Crisis and Renewal in Irish Public Health: Analysis of a Neo-liberal State

Carol Ellis, Shane O'Donnell

School of Sociology, University College Dublin, Ireland
ciisn.ucd@gmail.com

ABSTRACT
Approaches to health in Ireland have been traditionally based on the curative biomedical model, with public health infrastructure underdeveloped and typically focused on the treatment of disease rather than its prevention. Based on three papers presented at the Critical Issues in Irish Society Network conference (2012) ‘Health in Crisis’, this article explores to what extent Ireland is moving towards addressing the broader social structures which both enable and constrain health and wellbeing. It will argue that despite isolated examples of patient-centred approaches to care, a less atomised and more holistic understanding of the treatment of illness is required in Ireland. Similarly, Ireland’s record on addressing the wider social determinants of health (SDH) through specific public policy measures, even when compared with similar liberal welfare regimes (UK, Australia and Canada) remains poor. While a strong evidence base on the SDH has emerged in Ireland in recent years, the historical weakness of the welfare state, in combination with the present day dominance of neo-liberal governance, means that specific policy actions remain subordinate to an individualised approach to health promotion. It will conclude by arguing that in countries such as Ireland where there is a significant absence of political will to address the SDH, the need for a ‘public sociology’ which raises awareness of the relationship between class, inequality and health to audiences outside of the academic and political spheres is critical.

INTRODUCTION
The social determinants of health (SDH) is a concept that is ubiquitous in health related government policy documents worldwide. However, there are vast differences between countries in the interpretation, understanding, and implementation of SDH policies (Raphael 2012). This article examines to what extent a holistic, social determinants of health (SDH) model for both the treatment and prevention of illness has been discussed, debated and implemented in a country with little tradition of public health, and which has been strongly influenced by the political philosophy of neo-liberalism (Kirby 2010). In particular, it will examine to what extent the Irish state has addressed the key elements of the SDH model. It will argue that although there is some recognition of the SDH model in key policy documents, it has yet to be prioritised in policy and practice.

In order to carry out such an appraisal, the Conceptual Framework for Action on the Social Determinants of Health provided by the World Health Organisation will be used to assess the Irish states performance to date (Solar and Irwan, 2010). The authors identify social, economic and political arrangements as key mechanisms in determining health outcomes along class, gender and ethnic lines. Of critical importance are policies which affect the distribution of wealth and power in a given society, including in areas such as taxation, employment, housing, education, health and social protection. Unlike other SDH models
which have traditionally downplayed the role of the health system as a tool for addressing health inequalities, the report suggests that universal access to services plays an important role in minimising the consequences of illness, thus ensuring that those occupying lower low income groups are not further disadvantaged through disability or other health related barriers to participation in society. Furthermore, it argues that services should be organised in a non-hierarchical and person-centred manner as possible. In order to achieve such a pro-equity service, the WHO has indicated elsewhere that a holistic approach must be taken which encompasses of the social, psychological and spiritual whole (WHO 2007). This has been emphasised also in the Commission on the Social Determinants of Health 2008, the 2011 Rio Political Declaration on Social Determinants of Health and the EU report, Europe: Health 2020.

In addition, the theoretical frameworks in this paper will also be informed by more sociologically oriented theories of public health approaches to health inequalities, which at its core examines the social forces which shape economic and political arrangements which Irwin et al. (2010) identify as essential in determining health. This requires analysis of the historically disproportionate influence which elite members of society have over both policy making and governance, and its possible role in the generation and perpetuation of health inequalities (Scambler 2012; Raphael 2012; Muntaner 2011; Coburn 2004). In this respect Scambler argues the health inequalities research agenda should be critically focused not on whom it harms, but more on whom it benefits (Scambler, 2012).

This article firstly will provide a brief overview of the history and current state of public health in Ireland. It will argue that the underdevelopment of the Irish public health system can be explained by the absence of a left-right divide in Irish politics; the historical strength of the Catholic Church and medical profession in defining matters around health, as well the contemporary influence of neo-liberalism. The main section will then proceed to draw upon the works of three academics who presented at the Critical Issues in Irish Society Network (CIISN) conference. This article challenges researchers and policy makers to analyse critically and creatively about new directions and priorities needed in the field of health research in Ireland. Finally, this article will analyse the current predicaments and future directions in Irish public health research.

