

IMO Position Paper on Health Inequalities

March 2012

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IRISH MEDICAL
ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Mission Statement

The role of the IMO is to **represent** doctors
in Ireland and to **provide** them with all relevant services.

It is committed to the **development** of a caring,
efficient and effective Health Service.



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Introduction

Ireland has significant levels of health inequalities. Throughout the boom years of the “Celtic Tiger”, these inequalities were evident and since the Recession, these inequalities appear to be worsening. Addressing health and social inequalities is important for our country; it is a long-term undertaking. Improving the health of all our citizens (particularly the poorest and most deprived) will reap long-term dividends by ensuring a healthier population, and more productive workforce, who will have less need for expensive health interventions and social economic supports.

Health Inequalities

The Irish Medical Organisation (IMO) wishes to highlight the social, economic and environmental factors affecting the health of our patients, factors recognised by all IMO doctors- whether working in a hospital, general practice, or public or community health setting. 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. Evidence shows that lower socio-economic groups have relatively high mortality rates, higher levels of ill health and fewer resources to adopt healthier lifestyles when compared to better-off sections of society.

Life Expectancy and Mortality Rates

Recent CSO figures found marked inequalities in life expectancy rates and mortality rates depending on area of deprivation, social class/occupation and level of education obtained.¹

Live expectancy at birth by area of deprivation (quintile)

	Males	Females
First quintile (least deprived)	78.0	82.7
Second quintile	77.1	81.8
Third quintile	76.4	81.6
Fourth quintile	75.5	81.1
Fifth quintile (most deprived)	73.7	80.0
All	76.3	81.5

Source: CSO Mortality Differentials in Ireland 2010

Life expectancy at birth for males living in the most deprived areas is 4.3 years less (73.7 years vs. 78 years) than that for males living in most affluent areas while life expectancy for females living in the most deprived areas is 2.7 years less (80 years vs. 82.7 years) than that for females living in the most affluent areas.

Furthermore, life expectancy at birth is 6.1 years higher for male professionals and 5 years higher for female professionals than their unskilled counterparts.

1 Central Statistics Office, Mortality Differentials in Ireland 2010

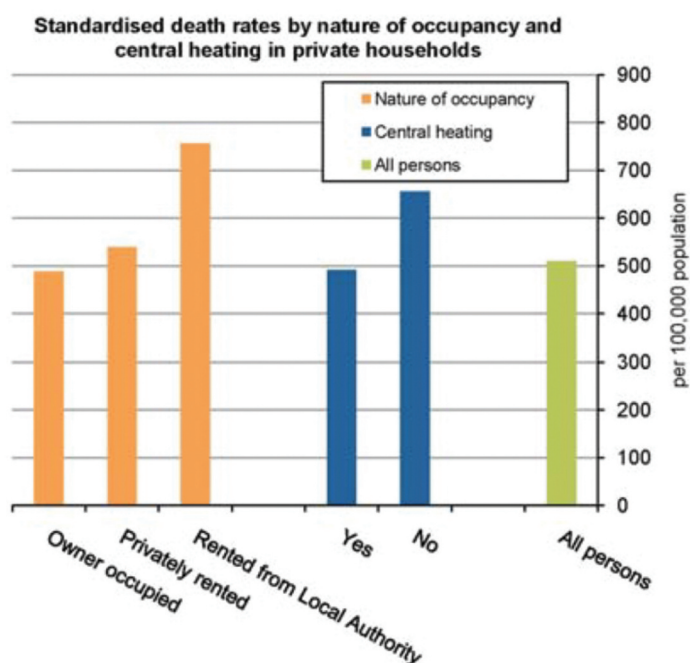
Standardised Death Rates (per 100,000 population)		
Persons	Males	Females

(a) Usually resident persons present in the State on Census Night

All persons	672	686	657
Social class			
Professional workers	456	449	402
Managerial and technical	524	540	478
Non-manual	530	609	518
Skilled manual	646	598	632
Semi-skilled	650	635	643
Unskilled	790	798	699
Others including unknown	997	1,112	951

Source: CSO Mortality Differentials in Ireland 2010

Similarly standardised mortality rates (per 100,000 population) are higher among unskilled workers (790) than professionals (456) and higher among those who live in the most deprived areas (804) compared to those who live in the least deprived (608).



Source: CSO Mortality Differentials in Ireland 2010

Mortality rates are also higher among those residing in accommodation rented from local authorities or voluntary bodies (757) compared to those in owner occupied accommodation (489) and mortality rates are lower in households with central heating (492) compared to those without (656).

Traveller Health

The All Ireland Traveller Health Study² found mortality rates significantly higher among Travellers than among the general population. Mortality rates among Traveller males are 3.7 times higher than the general male population and among Traveller women mortality rates are 3 times higher. Traveller infant mortality rates are 3.6 times higher than of the general population.

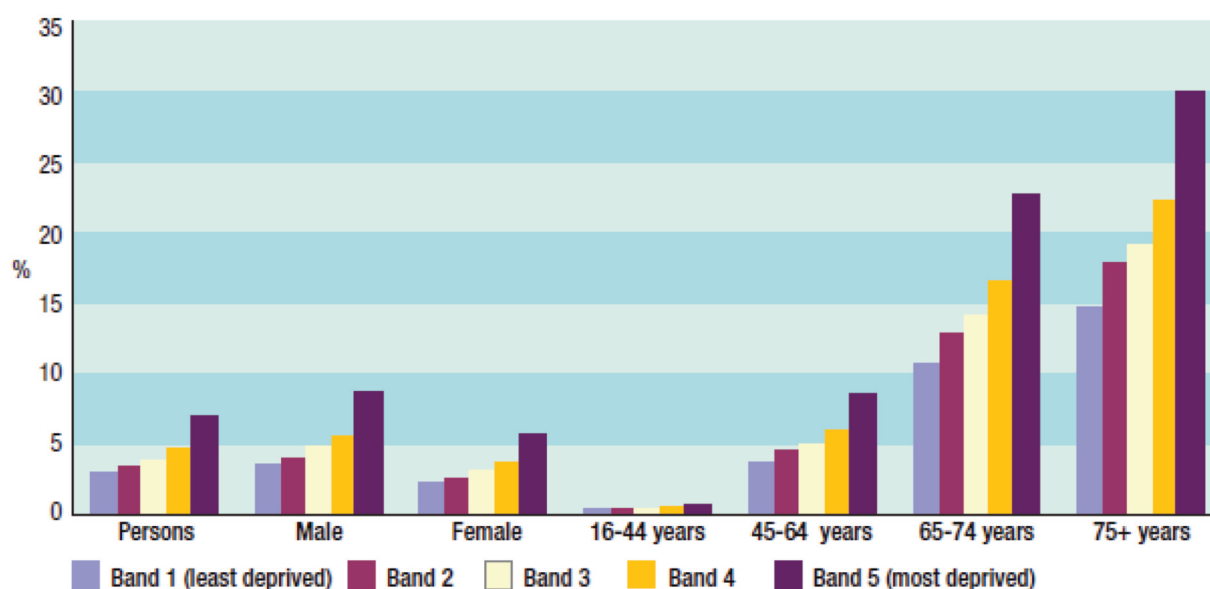
This study also revealed that life expectancy at birth for Traveller males is 15.1 years lower than the general male population and suicide rates among male Travellers are 6.6 times higher than among the general male population.

