

A picture of health?

**Tackling health inequalities
in Northern Ireland**

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Preface

This paper stems from a project conducted by the think tank Democratic Dialogue and the public-affairs company Stratagem and supported by Pfizer. The aim was to raise the level of debate about health in Northern Ireland, which has hitherto tended to focus on *healthcare* matters like waiting times and acute-hospital rationalisation rather than on public health and health inequalities, despite the publication of *Investing for Health* by the former devolved government in 2002.

To this end, DD and Stratagem organised a series of four round-table discussions in 2006. These brought together policy-makers, political representatives, experts and practitioners. They focused respectively on the evidence on mortality and morbidity, the effectiveness to date of public-health interventions, a policy agenda for Northern Ireland and, finally, the nuts and bolts of how that should be effected.

This paper distils the lessons of the project, concluding with a series of recommendations. It will hopefully be of considerable value to a devolved or a direct-rule administration. It draws on the wealth of material presented to the round tables, for which the authors are fulsomely grateful—though as these were held under the Chatham House Rule it does not acknowledge the source except where this is a publication—as well as a body of recent research. While it does seek to collate the views of many others, the propositions it contains are of course the responsibility of the authors alone.

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I. Ill-health and health inequalities

'Health is as good or bad as the society we create.' This simple statement (Politics of Health Group, 2005: 5) gets to the heart of the matter at a time when the UK political, and so media, focus on health is overwhelmingly on the 'choice' agenda with regard to hospital provision. This vaguely presumes that health *conditions* will be improved by competition between secondary-care providers—and, even more tendentially, that the needs of the most disadvantaged will be particularly attended to in this process—even though most hospital admissions are not elective (*Guardian*, February 26th 2007).

Choice has come less to the fore in Northern Ireland, but here too the emphasis has been on 'delivery' rather than on health outcomes. It is not to dismiss how health-care is 'produced' by the National Health Service to argue that market-mimicking mechanisms as to its 'consumption' may, at best, have an indirect effect on the quality of treatment of a pre-existing condition. And outmoded 'Fordist' forms of production in the NHS, which rely on a large-scale and hierarchical system, represent a substantial barrier, when a key challenge is to ensure more care takes place in primary and community settings.

The bigger, underlying, difficulty is that the main focus always returns to the health service, and hospitals in particular, at all. As Coote (2004: 12) explains it, 'The headlines about health policy have focused on the NHS for so long that the public has come to expect the main action to take place on this front. There is a mutually reinforcing process of narrative-building, whereby governments promise to reform health services, voters expect services to be reformed, media scrutinise government performance and seek out stories about its failure to deliver, voters become increasingly alarmed and government raises the stakes by making more promises, intensifying the circle of claim and blame. A climate of opinion develops that leaves little room for public discourse about how to reduce the need for health services by keeping people well.'

Perversely, health-service professionals have no incentive to keep people well, as against make them better after they have already become ill—even though the vast majority of illnesses are avoidable. This has been likened to putting locksmiths in charge of dealing with burglary. But the official emphasis on 'finished consultant episodes' and 'throughput' means it is the *outputs* of the system to which attention is paid, crowding out attention to the *outcomes* for the citizen. This is reinforced by the way pharmaceutical companies skew research funding towards new treatments, when the most pressing health-research need in the world is a vaccine against AIDS.

The World Health Organisation defines health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'. There is a growing worldwide movement towards recognising the importance of inequalities in health. But

although this has been on the agenda since the 1980s, it is only now coming to the fore. In 1984 the WHO member states agreed a target to reduce ‘actual differences by health status’ by at least a quarter by 2000, yet in most cases these inequalities have widened rather than narrowed. As Mackenbach *et al* (2002: 30), explain, ‘although many countries reported they had done something to reduce inequalities in health, in reality policies and interventions were mainly limited to achieving equal access to healthcare’.

A change of focus immediately reframes the challenge in much broader and profound ways. Coote (2004: 5) presents the alternative thus: ‘A system geared towards improving health for all and reducing health inequalities would have to comprise measures to tackle the underlying causes of ill health, promote better health, prevent illness and intervene early in the development of life-limiting and life-threatening diseases. This would involve, among much else: creating healthy environments through housing, transport, neighbourhood design, crime control and access to green spaces; promoting social and economic opportunities through education, employment and income distribution; creating optimal conditions for healthy living and working, including diet, exercise, alcohol, smoking, drugs and sexual health; preventing illness by means of antenatal and infant care, vaccination, screening and regular health checks for older people; and intervening early to limit the effects of heart disease, cancer, mental illness and chronic conditions such as diabetes and arthritis.’

This is, inevitably, an extremely broad agenda. It recognises that the key choice every citizen should be able freely to make is to enjoy good health, rather than which doctor they see—it is, in other words, to provide ‘a better choice of choice’ (Levett, 2003). But then an agenda for a better society—as the context for better health—has to be. It recognises that most of the determinants of bad health must be dealt with ‘upstream’ of their manifest effects (Politics of Health Group: 2005: 3), focusing on prevention rather than cure (Coote, 2004). It also recognises that these wider social determinants tend to bear most heavily on the most disadvantaged, such as pollution from factories in the first, and particularly the third, worlds.

This argument was echoed in a speech by the Democratic Unionist Party health spokesperson, Iris Robinson, at her party’s 2006 conference. Ms Robinson said: ‘The social model of health isn’t just about disease and illness. It also emphasises the environment, education, employment, poverty and housing among other factors. The health of any individual is a product of social, interpersonal, psychological and environmental factors, and is not simply a medical matter (*Irish Times*, February 6th 2006). It has also been the basis of Scottish health policy under devolution since the publication of *Our National Health* by the Scottish Executive (2000): as one former senior health official put it, public health has become ‘the day job’ for the health service and local authorities there, with the emphasis within the NHS tilting towards primary care and prevention.

Two major issues arise from this changed frame of reference. The first is that inequality matters. Wilkinson and Pickett (2006) found that nearly three quarters of 168 studies found a relationship between the health of citizens and income inequality. This relationship was

stronger still as one moved from local to regional to national studies, suggesting that class structures, coming more clearly into view as the scale enlarged, were the key determinant. By comparison, there was only a weak relationship between overall income—gross national product—and health, diminishing further for richer societies. Paradoxically, even though demand upon it reflects the extent of illness, the NHS is conventionally captured by economists as contributing to GNP.

So inequality, rather than lack of income as such, is a major source of ill-health. And that this is about social status is evidenced by the graduated nature of health as one moves up or down the social hierarchy, as Marmot's study of morbidity and mortality among Whitehall civil servants found in exquisite detail (Marmot, 2004). Men (to whom the study was initially confined) at the bottom of the office hierarchy had, at ages 40 to 64, four times the risk of death of the men at the top. Even among the senior ranks, different civil-service grades made a difference to well-being. Wilkinson and Pickett (2006: 1776) argue that this conclusion is reinforced by the further relationship between inequality and behavioural effects like violence, teenage pregnancy and obesity. The connecting link is the 'psychosocial stress' that inequality engenders.

