HEALTH AND INEQUALITIES IN NORTHERN IRELAND: DEFINING THE PROBLEM AND POSSIBLE SOLUTIONS

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Background

Northern Ireland (NI) has traditionally had the highest unemployment rates of any UK region. In 1995 it was about 13% higher than the EU average (Focus of Northern Ireland, 1997). The difference between NI and GB employment rates is explained fully by the much greater levels of long-term unemployment here (Gorecki, 1995). GDP *per capita* in NI is about 83% of the UK average. For those in employment the average wages are about 10% lower than the national average.

Despite these signs of relative disadvantage there has been a paucity of research into health inequalities in NI compared to other parts of the UK. Campbell (1993) has suggested that this has been 'an unfashionable area for researchers', and the London Health Economics Consortium (1995), have observed that'… taken on its own, the extent to which the current body of research into health inequalities in NI can provide a basis for policy development is limited.' The aim of this paper is to briefly describe the relationship between disadvantage and ill health in NI, to outline some NI specific problems (the 'Troubles' and the 'two communities'), and finally to describe some of the policy initiatives aimed at reducing these inequalities in health.

Inequalities in health

What limited research there is shows that the general relationship between material deprivation and ill health in NI mirrors that found in the rest of the UK. Men in affluent areas can, on average, expect to live 6.6 years longer than their peers in the more deprived areas; women can expect to live 4.1 years longer (Campbell, 1999). Those living in the most deprived areas have about 60-80% more heart and respiratory disease and strokes, a two-fold excess of accidents and a three-fold excess of lung cancer (EHSSB Public Health Matters, 1994). Many children born to poorer families in Northern Ireland fail to reach their full physical and mental potential. They have higher rates of accidents, are 15 times more likely to die as a result of a house fire and are four times as likely to die before the age of 20. Suicide rates among those aged 15-24 are almost three times higher in the lowest income groups.

Deprivation, however, has a greater impact on general health than is reflected in the mortality differentials. Not only do affluent populations live longer, but they also spend a greater proportion of their longer lives in good health. The 1997 NI Health and Social Wellbeing Survey shows that those in the poorest households are about 2.5 times as likely as

the most affluent households to have suffered from a recent bout of ill health, or to describe their health over the last year as poor (O'Reilly and Browne, 2001). They are also 3-4 times as likely to complain of a longstanding illness and 6-7 times as likely to have a disability. The incidence of dental caries is also much higher in poorer areas. The likelihood of multiple disadvantage increases with age and if appropriate indicators of deprivation are used, inequalities in health at these ages are also found (O'Reilly, in press).

The well attested associations between lower socio-economic standing and adverse lifestyle factors such as smoking, excess alcohol consumption and a diet that is orientated more towards fatty foods than to fresh fruit and vegetables are also found in NI (O'Reilly, 1999). However, it is important that these are considered within the context of people's lives rather than as evidence of fickle self-indulgence. Other aspects of the lives of people in poorer households are less frequently noted or quantified; for example, significantly higher levels of stressors and poorer levels of social support (O'Reilly, 2001). They endure higher levels of crime and worry about serious legal or financial problems or about the health of family members and have greater levels of concerns about parenting. It is therefore not surprising that people in poorer households are 3-4 times as likely as those in the more affluent households to be on 'medicine for their nerves'.

The troubles'

One obvious difference between NI and the rest of the UK is the civil disturbance, colloquially known as the 'Troubles', that the people have endured for the last 30 years. During this time more than 3,600 people have been killed (Fay *et al,* 1997; McKittrick *et ah,* 1999) and thousands more injured or traumatised. The Troubles show a definite socio-economic gradient with the greatest effects concentrated in more disadvantaged areas (Fay *et ah,* 1997) and amongst poorer people (O'Reilly, 2000). This heightened anxiety and worry may be a contributory factor in explaining why levels of mental ill health are higher here than in other parts of the UK. Yet over the years there has been relatively little study of the impact of the Troubles on the health of the public (Froggatt, 1999) and it has never featured in any of the Director of Public Health annual reports.

The death toll from the Troubles may have abated somewhat in recent years but the health impact in terms of 'knee-cappings', punishment beatings and other associated criminality continues. Indeed, in many areas, particularly the more deprived areas, drug-related crime has belatedly emerged to replace or coexist and compound the misery associated with the Troubles.

The two communities

An almost constant feature of the NI political and social landscape is the tension arising from the differences between the Catholics and Protestants who live here (known locally as the 'two communities'). Almost 42% of the population are Catholic and 54% are Protestant (Northern Ireland Statistics and Research Agency, 1997). Forty-one percent of the population are living in electoral wards that have more than 90% of one religion and 60% in wards with more than 80% of one religion (The Northern Ireland Census, 1993), making for

a very segregated society. Protestants tend to be in the majority in the east and north of the region, while Catholics predominate in the south and west. Consequentially any geographically-based government initiative will naturally tend to favour one side over the other.

There are significant differences between the two communities. For example, Catholics tend to have higher birth rates, giving them a younger age profile and larger average households (Northern Ireland Statistics and Research Agency, 1997). They are also, on average, more economically deprived than their Protestant peers with substantially higher levels of unemployment (Labour Force Survey Religion Report, 1994), a greater dependency on social security benefits, and lower average household income levels (Family Expenditure Survey, 1995). They are over represented in deprived areas with higher mortality and long-term illness rates (O'Reilly and Stevenson, 1998) and exhibit poorer health when measured on a range of health indicators, though these health differentials are (statistically) explained by differences in socio-economic status between the communities (O'Reilly and Stevenson, 1998; O'Reilly and Browne, 2001).