Prevalence of Chronic Conditions Ireland

Prevalence of chronic illness is higher in more deprived areas. The Institute of Public Health in Ireland³ has calculated that in the Republic of Ireland, the incidence of stroke is 2.2 times higher, and Coronary Heart Disease (CHD) is 2.5 times higher in the most deprived Local Health Office Areas (LHOs) compared to the least deprived LHOs. In addition, diabetes prevalence in the most deprived LHOs is 1.4 times that in the least deprived LHOs.

The Institute of Public Health in Ireland also estimates that, as a result of Ireland’s ageing population, by 2020 the number of people living with CHD and stroke will rise by almost 50% (49.4% and 47.8% respectively) while the number of people with diabetes is likely to rise by 62%, due principally to a marked increase in maturity-onset diabetes, the primary risk factor for this condition being obesity which is more prevalent among poorer socio-economic groups.

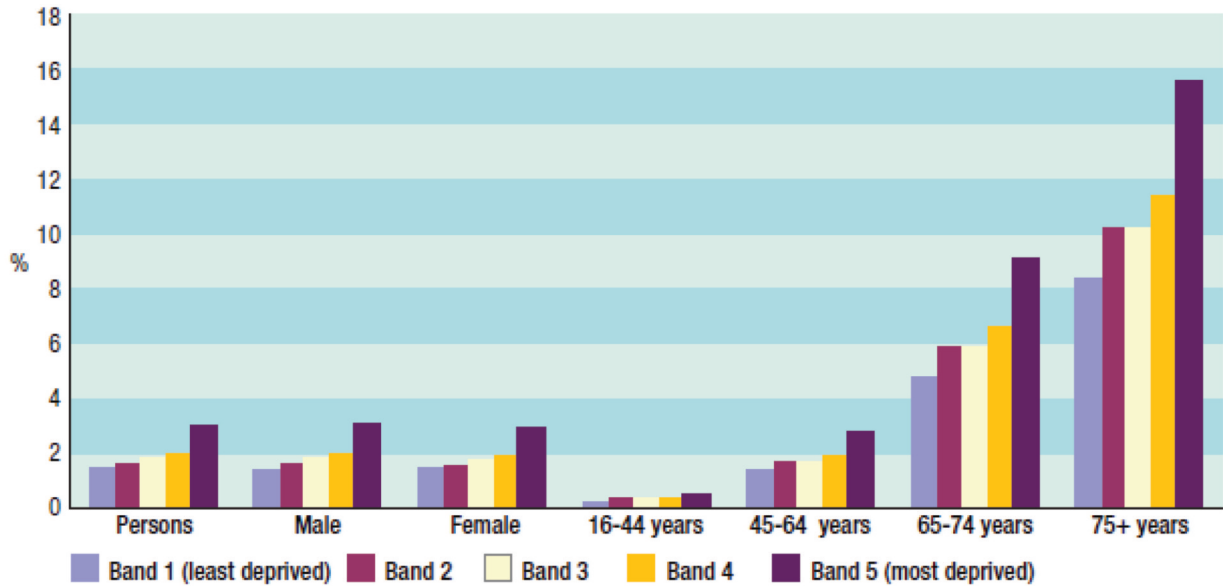
Percentage of adults who have ever had angina or a heart attack; across the deprivation bands in the Republic of Ireland within each sex and each age group (2007).



Source: Balanda et al. *Making Chronic Conditions Count*, Institute of Public Health in Ireland, 2010.

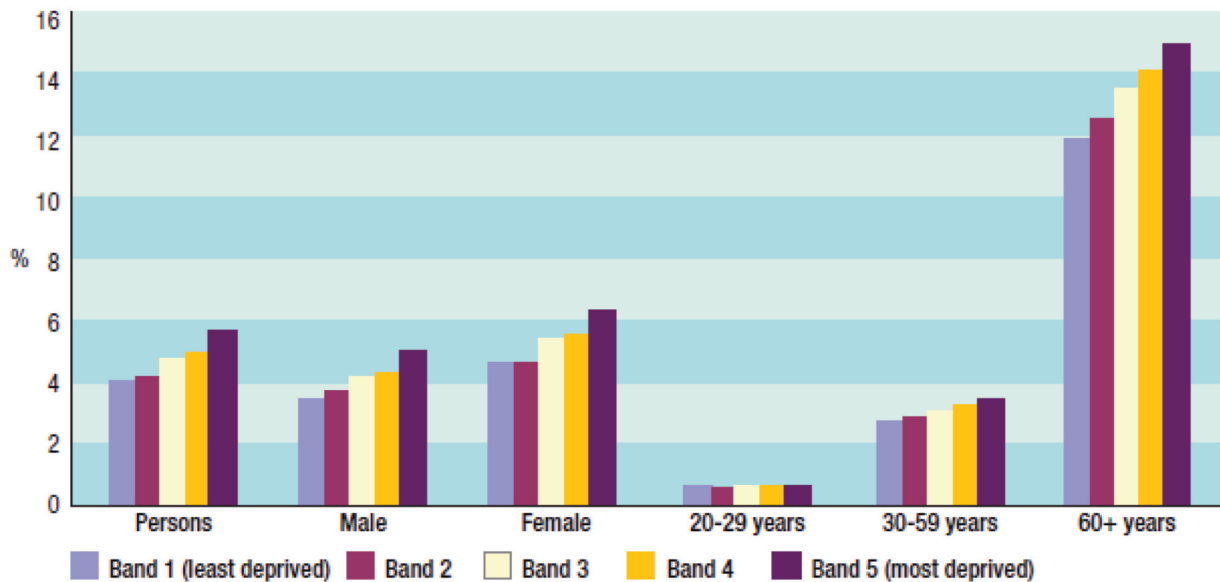
2 All Ireland Traveller Health Study Team UCD, Our Geels, All Ireland Traveller Health Study – Summary of Findings DOHC, 2010
 3 Balanda, K.P., Barron, S., Fahy, L., McLaughlin, A. *Making Chronic Conditions Count: Hypertension, Stroke, Coronary Heart Disease, Diabetes. A systematic approach to estimating and forecasting population prevalence on the island of Ireland.* Dublin: Institute of Public Health in Ireland, 2010.

