Women, Debt and Health

A joint report of
The Women’s Health Council & MABS ndl

Autumn 2007
Women's Health Council
The Women's Health Council is a statutory body set up in 1997 (under statutory instrument No. 278 of 1997) to advise the Minister for Health and Children on all aspects of women's health. Its mission is to inform and influence the development of health policy to ensure the maximum health and social gain for women in Ireland. The membership of the Women's Health Council is representative of a wide range of expertise and interest in women's health.

Background
In 1995 the Department of Health held a nationwide consultation with women aimed at defining a framework for women's health policy. Out of this process came the Women's Health Plan. The Plan recommended the setting up of the Women's Health Council, a permanent body to ensure effective and appropriate policy for women's health care. The work of the Women's Health Council is guided by three principles:
1. Equity based on diversity - the need to develop flexible and accessible services which respond equitably to the diverse needs and situations of women
2. Quality in the provision and delivery of health services to all women throughout their lives
3. Relevance to women's health needs.

Mission Statement
The Women's Health Council exists to influence the development of Health Policy at regional, national and international levels in order to ensure the maximum health and social gain for women.

MABS
The Money Advice and Budgeting Service (MABS), funded by the Department of Social and Family Affairs, is a free, confidential, independent, non-judgemental and non-profit making service for people in debt or at risk of getting into debt. There are over 60 offices nationwide staffed by professional money advisers who:

- Provide a confidential, independent and free money advice and budgeting service, mainly to low income families who are in debt or who are at risk of getting into debt.
- Facilitate low income families to develop the knowledge and skills they need to avoid getting into debt and to deal effectively with debt situations which arise.
- Identify sources of credit that best meet the needs of the target group and facilitate them access these sources.
- Highlight changes in policy and practice that need to be implemented at local and national level to eliminate poverty and over-indebtedness.
- Contact creditors on a person's behalf where necessary.

MABS also provide information and general advice to people in debt or in danger of getting into debt through their website www.mabs.ie

This research project marks the first collaboration between our two organisations. The joint initiative has proved an extremely successful and fruitful undertaking. We would like to take this opportunity to sincerely thank the women and the MABS officers who participated so generously in this research and whose contributions have resulted in this important and informative report.
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Introduction and Aims

“It is clear that inequalities exist in relation to health in Irish society, those who live in poverty are subject to poorer or bad health, ...women have a critical influence in relation to family and social support as well as to their own direct health” (Women's Health Council, 2002).

“As poverty is a major determinant of ill health.... Introducing and enforcing policies specifically to alleviate poverty among women will have a positive effect on the health of women and their families” (WHO Regional Office for Europe, 2001).

The Money Advice and Budgeting Service (MABS ndl) was established in 1992 to help people cope with debt and take control of their own finances. Women make up a large proportion (64%) of clients attending MABS services 1, and anecdotal evidence from MABS money advisors has suggested that health is an issue for them. The Women's Health Council (WHC) is a statutory body established in 1997 to advise the Minister for Health and Children on all aspects of women's health. Disadvantage is a key theme in the WHC's work. Given this clear common area of interest an exploratory study on 'Women, Debt and Health' was jointly undertaken by the two organisations.

The main aims of the 'Women, Debt and Health' project were to:
• explore whether women attending the MABS service commonly discuss health during their money advice and budgeting consultations;
• investigate whether women attending MABS identified links between their debt or financial difficulties and their health; and
• document the types of health issues experienced by MABS clients.
• A secondary aim of the research was to explore the need for, and nature of, further research in this area.

METHODS

In order to achieve these aims information was gathered on 97 female MABS clients of nine MABS offices. The offices were located in both urban and rural centres across Ireland, and the clients included had had more than one consultation with MABS. Before a regular consultation, the MABS money advisor informed female clients about the study orally and gave each an information sheet on the research. The information sheet outlined the purpose of the study and guaranteed anonymity and confidentiality. If the client was happy to take part in the research and consented to her information being used for research purposes, the MABS money advisor asked her to sign a consent form. On receiving the client's informed consent 2, the MABS money advisor completed a short questionnaire 3.

The questionnaire used for the study was prepared with input from both the WHC and MABS, and its design was aided by findings from the Do the Poor Pay More? study (Conroy and O'Leary, 2005). The questionnaire gathered information on the client's socio-economic profile, their family/household status, income patterns, debt issues and the circumstances which may have contributed to debt. It asked if health was mentioned during the client’s consultation and whether the client

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1 64% of a total of 14,506 clients in 2006 were women.
2 The study received ethical approval from the Royal College of Physicians of Ireland Faculty of Public Health Medicine Research Ethics Committee.
3 The questionnaire is included in Appendix 1.
indicated that their financial difficulties had a negative impact on their health. The questionnaire was piloted to ensure it was user friendly for the MABS money advisors and to provide an opportunity for feedback on the type of questions asked.

