IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

BMA NORTHERN IRELAND

HEALTH Inequalities

A Joint Paper from the Irish Medical Organisation and the British Medical Association Northern Ireland

March 2012

THE MEDICAL PROFESSION HIGHLIGHT THEIR CONCERNS

Health Inequalities

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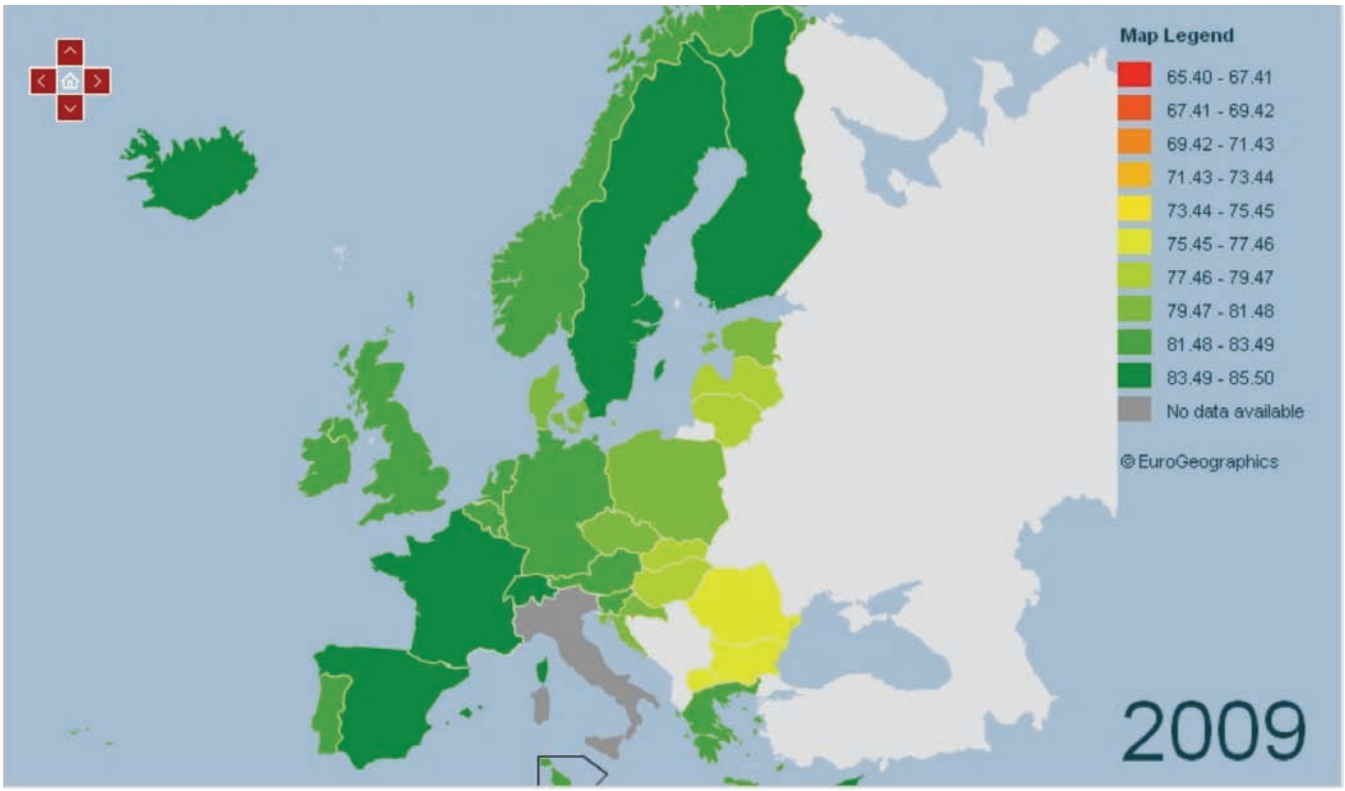
Health Inequalities in Europe

A Joint Paper from the Irish Medical Organisation (IMO) and the British Medical Association Northern Ireland (BMA NI).

In the EU, despite overall improvements in health, significant health inequalities exist both between and within member states. Eurostat figures for 2009 continue to show a large discrepancy in the rates for life expectancy at birth between Central and Eastern European member states and other European member states.

Female life expectancy at birth varies from 77.4 to 79.1 years in Bulgaria, Latvia, Lithuania, Hungary, Romania, and Slovakia compared to 83.2 to 85 years in Spain, France, Cyprus, Luxembourg, Austria, Finland and Sweden.