It is not thus that income inequalities *in themselves* make for bad health (in the developed world, at least), but rather that they do so via a *social* gradient which ensures that the healthy experience of a life of flow—of 'autonomy and control'—is, contrary to the stereotype of the stressed executive, concentrated at the top of the hierarchy (Marmot, 2004: 47). The relationship between poor health and low control has been vindicated through seven further studies in eastern Europe by Marmot (2004: 214) and colleagues. We can also identify such a gradient in Northern Ireland mortality and morbidity data, ranked by social class, as the next section indicates.

Indeed those concerned with income inequality have tended in recent years to come to conclusions which converge with those driven by concern about public health. Thus Sen (1999), looking at the developing world, defines poverty more broadly as deprivation of the freedom to achieve what one values in life, while the Fabian Commission on Life Chances and Child Poverty (2006) has concluded that equality of 'life chances' should be the policy goal for a country like the UK too.

The 'status syndrome' (Marmot, 2004) alerts us to the key role of mental health in our overall well-being—in contrast to its Cinderella status in the health service. Good mental health provides a resilience in coping with life's inevitable adversities—one of the reasons why high-quality childcare can have such lasting positive effects—and engenders a sense of optimism. Yet mental ill-health is a larger source of illness than even cardiovascular disease or cancer, and anxiety and depression are on the rise in developed capitalist societies. Moreover, poor mental and physical health tend to go together. Why should all this be, when so many are now so affluent?

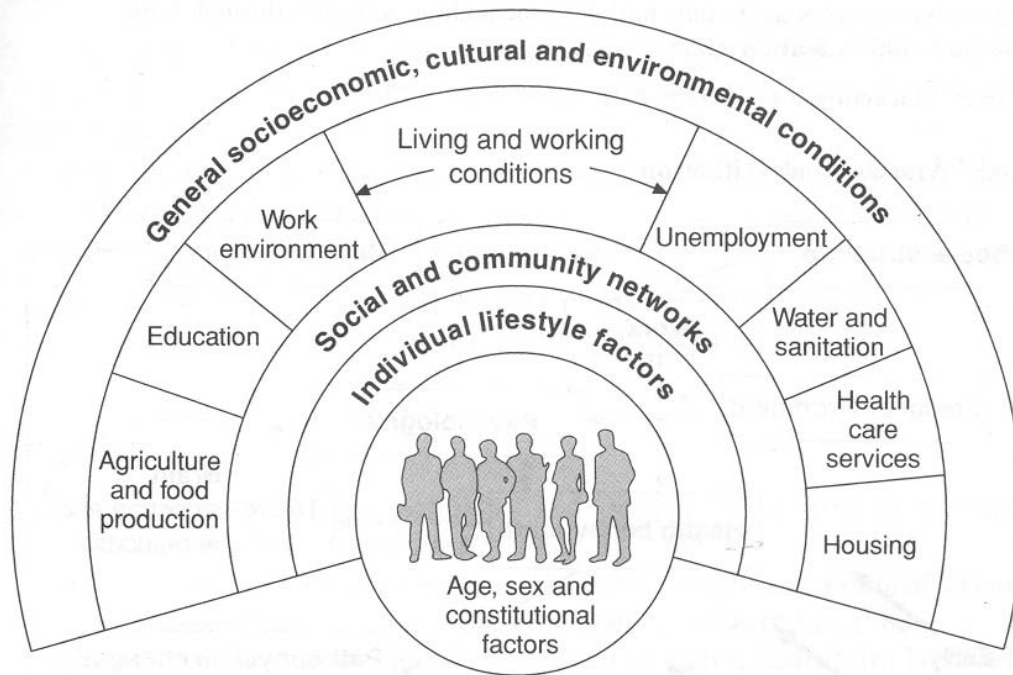
Low self-esteem appears to mediate. Human beings are inherently ‘reflexive’, monitoring constantly how others evaluate us (Wilkinson, 2005). And much of our behaviour is ‘mimetic’, or imitative. In the 18th century Adam Smith famously linked poverty to prevailing social norms when he said that, in his day, possession of a linen shirt was necessary to go out in public without shame—the equivalent of today’s designer clothes. Where commodities are valued above all else in society, rivalry for possession of them creates winners and losers: by definition, they are ‘positional’ (or status-linked) goods rather than the public goods everyone can share.

The psychological phenomenon of ‘adaptation’—which in lay terms means eaten bread is soon forgotten—devalues the pleasure we derive from the commodities and services increased affluence allows us to buy (Layard, 2006). The irony is that the pursuit of endless economic growth—to the extent, as we now know, of the potential destruction of the planetary ecosystem—is premised on there always being consumer *dissatisfaction*, as exploited constantly through advertising. And as positional goods some enjoy are progressively acquired by others—for example, as foreign holidays have become the norm—the pressure to compare or stay ahead is relentless (Levett, 2003). Celebrities in business, sport and music know what it is like to enjoy huge and repeated social valuation. But for the much larger number at the base of the social pyramid, the persistent experience of being a loser brings with it a lack of self-worth.

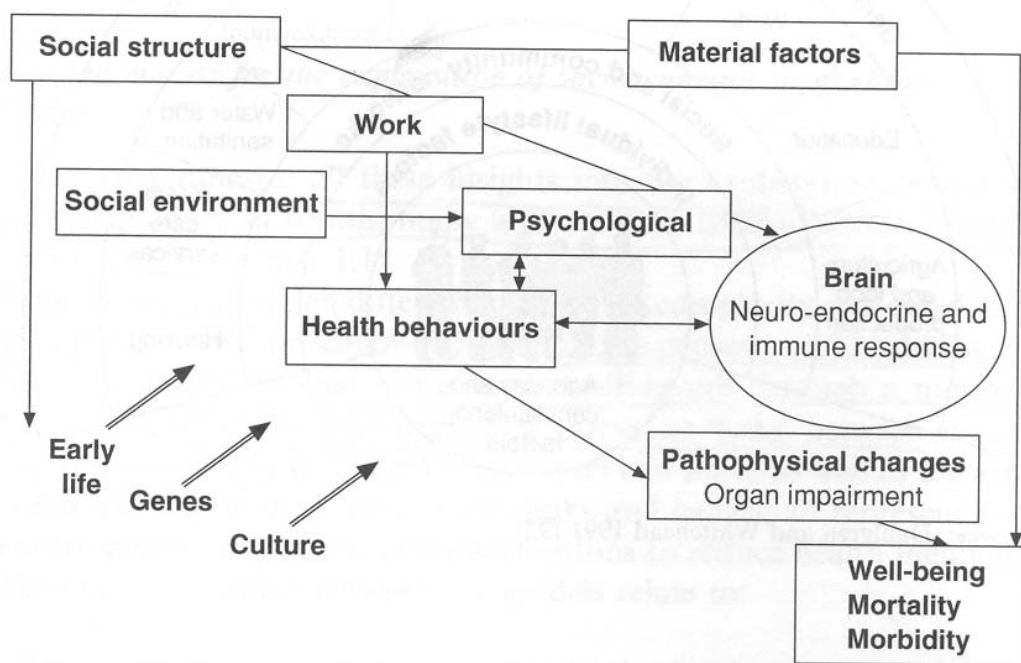
As the Civic Forum (2002) recognised in preparing its Northern Ireland social-inclusion strategy, social exclusion is associated with ‘stigmatisation and stereotyping’. This is the basis for what economists call the ‘hysteresis’ effect (where a phenomenon is exacerbated by positive feedback) associated with long-term economic inactivity. Not only do skills fall into desuetude if people are detached from the labour market, but they progressively lose social ties and self-confidence, falling all too easily into despondency and fatalism.

