

# **‘Say nothing for a wee while, and then say nothing at all’: Still hiding the evidence on health inequalities in Ireland**

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## **Abstract**

Social and spatial inequalities in health status and health service access are pervasive throughout Ireland. However, they rarely form the subject of prolonged public scrutiny. It is clear that the Irish Government has systematically under-funded and stifled attempts to explore health inequalities. What little data exists on health inequalities in Ireland is routinely out of date, or has been the subject of media manipulation in order to minimise its impact. Critically important information to explore such inequalities, such as routine small area mortality data, postcodes or ethnic identifiers simply do not exist in Ireland. Similarly, mortality data is not routinely analysed by social class, occupation, wealth or educational level in Ireland. Ireland’s blatantly two-tier health system reinforces health inequalities, while future health service developments, ostensibly designed to foster the health of those most at most need, are subject to parochial favouritism.

## **Introduction**

While examining inequalities in the UK Coates and Rawstrom (1971, p. 289) argue that in society *‘many ... variations ... are to be observed that would surely be unacceptable severally or separately to an informed democratic society’*. This proposition exposes a key issue concerning access to information about inequalities in health and health service provision in Ireland.

Two decades ago Aiach and Carr-Hill (1992, p. 35) commented that *‘there is very little political debate in Ireland on the general effect of social inequalities on health status’*. Five years later O’Shea (1997, p. 803) also noted that there was *‘very little information on differences in mortality by*

*socio-economic group in Ireland*'. Today the issue of health inequalities remains largely off the map in Ireland. Historically only a small number of studies have explored the relationship between deprivation and ill-health in Ireland (Kirke, 1984; Lyons et al., 1996; Nolan, 1990; O'Shea, 1997; O'Shea & Kelleher, 2001; Pringle, 1986).

This deficit is unusual given the wealth of literature exploring health inequalities that emerged in the UK, Ireland's nearest neighbour and chief trading partner, after the publication of the famous Black Report (DHSS, 1980). A small number of key reports emerged towards the height of the economic boom exploring health inequalities (Balanda & Wilde, 2001, 2003; Barry et al., 2001). However, despite the evidence of the existence of deep rooted health inequalities in Ireland, these reports sparked little discussion or action.

This dearth of debate is a notable paradox given the strength of health inequalities identified in Ireland. The most significant mortality report produced in Ireland in recent times is the 2001 report by Balanda & Wilde '*Inequalities in mortality 1989 - 1998: A report on all-Ireland mortality data*'. This report noted differences in all-cause mortality of up to 200% on the basis of social class. While deaths from respiratory disease were observed as being over 200% higher among the lowest occupational class, compared to the highest, the equivalent figure for mortality from transport accidents was 354% higher (Balanda & Wilde, 2001). Stark inequalities in health have also been noted in relation to cancer incidence (National Cancer Registry of Ireland, 2011), and survival (Public Health Alliance, 2007), as well as in hospitalisation for mental illness (Daly & Walsh, 2002), child mortality (Ryan et al., 2000), and low birth-weight (McAvoy, Sturley, Burke, & Balanda, 2006). As one might expect the health status of particularly vulnerable minorities such as the homeless, refugees and asylum seekers and Irish Travellers have been identified as being particularly poor (Condon, 2001; Focus Ireland, 2000; All Ireland Traveller Health Study Team, 2010). Despite all of this evidence basic issues such as the standard inclusion of an ethnic identifier in health systems data remains unresolved (Houghton, 2013).

Exploration of health status in Ireland is notoriously difficult (Houghton & Houghton, 2013). Significant deficits in Irish health information systems have been noted before (Houghton, Gleeson, & Kelleher, 2003; Houghton, 2006; 2009a; 2009b; Houghton & Kelleher, 2002). Ireland's health information systems are pitifully inadequate in comparison to leading health systems, such as those in Finland (Department of Health & Children, 2004).