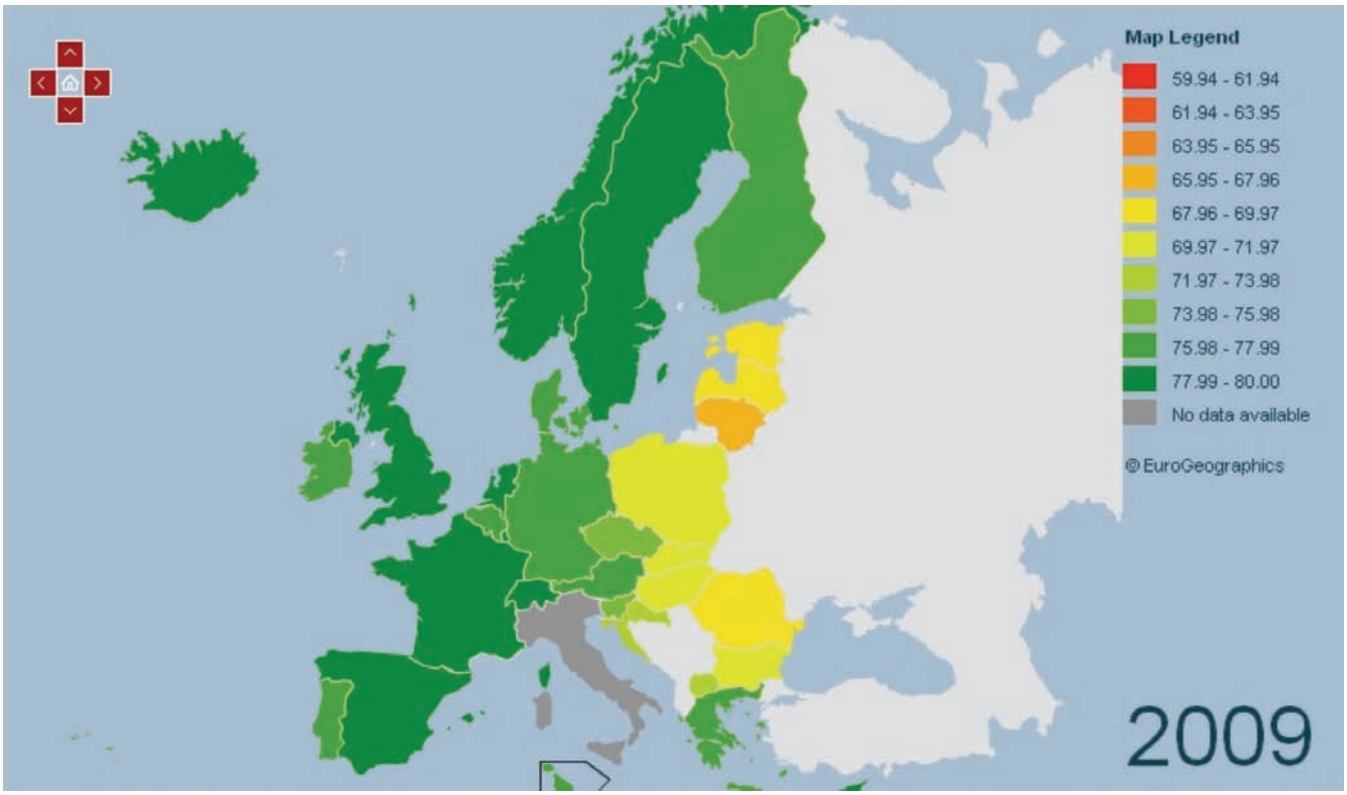
Female Life Expectancy at Birth in Years



Source: Eurostat and Heidi Data Tool.
downloaded from http://ec.europa.eu/health/social_determinants/indicators/index_en.htm

Male life expectancy at birth varies from 67.5 to 70.3 years in Bulgaria, Estonia, Latvia, Lithuania, Hungary, and Romania compared to 78 to 79.4 years in Spain, France, Cyprus, Luxembourg, Netherlands, Sweden and the UK.

Male Life Expectancy at Birth in Years



Source: Eurostat and Heidi Data Tool.
downloaded from http://ec.europa.eu/health/social_determinants/indicators/index_en.htm

Standardised death rates (SDRs) in Europe also show marked regional differences in death rates from cerebrovascular and ischaemic heart diseases with the highest rates in Eastern European Countries.

- For cerebrovascular diseases, SDRs of more than 1,000 per 100,000 inhabitants were found in regions of Bulgaria, Latvia and Romania while rates of less than 250 per 100,000 were found in areas of Austria, Denmark, Spain and France.

- For ischaemic heart diseases, SDRs of more than 1,500 per 100,000 were found in the Czech Republic, Estonia, Latvia, Lithuania, Hungary, Romania and Slovakia while rates of less than 250 per 100,000 were found in areas of France, Portugal and Spain.

While disparities in health exist between Countries and Regions in the EU, large disparities also exist within EU states. On average mortality rates in Ireland and Northern Ireland are closer to the EU average, however significant inequalities in health exist between socio-economic groups.

Health Inequalities in Ireland and Northern Ireland

In Ireland evidence shows that lower socio-economic groups have relatively high mortality rates, higher levels of ill health and fewer opportunities and resources to adopt healthier lifestyles.

- Recent CSO figures[1] show life expectancy at birth for males living in the most deprived areas is 73.7 years compared to 78 for those living in more affluent areas while life expectancy for females is 80 years in the most deprived areas compared to 82.7 years for females living in the most affluent areas.

1 Central Statistics Office, Mortality Differentials in Ireland, 2010

- Standardised mortality rates (per 100,000 population) are higher among unskilled workers (790) than professionals (456) and mortality rates almost double among those who have only completed primary level education (1,239) compared to those who have completed third level education (624).
- Life expectancy at birth for traveller males is 15.1 years lower than the general male population and mortality rates among traveller men women and infants are over 3 times higher than the general population.[2]
- Prevalence of chronic illness is higher in more deprived areas. The Institute of Public Health in Ireland[3] has calculated that in the Republic of Ireland incidence of Stroke is 2.2 times higher and of Coronary Heart Disease is 2.5 times higher in the most deprived Local Health Office Areas (LHOs) compared to the least deprived LHOs.
- A recent report from the National Longitudinal Study of Children[4] found children, particularly girls, from less socio-economically advantaged households were more likely to be overweight. The Report shows that 19% of boys and 18% of girls from professional households are overweight or obese. This increases to 29% of boys and 38% of girls from semi- and unskilled social-class households.