Recent scientific research has reinforced these causal connections. Telomeres protect the ends of chromosomes from damage, and are believed to be linked to ageing as they shorten each time a cell divides. Researchers at St Thomas’ Hospital in London found that working-class volunteers they studied had shorter telomeres than those higher up the social ladder: being working-class could make someone appear seven years older. The researchers ruled out differences in income (as such) and ‘lifestyle’ factors and attributed the cellular damage to the stress of being at the bottom of the social pile (*Guardian*, July 20th 2006).

This is an important innovation in understanding. Hitherto, public-health exponents have used the diagram developed by Dahlgren and Whitehead (1991) to advance their cause.



In particular, this concentric-circles model has been used to stress that 'lifestyle' factors, still less genes, are not everything when it comes to the determinants of an individual's health. But while valuable enough, this model only presents general contextual relationships. What we know of how the key hypothalamus-pituitary-adrenal axis in the body converts stressful signals into unhealthy somatic effects, such as the premature ageing arising from over-production of the stress hormone cortisol, has allowed Brunner and Marmot (2006: 9) to offer a model which presents direct causal pathways—a model which thus suggests a more specific policy focus. Rather than generally seeking to improve social and economic conditions, the key concern is to level the gradient in the social structure, including in work and the social environment, which has such pathogenic effects on well-being.



The inequalities arising from the class structure of capitalist societies are not a force of nature. On similar poverty measures, market incomes in Sweden, if unadjusted, would leave just as high a proportion of the population in poverty (28.3 per cent) as in the UK (28.8 per cent). But the highly progressive tax system in Sweden allows for social transfers which leave only a tiny poor residuum (3.3 per cent), while in the UK 16.4 per cent still remain poor when post-market incomes are compared (Bryant and Raphael, 2006: 16). The Swedish social gradient, in other words, is much shallower. As the Fabian Commission on Life Chances and Child Poverty (2006: 195) put it more generally, in a comment relevant to the state of health of the huge NHS workforce itself, ‘A doctor, a hospital clerk and a hospital cleaner in Nordic countries are more likely to live in the same neighbourhood and send their children to the same day care nurseries and the same schools and afford similar holidays and cars.’

Looked at over time, inequality in the UK mushroomed during the Thatcher years. The proportion of households with income below half of the equivalised household average (before housing costs) rose from 6 per cent in 1977 to over 20 per cent in the early 1990s (Burgess and Propper, 2002: 46). This dramatic growth in inequality was mirrored in Northern Ireland, as demonstrated by McGregor and McKee (1995). Interestingly, they argued that household expenditure provided a more reliable indicator of inequality than income, and recent UK data would suggest that while inequality on this measure may not have risen quite so dramatically under the Tories as the income trend, the gap has continued to widen under New Labour, whereas income inequality appeared to have stabilised (Brewer *et al*, 2006). The inexorably rising graph of inequality on the expenditure measure accords

better with that for inequalities in UK life expectancy, *whose continuing upward movement has realised a peak not seen since Victorian times* (Shaw *et al*, 2005).

It is sometimes argued that the UK and the US, while substantively less equal than their Nordic counterparts, substitute for this by greater social mobility: if the class structure will not change, at least people can change their positions within it. This is the narrative underpinning ‘the American dream’ and a paler version seems to be articulated by New Labour. Yet this is entirely mythical: social mobility is at least as great if not greater in societies with the narrowest inequalities, since shallower social gradients are easier to climb. Empirical data comparing the US with the Nordic countries bear this out (Hutton, 2002: 166-7).

Sweden and the UK, and in this the Republic of Ireland follows the UK (NESC, 2005; Timonen, 2005), are paradigmatic cases of the ‘social-democratic’ and ‘liberal’ welfare models, respectively, identified in the classic study of welfare states by Esping-Andersen (1990). Following this categorisation, ‘liberal’ states were found to show the poorest progress in infant mortality between 1960 and 1996 (Bryant and Raphael, 2006: 19).

Whether measured by average earnings of those in work or the proportion of the population dependent on social-security benefits, Northern Ireland today has the highest proportion of poor citizens of any UK region (Causar and Virdee, 2004: 121), though this has been offset in recent years by relatively low housing costs (now dramatically rising) and Labour’s in-work benefits (Kenway *et al*, 2006). But, even if the Northern Ireland Assembly were to return, none of the political parties is arguing that it should have any tax-varying power, outside of the regional rate, to enhance redistribution. Indeed, all the pressures on tax in Northern Ireland have been in the opposite direction, with business seeking reliefs from the Treasury—for corporation tax to be reduced and industrial derating retained—which, despite opportunistic support from the regional political parties, the Treasury has rightly rejected. It is little known that the UK tax system as a whole, including national insurance and indirect taxation, is regressive: mainly because of indirect taxes, the poor already pay a higher proportion of their limited incomes than the rich (Fabian Commission, 2006: 129).

The second implication of Coote’s argument is that, if devolution were to be restored, tackling ill-health and health inequalities in Northern Ireland should not be left to the health department. Indeed, *every* department, embracing the economy, education, social policy and the environment, has a key part to play. *Investing in Health*, the public-health strategy published by the Department of Health, Social Services and Public Safety in the year devolution collapsed (DHSSPS, 2002), represented a bold attempt to set such a broad agenda. It was pursued through the cross-departmental Ministerial Group on Public Health, chaired by the health minister, Bairbre de Brún, which provided a mechanism for ‘joined-up’ government. But the strategy has faded from view under direct rule, with Northern Ireland following a much more New Labour, hospitals-focused, approach.

Yet even if devolution had survived, a major barrier to progress with *Investing for Health* would have been the ‘chopped-up’ government—as it has been described by one former permanent secretary—conferred by the Belfast agreement. The absence of any form of collective responsibility in government was compounded by and sustained the mistrust between the parties across the sectarian divide: one minister described relationships before the devolved administration collapsed as ‘poisonous’ (Wilford and Wilson, 2006). One former senior official laconically commented, ‘The considerable effort which was expended in establishing the assembly, in determining an agreed programme for government, did not result in an energetic and decisive vehicle for policy decision-making.’