The CIISN conference ‘Health in Crisis’ was held on April 19th 2012, which was convened to provide a platform for the latest research examining the relationship between society, health and well-being in the context of Ireland.1 The event was part of a wider initiative started by PhD students based in the UCD School of Sociology which aimed to address the lack of opportunities for early stage researchers in the field of sociology and similar disciplines to network, connect and exchange ideas. The objective of the ‘Health in Crisis’ conference was to encourage multidisciplinary dialogue in relation to health, wellbeing and society while still retaining a sociological focus. Although the papers were diverse in scope, when discussed together they formed a coherent narrative on the current state of the health of the population in Ireland. Discussions at the conference revolved around two main themes: firstly, to what extent Ireland is moving away from the traditional biomedical model, and secondly to what extent is Ireland addressing the wider social determinants of health. In order to examine to what degree these changes are occurring, this article will draw on three papers presented at the conference. These papers were chosen on the basis that they provide particular insight into some of the successes, and challenges, which face the public health system in Ireland.

The first paper delivered by Peter Kearney, ‘The Barretstown Experience: a healthy response to crisis‘ highlights an example of a successful holistic approach to paediatric therapeutic care in the context of Ireland and Europe. The second paper, ‘Reforming Health Production in Ireland’ presented by Prof Eamon O’Shea, discusses government proposals
for equity within the health care system and questions whether this may lead to reductions in health inequalities across the population. The third paper ‘Inequalities and Men’s Health? Turning the policy spotlight on men’ presented by Dr Noel Richardson assesses the intersection between economic inequality and gender in the context of men’s health and possible policy prescriptions. Drawn together, these papers present a snapshot of the current research landscape in Ireland. Before approaching this question however, it is first necessary to briefly discuss the historical and contemporary reasons why public health has remained underdeveloped relative to other rich market based democracies.

Historical Factors Constraining the Irish Public Health System

Ireland has been noted as having a severely underdeveloped and under-sourced public health system (Burke 2011). The medical and social historian Dorothy Porter has pointed out that most public health systems in Europe developed under the backdrop of a ‘collectivist political will’ which ‘promoted increased state intervention in the provision of welfare in industrial societies’ (Porter 1999:239). However, as Barrington (1987) noted the development of public health provision in Ireland was socially and politically determined through the power of the Catholic Church and the medical profession; both of whom from the earliest juncture in the formation of the state were ideologically opposed to the intervention of the state in matters related to health.

One of the defining moments in this regard, was in 1951 when the then Minister for Health, Dr Noel Browne, proposed The Mother and Child Scheme (Barrington, 1987). The proposal, which sought to provide free medical maternity care for all mothers and free healthcare for all children up to the age of sixteen, regardless of income, represented the first major step-up in the state’s role in public health in Ireland. The plan was however opposed by the Church hierarchy, who viewed the scheme as contravening the papal principle of subsidiarity, which stated that welfare was first and foremost the responsibility of the family, church and voluntary organisations rather than the state (Whyte 1971). It was equally opposed by the Irish Medical Organisation who saw it as a threat to private practice, and a stepping stone towards socialised medicine, similar to the establishment of the NHS in the UK. A long and protracted confrontation between the state and these two interest groups eventually led to the defeat of the bill, leading to the resignation of Noel Browne and strengthening the role of the private practice and the voluntary sector in the provision of healthcare.

While the state eventually did start to expand its role in the health of the Irish public during the 1960s and 70s, it did so largely under the parameters set out by the Catholic hierarchy and the medical profession; both of whom blocked any move towards universality in the provision of care. Thus even as free hospital care was gradually extended, by means of general taxation to include 75% of the population, private practice remained an entrenched feature of the Irish health system (Barrington, 1987). This was cemented further with the establishment of the Voluntary Health Insurance (VHI). A significant consequence of these concessions made to both the Catholic Church and the medical profession, was that public health infrastructure remained underdeveloped, minimal, and confined to the treatment of disease rather than its prevention. Health was not perceived as an inalienable right, to be guaranteed through various interventions of the state, in the traditional social democratic sense seen in other European countries (Porter 1999), but as an issue of personal responsibility. The 1980s and 1990s bared witness to the diminishing role of the Catholic Church and to a lesser extent the medical profession who lost credibility in the face of treatment related scandals. For example, the Irish hysterectomy scandal, where between 1992 and 1988 the rate of hysterectomies in Our Lady of Lourdes Hospital Drogheda was 20
times that of other similar hospitals; Dr Neary’s gynaecological patients were subjected to unnecessary hysterectomies and/or oophorectomies (McCarthy et al. 2008).

