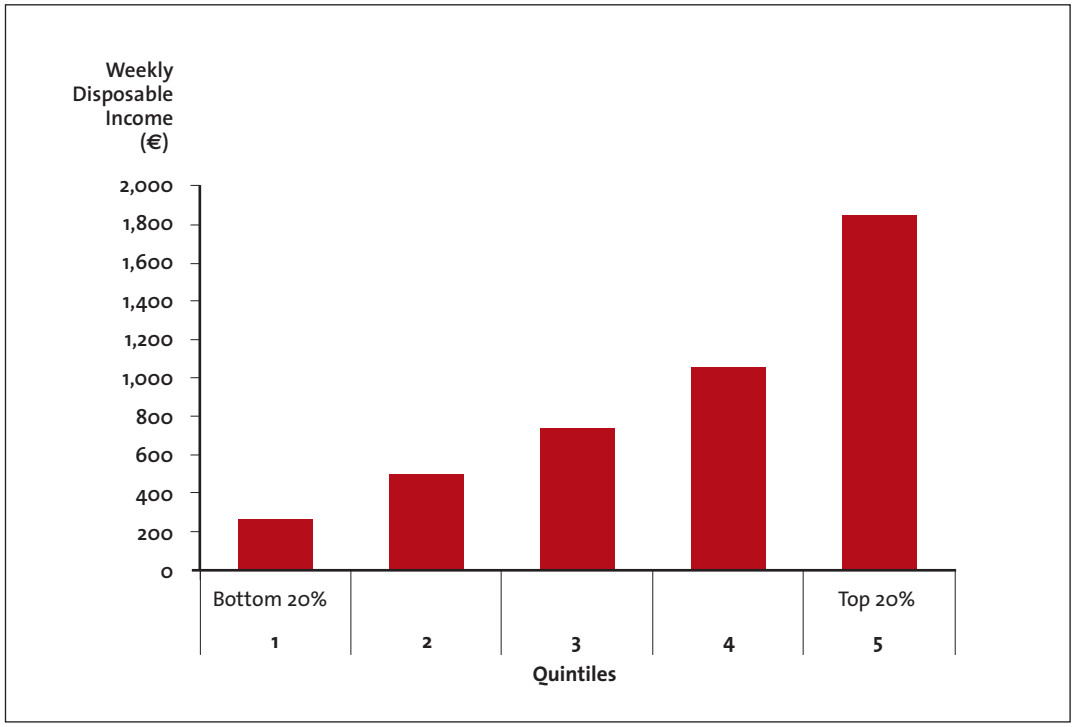
with a third level degree or higher experiencing poverty compared to over 21 per cent of those who left school at primary level or below.

2.33 TASC's research on the *Hierarchy of Earnings, Attributes and Privilege* report (HEAP) demonstrates how higher income levels are concentrated in households with higher levels of education, and this research also shows the extent to which incomes became more unequally distributed between 1987 and 2005 as the gap between those at the top and those at the bottom widened. In terms of income levels, HEAP shows that over half of all families live on less than €40,000, while one quarter live on less than €20,000 [8].

2.34 The HEAP research also reinforced previous findings on inequality in earnings between men and women. More recent research confirms that this is still the case, with women's income found to be 69.7 per cent of men's income. After adjusting for differences in hours worked, women's hourly earnings were approximately 90 per cent those of men [21].

2.35 The most recent data from the CSO, for 2009, shows the distribution of net disposable income across all income groups (Figure 6). The introduction of the Universal Social Charge, coupled with cuts to social transfers and the minimum wage announced as part of Budget 2011, will have a devastating and disproportionate impact on the lowest income groups[5]. This will have a direct impact on their health and wellbeing as shown above, where there is a clear link between poor health and deprivation.

Figure 6: Net Disposable Weekly Income by Quintile



Source: Central Statistics Office (2010, pp. 24-25). Survey on Income and Living Conditions 2009 [online]. Available at: http://www.cso.ie/releasespublications/documents/silc/2009/silc_2009.pdf [accessed 8 February 2011].

5 The Government stated its intention to reverse the cut in the minimum wage as part of the 'Jobs Initiative' announced on 10th May 2011, which is due to come into effect through the Social Welfare and Pensions Bill 2011.

2.36 The prospects for the next few years suggest that many of the gains of the early years of the century will be reversed, as the implementation of the EU/IMF agreement begins to take effect [22]. The decline in incomes and living standards will have a disproportionate impact on the health of those in lower socio-economic groups, and particularly on children.

2.37 The link between poverty and health is incontrovertible. Concerted government action and public policy can reduce health inequalities and ensure that everyone lives healthier, longer lives. In Part 5 of the report, TASC sets out the actions that are needed to improve the distribution of income, wealth and resources in order to create the conditions for addressing health inequalities.

3. Fiscal Policy, Public Spending and Health Inequalities

3.1 Significant levels of inequality exist across many areas of Irish society, such as income and health. TASC argues that we have the means and opportunity to achieve a more equal society through changing the structure of our economy. We cannot achieve a more equal society in the absence of economic equality.

3.2 Economic inequality exists across many areas of the economy – for example, asset ownership, wealth, taxation, access to health, housing and education. Addressing economic inequalities is about ensuring that economic interests are rendered subordinate to the common good in areas such as education, health and welfare. It is also about redistributing risk, wealth and power [23].

3.3 For the past two decades, Ireland has pursued an economic model characterised by the liberalisation of markets, a decreasing tax take, an increasing although still comparatively low social spend and a *laissez-faire* attitude to regulation which culminated in the disastrous failures in the banking system. A dependency on foreign direct investment and a property bubble fuelled by generous tax breaks, a pro-cyclical fiscal policy and easy credit all contributed to the economic crisis Ireland is experiencing.

3.4 The response to the crisis has been, and continues to be, to severely cut public expenditure, to introduce regressive tax measures and to continue injecting money into banks on an ongoing basis. The four budgets introduced since the onset of the crisis have had a disproportionate impact on low-income groups, and the policies pursued have failed to stem the rising debt-to-GDP ratio, failed to end the jobs crisis and failed to stimulate growth in the economy [24].

3.5 Commitments set out in the National Recovery Plan, the EU/IMF Programme of Financial Support for Ireland and Budget 2011 all seek to restate and reinforce previous, unsuccessful policy [25] [22]. In the EU/IMF Programme of Financial Support for Ireland, the previous government promised to accelerate fiscal consolidation measures already introduced, despite the manifest failure of these policies. The new government is also committed to this path. Quite clearly a new strategy is required which is more economically, socially and environmentally sustainable.

3.6 Part 2 of this report sets out the body of evidence demonstrating that more equal societies do better across a range of outcomes, including health, education and crime. Equality is good for everyone in society, regardless of whether they are at the top or the bottom of the income ladder. There is also emerging evidence that rising inequality helped create the global crisis [26]. Countries with greater levels of equality are faring better in the economic crisis. They have not felt the acute economic decline to the same extent as less equal societies, and are proving to be better able to recover from it [27].

3.7 Public policy in a range of areas can exacerbate or ameliorate inequalities in society. The two areas which have the greatest impact on the levels of economic equality are taxation and public services. While public policy during the boom failed to adequately use the taxation system to redistribute resources (whether directly, or through improved funding of public services), the austerity policies pursued over the last four budgets have resulted in reduced incomes for many low-income families and social welfare recipients, while also degrading public services through spending cuts.

3.8 The Programme for Government accepts the parameters of the National Recovery Plan and EU/IMF Programme of Support for Ireland, and the policies pursued by the last government have largely been adopted by the new government [28]. Reducing the incomes of those who are already struggling to meet their basic needs has a direct impact on their health and wellbeing in the short and long term. As well as reducing incomes in real terms, the last four budgets have increased the cost of paying for some essential services.

3.9 For example, these budgets have resulted in increased fees for accessing Emergency Departments and public hospital beds, and in payments for drugs prescribed to patients with medical cards. Low-income health service users are being hit twice: not only do they have even less money in their pockets, but they are increasingly being asked to pay more for drugs and essential health services.

3.10 Regressive and punitive budgetary measures over the last three years have included three cuts in social welfare (two cuts and the loss of the Christmas bonus), cuts to public sector pay (especially those on low incomes), combined with increased levies, lower tax bands and reduced child benefit.

3.11 These measures will all contribute directly to higher levels of poverty and deprivation, and put more people's health at risk. This will lead to increased health inequalities by lowering the incomes of the poorest, increasing charges for many services and shrinking the provision of public services – services upon which the poorest and the sickest depend.

