Giving people a say on poverty and health

LEARNING FROM THE NATIONAL ANTI-POVERTY STRATEGY AND HEALTH CONSULTATION PROCESS

Prepared by Sara Burke

for

The Institute of Public Health in Ireland

March 2002

If you have any comments on the consultation process
or
if you would like a copy of the Summary of submissions
please contact
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Special thanks to all those who facilitated and participated in the consultation process, without whom these lessons would not have been learned.

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Learning from the National Anti-Poverty Strategy (NAPS) and Health consultation process

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Executive summary

Introduction

This is a report on what was learned from the National Anti-Poverty Strategy (NAPS) and Health consultation process. It briefly outlines what consultation is and why consultation should take place. It details the development of this consultation, who participated and how, and what was learned from the process. It also summarises the priorities emerging from this consultation exercise.

What is consultation?

To consult is to ask for advice from someone, to refer to information and to have regard for people's beliefs and considerations.

Why consult?

A consultation process is a way of proactively involving and supporting the participation of people who are the subject of policy and action.

Why document the lessons from the NAPS and Health consultation process?

When planning the NAPS and Health consultation process the absence of information on specific learnings from other consultation processes became apparent. While there are many reports of outcomes from consultations, there is little information on the lessons learned from such processes. This report documents what was learned from the NAPS and Health consultation process and it will help to inform future consultation processes.

Lessons learned from the consultation are highlighted (in bullet points) throughout the text.

When carrying out a consultation, the following guidelines may be helpful

1 Have a team of key stakeholders, with a designated co-ordinating role, dedicated to the development, support and reporting of the consultation.
2 Be clear from the outset of the objectives, constraints and desired outcomes.
3 Base the consultation process on explicit principles.
4 Be aware of barriers to participation and pre-empt them as much as possible, eg by building the participative capacity of people and organisations, or providing access to events for people with disabilities
5 Develop a range of approaches to elicit information in different ways from different groups eg the multi-strand approach of the NAPS and Health process. Prompt questions are a means of guiding those who are making submissions and of assisting the analysis of submissions.
6 Allow at least three months for people and groups to participate and be aware of the timing of other consultation exercises.
7 Utilise creative methods of participation, eg art, drama, photography, story- telling, role-playing, sharing of personal experiences.
8 Utilise local and regional structures, as appropriate.
9 Provide resources for participation, particularly for those who are the subject of the action and policy.
10 Host a checkback seminar before deciding the final results and priorities.
11 Use qualitative, as well as quantitative, methods to analyse the information gathered. Utilise the quotations of respondents when producing documentation.
12 Circulate widely the outcomes of the consultation.

Why consult?

A consultation process is a means of proactively involving and supporting the participation of people who are the subject of policy and action. The involvement of organisations and communities who are responsible for the development and implementation of policy and programmes has also become central to policy making, implementation and review. A commitment to consultation has emerged as a means of developing more effective policy making at local, regional, national and international levels. Consultation is a mechanism for implementing participative democracy and broader ownership of government policies. Involvement in consultation can increase the skills and knowledge base of participants.

There is often criticism of the under-representation of excluded people in consultation exercises and of tokenism on the part of those leading the process. The National Anti-Poverty Strategy (NAPS) and Health consultation exercise set out to involve people who are poor and excluded and those who work with them in the development of health targets for NAPS. It was also an effort to put linked poverty and health issues on the public and political agendas in order to contribute towards the building of a more inclusive, equitable and healthy society.

Why consult for NAPS and Health?

The NAPS and Health Working Group was set up by the Department of Health and Children in October 2000, to develop health targets for the NAPS and an associated implementation and monitoring framework, as committed to in the Programme for Prosperity and Fairness (PPF), 2000. The Working Group completed its work in July 2001 and its recommendations were integrated into an overall framework document for the NAPS review. Drawing on this work the government published *Building an Inclusive Society* in February 2002. In developing its work, the NAPS and Health Working Group initiated a consultation process to inform the development of the NAPS and Health targets. The consultation process was carried out in the context of the original NAPS principles, the most relevant of which are as follows:

1 Ensuring equal access and encouraging participation for all

2 Actively involving the community and voluntary sector

3 Engaging in appropriate consultative processes, especially with users of services.

Lessons learned

- The consultation process should be based on explicit principles.
- The involvement of the Social Partners from the outset, in particular that of the Community and Voluntary Pillar and Platform, ensured a more inclusive and consultative approach.