However, the emergence of neo-liberalism as the dominant political ideology in the state began to fill the void left by the Catholic Church, hence ensuring that an individualised approach to health and well-being among policy makers in Ireland remained firmly intact (Burke, 2009; Wren, 2006).

Throughout the early 2000s, there was an increased rhetoric for the need for an equitable and holistic approach to health (Department of Health, 2001). However, even during the economic boom of the ‘Celtic Tiger’ inequities in access to care remained entrenched, and although funding was greatly expanded to the acute care sector, primary and community care remained underfunded, with access dependent on means. With Ireland in economic crisis, the current governing coalition of Fine Gael and Labour have now acknowledged the need for social solidarity, where ‘reform is no longer just an aspiration for Irish health care – it is now an essential’ (Labour 2010:2). The Irish government now view Universal Health Insurance (UHI) as a means for not only insuring equity and health for its citizens, but also to provide good quality care for all of its citizens.

Challenging Reductionist Medicine in the Irish Health Care System

The 2001 Health Strategy in Ireland (2001:187) pointed out the necessity for the ‘provision of holistic and seamless services’ within the health system. Deficiencies in addressing these have led the Irish public to seek alternative methods of care through voluntary organisations such as Barretstown. A clear departure away from the traditional biomedical model towards holistic, patient-centred care can be seen in Peter Kearney’s research paper on the Barretstown Experience, which he argues is an example of a successful approach to holistic care in Ireland. The Barretstown Castle Holiday Camp is a specially designed camp that provides therapeutic recreation programmes for seriously ill children (primarily cancer and serious blood diseases). Barretstown was founded by the late actor Paul Newman as part of the Serious Fun Children’s Network, the first camp of its kind in Europe, catering for over 1,500 children per annum. Although the premise of Barretstown Castle was donated by the Irish Government, it is operated on a completely voluntary basis and is funded without state support. The Barretstown experience according to Kearney may be seen as a step towards a more holistic and patient-centred approach to health and well being, breaking down the boundaries between doctor and patient, by creating a non-hierarchal structure with voluntary and non-uniformed health professionals, trained specifically in therapeutic care. Critically, health professionals are not referred to by their status, rather to as a Cara (Gaelic for friend). Kearney goes on to argue that the core values of ‘serious fun’ represent an experience that is in many ways opposite to the rationalised and medicalised world in which children normally experience treatment for serious illnesses.

For Kearney, Barretstown is a social and psychological transformation, with profound improvements in health outcomes for children. During their stay at Barretstown, children are temporarily removed from the norms, expectations, and stigmas that predominate in the broader social and cultural environments in which they live. Instead a temporary community of equals is created, giving the child the psychic-space in which to come to a sense of coherence and self-identity; which is not impinged by social stigmas surrounding illness.

Kearney presented evidence that children have an improved sense of coherence after camp, which enables them to cope better with the demands of ill health. Kearney linked this ‘sense of coherence’ theoretically with Antonovsky’s (1979) concept of salutogenesis, a ‘specific way of viewing life as comprehensible, manageable and meaningful’ claiming that the way in which people relate to their life influences their health (Eriksson et al. 2007:684).
Barretstown caters beyond the treatment of the disease, where within the sphere of fun and engagement, the situations of predictability or unpredictability enable the child to learn to adapt and maintain stability. In evaluating research on serious chronic illness to date, Kearney noted how emphasis lay with poor self-esteem and self-image, rather than questioning the possibility of the patient exceeding expectations and engaging with life. This indicates the importance of drawing to the SDH and holistic care within the treatment of illness, which is supported by the success of Barretstown in both achieving a sense of coherence among children. As far back as 2001, the Irish government placed the importance of providing a holistic approach as a core value of their Health Strategy (2001). Despite being a successful example of a holistic and patient-centred approach Barretstown remains an isolated case, completely separate from the rest of the health system in Ireland.