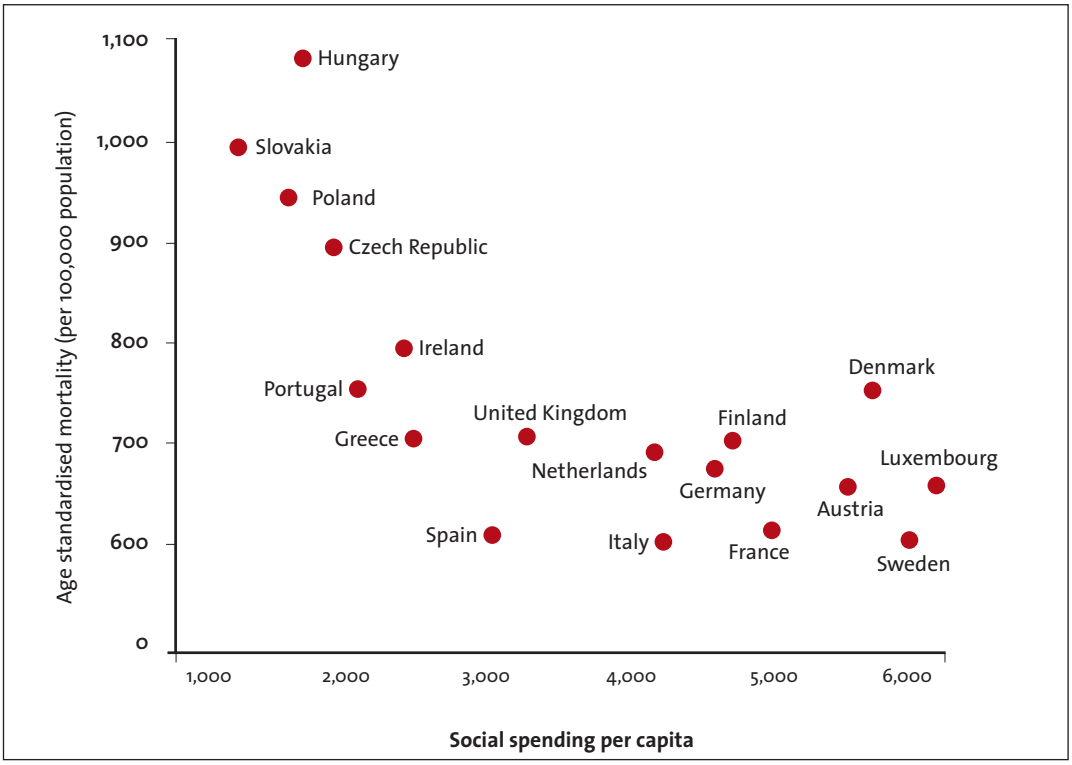
SOCIAL SPENDING AND HEALTH INEQUALITIES

3.12 The current economic crisis has fuelled debate regarding the appropriate level of public spending in Ireland. The benefits of public spending are numerous and include the provision of public goods such as education and health; the elimination of market failures through the subsidy or direct provision of these public services; the reduction of inequality through redistribution measures; the provision of a social safety net and a minimum standard of income; and even economic stabilisation during times of recession.

3.13 There is a direct relationship between social spending and health status. Recent work evaluating social spending across 15 EU countries with 'age standardised all-cause mortality'[6] found a clear association between spending and death rates [29]. The evaluation defined social spending as unemployment payments, active labour market programmes, public pensions, spending on childcare and preschooling, family support programmes, maternity and paternity leave, health care, housing subsidies, and support for people with disabilities. The research found that, for each additional $100 of social spending per person, there was a 1.19 per cent drop in all-cause mortality (Figure 7).

6 All-cause mortality is the annual number of deaths per 100,000.

Figure 7: Relation between social welfare spending and all-cause mortality in 18 EU countries, 2000



Source: Stuckler, D., et al. (2010) Budget crises, health, and social welfare programmes.

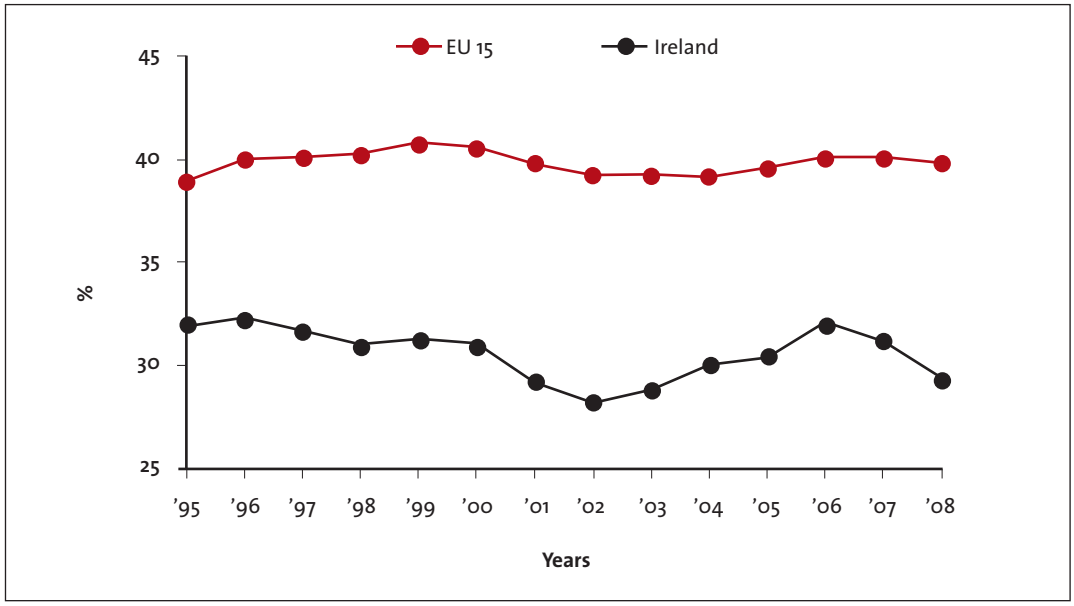
3.14 While higher GDP was also significantly associated with lower mortality, the research found that the marginal effect of an additional $100 in social spending was seven times more important than an additional $100 in overall GDP. According to the authors, Stuckler et al, ***"this means that the potential health benefits of increased wealth crucially depend not just on increasing income but on what fraction goes into social welfare spending from governments"*** (no page number) [29]. They also found that social spending on non-healthcare services has the greatest impact on health.

3.15 The 2010 UN Human Development Report found a strong negative relationship between inequality and human development across high, middle and low-income countries. It identifies fiscal policy as a 'vital lever' to reduce inequality ***"...with spending much more powerful than taxation. Public spending on services and social protection improves distribution – and among publicly provided services, healthcare and primary and secondary education have the biggest impacts"*** (p.69). [10].

3.16 Ireland maintained the third-lowest average level of public spending in the OECD as a proportion of GDP over the period from 1995-2008 [30]. Levels of social spending directly impact on health and wellbeing. Consequently, Ireland's social spending levels may help explain our poor outcomes for particular groups in Irish society – for example, those living in deprived areas; those who are socio-economically disadvantaged; and specific groups such as children and Travellers. When combined with regressive economic and social policies, this has led to a poorer health status and high levels of health inequalities for such groups.

3.17 Ireland maintained a persistently low tax take as a proportion of GDP between 1995 and 2008 (Figure 8), well below the EU 27 average, and since the mid 1990s has had the lowest overall tax take when compared with the EU 15 [31]. By the end of the economic boom, Ireland was one of the lowest taxing and spending economies in the EU 27 (measured as a proportion of GDP). If Ireland wants to achieve EU levels of social protection and quality public services, which are essential to addressing health inequalities, it will need to pay EU levels of tax and social expenditure.

Figure 8: Taxation revenue (Including social contributions) as a percentage of GDP: Ireland and the EU.



Source: Eurostat (2010) Government finance statistics (online). Available at: http://epp.eurostat.ec.europa.eu/portal/page/portal/government_finance_statistics/data/database [16 December 2010].

3.18 An analysis by the Canadian Centre for Policy Alternatives (CCPA) has found that the per capita value of public services is greatest for low-income households, and declines as income increases [32]. The CCPA also find that more and better quality public services ameliorate the negative impact of income inequality on quality of life. In particular, personal transfer payments and health care were found to be relatively more important as sources of benefit from public spending to lower income ranges than to higher household income ranges.

3.19 In the current economic context, the €19 billion gap between income and expenditure is not sustainable. Government expenditure as a proportion of GDP declined steadily from the mid 1990s until 2000, at which point it stabilised at around 34 per cent of GDP for the next seven years. In 2008, Ireland's pre-crisis level of taxation was 29 per cent of GDP, compared to an EU-27 average of 39 percent [31]. Even when Budget 2011 is taken into account, tax still only generates 35 per cent of GDP [33].

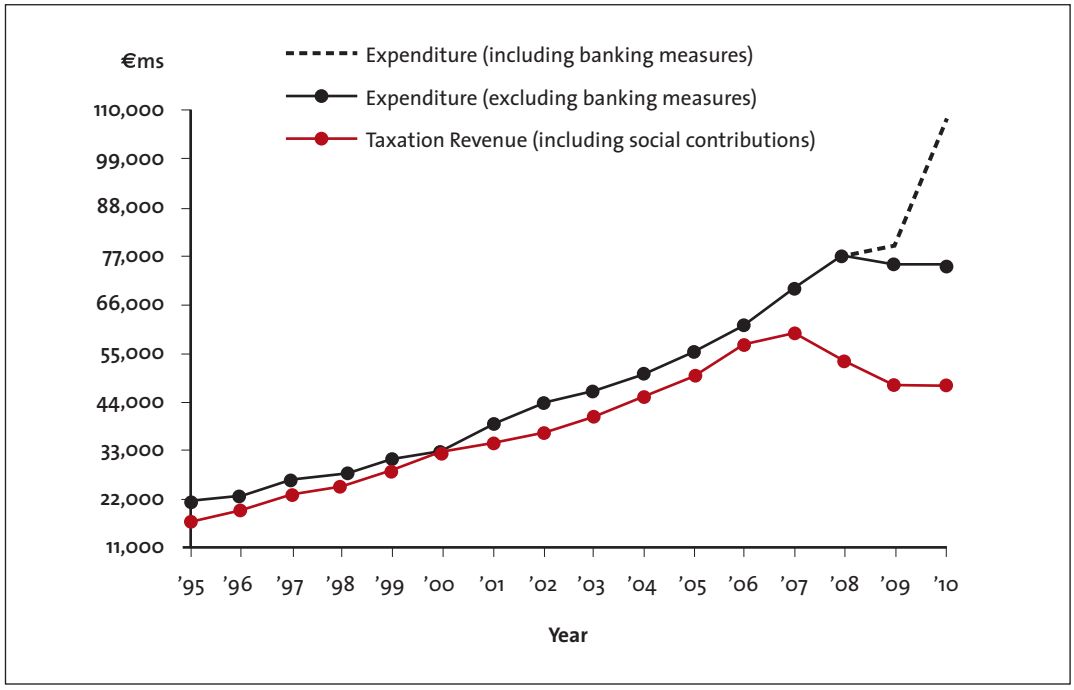
3.20 The composition of tax revenue is unsustainable and has become increasingly narrow, with heavy reliance on income tax (40.5 per cent) and consumption taxes (VAT 29.3 per cent and excise duty 13.4 per cent) projected for 2011 [34]. With €8.32 out of every €10 in state tax revenue coming from income and consumption taxes, the current crisis

highlights the fact that wide-reaching tax reform is a necessity, not an option [7]. However, tax reform must be undertaken in a way that makes the tax system more progressive, with those who benefit the most from our economy contributing the most through taxation.