The questionnaire was completed after the client consultation to avoid disruption to the much-needed services provided by MABS and to help ensure client confidentiality and anonymity. The MABS money advisors were asked to complete the questionnaire with reference to client records and all of the client’s previous consultations. Each office was asked to complete 15 questionnaires – giving a potential sample size of 135.

As with all research of this nature, this study has limitations. It is an exploratory study, and whilst it provides some insight into the issue of women, health and debt, it does not explore in detail the exact nature of the relationships concerned. The study is not representative of all Irish women with debt worries - it solely focuses on MABS clients. Therefore only those who are aware of the MABS service and are users of its services had the potential to be included in the study. The study also does not claim to be representative of MABS service users as only nine out of a possible sixty-five (14%) MABS offices were included. This was partially due to budgeting restrictions and time constraints. However, it was deemed acceptable as the research was envisaged as an exploratory work to investigate if health issues were a concern for women attending MABS, with possibility of more detailed research to follow.

The findings of the study, their implications and some policy recommendations comprise the bulk of this report. However, firstly, a number of key issues in this area are briefly explored. These include the areas of debt, debt and health, and women and debt.

Women’s Health and Debt – What’s the link?

The relationship between debt and poor health can be complex and self-reinforcing - debt can be both a cause and a consequence of ill-health.

While poverty is one of the major determinants of health status, poor health is often an indicator and cause of poverty; ...people experiencing poverty become sick more often and die younger than those who are better off (Combat Poverty Agency, 2004).

A recent study undertaken by the IIB/ESRI showed a rise in indebtedness in Ireland with the average debt levels of consumers increasing by 11% from 2005 to 2006 (Duffy and Hughes, 2006). According to the Irish Central Bank, problems with debt are unavoidable since loans to the personal sector in Ireland have been growing substantially faster than personal disposable income in recent years (Central Bank, 2004). Therefore, despite a growing economy with lower unemployment and higher income levels, debt is an increasing problem in Irish society. Clearly, not everyone who is in debt will experience negative effects on their health - most Irish people today are ‘in-debt’. However, what is crucial is the ability to service that debt. The area of concern in this study is women who are struggling with their debt and the potential link between this and their health.

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4 IIB Bank and the Economic and Social Research Institute
5 At end-2005 the ratio of personal debt to disposable income had increased to 132 per cent (Irish Central Bank, 2006).
DEBT CAN CAUSE ILL-HEALTH
Research has consistently shown links between relative deprivation and a person’s overall health experience (MacLeod et al, 1998). In Ireland, poor people experience more sickness and die younger than the better off (Combat Poverty Agency, 2004). An Institute of Public Health in Ireland study in 2001 found that between 1989 and 1999 the death rate of the lowest occupational group was 100 to 200 percent higher than in the wealthiest population groups (Balanda and Wilde, 2001); and those in lower income groups are more at risk of illness throughout their lives (Barry et al., 2001). Women are particularly vulnerable to poverty and indebtedness (Women’s Health Council, 2003); the risk of poverty for women is now 23% compared to 19% for men (CSO, 2006). Previous work carried out by the WHC identified a clear link between disadvantage, deprivation and poor health status for women (Women’s Health Council, 2003).

This ill-health can manifest in both mental and physical conditions. International research has found poor mental health to be both a cause and a consequence of experiencing financial difficulty; people living in debt exhibit measurably higher levels of stress, anxiety and depression than those living in more comfortable economic circumstances (Edwards, 2003; Lynch et al, 1997; Berthoud & Kempson, 1992; Balmer et al., 2005; Lee & Kim, 2003; Ermisch et al: 2001; Wilkinson, 1996). In Ireland the recently published National Action Plan for Social Inclusion 2007-2016 notes the strong body of evidence linking poverty and poor mental health, and that poverty is associated with greater use of mental health services (Government of Ireland, 2007). Debt has also been found to have specific effects on the mental health of women. Mothers living in poverty are particularly vulnerable to mental ill health, and strong links have been made between maternal depression and worries about debt (Jenkins & Rigg, 2001; Readings & Reynolds, 2001; Hobcraft & Kiernan, 1999; Maughan and Lindelow, 1997; Brown & Harris, 1978). Similarly, the links between poor physical health and financial difficulty or debt have been documented (Abbot and Hobby, 2000; Nettleton and Burrows, 1998).