Throughout Northern Ireland there is considerable evidence of health inequalities with life expectancy differing by as much as six years between deprived areas such as the Shankill ward in West Belfast and affluent areas such as Portstewart. Male life expectancy ranges from 73.5 years in the most deprived areas to 79 years in the wealthiest, and female life expectancy ranges from 79.6 years on the most deprived areas to 81.5 years in the wealthiest.

According to figures from the Northern Ireland Health and Social Care Inequalities Monitoring System[5] the largest inequality gaps between disadvantaged areas and the Northern Ireland average were evident in the following areas:

- alcohol and drug related deaths (both more than two times greater than the average, at 121% higher)
- admissions for self-harm (94% higher)
- teenage births (80% higher)
- suicide (73% higher)
- respiratory death rates and lung cancer incidence (both nearly two thirds more than the average at 66% and 65% higher, respectively).

Children from the poorest families are four times more likely to die before the age of twenty and fifteen times more likely to die in accidents.[6]

In Northern Ireland the Troubles have left a legacy of health inequalities by disproportionately affecting the poorer segments of society. People living in areas with higher levels of violence suffered poorer health than those who lived in less violent areas.[7]

The Socio-Economic Determinants of Health

A wide range of factors – such as poverty, inequality, social exclusion, employment, income, education, housing conditions, transport, access to health care, lifestyle, stress – all impact significantly on an individual's health and wellbeing. That absolute poverty is a powerful risk factor for a range of diseases has been recognised for hundreds of years. It has, however, only been relatively recently appreciated, that socioeconomic conditions exert their effects on health and wellbeing across the range of human economic strata, their injurious impact being incrementally felt as one moves downwards through the socioeconomic spectrum from relative advantage to relative disadvantage.

2 All Ireland Traveller Health Study Team UCD, Our Geels, All Ireland Traveller Health Study – Summary of Findings DOHC, 2010

3 Balanda, K.P., Barron, S., Fahy, L., McLaughlin, A. Making Chronic Conditions Count: Hypertension, Stroke, Coronary Heart Disease, Diabetes. A systematic approach to estimating and forecasting population prevalence on the island of Ireland. Dublin: Institute of Public Health in Ireland, 2010.

4 R. Layte, C. McCrory, Growing up in Ireland - National Longitudinal Study of Children: Overweight and Obesity Among 9-Year-Olds, Department of Children and Youth Affairs Dublin: Government Publications 2011

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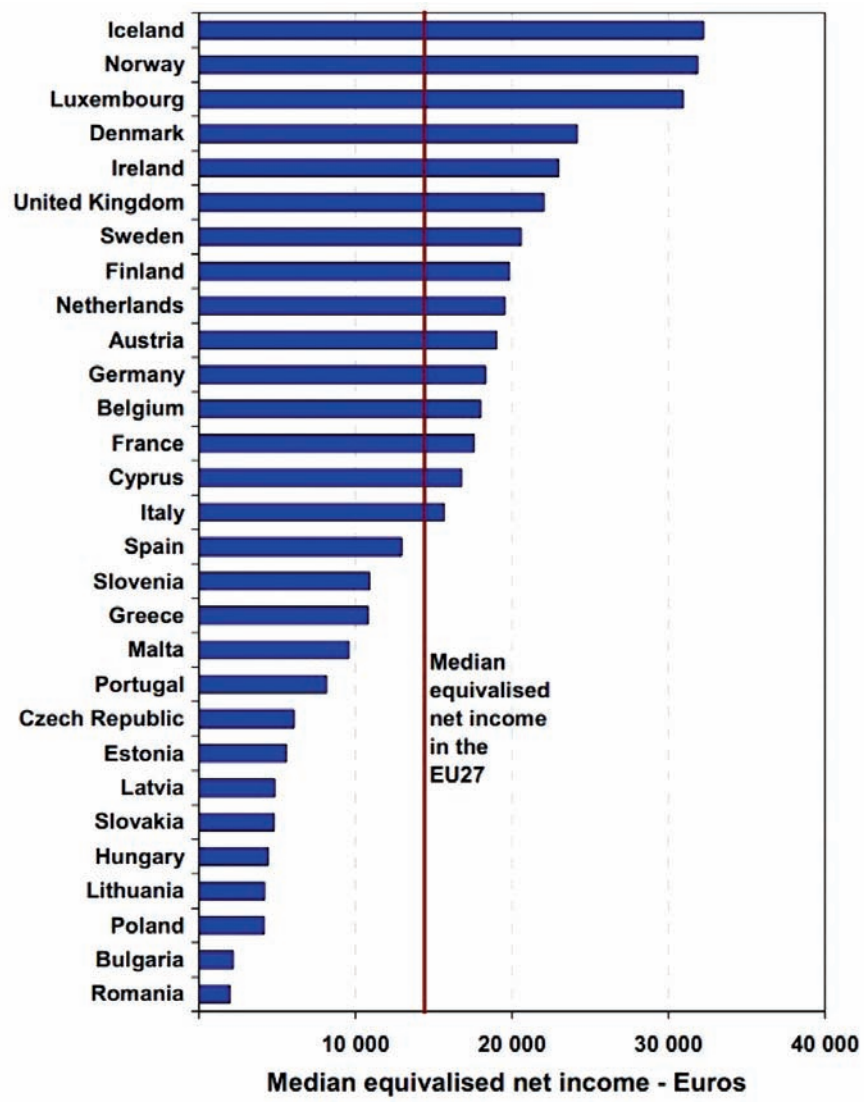
6 Death by Postcode. A Report in Health Inequalities conference held in Farset International , Oct 2009