During the lifetime of devolution, therefore, administering the health department became largely a matter of crisis-management, with the minister repeatedly demanding major increases in the departmental allocation from her counterpart at Finance and Personnel, to assuage the huge pressures the system faced. The most remarkable thing about the Wanless (2002) report on the UK health service, commissioned by the Treasury, was that it took a banker to articulate the public-health message that unless there was a move to a ‘fully engaged’ (preventative) scenario, by 2022-23 the cost to the UK taxpayer would be huge—some £30 billion a year. In the consequent Appleby (2005) report on Northern Ireland, the same conclusion as to the unsustainable nature of current trends was drawn.

There has been much effort on the part of London and Dublin to get the assembly ‘up and running’ again. But there has been no serious discussion of how the governance structures for Northern Ireland can be tailored to encourage more joined-up approaches. Progress can only be made in levelling the social gradient in health if all ministers—not just the health minister—see it as a political priority and are prepared to work as a team to achieve it.

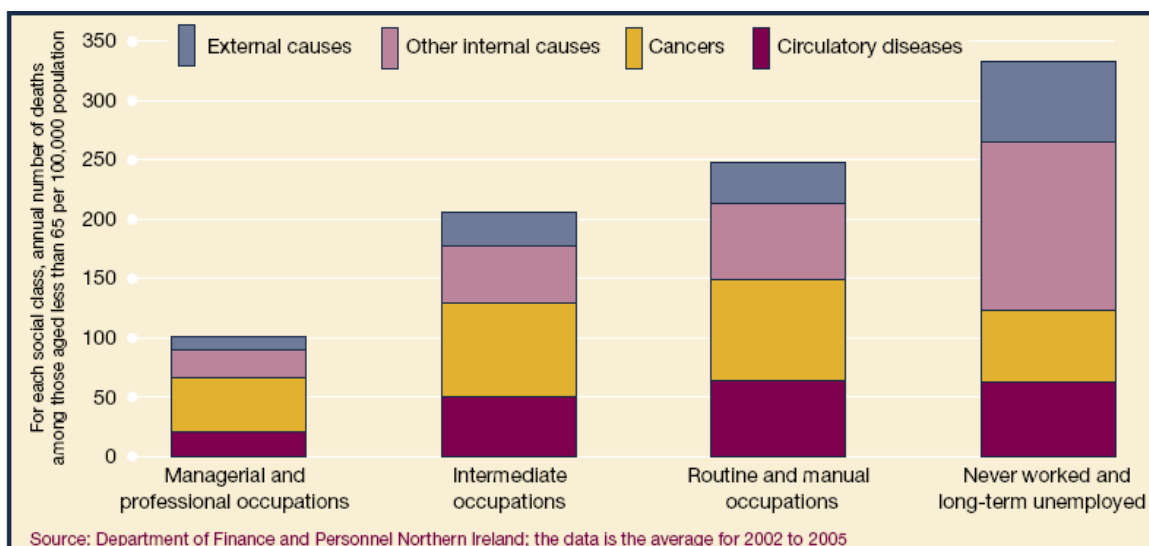
2. Morbidity and mortality in Northern Ireland

Northern Ireland has a history of poor health (Bates, 2005: 32) and poor public discussion of it. On morbidity, compared with England and Scotland for males and England, Scotland and Wales for females, it has a lower proportion of citizens reporting a 'good' state of general health, despite having a relatively young age profile (Causar and Virdee, 2004: 106). Compared with the Republic of Ireland, it also has a lower proportion declaring freedom from a limiting long-term illness, even after qualification for the republic's still younger age profile (Balanda and Wilde, 2003: 65).

While Northern Ireland has lower age-standardised mortality rates than Wales and particularly Scotland, it is still significantly above the UK average (Causar and Virdee, 2004: 107). The average Northern Ireland resident consumes more fat and more calories per day than in England, Scotland and Wales (Causar and Virdee, 2004: 110) and utilises more prescriptions than in England and Scotland (Causar and Virdee, 2004: 112). Waiting lists for hospital treatment are much longer than in England, Scotland and Wales (Causar and Virdee, 2004: 40, 113), though they have been coming down under restored direct rule.

On a wider western European canvas, averaging mortality over 1989-98, Northern Ireland has a significantly higher rate, particularly for women. Were men and women in Northern Ireland to have experienced the same standardised mortality rates as the average for the EU 15 over the decade, some 1,538 fewer deaths would have occurred per year, a reduction of more than a tenth on the actual figure (author's calculation from Balanda and Wilde, 2001: 38). For comparison, an average of 56 people died as a result of the 'security situation' in Northern Ireland in each of those years (author's calculation from PSNI statistics).

Northern Ireland shows the typical gradient linking health and wider social inequalities (Marmot, 2004; Wilkinson, 2005). The rate of premature death, in comparison with those in professional and managerial positions, is twice as high among those in intermediate occupations, two and a half times as high among those in routine and manual occupations, and well over three times as high among the long-term unemployed and those who have never worked (Kenway *et al*, 2006: 106):



Rates of lung cancer are more than twice as high among the most deprived quintile as among the least deprived (McWhirter, 2004: 84). Only 30 per cent of professional and managerial citizens suffer from a long-standing illness, as against nearly half of the unskilled (McWhirter, 2004: 121). Standardised admission rates are one fifth above the Northern Ireland average for north and west Belfast, nearly one fifth below for north Down.

These intra-regional inequalities are exacerbated by the concentration of victimisation due to politically-motivated violence, which also follows the social gradient. Thirty-two people from the whole North Down council area were killed during the ‘troubles’, while 67 died in the few streets which comprise the north Belfast neighbourhood of Ardoyne (Fay, Morrissey and Smyth, 1999: 142, 144). Residents of Northern Ireland are twice as likely to be suffering from post-traumatic stress disorder than their counterparts across the border. And those most affected, because of their position on the social gradient, tend to be least well endowed with the financial, psychological and social resources which can provide the resilience to cope (Muldoon *et al*, 2005). Since we know that social mistrust is bad for health and that access to social networks is good for it ((Marmot, 2004: 143), this highlights how *A Shared Future*, the policy framework on community relations, is unavoidably relevant, in this as in so many other domains in Northern Ireland.

In Scotland and Wales, devolution-linked health initiatives arose from their party systems and from their policy communities. But in Northern Ireland what Greer (2005: 510-511) calls the ‘logic of enemies’ defined the political system, while direct-rule dependency enervated policy networks. This meant the delayed abolition of GP fund-holding was the main change brought about by the devolved government in the health domain.

Inexorably rising hospital waiting lists—at one stage claimed by BBC Northern Ireland’s health correspondent to be the longest in Europe—symbolised a system that was being overwhelmed, while recurrent consultations took precedence over substantive decisions by the health minister, Ms de Brún (Wilson and Wilford, 2002). Asked in the Northern Ireland Life and Times survey a year after suspension whether they felt health had ‘got better’, ‘got worse’ or ‘stayed the same’ under devolution, just 15 per cent of respondents said ‘better’, while 32 per cent said ‘worse’ and 44 per cent ‘the same’.¹ Similar questions asked *vis-à-vis* the economy and education evinced by contrast a positive balance of responses (albeit again with indifference predominating).