See Appendix A for members of the Working Group.

Developing the consultation process

In order to plan and oversee the consultation process, a team was established comprising members of the NAPS and Health Working Group, staff of the Institute of Public Health and staff of the Department of Health and Children. The team comprised people with experience of carrying out and participating in consultation processes and was co-ordinated by the Institute of Public Health. The Department of Health and Children had commissioned the Institute to provide technical, research and administrative support to the Working Group on NAPS and Health. This ensured a dedicated staff and team based outside the department with sole responsibility to support this work. Such time and dedicated responsibility is necessary to operationalise effective consultation activities and to meet the commitments of the PPF, as both processes have significant time and resource implications for all involved. A staff member from the Department of Health and Children was seconded to the Institute for the duration of the project and a health board staff member was seconded to the Department of Health and Children to assist in the process. This facilitated shared learning between the Institute, the Department of Health and Children and the health boards.

- It is essential that key stakeholders are involved in the planning and overseeing of the consultation process and that there is a designated co-ordinating role.

As part of this work, the Institute carried out a review of lessons learned from existing consultations and met with key stakeholders in order to inform the development of the consultation process. While there are many reports of outcomes from consultations, there is a distinct absence of information on learning from previous processes. The decision to document the NAPS and Health process has led to the production of this document to better inform future consultation processes.

- Documenting the process as well as the outcomes of a consultation is a useful way of informing future consultations.

During the planning process a number of strands to the consultation process was developed. The strands were chosen to make the process as open and inclusive as possible within the given timeframe of three months.
It was felt necessary to go beyond a public call for submissions (placing an advertisement in national newspapers) by proactively targeting a range of sectors and disciplines and supporting their participation in the NAPS and Health process.

- Developing a variety of approaches to elicit information in different ways from a wide range of groups is an effective way of being inclusive.
- In carrying out a consultation process, it is essential to be clear about the extent of participation so that appropriate levels of expectation are set from the beginning and scepticism and consultation fatigue are avoided.

See Appendix B for members of the team overseeing the consultation process.

Participation

Who participated?

Of the 151 submissions received, 20 per cent (30) came from individuals and 80 per cent (121) came from organisations. Over half the individuals who submitted, did so in a personal capacity, while the remainder wrote from their professional perspective. Of the organisational submissions, 72 per cent (88) came from the voluntary sector with 63 per cent (55) of these coming from umbrella or network organisations and the other 37 per cent (33) came from community based voluntary organisations. Sixteen per cent (19) of the organisational submissions were from the statutory sector, the majority of which were from the health boards; others included four Local Partnerships, two City and County Development Boards, the Combat Poverty Agency and the National Disability Authority. Twelve per cent came from a range of other types of organisations including trade unions, academic institutions, and organisations such as the Dental Health Foundation, Best Health for Children and the National Consultative Committee on Racism and Inter-Culturalism.

The low number of submissions from statutory bodies, apart from health boards, is apparent. However, many of the organisational submissions were very extensive and some were based on consultations with a large range of individuals and organisations whom they represent. Most notable were the consultations within the health boards with their 81,000 workers and thousands more service users and clients, and those within the community and voluntary sectors which are made up of hundreds of organisations and networks representing individuals and groups.

The submissions came from a very broad range of organisations, many of whom do not have a specific health brief. Only 29 per cent (35) were from organisations with a specific health remit. This may reflect the efforts of the Working Group to seek people with experience of poverty and health issues, rather than focusing solely on health service groups.

- Having a broad-based approach to the issues involved positively influences the breadth and depth of the consultation.

The prompt questions were developed to reinforce this broad view of health and contributed to the wide range of organisations who responded and the breadth of responses.

- The use of prompt questions ensures that responses are focused on the specific issues of the consultation exercise. These questions also facilitate the analysis of large amounts of information at a later stage.

What was the experience of those who participated?