Percentage of adults who have ever had a stroke; across the deprivation bands in the Republic of Ireland within each sex and each age group (2007).



Source: Balanda et al. *Making Chronic Conditions Count*, Institute of Public Health in Ireland, 2010.

Percentage of adults who have diabetes; across deprivation bands in the Republic of Ireland within each sex and each age group (2007).



Source: Balanda et al. *Making Chronic Conditions Count*, Institute of Public Health in Ireland, 2010.

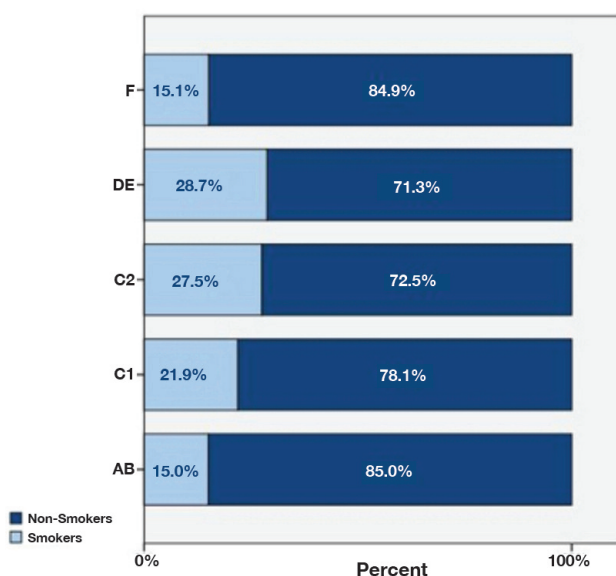
Lifestyle Factors

The SLÁN Report 2007⁴ showed higher levels of obesity in adults from poorer social classes 5-6 compared with other groups (SC1-2: 13%, SC 3-4: 15%, SC 5-6: 18%). Wealthier social classes are also more likely to consume five or more daily servings of fruit and vegetables (SC1-2: 71%, SC 3-4: 64%, SC 5-6: 58%)⁵ and be physically active (SC1-2: 59%, SC 3-4: 55%, SC 5-6: 53%).

A recent report from the National Longitudinal Study of Children⁶ 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.

Statistics from the Office of Tobacco Control⁷ shows that the highest cigarette smoking prevalence rates were in the poorer income groups (DE and C2 category).

Cigarette Smoking Prevalence by Social Class 12 month period ending June 2010



Social Class Categorisation

- A** Professional people, very senior managers in business and commerce, or top-level civil servants
- B** Middle management executives in large organisations; Principal Officers in local government and civil service; top management or owners of small business concerns, education and service establishments
- C1** Junior management, owners of small establishments and all others in non-manual positions
- C2** All skilled manual workers and those manual workers with responsibility for other people
- D** All semi skilled and unskilled manual workers
- E** All those entirely dependent on the state long-term; those unemployed for period exceeding 6 months
- F** Farmers or farm managers

(Source: AIMRO Standard Guide for Social Class)

Source: Office of Tobacco Control, Ireland: Current trends in cigarette smoking, downloaded from <http://www.otc.ie/research.asp>

4 Morgan K, McGee H, Watson D, Perry I, Barry M, Shelley E, Harrington J, Molcho M, Layte R, Tully N, van Lente E, Ward M, Lutomski J, Conroy R, Brugha R 2008, SLÁN 2007: Survey of Lifestyle, Attitudes & Nutrition in Ireland. Main Report. Dublin: Department of Health and Children

5 Morgan et al 2008, SLÁN 2007...p64

6 R. Layte, C. McCrory, 2011, 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

7 Office of Tobacco Control, Ireland: Current trends in cigarette smoking, downloaded from <http://www.otc.ie/research.asp>

Self-Reported Health

The EU Survey of Income and Living Conditions shows that as income increases more people are likely to report good or very good health. This gradient is reflected across Europe.

**Self Perceived Health by Income Quintile:
Good, Very Good Health, Ireland and EU-27 2009**



Source: EU-SILC EuroStat in Dept. of Health and Children, *Health in Ireland Key Trends 2011*

