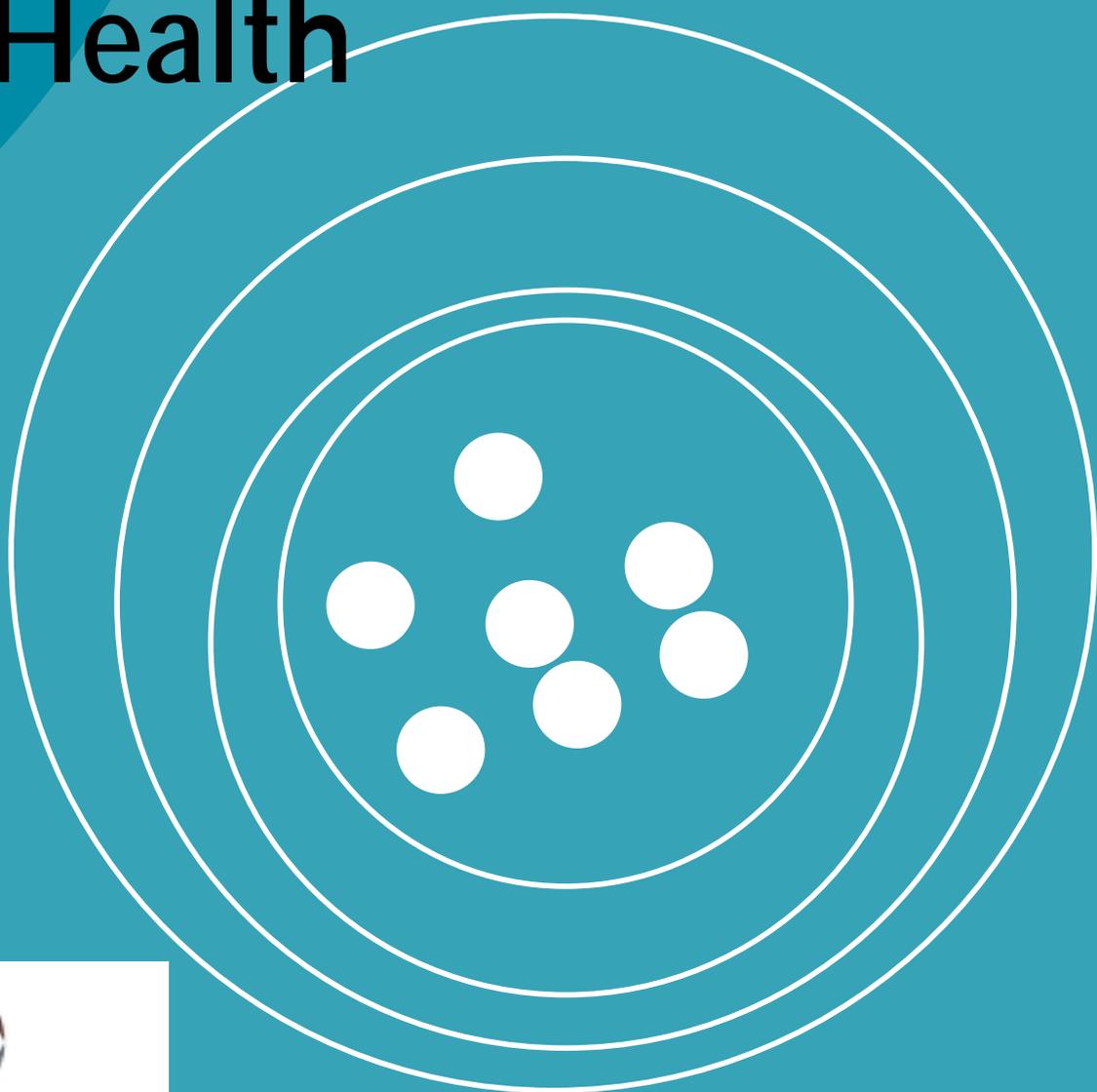


# Report of the Working Group on the National Anti-Poverty Strategy and Health



THE INSTITUTE OF  
PUBLIC HEALTH IN IRELAND

**REPORT OF THE WORKING GROUP  
ON THE NATIONAL ANTI-POVERTY  
STRATEGY AND HEALTH**

Prepared by the  
**Institute of Public Health**

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The Institute of Public Health in Ireland Project Team:

Wilde, Jane

Boydell, Leslie

Burke, Sara

Harkin, Anna-May

Balanda, Kevin P

Metcalf, Owen

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For further copies of this paper please contact:

The Institute of Public Health  
6 Kildare Street  
Dublin 2

Tel: 00 353 1 662 9287

Fax: 00 353 1 662 9286

Email: [iph@RCPI.ie](mailto:iph@RCPI.ie)

[www.publichealth.ie](http://www.publichealth.ie)

Also contactable at Belfast: 00 44 28 9079 3050

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**Supporting documents available from the Institute of Public Health**

- 1 Report of the consultation process
- 2 Setting health targets for the National Anti-Poverty Strategy – A background research paper
- 3 Equity of Access to Health Services – Some relevant issues in an Irish context
- 4 Health Impact Assessment – A position paper

These documents are available on request.

## Preface

As Chairman of the Working Group on the National Anti-Poverty Strategy and Health, I am very pleased to present this report to the Minister for Health and Children. This report is the culmination of intensive work which took place in the context of the 2000 Programme for Prosperity and Fairness. The commitments contained therein were to develop health targets for the National Anti-Poverty Strategy and an associated monitoring and implementation framework. I am satisfied that the contents of this report meet these requirements.

Following presentation to the Minister of Health and Children the report was forwarded to the Inter Departmental NAPS Review Group and in turn their report was forwarded to the Cabinet Sub-Committee on Social Inclusion.

The Working Group was comprised of representatives from the departments of Education and Science; Enterprise, Trade and Employment; Environment and Local Government; Finance; Justice Equality and Law Reform; Health and Children; Social Community and Family Affairs; the Taoiseach; Tourism Sport and Recreation; the Health Boards; the Social Partners, through IBEC, Macra na Feirme, the Community and Voluntary Sector and the Trade Unions; the Combat Poverty Agency and the Institute of Public Health in Ireland. I am very grateful to all the individuals and organisations who gave unstintingly of their time to ensure that this report contained essential information and that agreement was reached as to how issues in relation to poverty and health can be best addressed. (See Appendix 1 for Working Group and Sub-group members).

I am also grateful to all those who engaged in the consultation process as their views were essential in helping formulate relevant targets. The role played by the NAPS team in the Institute of Public Health was pivotal in bringing this work to fruition. I would like to particularly thank Sara Burke and Anna-May Harkin for their diligence in helping to prepare this document.

In my opinion this report will be an extremely important document in helping us to reduce inequalities in health and move towards a healthier society.

A handwritten signature in black ink that reads "James Kiely". The signature is written in a cursive, flowing style.

Dr Jim Kiely

Chief Medical Officer, Department of Health and Children

## Summary

### Poverty and Health

- The link between poverty and health is strong and well established in Ireland and other countries.
- Poverty contributes to poor health directly through, for example, inadequate housing or dangerous environments and indirectly, for example, through poor diet.
- Being poor or socially excluded makes it more difficult to access or afford health services.
- In Ireland, the gap in health between rich and poor is substantial. Mortality rates in the lowest socio-economic groups are over 100% higher than in the highest socio-economic groups for all the major causes of death.
- As well as the huge gap in mortality between poorest and richest, the risk of poor health increases as one goes down the socio-economic scale. This gradient has been demonstrated in Ireland.

### Background

As part of the review of the National Anti-Poverty Strategy, a NAPS and Health Working Group was established by the Department of Health and Children to develop health targets and an associated implementation and monitoring framework. In order to support this work a wide ranging consultation process was carried out.

Based on a review of international experience in target setting and the links between poverty and health, a number of criteria for targets were set. The targets proposed by the Working Group have been selected with the aim of reducing the gap in health between rich and poor, promoting equity of access to health services and developing new ways of working to address the main factors which link poverty and ill health. The targets are intended to address the main impacts of poverty on health and vice versa. The process has been constrained by lack of information and the need to develop better information systems has been built into the targets, as well as the need to review and revise the targets as better information emerges.

### Proposed targets

#### *Health status targets*

The first four targets have been selected to reflect the overall goal of the NAPS health targets, that is, to eliminate the impact of deprivation and disadvantage on health

status. Targets for circulatory diseases, cancers, injuries and poisoning have been specified because these are the major causes of premature death in Ireland. Death rates from these conditions are much greater for lower socio-economic groups than for higher socio-economic groups. The health of Travellers is known to be unacceptably poor in comparison with the whole population and therefore this group has been given particular emphasis. Asylum seekers and refugees are also regarded as a group at high risk of experiencing poor health. A target on birth weight rates has been included because babies born to mothers from lower socio-economic status tend to be lighter, reflecting the disadvantaged circumstances of the mother and a less advantageous start in life for the baby.

**Target 1** The gap in premature mortality between the lowest and highest socio-economic groups should be reduced by at least 10% for circulatory diseases, for cancers, for injuries and poisoning by 2007.

**Target 2** The gap in life expectancy between the Travelling Community and the whole population should be reduced by at least 10% by 2007.

**Target 3** The life expectancy and health status of Travellers, asylum seekers and refugees should be monitored so that targets can be set for asylum seekers and refugees and reviewed and revised for Travellers, by 2003.

**Target 4** The gap in low birth weight rates between children from the lowest and highest socio-economic groups should be reduced by 10% from the current level by 2007.

### ***Equity of access targets***

The Working Group on NAPS and Health identified access to health and personal social services as an important area for target setting, to ensure that those experiencing poor health as a result of deprivation or disadvantage are able to gain access to the services they need. The targets have been selected to cover the spectrum of primary health care, (including health promotion, preventative services, diagnosis, treatment and rehabilitation), acute hospital care and continuing care in the community. Each of these targets is supported by a range of specific actions to be implemented between now and 2007. Cardiovascular and cancer services have been specified within a separate target because these make a major contribution to illness, disability and death in Ireland. There are effective diagnostic, treatment and rehabilitation services available and these conditions are the subject of national strategies which should be

implemented equitably. Injury is an important and preventable cause of disability and death, affecting children, young men and elderly people from lower socio-economic groups disproportionately. For this reason a specific target has been identified.

It is important to remove the obstacles, including financial obstacles, to access to services for people who are disadvantaged. For this reason a target in relation to improved access to the Medical Card for people on low income, particularly families with children is proposed.

**Target 5** There should be increased equity of access to effective primary health care services by 2007.

**Target 6** There should be increased equity of access to public acute hospital services by 2007.

**Target 7** There should be equitable access to available effective interventions for cardiovascular disease and cancers by 2007.

**Target 8** There should be increased equity of access to community supports for continuing care by 2007.

**Target 9** A comprehensive injury prevention strategy to reduce higher injury rates in people at risk (children, young men and older people in lower social economic groups) should be developed by 2003.

**Target 10** The income threshold in the guidelines for the medical card should be increased with a view to removing impediments to access to health services and taking particular account of the needs of children.

**Target 11** An equality dimension should be integrated into the delivery and development of health and personal social services by 2007.

***Impact of public policy on health target***

Many factors within the social and economic environment impact on health including housing, education, levels of inequality, employment, agriculture and transport. The Working Group on NAPS and Health has therefore recommended a target which requires all government departments to take responsibility for the impact of their policies on health. This requires multisectoral collaboration and the use of Health

Impact Assessment as one mechanism to highlight the health impacts of different policies.

**Target 12 It should be government policy for all relevant sectors to recognise and accept their responsibility for health by developing multisectoral working and the adoption of Health Impact Assessment by 2007.**

Recognising the importance of the social determinants of health, the Working Group on NAPS and Health recommends that targets on the following be outcomes of the NAPS review:

- **Child poverty**
- **Relative income inequality**
- **Income adequacy**

The Working Group also strongly endorses the importance of targets in the following areas to support the improvement of people's health and the reduction of inequalities in health, particularly those for who are living in poverty and experiencing social exclusion:

- **Housing**
- **Transport**
- **Education**
- **Environment**

#### ***Monitoring and revision targets***

The last three targets proposed by the Working Group are concerned with the need to monitor progress in achieving NAPS health targets. For each target, a range of indicators has been proposed and the National Health Information Strategy will provide an important mechanism for enabling these to be monitored. Research is needed to identify new indicators where there are gaps and to inform the future review and refinement of the NAPS and health targets.

**Target 13 Systems to monitor NAPS health targets and indicators should be included within the National Health Information Strategy.**

**Target 14 A programme of research should be set up to support the development of further NAPS health targets and indicators.**

**Target 15 Adequately resourced and supported systems should be put in place to ensure that NAPS health targets and implementation strategies are reviewed and revised.**

These targets are underpinned by an implementation and monitoring framework, which includes a range of indicators, which will demonstrate progress in achieving the targets.

### **Definition of health**

“Various definitions of health have been developed over the years that focus on the notion of health as a positive concept rather than merely the absence of disease. Health is now regarded as a resource to be protected and developed so as to enable people to attain their maximum physical and mental capacity.” (Annual Report of the Chief Medical Officer, 1999, Department of Health and Children: 5). This is the definition which guided the Working Group in its deliberations.

## **Part A: Background**

### **1. Policy Context**

The National Anti-Poverty Strategy (NAPS) was published in 1997. It originated from a government commitment to the development of an anti-poverty strategy at the UN World Summit in Copenhagen in 1995. The NAPS set a ten year programme for poverty reduction and outlined five areas of focus. These areas were income adequacy, unemployment, educational disadvantage, urban concentrations of poverty and rural poverty. The NAPS set an overall global poverty reduction target, alongside five other targets in the above areas.

While health issues were outlined in the NAPS, no specific health targets were set.

However, the NAPS did oblige all government departments to take the reduction of poverty into account in their strategic planning process and poverty proofing was introduced across all government policies. Under the Programme for Prosperity and Fairness (PPF), the NAPS is being reviewed and new targets will be set in 'health' and 'accommodation/housing', while targets in the other areas are being revised. Poverty proofing is to be extended in a phased manner at local level through Local Authorities and Health Boards.

This NAPS review is also taking place in the context of the development of National Action Plans against Poverty and Social Exclusion (NAPinCl) by each EU member state. The NAPS review will feed into the NAPinCl.

The new National Health Strategy offers an important opportunity to promote action to address inequalities in health and access to healthcare.

### **2. The link between poverty, social exclusion, inequality and health**

The link between poverty and health is well established. Poorer people experience poorer health.

Poverty is known to contribute to poor health directly, for example, through inadequate housing or poor environments and indirectly, for example, through poor diet or stress.