DEBT MAY INHIBIT TREATMENT OF ILL-HEALTH
As well as causing poor health, debt problems may exacerbate health problems if people do not have the resources to access healthcare. A growing body of evidence links access to primary health care and health status (Wilkinson, 1996; Shi, 1999). According to a 2002 Irish study, approximately 33% of men and 45% of women identified financial difficulties as the greatest inhibitor to improving their health status (Kelleher et al., 2003). Preliminary analysis from an ongoing study by the ESRI found that 50.7% of the population studied had an unmet medical need as they could not afford the medical examination or treatment for the health problem (Layte et al, 2006).

The fact that those on lower incomes may have difficulty accessing health services is acknowledged in the Irish health system through the provision of medical and GP visit cards. However, in recent years the number of medical cards in Ireland has fallen despite a growing population. For example, between 2001 and 2004 the number of medical cards fell by 46,171 (from 1,199,454 to 1,153,283) (Dept. of Health and Children, 2006). Further, current income limits ⁶ result in instances where people whose only income is a social welfare payment may not qualify for a medical card. This obviously has negative implications for health, particularly for mothers, who have been found to

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⁶ The following is a sample of weekly income levels for Medical Cards (as of June 2006): €184.00 for a single person living alone (up to 65 years), €266.50 for a married couple / single parent family with dependent children (up to 65 years), with additional allowances for dependent children of €38 for the first two under 16 years and €41 for 3rd and subsequent. For the GP visit card the equivalent limits are, respectively, €276, €400 (€57 and €61.50) – i.e. the limits are 50% above those for full medical cards.
neglect their own health problems in order to ensure that their children get any necessary medical care (Comhairle, 2004). People experiencing debt have also been found to be far less likely to fill a prescription, see a specialist when needed, visit a doctor or clinic for a medical problem, and more likely to skip a needed test, treatment, or follow-up visit (Plax and Seifert, 2006; Doty et al., 2005); or they may deepen their debt to cover the expenses of medical treatment.

**ILL-HEALTH MAY LEAD TO DEBT**

Ill-health can also be a cause of debt, through inability to work and/or medical expenses (Smith 1997, 1999; Lee and Kim 2003). Results from the Living in Ireland Survey found that households headed by a person who is unemployed, ill or disabled are at higher risk of falling into poverty (Nolan et al., 2002). This may be because of the deterioration of income levels with the onset of illness or disability, or because extended sick leave leads to a decrease in income or perhaps even dismissal. Those who suffer from poor health are also more likely to experience debt issues as a result of paying medical fees. The Irish League of Credit Unions reported that in 2004 €30 million was borrowed by its members in order to pay for necessary medical treatment such as heart surgery, hip replacements, knee surgery, eye surgery, MRI scans, X-rays, orthodontic work, consultants’ fees, outpatient fees and health insurance (Holland, 2005). Other Irish research has found a high rate of financial strain and debt among parents with a child in hospital (Fitzgerald, 2004).

Particular instances where ill-health can directly lead to debt are those of long-term illness and disability. The onset of a disability can be connected to debt because of the consequent sudden fall in income and because financial responsibilities are often neglected during a personal crisis; further, it has also been shown that there are significant additional costs associated with having and living with a disability, including medication, treatment, rehabilitation, transport and insurance (National Disability Authority, 2004). Despite a persistent lack of information on the position of women with disabilities in Ireland, people with disabilities have been found to have consistently higher unemployment levels and rates of poverty than the general population - households headed by a person with a disability or by someone who is ill have a 28% risk of poverty (National Disability Authority, 2004). In 2001, two thirds of households headed by such persons fell below the 60% median income line (Government of Ireland, 2003).

**DEBT AND WOMEN’S HEALTH**

There is a growing amount of international literature analysing the links between gender and indebtedness. It has been found, for example, that women are more likely than men to be in poverty for long periods of their lives, that mothers living in poverty are particularly vulnerable to mental ill health, and that the vulnerability of women increases when material deprivation is combined with low social and personal support (Jenkins & Rigg, 2001; Baker & Taylor, 1997; Brown & Harris, 1978; Hobcraft & Kiernan, 1999; Maughan and Lindelow, 1997). The 2004 EU-SILC 7 found that households headed by a person who is unemployed, ill or disabled - mainly women - are at higher risk of falling into poverty (CSO, 2005). Changing demography means that women are now more likely to be poor due to the economic consequences of parenting alone, their caring role(s),

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7 EU-SILC is the EU survey on Income and Living Conditions.
Research has also demonstrated that it is impossible to evaluate the impact poverty has on women's health without taking their family situation into account - it has been found that as households begin to experience debt problems, women extend their responsibilities and take on financial responsibilities for debt management (Ford, 1988; Bradshaw and Holmes 1989; Phal 1989; Parker 1992). Women use their earnings for household rather than personal expenses (Phal; 1989) whilst men save part of their earnings for personal consumption, even when money is tight (Townsend and Davidson, 1982; Graham, 1987). When confronted with demands for more food within families, it is often the mother who forgoes her portion in favour of feeding the children (McIntyre, et al 1998).