7 http://www.dhsspsni.gov.uk/conflictinterfaceareas.pdf

Sir Michael Marmot has carried out an extensive review of health inequalities and the social determinants of health.

The Review of the social determinants of health and divisions in health in the WHO European Region chaired by Sir Michael Marmot[8] found *"A growing body of data shows an inverse socioeconomic gradient in various health outcomes in the central and eastern parts of the European Region: the lower the socioeconomic status, the higher the rate of ill health".*

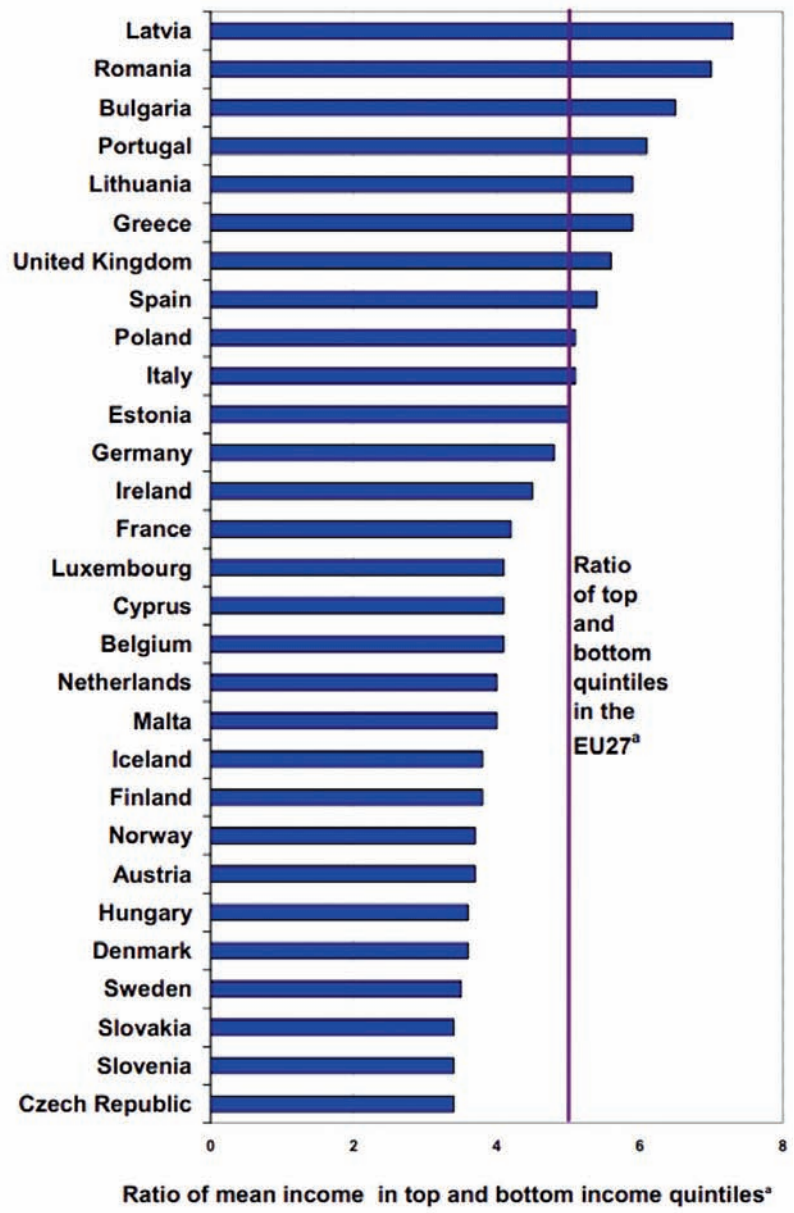
Annual median equivalized net income for countries reporting from the EU SILC, 2008



Source: Income, social inclusion and living conditions [EuroStat online database] in *Interim First Report on Social Determinants of Health and the Health Divide in the European Region*

8 World Health Organisation Interim First Report on Social Determinants of Health and the Health Divide in the European Region, 2010