Being poor also makes it more difficult to access or afford health care, and to reduce the opportunity for adopting a healthy lifestyle.

Some groups experience particularly poor health. For example Travellers are known to have very high infant mortality rates and low life expectancy. There is also growing concern about the health of refugees and asylum seekers.

As well as the wide gap in the health of rich and poor as demonstrated by many studies in Ireland and elsewhere, there is also strong consistent evidence of a gradient in health favouring those higher up the socio-economic scale.

Mounting evidence is leading to recognition that inequalities in health are a major challenge in Ireland, as in many countries. While this is giving rise to concern, there is also increasing understanding that these inequalities are not inevitable and they may be reduced by appropriate policy and action.

What is of most concern to policy makers are inequalities in health status and access to health services which are unjust and unnecessary and which can be addressed through the development of more equitable public policies and access to services.

### **3. The Working Group on NAPS and Health**

A Working Group on NAPS and Health was set up by the Department of Health and Children in Autumn 2000. Membership included representatives from the Social Partners; Farmers, Unions, Community/Voluntary, Industry/Business; Government Departments – Health and Children, Finance, Education and Science (the National Childrens Strategy Office), Social, Community and Family Affairs, Environment and Local Government, Trade, Enterprise and Employment, Justice, Equality and Law Reform, Taoiseach; the Health Boards and health service providers; the Combat Poverty Agency (CPA) and the Institute of Public Health in Ireland (IPH). The Working Group was chaired by the Chief Medical Officer of the Department of Health and Children, Dr Jim Kiely. Research, administrative and technical support was provided by the Institute of Public Health in Ireland. (See Appendix 1 for list of members of The Working Group and Subgroups, Appendix 2 for Terms of Reference of the Working Group on NAPS and Health and, Appendix 3 for Organisational Chart).

The Working Group on NAPS and Health met nine times between 27 October 2000 and 9 July 2001. Subgroups on the Impact of Public Policy on Health, Equity of Access to Services and Information & Research were set up to work on areas of particular concern. The Equity of Access subgroup met ten times and the other two subgroups met six times each. (See Appendix 1 for membership and chairs of Subgroups). The Working Group on NAPS and Health completed its work in July 2001.

#### **4. Consultation**

A wide ranging consultation included:

- A public call for submissions in national newspapers on 20 February 2001
- A targeted call for submission to over 200 organisations and networks with a brief relevant to NAPS and Health
- Consultation process by regional Health Boards, in conjunction with their consultations for the National Health Strategy
- Gathering information through the networks and constituent organisations of the Community and Voluntary Pillar and the development of a composite report
- Gathering information through City and County Development Boards
- Providing resources for advocacy groups and organisations to encourage direct consultation with excluded people
- Hosting a national 'checkback' seminar in June 2001

The consultation process was facilitated by the Institute of Public Health which was assisted by an operational team (See Appendix 1).

152 submissions were received from the different strands of the consultation process. There were 132 written submissions, 10 oral (received through the Lo-Call comment line), one video, nine oral presentations by representatives of organisations who attended a consultative seminar hosted by the Community and Voluntary pillar. Twenty-seven came from private individuals, 125 came from organisations. A majority of submissions came from voluntary and community organisations, networks and projects, with other submissions received from Regional Health Boards, statutory bodies, religious groups, trade unions, doctors, academics, City and County Development Boards, Local Area Partnerships, a political party and many other organisations. A report summarising the submissions has been prepared and includes a list of organisations which participated and feedback from the checkback seminar. The main themes emerging from the consultation process are summarised below.

## **5. Main themes emerging from summary of submissions**

A number of key themes emerged from the submissions and addressing these issues was widely viewed as the way forward in tackling issues of poverty, social exclusion and inequalities in health.

The Summary on Submissions report is available in the *Report of the Consultation Process*, Supporting Document 1. Additional information was obtained from organisations involved in the consultation process and is also available in this document.

### **5.1 Social model of health and social determinants of health**

Emphasis is placed on the need for a holistic and broader social model of health which encompasses the concept of well-being and is concerned with quality of life. This recognises the importance of tackling the social determinants of health.

### **5.2 Impact of poverty and social exclusion on health**

The link between poverty, social exclusion and health is stressed very strongly and therefore efforts to tackle these are critical to improving the health of people who are living in poverty or experiencing social exclusion.

### **5.3 Housing**

The provision of good quality public, affordable and social housing and accommodation is an essential factor influencing people's health.

### **5.4 Transport**

Improved transport provision for people from marginalised communities, particularly in rural areas, is essential to enable people to access services.

### **5.5 Participation in decision making**

The engagement of citizens and communities, particularly those who are living in poverty or experiencing social exclusion, is a critical factor in developing effective health and other public policies and services.

### **5.6 Community development**

Community development is identified as playing a very significant role in supporting people who are living in poverty or experiencing social exclusion and is a key tool for developing healthier citizens and communities.

### **5.7 Co-ordination of services and policies**

Many sectors and disciplines currently work in isolation from each other and increased co-ordination, co-operation and integration of policy, service development and implementation is identified as a critical way of enhancing public policies and services.

### **5.8 Equitable access to health and personal social services**

Equitable access to health services is recognised to include issues of timeliness, waiting lists, physical accessibility and access to information. The negative effect of the two tier health system on equitable access is stressed as is the positive effect of a medical card in accessing services.

### **5.9 Primary care**

A comprehensive integrated and accessible primary care service is fundamental to improving the health of people who are living in poverty or experiencing social exclusion.

### **5.10 Information and research**

The importance of a research and information base for target setting, monitoring and reviewing is stressed.

## **6. Guiding principles**

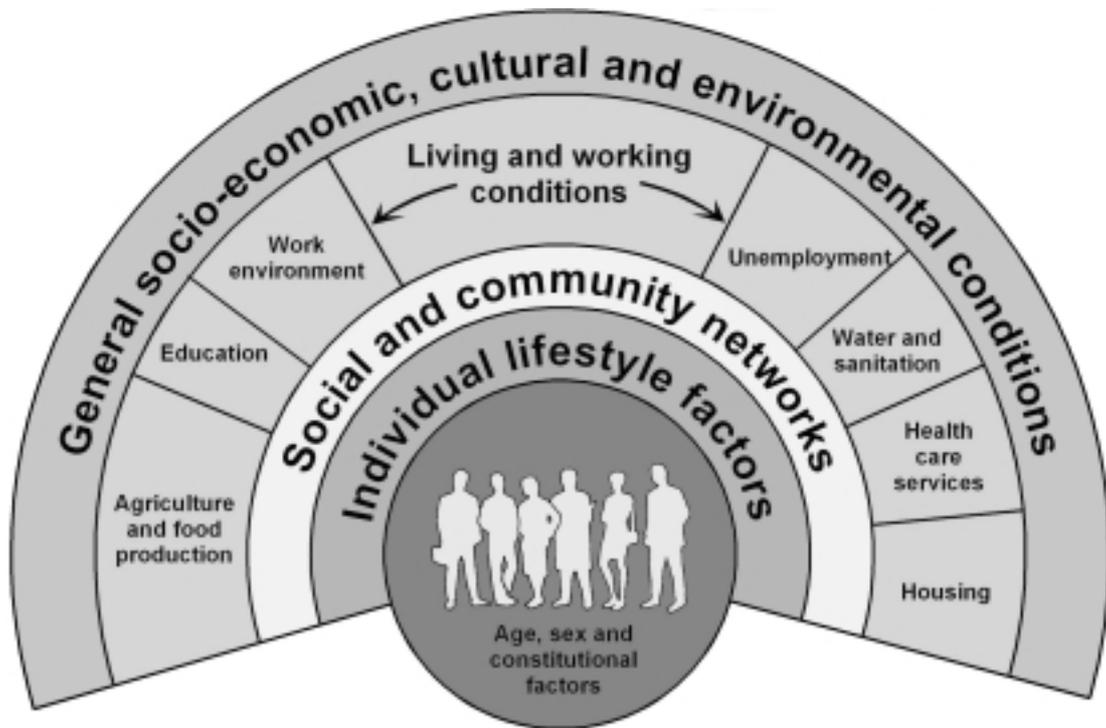
The following key principles guided the Working Group. The Working Group proposes that these principles should be an important consideration in the adoption of health targets, the associated implementation strategy, monitoring framework and review processes.

### **6.1 Addressing the social determinants of health**

The Working Group carried out its work and formulated targets based on a broad social model of health (Diagram 1). The use of this model has been endorsed and supported throughout the consultation process. The model shows that the social and economic environment in a country contains key influences on the population's health and well-being. There are very many determinants of health. Some, such as age and sex, are fixed. Others range from individual behaviour to living and working conditions, psycho-social and community influences and the broader socio-economic environment. These factors interact with each other. All are amenable to change. Health services are just one and not necessarily the most important of these factors. There are some important factors which are not detailed in this model but which were

emphasised by the consultation process as essential for consideration in the Irish context, e.g. income adequacy, levels of income inequality, accommodation, racism and discrimination, geographical location, opportunities and ability to participate in society.

**Diagram 1: Health Determinants Model**



*Dahlgren and Whitehead, 1991*

Addressing the broader determinants of health, particularly for those who are living in poverty or experiencing social exclusion, and reducing poverty, income inequality and social exclusion are central to the NAPS and Health process achieving its outcomes. Other policy areas such as the environment, education, housing and transport are all critical to improving health.

**6.2 A rights based approach to social and economic development (and therefore health)**

A consideration which guided the Working Group was the growing international and national interest in rights based approaches to social and economic development. While everyone cannot have equal health, it should be an objective of the NAPS and

Health targets, that everybody has the opportunity for maximum health gain and enhancement, through healthier public policies, supportive environments, and access to appropriate services when needed. The UN Committee on Economic, Social and Cultural Rights 'recommends that Ireland integrates a human rights approach into the NAPS.' It is essential that should such an approach be adopted that a right to health be incorporated into this overall position.

### **6.3 Health, investment in health and reducing inequalities in health, are central to public policy and political development**

Making health, investment in health and reducing inequalities in health, central to public policy and political developments, is a key element to effectively addressing the social determinants of health and reducing inequalities in health. Health Impact Assessment is one tool which can facilitate this process. Educating the public, service providers, managers, decision makers and policy makers on investment in health and reducing inequalities in health is also a fundamental way of achieving this objective.

### **6.4 Reorienting the health services**

Accessible, good quality, appropriate, holistic health and personal social services are fundamental to supporting people's health and well being, particularly when they have specific needs, e.g. children, older people, people with disabilities, people with mental health needs, homeless people. In order to achieve this, services need to put the citizens and the communities they serve at the centre of their decision making processes. Services also need to be reoriented so as to provide earlier interventions and more preventative and social support services. While acute services are essential, if preventative, community based and step down services are better resourced and more available, there would be less demand for the acute health services and crisis social services. It is also crucial that health promotion permeates all aspects of health service delivery from preventative services to long term care.

### **6.5 Primary health care**

The significant role that primary care plays in investment for health should be supported in the NAPS and Health targets. The development and support of primary care services which incorporate health promotion and community development approaches have a critical role to play in health investment. This would involve multi-disciplinary working at community level, with community development as a core component of this work.

### **6.6 Equity of access to and quality of acute health services**

Adopting Whiteheads definition of equity – equal access to available care for equal need (in the Irish system this means equal access to public services for equal need), equal utilisation for equal need (in practice this would mean monitoring of uptake and supportive action where uptake is noticeably unequal) and equal quality of care (in the Irish system this means in public facilities i.e. public and private patients in public hospitals) – achieving equity of access and quality of acute health services will require significant changes in the way the health service is structured and operated.

### **6.7 Capacity building and training for health and health service providers**

Building the capacity of health service providers to address the needs of service users will facilitate the development of more responsive and effective health and personal social services. Building the capacity of personnel in other relevant sectors, e.g. education and environment, in relation to the opportunities for addressing the social determinants of health will facilitate the achievement of more effective investment in health.

### **6.8 Inter-disciplinary working within the health sector and co-ordination of policies and programmes across sectors**

When working on the basis of the broad social model of health, multi-sectoral working for health is an essential component of effective policy and programme development and implementation. Collaborative working between health and personal social service providers is necessary for a seamless provision of these services. It is also necessary to include citizens, service users and communities as partners in service provision. Co-ordination and collaboration across sectors is also key to developing effective policy and programmes which address the social determinants of health. It is necessary for policies and programmes in one area to support and be supported by developments in another.

### **6.9 Consultation and participation in decision making**

Consultation with and participation of citizens, communities, health service users and providers is an essential component of any planning process. Mechanisms need to be put in place and resourced which facilitate this participation and build it in as a core component of planning, development and implementation processes.

### **6.10 Community development**

Community development is about people working collectively for social change which will improve the quality of their lives, the communities in which they live or the society of which they are part. It is about enabling and empowering those who are

disadvantaged to identify and articulate need, to participate in working for change and to influence decision making structures that affect them, their communities and wider society. It is an essential mechanism for supporting peoples and communities health. It must be committed to and resourced at national, regional and local level.

### **6.11 Meeting the needs of specific groups**

While targets are set for the whole population, there are particular population groups i.e. children, women, older people, people with disabilities, homeless people, people with mental health needs, Travellers, refugees and asylum seekers, ethnic minorities, lesbians, bisexuals and gay people, people living in rural and urban areas of disadvantage, drug users etc. whose needs can only be met with specific interventions and when given special attention. It is therefore critical that while the NAPS and Health targets are set in relation to the whole population, there should be scope for specific interventions to meet the needs of these groups. It is important that such interventions are resourced and supported accordingly.

### **6.12 Monitoring and review processes**

Targets must be monitored in order to oversee progress towards meeting them. Targets should also be reviewed periodically so that actions can be adapted and revised as appropriate with changing environments, economic situations and as new issues emerge.

### **6.13 Information and research**

A major issue which arose during the target setting process was the need for appropriate, timely and accurate information, with appropriate disaggregation by relevant NAPS groups. This is a key issue for the National Health Information Strategy. Developing information and research systems will assist a better understanding of the complex relationships between poverty, social exclusion and health. It will also lead to more effective responses to these complex areas and provide an evidence base upon which future policies and programmes can be built. These programmes will contribute to effective reviews of the NAPS health targets, implementation strategy and monitoring framework.

## **7. Supporting Documents**

A series of background papers were prepared to inform the Working Group and Subgroups, details of which are available in relevant Supporting Documents:

- *Setting Health Targets for the NAPS – A background research paper*, (Supporting Document 2)
- *Equity of Access to Health Services, – Some relevant issues in the Irish context*, (Supporting Document 3)
- *A position paper on Health Impact Assessment*, (Supporting Document 4).