This brief overview illustrates that previous research has found a link between debt and health, and in particular debt and women's health. An outcome of this study was an investigation of these issues in an Irish context, thus making a contribution to both the national and international debate in this area.

Findings

The study gathered information on the socio-economic, debt and health circumstances of 97 female MABS clients during summer 2006.

The ‘typical’ woman who participated in the study is aged forty, describes herself as ‘single’, has two financially dependent children, and lives in local authority rented housing. She has a medical card and her main source of income is a weekly social welfare payment of between €201 and €300. She identifies utility arrears as being her main debt issues; and also identifies three other areas of debt - rent/mortgage arrears, bank loans, and credit union loans. She feels living on a low income is the main contributory factor to her debt situation. During her consultation with her MABS money advisor she mentions having an emotional health problem, but not a physical health problem. In particular, she suffers from stress. She specifically mentions that her financial difficulties have had an effect on her health, but not on the health of her family members.

* the profile of the ‘typical’ study participant is constructed using mean and modal values.

CLIENT SOCIO-ECONOMIC PROFILE

The age, family size and structure, and housing tenure of the female MABS clients are presented in figures 1 to 4 below. The majority (53%) of the clients were in the 35-54 years age group (Figure 1). Seventy-six percent of women had 3 or less children (Figure 2).
Eighty-eight percent of respondents had children, and 73% had financially dependent children. Sixty-eight percent of those with children are parenting alone – again similar to the comparable percentage for all MABS female clients of 63% in 2006. Women parenting alone with financially dependent children made-up almost half of the entire study population (48%). In Ireland, one parent households have the highest rates of consistent poverty at 31% compared with a national rate of 7% (CSO, 2005). The relatively high proportion of mothers parenting alone represented in the study is significant since, as was noted above, the vulnerability of women to poor mental health has been found to increase when material deprivation is combined with low social and personal support.

Sixty-nine percent of clients were sole heads of household (Figure 3) – a similar figure to the percentage of all MABS female clients that are sole heads of household (68%) in 2006.

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9 This is the most recently available figure and relates to 2003 – therefore it should be treated as a proxy for the true 2006 figure.
Half of the clients lived in local authority rented accommodation, while only 25% owned their own home or had a mortgage (Figure 4) – compared to a national average of 72% owner-occupancy (CSO, 2003).

In terms of income sources, the largest category of women (44%) were those living on social welfare benefits alone; while a further 30% were living on social welfare and other sources (Figure 5).

Ten percent received their income from employment alone, while a further 10% had their paid employment supplemented with welfare payments. Eighty-five percent of women reported living on a net weekly income of under €400, while one quarter lived on between €100 and €200 a week (Figure 6). This compares with a gross average industrial wage for women in 2006 of €452.80 per week (CSO, 2007a). Of the women in the lowest income bracket (< €200 per week) 74% received this income from social welfare payments, 52% lived in local authority rented housing, all were sole heads of household, and 36% had financially dependent children.

Eighty-two percent of women had a medical card, while a further 6% had a GP visit card (Figure 7). Ten percent of social welfare recipients did not possess either card. This group in particular may have the potential to neglect their health - how likely is it that these women would spend €50 of their weekly income on a GP visit? Further, 9% of those who did not have either card had financially dependent children.

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10 The gross average industrial wage for men in 2006 was €656.26 per week (CSO, 2007a).
11 Note - this refers to women who work a 39 hour week 33% of women in employment work less than 20 hours per week (compared to 9% of men) (CSO 2006).
CLIENT DEBT PROFILE

The following gives an overview of the types of debts experienced by the women in the study group, and some of the main circumstances they identified as contributing to their debts.

The most commonly cited ‘main debt issue’ (30%), was arrears on household utilities such as electricity, gas, a telephone, cable television or insurance (Figure 8).

Perhaps of even greater concern was the fact that two-thirds of women (67%) reported having three or more debt issues, while one third (32%) cited having a total of four debt issues (Figure 9). The complex nature of the women’s debt situations would have to be taken into account when devising policies and developing supports.