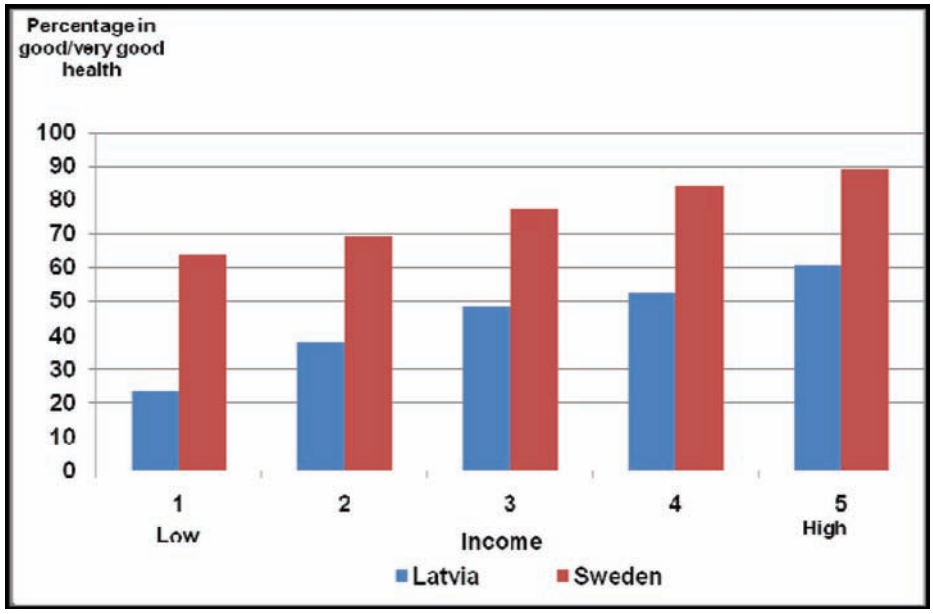
EU income distribution indicator in the EU countries, Iceland and Norway, 2008:
Ratio of the total equivalized disposable income per person received by the population quintile with the highest income to that received by the lowest quintile.



Source: Income, social inclusion and living conditions [EuroStat online database] in *Interim First Report on Social Determinants of Health and the Health Divide in the European Region*

A comparison of self-reported health status from the EU SILC found the higher the household income, the more people report favourable health. However gradient in health according to income varies by country. A comparison of Latvia and Sweden shows a steeper gradient income in Latvia and even the most affluent quintile in Latvia reports lower levels of health than the least affluent quintile in Sweden.

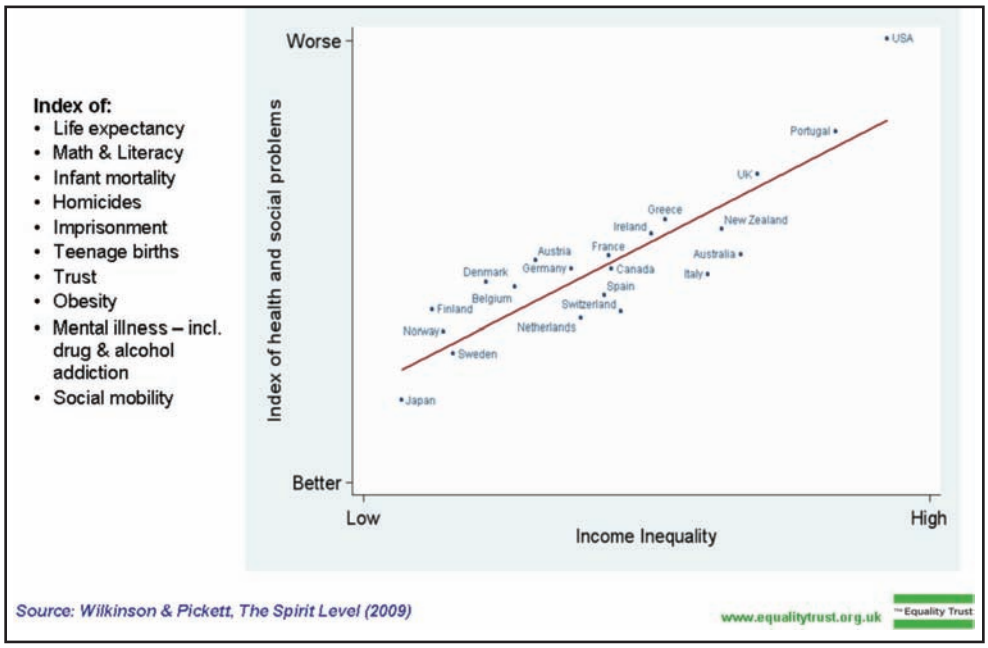
Percentage reporting their health as good or very good by household income quintiles in Latvia and Sweden, EU SILC, 2008



Source: E. Mayhew and J.Bradshaw, University of York, personal communication, 2010: analysis of EU SILC data from 2008 in *Interim First Report on Social Determinants of Health and the Health Divide in the European Region*

Wilkinson and Pickett[9] (The Spirit Level) have further demonstrated that those countries with the greatest income inequality are most likely to have health and social problems. Countries such as Sweden, Denmark and Finland with high levels of social protection and comprehensive social safety nets have lower income inequality and thus lower levels of health and social problems.