The majority of those who participated in the process supported the multi-dimensional nature of the NAPS and Health consultation process. However, there were also concerns raised in relation to the capacity of organisations to constantly respond to government consultation exercises. Questions were raised about how a consultation process influences the decision making process. Some participants said they no longer just wanted to be listened to but wanted to have a role in decision making. There seemed to be a level of consultation fatigue/overload among organisations involved, yet at the same time these organisations wanted to participate. The general public also wanted a stronger voice in decision-making processes.

- The quality, detail and time spent on the development of submissions demonstrates the interest and concern that exists in relation to the issues in question.
- There are resource implications for all organisations involved in a consultation process and adequate resources are required to ensure participation.

How did they participate?

Of the 151 submissions received, 140 were in written form. Ten came orally on the comment line or directly to the office phone. A submission from the Irish Deaf Women's Group was received by videotape. Eighty-one of the 121

organisations who submitted responses sent representatives to the national checkback seminar held in June 2001.

Carrying out the consultation

Timing

Many of those who participated were concerned about the short time they had to prepare submissions. While the closing date was planned for 30 March 2001, submissions were accepted up to early June. This flexibility was a response to the concern about time, to the outbreak of foot and mouth disease and to organisations which were compiling composite reports, eg the health boards and the Community and Voluntary Pillar/Platform.

- Timing is an essential factor in the success of a consultation process. A minimum of three months is necessary to give organisations a chance to actively seek the views of their clients, members, staff etc., and to formulate a response. This is particularly true for small, community based, volunteer-run organisations.

The activities of six other NAPS Working Groups and the Health Strategy consultation process coincided with the NAPS and Health consultation process. This may have contributed to the consultation fatigue/overload described and resulted in some confusion about the different processes. On the other hand the simultaneous timing with these other processes could be seen to be beneficial, as there was a heightened awareness of and dialogue on health and other poverty issues. This process also coincided with the development of a National Health Information Strategy. Again the timing may be seen as positive as some of the information needs identified for monitoring the NAPS and Health targets may be addressed through this strategy.

- There is a need to be aware of other consultation processes in order to prevent consultation fatigue/overload.

Strands of the process

National advertisement

An advertisement was placed in national newspapers seeking the views and opinions of the public on how to improve the health of people who are poor

or excluded. The advertisement was also placed in three special-interest newspapers in order to proactively seek the views of the readership of these papers, namely the Irish-speaking community, refugees, asylum seekers, minority immigrants, and the farming community.

Responses were welcomed in writing, by e-mail, through a lo-call comment line and on tape.

Respondents were encouraged to use prompt questions, which were made available through a webpage and as part of an information pack.
See Appendix C for a copy of the advertisement.

- The advertisement, communication and operationalising of the consultation process can determine the types and number of responses.

Targeted call for submissions

Views were also sought directly by letter from a range of 150 organisations whose role was considered particularly relevant to poverty and health. The aim of this targeted call for submissions was to produce a cascade effect within these organisations and networks.

- Directly writing to organisations and inviting submissions can yield significant numbers of responses from these organisations.

The organisations were also circulated with background information and prompt questions.

See Appendix D for a copy of the prompt questions.

Lo-call comment line and query phone line

A lo-call comment line was in place for the duration of the consultation process and staff from the team supporting the process were also available to take calls during office hours. Only a limited number of those who participated utilised the lo-call comment line. Direct calls received in the

office were mostly general enquiries rather than actual submissions. However, some of them were from people citing their personal concerns, their experiences of the health services and the two-way relationship between ill health and poverty. All the calls to the office and the lo-call comment line were in response to the national advertisement.

Many of the office calls were from people who had first called the lo-call comment line but did not wish to use an answering machine or found they had not enough time to give a complete response. Some callers needed support and were referred to the appropriate services, eg local health board, county council, citizen advice bureau.

- Feedback shows that people are not comfortable talking to a comment line and prefer to have a person on the other end of the phone.

Webpage

A webpage was set up on the website of the Department of Health and Children which outlined the public call for submissions, background information and prompt questions to assist people in their responses. It also contained an e-mail address to contact the NAPS and Health office directly from the website with any queries. No mail message was received at this address. However, people may have used the webpages to gain information on the process.

- Webpages are not currently an effective mechanism for seeking participation in a consultation process, particularly those focused on poverty and exclusion.