Utility arrears were the leading source of debt for both women with social welfare as their sole source of income (42%) and for those who receive social welfare benefits plus income from other sources (28%) (Figure 10). For women working in paid employment alone, bank loans were found to be the leading source of debt (45%), followed by credit union loans (22%). Rent and mortgage arrears (40%) and credit union loans (40%) were found to be the main sources of debt for women who received supplementary benefit as well as being in paid employment. Thus, the debt experience differs for women with different income sources.
Figure 10. Debt issues by client income sources

A similar picture emerges when debt issues are examined with regard to average weekly income. Those in receipt of higher incomes are more likely to have bank loan and credit card debt, while those living on lower incomes are more likely to have utility arrears (Figure 11).

Figure 11. Debt issues by average weekly income

Lastly, it is worth noting that differences arise when comparing the main type of debt issues of those who have and have not financially dependent children. In particular, in the women studied, credit union debt only occurs for those who have children; and occurs most often for those that have financially dependent children (Figure 12).
CIRCUMSTANCES CONTRIBUTING TO DEBT

‘Living on a low income’ was selected more often than any other event as a circumstance contributing to the client’s debt – it was cited as the main debt trigger for 38% of women (Figure 13). It was particularly likely to be cited for women on the lowest incomes - it was chosen as the main cause of debt for 42% of those on a weekly household income of €100-€200, as well as for 28% of women on €201-€300 per week, and 25% of those earning €301-€400 per week.
Notably ill health or disability\textsuperscript{12} was the second most common ‘main’ circumstance contributing to debt - it was cited as the ‘main’ cause of debt in 16% of cases and mentioned as a contributory factor to debt in a further 26%, i.e. in total 42% of women identified ill-health/disability as having contributed in some part to their debt situation. This supports the argument that ill-health is a cause of debt problems. The majority (60%) of those who cited ill-health/disability as their ‘main’ cause of debt were living on less than €300 per week. This is perhaps unsurprising since, as was noted earlier, ill health can mean that a person is unable to take up or has to leave employment, and thus her earning capacity is greatly reduced. Those who identified ill-health/disability as the number one cause of their debt were slightly older than the study population as a whole - 67% were in the 35-54 years category, compared to 54% of the total study group.

The third most commonly identified ‘main’ circumstance contributing to debt was relationship breakdown, at 15%. This factor has been identified in a number of other studies (Edwards, 2003; Nolan & Watson, 1999; Doyal, 2000)

All of findings support previous work carried out by MABS that identified the economic consequences of ‘living on a low income’, ‘separation, divorce or relationship breakdown’ and ‘disability or illness’ as being among the key triggers of debt (Conroy and O’Leary, 2005).

Again, the intricacy of debt is evident. For most women the factors that have contributed to their debt are complex, with 84% identifying two or more contributory factors. This has implications for any policy devised to help prevent debt and address its causes.

**CLIENT HEALTH PROFILE**

A core aim of this research was to discover if health arose as an issue during client consultations with MABS money advisors. Eighty-one percent of the women included in the study had discussed their health with their MABS money advisor at some point – supporting MABS’ prior anecdotal evidence. All of the 81%\textsuperscript{13} of women had discussed their mental/emotional health, and 40%\textsuperscript{14} had discussed their physical health – i.e. all of those who mentioned a physical health problem also mentioned a mental health one as well.

Two-thirds of the women who participated had discussed stress, 38% reported experiencing from depression, 32% had mentioned anxiety, 19% of the clients had experienced insomnia, 8% mentioned panic attacks, and 6% of the clients had alcohol misuse problems (Figure 15). Three percent of the clients were reported to self-harm; in each case, stress, anxiety and depression were also identified as major emotional health problems of the women concerned. As was noted above, research has previously found that mothers living in poverty are particularly vulnerable to mental ill health. The fact that so many of the women attending MABS for advice were responsible for financially dependent children may go some way to explaining the high levels of poor mental health reported in the study.

\textsuperscript{12} The WHC and MABS ndl acknowledge that ill-health and disability are not the same thing – they can, and often do, exist independently of each other. However for ease of gathering information and interpretation of results the two categories were combined here.

\textsuperscript{13} Of the remaining 19%, 4% explicitly said they had no mental health problem and 15% had not discussed one.

\textsuperscript{14} Of the remaining 60%, 17% explicitly said they had no physical health problem and 43% had not discussed one.
Almost half of the women (43%) who participated in the study mentioned physical health problems to the money advisor (Figure 16). Some of the more frequently occurring physical health difficulties that were discussed included exhaustion (9%), respiratory difficulties (8%), high blood pressure (5%), heart problems (5%) and cancer (3%). In addition, 10% had discussed general aches and pains with their MABS money advisor and 4% had mentioned accidents that resulted in various health problems.