Many of the current administrative structures in NI have their origin in a 1968 report into the Troubles (Elliot, 2000), which concluded that much of the Catholic grievances relating to manipulation of the electoral boundaries and discrimination in local authority housing (one of the key issues to spark the Troubles in 1969) '…had a substantial foundation in fact'. Centralisation of administrative functions followed, with a series of legislation to ensure fairness and equality, a process that continues to the present.

Possible solutions

The introduction of initiatives and policies aimed at reducing inequalities in health has been a gradual process, with more concerted and targeted approaches in recent years, most notably following the change of government in 1997. Box 1 shows some of the most notable initiatives aimed at reducing social and health inequalities in NI.

Box l

1991:	Launch of Targeting Social Need (TSN)
1992-1997:	Regional strategy … Targeting Health 8c Social Need (THSN)
1997-2000:	Health 8c Wellbeing into the new millennium
1998:	New-TSN to incorporate Promoting Social Inclusion
	April - Belfast Agreement
	June - Assembly elections
	November - The Northern Ireland Act… Equality schemes
1999:	December - Appointment of ministers
2000:	Health of the Public in Northern Ireland: Report of Chief Medical Officer
2001:	Investing for Health (consultation document)
	Target setting for Investing for Health

In 1991, we saw the launch of the TSN (Targeting Social Need) policy. This was provoked by research evidence showing significant differences in the socio-economic profiles of the

Catholic and Protestant communities. The aims of TSN (Quirk and McLauglin, 1996) were 'to tackle disadvantage by diverting resources and efforts towards individuals, groups and areas objectively defined as being in greatest need … and while not discriminating in favour of one community and against the other ... it should also lead to the erosion of socio-economic differences between the two communities over time'.

In the third regional strategy (1992-1997) TSN became translated into THSN (Targeting Health & Social Need). Its aims were to 'to minimise inequalities in population health and social wellbeing and in the need for and access to health and social care in NI', but it was not until the later 1997-2000 regional strategies (DHSS, 1997a; DHSS, 1997b) that guidance on its application became explicit. There is now a regional action plan in place to support and coordinate THSN with a steering group established at the Department of Health, Social Services and Public Safety (DHSSPS) to advise on specific actions. As Labour was transformed into New Labour, in 1998 TSN was re-launched as New-TSN, and while the rest of the UK embraced the principle of social exclusion we espoused social inclusion (DHSS, 1998). As a sign of the importance given to equality issues in NI they were placed under the Offices of the First and Deputy First Ministers.

For the first time in NI, the 1999 Chief Medical Officer's Report majored on inequalities in health, though the tackling of these inequalities was definitely placed in the political arena: 'Health is a matter of politics as much as individual personal practice, and when major inequalities in health exist then health is inescapably a matter for the assembly' (Campbell, 1999).

The year 2000 saw a review of the public health function in NI, culminating in the publication of Investing in Health (DHSS, 2000), in which inequalities in health formed a major theme. The consultation period for this report is now finishing and the DHSSPS is in the process of drawing up health inequality targets, though there is an acknowledgement that the utility of such an exercise is questionable (McKee and Bergman, 2000; La Parra and Alvarez, 2001). While the English targets have focused primarily on health outcomes, we hope that the NI targets will focus heavily on the intermediate processes, such as poverty and educational attainment, which perpetuate the cycles of socio-economic disadvantage that generate and sustain health inequalities. It remains to be seen whether the political will exists to recognise and act upon these factors, although some initiatives, such as redistributive tax policies, are not within the powers of the NI Assembly.

I now want to say a little about Equality Schemes. Section 75 of the 1998 NI Act 'requires public authorities to have due consideration to the need to promote equality of opportunity between nine different groups (see Box 2)'. This new equality legislation encompasses the ideas of Policy Appraisal and Fair Treatment (PAFT) (Osborne *et al,* 1996) but goes much further. Public authorities must now prepare Equality Schemes (stating how they propose to fulfil their new duties) for approval by the Equality Commission and then undertake an Equality Impact Assessment of all their existing and proposed policies. To date only a handful of the latter have been carried out and it is uncertain what the effects of this legislation will be in the longer term. It undoubtedly has the potential to greatly enhance the planning process by getting public authorities to meaningfully engage with parts of the population whose views would not, previously, have been so obviously canvassed. It also has

Box 2

Religious belief:	Protestants, Catholics, other belief, and no belief.
Political opinion:	Unionists generally, Nationalists generally, members/supporters of any political party.
Racial group:	As defined by the Race Relations Order.
'Men and women':	Men, women, and trans-gendered people.
Marital status:	Married, unmarried, divorced or separated or widowed.
Age:	Policy depend but generally children under 18; people aged 18-65; over 65.
Persons with a disability:	As defined by Disability Discrimination Act.
Persons with dependents:	Persons with primary responsibility for the care of a child, a person with disability or a dependent elderly person.
Sexual orientation:	Heterosexuals, bisexuals, gays, and lesbians.

the immediate effect of focusing attention on the primary aims of policies and on the need for their justification, especially when balancing issues of efficiency against the additional costs to society or sub-sections thereof.

The downside is that it may also to lead to stagnation and 'paralysis by analysis'. Reviewing all existing and proposed policies will be a mammoth task and the requirement to quantify any differential impact on all of the various subgroups (Box 2) will be onerous considering the paucity of such classificatory variables in most routine data systems. Many of the smaller interest groups are already pleading consultation fatigue. While the objectives of the equality legislation are laudable, it also needs to be shown that Equality Impact Assessments can themselves have a useful impact. It could be argued that the PAFT initiative, which predates these by about five years, produced few tangible benefits or changes. The new equality legislation, as with all other initiatives to reduce inequalities, will require rigorous evaluation.

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