## Improvements?

Although there was a long tradition of largely ignoring health inequalities in Ireland, the early years of the new Millennium promised a sea-change. The All-Ireland mortality report was followed by other reports examining both the border region (Balanda, 2001) and urban-rural differences (Shortt & Balanda, 2003). It would be easy therefore to mistakenly assume that the prior dearth of information has been replaced by a plethora of studies in this field. However close examination reveals this is not the case. The All-Ireland Mortality Study continues to form the bedrock of discussions on health inequalities in Ireland and continues to be widely cited (e.g. Public Health Alliance, 2007).

A major difficulty with this report forming the basis of discussion now is the timeliness of some of the data used. This report relates to mortality over the decade from 1989 to 1998. At the time of writing this article in December 2014 therefore some of the data used in this report is almost 26 years old. Subsequent studies have continued to use this original dataset (Balanda, 2001; Shortt & Balanda, 2003), rather than collecting and analysing current data. Ireland has since experienced both 'boom' and 'bust', as well as significant cultural changes. This study though remains the only substantial survey covering mortality over more than a single year period in Ireland. Other reports examining health inequalities in Ireland are often equally dated. A comprehensive study examining inequalities in birth weight in Ireland published in 2006 also featured data from 1999 (McAvoy et al., 2006). The Department of Children and Youth Affairs have just released a new analysis of low birthweight in Ireland in 2012. However, once again this features the same venerable dataset (1999), now 13 years old (Department of Children and Youth Affairs, 2012).

Access to timely, accurate, relevant and spatially disaggregated data remains a longstanding issue in Ireland. For example access to data on mortality produced by the Central Statistics Office (CSO) has long been identified as problematic. Specifically this includes, among other issues, an on-going decline in the detail included in annual Vital Statistics reports (Houghton, 2005). This has included, for example, the removal of the standardized death rates in each province, county and county borough in the mid-1990s. Evidence of the declining detail in these reports can be seen in their shrinking size. For example in 1995 the annual report of Vital Statistics was 253 pages long. By the following year it had declined to 242 pages. By 1999 it had reduced to 213 pages, and by 2001 to 169 pages in length. Between 2002 and 2006 these reports ranged in length from 177 pages to 183 pages in length, before

further declining dramatically to between 115 and 117 pages for the last three annual Vital Statistics reports (2007 - 2009).

The increasing information deficit in the Annual Reports of Vital Statistics is exacerbated by their tardy publication. The World Health Organisation (WHO) states that it '*is vital that up-to-date, relevant information is available to decision-makers at all levels of the public health system*' (World Health Organisation, 2004, p. 1). It is notable therefore that the 2009 Vital Statistics Annual Report was only released by the Central Statistics Office on 31<sup>st</sup> May 2012, almost two and a half years after the end of the year in question. Although there has been some improvement, the 2012 Vital Statistics Annual Report has just appeared in November 2014, the delay is still notable. This compares to the routine publication of the Annual Reports of the Registrar General in Northern Ireland within 11 months of the end of the year concerned (Northern Ireland Statistics and Research Agency, 2011).

The delay in the release of this crucial information undermines attempts to stimulate debate around health inequalities, as the Government can simply point out the '*historic*' nature of the data, while citing various initiatives they claim have been put in place since. Access to CSO information has also been restricted in other ways. For example, the economic downturn provided the excuse for the CSO to close both of its public access libraries in Cork and Dublin, further restricting access to crucial information.

It should however be acknowledged that the CSO were responsible for a recent examination of mortality differentials by class in Ireland. This research was based on a data-matching exercise linking the Vital Statistics Deaths file with the 2006 Census of Population (Central Statistics Office, 2010). The results, not surprisingly, starkly demonstrate the nature and extent of health inequalities in Ireland. However, it is the release date of this report which is perhaps most notable. This significant report was released on December 22<sup>nd</sup> 2010, just days before the Christmas holidays. It is difficult not to view the release date as anything other than a tactic designed to minimise the impact of this study. This release date is somewhat reminiscent of the infamous launch of the Black Report by the newly elected Conservative Government on the eve of a bank holiday weekend in 1980 (Delamothe, 1989). Similar crude tactics have been noted repeatedly elsewhere (Shaw, Dorling, Mitchell, & Davey Smith, 2005; Smith, 1990).