Regional Health Boards

The Chief Executive Officer of each of the regional health boards nominated a lead person to drive and co-ordinate the consultation process within each health board area. This process coincided with an extensive consultation process which was being carried out for the National Health Strategy. In

addition to the generic questions being asked for the Health Strategy, an additional question was asked, seeking information on poverty, inequality in health and equity issues. Health service users, providers, staff, management teams and the boards were consulted in each area. Each health board submitted a composite report of its findings. The benefits of this double role were that all 81,000 staff of the health boards, and many services users and providers, were consulted with directly as part of the Health Strategy process. This provided the NAPS and Health process with a much more extensive audience than otherwise would have been the case. It also reinforced the fact that issues of poverty, inequalities in health and equity in health service provision were high on the Health Strategy agenda.

The health board Health Strategy consultation process was naturally more focused on health systems and services provision, rather than the broader approach taken by the NAPS and Health process. Nonetheless, each board provided a specific NAPS report, drawing out poverty and equity issues from the overall process. Feedback from the boards was that most of the NAPS health issues were being reflected in the Health Strategy process. This feedback also showed that there was some confusion on the ground between the two processes.

- Clarifying the parameters and extent of the consultation is necessary to ensure effective consultation.
- Integrating two consultation processes can enable more extensive consultation. However, distinction between the two processes is necessary to avoid confusion.

Community and voluntary sectors

The community and voluntary sectors carried out extensive consultations with their constituent organisations and networks. This reflects the proactive approach of the sector in this process and their concentrated effort to support involvement. Funds were provided for organisations who needed support in carrying out direct consultations with the people they represent and/or in the compilation of their submission. Members of the consultation

team also made themselves available to make presentations and respond to queries at consultation meetings. Organisations responded individually and the Community and Voluntary Pillar/Platform also made a collective response. The health representatives from the pillar/platform brought the interested organisations together to agree priorities for their collective response. A consultant was hired to synthesise the wide range of submissions into a composite report from the sector. This process was also used to develop the sectors' submission to the National Health Strategy. Such participation was actively supported by the four Community and Voluntary Pillar/Platform representatives on the NAPS and Health Working Group.

The community and voluntary sectors are particularly articulate about wanting to be included but also on the burden of participation and consultation 'overload'. Support and resources were put in place to address these issues. While the time constraints remained a concern, feedback from the majority of this sector was positive about the inclusive nature of the NAPS and Health process.

- Resources must be sufficient to enable and support relevant participation in the process, in particular, resourcing those who are the subject of action and policy and the community and voluntary sectors.
- It is important that those involved in leading the consultation are committed to the process so that they can meaningfully engage and maintain the participation of their respective constituencies and ensure that the process is inclusive of all the relevant stakeholders.
- Prioritisation exercises and composite reports from large organisations or groups are very useful tools to support the analysis of information.
- The effort made by these groups to prioritise their issues can be very positive in terms of enabling the process of decision making.

City and County Development Boards

The Directors of Community and Enterprise of the City and County Development Boards were asked to carry out consultations through the newly established Community Fora. Only two City and County Development Boards (CDBs) submitted individual responses. However, many of the health boards

involved the CDBs in their processes so the figure is not a true reflection of the participation from this sector. Because the CDBs were using their Community Fora as their mechanism for consultation, there may have been overlap between members of this group and those who participated from individual organisations.

Given the early stage of formation of the Community Fora their level of involvement in the process is considered a successful response. The Directors of Community and Enterprise of the CDBs were approached by both the Health and Housing and Accommodation Working Groups to assist in consultation. The level of involvement of Local Authorities in the latter process may have overshadowed the NAPS and Health consultation. The outbreak of foot and mouth disease also created problems for this strand.

- New structures at local and regional level should be utilised for consultation exercises as appropriate.

A National Checkback seminar

A National Checkback seminar was held early in June 2001, to which all those who participated in the consultation process were invited. Each participant was circulated in advance of the seminar with a summary of the submissions received. An outline of the main themes emerging from the process was presented along with presentations from some organisations and individuals directly involved in the process. The proposed target areas were also outlined. Workshops were facilitated so that those attending could have a further input into the decision-making process. One hundred and twenty people attended this seminar comprising those who participated in the consultation process, those involved in the broader NAPS review and development and Working Group members. This seminar was hosted to provide a forum where those who had participated in the consultation process could be updated on progress and influence the final decision-making process.