3.21 Spending on public services is financed through tax revenue (including social contributions), which must be stable, sustainable and sufficient. The structure of the tax system should also be broadly based, drawing from all sectors of the economy, so that it can better withstand recessions and global financial turmoil. Ireland's tax policy did not meet these criteria in recent years.

3.22 Ireland's tax revenue fell by nearly a third (€14.5 billion) in the two-year period from 2007 to 2009 [35]. Figure 9 illustrates the collapse in tax revenue, which was a result of the tax system's vulnerability and the over-reliance on certain industries. For example, at least a quarter of the fall in revenue can be explained by the collapse in the housing/construction industry; and tax receipts from construction-related activity are unlikely to ever recover their previously high levels. The scaling back in government spending itself also impacted negatively on tax receipts.

Figure 9: Total state expenditure v. total tax revenue (including social contributions) in €ms.



Source: Eurostat (2010) Government finance statistics (online). Available at: http://epp.eurostat.ec.europa.eu/portal/page/portal/government_finance_statistics/data/database [16 December 2010].

3.23 A stable and progressive tax system requires taxes on wealth, as well as income and consumption. Taxes on wealth (such as property tax) are redistributive and tend to be more stable during a recession. These taxes need to be part of the mix in providing stable and sustainable revenue for the State [23].

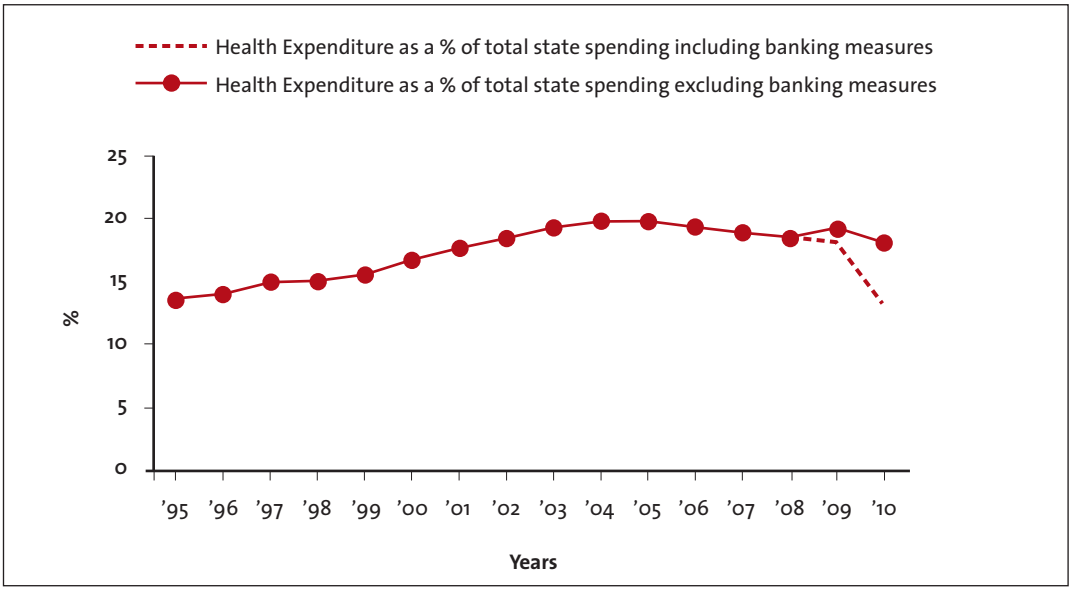
7 Note that social security contributions are additional to 'tax revenue', and thus these three sources are not 83 per cent of all revenue

3.24 Eliminating health inequalities requires a different economic model. Such a model would provide sufficient levels of social spending which protect the health and wellbeing of the poorest, and of society generally, through universal, quality public services. In Part 5 of this report, TASC sets out the re-distributive measures that are needed to increase the tax take, ensuring that those who benefit most from the economy contribute the most through taxation. TASC also identifies the areas of public spending that impact most on health inequalities, and therefore require increased resources.

IRISH HEALTH SPENDING

3.25 Government spending on healthcare significantly increased in real terms over the period 1995-2008 (Figure 10). The nominal amount the State allocated to the health services increased from just under €3 billion in 1995 to €13.5 billion in 2010[8]. In the period between 1995 and 2005, spending on health accounted for a growing proportion of overall public spending. This trend started to reverse in 2006, when the proportion of public spending allocated to health declined. Although the ratio of government spending on healthcare to GDP increased between 2007 and 2008, this increase occurred because of the sharp contraction in the economy in 2008, as opposed to a surge in government spending on healthcare services.

Figure 10: Public spending on healthcare as a percentage of total government expenditure.



Source: Eurostat (2010) Government finance statistics (online). Available at: http://epp.eurostat.ec.europa.eu/portal/page/portal/government_finance_statistics/data/database [16 December 2010].

3.26 International comparisons of government expenditure on healthcare show that public spending on health services in Ireland has risen quite rapidly compared with other EU and OECD states. However, when Ireland is compared with other OECD countries over time (1995-2008), we are ranked 17th out of 25 countries (see Table 1), with spending averaging 6.1 per cent of GDP. The top three spending countries over the same timeframe were Iceland (8.1 per cent), Austria (7.7 per cent) and France (7.5 per cent).

8 These figures are calculated using the COFOG method which is explained further in footnote 9

Table 1: Total government expenditure on health as a percentage of GDP (OECD data): A 14-year average, 1995-2008.

RANK	COUNTRY	AVERAGE
1	Iceland	8.08
2	Austria	7.67
3	France	7.50
4	Norway	7.29
5	Denmark	6.99
6	United States	6.94
7	Belgium	6.64
8	Sweden	6.60
9	Japan	6.47
10	Czech Republic	6.44
11	Canada	6.41
12	Finland	6.35
13	Germany	6.23
14	Italy	6.23
15	New Zealand	6.22
16	United Kingdom	6.21
17	**Ireland**	**6.10**
18	Slovak Republic	5.50
19	Spain	5.41
20	Hungary	5.26
21	Luxembourg	4.75
22	Greecec	4.73
23	Poland	4.50
24	Netherlands	4.36
25	S. Korea	2.90

Source: McDonnell T. and McCarthy D. (2010) Public Expenditure Discussion Paper: The Composition of Spending, Income Equality and Economic Growth, TASC, Dublin 2010.

3.27 Although Table 1 uses GDP, Irish government analyses use GNI (Gross National Income) as well as GDP, since Ireland is a 'special case' given the larger gap between GDP and GNI, compared to other developed countries[9]. Government expenditure on health was 7.65 per cent of GNI over the same period. Using GNI, the level of health spending in Ireland compares well with other OECD countries.

3.28 To put Ireland's improved health spend into context, increases in health spending started from a low base in the 1990s following the severe cutbacks in the 1980s which were made in response to the then weakness in the public finances. It took a considerable time for health spending to recover from the cuts in the 1980s, and it can be argued that the provision of health services did not fully recover from these cuts.

3.29 In the current climate of cutbacks there is a real danger of repeating the same mistakes as were made in the 1980s. While greater efficiencies are required in the delivery of health services, it will be increasingly difficult for the Health Services Executive (HSE) to provide the same level of services to a growing population with fewer staff and less money[10].

3.30 Budget 2010 resulted in a five per cent cut in health expenditure, while Budget 2011 resulted in a further 6.6 per cent cut to the health budget, with €746 million less allocated to health in 2011 than in 2010. Many of the cuts are earmarked for non-frontline services, such as a €200 million reduction in drug costs, €200 million reduction in staff and professional fees' costs and €170 million through procurement.

3.31 Four-fifths of Irish health expenditure is public money, while the remaining fifth is derived from private sources – with about half of this coming from health insurance, and the rest from increasing out-of-pocket charges [(36)]. Low-income groups are less likely to have private health insurance and are more dependent on the public health system. A failure to invest in public health and social care, or investment without systemic reform that eliminates inequities in the system, disproportionately affects those who need the service most.

3.32 In Part 5 of this report, TASC examines commitments in the Programme for Government to a universal single-tier health service based upon ***"the principle of European social solidarity"*** and suggests the actions required to fully realise this commitment.

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9 The TASC figures used in Table 1 are calculated based on the United Nations methodology of dividing public spending into ten functional categories of Government (known as the COFOG categories). For example, health, education and defence are three separate functional categories. The COFOG system is the universal standard for quantifying public spending and is endorsed and used by the CSO, the OECD and Eurostat because it facilitates international comparisons of spending patterns in terms of GDP. The Department of Health calculates health spending using GNI, because of Irish exceptionalism with regard to GDP. The Department also includes certain items of expenditure which are not counted as items of health spending at the international level – for example residential services for children and people with disabilities. The OECD uses 'GDP only' for all of its COFOG (functional categories of government) spending.

10 The Programme for Government states that the HSE will cease to exist over time. It is not yet clear how the Department of Health will deliver health services into the future.

4. Health Services as a Determinant of Health

HEALTH SERVICES AND INEQUALITY

4.1 The Irish health system is a complicated mix of public, private and voluntary care providers, with unfair, unclear and complex routes in and through the system for the patients and users of health services.

4.2 Ireland, unlike many other European countries such as France, Germany and the UK, does not provide universal access to healthcare which is free at the point of delivery. Access to essential healthcare can depend on ability to pay rather than medical need.

4.3 The structural inequality in access to the Irish healthcare system compounds existing inequalities in the health status of the Irish population. Successive governments have reinforced the fundamental fault-line in the Irish health system – unequal access for public patients who are usually poorer and sicker.