It should be noted that mortality data released by the CSO in Ireland would appear to be almost purposefully designed to defeat any investigation of the relationship between social class and ill-health. Although occupation and address are detailed on the forms related to

the death certificate, these are not routinely coded. Therefore the Annual Reports of Vital Statistics detail mortality by cause, gender, age and County/ County Borough. However, they do not detail mortality by social class, occupation, educational level, income or any other routine measure of relative standing or affluence/deprivation. A common tactic in such situations might be to explore mortality at the local area level using a small area deprivation index score. However mortality data is not released by the CSO at below County and County Borough level. Enumeration Districts (EDs) exist and are routinely used as the basis for most Census data, but not for mortality data. Although address information is captured and address geocoding systems have been developed (Geodirectory, 2012) and marketed by the state mail service (*An Post*) this data remains inaccessible. Therefore, the population counts in the areas for which mortality data is available are not only too large to facilitate an analysis based on deprivation, but are disparate, ranging from 30798 in County Leitrim to 527612 in Dublin City (CSO, 2012a).

### **A picture is worth a thousand words**

The graphical representation of information can be a crucial means of transmitting information. Although not without some dangers, such as small numbers/ large area issues, it can provide an accessible avenue through which information can be shared more widely. It is perhaps for reasons of this accessibility that the Irish State has vehemently steered clear of useful mortality mapping. Kelly and Rybaczuk (2002: 2) comment, in what can only be described as comical understatement, that '*in Ireland the mapping of disease is not a heavily exploited area*'.

The main tool that has been developed to display in graphical and tabular form health information in Ireland is the *Public Health Information System* (PHIS). This package includes data on mortality, hospital discharges, cancer, birth and psychiatric in-patient activity. However, significant difficulties in accessing this system by members of the general public have been noted elsewhere (Houghton, 2005). Although access to PHIS is now possible via the Health Well website ([www.thehealthwell.info](http://www.thehealthwell.info)), it remains awkward and clumsy. It should be noted that although the information included is relatively new, analysis below County and County Borough level, or by social class, occupation or education is not included.

The more recently developed *Health Atlas Ireland* package offered the potential to overcome many of the deficits outlined above. A presentation on *Health Atlas Ireland* on the website of the funding agency, the Health Research Board (HRB, no date), the main State

health research funding agency, clearly indicates that this system was designed to include such issues as hospital activity, mortality, cancer, perinatal health, prescribing, vaccination and disability. The same publication clearly suggests that geocoding of raw data would occur facilitating the presentation of information at various levels, including county, postal area, electoral division, and service catchment area levels. However despite significant promise and potential, the publicly available product of this publicly funded project, is little more than a local health service identifier, rather similar to routine Google Maps applications identifying local businesses. Local area data on health status and mortality is either not included in this system, or hidden from public scrutiny.

Deficits in mortality mapping in Ireland have been explored in detail elsewhere (Houghton, 2002, 2005). It clear that there has been a clear trend of decreasing detail in mortality mapping in the Vital Statistics Reports in Ireland from 1950 onwards (Houghton, 2002). Between 1950 and 1958 for example, the few mortality maps appearing in the Vital Statistics Report detailed five different levels of mortality (known as map classes). However, between 1959 and the mid-1970s the level of detail in such mortality maps declined to four map classes. Over the following ten years (1977-1987) this detail further declined to include just three map classes. Although there was a slight increase in the number of maps contained in the Vital Statistics Reports over much of the next decade (1982-1990), such maps have steadily decreased in size, making them increasingly difficult to interpret.

The most alarming and indicative aspect of State disease mapping in Ireland is that from 1991 until the most recent Vital Statistics Report (for the year 2009) no maps have been included in the Annual Vital Statistics Reports. It should be remembered that this deficit developed at the point in time when computer hardware and basic mapping and Geographical Information Systems (GIS) packages were increasingly available, as well as both easier to use, and cheaper to purchase.