The checkback seminar proved very useful in highlighting particular issues and gaps not yet identified by the Working Group. Representatives of eighty-one organisations out of the 121 (67 per cent) who made submissions attended, as did most of the Working Group members and those involved in the broader NAPS process. Attendance, participation and feedback from the evaluation forms indicate a high level of satisfaction with the seminar and the process.

- Hosting a checkback seminar at the final stage of a consultation process is a useful component of any consultation process.
- Circulating a draft report a week in advance of the checkback seminar facilitates participation so that participants have time to develop constructive responses.
- Traditional written responses may not be the best or only method of seeking the opinions of people. More creative and participative methods used by organisations in developing their responses can be useful, eg drama, art, story-telling, video- making, role-playing and sharing of personal experiences.

Reporting and following up from the consultation process

- Using quotations from respondents is an accessible way of reporting outcomes.
- Widely circulating the outcomes of the consultation is central to the inclusiveness of the process.
- The challenge for any consultation process is to move from recommendations to actions and to produce results which address the issues of concern.
- Monitoring and reviewing the outcomes of any consultation process is central to its effective implementation. All relevant stakeholders should be central to such a process.

What were the constraints of the consultation process?

Foot and mouth disease

The outbreak of foot and mouth disease, shortly after the commencement of the consultation process, constrained some aspects of the consultation process as it restricted the capacity to bring people together, particularly in rural areas.

Timescale

The consultation process was planned to run from January to March. In fact submissions were accepted until early June, two months later than planned. The extension of government deadlines facilitated a more realistic timescale but it would have been better if this was known by all at the start of the process.

Emerging priorities

The main issues emerging from the consultation process were drawn from the summary of submissions and the national checkback seminar. The emphasis placed on these issues suggests that these are the areas to be addressed to tackle linked issues of poverty, social exclusion and inequalities in health.

1 Social model of health and social determinants of health

The NAPS and Health Working Group used a social model of health as the basis for its work. Such an approach was fully endorsed by the majority of those who participated in the consultation process as a starting point from which the social determinants of health can be addressed. There was strong support for the use of targets which reflected this social model of health (specific mention was given to the possibility of health status targets using morbidity, mental health and quality of life measurements). Submissions identified the importance of other NAPS targets and the new Health Strategy in effecting positive health outcomes. The need for an overarching framework to guide the adoption and implementation of the targets was also emphasised.

2 Impact of poverty and social exclusion on health

The link between poverty, social exclusion and health was consistently stressed by those involved in the consultation process and therefore efforts to tackle these were identified as ways of addressing such complex inter-related issues. Adequate levels of income and reducing inequalities in income were pinpointed as central to improving the health of people who are living in poverty or experiencing social exclusion.

3 Equitable access to health services

The requirement for equitable access to health services in terms of timeliness, waiting lists, physical accessibility and access to information was highlighted throughout the process. The negative effect of the two-tier health system on equitable access to, experience of and outcomes from services was emphasised as was the positive effect that having a medical card can have on accessing services. Consistent themes emerging were the need: to

address the current inequity of access to acute hospital services; for health services to undergo a culture change that puts citizens and communities at the centre of the service and reorients provision towards an increased emphasis on prevention; to acknowledge the significant role of early intervention, of community based and outreach services, of social supports, of involving service users in service planning and development; for a commitment to a holistic health service. The importance of people being able to access and utilise the information and services they need at the appropriate time was also stressed as was the need to extend eligibility for the General Medical Scheme. The need for good quality and standards in health and personal social service provision was emphasised alongside the importance of training and development of staff in relevant areas, eg Health Impact Assessment (HIA), sensitising health professionals to the particular needs of excluded groups, training in multi-sectoral working, in community development and on the collection of information and utilisation of information systems.

4 Primary care

Support for the development of a comprehensive, holistic, integrated and accessible primary care service was identified as fundamental to improving the health of people who are living in poverty or experiencing social exclusion.

5 Public policy

Many aspects of public policy were identified as central to positively influencing the health of people who are poor and excluded and reducing inequalities in health. Poverty proofing, Health Impact Assessment (HIA) and the co-ordination of sectors and disciplines were specified as mechanisms that could facilitate healthier public policy development. The setting of a public policy target was singled out as a way of bringing people together to plan, spend, work and monitor in favour of health and of reducing poverty, social exclusion and inequalities in health. Specific mention was given to how other public policies could improve the health of people who are living in poverty or experiencing social exclusion.