Health and Social Problems are Worse in More Unequal Countries



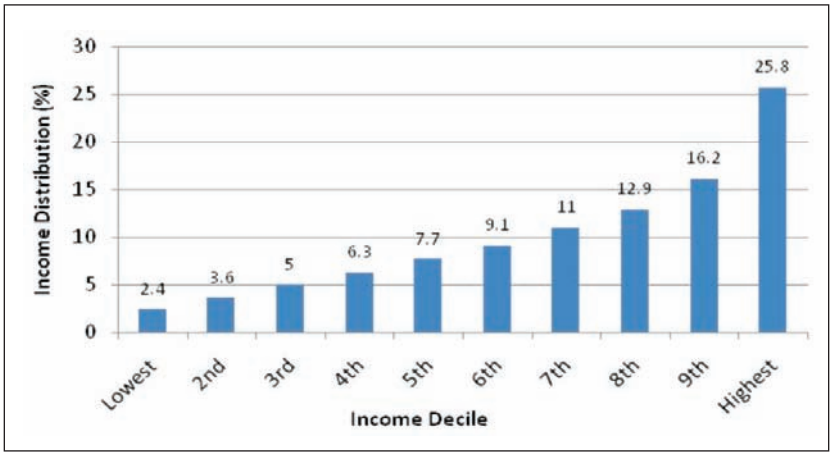
9 Wilkinson R and Pickett K, *The Spirit Level: Why More Equal Societies Almost Always Do Better*. London, Allen Lane 2009

Income Distribution in Ireland and Northern Ireland

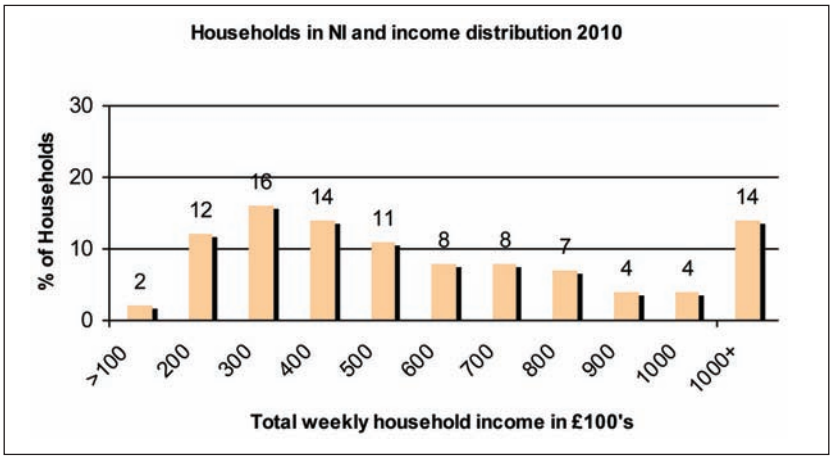
Again while income levels in Ireland and Northern Ireland are closer to the European average, substantial inequalities exist in the distribution of income.

The figure below shows that the wealthiest 10% of the population possess more than one quarter of all income, while the least wealthy 10% possess less than one fortieth of all income, a tenfold difference in income distribution.

Income Distribution by Decile



Source: calculated from CSO data 2010



Source: Family Resources Survey 2009-2010 Department for Social Development N. Ireland

Addressing Health Inequalities

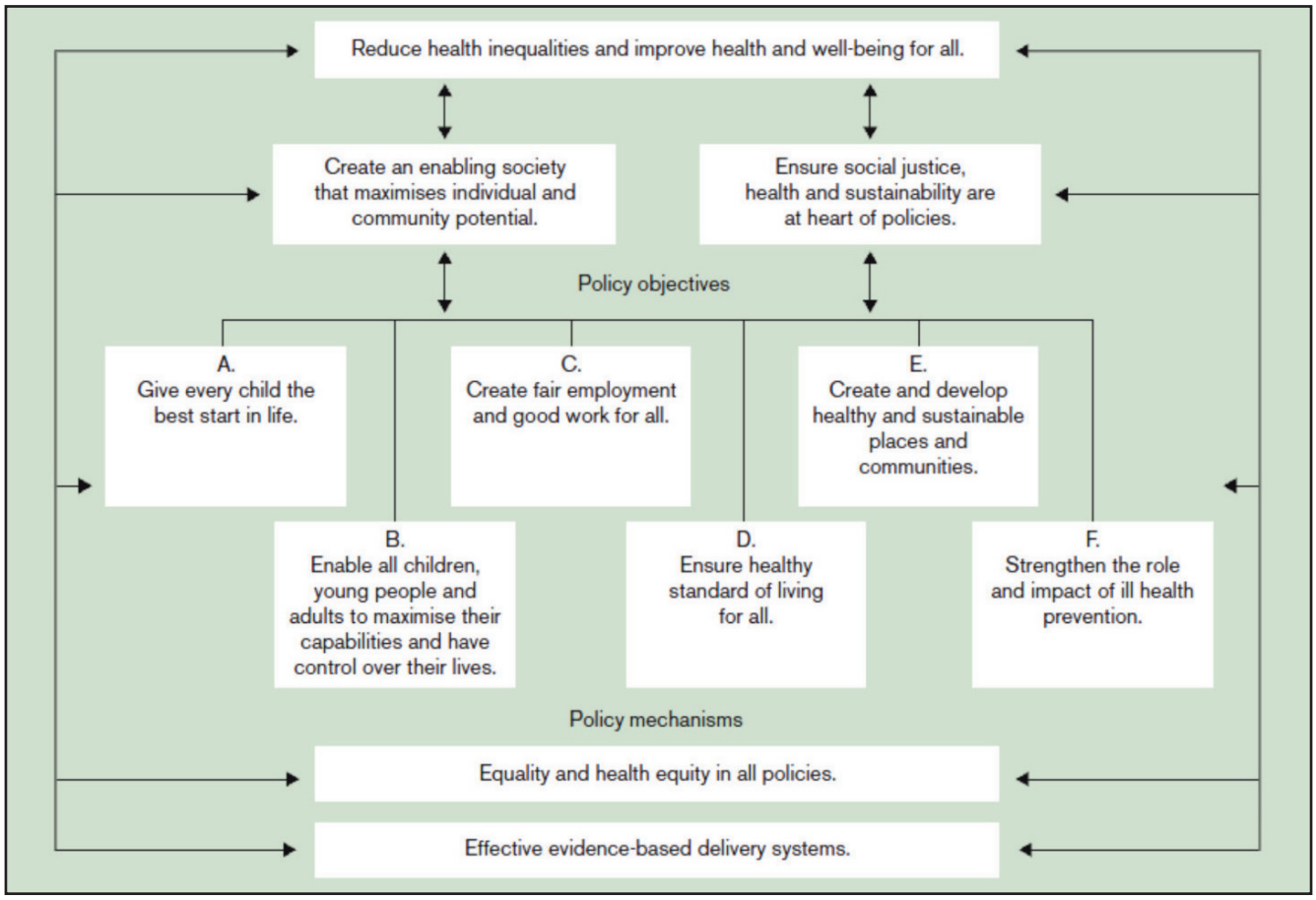
A key message from Marmot's European Review is that health inequalities are not inevitable and are hence modifiable.