Addressing the Social Determinants of Health

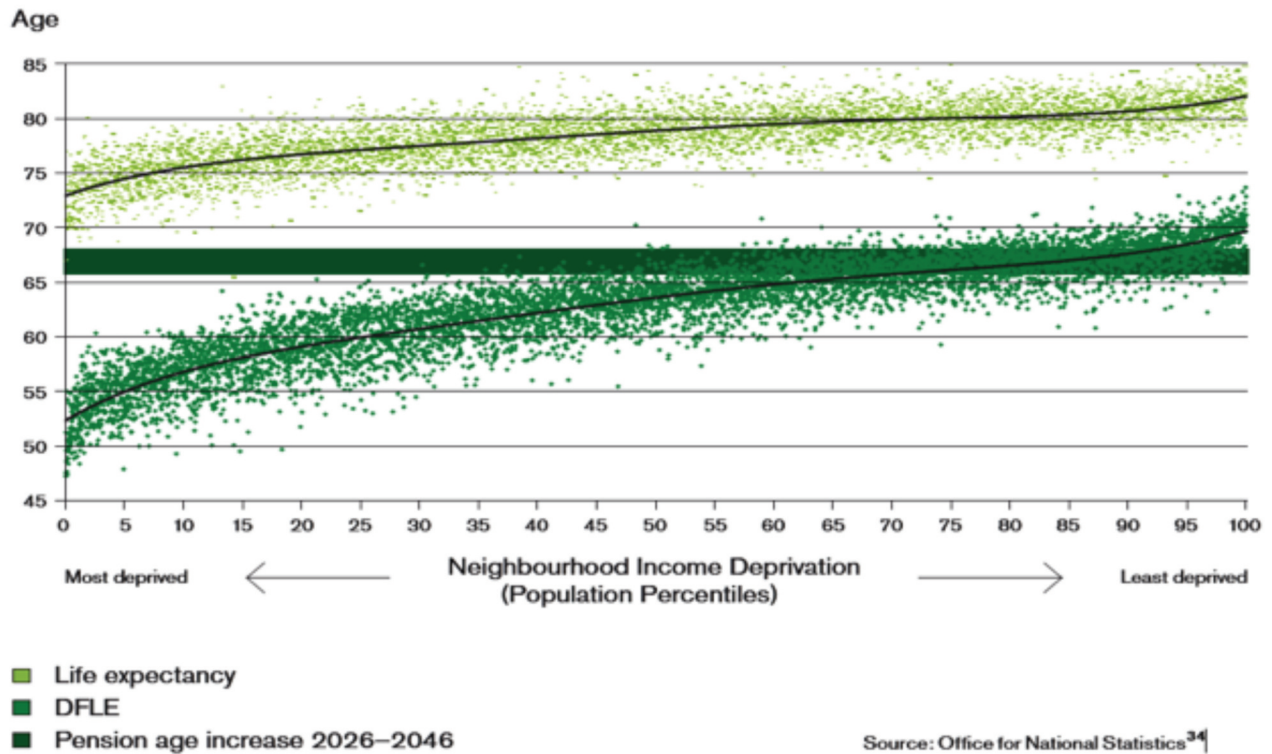
That absolute poverty is a powerful risk factor of a range for diseases has been recognised for hundreds of years. It has, however, only been relatively recently appreciated, that relative disadvantage harms health; socioeconomic conditions exerting their effects on health and wellbeing across the range of human economic strata, their injurious impact being incrementally felt as one moves downwards through the socioeconomic spectrum from relative advantage to relative disadvantage.

Sir Michael Marmot, having first demonstrated the effects of relative deprivation on health in the Whitehall II Study (<http://www.ucl.ac.uk/whitehallII/>), has carried out an extensive review of health inequalities and the social determinants of health in the UK (Fair Society, Healthy Lives)⁸.

Marmot demonstrated that people in least deprived areas have a dual health benefit from their more favoured position: They live longer and they live more years of life free from disability.

8. Marmot M. *Fair Society, Healthy Lives, The Marmot Review: Strategic Review of Health Inequalities in England post-2010*. University College London: 2010. Available at www.ucl.ac.uk/marmotreview. Accessed 21/2/2012.

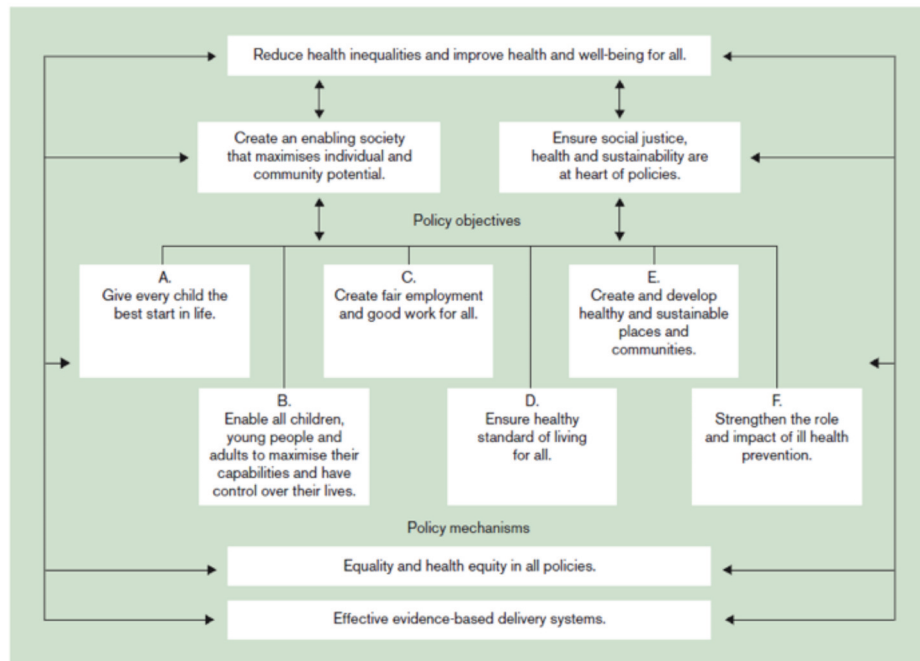
Figure 1.1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003



Because health inequalities result from social inequalities, action is required across all the social determinants of health. 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.

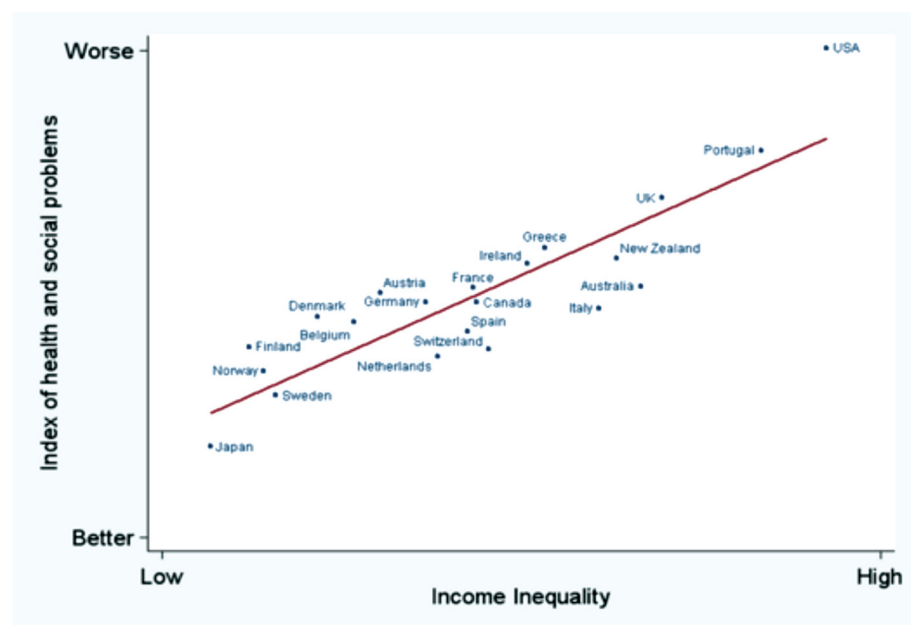
Marmot's Conceptual Framework for Reducing Health Inequalities