## **8. Special groups**

In reviewing NAPS, special attention is to be paid to children in poverty, women in poverty and older people. The following targets and actions are among those being proposed by the Working Group which are relevant to these specific groups. The impact on these special groups will be monitored by the indicators outlined in Part B, with the appropriate disaggregation of data.

Target 1 – to reduce the gap in premature mortality between the highest and lowest socio-economic groups – aims to improve the health of those in the lowest socio-economic groups. The public policy target 12, is intended to provide for more comprehensive multi-sectoral collaboration on health issues and the health equity proofing of other policies. While neither of these targets are specific to children, women and older people, each should contribute to better health for these groups. The recommendation for targets in the areas of child poverty, relative income inequality and income inadequacy should also contribute significantly to better health for children, women and older people.

Targets 6, 8, and 11, which aim respectively to increase equity of access to public acute hospital services, lead to nationally standardised rules for community supports and integrate an equality dimension into health and personal social services should all impact positively on these groups. Target 10 which proposes to increase the income threshold in the guidelines for the Medical Card should improve access for women and children in poverty. Targets 13, 14 and 15 will enable better monitoring of a range of issues in relation to these specific groups and therefore the development of more effective strategies and targets which should result in improved health for each of the groups.

### **8.1 Children**

Target 4 which aims to reduce the gap in low birth weight rates between children from the lowest and highest socio-economic groups, and targets 5, 6 and 8 which aim to increase equity of access to primary health care, acute care and community supports should all impact positively on the health of children living in poverty. Assessing the

need for supports for adolescents with mental health needs and extending family support services will lead to increased support for young people at risk. Reducing the numbers of young people who become and stay homeless will also positively impact on this target group. Target 9 – to develop a comprehensive injury prevention strategy – should impact on, among other things, the higher injury rates for children from lower socio-economic backgrounds. The recommendation from the Working Group that a target on child poverty be an outcome of the NAPS review is intended to improve children's health and well-being.

## **8.2 Women**

Targets 2 and 3 will impact on the health of women Travellers, refugees and asylum seekers. Targets 5, 6, 7 and 8 which aim to increase equity of access to primary health care, acute care, effective interventions for cardio-vascular disease and cancers, and community supports should impact positively on the health of women living in poverty. Action on increasing regional access to breast cancer treatment services is included.

## **8.3 Older people**

The Working Group considered the important area of setting health status targets for older people. Inequalities in health may be even greater for older people than for younger people, and evidence suggests that action is likely to produce important benefits. However there is little morbidity information on the socio-economic background of older people. This creates problems in identifying inequalities, in setting targets and in subsequent monitoring and implementation of policies.

Life expectancy after the age of 65 would be a possible target but it was considered desirable to develop a target which also recognised the importance of years free from disability. Appropriate measures such as disability-free life-years, to monitor healthy life expectancy should be developed. This should then be considered for new NAPS health targets.

Targets 5, 6, 7 and 8 which aim to increase equity of access to primary health care, acute services, effective interventions for cardio-vascular disease and cancers, and community supports, should impact positively on the health of older people. There is reference here to improving access to orthopaedic services with particular reference to hip replacement, with a view to improving quality of life for older people. National guidelines will be in place for the provision of respite care services to carers for older people. Target 9 – to develop a comprehensive injury prevention strategy – is intended to reduce the higher injury rates for older people from lower socio-economic backgrounds.

## Part B: Targets and implementation strategy

### 9. Introduction to target setting

Many commentators have described the purpose of setting targets is to reduce inequalities in health. At one level targets can be inspiring and motivating, as well as encouraging co-operation among agencies. Targets of this nature are often aspirational, for example, as those set out by the World Health Organisation.

Targets can also help to measure progress towards equity and improve accountability in the use of resources.

International reviews suggest that target setting is most successful when a limited number of targets are set. It is suggested that targets should also move away from a traditional focus on disease outcomes and risk behaviours towards addressing the wider determinants of health.

Setting targets involved a series of stages:

- Reviewing the literature on setting targets around poverty, health and health inequalities
- Developing preliminary criteria and criteria for target setting
- Drawing up a list of targets already set nationally and internationally and assessing them against the criteria
- Developing a final list of criteria

International literature and experience offered a range of criteria which could be used to determine the selection of targets.

The Working Group identified the following criteria to guide the selection of targets:

#### **Contextual criteria**

Targets should take into account key policies and strategies. Targets should reflect areas of community concern.

#### **Evidence-based criteria**

There should be evidence that achieving the target will lead to a reduction in health inequalities and associated poverty. There should be evidence that there are effective public policy interventions by which the target can be achieved.

### **Information-based criteria**

Targets should be based where possible on historical trend data. Systems that effectively monitor progress towards achieving the target should exist or be developed. Targets should be based, as far as possible, on indicators which allow international comparisons to be made.

### **Smart criteria**

Targets should be specific, measurable, achievable, realistic and time bound.

### **Resources**

It is the view of the Working Group that a serious commitment to delivering on these targets must be underpinned by additional resources and in some cases the redirection of existing resources. It will also be important that, where relevant, resources are allocated in a way that supports interdepartmental and multi-sectoral working. The required resource commitment should be viewed as an investment, not just in health and health services, but in building a more inclusive society generally.

### **Target setting**

The Working Group took the view that it was important to have targets which related to health status, access to health services and wider public policy issues. These targets, when considered together, were seen as an appropriate way to drive action and monitor progress in reducing inequalities in health.

The targets are in boxes outlined below. They are followed by actions in bold and relevant indicators. These actions are the core component of the Implementation Strategy. The indicators identified will be used to monitor progress towards meeting the targets. Apart from the health status indicators, the indicators outlined are performance indicators.

## **10. Health status targets**

*Implementation actions necessary to achieve the target are in bold type:*

<p><b>Target 1</b> The gap in premature mortality between the lowest and highest socio-economic groups should be reduced by at least 10% for circulatory diseases, for cancers and for injuries and poisoning by 2007.</p>
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## **Rationale**

Circulatory diseases, cancers and injuries and poisonings account for nearly three quarters of all deaths each year in Ireland.

National differences in death rates in different socio-economic groups have been documented in a number of studies.

In order to compare the death rates of different socio-economic groups, the death rate of the lowest socio-economic group was compared to the highest socio-economic group. This measure (known as the directly standardised mortality rate ratio, DSRR) shows that for the main causes of death, the death rate for working age males in the lowest socio-economic groups was disturbingly higher than the rate in the highest socio-economic groups.

- For circulatory diseases it was 312% higher.
  - For cancers it was 224% higher.
  - For injuries and poisonings it was 614% higher.
- (Inequalities in mortality, 1989-1998. A report on all-Ireland mortality data.)

## **Objective**

Reducing the gap in premature mortality between the lowest and highest socio-economic groups addresses a fundamental inequality in health.

## **Type of target**

This is a long term health status target.

## **Links to other government policies**

This target links to the stated commitment to equity in the National Health Strategy.

## **WHO target**

The target is linked to the WHO target 2 – equity in health which calls for a 25% reduction in the burden of ill health experienced by the poorest groups by the year 2020.

## **Implementation**

**The achievement of this target requires integrated action as identified by other NAPS targets. It is also supported by targets set out in the National Health Promotion Strategy and by the National Strategies to reduce cancers and cardiovascular disease.**

### *Indicator*

The underlying indicator is the ratio of the directly standardised mortality rate in the lowest socio-economic group to the rate in the highest socio-economic group. The rates are based on deaths amongst the 15-65 years age group.

Three ratios for circulatory disease, for cancers and for injuries and poisonings, are incorporated in this target.

### *Information requirements*

The poor quality of occupation data on death records in Ireland, particularly among people outside working years and among females severely limits our ability to set specific targets for older people and for women.

Immediate action is needed to improve the quality of occupational data in mortality collections.

### **Reviews and revision**

Further studies of occupational data and socio-economic group recording on death records are recommended.

Reassessment of targets should be undertaken when further work has been carried out.

**Target 2 The gap in life expectancy between the Travelling Community and the whole population should be reduced by at least 10% by 2007.**

**Target 3 The life expectancy and health status of Travellers, asylum seekers and refugees should be monitored so that targets can be set for asylum seekers and refugees and reviewed and revised for Travellers, by 2003.**

### **Rationale**

There is evidence that the life expectancy for the Traveller community is considerably less than that of the whole population.

Travellers and other marginalised groups particularly asylum seekers and refugees suffer much poorer health than that of the whole population.

### **Objective**

The objective is to improve the health and life expectancy of Travellers by reducing the gap in life expectancy between Travellers and the wider population.

Setting a target to monitor the life expectancy and health status of Travellers, asylum seekers and refugees aims to focus action on protecting and promoting the health of marginalised groups.

### **Type of target**

These targets combine long term health status targets with shorter term process targets.

### **Links**

The targets link with a number of government strategies including those related to social inclusion, and the emphasis on equity in the National Health Strategy.

### **Implementation**

**The adoption of the Travellers Health Strategy would lead to action aimed at reaching these targets. Other actions to support implementation are outlined in the full range of NAPS health targets.**

### *Indicator*

The underlying indicator is the difference in life expectancy at birth of the marginalised groups and the whole population. Indicators relating to health status will include qualitative and quantitative indicators.

### *Information requirements*

Specification of the target for the Travelling community should be assessed as soon as an estimated life expectancy target for the Travelling community has been updated.

Monitoring of the health status of the Travelling community and of refugees and asylum seekers should be undertaken by commissioned studies on health status. These would include quantitative and qualitative data and be undertaken with the involvement of marginalised groups.

Studies should be linked to the review process outlined in Chapter 17, and this would include revision of targets when required.

**Target 4** The gap in low birth weight rates between children from the lowest and highest socio-economic group should be reduced by 10% from the current level, by 2007.

#### **Rationale**

Low birth weight is strongly socially patterned. There is strong evidence that it is related to inter-generational experiences as well as maternal nutrition. Low birthweight especially if it is associated with later obesity increases the risk of death from diabetes, high blood pressure and heart disease.

The gap in low birth weight between different socio-economic groups is considerable. Analysis shows that the low birth weight rate in unskilled manual groups is nearly twice that of professional groups.

#### **Objective**

To improve the health of babies born to parents with low socio-economic status by reducing the gap in low birthweight rates between socio-economic groups.

#### **Type of target**

This is a long term health status target.

#### **Links**

The target links to many government strategies, such as the National Children's Strategy and the National Health Promotion Strategy, both of which recognise the crucial importance of reducing disadvantage for children.

#### **Implementation**

**Reducing the gap in low birthweight rates between different socio-economic groups depends on wide social, economic and environmental action as well as the provision of accessible public services. Action is required across the full range of NAPS health targets.**

#### *Indicator*

Low birthweight and estimates of low birthweight rates based on the Perinatal Reporting System.

### *Information requirements*

Lack of information prohibited the setting of more precise targets.

Action is needed to:

- Update the estimate of low birthweight rates in different socio-economic groups
- Improve the quality of occupational data on the Perinatal Reporting System
- Review the interpretation of occupational data on existing Perinatal Reporting System records
- Review and revise this target as soon as is possible

## **11. Equity of access to health and personal social services**

### **Introduction**

Access to health and personal social services has an important contribution to make to a reduction in inequalities in health. The equitable delivery of health and personal social care is therefore an integral part of a strategy to reduce differences in health status between those in the highest socio-economic group and those in the lowest and between those suffering social exclusion and the population as a whole.

The inverse care law formulated by Tudor Hart as far back as the 1970s states that those most in need of services are least likely to get them. This can be due to inequities in either access, utilisation or quality. Despite increases in the resources provided and the services available in recent years, there are still inequities in access to services and there is a strong public perception that these persist. A recent Institute of Public Health publication *Equity of Access to Health Services* outlines some of the relevant issues – see supporting document 3.

### **Barriers to equity of access**

Barriers to equity of access include the following:

- The cost of medical care – Medical Card income guidelines are now just above the social welfare rates for most groups. For those just above the guidelines, the cost of care, especially of primary care, can constitute a barrier to access particularly for families with children.

- Lack of a proactive approach to ensuring that all those who are entitled to a card and wish to have one, do have one. Lack of flexibility in the administrative system can make it difficult for people who are homeless or nomadic (i.e. Travellers) to have a medical card.
- Long waiting times in public acute hospitals for public patients in some specialties means that people who can't afford to go privately, do not have access as quickly as those who can afford private care. Long waiting times for outpatient clinics can constitute a disincentive to avail of care, especially for those with heavy work responsibilities and/or family/caring responsibilities.
- Inadequate provision and variation in provision of community support services including access to some therapies ( e.g. physiotherapy, speech therapy) and to respite care and other carer support services. There is also inadequate provision of mental health support services both in terms of early intervention and continuing care.
- Geographic distribution of services. Some areas, particularly disadvantaged areas, are not as well provided with GP services or pharmacies as others. Likewise there is regional variation in access to some treatments for heart disease and cancer.
- Lack of choice e.g. of female GPs, can mean that some people e.g. Traveller women, don't access gynaecological care.
- Lack of transport is a barrier to access both in rural and urban areas.
- Inadequate integration of service provision and insufficient multi-disciplinary working, particularly in primary health care and continuing care. The scattered location of services in urban areas exacerbates this situation (and also exacerbates transport difficulties for people seeking services).
- Lack of knowledge of rights, entitlements and services.
- Inadequate provision of appropriate, accessible health education and information.
- Inadequate provision of culturally appropriate services e.g. for Travellers, for refugees and asylum seekers and inadequate provision of services that accommodate the diversity of needs across the nine grounds of the equality legislation. Lack of awareness and insensitivity of some staff to the needs of vulnerable groups e.g. people with low literacy, different cultural values, disability, different sexual orientation.
- Lack of opportunity and resources to participate in needs assessment, planning, implementation, monitoring and evaluation of services so that these can be made more responsive.

The seven targets proposed in this chapter aim to address these barriers through a range of specific action areas, some directed at improving access to the existing

system and some aimed at development and reform. These targets are listed in the box below.

<b>Target 5</b>	<b>There should be increased equity of access to effective primary health care services by 2007.</b>
<b>Target 6</b>	<b>There should be increased equity of access to public acute hospital services by 2007.</b>
<b>Target 7</b>	<b>There should be equitable access to available effective interventions for cardiovascular disease and cancers by 2007.</b>
<b>Target 8</b>	<b>There should be increased equity of access to community supports for continuing care by 2007.</b>
<b>Target 9</b>	<b>A comprehensive injury prevention strategy to reduce higher injury rates in people at risk ( children, young men and older people in lower social economic groups) should be developed by 2003.</b>
<b>Target 10</b>	<b>The income threshold in the guidelines for the medical card should be increased with a view to removing impediments to access to health services and take particular account of the needs of children.</b>
<b>Target 11</b>	<b>An equality dimension should be integrated into the delivery and development of health and personal social services by 2007.</b>

#### **Relationship to other targets**

The equity of access targets and their associated action areas, will contribute to achieving the longer term health status targets.