> *"Inequality in health arises from inequalities in the social determinants of health: social policies and programmes, economic arrangements and the quality of governance. This, in turn, is responsible for inequalities in the lives people are able to lead: early years, education, working conditions and employment levels, levels and distribution of income, communities and public health and health systems."*[10]

10 World Health Organisation Interim First Report on Social Determinants of Health and the Health Divide in the European Region, 2010

In order to address health inequalities, it is widely recognised that action must be directed towards the causes of ill-health and disease determinants, most of which lie outside the control or influence of the health system. Marmot also demonstrates that while health systems play a role, health systems alone cannot reduce health inequalities, action is needed across all key government sectors (for example in policies relating to employment, education, transport, agriculture, environment, communications, justice etc.).

The Conceptual Framework



In his extensive review of inequalities in the UK (Fair Society, Healthy Lives) Marmot proposes a conceptual framework for reducing health inequalities which includes action on six policy objectives:

- Give every child the best start in life
- 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 standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

Marmot states that reducing health inequalities is a matter of fairness and social justice as many people are currently dying prematurely.

Reducing health inequalities not only improves the health of the population but will, by extension, lead to improvements in the productive capacity of the country and long-term savings to health and social welfare spending. It is estimated that inequalities in health account for 20% of health care costs and 15% of social security cost in the EU.[11]

EU Policy on Health Inequalities

The EU has adopted a number of strategies and policies for addressing health inequalities.[12] The EU Health Strategy – Together for Health: A Strategic Approach for the EU (2008-2013) states that "*Values relating to improving health must include reducing inequities in health".*

In October 2009, the European Commission issued a communication Solidarity in Health: Reducing Health Inequalities in the EU which sets out the Commission's measures to address health inequalities including:

- Collaboration with national authorities, regions and other bodies;
- Assessment of the impact of EU policies on health inequalities to ensure that they help reduce them where possible;
- Regular statistics and reporting on the size of inequalities in the EU and on successful strategies to reduce them;
- Better information on EU funding to help national authorities and other bodies address the inequalities.

The recommendations of the Commission were adopted by resolution in the European Parliament in March 2011.

Since 2006, all EU policies are required by Treaty to follow the Health in all Policies approach, a policy strategy, which targets the key social determinants of health through integrated policy response across relevant policy areas with the ultimate goal of supporting health equity.

The following EU policies have been identified as having a role to play in reducing health inequalities[13]:

- public health and the Health programme
- employment, health and safety at work
- social policy
- equal opportunities and fundamental rights
- diversity and non-discrimination
- research
- the Europe 2020 Strategy (through promoting sustainable economic growth and social cohesion)
- the EU's sustainable development strategy
- EU structural funds (as an instrument for reducing disparities in economic and living conditions)

Other EU initiatives exist which aim to support EU member states address health inequalities, including an expert group which shares information and good practice on health and the open method of coordination which provides a framework for strategy development and policy coordination on health and social issues.

Despite extensive policy at EU level, strategies to address health inequalities have not been extended down into all member states. In order to be effective the EU approach to health in all policies must be adopted at national, regional and local level.[14]

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11 Mackenbach JP, Meerding WJ and Kunst AE, Economic Implications of Socio-economic Inequalities in Health in the European Union, DG Sanco 2007

12 http://www.health-inequalities.eu/HEALTHEQUITY/EN/about_hi/health_inequalities/european_union/

13 http://ec.europa.eu/health/social_determinants/policy/index_en.htm

14 http://ec.europa.eu/health/health_policies/policy/index_en.htm

BMA Action on Health Inequalities

The BMA has previously looked at rural access to healthcare, encompassing rural deprivation.