Wilkinson and Pickett (The Spirit Level), having examined international data, found that countries with the greatest income inequality are most likely to have health and social problems. While 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. Policies are therefore needed that address the unequal distribution of wealth.

Health and Social Problems are Worse in More Unequal Countries

- Index of:**
- Life expectancy
 - Math & Literacy
 - Infant mortality
 - Homicides
 - Imprisonment
 - Teenage births
 - Trust
 - Obesity
 - Mental illness – incl. drug & alcohol addiction
 - Social mobility



Source: Wilkinson & Pickett, *The Spirit Level* (2009)

www.equalitytrust.org.uk

Equality Trust

In Ireland a number of pieces of work have been undertaken in the field of health inequalities including the report by the Combat Poverty Agency and the Institute of Public Health in Ireland *Tackling Health Inequalities: An All-Ireland Approach to Social Determinants* and TASC's report, *Tackling Inequalities: a matter of life and death*.

The IMO supports the findings of these reports and the core recommendations which give priority to:

1. Developing a valid evidence base to support policy decisions. This should ensure that inequalities in different sections of society (gender, those living in poverty, the unemployed, immigrants, Travellers) are documented in order to assess the benefits of policies to reduce inequalities;
2. Ensuring that redistributive policies are directed towards reducing inequality;
3. Lowering the barriers to job creation to ensure that as many citizens in Ireland can have the opportunity of satisfying and sustaining employment;
4. Ensuring that health is considered a basic human right and that health services are provided on the basis of solidarity;
5. Realigning the country to ensure the conditions exist in which people and communities can flourish in health. This must take place at the highest policy level and should be achieved through a policy of health-proofing all public policy – in other words deleterious as well as beneficial effects of policy should be gauged using health impact assessment.

EU Policy on Health Inequalities

The EU has adopted a number of strategies and policies for addressing health inequalities.⁹ 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.

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.

In June 2006 the Council adopted a statement on common values and principles in EU healthcare systems¹⁰ which declares

The health systems of the European Union are a central part of Europe's high levels of social protection, and contribute to social cohesion and social justice as well as to sustainable development.

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

10 [Council Conclusions on Common Values and Principles in European Union Health Systems \(2006/C 146/01\)](#).

The overarching **values** of *universality, access to good quality care, equity, and solidarity* have been widely accepted in the work of the different EU institutions. Together they constitute a set of values that are shared across Europe. Universality means that no-one is barred access to health care; solidarity is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; equity relates to equal access according to need, regardless of ethnicity, gender, age, social status or ability to pay. EU health systems also aim to reduce the gap in health inequalities, which is a concern of EU Member States; closely linked to this is the work in the Member States' systems on the prevention of illness and disease by inter alia the promotion of healthy lifestyles.

Despite extensive policy at EU level, strategies to address health inequalities have not been extended down into all member states.

IMO Position on the Reduction of Inequalities in Health

Reducing inequalities in health is primarily a matter of fairness and social justice¹¹, as people in poorer socio-economic groups are more likely to be ill and to die 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.¹² Reducing health inequalities through reduction in societal inequalities is the best long-term investment that any Government can make on behalf of its citizens

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.

Public Health and Health in All Policies

In order to address the determinants of health (and hence, 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. In recognising this, Public Health, that branch of medicine that is concerned with identifying and correcting the factors that underlie disease, has been defined by the US's National Institute of Medicine in 1988 as “what we, as a society, do collectively to assure the conditions for people to be healthy.”¹³ In other words, Public Health is a contract between a Government and its citizens which is intended to produce the greatest possible degree of health and social gain. Policy choices implemented by all departments and not just the Department of Health can therefore significantly impact on an individual's health thus action across all key government sectors is needed (for example in policies relating to employment, education, transport, environment, agriculture, communications, justice etc.)