### **Links to government policies, strategies and programmes and WHO targets**

These targets link to a number of key Government Policies, strategies and programmes for health and personal social services. The National Health Strategy "Quality and Fairness. A Health System for You" has equity and people centredness as two of its principles. The four goals of the new Health strategy are:

- better health for everyone
- fair access
- responsive and appropriate care
- high performance

Other strategic documents taken into account in developing these targets include: the Chief Executive Officers' (CEOs) Report on the Development of General Practice, the Review of Bed Capacity (due to go to Government in the near future), the Report of the Forum on Medical Manpower, the Report of the Cardiovascular Health Strategy (CHSG), the National Cancer Strategy, the National Health Promotion Strategy, The National Children's Strategy, Best Health for Children, Get Connected – Developing an Adolescent Friendly Health Service (2001), The Years Ahead – A Policy for Elderly, The National Health Strategy for Travellers, The National Strategy on Youth Homelessness, The Report of the Task Force on Suicide, The Report of the CEOs' Review Group on the Medical Card (currently underway under a separate PPF commitment), the National Development Plan and the White Paper on Supporting Voluntary Activity. In addition target 15 of WHO Health 21 for the European Region states that "By the year 2010, people in the Region should have much better access to family- and community-oriented primary health care, supported by a flexible and responsive hospital system".

### **Link to NAPincl**

Objective 1 of the NAPincl objectives as set down in Objectives in the Fight Against Poverty and Social Exclusion at Nice in December 2000 requires "*the facilitation of access for all to resources, rights, goods and services*" and more specifically 1.2 (c) requires "*putting in place policies which aim to provide access for all to healthcare appropriate to their situation including situations of dependency*". Other objectives relevant to targets in this section are Objective 2 "*To prevent the risks of exclusion*" particularly 2(b) "*to put in place policies which seek to prevent life crises which can lead to situations of social exclusion*", 2 (c) "*To help the most vulnerable*" and objective 4 "*to mobilise all relevant bodies*".

## Interpretation of terms

### *Equity*

The interpretation of equity of access to health care underlying this target is that of Whitehead adapted from WHO Health for All Targets 2000:

- Equal access to available care for equal need (in the Irish system this means equal access to public services for equal need)
- Equal utilisation for equal need (in practice this would mean monitoring of uptake and supportive action where uptake is noticeably unequal)
- Equal quality of care for all (in the Irish system this means in public facilities i.e. public and private patients in public hospitals)

### *Health and personal social services*

This refers to the health and personal social services within the remit of the Department of Health and Children. Health services include those directed at health promotion, disease prevention, treatment (including of chronic conditions) and rehabilitation. Personal social services refer to services such as social work, family support, childcare and protection, home helps, meals on wheels, day care services and aids and appliances.

**Target 5 There should be increased equity of access to effective primary health care services by 2007.**

### **Rationale for the target**

Effective primary health provides early intervention and continuity of care in the environment closest to people's homes. It also offers one of the best settings for opportunistic health education and health promotion. Within primary care GPs have a role in filtering appropriate demand to acute services.

Within primary health care people themselves, their families, friends and social networks are major providers of health and personal social care and should be supported in this role. To achieve this, services need to be centred on people's needs.

This requires consultation and a community development approach involving people and communities in assessing their health needs and in various stages of design, delivery, monitoring and evaluation of health and personal social services.

## **Interpretation of the target**

### *Equity*

Access should be based on need, not ability to pay nor geographic location.

### *Primary health care*

Primary health care means all the supports and health and personal social services required to promote health, prevent, diagnose and treat illness. It includes GP and public health nursing services at its core, and a range of other services – therapy services (e.g. physiotherapy, occupational, speech and language), psychology, counselling, nutrition, social work, community pharmacy, drug treatment services, community drugs workers, community welfare officers, health promotion officers and community development and family support workers. Primary health care also includes dental, aural and ophthalmic services. International evidence strongly suggests that team work among the above disciplines is the most effective way to deliver primary health care.

A distinction is sometimes made between primary health care as a community-based participatory approach and primary or medical care as a professional model. In the context of a partnership approach the term primary health care is being used here to denote an inclusive approach which encompasses both aspects and which the target aims to strengthen. It is recognised that community participation is a key requisite for the success of primary health care.

## **Implementation strategy**

**The implementation strategy for this target will focus on the following issues:**

- **Multidisciplinary working**
- **Better access for the public to diagnostic and treatment services through their GP**
- **Intensive family support projects**
- **Adolescent-friendly counselling services**
- **Services for young homeless people**
- **Strengthening community development in primary health care**

**Specific action areas around these issues and their associated indicators are set out below.**

*By 2003*

**Primary health care will be significantly strengthened through multidisciplinary working and local case management (i.e. where an identified member of staff assists in the co-ordination of services for a patient).**

*Indicators*

Levels of multidisciplinary working at primary care level

Case management introduced by individual health boards

**Better access will be provided for patients to diagnostic and treatment services through their GP by increasing the services carried out universally in general practice e.g. minor surgery, shared care for chronic illness with specialised units and by giving direct access for GPs to hospital diagnostic and treatment services e.g. CAT scans, MRIs, ultrasound, gastroscopy, colonoscopy, physiotherapy.**

*Indicators*

Number of GP practices providing additional procedures and services e.g. minor surgery, shared care etc.

Guidelines agreed nationally by GPs and hospital managers for direct access to diagnostic and therapy services.

Number of GP practices having direct effective access to hospital based diagnostic and therapy services e.g. CAT scans, MRIs, ultrasound, gastroscopy, colonoscopy, physiotherapy.

*Information requirements*

Data on the number of GP practices providing additional procedures and services at community level.

Data on the number of GP practices having direct access to hospital diagnostic and therapy services such as CAT scans, MRIs, ultrasound, gastroscopy, colonoscopy and physiotherapy.

**Health boards will undertake an assessment of the need for supports for adolescents with mental health problems in primary care settings in line with the recommendation to this effect in the report *Get Connected – Developing an Adolescent Friendly Health Service* by the National Conjoint Child Health Committee.**

*Indicator*

Availability of Health Board reports on assessment of need for support for adolescents with mental health problems in Primary Care settings.

*Information requirement*

Assessment of need for support for adolescents with mental health problems in Primary Care settings.

*By 2005*

**Springboard or equivalent intensive family support project targeted at young people at risk will be established in 12 additional areas following agreement with key stakeholders in the community.** Early intervention preventative services to support children, young people and their families have the potential to improve the well being of children and their families, promote children's safety and development and reduce anti-social behaviour. This is achieved by improving competence in parents and children and connecting them to appropriate social supports and resources in their community. Springboard is one model of this type of project in use in Ireland with 17 such projects currently underway. Evaluation of the Springboard project has shown that, as a model of service delivery, it is meeting a recognised need to support vulnerable families. The projects have improved personal and family life, are well located within communities to meet that need and are working well in partnership with other agencies. As with all existing Springboard projects, the health boards will have the lead role in setting up new projects. They will be responsible for putting in place integrated structures at community level, where they do not already exist, to progress the implementation of the action.

*Indicator*

Availability of intensive family support projects targeted at young people at risk and their families in each community care area, focusing as a priority on the locations under the RAPID initiative where such support is not currently provided.

### *Information requirements*

The Child Care Management Information Consultancy\* will report on options to improve management information on services including family support services at local level which would facilitate the evaluation of the effectiveness of services at regional and national level. This report will be available at the end of 2001.

Audit of existing family support services, assessment of future need and determination of a framework for measuring outcomes is required.

Evaluation of family support services including impacts on children, impacts on parents, impacts on service delivery ( the perspective of parents and children and of agencies and professionals).

**The incidence of youth homelessness will be reduced significantly, through increasing family and community based supports to prevent homelessness and providing appropriate emergency response so as to prevent young people staying homeless and to facilitate their reintegration into the community.**

### *Indicators*

Numbers of young people becoming homeless, as monitored by new information systems of the Health Boards.

Numbers of young people staying homeless as monitored by above.

Extent of family and community support for young people and their families to prevent them becoming homeless.

**A community development approach will be integrated into health and personal social services, with a focus on primary health care. The approach will use existing networks and create new alliances to encourage participation in needs assessment, planning, implementation, monitoring and evaluation.**

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\* The quality and availability of information in relation to child care services is currently unsatisfactory. A Steering Group was set up by the Department of Health and Children and the health board CEOs to undertake a major review of child care information systems and to define management information requirements in this area. Child Care Information Management Consultancy refers to the consultants who have been retained to assist the Steering Group in its task.

### *Indicators*

Models of good practice around community and user participation in needs assessment in pre-primary and primary care.

Resourced participation of excluded groups and marginalised people in identifying needs. Community representatives involved in negotiating local service agreements with health boards in relation to primary health care.

Community development workers appointed in the community, including in rural areas.

A community development and health network established and resourced to build capacity in the community and voluntary sector.

### *Information requirements*

Audit by 2003 of current situation in relation to community development approach in primary health care with specific focus on the areas outlined in the indicators. Follow up audit in 2006/7.

### **Link to NAPincl**

The target to increase equity of access to primary health care and the associated implementation strategy links closely to the NAPincl objectives. All aspects link to 1.2 (c) *"To put in place policies which aim to provide access for all to healthcare appropriate to their situation including situations of dependency"*. Actions in relation to intensive family support projects and to assessment of need for support in primary care settings for adolescents with mental health problems link to Objective 2(b) *"to put in place policies which seek to prevent life crises which can lead to situations of social exclusion"*. Proposed actions in relation to services for young homeless people link in particular to Objective 2 *"To prevent the risks of exclusion"* and to Objective 3 *"to help the most vulnerable"*. Proposed actions in relation to integrating a community development approach link closely to Objective 4 *"to mobilise all relevant bodies"* in particular 4(a) *"to promote the participation and self expression of people suffering exclusion, in particular in regard to their situations and the policies and measures affecting them"* and 4(c) *"to promote dialogue and partnership between all relevant bodies, public and private"*

**Target 6 There should be increased equity of access to public acute hospital services by 2007.**

**Rationale for the target**

In public acute hospitals, in March 2001, 9,872 adults were waiting 12 months and over in the specialities targeted in the Waiting List Initiative. There were 1,892 children waiting 6 months or over in the targeted specialties. In all, 26,382 people (adults and children) were waiting more than 3 months for acute hospital care – a 23% decrease on the comparable figure for 2000. The numbers on waiting lists constitute just over 3% of acute hospital activity as measured by annual discharges. The fact that people who opt to be treated as private patients have faster access within the public hospital system is widely perceived as inequitable.

In 1986, the total number of beds in the general hospital system was about 14,500 and catered for a population of 3.5 million. Between 1987 and 1989 the number of beds fell proportionally more than in any other OECD country. In 1990 the figure stabilised at 12,000. Since then the overall productivity of the system has increased by between 2-3% each year, with the highest growth being seen in day work. The number of in-patients and day patients treated on an annual basis in public hospitals was 34% higher (over 221,000 additional patients) in 2000 than in 1990. Looking at recent years, the number of in-patients and day patients treated in public hospitals rose by 10%, or over 80,000 from 1997 to 2000. However, there has only been a marginal increase of about 300 since 1990 in overall bed numbers, in a context where the population is projected to increase to 4.25 million by 2011. Bed occupancy levels in many major hospitals are very high by international standards, running close to 100%. About 10% of available bed days are lost due to delayed discharge and 75% of lost bed days are attributable to patients aged 65 years and over. The inadequate capacity in the system is acknowledged at Ministerial and Official level and is being addressed in the context of the National Development Plan and the Review of Bed Capacity.

### **Implementation strategy**

The implementation strategy will focus on reducing differences in waiting times between public and private patients for elective work in public acute hospitals. This will be achieved through measures to reduce demand such as improving access to primary care, and measures to improve supply such as increased bed numbers, more out-of hours service delivery by senior clinical decision makers and reduced incentives for use of public beds by private patients.

The more specific action areas around these issues and their associated indicators are set out below.

#### *By 2003*

**The difference between public and private patients in waiting times for public acute hospital care will be reduced with a focus on: increasing bed numbers in line with relevant measures in the National Development Plan and the recommendations of the Bed Capacity Review; more service delivery by senior clinical decision makers in line with the recommendations of the Report of the Forum on Medical Manpower; and reducing incentives for use of public beds by private patients.**

#### *Indicators*

Number of a) adults b) children waiting over three, six and twelve months for acute hospital inpatient care disaggregated by relevant NAPS groups.

Average waiting time and % waiting given lengths of time in A& E Departments.

Average waiting times and % waiting given lengths of time for outpatient appointments for particular specialties disaggregated by relevant NAPS groups.

#### *Information requirements*

Statistics on waiting times for acute hospital inpatient care for a) adults b) children disaggregated by relevant NAPS groups.

Statistics on waiting time in A& E Departments.

Statistics on waiting times between referral and outpatient appointments for particular specialties disaggregated by relevant NAPS groups and on waiting times in outpatient departments.

*Further indicators*

Number of beds in the public acute hospital system.

Number of step down beds.

Access to senior clinical decision makers in out-patient departments of public acute hospitals and in A & E departments.

*Information requirements*

Statistics on bed numbers in acute hospitals and on step down beds.

Audit of situation in relation to availability of senior clinical decision makers in out-patient departments and in Accident and Emergency departments – current position and follow-up in 2003.

**Access to orthopaedic services will be improved so that no one is waiting longer than 12 months for a hip replacement. This is an initial short term action to improve quality of life for older people and it will be reviewed in 2003.**

*Indicator*

Number of adults waiting longer than twelve months for hip replacements

*Information requirements*

Statistics on number of adults waiting longer than twelve months for hip replacements, ideally with disaggregation by gender, socio-economic group and ethnic status.

*By 2005*

**The difference between public and private patients in waiting times for acute hospital inpatient care will be further reduced from the position achieved in 2003. Indicator and information requirement as under 2003.**

**Link to NAPincl**

The target to increase equity of access to public acute hospital services and the associated implementation strategy links closely to the NAPincl objectives in particular to 1.2 (c) "*To put in place policies which aim to provide access for all to healthcare appropriate to their situation including situations of dependency.*"

**Target 7 There should be equitable access to available effective interventions for cardiovascular disease and cancers by 2007.**

### **Rationale**

Cardiovascular disease and cancer are two major causes of premature mortality and of morbidity. Rates are considerably higher among lower socio-economic groups compared to higher socio-economic groups. The Report of the Cardiovascular Health Strategy Group found regional variation in access to certain procedures such as angioplasty and coronary artery bypass graft. Lifestyle associated risk factors are also higher in lower socio-economic groups. In relation to cancer, a recent Report of the Variations in Cancer Treatment and Referral Practices in Ireland highlights some inequities in access to cancer treatment services for the years 1994-1997.