**Challenging the Individualised Approach to Irish Public Health**

The conference heard from Professor Eamon O’Shea (School of Economics NUIG) that interest in health in Ireland has predominantly revolved around the healthcare system, and not enough on the wider social and political determinants of health. This, he asserted is to some degree understandable given the deep inequities and inefficiencies that have been a feature of Irish health services for many years. However, he argued that there should now be a concerted effort to increase government awareness of the need to take action on the SDH.

O’Shea began his paper by pointing out that there have already been significant attempts to put the health inequality agenda on the map in Ireland. The Irish Institute for Public Health (IPH) for example, have been prolific in publishing numerous studies documenting the close relationship between socioeconomic status and health on the island of Ireland (Balanda & Wilde, 2001; Dillon, Paul, Metcalf, & Cotter, 2011; McAvoy, Sturley, Burke, & Balanda, 2006). These studies have highlighted the poor health outcomes and relatively lower life expectancy of deprived communities which have benefitted little during the Celtic tiger era, now bearing the brunt of the country’s economic recession. In recent years, the Combat Poverty Agency and IPH produced the policy document, *An All Ireland Approach to Social Determinants* (Farrell, McAvoy, & Wilde, 2008), which outlines a range of evidence based interventions which could be adopted to improve health inequalities. This coupled with the independent think-tank TASC report, *Eliminating Health Inequalities: A Matter and Life and Death* (Burke & Pentony, 2011), provides a significant blue print which government could follow in order to improve population health. Recommendations by TASC, for example include proposals for an independent review of health inequalities modelled on the UK Marmott review *Fair Society, Healthy Lives*, which would form the basis of future population health policy in Ireland (Burke & Pentony 2011:vii), and additionally aiming to increase social spending in health and education through higher taxation. However, despite having garnered support from a number of key stakeholders, including the Irish Medical Organisation (2012), the Irish political establishment have yet to signal intent to adopt any of these recommendations. This is in contrast to other western countries, where attempts at tackling health inequalities have occupied the political agenda for decades (Raphael, 2012).

O’Shea viewed recent debates around inequities in the Irish health care system as being particularly illustrative in this regard. He highlighted that over the last number of years there has been increasing media attention and public pressure to bring to an end the provision of care based on a public-private mix; which enables holders of private health insurance speedier access to treatments than those who enter the healthcare system as public patients. In 2011, the Fine Gael and Labour parities were elected to government, promising to abolish Ireland’s two tier health system and replace it with the Universal Health Insurance model, similar to services currently in place in the Netherlands and Belgium (Fine Gael & Labour, 2011). O’Shea noted that while equalising health outcomes across the population...
was a core objective of these reforms, discussion of the wider SDH was notable only in its absence. Citing Burke and Pentony (2011), he observed that the vast majority of the Department of Health budget remains focused on acute, technology-driven medicine, and little attempt has been made to coordinate with other government departments to make investments in health across the population.

A particular problem O’Shea observed is that other government departments view responsibility for health as entirely beyond their remit. For example, little awareness is demonstrated that improving peoples’ material living conditions through investment in social welfare and other forms of wealth redistribution could lead to substantial health gains in the long run. The consequence he argued is that Ireland is comparatively:

some distance away from addressing the broad life course determinants of health through active health policy interventions outside of the health care sector (O’Shea & Connolly, 2012: 1365).

O’Shea therefore called on key stakeholders and policy makers to take a broader view of health which takes into account material living conditions, and to enact interventions which would lead to

Equalising opportunities for health across the life course, an essential component of maximising health production’ (O’Shea & Connolly, 2012: 1365).

O’Shea concluded by arguing that a cost-benefits analyses approach could be particularly useful in persuading government of the clear economic rationale for addressing the SDH, which he argued would lead to long term savings through reductions in demand for acute services and hospitals.

**Barriers to SDH Implementation**

The lack of action on SDH in Ireland was further discussed in a paper presented by Dr Noel Richardson, Director of the Centre for Men’s Health in Carlow IT. There has been a surge of interest in men’s health in Ireland in the wake of unprecedented increases in the number of suicides among young men (Dillon *et al.*, 2011). The vast majority of these cases are among lower socioeconomic groups where the collapse of local industries, high levels of long-term unemployment and lack of opportunities have had a significant impact on mental well-being (Dillon *et al.*, 2011). Whilst these problems are structural in nature and more than likely cannot be addressed without significant government investment in these areas, public health agencies attribute men’s relatively poorer outcomes to individual behaviours and attitudes.