More recently (in October 2010), the BMA hosted a breakfast debate on health inequalities which was chaired by Dr Hamish Meldrum (Chairman of BMA Council) and included Rt Hon Andrew Lansley CBE MP (Secretary of State for Health), Professor Sir Michael Marmot (BMA President) and Professor Sir Ian Gilmore (Immediate Past President, Royal College of Physicians) as guest speakers. The debate provided an opportunity to hear the Government's response to issues over health inequalities and the NHS white paper.

On 4 November 2010, BMA President Sir Michael Marmot hosted a roundtable meeting and dinner with representatives from the medical Royal Colleges and other key stakeholders to discuss ideas on how each organisation will encourage and support the development of policies and activities to address the social determinants of health.

The BMA hosted a conference on the 10 February 2011 to celebrate the one year anniversary of the publication of Fair Society, Healthy Lives. This explored ways in which the social determinants of health can be addressed through local action, in particular how the role of the medical profession can play a crucial part in tackling health inequalities.

Within Northern Ireland, we are now seeking to develop this work, having previously called for all Government Departments to work with the Department of Health and Social Security (DHSSPS) to reduce inequalities in Health.

The role of doctors in tackling health inequalities

The BMA has recently looked at how doctors can use their expertise to act as community leaders to tackle social determinants of health and health inequalities in its publication Social determinants of health – what can doctors do?

As doctors treat patients from many different backgrounds and often live within the same communities in which their patients live they understand the social determinants affecting the health of their communities. A holistic approach to medicine and treatment of patients is crucial.

Doctors in different specialities spend a considerable amount of time counselling patients, and supporting them to make changes to their lifestyles to embrace a healthier set of options.

Whatever doctors do, it is vital that they act in a cross-sectoral or intersectoral manner, working with others in areas outside the direct health systems they might traditionally, solely work in. The BMA encourages doctors to act not only as clinicians but also as community leaders.

BMA(NI) will continue to lobby the Northern Ireland Assembly to ensure that tackling health inequalities in Northern Ireland is a top priority for government.

The IMO and Health Inequalities

The IMO also support a holistic approach to medicine and the treatment of patients, and has identified the role of the doctor as advocate as one of the most important duties and responsibilities of each and every doctor.

As the economic crisis continues the IMO has become increasingly concerned about health inequalities and the long-term impact the recession is having on the health of lower income groups.

At the 2010 AGM, the IMO raised the issue of growing health inequalities in a scientific session on Health and Medicine in Recession. Addressing Health Inequalities will again be a central theme at this year's AGM from the 12th to the 15th of April 2012.

In the IMO budget submission 2012, and the Submission to the Department of Health on a Public Health Policy Framework the IMO recommended:

- The Taoiseach publish an annual review of inequalities and inequities in health. This review should include inequalities in health status, and variances in access to health care by economic grouping and geographic location;
- Public policy must be "health proofed" to ensure that the net effect of public policy is to improve the health and wellbeing of the population while, at the same time reducing health inequalities between different sections of society;
- The establishment of a Minister for Public Health to oversee the development and implementation of policy to address the social determinants of health;
- Funding is ring-fenced for the implementation of a new public health strategy. Secured funding for Public Health is of vital importance, particularly in view of the Government's plans to introduce universal health insurance – a funding mechanism which traditionally caters poorly for Public Health requirements;
- Renewed focus and investment is needed in Child Health Services.

The IMO also supports the introduction of a universal health system in Ireland where equitable access to healthcare services is based on medical need and not on ability to pay or any other criteria including age, place of residence or cultural identity.

EU Opportunities

The IMO and the BMA NI are calling on the EU to use its influence on National Governments to ensure that coordinated policy initiatives to address health inequalities are prioritised at national, regional and local level.

Conclusions

Health and wellbeing are inextricably linked. The greater the control and security a person feels, the greater is the wellbeing s/he experiences and the healthier s/he is likely to be. In addition to extending the lives of our citizens, policies that aim to reduce social and health inequalities will also have the effect of compressing morbidity in later years resulting in "adding more years to life and more life to years". In order for this to happen, as many of our citizens as possible should feel that they belong and are needed as useful and important members of the society in which they live.

The IMO and BMA NI

- Would urge their respective Governments to ensure that health inequalities are addressed in a holistic manner. Government policies should be "health-proofed" through the use of Health Impact Assessments to ensure that policies potentially deleterious to health are engineered in such a way to have the maximal health benefit for as large a proportion of the population as possible.
- Would urge their respective Governments to recognise that reducing health inequalities through reduction in societal inequalities is the best long-term investment that any Government can make on behalf of its citizens
- Recognise the importance of as large a proportion of the population as possible having rewarding, productive and secure employment, and would urge their respective Governments to adopt policies that encourage growth.
- Dr Samuel Johnson said that "A decent provision for the poor is the true test of civilization". This should be the metric by which we as a society determine how successful we are.

For further information please contact:

Ruth Fitzsimons, Public Affairs Officer, BMA(NI)
16 Cromac Place, Cromac Wood, Ormeau Road, Belfast, BT7 2JB, Northern Ireland
Tel: +44 (0) 28 9026 9666 or email RFitzsimons@bma.org.uk

Maria Murphy, Director of Communications and Public Affairs, IMO
IMO House, 10 Fitzwilliam Place, Dublin 2, Republic of Ireland
Tel: +353 (0) 1 676 7273 or email mmurphy@imo.ie