### **Implementation strategy**

The strategy will focus on ensuring equity of access for poor and excluded people in the implementation of the national strategies in relation to cardiovascular disease and cancer, including improving regional access to services. In relation to the higher levels of lifestyle related risk factors in lower socio-economic groups, priority will be given to identifying the social and economic barriers which effectively deter and dissuade such individuals from adopting a healthier way of life. Specific actions and their associated indicators are outlined below.

**Particular attention will be paid to the needs of people who are poor or socially excluded in the implementation of the Cardiovascular Health Strategy. This will be pursued in consultation with the groups responsible for the implementation of the Cardiovascular Health Strategy and the management committees for the relevant programmes.**

### *Indicators*

Differences in the risk factors for cardiovascular disease between the lowest and the highest socio-economic groups (the percentage of adults and children smoking, consuming alcohol above the recommended limits, eating a low fat diet, engaging in recommended levels of physical activity, and being screened for risk factors and having blood pressure and weight within recommended levels). Indicators will be disaggregated by age and gender and where evidence suggests, by relevant NAPS groups e.g. ethnicity.

Participation of patients (disaggregated by relevant NAPS groups) with identified heart disease in a structured programme of secondary prevention in general practice.

Uptake of B-blockers and aspirin and appropriate use of anti-hypertensive and cholesterol lowering medications following myocardial infarct by age, gender and by GMS status or possibly by socio-economic group/ other vulnerable group (where indicated).

#### *Information requirements*

The percentage of adults and children smoking, consuming alcohol above the recommended limits, eating a low fat diet, engaging in recommended levels of physical activity, and in relation to adults, being screened for risk factors and having blood pressure and weight within recommended levels. Indicator to be disaggregated by age and gender and where evidence suggests, by relevant NAPS groups e.g. ethnicity.

The overall research programme for the implementation of the Cardiovascular Health Strategy should include reference to equity.

**In line with the Chief Executive Officers' Report on Developing General Medical Practice, work will take place at general practice level to improve the care of patients with cancer at all stages. This will include the development of protocols for urgent referral to hospital diagnostic and therapeutic services by 2003 and guidelines for shared continuing care between hospitals and general practice and for improved palliative care at general practice level by 2005.**

#### *Indicators*

Protocols in place by 2003 for urgent referral of patients with cancer to hospital diagnostic and therapeutic services.

Guidelines in place by 2005 for shared continuing care, including palliative care, (between hospitals and general practice) of patients with cancer.

**Regional access (as measured by age standardised discharge rates by health board of residence) for procedures such as angioplasty and coronary artery bypass graft will be improved in line with the basic levels of service recommended in the Report of the Cardiovascular Health Strategy Group.**

*Indicators*

Age standardised discharge rates for angioplasty and coronary artery bypass grafts (CABGs) by health board of residence.

*Information requirements*

Hospital In-Patient Enquiry data with disaggregation by relevant socially excluded groups e.g. ethnic groups and by socio-economic status. (A Working Group to include new fields on HIPE has just been established by the Department of Health and Children).

**Access to services for cardiovascular disease will also be monitored by the following indicator on improved access to prehospital emergency care for cardiovascular disease.**

*Indicator*

Availability of Pre-hospital Emergency Care (taking on board experience from the current NWHB model) for populations at a distance from acute hospitals in relevant health boards.

*Information requirements*

Audit on pre-hospital emergency care provision for populations at a distance from acute hospitals.

**Regional access for women to breast cancer treatment services will be improved by expediting the implementation of recommendations of the Report on Symptomatic Breast Cancer Services.**

*Indicator*

Percentage of women receiving appropriate treatment for breast cancer disaggregated by health board of residence, age, GMS, public/private status and ethnicity.

*Information requirements*

Treatments received for breast cancer disaggregated by health board of residence, age, GMS status, public/private status and ethnicity – baseline data for 2001 with follow up in 2006/2007. This information is available through analysis of National Cancer Registry data.

### **Link to NAPincl**

The target to have equitable access to available effective interventions for cardiovascular disease and cancer and the associated implementation strategy links closely to the NAPincl objectives particularly to 1.2 (c) "*To put in place policies which aim to provide access for all to healthcare appropriate to their situation including situations of dependency*".

**Target 8 There should be increased equity of access to community supports for continuing care by 2007.**

### **Rationale**

There are a number of services for which no eligibility criteria, or rules governing charges, are set down in legislation, in many cases because these services have developed since the last major overhaul of the Health Act in 1970. These include services which now play a very important role in providing appropriate care in the community to people who might otherwise need residential care. There are considerable differences from area to area in community services, for example, community paramedical services, home helps, meals on wheels and day care centres, and in who is entitled to them and what charges, if any, can be made.

### **Implementation strategy**

The implementation strategy for this target will focus on improving access for groups such as older people and people with disabilities to the supports needed by themselves, their families and carers to enable them to be cared for in the community. It will also focus on improving access for children and young people with mental health needs to consultant-led multidisciplinary care.

*By 2003*

**National guidelines will be put in place for the provision of respite care services to carers of older people.**

### *Indicators*

National guidelines in place for the provision of respite care to carers of older people.  
Percentage of carers of older people in receipt of a respite care service.

*Information requirements*

Audit of access of carers of older people to planned respite care in 2003 with follow up in 2006/ 2007.

**Improvements will be made in access to planned respite care for carers of disabled people.**

*Indicator*

Percentage of carers of disabled people who have access to planned respite care.

*Information requirements*

Audit of access of carers of disabled people to planned respite care.

*By 2005*

**There will be nationally standardised rules for eligibility for community support services.**

*Indicator*

Standardised rules for eligibility for community support services in place.

**With a view to providing timely access for vulnerable groups to child and adolescent psychiatric services, the recommendations of the Report of the Working Group on Child and Adolescent Services 2001 in relation to the provision of consultant-led multidisciplinary teams will be expedited.**

*Indicator*

Waiting time for appointment with consultant-led multidisciplinary child and adolescent psychiatric teams.

*Information requirements*

Statistics on waiting times for appointments with consultant-led multidisciplinary child and adolescent psychiatric teams disaggregated by appropriate NAPS groups.

**Links to NAPincl**

This target links closely to Objective 1.2 (c) "to put in place policies which aim to provide access for all to healthcare appropriate to their situation including situations of

dependency" and also to Objective 2 "To prevent the risks of exclusion" particularly 2(b) "to put in place policies which seek to prevent life crises which can lead to situations of social exclusion" and to 2 (c) "To help the most vulnerable".

**Target 9 A comprehensive injury prevention strategy to reduce higher injury rates in people at risk (children, young men and older people in lower social economic groups) should be developed by 2003.**

#### **Rationale**

Standardised deaths rates from injuries and poisonings are very much higher in lower socio-economic groups compared to higher groups. The relationship is particularly true of childhood injury. Hospital admission rates for unintended injury (mainly falls) are particularly high for older women. The many and varied factors which can lead to injuries mean that this issue can only be addressed effectively in a multi-sectoral way. The fact that many government departments have a role in injury prevention has contributed to the fact that the development of a comprehensive injury prevention strategy has, up to now, fallen between stools. This is a clear example of the need for the type of "joined up" working being proposed in the public policy target.

#### *Indicator*

National Injury Prevention Strategy in place.

#### *Information requirements*

Data collection based on the framework adopted by the International Collaborative Effort on Injury Statistics 1998 with disaggregation by ethnic and other relevant excluded groups as well as by socio-economic status.

#### **Links to NAPincl**

This target links closely to Objective 2(b) "to put in place policies which seek to prevent life crises which can lead to situations of social exclusion" and to 2 (c) "To help the most vulnerable".

**Target 10 The income threshold in the guidelines for the medical card should be increased with a view to removing impediments to access to health services and taking particular account of the needs of children.**

## **Rationale**

Access without charge to primary care services is, generally speaking, limited to medical card holders. (The card also gives access without charge to hospital services.) It can be argued that if the emphasis of a health care system is on prevention and on treatment of people at the earliest stages of illness, then there should be no financial disincentive to appropriate uptake of primary care. Compared with other OECD countries Ireland is distinctive in providing universal access to public acute hospital services, subject only to modest statutory charges, while currently less than one third of the population (31%) have access without charge to primary care and other publicly funded services. Even for this latter group, services such as cervical screening and mental health support services such as counselling are not provided without charge. The income guidelines for the medical card are increased annually in line with the consumer price index. However the current income guidelines are just above social welfare rates. The cost involved in use of services for those without a card, particularly for those just above the income guidelines and those with large families, is seen as being a deterrent to use of services for groups who may need them most. In submissions received in the course of the NAPS/ health consultation, particular concern was expressed for the position of children in this regard. This concern is also highlighted in the report *Best Health for Children*.

## **Implementation strategy**

- Implementation will focus on more proactive approaches to ensuring uptake of the medical card by those entitled to one including addressing the particular problem of groups such as Travellers and refugees and asylum seekers.
- Increasing the income threshold in the guidelines for the medical card with a view to removing impediments to access to health services and taking particular account of the needs of children.
- Increasing the range of services covered on the medical card, in particular cervical screening and counselling.

*By 2003*

**The income threshold in the guidelines for the medical card will be increased with a view to removing impediments to access to health services and taking account of the particular needs of children.**

*Indicator*

Indicators will set in the context of the Report of CEOs' Review of the Medical Card and of the National Health Strategy.

**Health boards will have a more proactive approach to ensuring uptake of the medical card by those entitled to one, including addressing the particular needs of specific groups such as Travellers, refugees and asylum seekers.**

*Indicator*

Level of uptake of medical cards among those entitled to one.

*Information requirements*

Audit by 2003 of extent to which some people who are eligible for a medical card do not have one. A follow up audit will be required in 2005/2006.

*By 2005*

**Access to an increased range of services will be provided under the General Medical Services Scheme, in particular to cervical screening and counselling.**

*Indicator*

Availability of services such as cervical screening and counselling under the GMS.

*Information requirements*

Audit of situation regarding access to cervical screening and counselling services.

**Links to NAPincl**

This target links closely to Objective 1.2 (c) "to put in place policies which aim to provide access for all to healthcare appropriate to their situation including situations of dependency" and also to Objective 2 "To prevent the risks of exclusion" particularly to 2 (c) "To help the most vulnerable".

<p><b>Target 11 An equality dimension should be integrated into the health and personal social services by 2007.</b></p>
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**Rationale**

The Irish NAPincl has identified as one of its key challenges "enhancing the equality dimension in public policies and services, with particular reference to women, people

with disabilities and refugees and asylum seekers". The links between poverty, exclusion and inequality are now better understood and groups that are likely to experience discrimination are also those that are likely to experience poverty and exclusion. People often contact the health services when they are at their most vulnerable, and it is important that their difficulties are not compounded by discriminatory policies or treatment in that service. It is also important that services are delivered in a manner which not only responds to the particular needs of some groups but are also provided in a way that reflects the diversity within society. In the context of a multi-cultural society there is a particular need for the development of anti-racist policies and codes of practice. For these reasons integrating an equality dimension into the health and personal social services should strengthen and reinforce the equity of access objectives underpinning the earlier targets in this chapter.

Integrating an equality dimension into the health and personal social services has two main aspects — equality proofing and equality policies in service delivery.

Equality proofing of policy and provision in the health sector will assist:

- A preventative approach that ensures new inequalities do not emerge across the nine ground equality agenda
- Enhanced access and outcomes for groups experiencing inequality
- The accommodation of diversity across the nine grounds
- The establishment and realisation of equality objectives

### **Implementation strategy**

Equality proofing will focus on all of the nine grounds established in equality legislation. It will involve a screening mechanism to identify those areas of policy and provision in the health and personal social services that are a priority for equality proofing. Equality proofing will involve the four steps of:

- Establishing equality objectives and/or equality dimensions to mainstream objectives
- Implementing an equality impact assessment on policy or provision to assess its contribution to equality objectives and its impact on the nine grounds (see page 69 for list of nine grounds)
- Securing a participation of equality interests in carrying out this impact assessment
- Monitoring to track the actual contribution and impact of the policy or provision

*Indicators in relation to equality proofing*

The number of policies or measures with a stated equality objective.

The number of equality impact assessments carried out.

The number of consultations carried out under the nine grounds in relation to equality impact assessments.

*Information requirements in relation to equality proofing*

Equality proofing will require data gathering across the nine grounds of the Equal Status Act. It will require a template for equality impact assessments. The Equality Authority is committed to the production of such templates designed for specific policy/provision areas.

The implementation strategy for equality proofing will follow a timetable to be discussed with the Equality Authority which has a national brief on this issue.

**Other specific actions in relation to integrating an equality dimension.**

*By 2003*

**Awareness and sensitivity training will be provided for health care staff in relation to NAPS groups and groups covered under the nine grounds under the Equal Status Act.**

As a first step an audit to a standardised template will be carried out in 2002 to ascertain the type and extent of such provision to date. This will be followed in 2003 by the development of appropriate training modules in conjunction with representatives of relevant groups. The training will cover issues across the nine grounds of the Equal Status legislation, economic disadvantage, the relationship between social factors and health status. In the context of a multicultural society there will be particular attention to issues of ethnicity and racism. Baseline research, which will include qualitative methods, will be carried out to ascertain the degree of satisfaction of relevant groups with the awareness and sensitivity of staff.

**Information and education materials will be provided that are culturally appropriate. They will be provided in a manner that accommodates diversity in society. In the context of a multicultural society there will be particular attention to issues of ethnicity and racism. An audit will be carried out of existing information and education materials on health and health services to assess their appropriateness and to prioritise gaps. New materials will be developed and disseminated in consultation with representatives of relevant groups and the National Adult Literacy Association (NALA).**

*Indicator*

Availability of culturally appropriate information and education materials for NAPS target groups and other groups covered under the nine grounds under the Equal Status Act.

*Information requirements*

An audit by 2003 of existing materials to assess their appropriateness and prioritise gaps

Follow up audit in 2005/6.

**Agreed equal status policies and codes of practice in relation to the nine grounds covered under the Equal Status legislation will be developed in conjunction with the relevant vulnerable groups and statutory and voluntary agencies. Considerations under the gender ground will include issues such as domestic violence and rape. These will link to, and build on, work already underway e.g. in A& E departments in relation to victims of domestic violence. In the context of a multicultural society there will be particular attention paid to issues of ethnicity and racism including the need for trained interpreters who have an understanding of cultural difference. Account will be taken of experience elsewhere that the most effective interpreters are recruited from the minority ethnic community itself.**

*Indicator*

Extent to which agreed equal status policies and codes of practice are in place in the health and personal social services.