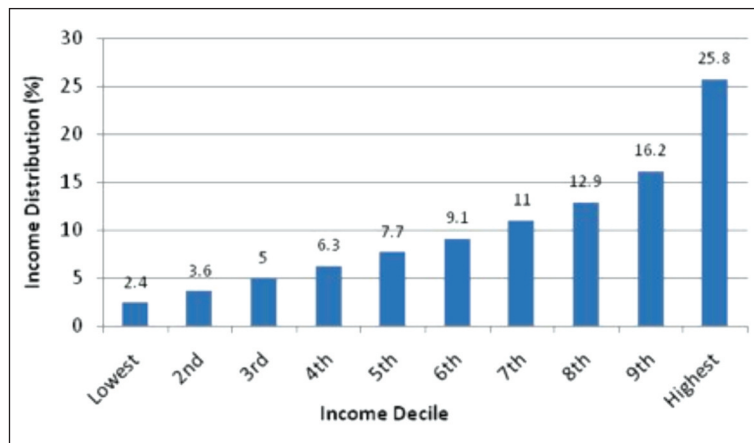
11 Marmot 2010

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

13 Institute of Medicine. *The Future of Public Health*. National Academy Press, Washington D.C., 1988.

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

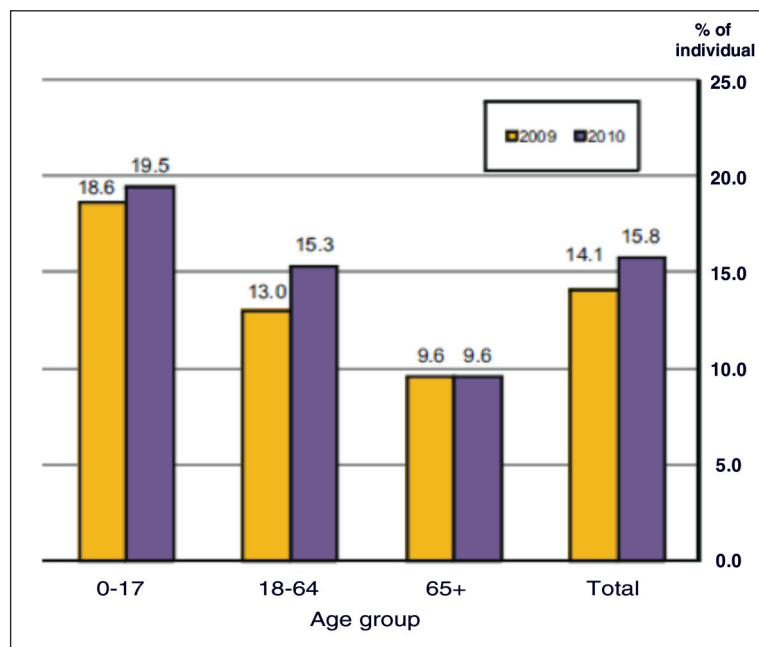


Source: calculated from CSO data 2010

Policies should focus on tackling the unequal distribution of wealth including:

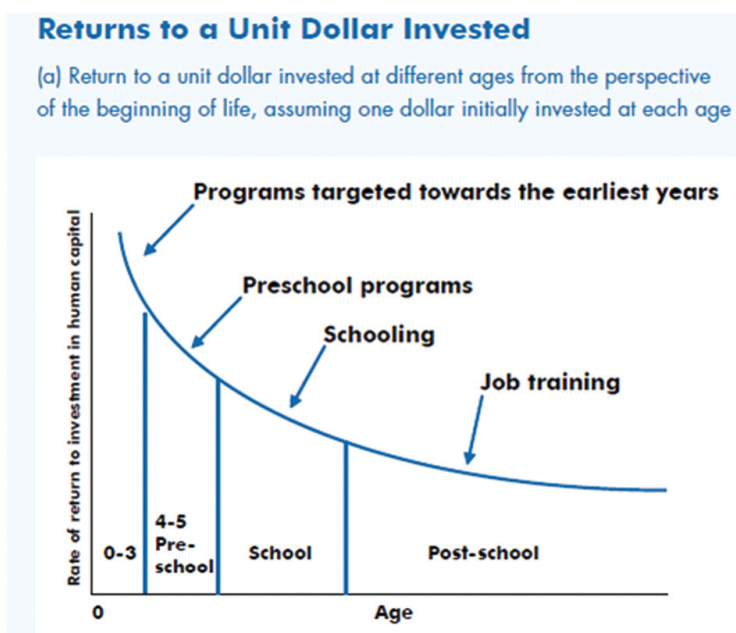
- Economic policies that focus on growth and provide as large a proportion of the population as possible with rewarding, productive and secure employment;
- Fiscal policies that are progressive;
- Social welfare policies that ensure a minimum standard of living for all.

At Risk of Poverty Rates by Age Group and Year



Source: CSO Survey on Income and Living Conditions Preliminary Results 2010

The preliminary results from the 2010 Survey on Income and Living Conditions show that children under 18 years old are most at risk of poverty with one in five children at risk of poverty compared with 15.8% of people generally. As well as poorer health, childhood poverty is associated with a wide range of negative outcomes, including lower academic achievement and emotional and behavioural problems.¹⁴ Children living in persistent poverty are also more likely to be poor as adults.



Source: Heckman J.J. *The Case for Investing in Disadvantaged Young Children in Big Ideas for Children: Investing in Our Nation's Future First Focus 2008: 49-58* downloaded from http://www.firstfocus.net/sites/default/files/r.2008-9.15.ff_.pdf

Heckman (*The Case for Investing in Disadvantaged Young Children*) states that about half of the variance in lifetime earnings is determined by the age of 18 and that educational interventions early in the lifecycle of disadvantaged children yield higher economic returns than interventions later on.¹⁵

Policies are required that ensure that all children have the opportunity to realise their maximum potential including:

- Family policies to eliminate child poverty
- Education policies that focus on early childhood including:
 - formal statutory preschool access for all children;
 - active collaboration between the Department of Education and the Department of Health to deliver on early educational intervention.

All Government policies should be “health proofed” through Health Impact Assessments, 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.

14 Moore K.A. Redd Z. Burkhauser M. Mbwana K. and Collins A. *Children in Poverty: Trends, Consequences and Policy Options*, in *Child Trends Research Brief 2009:11* downloaded from http://www.childtrends.org/files/child_trends-2009_04_07_rb_childreninpoverty.pdf

15 Heckman J.J. *The Case for Investing in Disadvantaged Young Children in Big Ideas for Children: Investing in Our Nation's Future First Focus 2008: 49-58* downloaded from http://www.firstfocus.net/sites/default/files/r.2008-9.15.ff_.pdf

IMO recommendations:

- An explicit statement from Government that health is a basic human right and its protection should be a core aim of Government and the State;
- An explicit statement that the State recognises the crucial importance of prevention and that preventing ill-health through the reduction of health and social inequalities would be a stated priority of Government;
- An immediate review of inequalities and inequities in health to include inequalities in health status, and inequities in access to health care by socio-economic grouping, geographic location and ethnic minority;
- The establishment of an inter-sectoral committee to prioritise the development and implementation of evidence-based initiatives across departments and across sectors that tackle the unequal distribution of wealth and ensure that all children have the opportunity to realise their maximum potential including;
 - Economic policies that focus on growth and provide as large a proportion of the population as possible with rewarding, productive and secure employment;
 - Fiscal policies that are progressive;
 - Social welfare policies that ensure a minimum standard of living for all;
 - Family policies to eliminate child poverty
 - Education policies that focus on early childhood including:
 - formal statutory preschool access for all children;
 - active collaboration between the Department of Education and the Department of Health to deliver on early educational intervention.
- In view of the large contribution social determinants make to the health status of the population of Ireland, the IMO recommend the establishment of a Minister of Public Health with direct responsibility for overseeing the delivery and implementation of Public Health Policy and to ensure that public policy is health proofed across all Government Departments;
- The Minister for Public Health should have a statutory function in each of the Departments involved and funding within each Department should be ring-fenced for Public Health initiatives;
- The Office of the Minister for Public Health should also be responsible for ensuring that Health Impact Assessments are carried out on all new government policies at design, implementation and review stages. In addition a national Public Health Executive Agency should be established to ensure that the core functions of public health (Health Protection, Health Intelligence and Service Public Health), drive progress and are accountable for implementing policies set by the Public Health Minister;
- The contribution, to the overall economic strength and well-being of Ireland, of Public Health interventions and measures should be recognised through priority funding. 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.
- Develop an integrated Public and Community Health workforce plan.