Richardson argued that men are predominantly framed as being risk takers who engage in practices which endanger their physical and mental well-being, and avoid seeking out help where support or treatment is required. Indeed much of the public health response has been predicated on media information campaigns raising awareness of the importance of self-help behaviour among young men, and in particularly confiding in family and close friends when experiencing emotional distress. Richardson noted however, that men already have a more multifaceted and complex understanding of the notion of responsibility for their own health than these dominant views suggest. In a qualitative study carried out on the beliefs and health practices of men in Ireland, Richardson observed that men were largely aware of having a duty of care towards their own health, to engage in the ‘right’ health practices, and to act as a ‘responsible’ citizen (Richardson 2010:423). At the same time, some of these men also rejected top-down health promotion messages and knowingly engaged in risky behaviours, often viewing the notion self-care as intrinsically effeminate. Their rejection was
seen as a form of principled resistance which gave them a way of reasserting a feeling of control and independence in their lives.

Richardson placed the emphasis on individual responsibility in government responses to the ‘crisis’ among young men within the context of the hegemony of neo-liberalism in Irish political discourse. Drawing on a Foucauldian perspective, he argued this can be seen as part of a wider process of the state attempting to further reduce its role of guaranteeing rights and entitlements for health by transferring responsibility to the individual. He argued however that the attitudes and behaviours of men cannot be viewed in isolation from their social and economic living conditions. Instead men’s health outcomes could only be improved

*by challenging the institutions in which men live and work, and by giving due consideration to the social determinants of health (Richardson 2010:434).*

The conference heard how Richardson had become involved in the drawing up of a men’s national health policy, with the explicit objective of moving the debate around men’s health in Ireland away from these victim blaming tendencies. He was one of the co-authors of the *National men’s health policy 2008-2013: working with men in Ireland to achieve optimum health & wellbeing*, the first of its kind in the world (Richardson & Carroll, 2008). However, despite being in a position of influence around policy formation in this area, evidence that Richardson was able to get SDH prioritised by government was mixed. Thus, while the report acknowledged ‘that social and economic factors, including poverty are key determinants of the health status of men’ (Richardson & Carroll, 2008:2), it failed to outline any recommendations on structural level interventions which government could take to improve the living conditions of men. Instead, the report noted the importance of challenging males to better look after themselves, with actions based around recommendations such as targeting

*the home as a setting for enabling men to take greater responsibility towards their own health (Richardson & Carroll, 2008:9).*

Richardson cited Ireland’s unfavourable economic climate as reasons why perhaps a more radical approach to addressing the SDH could not be sought after and argued the development of men’s health policy must dovetail ‘with existing policy across different government departments’ (Richardson & Carroll, 2009:112).

**Possibilities for SDH Implementation**

As the accounts of Kearney, O’Shea and Richardson have shown, discourses around the SDH remain largely aspirational in tone. This does not just apply to men’s health policy, but across all policy related to health and well being in Ireland. For example, the national health policy documents on diabetes (Diabetes Expert Advisory Group 2008) and on cardiovascular disease (Department of Health 2010) both recognised income inequality and the SDH as the most significant factors in driving increasing rates of chronic conditions in Ireland. However, these reports give no explicit recommendations on how to address SDH; instead they focus almost exclusively on individual level interventions such as education around healthy eating, and programmes which encourage frequent exercise and smoking cessation. The 2005 report on ‘Obesity: the policy challenges’ (Treacy 2005) gives more recognition to the constraining effects of poverty by recommending increasing social welfare benefits in order to enable individuals on low incomes to make healthier food purchases. However, interventions to prevent obesity were discussed largely within the context of fostering individual responsibility for personal lifestyle choices. This tendency to extol the importance of the SDH at the outset of health related policy documents, only to fall back on an individualised behavioural approach in setting out key recommendations, interventions and
targets, is not unique to the policy formation in Ireland. ‘Lifestyle drift’ as Marmot calls it (Popay et al. 2010:148), is a predominant feature of policy documents related to health inequalities in countries where there is a strong neo-liberal emphasis in public policy prevails (Raphael, 2012).