¹ data available at www.ark.ac.uk/nilt/2003/Political_Atitudes/DEVHEAL.html

3. Policy interventions

There was, however, an important legacy of devolution. *Investing for Health* was described by the British expert Donald Acheson as the greatest public-health strategy he had seen published in the English language. And this did define its twin aims as improving health status and reducing health inequalities (DHSSPS, 2002: 58). These were translated into nine objectives and 12 quite specific targets and timescales, the latter variously between 2004 and 2010. They included increasing male and female life expectancy respectively by at least 3 and 2 years ‘towards the level of the best EU countries’, and halving the gap in expectancy between the quintile of most deprived wards and the average, both by 2010.

Yet the constraints on policy-making in Northern Ireland highlighted above were evident here too. Nor did the strategy address how its ambitious goals were to be achieved within the framework of the ‘Anglo-Saxon’ UK welfare system, which, as indicated above, leaves market income inequalities relatively untouched by low taxation and is accordingly marked by lower social-protection expenditure than other EU countries, especially the Nordics.

This reflects a wider devolution dilemma across the UK: egalitarians in Northern Ireland, Scotland and Wales tend also to be civic-minded devolutionists, but they have yet to explain how the UK as a whole is to be moved up the political value chain to a high-tax/high-spend welfare system, which instead of fearing middle-class exit while providing poor services for poor people ensures high standards of well-being for all. This would at minimum require a far more inter-governmentally co-ordinated system than has hitherto been the case (Jeffery, 2005; McEwen, 2005).

Indeed, *Investing for Health* did not even propose any significant new legislation within the devolved arena. The many ‘actions’ referred to in the document mainly collated what departments were already doing or were already committed to. This is a chronic feature of cross-departmental strategies in the system of 10 largely autonomous ‘fiefdoms’ (Laver, 2000) bequeathed by the Belfast agreement—a rock on which the critical community-relations strategy (OFMDFM, 2005), similarly marked by worthy aims, threatens also to be grounded and which delayed the appearance of the anti-poverty and sustainable-development strategies (OFMDFM, 2006a, 2006b).

Investing for Health has been working well operationally; what it has lacked is political and interdepartmental leadership. The positive experiences of Barcelona in seeking to reduce health inequalities show that ‘a strong and permanent political commitment’, alongside an evidence base and the instruments for effective intervention, is critical to success (Borrell *et al*, 2002: 83).

The strategy did propose new policy networks: an Investing for Health Forum and, at the level of the four area health-and-social-services boards, Investing for Health Partnerships. The forum was never established—another former senior official described this as ‘a disgrace’—but the partnerships have been able to mobilise local enthusiasm for the public-health cause, which after all emerged in Victorian Britain at the municipal level. Indeed, it was only in 1973 in Northern Ireland that health and local government were placed in separate departments. The fate of the partnerships, however, became caught up in the Review of Public Administration (see below).

In 2003 the Department of Health, Social Services and Public Safety commissioned a review of the ‘public health function’ by a generalist private management consultant, Capita Consulting. This concluded (Capita Consulting, 2004: 65) that public health in Northern Ireland was ‘fragmented in terms of the number and coordination of organisations involved’.

Capita reported in December 2004. The report recommended (Capita Consulting, 2004: 74-75) that the Ministerial Group on Public Health, which pre-existed *Investing for Health*, should arrange with the Department of Finance and Personnel mechanisms for cross-departmental funding of initiatives, as with the Executive Programme Funds established by the devolved government. But the EPFs, one of the innovations of the devolved executive, were by now defunct.

The report also said the chief medical officer needed support to give ‘strong public health leadership across departments’ (Capita Consulting, 2004: 75). The then CMO had however indicated that she wanted the issue to be treated as one of the top three on which the Office of the First Minister and Deputy First Minister would focus (Wilford and Wilson, 2002: 17). This would chime with the evidence (see above) of the wider social determinants of health. The community-relations, anti-poverty and sustainable-development strategies have all been located in OFMDFM for similar reasons.

Capita also stressed how, supported by multi-disciplinary teams, public-health directors needed to be able to drive forward the *Investing for Health* agenda (Capita Consulting, 2004: 77). Employed in senior positions by the boards, these figures were indeed the obvious hub of area partnerships. And it called for the new local authorities to be established following the Review of Public Administration to be given a power of general competence, to allow of a role in public health locally (Capita Consulting, 2004: 76).

But the RPA took an attenuated, public-services, view of what public *policy* in the round is about. And so its proposals, published in March 2005, attributed only one paragraph of a 246-page document to public health (RPA, 2005: 72). This advocated locating public health primarily in a new single regional health authority, a proposal it (wrongly) attributed to Capita. Eschewing the idea of a power of general competence in favour of a few additional powers for a much smaller number of local authorities—which in the health arena would only acquire the environmental-health powers of their predecessors—the review added *en*

passant that local government could ‘identify and highlight’ public-health issues via the new process of ‘community planning’ envisaged to take place with local civic partners.

Also in December 2004, the Department of Health, Social Services and Public Safety had published its ‘twenty year vision for health and wellbeing’, *A Healthier Future* (DHSSPS, 2004). While repeatedly invoking ‘the spirit’ of *Investing for Health*, the document quietly removed the ambition from the latter’s targets. Expectancy was now merely to be improved towards the level of the EU best by an unspecified amount, and the broad social thrust of the original targets—which spanned poverty, education, housing, the environment and lifestyle—was narrowed to a focus on expectancy alone (DHSSPS, 2004: 15). Moreover, in only one case was a timescale now attached. And while this target increased the goal to a two-thirds reduction in the expectancy gap between the bottom quintile and the average, this was now to be achieved only by 2025 (although the document assumed the Neighbourhood Renewal Strategy would still achieve the original target).

Bates (2005: 36) describes *Investing for Health* as ‘a ground breaking policy document, strongly making the point that social and economic issues must be addressed to improve health standards and reduce inequalities’. But he goes on: ‘Although initially prominent in the annual Programme for Government, some of the objectives and goals no longer have such prominence; and some targets have been lowered. There seems to be a re-emerging emphasis on “lifestyle” issues, and on personal responsibility for one’s health.’

The problem with a ‘lifestyle’ view of public health is that it is based on weak science and strong ideology. Lurking behind it is a patronising attitude to working-class citizens, which derives their poor health from their own behaviour rather than their status. Sapolsky’s studies of baboons in the Serengeti found the same gradient, by which health improves with social status, as Marmot (2004) found among Whitehall civil servants. Controlling for ‘lifestyle’ differences had only a modest effect on the Whitehall mortality gradient, and Marmot (2004: 83) wryly notes: ‘Low-status baboons don’t smoke, eat hamburgers, or fail to keep appointments with their doctors; high-status baboons don’t read the health pages of the *New York Times* or belong to fitness clubs. Yet there is a social gradient in health among baboons.’