Housing

The need to provide good quality, affordable public housing, social housing and accommodation was emphasised.

Transport

Improved transport provision from marginalised communities, particularly in rural areas, to enable people to access services was consistently highlighted throughout the consultation process.

Education

The critical role that educational opportunities can play in supporting people's health was repeatedly emphasised in submissions.

6 Specific groups

Much emphasis was given to the needs of specific groups, in particular

- people with disabilities
- homeless people
- people in rural areas
- Travellers
- refugees and asylum seekers
- carers.

7 Consultation and participation in decision making

The engagement of citizens and communities, particularly those who are living in poverty or experiencing social exclusion, was seen as a critical factor in developing effective policies and services. Many of those who participated in the process outlined how they wanted to be listened to and involved in decision-making processes on issues and services relevant to them. A need was identified to build upon existing mechanisms and create new mechanisms, where appropriate, for effective consultation with citizens, communities, health service users and providers. The potential of advocacy services to support the participation of people and groups who are excluded was detailed.

8 Community development

Community development was identified, throughout the submissions and the checkback seminar, as playing a very significant role in supporting people who are living in poverty or experiencing social exclusion and as a key tool for investment in health and the development of healthier citizens and communities. The importance of policy, programme and financial commitment to community development and the positive role that volunteers could play in community development and support work were highlighted.

9 Co-ordination of services and policies

Many sectors and disciplines currently work in isolation from each other. Increased co-ordination, co-operation and integration in the development and implementation of policy and services was identified as a critical means of enhancing effective implementation of public policies and services.

10 Monitoring and reviewing, research and information

The important role of monitoring and reviewing the NAPS and Health targets so that progress can be measured, reviewed and revised as appropriate was given particular attention by those involved. Such a review mechanism is essential so that new issues emerging can be incorporated into NAPS, eg racism.

Research and information were identified as the essential basis for target setting, monitoring and reviewing. The crucial role of research and information in underpinning the knowledge base, the use of qualitative as well as quantitative measurements and the disaggregation of data were also highlighted.

11 Rights-based approach

The adoption of a rights-based approach to the NAPS review was proposed by some of the central players in the process, eg the Combat Poverty Agency, the Community and Voluntary Pillar/Platform, the trade unions.

Appendices

Appendix A

Members of the Working Group on NAPS and Health and co-opted members of subgroups

1 Bell, Paul - SIPTU

2 Boydell, Leslie - Institute of Public Health in Ireland

3 Deane, Audry - Society of St Vincent de Paul *Alternate* Cronin, Sheila - CORI

4 Donnelly, Pat - South Western Area Health Board

5 Doyle, Eileen - Macra na Feirme

6 Farrell, Clare - Combat Poverty Agency

7 Hardy, Charlie - Department of Health and Children

8 Hargaden, Mary - Department of Health and Children

9 Hynes, Mary - Western Health Board

10 Kehoe, Eileen - Department of the Taoiseach

11 Kiely, Jim - Department of Health & Children *Chair*

12 Mulcahy, Ide - National Children's Strategy

13 McCutcheon, Niall - Department of Justice, Equality and Law Reform *Alternate* O'Donnell, Stephanie - Department of Justice, Equality and Law Reform