Approximately 15% of the women who participated in this study were reported to have a disability. These included epilepsy, spina bifida, Reynauds and Friedrichs Ataxia. This is significantly higher than the national level of disability for women of 9.6% reported in the 2006 Census (CSO, 2007b).

Lastly, although the questionnaire did not contain a direct question on the literacy of participants, some MABS money advisors made reference to their client’s low level of literacy as a contributory factor to their debt problems. A total of five women were reported to have literacy difficulties, a problem which had caused difficulties around their social welfare entitlements, both in terms of knowing what they were entitled to and accessing those entitlements.
WOMEN’S HEALTH AND DEBT

In relation to the second aim of the research, to investigate whether the women made links between their debt or financial difficulties and their health, the findings showed that the women who participated in the study were very much aware of the effects that poverty and debt can have on health. Sixty-eight percent of participants had told their MABS money advisor that their financial difficulties had had a negative effect on their overall health and well-being, while 27% said that their financial situation had had a negative effect on the health of their family members. In nearly half (46%) of the cases reported upon in the study, MABS money advisors said they had given the client health-related information. The information offered ranged from recommending a suitable counselling or psychiatric service, to recommending that the client should visit a G.P.

Older women discussed health problems more than younger women (Figure 17). This may reflect increasing health problems with age, or an increased willingness to discuss health problems with age, or both.

Figure 17. Client discussed a health issue by age

Figure 18. Ill-health/disability contributed to debt by income

It also appears that those on lower incomes identify ill-health/disability as contributing (in some part) to their debt to a larger extent than those on relatively higher incomes – 57% in the €101-200 income category versus 25% in the €400+ category (Figure 18).

Seventy-one percent of those with a disability attributed their debt circumstances to some extent to their poorer health, nearly twice the rate of those in the rest of the sample, where ill health/disability as one of the triggers of debt was reported by 42% of clients. All of the female MABS clients who had a disability relied on social welfare recipients for at least part of their income, with social welfare as the sole source of income for 43%, and all held medical cards. Building on the previous work of the WHC, this further confirms these women’s vulnerability to poverty (Women’s Health Council, 2003).
Summary findings

- 81% of women mentioned their health during their consultation with the MABS money advisor;
- specifically, 81% of women discussed a mental/emotional health problem with their MABS money advisor – most commonly mentioning stress, depression and anxiety; and
- 40% of women discussed a physical health problem – most commonly mentioning general aches and pains, extreme tiredness and respiratory problems.
- female clients of MABS identified a link between their debt and their health - 68% reported that their debt affected their health,
- the clients also identified a link between their debt and their families' health - 27% reported that their debt affected the health of their family members;
- almost one sixth (16%) of women identified ill-health/disability as the ‘main’ contributory factor to their debt situation, while a further 26% mentioned it as one of the factors that contributed to the debt;
- 15% of women reported having a disability – 71% of whom identified ill-health/disability as contributing to their debt.

CONCLUSIONS, POLICY IMPLICATIONS AND RECOMMENDATIONS

This study has investigated an area of key concern in Ireland today, i.e. Women, Debt and Health. The research confirms the anecdotal evidence from MABS money advisors that health, both mental and physical, is an issue for their clients. It also confirms the existence in an Irish context of the internationally reported link between debt and women’s health. The nature of this link is complex, and there are at least two phenomena occurring - debt is both a cause and a consequence of ill-health/disability. Therefore policies/actions must tackle both.

‘Living on a low income’ was the most commonly identified contributory factor to debt by the MABS clients. Eight-five percent of MABS clients in this study are living on considerably less than the average industrial wage for women – in other words these women are among those surviving on the lowest income levels in our society and, given the proven link between poverty and ill-health, are a particularly vulnerable group in terms of their mental and physical health.

- Policies to increase income levels of those surviving on the lowest incomes must be enhanced and thus reduce the incidence of debt in the first place.

The importance of enabling people build an asset base to ensure they remain debt free and out of poverty is widely accepted. These assets can be educational, training, employment, financial, etc. This study of MABS clients highlighted the very low income levels that some women are surviving on, with no potential to enhance their asset base, leaving them at constant risk of indebtedness and its consequences for health. This is already recognised in policy documents, for example the National Action Plan for Social Inclusion 2007-2016 highlights that improving the health status of those socially excluded “will contribute to their greater participation in education, training and employment, thus helping to break the cycle of disadvantage and poor health over the long-term” (Government of Ireland, 2007).
Employment is consistently identified as a preventative factor and a route out of poverty. The significant increase in job creation in Ireland in recent years has highlighted that a number of factors are impeding women from taking up these jobs. As outlined in the WHC ‘Submission on Proposals for Supporting Lone Parents’ (2006) these factors include a lack of quality affordable childcare options, disabilities, difficulties accessing training and education, literacy problems, caring responsibilities, etc.