*Information requirements*

Audit of current situation in relation to protocols, procedures and codes of practice on anti-racism, equality policies, domestic violence and rape to be completed by 2003.

Follow-up audit in 2005/6.

*By 2005*

**A phased programme of undergraduate and in service awareness and sensitivity training in relation to NAPS groups and groups covered under nine grounds of the Equal Status Act will be undertaken during the period 2003 to 2007. Health Board Service Plans will include information on training planned and delivered.**

### *Indicators*

Percentage of staff and relevant undergraduates who have undergone awareness and sensitivity training for health care providers in relation to NAPS groups and other groups covered under the nine grounds under the Equal Status Act.

Degree of satisfaction of relevant NAPS groups with treatment by staff.

### *Information requirements*

Audit of existing situation and ongoing reporting system from health boards /agencies and third level institutions on progress in provision of awareness and sensitivity training in relation to NAPS groups /groups covered under the nine grounds of the Equal Status legislation.

Baseline survey and relevant qualitative research on patient satisfaction with treatment by staff in 2003 with a follow-up in 2006/7. Disaggregation by relevant NAPS groups/ groups covered under nine grounds of equal status legislation.

## **12. Public policy target**

**Target 12 It should be government policy that all relevant sectors recognise and accept their responsibility for health by developing multi-sectoral working and the adoption of Health Impact Assessment by 2007.**

### **Rationale**

A wide range of factors influence health. Targets designed to address the poverty/health interface need to impact on these wider determinants of health and specifically on inequalities in health. It is important to establish mechanisms for multi-sectoral working for health and the management of health as a cross cutting issue. In view of the strong relationship between poverty, social exclusion and health, it is important to explore the potential for assessing policies not only for their impact on poverty, as the current poverty proofing requires, but also on health. Such work can be done through Health Impact Assessment. It is also necessary to consider the current gaps in provision of public policies which impact positively on health.

Two ways of addressing the determinants of health and developing healthier public policies are incorporated into this target:

- 1 Multi-sectoral working for health
- 2 Health Impact Assessment

### **Objective**

The achievement of this target will lead to the establishment of multi-sectoral working for health and healthier public policies, which in turn aim to result in improved health status and reductions in inequalities in health.

### **Type of target**

This is a long-term process target, with some short and medium term actions and indicators as outlined in the implementation strategy.

### **Links to government policies, strategies and programmes**

The indicators and actions contained within this target are directly relevant to the National Health Strategy "Quality and Fairness – A Health System for You". Multi-sectoral collaboration is highlighted within the Health Promotion Strategy and the need for information on the wider determinants of health, including information from different sectors, is being promoted through the National Health Information Strategy.

The successful implementation of this target will impact on a wide range of public policies and programmes.

### **WHO targets**

The target is closely linked to WHO Health 21 Target 14 – Multi-sectoral responsibility for health:

"By 2020, all sectors should have recognised and accepted their responsibility for health."

- 14.1 Decision makers in all sectors should take into consideration the benefits gained from investing for health in their particular sectors and orient actions accordingly.
- 14.2 Member States should have established mechanisms for health impact assessment and ensured that all sectors become accountable for the effects of their policies and actions on health".

### **NAPincl objectives**

Each of the four NAPincl objectives is relevant to this target. Objective one details the importance of facilitating employment and access to an adequate income, housing/accommodation, health care and education. Objective two outlines the importance of preventing risks of exclusion. Both of these are relevant to the objective of addressing the determinants of health. Objective three is to help the most vulnerable and is relevant to this target due to its concern with children and targeting the most excluded. Objective four, to mobilise all relevant bodies, is particularly relevant to efforts to develop multi-sectoral work, to involve the most excluded in decisions making and to mainstream the fight against exclusion.

### *Poverty proofing*

The NAPS led to the development of poverty proofing and its implementation on a pilot basis in government departments. The Partnership for Prosperity and Fairness (PPF), 2000, committed to extending poverty proofing nationally and in a phased manner regionally to the Health Boards and Local Authorities. The Working Group endorses the commitment to the full implementation of poverty proofing at national level and its extension regionally and views this development as a critical component to addressing the determinants of health for people living in poverty. Given the role of HIA, it may be necessary to consider if and how poverty proofing and HIA are compatible and where they fit with equality proofing, which was also a commitment in the PPF. The Working Group also recommends that existing and forthcoming health policies are poverty proofed.

### **Interpretation of terms**

*Multi-sectoral working* is a term used to describe working across a range of sectors and disciplines.

*Health Impact Assessment* is an approach by which a policy, programme or project can be judged for its impact on health. As HIA is a tool for addressing inequalities in health, achieving equity is a core component of HIA.

*Cross cutting issues* is the term used to describe policy issues which cut across departments, sectors and disciplines at varying levels and require co-ordination if they are to be addressed in a coherent manner, e.g. children, crime, drugs.

*Relevant sectors* refers to all sectors whose role impacts upon health. These include all those outlined in section 6.1. It also refers to statutory, non-statutory, community, voluntary, public and private sectors.

### **Implementation strategies**

The following actions are recommended by the Working Group as an implementation strategy for addressing the determinants, through multi-sectoral working and the adoption of Health Impact Assessment. The implementation strategy outlines a series of actions and milestones by which progress can be monitored. The indicators outlined for this target are process indicators which reflect progress towards the achievement of this target.

**There are two areas for action in this target**  
**A) Multi-sectoral working for health**  
**B) Health Impact Assessment**

*A: Multi-sectoral working for health*

*By 2003*

**The Department of Health and Children lead awareness raising amongst policy makers, managers and decision makers across all relevant sectors and disciplines on the broader determinants of health and how broader public policies impact upon health.**

**The Department of the Taoiseach and the Department of Health and Children lead cross departmental collaboration for health within and between government departments.**

*Indicator*

Level of collaboration for health within and between government departments.

*Information requirements*

Level of cross departmental collaboration for health within and between government departments.

**Existing networks and structures are utilised, where possible and appropriate, for developing multi-sectoral work for health at national, regional and local level.**

**The regional Health Boards and City and County Development Boards provide leadership, co-ordination and facilitation for multi-sectoral work for health at**

**regional and local level in close collaboration with the community and voluntary sector and other relevant sectors.**

*Indicator*

Level of engagement of key stakeholders in multi-sectoral working for health.

*Information requirements*

Assessment of extent and range of multi-sectoral working for health.

**Establishment of a community development and health network in Ireland in conjunction with the community and voluntary sector to facilitate community participation and community development in multi-sectoral work for health, utilising and building on existing structures where appropriate.**

*Indicator*

A community development and health network established.

This is also a recommendation for action in the equity of access target.

**Establishment of an independent Public Health Alliance to bring together all those working for public health from all sectors to advocate for the reduction of health inequalities.**

*Indicator*

A Public Health Alliance established.

**Benchmark the quality of the structures and processes adopted for multi-sectoral work using international benchmarks e.g. Verona Benchmark, WHO.**

([www.who.dk/verona/bench.htm](http://www.who.dk/verona/bench.htm))

*Indicator*

Standard of the structures and processes adopted for multi-sectoral work for health.

*Information requirements*

Assessment of standards of the structures and processes adopted for multi-sectoral work for health.

**Establish a research programme on the determinants of health and the effectiveness of interventions to improve health through the determinants of health.**

*Indicators*

Establishment of research programme on determinants of health.

**Develop mechanisms for engaging citizens and communities in multi-sectoral working for health, utilising existing structures, processes and projects.**

*Indicators*

Level of involvement of citizens and communities in multi-sectoral working for health.

*Information requirements*

Audit current mechanisms for engaging citizens and communities in multi-sectoral working for health.

*By 2005*

**Mainstream capacity building programmes on multi-sectoral work for health, where possible within existing training programmes across relevant professions.**

*Indicator*

Integration of multi-sectoral work for health in training programmes in relevant sectors.

*Information requirements*

Review of training programmes.

**Resources are allocated for cross cutting and multi-sectoral work.**

*Indicator*

Amount of money allocated across departments and sectors to enable multi-sectoral working for health.

**Ongoing development of a community development and health network in Ireland in conjunction with the community and voluntary sector.**

*Indicators*

Numbers involved in a community development and health network  
Impact of participation in community development and health network for members organisations.

## **Ongoing development of a Public Health Alliance.**

### *Indicators*

Numbers involved in Public Health Alliance.

Impact of participation in Public Health Alliance for member organisations.

### *By 2007*

**All relevant sectors will recognise and accept their responsibility for health by demonstrating their capacity for and action in multi-sectoral collaboration for investment in health through addressing the determinants of health.**

### *Indicators*

Level of awareness of the social determinants of health among key stakeholders and leaders across the range of relevant sectors.

Extent of multi-sectoral collaboration for health.

Quality of multi-sectoral collaboration for investment in health.

### *Information requirements*

Survey of level of awareness of the social determinants of health among key stakeholders and leaders across the range of relevant sectors.

Assessment of amount and quality of multi-sectoral collaboration for health.

## *B: Health Impact Assessment (HIA)*

### *By 2003*

**Establishment of a steering group to drive HIA development in Ireland.**

**Map health relevant policies and policy development cycles.**

**Begin to identify sources of accessible, routinely collected health information**

**Initiate a central bank of HIAs.**

**Develop and run a programme of prospective and retrospective, rapid and comprehensive pilot HIAs.**

*Indicators*

Numbers of HIAs being carried out.  
Changes in policies as a result of HIA.

*Information requirements*

Audit HIAs as they are carried out.  
Develop mechanisms for assessing impact of HIA on policies.

**Review and assessment of where and how HIA fits with other proofing mechanisms such as poverty proofing and equality proofing.**

*Indicators*

Level of intergration of HIA with other proofing mechanisms.

**Review and adapt international HIA tools for application in Ireland.**

*Indicators*

Development and utilisation of HIA tool for Ireland.

*By 2005*

**Establish a national HIA function to co-ordinate HIA, to undertake the following tasks:**

- **Identify policies, programmes or projects for HIA**
- **Provide assistance to those conducting HIA**
- **Review the quality and learning from HIAs**
- **Act as a central 'bank' of HIAs**
- **Co-ordinate capacity building programmes**
- **Administer funding for HIAs**
- **Lead cross-departmental audits of government departments re their inclusion of health in policy development**
- **Co-ordinate a research programme on the development of HIA in Ireland**

*Indicators*

Numbers of HIAs.  
Progress on achieving the above actions.  
Changes in policies as a result of HIA.

*Information requirements*

Audit HIAs as they are carried out.

**Identify funding for HIAs based on the programme of HIA pilots.**

*Indicator*

Funding mechanism established.

**Establish and develop local, national and international networks of HIA practitioners.**

*Indicators*

The existence of a network of HIA practitioners.

Linkages with and contribution to other international networks.

*Information requirements*

Numbers and level of involvement in HIA network.

Assessment of linkages with and contribution to other international networks.

**Mainstream capacity building programmes on HIA where possible within existing training programmes across relevant professions.**

*Indicator*

Integration of HIA in training programmes in relevant sectors.

*Information requirements*

Review of training programmes.

*By 2007*

**Establish administrative systems within and between government departments and agencies to flag policies, programmes and projects suitable for HIA.**

**Conduct a review of HIA development process to include consideration of the agency establishing a legal mandate for the inclusion of HIA into national and local governmental policy development processes.**

### *Indicators*

Extent of development of administrative systems within and between government departments and agencies to identify and carry out HIA on appropriate policies, programmes and projects.

Extent of change in policy development as a result of HIAs.

### *Information requirements*

Assessment of administrative systems within and between government departments and agencies on capacity to carry out HIA.

Assessment of impact of HIAs on developing healthier public policies.

Health Impact Assessment will give rise to new information requirements across the broad range of health determinants outlined above.

### *Possible HIAs:*

The following policies and programmes have been suggested as possible areas for piloting HIA:

- a) RAPID Programme – Advantage of using RAPID would be that it is an existing programme not primarily focused on health but with the potential for significant health gain. HIA would not constitute an evaluation of RAPID, but would assess specifically the extent to which opportunities for enhancing health gain were realised, the project's impact on health status and the distribution of that impact in the community. Specific mention was given to carrying out a HIA on the Fatima Mansions Redevelopment Project which is taking place in the context of RAPID.
- b) Play & Recreation Policy; This addresses the special group of children.
- c) Rural transport; This is important for the elderly as there is a particular problem for isolation for elderly people in rural areas.
- d) City and County Development Plans.

### **Comment on international comparisons**

As both multi-sectoral work for health and HIA are new areas for development internationally, it would be very useful to carry out the above in line with international developments so that comparisons can be made.

### **Monitoring of target and evaluation of implementation strategy**

If the above areas are monitored, progress can be assessed and indicators and actions reviewed and revised as appropriate.

### **Targets in other public policy areas of the NAPS Review**

In the context of the review of NAPS currently underway, specific consideration should be given to strengthening and expanding the global poverty reduction target which focuses on the consistent poverty measure. In particular this Working Group recommends the introduction of a relative income inequality target (given the clear evidence of the link between income inequality and health status) and the identification of a child poverty target (given the commitment in the National Childrens Strategy on the one hand, and the evidence that poor health in childhood has lifelong consequences on the other). These two new poverty reduction targets would complement the global target, and provide a fuller picture of how NAPS is contributing to the reduction of poverty in our society and would in particular contribute to reducing health inequalities and improving the health status of those who are poor.

The Working Group on NAPS and Health recommends that targets on the following will be outcomes of the NAPS review:

- **Child poverty**
- **Relative income inequality**
- **Income adequacy**

The Working Group on NAPS and Health holds a perspective which recognises the importance of the social determinants of health. Poor housing, homelessness, low levels of literacy, social exclusion, high-risk environments, poor education and lack of social networks have fundamental and substantial influences on health and inequality in health. This Working Group endorses the importance of targets in the following areas to support the improvement of people's health and the reduction of inequalities in health, particularly for those who are living in poverty and experiencing social exclusion:

- **Housing**
- **Transport**
- **Education**
- **Environment**

### **13. Monitoring and revision**

The last three targets proposed by the Working Group are concerned with the need to monitor progress in achieving NAPS health targets. For each target, a range of indicators has been proposed and the National Health Information Strategy will provide an important mechanism for enabling these to be monitored. Research is needed to identify new indicators where there are gaps, and to inform the future review and refinement of the NAPS and Health targets.