14 McGovern, Shay - Department of Health and Children *Alernate* McGovern, Olive

15 Mrwicka, Lenore - Irish Nurses Organisation *Alternate* Syron, Mary

16 O'Donoghue, Mary - Department of the Environment and Local Government

17 O'Raghallaigh, Brian - Department of Social, Community and Family Affairs

18 O'Sullivan, Sheila - IBEC

19 Quirke, Brigid - Pavee Point *Alternate* McGrory, Siobhan - NYCI

20 Sheedy, Leo - Department of Enterprise, Trade and Employment

21 Stack, Kathleen - Department of Tourism, Sport and Recreation

22 Thompson, John - Department of Finance

23 Wilde, Jane - Institute of Public Health in Ireland

Appendix B

Members of the team overseeing the consultation process

Burke, Sara - Institute of Public Health in Ireland

Cooney, Sarah - Institute of Public Health in Ireland

Dunne, Clare - Northern Area Health Board

Farrell, Clare - Combat Poverty Agency

Harkin, Anna May - Department of Health and Children

Jackson, Mary - Department of Health and Children

Metcalfe, Owen - Institute of Public Health in Ireland *Chair*

Quirke, Brigid - Pavee Point, Community and Voluntary Pillar/Platform

Appendix C

Health – Your Opinion Counts

The Working Group on NAPS & Health

The National Anti-Poverty Strategy (NAPS) is a Government initiative to reduce poverty, inequality and social exclusion. As part of this strategy, the Government wants to improve the health of people experiencing poverty or disadvantage, and reduce health inequalities. A Working Group has been set up by the Department of Health and Children to recommend relevant targets for NAPS and this work is being supported by the Institute of Public Health. We would like to hear from the public on these issues.
If you have any views on the kind of targets that should be set, or on what kind of issues the Working Group should consider as part of its work, we would like to hear from you, **in writing, by email, through our comment line or on tape** - **contact details below.**

Note that the Working Group aims to set targets which will:
- improve health for people in poverty or experiencing social exclusion and reduce health inequalities
- reduce poverty and social exclusion arising from or contributing to poor health
- increase equity of access to health and personal social services
- ensure that government policies in other areas support these goals
- be based on relevant information and research data.

In your reply, you may wish to consider the prompt questions which are available on our webpage (www.doh.ie/naps) **or through any of the contacts below.**

This call for submissions is one part of a wider consultation process.
Further information is available at our webpage **www.doh.ie/naps**

The results of this exercise will be one of the elements which will feed into the development of the new National Health Strategy.

We welcome submissions (including tapes):
- **By post** **Working Group on NAPS and Health, Room 822**
  Department of Health and Children,
  Hawkins House,
  Dublin 2.
- **By fax** **01 6616762**
- **Or if possible by e-mail to napsandhealth@health.irlgov.ie**
- **A Lo-Call Comment line is available for oral submissions at 1890 460 960**

If you need any clarification of the above or if you have any special requirements,
you can contact us over the next week at 01 6785935

The closing date for receipt of submissions is **Friday, 30th March 2001**.
Please note: Submissions may be released under the provisions of the Freedom of Information Act, 1997.

Appendix D

Prompt questions

1 What are the main things that affect the health of people living in poverty or experiencing social exclusion? What affects it

(a) negatively?

(b) positively ?

2 What improvements need to happen to help people most in need to be healthier?

3 How can health policies be improved to support people's health?

4 What public policies (e.g. Government policies), apart from health policies, affect people's health?

5 How can these public policies be improved to support people's health?

6 Access to health services is one of the factors which affect the health of people living in poverty or experiencing social exclusion.

(a) What makes it difficult for people to get the health and personal social services they need?

(b) What helps people to get the health and personal social services they need?

7 What information and research is needed to support the development and monitoring of health targets for NAPS?

Appendix E

List of respondants to the Working Group on NAPS and Health

1 Access Ireland
2 Accord
3 Best Health for Children
4 Bethell, Micheal
5 Breen, Mary
6 Blakestown Community Development Project Ltd
7 Blanchardstown Area Partnership
8 Bodywhys
9 Cadogan, Ethna
10 CAN – Community Action Network
11 CARI – Children At Risk in Ireland
12 Carelocal
13 Castlemaine Community Care
14 Cashel Community Resource Centre
15 Catholic Youth Care
16 Centre for Independent Living, Galway
17 Cherry Orchard Concerned & Active Citizens Group
18 Clinton, Sr Julie
19 Clondalkin Partnership
20 Clondalkin Travellers Development Group
21 Children's Rights Alliance
22 Children's Research Centre, Trinity College Dublin
23 Combat Poverty Agency
24 Comhairle
25 Community Development Support Programmes
26 Community Health Workers with Louth Primary Health Care for Travellers Project
27 Community and Voluntary Pillar/Platform
28 Community Workers Co-operative
29 CORI – Conference of Religious of Ireland
30 Cork Association of Parents & Friends of the Mentally Handicapped
31 Cork County Federation – Muintir na Tíre
32 Crowley, Philip
33 Cullen, Elizabeth
34 Daughters of Charity of St Vincent de Paul
35 Draíocht
36 DACT (Dublin Accommodation Coalition for Travellers)
37 Directors of Public Health Group
38 Dublin City University – Centre for Sport Science & Health
39 Dental Health Foundation
40 Disability Federation of Ireland
41 Dunleavy, Nuala
42 East Coast Area Health Board – Medical Co-ordinators of Services for Older people
43 East Coast Area Health Board – Social Inclusion Network
44 East Coast Area Health Board
45 ECO – Environmental Youth Organisation
46 Elliott, Iris