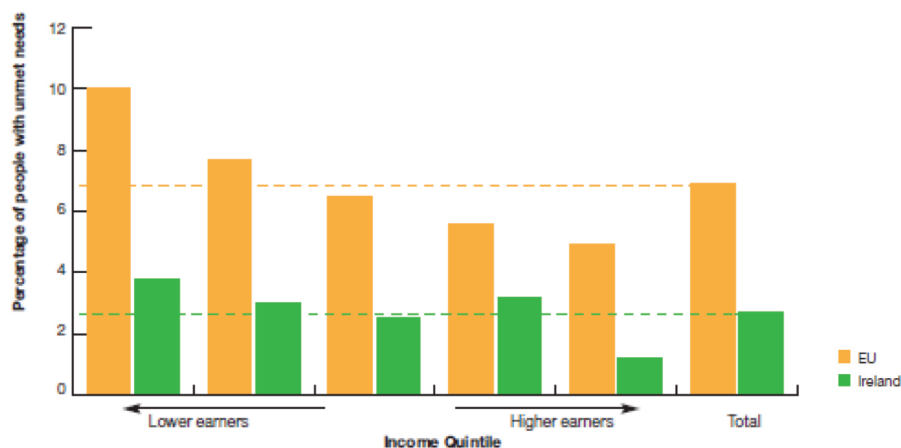
The Role of Health Systems in Addressing Health Inequalities

Health systems also have a role in addressing health inequalities by assuring equal access to quality services including preventive care for all citizens. The 2009 EU Survey of Income and Living Conditions shows that middle to low earners are more likely to have an unmet need for medical examination or treatment.¹⁶ Numerous factors can

¹⁶ EU Survey of Income and Living Conditions 2009, in Health in Ireland key trends 2011, DOHC

result in patients reporting an unmet need including financial barriers to care and the distribution of both human and financial resources.

People with Unmet Needs for Medical Examination by Income Quintile, Ireland and EU-27 2009



Source: EU-SILC EuroStat in Dept. of Health and Children, *Health in Ireland Key Trends 2011*

Note: Unmet need is defined as “really needing a medical examination or treatment for a health problem but did not receive it.”

Primary Care Services

Patients who have to pay the full costs of Primary Care may be deterred from seeking medical care, increasing the risk of delayed detection of medical problems and further accentuating health inequalities. Currently almost 40% of the population are covered by a medical or a GP visit card (1,694,063 people have a medical card and 125,657 have a GP visit card in December 2011)¹⁷ while the rest of the population pay for GP care in full. Although some private health insurance plans cover GP visits in part. Ireland is almost unique in having a healthcare system where all its citizens are entitled to treatment in a public hospital subject to a small co-payment, while 60% of the population (including many earning not much more than the minimum wage) are expected to meet the full economic cost of visiting a General Practitioner, as well as the full economic cost of accessing allied health care professions in the community, such as nursing, dietetics, counselling and physiotherapy. Ordinarily these costs are not recoverable through insurance or other mechanisms.

In 2006, towards the end of the boom years, 26% of people said there were times when they did not visit their GP with a medical problem because the cost was prohibitive.¹⁸ CSO figures from 2010 show that 86% of medical card holders visited a GP at least once in the previous twelve months, compared with 73% of adults with private health cover and just 57% of adults with only general public health cover.

¹⁷ HSE Performance report December 2011

¹⁸ Murphy A, cited in A Picture of health – A Selection of Irish Health Research 2006 Health Research Board downloaded from http://www.hrb.ie/uploads/tx_hrbpublications/POH_06.pdf

GP Consultations by Type of Medical Cover

	Type of medical cover					
	Medical card		Private cover		Neither	
	GP Consultations		GP Consultations		GP Consultations	
	% of adults with at least one consult	Average No. consults ¹	% of adults with at least one consult	Average No. consults ¹	% of adults with at least one consult ²	Average No. consults ^{1,2}
State	86	5.2	73	2.2	57	1.9

Source: CSO Health Status and Health Service Utilisation, Quarterly National Household Survey Q3 2010

1 Average is calculated across all persons including those with no GP consultations.

Primary care services have an important role to play in addressing health inequalities through preventive care and the early detection and management of chronic disease. The late Barbara Starfield (Contribution of Primary Care to Health Systems and Health)¹⁹ found substantial evidence in both cross-national and within national studies showing that access to Primary Care is associated with more equitable distribution of health in populations. For example in areas with high levels of income inequality, abundant primary care resources are associated with lower post-neonatal mortality rates, lower mortality rates from stroke and lower numbers of people reporting fair to poor health. In particular Starfield found a direct relationship between health and the overall number of Primary Care Physicians/ General Practitioners, for example with each additional GP per 10,000 population (15-20% increase) in the UK associated with a 6% decrease in mortality.²⁰

The OECD (Health at a Glance 2011) also highlighted the importance of strengthening prevention and management of chronic diseases and ensuring a sufficient supply of primary care providers as rising obesity pushes up health care spending.²¹

Public Expenditure on health has been cut by over €1.75bn in the last 3 years from €15.073bn in 2009 to €13.317bn in 2012. Services are increasingly being transferred to Primary Care without the equivalent transfer of funds and where for most the population the full economic cost of those services currently has to be met by the individual as an out-of-pocket expense. As a result Primary Care services are under resourced:

- At approximately 5.8 GPs per 10,000 population, there is a shortage of GPs in Ireland with the gap in GP services unevenly distributed across regions;²²
- 425 Primary Care Teams are established however they are at various stages of operation;
- there is currently no funding to implement chronic disease management programmes in Primary Care.
- While a rural practice allowance exists for practices in low populated rural areas, there is no similar allowance for practices in deprived urban areas.