EUROPEAN HEALTH POLICY

4.4 In 2006, the Irish government, together with its EU partners, agreed a statement of common values and principles that underpin EU health systems and provide the framework for an explicit statement of national health policy in this country [37]. Following the decision to exclude healthcare from the scope of a Directive requiring competition in the provision of services within the EU, the member states acknowledged that health systems are a central part of Europe's vision of social protection and make a major contribution to social cohesion, social justice and sustainable development [38].

4.5 In their statement, the European health ministers pledged to protect the values of universality, equity, solidarity and access to good quality care. It is worth elaborating on what these values mean:

- **Universality** – no one is denied access to medical care;
- **Equity** – there is equal access according to need regardless of ability to pay, ethnicity, gender, age or social status;
- **Solidarity** – the cost of medical care and health systems is borne fairly across society and in such a way that accessibility to all is guaranteed;
- **Access to good quality care** – medical care is safe, of a high quality and responsive to patients' needs.

4.6 In the same declaration, EU member states committed themselves to reducing the gap in health inequalities and to a greater focus on prevention and health promotion. The new government must ensure that the commitments set out in the Programme for Government are consonant with its commitment to these principles (and those of the health strategy).

4.7 The Programme for Government (p.31) makes an explicit commitment *"to developing a universal, single-tier health service, which guarantees access to medical care based on need, not income"* [28]. For this commitment to be realised, the policies reinforcing health inequalities will have

to be addressed. This part of the report highlights a number of key issues that need to be tackled as part of the Government's commitment to a single-tier health service based on need rather than ability to pay.

OVERVIEW OF IRELAND'S HEALTH SYSTEM

4.8 Reducing health inequalities and ensuring equitable access to services are objectives of the government's National Health Strategy set out in *Quality and Fairness – A Health System for You* [39]. These objectives were reaffirmed in the EU declaration of 2006. Little has been done since the strategy was published to measure, let alone reduce, health inequalities or the many inequities in access to health services. Instead, the emphasis has been on administrative and organisational change, the privatisation of health services and restrictions in entitlements to free care.

4.9 The *Report of the Expert Group on Resource Allocation and Financing in the Health Sector* (p. xi) [40] crystallises the ways in which current policy reinforces the two-tier health system. It noted that:

"...the group found that the current financing system lacks transparency, gives rise to serious inequities in access to care and results in numerous anomalies... for users of care. For example:

- *over two thirds of the population pay for GP and many community-based services on a pay-as-you-go basis, which takes no account of their ability to pay.*
- *individuals who can afford private health insurance gain access to some hospital services quicker than those with equivalent health needs who do not have insurance;*
- *high pay-as-you-go GP charges are known to deter use of care, increasing the risk of later detection of medical problems, with the likelihood of higher costs in terms of health care in the longer term;*
- *there are widespread anomalies in the current long-term illness system: some important diseases are covered, but equally serious ones are not."*

4.10 Users of the health system can be divided into three main groups, although there are some overlaps between these groups and significant diversity within them. The three main groups are those with medical cards, those with private health insurance and those without either.

4.11 The General Medical Services (GMS) scheme provides medical cards for individuals and their dependents on the basis of low income and, occasionally, on the basis of medical need, if that medical need is deemed to cause 'undue' hardship.

4.12 As of Feburary 2011, approximately 36 per cent of the population (1,634,676 people) was covered by medical cards. This represents a nine per cent increase from February 2010. The growing number of people who are eligible for a medical card reflects falling incomes and higher levels of unemployment [41].

4.13 The second (and largest) group – those with private health insurance – represents just under half of the population; 2,228,000 people had private health insurance in December 2010 (49.8 per cent). This represents a drop of less than one per cent from December 2009,

when just over half the population (50.6 per cent) had private health insurance [42]. Private health insurance covers inpatient hospital care but rarely covers all outpatient, diagnostic and primary care costs.

4.14 All Irish residents, including those with private health insurance, are entitled to specialist and hospital care at a charge capped at €750 per year. However, many Irish residents take out private health insurance out of fear of delayed access to essential hospital care if they do not have insurance. This is why there is such a high proportion of the population with private health insurance, and it is symptomatic of the two-tier nature of access to specialist and hospital care in Ireland.

4.15 Much of the private health care in Ireland is provided through the public hospital system, which in effect means that the provision of private health care is subsidised by public money. While nearly 50 per cent of the population has insurance, insurance contributions cover just ten per cent of all health care costs.

4.16 The third category is made up of people without either private health insurance or a medical card. These are the people who fare worst in the Irish health system, as they have to pay for every GP visit, all costs of prescription drugs up to €120 per month, and any hospital costs that exceed the annual cap of €750 per year.

4.17 Under the consultants' contract introduced in 2008, all public hospitals are required to have a common waiting list (for treatment rather than diagnosis) for all patients, both public and private. However, there are ways around the 'common waiting list' in public hospitals. For example, if one is referred by a GP to a specialist and the waiting time is months (or even years), by going privately, one can then be referred to the public hospital as 'urgent'. If deemed urgent, one will be seen by a consultant quicker than the patient who cannot afford to pay privately and has to wait to be assessed as a public patient. Furthermore, if one can get and afford care in a private hospital, access will usually be quicker than in a public hospital.

4.18 There are also many perverse incentives and contradictions within the Irish health system. For example, while it is government health policy to shift care from hospitals to the community, many services are provided free if accessed through the public hospital system (such as physiotherapy and drugs), whereas those without medical cards have to pay for them in the community [40].

IRISH HEALTH POLICY

4.19 The development of the Irish health services during the past decade was ostensibly guided by policy outlined in the National Health Strategy [39]. Although it outlined a seven-to-ten-year plan for Irish health services, many of the actions recommended in the report remain unimplemented ten years on from the publication of the Strategy [43].

4.20 Crucially, none of the follow-up reports (Hanly [44], Prospectus [45], Brennan [46] or the Health Service Reform Programme [47] [48]) made any recommendations to address the structural inequalities – such as the two-tiered health system – that exist within the Irish health system. Neither the Health Strategy nor any of the subsequent documents made any recommendations for a universal health system where access is based on need, rather

than ability to pay. The new Programme for Government marks a clear departure from previously stated policy in this regard.

4.21 As a result of the various reports published in the aftermath of the National Health Strategy, a 'health service reform' programme was embarked upon which resulted in the abolition of the health boards and the establishment of the Health Service Executive (HSE) in January 2005. The aim of the new HSE was to ensure quality and standards across health and social care services in all parts of the country, but crucially its remit did not include removing inequalities in access to services.

4.22 Six years on from the establishment of the HSE, the Programme for Government states that the HSE will cease to exist over time, with many of its functions returning to the Department of Health, or being taken over by the new Universal Health Insurance system[11]. There are also plans to create a number of new bodies/entities covering areas such as integrated care, child welfare and children's services, hospital insurance fund and a hospital care purchase agency.

4.23 This process of reconfiguration and transformation will require a considerable amount of co-operation, capacity and time. The goal of achieving a single-tier health system that is free at the point of delivery will have to be a driving force behind the planned change, and care will have to be taken to ensure that the process of change does not become an end in and of itself.

PRIMARY CARE POLICY

4.24 The literature on reducing health inequalities highlights how the organisation of primary care and mental health services, and the prevention of chronic diseases, are of particular importance in reducing the burden of ill health on those on low incomes [(2)].

4.25 Progress on the implementation of the Primary Care Strategy has been slow since its launch in 2001. However, the Programme for Government places a strong emphasis on primary care and sets out a series of commitments that have the potential to radically transform this area of care. In particular, the commitment to extend free access to GPs to the whole population by 2016 through the establishment of a Primary Care Fund, and through the provision of adequate staffing, is to be welcomed. The provision of free primary care is critical for more equal access to basic health care and for embedding preventative initiatives in the healthcare system.

MENTAL HEALTH POLICY

4.26 In 2006, a new mental health policy – *A Vision for Change* – was published [(49)]. This outlined an ambitious ten-year programme for reforming mental health services. It focused on moving care from the hospital to the community where possible and appropriate; on providing quality mental health services with a particular focus on

11 The first step was taken on the 28th April 2011, when the Board of the HSE resigned at the request of the Minister for Health.

recovery; on ensuring the participation of mental health service users in their own care plans, and on removing the stigma and discrimination associated with mental illness.

4.27 An independent monitoring group set up to assess progress of *A Vision for Change* has been consistently critical of the HSE's failure to deliver commitments in the policy, the lack of funding to match the service developments required, and the absence of senior HSE leadership in mental health. The Programme for Government's commitments to mental health incorporate the recommendations contained in *A Vision for Change*. These include:

- The provision of a comprehensive range of mental health services through universal health insurance;
- The provision of mental health services in the primary care setting;
- Ring-fencing €35m annually to develop community mental health teams and services outlined in *A Vision for Change*;
- Closing unsuitable psychiatric institutions and ending the practice of placing children and adolescents in adult psychiatric wards.

4.28 While the Programme for Government brings a much-needed renewed focus to the area of mental health, the ring-fencing of €35 million will do little more than extend existing pilot initiatives or support new initiatives on a pilot basis. Significant political leadership and resourcing is required to address the neglect and under-resourcing experienced by this area over the last number of decades.

FAILURE TO IMPLEMENT HEALTH POLICY

4.29 One significant feature of health policy and plans in Ireland in the last number of years has been the virtual absence of any policies or plans in relation to health inequalities.

4.30 The Programme for Government includes a range of commitments relating to political and public sector reform that will have implications for the policymaking process, as well as for the organisation and delivery of public services. These commitments present an opportunity for:

- The political system to provide the necessary political leadership required to address health inequalities at Cabinet and Committee level;
- The Department of Health to be reconfigured in a way that places a greater emphasis on population health;
- An evidence-based approach to population health policymaking to be institutionalised across all areas of public policy.