- **A multi-sectoral policy response is required to enable women invest in their asset bases and take-up employment.**

Eighty-eight percent of women in the study have children – debt may have serious implications for the health of both the women and the children. Further, 68% of women in the study are parenting alone, i.e. a large number of MABS clients are part of a group at a high risk of persistent poverty and its consequent implications for health.

- **It is critical that Government continues to support and fund agencies providing services to those parenting alone and those that may offer advice and information on entitlements.**

- **MABS could consider ways of co-ordinating with these agencies in a systematic way.**

Debt is complex - a majority of women in the study reported having a number of sources of debt and multiple contributory factors to that debt. The nature of the debt also differed according to income source and employment status. Further research may be required to better understand the origins of women’s debt problems, in particular in the area of how exactly some of the factors identified actually contribute to debt - after ‘living on a low income’, the two factors identified as most significant were ‘ill-health/disability’ and ‘relationship break-down’.

- **Debt prevention and alleviation measures must take account of the complex nature of debt.**

- **A scheme to enable people access affordable credit is required.**

- **As a preventative measure there is a clear need for more independent advice on financial products and services, thus giving women the knowledge and skills to avoid a debt situation. This could be delivered through an adult education forum.**

Confirming an internationally recognised phenomenon, this research has shown that mental health problems are experienced by a majority of women in debt. A number of policy documents have already examined how mental health services should be developed. The WHC report Women’s mental health: promoting a gendered approach to policy and service provision (WHC, 2005) suggested developing a model of care for women that is, among other factors, women centred, holistic (taking into account social circumstances and physical health) and community based. In 2006 the Irish Government adopted as policy the report of the expert group on mental health A Vision for Change (Government of Ireland, 2006). This report highlighted the need to provide an effective community-based service; and to enhance and formalise links between specialist mental health services, primary care services and voluntary groups that are supportive of mental health.
The study also identified a high incidence of physical health problems among female MABS clients, and a linking among women of debt to their health and, to a lesser extent, to the health of their families.

- **Information on women’s and family health issues should be readily available in MABS offices.**

- **Building on it’s existing networks MABS should publicise its services more widely by providing information to hospitals, health clinics, GP surgeries, etc.**

- **Additional training on health issues is required for MABS staff to ensure that they can provide the best information and direct the clients to the most appropriate service provider if necessary.**

The proportion of women availing of MABS services with a disability (15%) is considerably higher than the national figure for women with a disability (9.6%). Further, a large proportion (71%) of these women identified ill-health/disability as contributing to their debt. This suggests that this group are particularly vulnerable to debt and its potential negative health consequences. Further research is necessary to investigate the nature of the relationship between disability and debt. For example, the research might investigate if disability contributes to the debt directly through medical costs, indirectly through not being able to participate in the labour market, or both.

- **Female MABS clients with a disability require specific debt assistance and increased income. Increased income can be achieved by both increasing incomes supports and reducing barriers to labour force participation.**

Twelve percent of the MABS clients did not have a medical or GP visit card; and 10% of social welfare recipients had neither card – this suggests that their ability to access primary health care may be restricted.

- **The Government should examine the income limits and eligibility criteria for medical cards and investigate the up-take and public awareness of the GP visit card scheme.**

Lastly, it is important to note that the literacy problem identified in the study has implications for the successful up-take of any actions/policies devised to alleviate the debt-ill-health problem.

Overall, the study found that women experiencing debt believe their debt affects their health. Just as ill-health is a cause and a consequence of debt, assisting women overcome their debt problem will help them achieve their health potential and vice versa. Thus the goals of tackling debt and enhancing health for these women go hand-in-hand. This study has exposed the health reality of women in debt in Ireland, and the implementation of its recommendations would begin the task of addressing it.
RECOMMENDATIONS

- Income policies to support those surviving on the lowest incomes and thus reduce the incidence of debt.

- Multi-sectoral policies to enable women invest in their asset bases and take-up employment.

- Continued government support for agencies providing services and information to those parenting alone, and enhanced and systematic co-ordination between MABS and these agencies.

- Debt prevention and alleviation measures that take account of the complex nature of debt.

- A scheme to enable people access affordable credit.

- More independent advice on financial products and services – possibly delivered through adult education channels.

- Information on women’s and family health issues be made available in MABS offices.

- Enhanced publicising of MABS services in health care access points.