The IMO position paper on Universal Health Coverage calls on the Government to ensure equity of access to healthcare services is based on medical need and not on ability to pay or any other criteria including age, gender, place of residence or cultural identity.

19 Starfield B, Shi L and Mackinko J. Contribution of Primary Care to Health Systems and Health, The Millbank Quarterly, 2005: 83:3 457-502

20 Gulliford, M.C. Availability of Primary Care Doctors and Population Health in England: Is There an Association? Journal of Public Health Medicine 2002: 24:252-4.in Starfield B, Shi L and Mackinko J. 2005

21 OECD Health: medical care improving but better prevention and management of chronic diseases needed to cut costs, says OECD, OECD Press Room 23/11/2011 downloaded from http://www.oecd.org/document/3/0,3746,en_21571361_44315115_49048899_1_1_1_1,00.html

22 FAS & Expert Group on Future Skills Needs, A Quantitative Tool for Workforce Planning in Healthcare: Example Simulations June 2009

The IMO recommends

- Urgent consultation and negotiation on the funding and provision of universal access to Primary Care Services including resources for the prevention and management of chronic disease in the Primary Care setting.
- Building on the HSE Health Status reports which measure deprivation using the Haase and Pratschke Index and the SAHRU Index of Material Deprivation, a model for the allocation of resources to Primary Care is needed which takes into account patterns of co- and multi-morbidities and GP utilisation in areas of deprivation.
- The Government must ensure that vulnerable rural and deprived urban communities have adequate GP cover.

Child Health Services

Community Child Health Services also have a crucial role to play in addressing health inequalities.

A vital and productive society with a prosperous and sustainable future is built on a foundation of healthy child development. Health in the earliest years—beginning with the future mother’s well-being before she becomes pregnant—lays the groundwork for a lifetime of vitality. When developing biological systems occur in an environment of positive early experiences, children have a greater chance to thrive and to grow up to be healthy adults. Sound health also provides a foundation for the construction of sturdy brain architecture and the achievement of a broad range of skills and learning capacities. There is an extensive, and rapidly expanding, amount of scientific evidence illustrating the extent to which early experiences affect the biology of the body, becoming embedded in the development of multiple organ systems. As a result, the consequences of adversity early in life can be serious and long-lasting, affecting the body’s ability to, for example, regulate metabolism, fight disease, and maintain a healthy heart—as well as a healthy brain. Reducing toxic stress in early childhood is therefore an important strategy for lifelong health promotion and disease prevention.²³

Universal access to the Mother and Infant Scheme and the Child Immunisation scheme in General Practice play a vital role in reducing health inequalities in children however due to funding cuts and the moratorium on recruitment in Community Health Services, child health screening and school immunisation programmes are under threat in some parts of the country.²⁴

The IMO recommend

- Renewed focus and investment in Child Health Services.

23 Harvard University, Center for the Developing Child, Foundations of Lifelong Health downloaded from http://developingchild.harvard.edu/topics/foundations_of_lifelong_health/

24 O Cionnaith F. Child healthcare schemes at risk in wake of cuts, Irish Examiner 22 February 2012

Summary of Recommendations

Public Health and Health in all Policies

- An explicit statement from Government that health is a basic human right and its protection should be a core aim of Government and the State;
- An explicit statement that the State recognises the crucial importance of prevention and that preventing ill-health through the reduction of health and social inequalities would be a stated priority of Government;
- An immediate review of inequalities and inequities in health to include inequalities in health status, and inequities in access to health care by socio-economic grouping, geographic location and ethnic minority;
- The establishment of an inter-sectoral committee to prioritise the development and implementation of evidence-based initiatives across departments and across sectors that tackle the unequal distribution of wealth and ensure that all children have the opportunity to realise their maximum potential including;
 - Economic policies that focus on growth and provide as large a proportion of the population as possible with rewarding, productive and secure employment;
 - Fiscal policies that are progressive;
 - Social welfare policies that ensure a minimum standard of living for all;
 - Family policies to eliminate child poverty
 - Education policies that focus on early childhood including:
 - formal statutory preschool access for all children;
 - active collaboration between the Department of Education and the Department of Health to deliver on early educational intervention.
- In view of the large contribution social determinants make to the health status of the population of Ireland, the IMO recommend the establishment of a Minister of Public Health with direct responsibility for overseeing the delivery and implementation of Public Health Policy and to ensure that public policy is health proofed across all Government Departments;
- The Minister for Public Health should have a statutory function in each of the Departments involved and funding within each Department should be ring-fenced for Public Health initiatives;
- The Office of the Minister for Public Health should also be responsible for ensuring that Health Impact Assessments are carried out on all new government policies at design, implementation and review stages. In addition a national Public Health Executive Agency should be established to ensure that the core functions of public health (Health Protection, Health Intelligence and Service Public Health), drive progress and are accountable for implementing policies set by the Public Health Minister;
- The contribution, to the overall economic strength and well-being of Ireland, of Public Health interventions and measures should be recognised through priority funding. 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.
- Develop an integrated public and community health workforce plan.

The Role of Health Systems in Addressing Health Inequalities

Equity of Access to Healthcare

- Ensure equity of access to healthcare services based on medical need and not on ability to pay or any other criteria including age, gender, place of residence or cultural identity.

Primary Care

- Urgent consultation and negotiation on the funding and provision of universal access to Primary Care Services including resources for the prevention and management of chronic disease in the Primary Care setting.
- Building on the HSE Health Status reports which measure deprivation using the Haase and Pratschke Index and the SAHRU Index of Material Deprivation, a model for the allocation of resources to Primary Care is needed which takes into account patterns of co- and multi-morbidities and GP utilisation in areas of deprivation.
- The Government must ensure that vulnerable rural and deprived urban communities have adequate GP cover.

Community Child Health Services

- Renewed focus and investment in Child Health Services.

Position Papers published by the Irish Medical Organisation are available on www.imo.ie

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