## **Silencing Dissent**

In recent years the Irish Government has also been effective in silencing many of the bodies that previously existed to highlight issues such as poverty, marginalisation and health inequalities. For example since its creation in 1986 the Combat Poverty Agency (CPA) had provided a vocal, authoritative and critical commentary on issues of poverty and exclusion in Irish society. This resolute voice continued throughout the years of the 'Celtic Tiger' boom (CPA, 2004a), including a number of texts exploring health inequalities (CPA, 2004b; Barrington, 2004).

However, ostensibly for cost saving reasons, in 2009 the CPA was 'integrated' into a government department and has already been re-located within government several times since. It is not surprising that this relocation effectively silenced the largely independent voice of the CPA.

The loss of the voice of the CPA is notable. However, this was only one of many vocal and critical agencies that disappeared in recent years. Another noteworthy casualty of the Irish Government's '*cost-cutting exercises*' contained in the Health (Miscellaneous Provisions) Act 2009 was the dissolution of the National Council on Aging & Older People (NCAOP). Similar to the Combat Poverty Agency, the NCAOP had a long standing history of producing high quality research reports outlining key issues such as health and poverty (Layte, Fahey, & Whelan, 1999), health services (O'Hanlon et al., 2005) and elder abuse (O'Loughlin & Duggan, 1998; Working Group on Elder Abuse, 2005). Once again the systematic silencing of this agency, which had consistently identified and campaigned against poverty and its impacts in older people, was a blow to even the pretence of an active and informed democracy.

The voice of marginalised and excluded groups in Ireland was further minimised under the cloak of '*cost saving*' through the closing of the National Consultative Committee on Racism & Interculturalism (NCCRI). The culling of vocal agencies critical of government and health service short comings continues. An excellent example of this systematic trend can be seen in the fate of the Mental Health Commission (MHC). The MHC are notable for having have consistently produced a series of damning annual reports on the poor state of mental health services in Ireland since its formation under the Mental Health Act 2001. An impressive aspect of these reports has been the willingness of the MHC to identify the chronic and unresolved nature of many of their concerns which have re-appeared year after year. However, government policy now indicates that the MHC is to be amalgamated into the newly established Patient Safety Authority (Department of Public Expenditure and Reform, 2011; Reilly, 2011). It seems unlikely given the systematic eradication of dissent elsewhere, whether the critical and authoritative voice of the MHC will be permitted in its new guise to highlight continuing Government failures in the provision of mental health services.

## **A Postcode Lottery?**

Graley et al. (2011: 1) state that '*Postcode lotteries in health refer to variations in health care between different geographical areas that appear arbitrary and un-linked to health need*'. Ireland cannot be

accused of having a postcode lottery, if only because it does not have an effective postcode system. A crucial tool in the exposure of the relationship between deprivation and ill-health in many countries has been the use of zip codes or postcodes. When used alongside area-based deprivation indices, the use of such spatially referenced codes enables a quick, albeit crude estimation of the general level of deprivation among populations. These methods have been used in major national studies of health and deprivation for over 20 years (Carstairs & Morris, 1991). It is obviously significant therefore that more than 50 years after postcodes were comprehensively introduced into the UK, Ireland still does not have a postcode system. Only Dublin has a crude system in which the city is divided into 25 areas. Each of the postcode areas in Dublin City therefore has an average population of over 20,000 compared to less than 50 in the UK. The rest of Ireland currently has no postcode system. A postcode consultation exercise was launched in Ireland in 2005. Despite the significant delay, as of 2014, there is still no postcode system in Ireland. This deliberate deficit continues to severely hamper a clear examination of both spatial and socio-economic inequalities in health.