**Target 16 Systems to monitor NAPS health targets and indicators should be included within the National Health Information Strategy.**

**Target 17 A programme of research should be set up to support the development of further NAPS health targets and indicators.**

**Target 18 Adequately resourced and supported systems should be put in place to ensure that NAPS health targets and implementation strategies are reviewed and revised.**

These targets are underpinned by an implementation and monitoring framework, which includes a range of indicators, which will demonstrate progress in achieving the targets (See Part C, Monitoring Framework for details).

## Part C: Monitoring framework

### 14. Introduction to monitoring framework

The purpose of the monitoring framework is to ensure that progress towards achieving the NAPS targets is monitored and reviewed. The Terms of Reference (see appendix 2) for the Working Group on NAPS and Health identified the need for a monitoring framework. It is recognised as a particularly important element of NAPS and Health, as in several relevant areas there is currently a lack of information to set specific targets. This view was reinforced in the public submissions received where lack of knowledge and information was seen as a major impediment to advancing the NAPS and Health work. In addition, the preliminary assessment of the first phase of NAPS pointed to the need for systems to review and revise targets.

Key issues for the monitoring framework, as for the overall NAPS and Health work, are to identify the factors which play an important role in the relationship between poverty and health; to decide and define how these factors should be measured; to ensure that there is up to date knowledge and information about them and their relationship with health and well-being; and to ensure that this knowledge is used to advance NAPS and Health work.

The monitoring framework has been designed to respond to these issues. The Working Group believes that the framework is likely to be most effective if it:

- Strengthens existing data collections and research rather than replicates or replaces them
- Responds to the needs of, and input from, a range of stakeholders
- Emphasises the importance of analysing and using data rather than simply collecting it

The framework has four key elements:

- An indicators programme
- A research programme
- A monitoring system
- A review and revision process

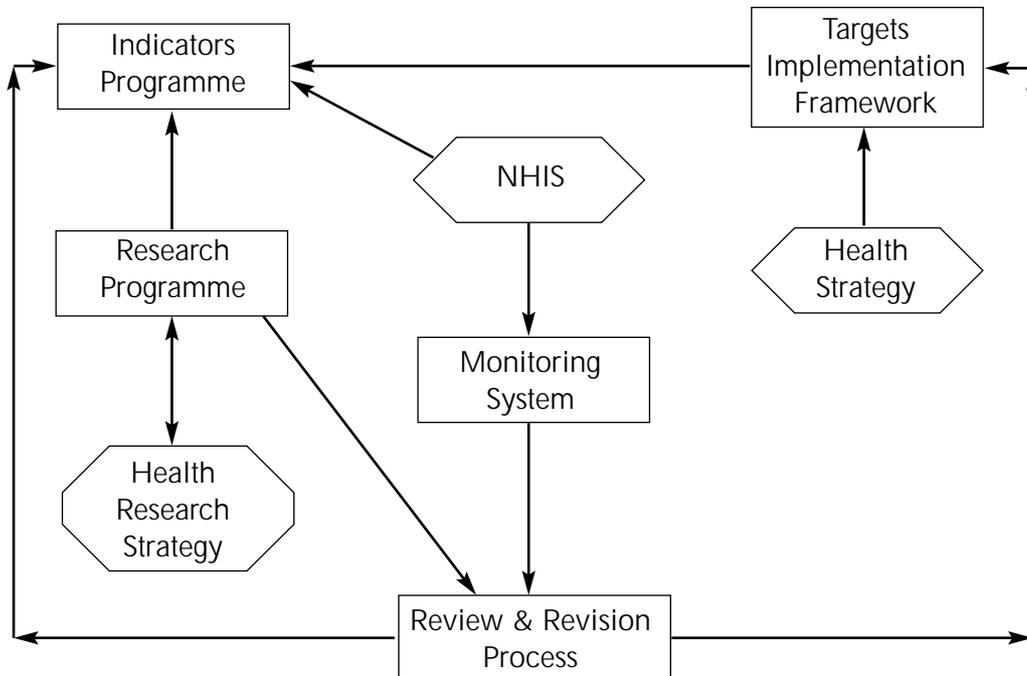
These elements aim to monitor progress on the targets and implementation strategy

outlined in chapters 10,11 and 12. Each element requires strong links with other government strategies.

The Working Group recommends that the targets and implementation strategy are incorporated into the new National Health Strategy, the indicators and monitoring system into the new National Health Information Strategy, and that the new Health Research Strategy gives priority to research to support NAPS and Health work.

These links are illustrated in the Figure below.

### Monitoring Framework for NAPS and Health



Many of the components of the proposed monitoring framework fulfil commitments made in the Programme for Prosperity and Fairness (PPF). Commitments or recommendations in PPF related to information and research, and relevant to NAPS and Health include the following examples:

- “Working in partnership with the Service Planning process and co-operating with the ongoing measurement and validation of performance indicators as agreed by each agency” (Framework 1, Modernisation of the Health Sector – key element)
- “To provide relevant data and data collection systems for the monitoring and evaluation of poverty, including systems for measuring poverty among groups not

currently included" (e.g. people living in institutions, Travellers and the homeless) and new studies to:

- i complement the current *Living in Ireland and Household Budget Surveys*, and
- ii address the gender dimension of poverty (Framework III, Social Inclusion – objective)

- "To promote general health and well-being through strengthened health promotion policies, health research and the creation of a supportive environment, with particular emphasis on at risk groups as indicated in lifestyle surveys or named in NAPS" (Framework III, Healthcare – objective)
- "Resources will be allocated to health research as part of a comprehensive approach to ensuring adequate medium and long-term planning of health provision. Data systems will be adapted to enable disaggregation of health access and outcomes across NAPS target groups. This data will be monitored and reported at a national level" (Framework III, Health Research – action)
- "A co-ordinated strategy including the relevant government departments, the Equality Authority and the Central Statistics Office will develop a system for the collection and dissemination of disaggregated data for women, and in relation to health, education and training, for Travellers" (Framework III, Equality – action)
- "The Department of Justice, Equality and Law Reform will put arrangements in place to review and identify key statistical needs in relation to people with disabilities or categories of people with disabilities for the purposes of informing policy, planning and delivery of services" (Framework III, Equality – action)
- "Framework V contains a strong commitment to the monitoring and evaluation as implementation progresses" (PPF, 2000, Government of Ireland: 130).

The Working Group believes it is essential that clear and transparent arrangements are put in place to manage the proposed monitoring framework.

## **15. NAPS and Health indicators programme**

The aim of the indicators programme is to manage the identification and development of indicators. Indicators measure (quantitatively or qualitatively) factors important to the relationship between poverty and health. Chapters 10, 11, 12 have identified a range of indicators necessary to monitor the NAPS and Health targets. The indicators programme will:

- Promote their use through co-ordination, standardisation and integration of measures in relevant data collections

- Oversee the development of new indicators, relevant to NAPS and Health.

A number of issues have been identified by the Working Group as important in the development of an indicators programme, these include:

- The development of psychometric indicators
- Study of the links between recognised indicators and measures that are included in existing data collections
- Development and maintenance of a schedule for indicators development.

The indicators programme could also include a number of 'Library' functions relating to the maintenance and promotion of:

- A data dictionary specifying accepted definitions of data items and rules for the calculation of recognised indicators
- A clearing house of information regarding development of indicators
- A data collection inventory.

The Working Group recommends a number of mechanisms to promote the use of indicators:

- Inclusion of recognised indicators as a criteria in the assessment of health research grants (NAPS, HRB and other granting agencies)
- Statutory requirement to include relevant data items in routine collections
- Statutory requirement to use recognised indicators in official publications
- Government requirements that commissioned research should, where feasible, use recognised indicators.

The Working Group recommends clear arrangements for the management of the indicators programme, based on:

- An inclusive consultative forum involving key stakeholders, including Community and Voluntary Pillar representation
- A technical advisory group
- An appropriate management board for the development of indicators.

These management arrangements should ensure that the indicators programme links closely with the National Health Information Strategy. Key issues to be considered are

consistency with the data framework of the Information Strategy and links to its indicators work.

## **16. NAPS and Health research programme**

The aim of the research programme is to increase understanding of the relationships between the key indicators in order to guide the development of further targets, indicators and implementation strategies.

The Working Group supports an emphasis on research on the social determinants of health. Much of current Irish social research looks at the distribution/correlates of income poverty and deprivation. Research has generally had to rely on relatively crude measures of socio-economic circumstances (e.g. occupational class, aggregate deprivation scores). Studies utilise area-based analyses and are essentially cross-sectional. There is a need for a more systematic investigation of the link between socio-economic environmental factors and health as summarised below.

The research programme includes a number of key elements. The Working Group therefore recommends that the proposed research programme should give priority to:

- Research on the social determinants of health
- Development of indicators to support NAPS and Health work
- The use of qualitative research to support quantitative research work.

Research should include an ethical framework and a commitment to community consultation. The programme should include 'Library' functions including the maintenance and promotion of a clearing house for research findings.

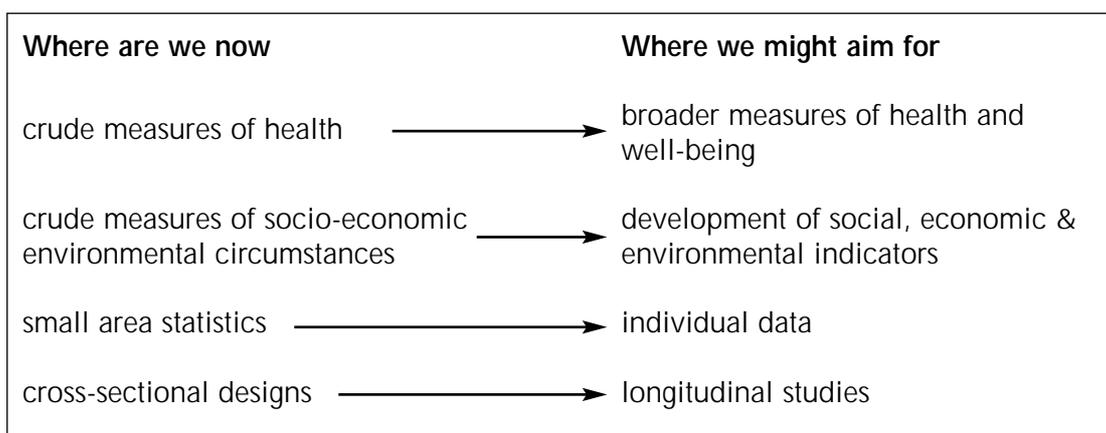
The Working Group recommends that the management of the NAPS and Health research programme incorporates:

- An inclusive consultative forum involving community stakeholders
- A technical advisory group
- An appropriate management board (for example, the Health Research Board (HRB) might consider managing the programme).

The Working Group recommends that NAPS and Health research is promoted by:

- Dedicated funding
- Commissioned research programmes
- Competitively awarded grant schemes (managed by the HRB, Combat Poverty Agency)
- Promoting NAPS and Health research with other grant funding agencies

**Figure: Key Features of Research into Social Determinants of Health in Ireland**



In order to develop current research, a number of approaches should be supported, including:

- Secondary data analysis programme
- Small area statistics research programme
- Longitudinal studies programme
- “Causal” pathways programme

## **17. Monitoring system**

The aims of the Monitoring System are to:

- Assess progress towards targets and aspirational targets
- Support the process and outcome evaluation of implementation strategies
- Monitor other indicators

The Working Group recommends that the Monitoring System is developed to include a workplan for existing and new data collections.

Existing data collections (within and outside the health care sector) need improved data quality through greater co-ordination, standardisation and integration; inclusion of necessary data items (including those relating to health and well-being measures); linkages between data collections to enable greater understanding of the inter-relationships between these factors; and the relationships between a range of factors and health.

New data collections are required for marginalised groups, process and outcome evaluation of implementation strategies.

The monitoring system should analyse trends in indicator values, limitations to interpretation of data and make recommendations for improvement.

The management of the monitoring system should include consultation with key stakeholders, and be based on technical advice.

The scope of data collections which might be included in the monitoring systems is wide ranging. Examples are identified below.

#### **General health-related collections**

Vital statistics

Disease registers

Population census

Health-related behaviours

#### **Relevant data collections in other sectors**

Social services/welfare statistics

Crime

Education

Transport

Environment

Local government

#### **Health services collections**

Home care

Community care

Health promotion/disease prevention:

Primary care

Pre-hospital care  
Hospital care  
Rehabilitation  
Palliative care  
Pharmaceuticals  
Radiological services

Strong links are required with the new National Health Information Strategy. There is a need for disaggregation of routine data by occupational class and for the nine grounds identified under the Equal Status Act :

Gender	Disability
Age	Marital status
Family status	Race
Sexual orientation	Traveller community
Religion	

In this context routine data would include: vital statistics, disease registers, health services, other administrative systems.

Consideration should also be given to inclusion of a health-related dimension to the Living in Ireland Survey and the Quarterly Household Budget Survey.

There are a number of marginalised groups such as:

Lone parent families	Chronic drug users
Disabled persons	Racial minorities
Lesbians, gay and bisexual people	Traveller community
Religious minorities	Homeless people

Supplementary collections should be developed for these groups.

The monitoring system will also cover the process evaluations identified in Part C.

## **18. Review and revision processes**

The aims of the review and revision processes are to ensure that:

- The targets are regularly reviewed and revised
- If necessary, implementation strategies are correspondingly adjusted
- The Indicator Programme and Research Programme are developed

Clear arrangements are required for the management of the review and revision process.