4.31 In Part 5, TASC sets out a number of actions that are required to put the necessary political and institutional frameworks in place to address health inequalities on a systemic basis.

PRIVATISATION OF HEALTHCARE

4.32 Over the past decade, the trend has been for many aspects of health and social care provision to be contracted-out and privatised. Government policy has supported privatised healthcare through a range of measures, including the use of tax expenditures [(23)]. Reliance on tax breaks[12] as the basis for healthcare clearly fosters inequality in our health system, since they favour high income earners who benefit from the breaks and who can afford to spend more on health care.

4.33 Changes to the Finance Acts in 2001 and 2002 opened up the healthcare market to developers through the use of generous tax breaks[13]. This has resulted in a significant increase in the numbers of private hospitals, health clinics and nursing homes, as well as the appearance for the first time in Ireland of shareholder-driven and profit-driven health companies.

4.34 The combination of tax breaks to support privatised healthcare with tax relief on medical expenses reinforces inequalities in the health system, rather than ensuring equitable access to health services by all sections of the population. On one level the State supports those on very low incomes through the medical card scheme while, on another level, the State supports higher earners through generous tax breaks/reliefs on medical expenses. In the middle, ordinary households struggle to pay health insurance or do not have adequate (or any) health insurance.

4.35 The 2009 Commission on Taxation estimated that tax relief on medical insurance and health expenses costs €500 million per annum.[14] The Resource Allocation Group recommended the phasing-out of tax reliefs for private health insurance. They found tax reliefs lacked transparency, were inequitable and were inefficient in terms of targeting government resources.

4.36 They also highlighted the *ad hoc* nature of tax reliefs granted to developers to build private health facilities. For example, while cancer services were centralised in eight specialist centres, tax breaks were given to developers to open small private hospitals anywhere, some of which provide cancer services.

4.37 The Programme for Government includes a commitment to publish cost-benefit analyses of major infrastructure proposals and 'tax expenditures' in advance of government approval. TASC has made a series of policy proposals in relation to the use of tax expenditures which are relevant to the provision of health care, and several of these proposals are summarised in Part 5 of this report.

PRIVATE HEALTH INSURANCE

4.38 Given that the vast majority of health care is funded through general taxation, a surprising number of people are covered by voluntary private health insurance in Ireland. This is because private health insurance can enable speedier access to diagnosis and care (even in public hospitals), and because it has been tax effective to buy health insurance.

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12 'Tax breaks' is the common term used to describe tax expenditures

13 The 2009 Finance Act terminated tax relief for the construction of private hospitals

14 Tax relief on medical insurance cost €321 in 2008 and tax relief on medical expenses cost €167 million in 2006

4.39 A robust health insurance market depends on the premia of the young and the healthy to fund those of older and less healthy subscribers. There has to be a measure of inter-generational solidarity underpinning the market if it is to work well. That is why the government, when opening the market to competition, insisted on community rating, prohibiting discrimination on grounds of age or medical condition.

4.40 To work, community rating must be underpinned by risk equalisation between companies so that those with larger numbers of older and sicker patients can afford to fund their medical costs. The failure to act on risk equalisation to protect community rating has created a very unstable health insurance market.

4.41 This has given rise to a situation whereby the company with the largest number of older and sicker members – the VHI – has raised some of its premia by up to 45 per cent. The VHI, a mutuality established by government in 1957, is being put at a disadvantage *vis-à-vis* the two other health insurance companies.

4.42 The Programme for Government commits the coalition to introducing a system of risk equalisation for the current insurance market, and it also reverses the decision of the previous government to sell the VHI: instead, it will be kept in public ownership to retain a public option in the new Universal Health Insurance (UHI) system.

FINANCING HEALTH CARE (PROGRAMME FOR GOVERNMENT)

4.43 In a bid to end discrimination between patients on the grounds of their ability to pay or insurance status, the Government plans to introduce Universal Health Insurance with equal access to care for all by 2016. Exchequer funding for primary care will go to a Primary Care Fund on a transitional basis; this will pay providers for primary care. A Hospital Insurance Fund will also be established, and Exchequer funding will be used to subsidise or pay insurance premia for those who qualify for a subsidy.

4.44 The goal under UHI will be to create an integrated system of primary and hospital care. UHI will be mandatory, with competing public or private providers and insurance payments related to ability to pay. The legislative basis will be established by the Universal Health Insurance Act.

4.45 In Part 5 of this report, TASC sets out the approach that should be taken and identifies a series of actions required to deliver health care rooted in the principle of need-based access that is free at the point of delivery.

5. Actions to Eliminate Health Inequalities

5.1 In order to improve health outcomes for all and reduce health inequalities, the evidence suggests that three interdependent approaches need to be adopted [1]. These are: targeting health initiatives at specific groups such as Travellers; reducing differentials in health outcomes between socio-economic groups by improving the health of deprived/ disadvantaged groups; and reducing the social gradient in health by narrowing the gap between high and low-income groups.

5.2 In this report TASC highlights the link between economic inequality and health inequalities. This section sets out a series of measures that take account of the interdependent approaches listed above from an economic, fiscal, institutional and policymaking perspective. The implementation of these measures will make a significant contribution to reducing health inequalities.

EVIDENCE-BASED POLICYMAKING APPROACHES TO ADDRESSING HEALTH INEQUALITIES

5.3 TASC recommends that an Independent Review of Health Inequalities be established. The time is right for Ireland to take action on the issue of health inequalities, and an Independent Review of Health Inequalities is needed to address the three main themes identified by the WHO Commission on the Social Determinants of Health which are re-stated below:

- **Improve daily living conditions.** In particular, emphasising early childhood development and education; living and working conditions; and social protection for all.
- **Address the inequitable distribution of power, income and resources** through strengthened governance, support for civic society, and an accountable private sector.
- **Measure and understand the factors contributing to health inequalities** and assess the impact of actions aimed at tackling health inequalities. This can only be achieved by ensuring that data is gathered in respect of health inequalities; that policy is reviewed, and that new policies are evidence-based.

5.4 The Independent Review should be modelled on the approach adopted in England, where the Secretary of State for Health appointed an international expert to chair an independent review of health inequalities[15]. The Marmot Review identified the most effective evidence-based strategies for reducing health inequalities in England from 2010 onwards.

5.5 Many of the Review's recommendations have been included in the British Government's White Paper *'Healthy Lives, Healthy People: Our Strategy for Public Health in England'*, which sets out the Government's long-term vision for the future of public health and aims to create a 'wellness' service, and to strengthen both national and local leadership [50].

5.6 TASC proposes that the Independent Review of Health Inequalities should report within 12 months, and that its recommendations be used to form the basis of a new population health policy in Ireland. A Cabinet Sub-Committee should provide the political leadership required to drive change on a cross-departmental basis, while a proposed Joint Oireachtas Committee on Population Health would play an ongoing and pivotal role in monitoring

15 In England, the international expert appointed was Michael Marmot, the Chair of the WHO Commission.

the implementation of policy measures and strategies identified in the Review, with progress reported to the Dáil on an annual basis. Section 5.22 – 5.27 provides more detail on the institutional and political framework that is needed to support actions on eliminating health inequalities.

5.7 An evidence-based approach is required to ensure meaningful monitoring of the implementation of policy measures and strategies aimed at eliminating health inequalities. TASC proposes that the CSO should be given responsibility for preparing regular monitoring reports on health inequalities in Ireland to verify that progress is being made on the health status and outcomes of the population over time.

REDISTRIBUTING FOR BETTER HEALTH

5.8 This report clearly demonstrates the link between economic inequality and health inequalities. Eliminating health inequalities therefore requires a more equal distribution of wealth, income and resources combined with investment in social protection and quality public services. TASC has identified a series of redistributive measures that need to be implemented to create the conditions for addressing health inequalities.

5.9 TASC proposes that an Equality Statement be published as part of the annual budgetary process. The Equality Statement should explain how the government is ensuring that budgetary decisions are informed by equality considerations. The Equality Statement should also cover all areas of public spending, and include the distributional impact of proposed budgetary measures (changes to spending and taxation) on all income levels and on specific demographic groups, such as women and children. Good practice in Sweden [51] and Scotland [52] should be examined in this regard.

5.10 TASC argues for a gradual move toward Western European levels of taxation, so as to enable the provision of European standard public services. TASC has identified a series of short and medium-term progressive taxation measures that would facilitate this goal. The main taxation measures are summarised below.[53]

5.11 *Reform tax expenditures/reliefs.* Plans to reform and/or abolish tax expenditures will commence in 2011. However, this process needs to be accelerated as part of a broader process of tax reform in order to raise revenue and enhance the efficiency of the tax system. TASC has identified significant scope for savings in a number of areas, including pension tax reliefs, legacy property-based tax reliefs and reliefs associated with private health provision. TASC has previously called for all items of tax expenditure to be subject to economic efficiency and equality auditing[16].

5.12 *Increase existing taxes.* As with tax expenditures, all rates and types of taxation should be periodically subject to efficiency and equality auditing. To give one example, TASC argues that changes to the social security system are required. Currently, social security (employer and employee) contributions are the second-lowest in the European Union, and less than half the European average. This low level is unsustainable and should be increased. However, increases in employer and employee social security contributions should be part of a process of reforming the way in which healthcare is funded in Ireland.

16 See p.29-32 in TASC's *Proposals for Budget 2011 – Investing in Recovery, Jobs, Equality* for more information on economic efficiency and equality auditing of tax expenditures

5.13 In addition, although the base of Capital Acquisitions Tax was broadened through changes to the tax-free threshold in Budget 2011, TASC argues that there is scope for the rates of Capital Acquisitions Tax and Capital Gains Tax to be increased in the short term, along with further changes to the thresholds.

5.14 *Introduce new taxes.* In the short term, TASC proposes that an equality-proofed residential property tax be introduced as part of a comprehensive tax on immovable assets. These taxation measures would provide a stable source of funding for the Exchequer and would result in a more equitable distribution of society's resources.