47 Focus Ireland
48 Forum for People with Disabilities
49 Galway Lesbian Line
50 Galway Travellers Support Group
51 Glen Leadership & Equality Network
52 Gibson, Tony
53 Headway
54 Healy, Theresa
55 Hanafin, Sinéad
56 Holywell Trust Support Agency
57 IACEA – International Organisation for children with Cerebral Palsy, Spina Bidifa, Adults with Parkinson, M.S. and stroke victims
58 ICON – Inner City Organisation Network
59 Irish Commission for Prisoners Overseas
60 Irish Deaf Women's Group
61 Irish Heart Foundation
62 Irish Nurses Organisation
63 Irish Pharmaceutical Union
64 Irish Refugee Council
65 Irish Rural Link
66 Irish Senior Citizens Parliament
67 Irish Wheelchair Association
68 IMPACT Trade Union
69 Kerry County Development Board
70 Labour Party
71 Little Sisters of the Assumption – Justice Desk
72 Longford Community Resources Limited
73 MABS, Liam Edwards
74 MABS Projects in the West Region
75 Mate, Claus & Reid, Marie
76 Mc Carthy, Mary
77 McManus, Teresa
78 Mental Health Matters
79 Merchants Quay Ireland
80 MFG Leader
81 Midland Health Board
82 Murphy, Ann
83 NAMHI – National Association for Mentally Handicapped in Ireland
84 National Adult Literacy Campaign
85 National Consultative Committee on Racism and Interculturalism
86 National Council on Ageing and Older People
87 National Disability Authority
88 National Heart Alliance
89 National Lesbian & Gay Federation
90 National Traveller Women's Forum
91 National Women's Council of Ireland
92 National Youth Health Programme
93 NEA – National Energy Action, campaign for warm homes
94 Network of Rape Crisis Centres
95 NICHE – Northside Initiative for Community Health (Cork)
96 North Eastern Health Board
97 North Western Health Board

98 Northside Travellers Support group
99 O'Brien, Michael Joseph
100 O'Keefe, Mrs
101 O'Hanlon, Patricia
102 O'Neill, Margaret
103 One Parent Exchange Network (OPEN)
104 Open Your Eyes to Child Poverty
105 O'Rouke, Mrs
106 O'Shea, J.
107 Parent Equality Report
108 PAUL Partnership, Limerick
109 Rape Crisis Centre
110 Presentation Sisters Justice Network
111 Roma Support group
112 Rowe, Mr
113 SAHRU, Trinity College Dublin - Dr Alan Kelly
114 Schizophrenia Ireland
115 Simon Community
116 Sláinte Pobal
117 Southern Health Board
118 South Western Health Board
119 SPICE – A group of one parent families
120 SPIRASI – Spiritan Asylum Seekers Initiative (Medical Programme for survivors of torture)
121 Spinal Injuries Action Association
122 Stack, John
123 St Brigid's Senior Citizen's Group & Women in Media & Entertainment
124 St Michael's House
125 St Munchin's Community Development Project
126 St Vincent de Paul
127 Tallaght Partnership
128 Tallaght Travellers Youth Service
129 Tipperary County Development Board
130 Traveller Visibility Group
131 Togher Family Centre
132 TRUST
133 Treoir
134 Tuiscint Training Centre
135 Tullamore Travellers Movement
136 Unknown
137 Unknown
138 Unknown
139 Unknown
140 Unknown
141 Unknown
142 Valrely, Michael
143 Vincentian Partnership for Social Justice
144 Voluntary Drugs Treatment Network
145 Voluntary Resource Centre
146 Western Health Board
147 Western Care Association
148 Women's Aid

149 Women's Health Advisory Committee – WHB
150 Women's Health Council
151 Youth Group (Unknown)