However even when compared to other liberal welfare regimes such as the UK, Australia, and Canada, it is possible to argue that Ireland’s performance relating to specific public policy measures aimed at addressing the SDH has been poor. As O’Shea alluded to, bold reforms have been proposed with respect of introducing equity in access to Irish healthcare system in recent years. However, equalising opportunity for health outside of the healthcare system through investment in early childhood welfare programmes for example, have been largely left off the table. This is in contrast to other liberal regimes such as UK and Australia, where despite having undergone significant welfare state retrenchment, governments have still undertaken policy initiatives to tackle health inequalities, with various degrees of success (Raphael, 2012). In addition, Houghton (2005) has noted Ireland’s exceptionally poor record in the funding of the monitoring and evaluation of health inequalities, with official publications becoming increasingly sparse in detail and often out of date.

Perhaps the most significant attempts in Ireland to address the SDH in line with UN declarations occurred during the Celtic tiger years through the implementation of the National Anti-Poverty Strategy (NAPS), between the years 1997 to 2007. In 2002, the government included explicit objectives in NAPS to reduce health inequalities in cardiovascular disease, cancers and low birth weights by at least 10% by 2007. Although these targets could again be considered comparatively conservative (Houghton 2005), the implementation of NAPs had some favourable outcomes. There is evidence for example that some wealth redistribution in the form of increased social welfare payments targeted at those on the lowest income gave rise to reductions in levels of absolute poverty and (to a lesser extent) relative poverty. The OECD have argued that because of this, the prevalence of inequality in Ireland during the Celtic Tiger years may have remained static, although still above the OECD average (Organisation for Economic Co-operation and Development, 2008). However, because of the lack of monitoring and evaluation systems, there is little knowledge of whether any targets on reducing health inequalities were achieved (McAvoy, 2008).

It is also important to note that throughout the Celtic Tiger, with the exception of NAPS, successive governments remained profoundly neo-liberal in their philosophical and ideological outlook, operating a programme of minimum state intervention, increased privatisation and de-regulation. Irish social and economic policy was based on a low tax model rather than a more progressive taxation system as exemplified among the Nordic countries and to a lesser extent the UK and Australia. Thus in order to fund increases in social welfare, the Department of Finance was reliant on accumulating revenue through unsustainable levels of economic growth, which was in turn fuelled by a speculative bubble in the property and construction sectors. Consequently when the Irish economy officially went into recession in 2009, these social welfare increases could no longer be sustained (Kirby 2010). Austerity measures introduced in response to the subsequent fiscal collapse included significant reductions in social welfare benefits, as well as a raft of stealth charges and increases in indirect taxation. This coincided with a steady increases in income inequality in subsequent years (Central Statistics Office, 2013).

Recent debates within sociology have suggested that those working in the fields of the SDH have often been too focused on consequences of income inequalities to the detriment of understanding its broader structural antecedents and causes (Coburn, 2004; Scambler, 2012; Wilkinson, 2000). Coburn (2004) has highlighted the importance of looking beyond the
surface effects of income inequality on health, to focusing on the ideological and political power structures which continue to justify, and thus ultimately serve to reproduce them. Here he identifies the influence of neo-liberalism in public policy, which he argues increases elite groups control over economic resources in society; as a key mechanism which exacerbates income inequalities and consequently, health inequalities. He views political configurations and ‘historically embedded variations in class and institutional structures,’ as being a significant factor in whether a country is more likely to adopt or resist neo-liberal reform (Coburn 2004:41). Hence countries which have a history of electing social democratic parties tend to be more concerned and have more success in addressing the SDH (Raphael 2011a), than in countries where conservative governments have spent a greater proportion of time in power. In Ireland, the absence of class based politics and the weakness of a left-right divide, as well as labour and trade union movements, is reflected in the fact that the state has never witnessed a majority left wing government (Mair 1992). This could in part explain why references to addressing health inequalities in key Irish health policy documents have remained as mere window dressing.

Consequently, it could be argued that while the Institute of Public Health in Ireland, as well academics such as Eamon O’ Shea and Noel Richardson, play a significant and necessary role in bringing to the attention of government issues surrounding the SDH, it is unlikely that the sheer weight of evidence they present will generate a fundamental shift in understanding how population health is understood. Furthermore, it appears that an individualised view of health is so historically and culturally embedded in the Irish context that any proposals which call for fundamental wealth distribution are likely to be disregarded. This is compounded by Ireland’s current economic crisis and cut-backs across all government departments. However, even in the context of the economic downturn and the constrains of the EU-IMF bailout programme, there is still manoeuvrability around political choices and fiscal matters which ultimately determine who will bear the brunt of the recession in society. Those working within the SDH framework in Ireland may need to find new strategies in challenging the government to follow through on the full implementation of SDH.