Given the disjunction between the will of *Investing for Health* and the means to will it, the retreat from the targets and timescales it embodied was perhaps inevitable. So, for example, while life expectancy has improved since *Investing for Health*, by 1.3 years for men and one year for women, the gap between the top and bottom quintiles has not significantly changed. The best response to this is to rethink the principle of targets altogether: they are not self-evidently the incentives to make progress, and the means to monitor it, that they seem at first sight to be.

The Commons Public Administration Committee (2003: 13-14) concluded from a general inquiry into government target-setting: ‘Targets can never be substitutes for a proper and

clearly expressed strategy and set of priorities, and we found that witnesses identified a significant risk that the target setting process had subverted this relationship, with targets becoming almost an end in themselves rather than providing an accurate measure of progress towards the organisation's goals and objectives. Targets can be good servants, but they are poor masters.'

Indeed, it is a sobering thought that the leader internationally in public-health strategies, Sweden, focuses on the objectives and sets no targets for them at all, but rather seeks continual improvement (Harris and Hastings, 2006: 18, 24). Interestingly, while the last four objectives in the Swedish strategy can be classified in terms of 'lifestyle', the preceding seven concern economic, social and environmental conditions, in line with Dahlgren and Whitehead (1991). The implications of the recent work referred to in this paper would be that the objectives of *Investing for Health* should be recast, in terms of levelling the social gradient in morbidity and mortality—rather than more particular, aspirational targets—and the robustness, or otherwise, of the policies necessary to do so should be reviewed. And this should be done in full cognisance that even a devolved government in Northern Ireland will have only limited control over these social determinants, many of which can only be regulated on a state-, or even EU-wide, basis.

There were positive innovations in *A Healthier Future*. The NHS is, traditionally, a huge, Fordist system. Particularly in secondary care, it is a structure in which all communication, notably in the central imposition of targets, tends to be top-down, which undermines staff morale: almost 800,000 days were lost through sick leave in the health service in Northern Ireland in 2005-06, with significantly stress the largest factor (*Belfast Telegraph*, October 27th 2006). And it depersonalises the service for users. In important respects, *A Healthier Future* signalled a move towards what John Benington and his colleagues at Warwick University have identified as a 'citizen-centred' or 'networked' form of governance (Wilson, 2002: 14), more in tune with a 'post-Fordist' world.

This approach builds on the tacit knowledge of users and recognises the importance of a tailored and holistic approach to their problems. Referring to 'citizens rather than patients' (DHSSPS, 2004: 45), the document advocated individuals with chronic conditions co-managing those conditions—with huge potential reductions in unnecessary hospital stays—with users engaged in the design, and voluntary organisations in the delivery, of services. Relatedly, it sought to make a reality of Northern Ireland's theoretically integrated health-and-social-care system by developing 'multi-skilled teams and networks', particularly in primary settings (DHSSPS, 2004: 52-56).

In October 2005 a primary-care strategy (DHSSPS, 2005) carried forward this idea. Highlighting that GPs only comprise 1,200 of the 20,000 staff engaged in primary care in Northern Ireland, it envisaged '1-stop shop' health and social care centres, so that 'a range of health and care services would be available to people under one roof' (DHSSPS, 2005: 9). Simultaneously, 'people will be encouraged and helped to take more responsibility for

managing their own health and wellbeing’ (DHSSPS, 2005: 11). And it expects that citizens, along with practitioners, ‘will have an effective voice in planning and evaluating services’ (DHSSPS, 2005: 14).

These themes of co-management and a seamlessly user-facing, networked system echoed a vision statement for the health service in Wales in 2015, produced by a consortium of Welsh organisations representing patients, doctors, health boards and trusts (Welsh NHS Confederation, 2005). They provide an essential corrective to the conventional view that health is about the ‘patient’, in a service which institutionalises the dependency and passivity which are the opposite of rude good health.

A barrier to team-working remains the independent status conceded to general practitioners at the foundation of the NHS: this militates against co-operation with nurses employed instead by the local health trust and can ultimately only be resolved by GPs becoming salaried employees too. The 2004 General Medical Services contract, however, is a contract with the practice, rather than the individual, so the potential is there for teams to be established.

The following month, government published its response to the Review of Public Administration, in a series of speeches by the four direct-rule ministers. Neither the Northern Ireland secretary, Peter Hain MP, nor the health minister, Shaun Woodward MP, nor the minister in charge of the review, Lord Rooker, mentioned public health at all. The focus of public attention was very much on the number of new local authorities—seven reduced from 26—rather than their competences.

Specifically, the speech by Mr Woodward on health restructuring took a populist tack, swapping the language of citizenship for consumerism. He said: ‘The patient will drive demand in the system.’² If this were strictly true, of course, it would mean that the demands of the most articulate and pushy patients—which would be unlikely to be those with the greatest health needs—would be privileged. In practice, the minister announced that seven new primary-care based commissioning bodies (rather than patients *per se*), co-terminous with the new local authorities, would commission hospital services from five new trusts, replacing the existing 19.

This would thus reaffirm the ‘purchaser-provider split’, supported in the recent review of health and social care in Northern Ireland by Prof John Appleby (2005) of the King’s Fund but rejected by the devolved administrations in Scotland and Wales (Greer, 2005). Leaving aside the philosophical arguments, it is difficult to see how, given the strong sense of locality in Northern Ireland and the small number of trusts, anything other than a very sticky ‘internal market’ is conceivable.

² DHSSPS media release, 22 November 2005

The problem with all this is that many will assume that in the new context, health is a matter for the local commissioning groups, rather than seeing the renewal (and simplification) of the *Investing for Health* partnerships and community planning as key. In the meantime, moreover, with the new arrangements not due to be fully operational until 2009, there will be a hiatus with a natural tendency to retreat into organisational defensiveness and consolidation.

The new councils are, however, in line with earlier legislation in Britain, to acquire a general power to promote local 'well-being'. Allied to community planning, this should be seen as central to their exercise of civic leadership. The best solution, in light of the history of the relationship between municipal politics and public-health initiatives, would be for the tacit expertise and network relationships developed in the *Investing for Health* partnerships to be transferred as seamlessly as possible to the new authorities, with public-health directors created as senior positions. By re-establishing the link severed in 1973, this would allow of a more 'joined-up' approach between health and local government.

In Scotland, the powers of well-being and community planning conferred on local authorities have been used to good effect in co-operation with the health service, for example between the council in West Lothian and the Lothian NHS, to the extent that a £160 million joint budget is administered by the West Lothian Community Health Partnership. With local targets driven by the community-planning process, in the context of national priorities, the CHP has focused on prevention in terms of children and older people, teenage pregnancy, local diagnostics and care on cancer, innovative models of self-care, and healthy eating and food distribution.

Mr Woodward, a reformed smoker himself, did however agree before his departure from the Northern Ireland Office to introduce the ban on smoking in public places, effective from April 2007. This was in line with developments in the republic and Scotland, but in advance of progress in England and Wales, and will have valuable mimetic effects on behaviour.