5.15 The introduction of the Universal Social Charge (USC) in 2011 was the most regressive taxation measure announced as part of Budget 2011, and will considerably exacerbate economic inequality [54]. The composition of the USC is more regressive than the combined health and income levies it replaced. The Programme for Government includes a commitment to review the USC. This review should be undertaken as a matter of priority and adjustments made to make it more progressive.

5.16 The redistribution of income and wealth requires more public spending on services and social protection. TASC argues that increases in taxation should be used to provide higher levels of social spending in the areas of health and education. Investment in public health services, together with investment in primary and secondary education, has been found to have the biggest impact on income distribution. Health service financing is considered further below.

5.17 In the area of education, TASC welcomes the commitment in the Programme for Government to establish a Ministry for Children. The Marmot Review (p.20) prioritised ***"...giving every child the best start in life..."*** and set out a series of policy recommendations in this regard. TASC argues for more investment to be targeted in the area of early childhood care and education. Investment in this area has been identified as playing a critical role in addressing health inequalities, especially where policy measures are designed to break the links between early disadvantage and poor outcomes in later life [2].

FUNDING HEALTH ON THE BASIS OF SOLIDARITY

5.18 TASC welcomes the commitment in the Programme for Government to a universal single-tier health service based upon 'the principle of European social solidarity'. This commitment will have definite and clear policy implications for financing health care for all. TASC also welcomes the Programme's commitment to primary care, as this is critical to ensuring more equal access to basic health care and embedding preventative initiatives in the healthcare system.

5.19 TASC argues that the financing of commitments related to health can only be fully realised through a model of universal social health insurance combined with general taxation. TASC contends that a model of social health insurance should be financed through increased employer and employee social insurance contributions. When this is combined with revenue from general taxation, social health insurance benefits can be extended to cover all Irish residents such as low earners and those who are not in the workforce (for example, dependent children/adults), in order to provide equal access to the health system.

5.20 There are many variations of universal health insurance, and TASC proposes that the merits of a single social health insurance fund be evaluated alongside the option of competing public and private insurers in the forthcoming White Paper on Financing Universal Health Insurance. TASC supports the analysis put forward by the Adelaide Hospital Society, which is in turn supported by international evidence, that a single not-for-profit fund should be established in the initial phase of implementing universal social health insurance [55] [56].

There are a number of benefits to this approach, which are summarised below:

- It would give the public confidence that the fund is focused primarily on the patient and patient care, rather than profit;
- It would minimise administration costs, avoid risk equalisation systems and minimise disruption;
- It would create greater efficiency through the economies of scale resulting from a single fund. The international evidence suggests that private health insurance companies do not yield greater efficiency and cost control. In the Netherlands, which has multiple competing private insurers, cost containment is a growing problem with the costs of the Dutch healthcare system rising by almost six per cent between 2008 and 2009 [17].

5.21 The Programme for Government includes a commitment to introduce a Universal Health Insurance Act establishing the legislative basis for universal health insurance. TASC welcomes the commitment in the Programme for Government to establish a Primary Care Fund on a transitional basis under the proposed Universal Health Care Act. A Hospital Insurance Fund will also be established, and Exchequer funding will be used to subsidise or pay insurance premia for those who qualify for a subsidy. TASC argues that the Primary Care Fund and Hospital Insurance Fund should be merged in the medium term to create a single universal social insurance fund.

MAKING IRELAND HEALTHIER: REALIGNMENT OF PRIORITIES THROUGH POLITICAL LEADERSHIP

5.22 TASC argues that improved health and a reduction in health inequalities must be put at the heart of public policy. For this to be achieved, a series of changes is required to put the necessary institutional framework in place to ensure that all draft legislation and government policies are assessed for their impact on health and health inequalities.

5.23 The Programme for Government states that the Minister for Health will be responsible for health policy and that the HSE will cease to exist over time, with many of its functions devolving back to the Department of Health. This planned restructuring presents an opportunity for the Department of Health to be reconfigured in a way that places a greater emphasis on population health.

5.24 Currently, the Department of Health is too narrowly focussed on health services. This needs to change, and TASC recommends that a Population Health Division (within the Department of Health) be established with the necessary expertise headed at Chief Medical Officer / Assistant Secretary level.

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17 http://www.cbs.nl/en-GB/menu/themas/gezondheid-welzijn/publicaties/artikelen/archief/2011/default.htm

5.25 This report clearly shows that policy measures aimed at improving health and preventing health inequalities require greater inter-departmental co-ordination. This process of co-ordination must be driven at a political level, and TASC proposes the creation of a Cabinet Sub-Committee on Population Health whose role should be to drive the process of inter-departmental co-ordination of health, and the addressing of health inequalities, across all relevant government departments. This Committee should be chaired by the Minister for Health.

5.26 The creation of a Cabinet Sub-Committee on Population Health must be accompanied by greater transparency, and this will require reform of cabinet confidentiality to ensure that all relevant documents associated with the work and decision-making of such Committees are made public. The Programme for Government includes a commitment to legislate on the issue of cabinet confidentiality.

5.27 The Programme for Government has also identified the need to reform Dáil committees to ensure government is held to account. TASC argues that these reforms should include the creation of a Joint Oireachtas Committee on Population Health as one of the fewer but stronger committees with appropriate resources. TASC welcomes the commitment to give key committees ***'constitutional standing',*** along with the power to introduce legislation. TASC also welcomes the commitment in the Programme for Government to ensuring greater Oireachtas accountability; this will be enhanced by the Government's commitment to making it mandatory for relevant Ministers to appear before strengthened committees.

CONCLUSION: EQUALITY IS THE BEST MEDICINE

5.28 In this report, TASC demonstrates that eliminating health inequalities is indeed a matter of life and death. The evidence shows that unskilled workers living in deprived areas are more likely to die earlier than professional workers living in affluent areas.

5.29 Inequality is thus a preventable cause of death, and in this report we outline a number of policy approaches which can form part of that prevention. Implementing those policy approaches, however, will require a different economic model – an equality-centred model which protects and promotes the health and wellbeing of the poorest in particular, and of society in general, through high-quality universal public services. EU levels of social protection and quality public services will require EU levels of tax and social expenditure.

5.30 High-quality public services, which disproportionately benefit low-income groups, are also crucial to economic redistribution, and thus to economic equality. There is a growing body of evidence indicating that more equal societies do better across a range of outcomes, including health. Equality is good for everyone in society, regardless of whether they are at the top or the bottom of the income ladder. Once countries have reached a certain level of affluence, it is the distribution of wealth, combined with economic and social policies, that determines how healthy we are – and how equally healthy we are.

Appendix A:

HEALTH OF THE IRISH POPULATION

A.1 The Irish population has grown significantly over the last decade, with latest figures estimating the population at 4.5 million people in April 2010 – a 17 per cent population rise over ten years [57][5]. Ireland's population is increasing due to increased life expectancy and fertility rates[18].

A.2 The 2011 population is at its highest level in 150 years, and is expected to exceed five million by 2016 and six million by 2040. The number of those over 65 years of age is set to triple in the next thirty years, while births in recent years have hit the highest level since the foundation of the State, reaching 75,000 in 2008, with 17 births per 1,000 [5].

A.3 In 2007, Ireland's fertility rate was the highest in the EU and the Irish population is younger than the rest of Europe [5]. This demographic has implications for public policy choices in relation to the provision of education, pensions and the planning of health and social care services.

A.4 Ireland has also witnessed a greater improvement in life expectancy. Ten years ago, Irish life expectancy was one year below the EU average; by 2009, it was one year above the EU average - even though EU averages have also increased during this time. Life expectancy at birth for women is now 81.6 years, and 76.8 years for men [5].

A.5 Over two-thirds of deaths in Ireland are caused by diseases of the circulatory system and cancer. Most of the improvement in Irish life expectancy is related to reductions in certain diseases such as circulatory diseases; however, Irish cancer rates remain above the EU average. [5].

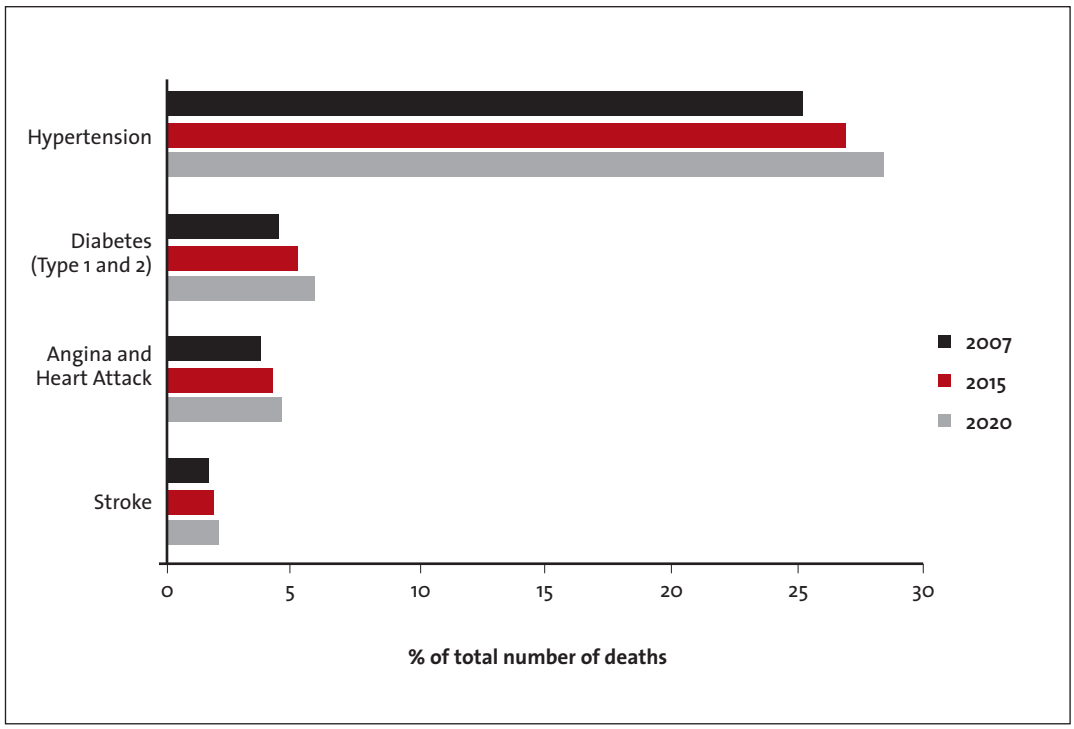
A.6 As people live longer, there is an associated rise in chronic conditions because the likelihood of living with one or more chronic conditions increases with age. There are no exact data on the prevalence of all chronic diseases in Ireland, but 38 per cent of the population reported having a chronic condition in 2007. This increased to over 62 per cent for those aged 65 years and over [58].