This lends itself to the recent work of Scambler (2012), who borrowing from Buroway (2005), has suggested that a ‘public sociology’ around health inequalities which engages with communities outside of the traditional academic and political sphere is essential. It is likely that only through drawing attention to the Irish public of the profound impact that political choices have on their health and well being, that there will there be any real and substantive action on the SDH.

A crucial part of this public sociology, Scambler asserts is studying ‘upwards’ and bringing to light those who benefits from such inequalities; his provocatively named ‘Greedy Bastards Hypothesis’ seems particularly apt in the context of Ireland:

widening health inequalities can be reasonably regarded as the unintended consequences of [a]...weakly globalised power-elite informed by an increasing irresistible, voracious and 'strategic' appetites of core members of its (strongly globalised) ‘capitalist-executive’. (Scambler 2007:305)

As the TASC report on health inequalities has pointed out, the disproportionate influence which business leaders, financial institutions and property developers had over the economic policy arrangements of the Irish state had a significant role to play in its eventual economic collapse. Although these issues are well-known within the public domain, there is less awareness of their significance in shaping both quality of life and life expectancy. Exploring the link between the disproportionate influence which elites’ have over the economic and political institutions of the state and outcomes for population health will ultimately be a crucial component of this public sociology in Ireland.
This article has argued that a holistic approach to healthcare and the SDH model more generally have been largely neglected in Ireland, and in line with recent debates around the subject, there is a need for a public sociology which raises their profiles. However, in order to achieve this it is necessary to first find appropriate communication outlets for raising awareness among the public. As has been shown in other countries, where neo-liberalism is the dominant political philosophy, the mainstream media (Raphael, 2011b) is unlikely to support this process of raising awareness of issues around the SDH, and will more than likely continue to uncritically equate health with lifestyle choices. It will therefore fall to alternative media sources to inform the public of how the social structures in which we live affect health outcomes. For example, in Canada, a country which has also undergone neo-liberal reforms, a simple-formatted booklet, *Social Determinants of Health: The Canadian Facts* (Mikkonen, J et al. 2010), proved hugely popular and disseminated widely among universities, public health institutions and high schools. It is important to note also that while the Irish population have been relatively acquiescent compared to other counties undergoing severe austerity programmes, there are examples of pockets of resistance and protests which have take place across the country(Allen 2011:80). Importantly, many of these protests have taken place around the threats of closure of local public hospitals, the end of universal access to primary care for the over 70’s, as well as cuts to home care and community services, indicating that people can often be highly mobilised around issues related to health and wellbeing. In a neo-liberal state such as Ireland, the need for those working within an SDH framework to increase public awareness of the link between unjust social structures and their consequences for health, is a critical component in influencing the future direction of policies which shape population health.

*Both authors contributed equally to this article.*
The conference was held in association and sponsored by the School of Sociology (UCD) and the Social Science Research Centre (UCD).

The committee (Carol Ellis and Shane O'Donnell) selected four areas as a basis for organising the conference programme: mental health, public health, live events and healthcare. The conference was chaired by Dr Ronnie Moore (UCD) and delivered in four phases, where each thematic area was delivered as a block with questions asked at the end of each session. Eleven papers were presented at the conference: Sarah Gibney (UCD), Darach Murphy (DIT), Dr Noel Richardson (CIT), Robert Mooney (ARC), James Fullham (UCD), Dr Ingrid Holme (UoS), Peter Kearney (UCC), Catherine Lynch (NCAD), Marcella McGovern (UCD), Maria Wegrzynowska (DCU), and Prof Eamon O'Shea (NUIG), where each paper contributed towards this paper, and we regret that they all could not be included in this paper, but thank everyone for their participation. With special thanks to Prof Tom Inglis, Dr Aogán Mulcahy, Veronica Barker, Dr Kieran Allen, Dr Michael Punch and Leon Dempsey.

For more information please see http://ciisn.wordpress.com/

REFERENCES


Mikkonen, J., & Raphael, D. (2010). *Social determinants of health the Canadian facts.* Toronto, York University,