While the picture is mixed in terms of performance at the regional level in Northern Ireland, there is much to celebrate in terms of action at other levels to address public-health issues. Belfast Healthy Cities is regarded within the wider international network as a leader. North and West Belfast Health Action Zone has provided 'joined-up' answers to huge local problems, leading the way on youth suicide—the tip of the iceberg of poor mental health—with a taskforce which did much to highlight the issue and spur government into action.

And Northern Ireland's voluntary sector has much of which to be proud. As indicated above, Northern Ireland has a 25 per cent higher incidence of mental ill-health than England, yet spends less of its health budget on addressing it—though the decision to appoint a director of mental health as a senior official in the health department is a good one. And again this follows the social gradient: the Northern Ireland Association of Citizens'

Advice Bureaux has shown a correlation between mental ill-health and dependence on social-security benefits. Voluntary organisations have tended to fill the gap.

Ballybeen Women's Centre, for example, has achieved much on health issues, having found through a local survey on the suburban Belfast working-class estate high levels of mental ill-health among women, related to dependency on anti-depressants and smoking-related illnesses. The centre uses peer-support approaches to improving public health, including also with young people, with a stress on raising self-esteem and user involvement in programmes. This provides a model of non-rivalrous relationships which can counter—though only at the margin—the effects of the social hierarchy on those at the bottom.

Much more could and should be done to universalise such good practice, through proper and sustained funding and a 'double devolution', delegating governmental power not just to the local but also the neighbourhood level. Information exchange and dissemination could be one of the functions of a public-health policy forum (see below). This could provide an important vehicle for conversations between voluntary organisations and statutory agencies. And it could be a means to encourage wider conversations—for example, with colleagues in Scotland, where devolution has as indicated been associated with a classic public-health agenda, unlike the emphasis in England on 'choice' in secondary care.

4. Conclusion

Improving public health, and above all tackling health inequalities, represents a huge challenge. It is, according to Steffen (2005: 287), a typical example of ‘complex policy problems’ which she defines thus: ‘They have connections with many policy sectors, actors and interests; most of them have moral implications; they can potentially affect the entire population; they cannot be eliminated definitively; solutions exist but require continuous policy involvement.’ Huge, but not impossible: in Scotland, for example, deaths from coronary heart disease fell by more than 40 per cent in the 10 years to 2004—albeit the absolute rate is still very high by western European standards.

In this light, the mix of policy and governance developments in recent years in Northern Ireland is not a particularly coherent one, and it can be expected to continue to deliver sub-optimal outcomes. Yet, treating the glass as half-full, there is considerable room for the development of a policy agenda which restores public health and health inequalities to the heart of the health debate in Northern Ireland.

The first issue is one of focus. The public-health agenda should not be centred on changing the ‘lifestyles’ of the poor but on tackling the social gradient in health. The goal—accepting this can only ever be asymptotically realised—should be to seek to level the gradient, so that those in lower positions on it can come to enjoy similar autonomy in, and control over, their lives to those at the top. This will be more effective than a conventional health-promotion agenda, and it will be more efficient in tackling poor public health: there is most scope for improvement the further down the gradient one goes.

Indeed, generalist campaigns on ‘lifestyle’ improvement can have the perverse effect of widening social inequalities, as those towards the top of the social hierarchy may be most likely to act upon them. Smoking is a good example, where a focus ‘downstream’ on increasing motivation to quit, through health-education campaigns allied to price increases, rather than an ‘upstream’ emphasis on tackling nicotine dependence (eg through equal access to Zyban), has seen smoking prevalence fall—but at the expense of a steeper social gradient in the addiction and the associated ill-health (Jarvis and Wardle, 2006: 234-5)

The politics of this can be widely pitched, as even those in middling positions on the gradient still suffer poorer health than those at the top, thus avoiding the risk that action targeted on the most disadvantaged can be seen as of no interest to the wider public. The quote at the beginning of this paper from Ms Robinson of the DUP—on most issues a party that leans well to the right of the political spectrum—shows how the wide support such a radical agenda requires for success can be achieved, given strong leadership.

The second issue is the breadth of the policy palette. *Investing for Health, A Healthier Future* and *Caring for People Beyond Tomorrow* provide much useful material on which to build. A key

building block should be the right of all citizens to a regular, primary-care ‘MoT’ test, as when one routinely goes to the dentist and the desired outcome is *no* treatment. An electronic record should be the basis of healthy life planning, with a copy kept by the citizen—thereby encouraging a sense of control and self-management, while minimising concern about inaccessible electronic records being shared among authorities.

But the implication of the argument that the social gradient causes ill health, rather than individuals of poor health selecting themselves for low-status positions by their behaviour, is that health is only one of the many policy domains involved. For instance, the civil-service estate in Northern Ireland is undergoing major reorganisation—and, in effect, privatisation—called Workplace 2010. This is being done as a cost-saving venture, rather than as an opportunity to introduce more post-Fordist systems, with greater autonomy for work units and flatter hierarchies, which would improve employee health as well as performance.

As regards the private sector, Invest Northern Ireland should offer particular assistance to firms which are committed to employee partnership and flexible working arrangements. This is one good way, as it happens, of spotting high performers worthy of significant public subvention, because of the links between employee involvement, productivity and innovation. But it will also mean less stress at work and less associated ill-health. Invest NI should also seek to generalise such improvements—mimesis again—among indigenous small and medium enterprises. As Hogstedt and Lundberg (2002: 90) note, ‘the work environment should be a major arena for preventive programmes intended to reduce social class differences, but very few, if any, such programmes have been instituted’.

The severe health difficulties of those at the bottom of the social hierarchy who are economically inactive are best addressed through placements in social enterprises, if they are unable effectively to compete—through lack of recent employment or disability—in the capitalist labour market, though this is not to detract from the responsibilities of public and private employers in these regards. While there has been an encouraging growth in public support for the social economy in recent years, including the formation of the Social Economy Network, government could boost it further by increasing demand for intermediate-labour-market programmes. This should be part of a wider ‘springboards’ approach to social support across the life cycle (Blane, 2006: 72; Bartley *et al.*, 2002: 91), recognising that welfare safety nets are least adequate for the most disadvantaged (in the case of the economically inactive, due to weak insurance contribution records).

Transport and planning are other key areas with important connections to health (Lavin *et al.*, 2006). If social networks matter to well-being, and they do, developing those networks requires a transport system in which the private car is not the focus. Public expenditure on new or wider roads (as against maintenance or upgrading) is wasted except over the short term as the traffic simply expands to fill. Moreover, the poorest children are much more likely to be victims of traffic accidents. The focus instead should be on developing quality

public-transport and community-transport modes (Richards, 2001). Translink has made progress in new rolling stock and (within Belfast) buses but one can only look with envy at the Luas light-rail system in Dublin.