A.7 Almost 40 per cent of all adults reported at least one health condition (Figure 11). The most common was hypertension (10 per cent), followed by back pain (8 per cent) and high cholesterol (8 per cent). Eleven per cent of the population reported a long-term illness, health problem or disability that limits daily activity. This increased to 25 per cent for over 65 year olds [5][59].

A.8 Work carried out by the Institute of Public Health in Ireland predicted a 40 per cent increase in the numbers of people living with chronic conditions such as hypertension, coronary heart disease, stroke and diabetes by 2020, as illustrated in Figure 11 [13].

18 The preliminary population results from Census 2011 will be published in June 2011

Figure 11: Predicted prevalence rates four chronic illnesses in Ireland: 2007, 2015 & 2020



Source: Institute of Public Health (2010, p9) Making Chronic Conditions Count: Hypertension, Stroke, Coronary Heart Disease, Diabetes. Available at: http://www.publichealth.ie/files/file/Making%20Chronic%20Conditions.pdf [17 December 2010].

A.9 In the absence of good health status data, lifestyle factors which are determined by a range of social and economic factors are used as a proxy for health. In the 2007 *SLÁN* survey, 38 per cent of adults were overweight and 23 per cent were obese. A higher percentage of Irish men and women are overweight or obese compared to the majority of our European counterparts, and Irish obesity levels are increasing year on year. Children and young Irish adults are emulating their parents' habits, with one in four nine year olds found to be either overweight or obese [60].

A.10 Just over half the adult population engages in physical activity two to three times per week for more than 20 minutes, while 22 per cent are physically inactive. Irish people have not become any more active over time, and are comparatively inactive when compared to many of our European neighbours [5]. However, there has been a reduction in overall smoking rates, decreasing for the population from 33 per cent in 1998 to 29 per cent in 2007 [5].

A.11 In Ireland, alcohol consumption levels are amongst the highest in the EU. A 2007 Eurobarometer study found that 34 per cent of Irish drinkers consumed five or more drinks per occasion compared to the EU average of 10 per cent [61].

A.12 Overall, the health of the Irish population compares well with other European countries. However, this masks inequalities in health outcomes for certain sections of the population – for example, low-income and deprived groups.

Appendix B:

INSTITUTE OF PUBLIC HEALTH EXPLANATORY NOTE ON POTENTIAL YEARS OF LIFE LOST DUE TO SOCIAL CLASS DIFFERENCES IN MORTALITY IN IRELAND

B.1 In 2001, the Institute of Public Health (IPH) estimated that approximately five thousand deaths amongst working aged males would be avoided if we could eliminate the socio-economic differences in mortality that exist across the island of Ireland [15]. This figure has been cited by a number of sources including the Combat Poverty Agency [62].

B.2 In December 2010, the CSO published a groundbreaking study which matched 2006/2007 death records and 2006 population census records [12]. This linkage provided a more accurate description of the social class of people who had died.

B.3 The 2001 estimate relates to deaths amongst working aged males that would be avoided in the year that socio-economic differences in mortality were eliminated. But for most people who do not belong to the most advantaged socio-economic group, the impact would not be so immediate.

B.4 Most such people would not be at risk of imminent death. For them, extra years would be added to the end of their lives and the mortality benefit would be realised (sometimes much) later in the future. The CSO report allows these delayed mortality benefits to be estimated.

B.5 The IPH has used the CSO report to produce preliminarily estimates of the potential years of life lost due to social class differences in mortality in the Republic of Ireland. Moreover, females and people outside the working ages can be included in the calculation.

B.6 An initial crude calculation suggests that, if social class differences in mortality in Ireland were eliminated, then:
i) males would gain over 7 million extra years of life; and
ii) females would gain an extra 6.5 million years of life.
Of course, this mortality benefit would be realised over a long period as those, alive when the mortality differences were eliminated, die.

B.7 It must be emphasised that these calculations are preliminary and the estimates are indicative. They are based on very broad published CSO data. More reliable estimates, based on the full life table, will be published in the near future. The life table is a table which shows, for each age, what the probability is that a person of that age will die before his or her next birthday.

REFERENCES

1. Farrell C., McAvoy H., Wilde J. Combat Poverty Agency. *Tackling Health Inequalities - An All-Ireland Approach to Social Determinants.* Dublin. Combat Poverty Agency/Institute of Public Health in Ireland. 2008. Available at: http://www.publichealth.ie/files/file/Tackling%20health%20inequalities_0.pdf
2. Marmot M. Fair Society, Healthy Lives. *The Marmot Review. Strategic Review of Health Inequalities in England post-2010.* London. 2010. Available at: http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf
3. Wilkinson R. and Pickett K. *The Spirit Level: Why More Equal Societies Almost Always Do Better.* London. Allen Lane. 2009.
4. Marmot M., Friel S., Bell R., Houweling T., Taylor S. *Closing the gap in a generation: health equity through action on the social determinants of health.* The Lancet. 2008; 372(9650):1661-9. Available at: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)61690-6/abstract
5. Department of Health and Children. *Health in Ireland. Key Trends 2009.* Dublin. Department of Health and Children. 2009. Available at: http://www.dohc.ie/publications/pdf/keytrends09.pdf?direct=1
6. Central Statistics Office. Live Register. May 2011. Dublin. CSO. 2011. Available at: http://www.cso.ie/releasespublications/documents/labour_market/current/lreg.pdf
7. Central Statistics Office. Quarterly National Household Survey – Quarter 4 2010. CSO. Dublin. 2011. Available at: http://www.cso.ie/releasespublications/documents/labour_market/current/qnhs.pdf
8. McDonagh T and Loughrey J. *The H.E.A.P. Chart - (Hierarchy of Earnings, Attributes and Privilege Analysis)* Dublin. TASC. 2009. Available at: http://www.tascnet.ie/upload/file/HEAP%20BOOKLET.pdf
9. Marmot M., Friel S., Bell R., Houweling T. and Taylor S. *Closing the gap in a generation: Health equity through action on the social determinants of health.* Geneva. WHO. 2008. Available at: http://www.who.int/social_determinants/thecommission/finalreport/en/index.html
10. Klugman J. *Human Development Report 2010. 20th Anniversary Edition. The Real Wealth of Nations: Pathways to Human Development.* New York. United Nation Human Development. 2010. Available at: http://hdr.undp.org/en/reports/global/hdr2010/
11. Stiglitz J. *Commission on the Measurement of Economic Performance and Social Progress. Paris. Commission on the Measurement of Economic Performance and Social Progress.* 2009. Available at: http://www.stiglitz-sen-fitoussi.fr/en/index.htm
12. Central Statistics Office. *Mortality Differentials in Ireland.* Dublin. CSO. December 2010 Available at: http://www.cso.ie/census/documents/Mortality_Differentials_in_Ireland.pdf
13. Balanda K.P., Barron S., Fahy L., McLaughlin A. *Making Chronic Conditions Count: Hypertension, Stroke, Coronary Heart Disease and Diabetes.* Dublin. Institute of Public Health in Ireland. 2010. Available at: http://www.publichealth.ie/files/file/Making%20Chronic%20Conditions.pdf
14. Madden D. *The Socioeconomic Gradient of Obesity in Ireland* in: SERIES UGIDP, editors. Dublin. University College Dublin. Geary Institute. 2010. Available at: http://ideas.repec.org/p/ucd/wpaper/201047.html

15. Balanda K.P., and Wilde J. *Inequalities in Mortality 1989 – 1998. A Report on All-Ireland Mortality Data.* Dublin. Institute of Public Health. 2001. Available at: http://www.publichealth.ie/files/file/Inequalities%20in%20Mortality.pdf

16. Brugha R., Tully N., Dicker P., Shelley E., Ward M. and McGee H. *SLÁN 2007. Survey of Lifestyle, Attitudes and Nutrition in Ireland. Smoking Patterns in Ireland: Implications for policy and services.* Dublin. Department of Health and Children. 2009. Available at: http://intranet.rcsi.ie/slan06/SLAN_2007_Smoking_Report.pdf

17. McAvoy H., Sturley J., Burke S. and Balanda K.P. *Unequal at birth - Inequalities in the occurrence of low birthweight babies in Ireland.* Dublin. Institute of Public Health in Ireland. 2006. Available at: http://www.publichealth.ie/publications/unequalatbirthinequalitiesintheoccurrenceoflowbirthweightbabiesinireland

18. All Ireland Traveller Health Study Team. *All Ireland Traveller Health Study: Our Geels.* School of Public Health, Physiotherapy and Population Science. Dublin. University College Dublin. 2010. Available at: http://www.dohc.ie/publications/traveller_health_study.html

19. Central Statistics Office. *Survey of Income and Living Conditions (SILC) 2009.* Dublin. CSO. 2010. Available at: http://www.cso.ie/releasespublications/documents/silc/current/silc.pdf

20. End Child Poverty Coalition. *Child Poverty: Ireland in Recession.* Dublin. April 2011. Available at: http://www.svp.ie/Files/Social-Justice/Child-Poverty-in-the-Recession-April-2011.aspx