### **Look the other way...**

Although lacking a postcode lottery, Ireland's health care system is fundamentally divided and unjust. The Irish healthcare system is divided into public and private provision. However, what complicates and obscures oversight in this system is that much of the Private work takes place in Public hospitals (Smith, 2010), by Medical Consultants already receiving a state salary of approximately €200,000 (Burke, 2009). Significant inequalities in access to health services in Ireland are the norm. Provision for the most economically disadvantaged in Ireland is provided by the means tested HSE Primary Care Reimbursement Service (formerly the General Medical Services [Payment] Board). This scheme, which is known colloquially as the 'medical card', largely covers in-patient, out-patient and GP access, as well as prescription payments and ancillary services (e.g. dental and ophthalmic services). Private patients usually pay to access all of these services, often with the help of private health insurance. A recent report has noted that 30% of the population have a medical card only, while 41% had private insurance only. A further 6% had both private health insurance and a medical card, while 23% had neither (CSO, 2011).

The Irish health system is characterised by significant inequalities in treatment times, and long-term waiting lists have come to typify public provision (Wren, 2003). Private patients however can easily and effectively queue-jump waiting lists. One interesting feature in Ireland



has been the length of time it has taken for such queue jumping to be openly acknowledged. For many years the official position in Government was that people chose private health insurance because of the hotel-like accommodation provided (Houghton & Connors, 1998) while never acknowledging the reality of queue jumping. It is alarming to note that at the turn of this Century the Economic and Social Research Institute (ESRI), noted that very little was known about the extent, nature and cost of private practice in public hospitals (Nolan & Wiley, 2000). Not surprisingly, waiting list initiatives to try and reduce such lists have had little impact (Comptroller & Auditor General, 2003), while public hospitals (The Sunday Tribune, 2010), and consultants (The Irish Times, 2011) have repeatedly been found to be exceeding their, already generous, quotas for treating fee-paying private patients. The system provides little oversight and no penalties for publicly paid medical consultants conducting unlimited private work.

Based on the situation outlined above, it will probably come as no surprise to learn that Ireland lacks a clear and transparent health funding model in Ireland. The 'formulae' used in Ireland resembles that which has been described as applicable to the UK's NHS in its early years (Hendry, 1998). Maynard & Ludbrook (1988, p. 293) have suggested that the annual funding was calculated on the basis of '*what you got last year, plus an allowance for growth, plus an allowance for scandals*'. Funding in Ireland is distributed largely on a historical basis and unlike the UK, which introduced the RAWP formulae in the mid-1970s, has never been seriously challenged. As Watters and Phillips (1994, p. 40) note '*the decisions surrounding healthcare resource allocation in Ireland reveal a noticeable lack of rational criteria*'.

Although there is no postcode lottery in Ireland significant inequalities in health service provision are evident. Parochialism and what are known as 'stroke' politics (Cullen, 2012) in healthcare allocations are commonplace. However, the allocation of such healthcare services is often justified by arguments citing unclear and dubious criteria. A notable example includes that the proposed siting of Ireland's new National Children's Hospital is in the constituency of former Taoiseach Bertie Ahern (Houghton, 2009a). More recently a Government Minister resigned after the Health Minister added two new primary care centres from his own constituency to a list of projects being prioritised. The resigning Minister stated openly that '*The public have a right to expect that decisions on health infrastructure and staffing will be made in the public interest based on health need and not driven by other concerns*' (Carr, 2012). Health service funding and resource allocation has been the focus of sustained academic attention in Ireland in recent years

(Brick, Nolan, O'Reilly, & Smith, 2010) but such work appears to have had little impact.

## **Conclusion**

It is clear that the Irish government has a clear policy of attempting to restrict access to information about inequalities in health and health service provision that are pervasive in Ireland. The government has also systematically under-developed the information/ research infrastructure that would facilitate investigations into this issue in Ireland. This is evident in the lack of small area health/ mortality data and the absence of such data being available by social metrics such as social class or occupation. Further evidence of this purposeful lack of development is clear in the absence of ethnic identifiers and postcodes in Ireland. The State has also conducted an effective campaign to silence the voice of many agencies that formerly advocated on behalf of the most marginalised in Irish Society.

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