Planning, meanwhile, should foster compact settlement patterns and urban villages rather than single housing. On the latter, the Department of Environment has rightly taken a lead in the face of substantial political opposition. Within towns and cities, brownfield development should be exhausted before greenfield sites are given permission, so that citizens can reasonably get around on foot, or by bicycle or bus, to local shops and services (Rogers, 1997). Big out-of-town retail developments—like the IKEA outlet to be built on the outskirts of east Belfast—should consequently not be supported.

Another arena is education. The move away from selection at 11 towards *election* of subject choices from 14 has important potential for breaking down the academic/vocational status hierarchy, particularly if linked to a move towards a broad *baccalauréat* (as in Wales) or Leaving Certificate (as in the republic) rather than the A-level ‘gold standard’. Offering teachers, particularly head teachers, in low-status schools premium payments would offset the limited life-chances they currently offer to children. Educating all children in a healthy life, including particularly mental health, would be a major breach in the departmental silos that keep the two domains apart.

A determined effort should be made through expansion—rather than the current contraction—of Reading Recovery schemes, to ensure no one wastes their years in school (and the associated taxpayer investment) by never mastering basic literacy skills. The particular needs of children with disabilities and those for whom English is a second language must also be more robustly addressed in this context, to avoid them emerging from school with few or no qualifications.

But the priority should be early years. This is for three reasons. First, we know that otherwise rich children of low talent overtake poor children of high talent in developmental terms by the time they get to school (Dixon and Paxton, 2005: 41). Universal, high-quality childcare in Sweden and Denmark has considerably weakened this ‘inheritance effect’, key to social mobility (Esping-Andersen, 2002: 27).

Secondly, much of the stress experienced by working-class women in Northern Ireland could be alleviated by better childcare and, relatedly, better job opportunities (though childcare has to be good enough to justify in child-development terms, not just because it gives working parents somewhere to leave the kids). While the economically inactive are stereotypically male manuals on disability benefits, many are in fact women who would wish to join the labour market if it were not for domestic caring responsibilities.

Finally, while recognising that parental (as against maternal) care is better for infants, high-quality childcare is of particular value in developing the social skills key to a flourishing adult

life and coping with its inevitable adversities. As Mielck *et al* (2002: 147) put it, ‘There is increasing evidence that early exposure to advantage and disadvantage has lifelong effects, making childhood a particularly critical period for interventions designed to reduce health inequalities.’ Expenditure on childcare is thus the most valuable social investment, as the High/Scope programme in the US demonstrated—found to return on average \$7 in improved adult employment, less crime, higher earnings, better health and other factors for every \$1 invested. The commitment to expanding children’s centres in Northern Ireland in the *Lifetime Opportunities* strategy is a modest next step along this road.

All this makes a case for locating responsibility for public-health *policy* within the Office of the First Minister and Deputy First Minister—but only on the key proviso that OFMDFM were to become a governmental centre with a real power of co-ordination over other departments. Here it could sit alongside the three other crucial strategies for tackling Northern Ireland’s sectarian malaise and poor social and environmental performance: *A Shared Future*, the framework on ‘community relations’; *Lifetime Opportunities*, the anti-poverty strategy; and *First Steps Towards Sustainability*, the policy document on sustainability. Indeed, there is an argument that having a public-health strategy at all is paradoxically an admission of failure, in the sense that *every other strategy* should contribute to levelling the social gradient that underpins poor health and health inequalities.

Examples of related policies are the *Working for Health* strategy on occupational health published by the Health and Safety Executive (2003), the *Ending Fuel Poverty* strategy promulgated by the Department for Social Development (2004), the *Accessible Transport Strategy* developed by the Department for Regional Development (2005), as well as the forthcoming new school curriculum (with a focus on personal development and life skills) and the recent consultation by the Department of Education on school-meal standards.

This would not mean removing specific public-health *functions* from the Department of Health, Social Services and Public Safety. It would make no sense, for instance, to place control over communicable disease in OFMDFM, rather than this being retained by the chief medical officer.

In Australia, officials with expertise in public health have been diffused across the public service, via a postgraduate qualification in the subject. In the context of the review of public administration and a stronger role for local government, there is a strong case for one of the two universities in Northern Ireland developing such a masters/diploma, whose graduates could subsequently pepper the public realm and ensure a network of public-health advocates spreads throughout civil society and the new local authorities.

There is the prospect of linking the development of this debate to the renewal of devolution, and so to arrangements for co-operation across the various jurisdictions in these islands. Indeed, it might arouse significantly the latterly dormant public interest in devolution if it were presented as a means to tackle major public concerns, such ill-health. A public-health

strategy can only be effective if part of a wider Programme for Government, as the devolved government was required to generate. In such a scenario, the first or deputy first minister should take over chairing the ministerial group on public health. And the Executive Programme Funds should be re-established, with the fund on social inclusion tapped for cross-departmental public-health efforts.

In an all-Ireland context, this includes the opportunity to build on the existence of the Institute of Public Health in Ireland, as a source of island-wide data and a potential broker of all-Ireland networks to exchange and develop good practice. The institute already has a strong focus on inequalities in its work.

Within Northern Ireland, the new local authorities should seek to be innovators in the public-health arena, using twinning arrangements abroad to introduce new ideas via the Investing for Health partnerships and their community plans. They should see the power of well-being and the community-planning process, working in conjunction with local commissioning groups and other organisations—in housing and the environment, for example—as offering the means to become co-designers of projects and services which can tackle public ill-health, and they should have a statutory duty to that effect.

There is a key role here too for the voluntary sector. It should never be a substitute for failings in statutory provision, though it often is, and here ‘community’ can prove a weasel word: in the real world disadvantaged neighbourhoods can often be fragmented and fractious places. Interestingly again, ‘community development’ does not figure in the Swedish public-health strategy (Harris and Hastings, 2006: 25). But the voluntary sector does play two key roles.

First, it is post-Fordist in structure—user-focused, pluralist, flexible. That makes it a source of innovation which the public sector, with its advantages of universal provision and economies of scale, can then take up. Secondly, it can generate capillary networks in society which the public sector cannot match, and such networks of social support are key to our resilience and well-being—especially for the elderly, the disabled and those (predominantly women) who care domestically for both.

There is, finally, a specific case for the establishment of a public-health policy forum, to capitalise on the considerable tacit knowledge of practitioners and help address the ‘policy deficit’ in the party-political system. That phrase was coined by Gabriel Scally, in his submission to the Opsahl inquiry into ways forward for Northern Ireland (Pollak, 1993: 319-20), which reported as long ago as 1993. Dr Scally was making the case for a series of social-policy fora.

Arguably, under renewed direct rule but with devolution always on the horizon, the idea of a public-health forum for Northern Ireland—engaging professionals, practitioners, academics, NGOs and politicians—remains as relevant today. It could encourage the universalisation

and assimilation of good practice across the voluntary/statutory divide. It could exercise a challenge function. And it could stimulate broader public awareness and action. The IPH sits well as a respected neutral broker to bring such a forum into being.

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