## Appendix 1

### Members of the Working Group on NAPS and Health

Kiely, Jim – Department of Health & Children (**Chair person**)  
Bell, Paul – Services Industrial Professional and Technical Union (SIPTU)  
Cronin, Sheila – Conference of Religious of Ireland (CORI), C/V pillar alternate  
Deane, Audry – Society of St Vincent de Paul, C/V pillar representative  
Donnelly, Pat – South Western Area Health Board, CEO Representative  
Doyle, Eileen – Macra na Feirme  
Farrell, Clare – Combat Poverty Agency  
Hardy, Charlie – Department Health & Children  
Hargaden, Mary – Department of Health & Children  
Hynes, Mary – Western Health Board, Directors of Public Health representative  
Kehoe, Eileen – Department of the Taoiseach, replaced Mary Butler  
Mulcahy, Ide – National Children’s Office for Department of Education & Science  
McCutcheon, Niall – Department Justice, Equality & Law Reform  
McGovern, Shay – Department Health & Children     **Alternate:** Olive McGovern  
McGrory, Siobhan – National Youth Council of Ireland, C/V pillar alternate  
Mrwicka, Lenore – Irish Nurses Organisation     **Alternate:** Syron, Mary  
O’Donnell, Stephanie – Department of Justice, Equality & Law Reform  
O’Donoghue, Mary – Department of the Environment & Local Government  
O’Raghallaigh, Brian – Department of Social, Community & Family Affairs  
O’Sullivan, Sheila – Irish Business and Employers Confederation (IBEC)  
Quirke, Brigid – Pavee Point, C/V pillar representative  
Sheedy, Leo – Department of Enterprise Trade & Employment  
Stack, Kathleen – Department Tourism, Sport & Recreation  
Thompson, John – Department of Finance  
Wilde, Jane – Institute of Public Health in Ireland

## Membership of the Subgroups

### Information and Research

Balanda, Kevin – Institute of Public Health in Ireland  
Hardy, Charlie – Department Health & Children  
Hynes, Mary – Western Health Board  
McGovern, Shay – Department Health & Children  
Nolan, Brian – Economic and Social Research Institute (ESRI)  
Quirke, Brigid – Pavee Point  
Stack, Kathleen – Department Tourism, Sport & Recreation  
Wilde, Jane – Institute of Public Health in Ireland **(Chair)**

### Equity of Access

Deane, Audrey – Society of St Vincent de Paul **(Chair)**  
Doyle, Eileen – Macra na Feirme  
Dunne Carmel – Northern Area Health Board  
Harkin, Anna May – Department of Health & Children  
Hargaden, Mary – Department of Health & Children  
Mulvihill, Noel – Northern Area Health Board  
Sullivan, Carole – Equality Authority  
O'Brien, John – General Practitioner  
McKeown, Declan – Western Health Board  
McCutcheon, Niall – Department Justice, Equality & Law Reform  
Syron, Mary – Irish Nurses Organisation  
O'Raghallaigh, Brian – Department of Social, Community & Family Affairs  
O'Sullivan, Sheila – IBEC  
Thompson, John – Department of Finance

### Impact of Public Policy

Bell, Paul – SIPTU  
Boydell, Leslie – Institute of Public Health in Ireland  
Burke, Sara – Institute of Public Health in Ireland  
Cronin, Sheila – CORI  
Donnelly, Pat – South Western Area Health Board **(Chair)**  
Farrell, Clare – Combat Poverty Agency  
Kehoe, Eileen – Department of the Taoiseach  
Lee, Anna – Tallaght Partnership  
Mulcahy, Ide – National Children's Office

O'Donoghue, Mary – Department of the Environment & Local Government  
Sheedy, Leo – Department of Enterprise Trade & Employment

**Team providing research, technical and administrative support, based in the Institute of Public Health in Ireland**

Balanda, Kevin – Institute of Public Health in Ireland  
Boydell, Leslie – Institute of Public Health in Ireland **(Co-chair)**  
Burke, Sara – Institute of Public Health in Ireland  
Cooney, Sarah – Institute of Public Health in Ireland  
Dunne, Carmel – Northern Area Health Board  
Elliott, Iris – Institute of Public Health in Ireland  
Harkin, Anna-May – Department of Health & Children  
Metcalf, Owen – Institute of Public Health in Ireland  
Wilde, Jane – Institute of Public Health in Ireland **(Co-chair)**

**Operational team of consultation process**

Burke, Sara – Institute of Public Health in Ireland  
Cooney, Sara – Institute of Public Health in Ireland  
Dunne, Carmel – Northern Area Health Board  
Farrell, Clare – Combat Poverty Agency  
Harkin, Anna-May – Department of Health and Children  
Jackson, Mary – Department of Health and Children  
Metcalf, Owen – Institute of Public Health in Ireland **(Chair)**  
Quirke, Brigid – Pavee Point

## **Appendix 2**

### **Terms of Reference for Working Group on NAPS and Health**

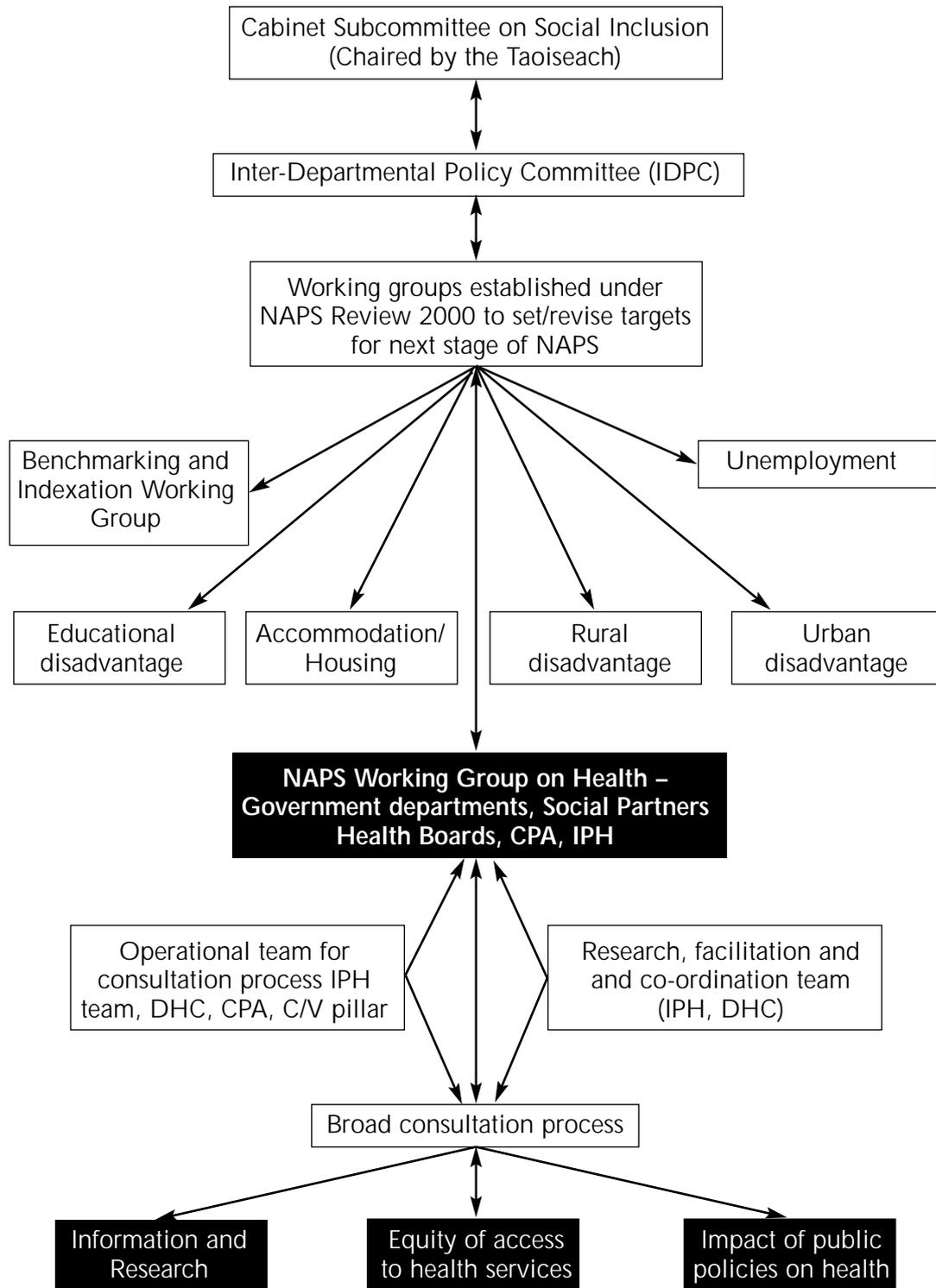
In accordance with a commitment given in the Programme for Prosperity and Fairness 2000, a Working Group on NAPS and Health has been established by the Department of Health and Children. Its remit is to develop health targets and an associated implementation and monitoring framework for the Department of Health and Children to submit to Government as part of the NAPS review. This exercise will be carried out within the general framework of the NAPS principles by:

- Outlining the context of the relationship between poverty, social exclusion and health and the rationale for setting health targets that will lead to a reduction in poverty and health inequalities
- Consultation and participation of the relevant sectors in the target setting process
- Recommending short, medium and long term targets that are measurable and that can be incorporated into the next set of NAPS targets
- Identifying strategies and actions/measures that contribute to the achievement of the targets
- Identifying indicators that can be used to measure the progress and monitor the performance towards meeting the targets and recommending mechanisms for periodic review of the targets

Particular attention will be paid to child poverty, women's poverty and older people.

### Appendix 3

## Organisational map for the Working Group on NAPS and Health



## **Appendix 4**

# **Glossary of Terms for Working Group on NAPS and Health**

### **Case management**

Case management refers to a situation where an identified member of staff assists in the co-ordination of services for a patient or client.

### **Community development**

Community development is about people working collectively for social change which will improve the quality of their lives, the communities in which they live or the society of which they are part. It is about enabling and empowering those who are disadvantaged to identify and articulate need, to participate in working for change and to influence decision making structures that affect them, their communities and wider society.

### **Continuing care**

Continuing care refers to the services provided to people who require on-going care in the community e.g. people with disabilities, some older people, people with mental health problems. These services would include those mentioned under primary care and in addition services such as day care, respite care, home help, supports to carers and meals on wheels.

### **Cross cutting issues**

Cross cutting issues is the term used to describe policy issues which cut across departments, sectors and disciplines at varying levels and require co-ordination if they are to be addressed in a coherent manner, e.g. children, crime, drugs.

### **Determinants of health**

This is the term used to describe the major factors which influence the health of a population.

### **Equality**

As applied to health status this would mean that everyone had the same level and quality of health. Put simply it would mean that everyone lived to the same age and that during their life they enjoyed the same level and quality of health. It is an unlikely

scenario, due to factors such as natural biological variation, freely chosen health damaging behaviour such as engaging in certain high risk sports and pastimes and the fact that some groups have a transient health advantage because they are the first to adopt a health promoting behaviour.

### **Equity**

The word equity relates to the concept of fairness. In WHO terms equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that none should be disadvantaged from achieving this potential, if it can be avoided. Based on this definition, the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level and quality of health but rather to reduce or eliminate those which result from factors that are considered to be both avoidable and unfair.

Whitehead (1992), an international expert on the issue, defines Equity in health care as

- Equal access to available care for equal need (in the Irish system this means equal access to public services for equal need)
- Equal utilisation for equal need (in practice this would mean monitoring of uptake and supportive action where uptake is noticeably unequal)
- Equal quality of care for all (in the Irish system this means in public facilities i.e. public and private patients in public hospitals)

### **Health**

“Various definitions of health have been developed over the years that focus on the notion of health as a positive concept rather than merely the absence of disease. Health is now regarded as a resource to be protected and developed so as to enable people to attain their maximum physical and mental capacity.” (Annual Report of the Chief Medical Officer, 1999, Department of Health and Children: 5)

### **Health Impact Assessment**

Health Impact Assessment is an approach by which a policy, programme or project can be judged for its impact on health. As HIA is a tool for addressing inequalities in health, achieving equity is a core component of HIA.

### **Health and personal social services**

This refers to the health and personal social services within the remit of the Department of Health and Children. Health services include those directed at health

promotion, disease prevention, treatment (including of chronic conditions) and rehabilitation. Personal social services refer to services such as social work services, family support, home helps, meals on wheels and day care services.

### **Inequality in health status**

This is the term used to describe differentials in health status within and between societies.

### **Indicator**

An “indicator” is a measure (quantitative or qualitative) of some factor which is considered important. It can be a characteristic of a person, a group, an organisation, an environment, a process, etc. Life expectancy, the level of childhood poverty, the level of utilisation of a health service, the percentage of government policies that have been subject to a Health Impact Assessment are all examples of indicators.

### **Life expectancy**

The average number of years an individual of a given age is expected to live if current mortality rates continue to apply.

### **Mortality (or death) rate ratio**

This is the ratio of the death rate for one group compared to the death rate for another group.

### **Directly Standardised Rate Ratio (DSRR)**

Directly standardised rate ratio is a measure which allows the comparison of death rates between groups, for example between social classes or areas. The comparisons used in this report compare death rates (standardised for age) of the lowest socio-economic group with those for the highest socio-economic group.

### **Multi-sectoral working**

Multi-sectoral working is a term used to describe working across a range of sectors and disciplines.

### **Poverty**

“People are living in poverty, if their income and resources (material, cultural and social) are so inadequate as to preclude them from having a standard of living that is regarded as acceptable by Irish society generally. As a result of inadequate income and resources people may be excluded and marginalised from participating in

activities which are considered the norm for other people in society.” (Sharing the Progress: National Anti-Poverty Strategy, 1997: 3)

### **Poverty Line**

Usually measured by household income. Households with incomes below half the average for all households, adjusted for size and composition, are deemed to be poor. This is a relative poverty line.

### **Primary Health Care**

Primary health care means all the supports and health and personal social services required to promote health, prevent, diagnose and treat illness. It includes GP and public health nursing services at its core, and a range of other services – therapy services (e.g. physiotherapy, occupational, speech and language), psychology, counselling, nutrition, social work, community pharmacy, drug treatment services, community drugs workers, community welfare officers, health promotion officers and community development workers. Primary health care also includes dental, aural and ophthalmic services. International evidence strongly suggests that team work among the above disciplines is the most effective way to deliver primary health care.

A distinction is sometimes made between primary health care as a community-based participatory approach and primary or medical care as a professional model. In the context of a partnership approach the term primary health care is being used here to denote an inclusive approach which encompasses both aspects and which the target aims to strengthen. It is recognised that community participation is a key requisite for the success of primary health care.

### **Relative poverty**

Having an income substantially below the average for that society and too low to secure a standard of living regarded as decent and acceptable by the society in which one lives.

### **Relevant sectors**

Relevant sectors refers to all sectors whose role impacts upon health. These include all those outlined in section 6.1. It also refers to statutory, non-statutory, community, voluntary, public and private sectors.

### **Social exclusion**

“Social exclusion is cumulative marginalisation from production (unemployment), from consumption (poverty), from social networks (community, family and

neighbours), from decision making and from an adequate quality of life". (Partnership for Inclusion, Employment and Competitiveness, 1996: 187)

**Socio-economic group**

Socio-economic groups are used to classify people according to their occupation, employment status and also their life-styles in terms of social, cultural and leisure behaviour. It is an aggregate concept based on both resources (material as well as social) and prestige.

**Target**

A target is a statement of something to be achieved and which specifies some (quite strict) conditions on the values of an indicator. The aim is to achieve the target (ensure that the value of the indicator satisfies the conditions) because it is expected to contribute to improved health.

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*Working for the health of the people of the island of Ireland*

The Institute of Public Health  
6 Kildare Street, Dublin 2

Tel: 00 353 1 662 9287

Fax: 00 353 1 662 9286

Email: [iph@RCPI.ie](mailto:iph@RCPI.ie)

Also contactable at Belfast: 00 44 28 9079 3050

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