- Additional training on health issues for MABS staff.

- Specific debt assistance and income policies for women with disabilities experiencing debt.

- Examination of the eligibility criteria and levels of awareness of the medical and GP visit card schemes.
REFERENCES


Combat Poverty Agency (2004), Poverty and Health, Poverty Briefing no.15, Dublin.


(CSO) Central Statistics Office (2007b) Principal Socio-Economic Results, Dublin
Dept. of Health and Children (2006) Health Statistics “Number of medical cards and percentage of
the population in each county covered by medical cards, 2000-2004”, Dublin.


Doyal, L. (2000) ‘Gender Equity And Public Health In Europe - A Discussion Document from the
European Institute of Women’s Health Report’, paper presented at the Gender Equity Conference,
Dublin 2002.


Edwards, S. (2003), In too deep. CAB clients’ experience of debt, Citizens Advice Bureau, UK.


Report for Phase Two, Dublin.


Children in Hospital Ireland, Dublin.


The Stationary Office, Dublin.

The Stationary Office, Dublin

Case-paper 28, Centre for Analysis of Social Exclusion, London.

Holland, K. (2005) “Looking for a clean bill of health can put you in debt”, The Irish Times,
(30th of May) Dublin.

Corporate Document Services, Leeds.

Kelleher, C., NicGabhainn S., Corrigan H., Friel S., Sixsmith J., Daly E., Galvin M., Daly L., and M. Lotya
Children Survey (HBSC), Department of Health and Children’s Health Promotion Unit, Dublin;
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### APPENDIX 1

**QUESTIONNAIRE**

**PLEASE TICK THE APPROPRIATE BOX (✓)**

1. Age (years):

2a. Family situation
   - Single
   - Cohabiting with partner
   - Married
   - Separated

2b. Family Situation
   - Children (Financially dependent on parent)
   - Children (Financially independent from parent i.e. no longer living at home and dependent on parent's income)
   - No Children
   - Number of Children
   - Ages of Children

3. Sources of income
   - Employment mainly
   - Employment & Supplementary Benefit
   - Social Welfare only
   - Social Welfare & other resources
   - Other sources (Please specify)

4. Average (NET) Weekly Household Income (£):
   - 0 - 100
   - 101 - 200
   - 201 - 300
   - 201 - 400
   - 401 - 500
   - 501 - 600
   - 601 - 700
   - 701 - 1000
   - Over 1000

5. Housing tenure
   - Local authority rented
   - Non-householder (e.g. living with parents/friends)
   - Private tenant
   - Homeless
   - Mortgage
   - Sheltered Accommodation
   - Other (please specify)

6. What are the main debt issues? (Please rate in order of preference if more than one issue is applicable e.g. If 4 different issues apply to the client, rating ‘1’ refers to the most important issue, ‘2’ the next most important and rating ‘4’ means that issue is the least important issue)
   - Rent/Mortgage arrears
   - Utilities arrears
   - Bank loans
   - Credit cards
   - Credit Union loans
   - Money lenders
   - Catalogue shopping
   - Hire Purchase Agreements
   - Friends & family
   - Caring Responsibilities
   - Other (please specify)
7. What circumstances contributed to debts? (Please rate in order of preference if more than one issue is applicable, or in question 8, and if possible give details)
   - Living on a low income
   - Changes in income
   - Difficulty accessing funds for awareness of entitlements
   - Ill-health/disability
   - Medical expenses (e.g., loan for an operation)
   - Substance misuse
   - Job loss/business failure
   - Relationship breakdown
   - Over-commitment
   - Irresponsible lending
   - Difficulty in managing budget
   - Other(s)

8. Does the client hold:
   - A Medical Card
   - A G.P. Visit Card
   - Neither

9a. Did the client mention her emotional health during any consultation?
   - Yes
   - No
   - Unknown

9b. Did the client mention her physical health during any consultation?
   - Yes
   - No
   - Unknown

10. Has the client reported to you that she has a disability?
    - Yes
    - No
    - Unknown

11. Did the client specifically mention the effects the financial difficulties had on her health? (e.g., ill-health brought on by worry, necessary to visit the doctor for health issues related to debt problems, etc.)
    - Yes
    - No
    - Unknown

12. Did the client mention the effects the financial difficulties had on the health of other family members? (e.g., ill-health brought on by worry, necessary to visit the doctor for health issues related to debt problems, etc.)
    - Yes
    - No
    - Unknown

13. Did you advise the client on steps to take regarding her health?
    - Yes
    - No
    - Unknown

14. Any other relevant details?
    - Yes
    - No
    - Unknown

Thank you for completing the questionnaire in full.