21. Central Statistics Office. *Women and Men in Ireland 2010.* Dublin. CSO. 2011. Available at: http://www.cso.ie/releasespublications/documents/other_releases/2010/womenandmen2010.pdf

22. Department of Finance. *EU/IMF Programme of Financial Support for Ireland.* Dublin. 28th April 2011. Available at: http://www.finance.gov.ie/documents/publications/other/2011/draftmoumay2011.pdf

23. O'Connor N. and Pentony S. *Failed Design? Ireland's Finance Acts and their Role in the Crisis.* Dublin. TASC. 2010. Available at: http://www.tascnet.ie/upload/file/Analysis%20of%20the%20Finance%20Act%202010%2004%20May%202010%20FINAL%20print%20format.pdf

24. TASC. *Response to Budget 2011.* Dublin. TASC. 2010. Available at: http://www.tascnet.ie/upload/file/TASC%20Response%20to%20Budget%202011.pdf

25. *National Recovery Plan 2011-2014.* Dublin. National Stationary Office. 2010. Available at: http://www.budget.gov.ie/The%20National%20Recovery%20Plan%202011-2014.pdf

26. Kumhof M. and Rancière R. *Inequality, Leverage and Crises.* IMF Working Paper WP/10/268, 2010. Available at: http://www.imf.org/external/pubs/ft/wp/2010/wp10268.pdf

27. Judt T. *Ill Fares the Land. A Treatise On Our Present Discontents.* London. Allen Lane. 2010.

28. Department of the Taoiseach. *Programme for Government 2011.* Dublin. 2011. Available at: http://www.taoiseach.gov.ie/eng/Publications/Publications_2011/Programme_for_Government_2011.html

29. Stuckler D., Basu S. and McKee M. *Budget crises, health, and social welfare programmes.* BMJ 2010; 340:c3311. 10 July 2010. Available at: http://www.bmj.com/content/340/bmj.c3311.full?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=David+Stuckler+&searchid=1&FIRSTINDEX=0&sortspec=date&resourcetype=HWCIT

30. McDonnell T. and McCarthy D. *Public Expenditure Discussion Paper: The Composition of Spending, Income Equality and Economic Growth.* Dublin. TASC. 2010. Available at: http://www.tascnet.ie/upload/file/DP%20PE%20Economic%20Growth%20and%20Inequality.pdf

31. European Commission. *Taxation Trends in the European Union, Data for the EU Member States, Iceland and Norway*. Brussels. Eurostat. 2010. Available at: http://ec.europa.eu/taxation_customs/taxation/gen_info/economic_analysis/tax_structures/index_en.htm

32. MacKenzie H. and Shillington R. *Canada's Quiet Bargain: the Benefits of Public Spending*. Toronto. Canada. CCPA. 2009. Available at: http://www.gpn.org/data/canada/PolicyAlternatives_ca_Benefits_From_Public_Spending.pdf

33. Department of Finance. *Economic and Fiscal Outlook 2010*. Department of Finance. Dublin. 2010. Available at: http://www.budget.gov.ie/budgets/2011/Documents/Economic%20and%20Fiscal%20Outlook.pdf

34. Department of Finance. *End-April Analysis of Taxation Receipts*. Dublin. Department of Finance. 2011. Available at: http://www.finance.gov.ie/documents/exchequerstatements/2011/Aprtaxanal.pdf

35. Eurostat. Government Finance Statistics. Brussels. 2010. Available at: http://epp.eurostat.ec.europa.eu/portal/page/portal/government_finance_statistics/data/database

36. Nolan A. and Brick A. *The Sustainability of Irish Health Expenditure*. In: Callan T., editor. Budget Perspectives 2011. Dublin. ESRI. 2010. Available at: http://www.esri.ie/UserFiles/publications/jacb201057/jacb201058.pdf

37. Council of the European Union. *Council Conclusions on Common values and principles in EU Health Systems*. Brussels. 2006. Available at: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2006:146:0001:0003:EN:PDF

38. European Parliament and Council. *Directive 2006/123/EC*. Journal L376/36-68. December 2006. European Parliament and Council: Brussels. Available at: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2006:376:0036:0068:en:PDF

39. Department of Health and Children. *Quality and Fairness. A Health System for You*. Dublin. Department of Health and Children. 2001. Available at: http://www.dohc.ie/publications/pdf/strategy.pdf?direct=1

40. Department of Health and Children. *Report of the Expert Group on Resource Allocation and Financing in the Health Sector*. Department of Health and Children. Dublin 2010. Available at: http://www.dohc.ie/publications/resource_allocation/resource_allocation_report_hiRes.pdf?direct=1

41. Health Services Executive. *Performance Report on NSP 2011*. HSE: Dublin. February 2011. Available at: http://www.hse.ie/eng/services/Publications/corporate/performancereports/February_2011_Performance_Report.pdf

42. Schedule for FOI Briefing for Ministers Reilly and Fitzgerald. Available at: http://www.dohc.ie/publications/pdf/briefings_2011.pdf?direct=1

43. Burke S. *Irish Apartheid. Healthcare Inequality in Ireland*. 1st edition. Dublin. New Island. 2009.

44. Department of Health and Children. *Report of National Task Force on Medical Staffing (Hanly Report)*. Dublin. Department of Health and Children. 2003. Available at: http://www.dohc.ie/publications/pdf/hanly.pdf?direct=1

45. Department of Health and Children. *Audit and Structures and Functions in the Health System (Prospectus Report)*. Dublin. Department of Health and Children. 2003. Available at: http://www.healthreform.ie/pdf/audit-1.pdf

46. Department of Health and Children. *Commission on Financial Management and Control Systems in the Health Service (Brennan Report.)* Dublin. Department of Health and Children. 2003. Available at: http://www.lenus.ie/hse/bitstream/10147/46721/1/1776.pdf

47. Department of Health and Children. *The Health Service Reform Programme.* Dublin. Department of Health and Children. 2003. Available at: http://www.healthreform.ie/pdf/hsprog.pdf

48. Health Services Executive. *Report of the National Acute Medicine Programme.* Dublin. HSE. 2010. Available at: http://www.hse.ie/eng/services/Publications/services/Hospitals/AMP.pdf

49. Department of Health and Children. *A Vision for Change.* Report of the Expert Group on Mental Health Policy. Dublin. 2006. Available at: http://www.dohc.ie/publications/pdf/vision_for_change.pdf?direct=1

50. HM Government. *Healthy Lives, Healthy People: Our Strategy for Public Health in England.* London. 2010. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122347.pdf

51. Swedish Ministry of Finance. *From the Budget Bill for 2010. Budget Statement.* Stockholm. 2010. Available at: http://www.sweden.gov.se/content/1/c6/13/21/92/3e93368b.pdf

52. The Scotish Government. *Equality Statement - Scotland's Budget 2011-2012.* Edinburgh. 2010. Available at: http://www.scotland.gov.uk/Resource/Doc/331780/0107965.pdf

53. TASC. *Investing in Recovery, Jobs, Equality.* TASC Proposals for Budget 2011. Dublin. TASC. 2010. Available at: http://www.tascnet.ie/upload/file/Investing%20in%20Recovery,%20Jobs,%20Equality_%20executive%20summary_141010.pdf

54. McDonnell, T. *Reviewing the Universal Social Charge.* Dublin. TASC. 2011. Available at: http://www.progressive-economy.ie/2011/03/reviewing-universal-social-charge.html

55. The Adelaide Hospital Society. Universal Health Insurance: The Way Forward for Irish Healthcare. Policy Paper. Dublin. 2010.

56. The Adelaide Hospital Society. *Effective Foundations for the Financing and Organisation of Social Health Insurance in Ireland.* Dublin. 2010. Available at: http://www.adelaide.ie/cms/cms/uploads/files/Effective%20Foundations_Adelaide%20Hospital1.pdf

57. Central Statistics Office. *Population and Migration Estimates April 2010.* Dublin. CSO. 2010. Available at: http://www.cso.ie/releasespublications/documents/population/current/popmig.pdf

58. Department of Health and Children. *SLÁN 2007, Survey of Lifestyle, Attitudes and Nutrition in Ireland.* Dublin. 2008. Available at: http://www.dohc.ie/publications/pdf/slan07_report.pdf

59. Health Services Executive. *Health Status of the Population of Ireland 2008.* Dublin. HSE. 2009. Available at: http://www.hse.ie/eng/services/Publications/HealthProtection/Public_Health_/Health_Status_of_the_Population_of_Ireland.pdf

60. Department of Health and Children. *Growing Up in Ireland. Key findings: 9-year-olds. National Longitudinal Study of Children.* Dublin. Department of Health and Children. 2009.Available at: http://www.drugsandalcohol.ie/13231/1/Growing_Up_in_Ireland_-_The_Lives_of_9-Year-Olds_Main_Report.pdf

61. European Commission. *Eurobarometer: Attitudes towards Alcohol.* Brussels. 2007. Available at: http://ec.europa.eu/public_opinion/archives/ebs/ebs_272b_en.pdf

62. Barrington, R. *Poverty is bad for your health.* Policy Briefing Paper. Dublin. Combat Poverty Agency. 2004. Available at: http://www.cpa.ie/publications/DP5_PovertyIsBadForYourHealth_2004.pdf

TASC is an independent think-tank dedicated to addressing Ireland's high level of economic inequality and ensuring that public policy has equality at its core.

Eliminating Health Inequalities – A Matter of Life and Death examines how health inequality and economic inequality are interrelated. The report examines the social and economic factors determining health status, from an Irish perspective. The report identifies a wide ranging set of measures that, together, offer a blueprint for how to eliminate health inequalities. Drawing on recent international research, the report concludes that, once countries have reached a certain level of affluence, it is the distribution of wealth, combined with progressive economic and social policies, that determines how healthy we are – and whether or not health is enjoyed equally.

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