EU EXPERT WORKING GROUP ON SOCIAL DETERMINANTS AND HEALTH INEQUALITIES

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Tackling Health Inequalities
The Irish Experience

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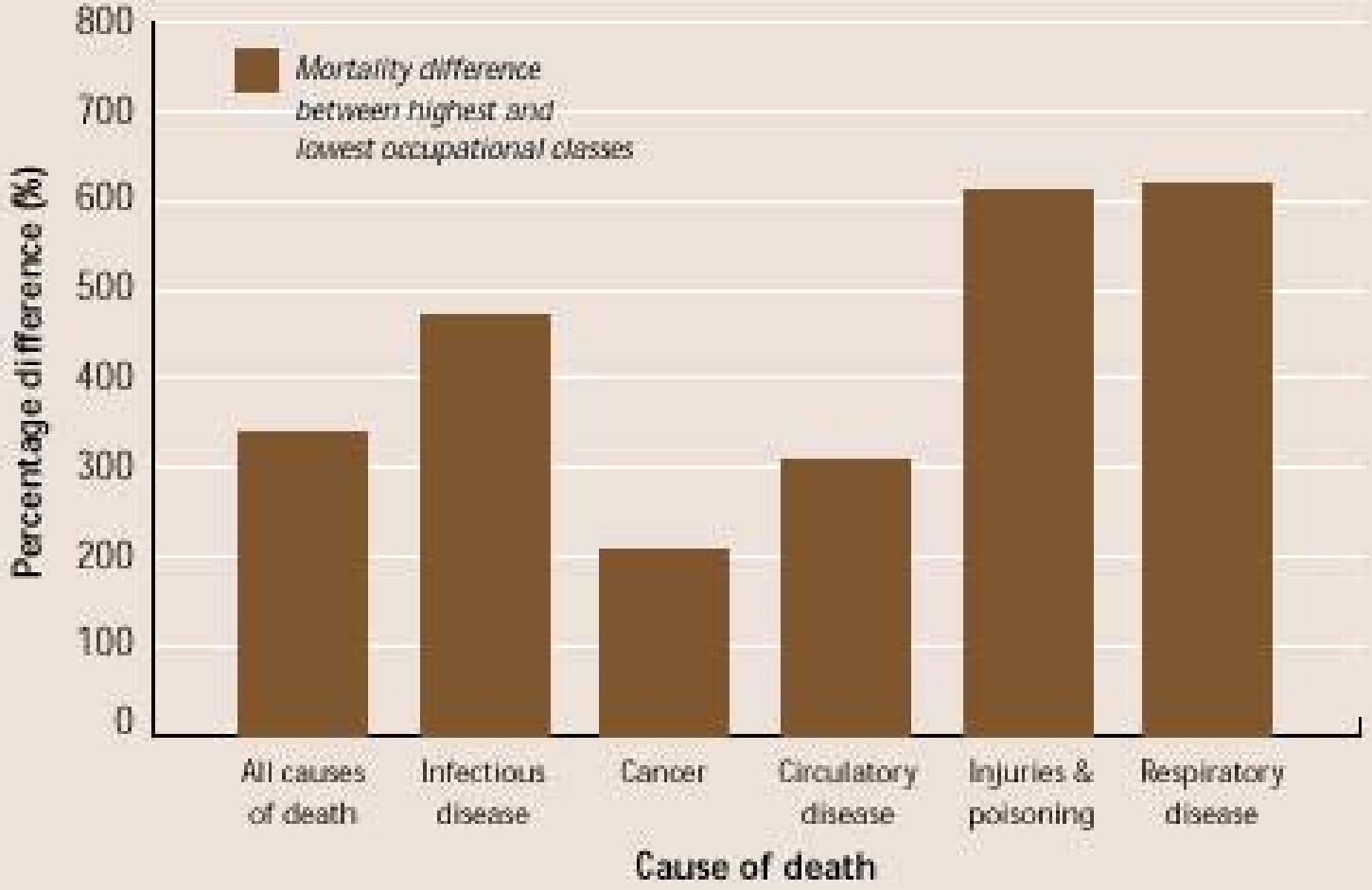
Figure 2.14 Occupational class gradients in health



Source: Institute of Public Health (2001)

Inequalities in Premature Mortality - males under 65 yrs - 2003

- Circulatory diseases

  79% more deaths in the lowest socio-economic group than in the highest socio-economic group (SMR =179)

- Cancers

  70% more deaths in men in the lowest socio-economic group (SMR = 170) compared to the highest

- External causes of injuries and poisoning

  Over 4 times as many deaths in men in the lowest socio-economic group compared to the highest (SMR = 446)

Source: Institute of Public Health in Ireland (2005) based on CSO data

Inequalities in Low Birth-weight - 2001

- The lowest socio-economic group was 1.43 times (RR) more likely to have low birth-weight births than the highest socio-economic group (SEG) in 2001
- Unemployed, home duties, occupation unknown all twice more likely to have low birthweight than the highest SEG

Source: Institute of Public Health in Ireland (2005) based on NPNRS data

Travellers (indigenous minority)

In 1987 (latest data available)

Life expectancy compared to general population

- 10 years less for men
- 12 years less for women

3% aged over 65 versus 11% of general population (2002 Census)

Less likely to be referred to hospital

Undertaking major study of Traveller Health Status

Concerns with homeless, drug users, prisoners and migrants

Lifestyle

Poorer people more likely to:

- Smoke cigarettes
- Drink alcohol excessively
- Take less exercise
- Eat less fruit and vegetables.

Source: National Health and Lifestyle Surveys (SLÁN) 1998 & 2002

How Ireland is Addressing Health Inequalities

- National Social Partnership Agreements
- National Anti Poverty Strategy (NAPS)
- Action Plans against Poverty and Social Exclusion
- National Health Strategy
- Range of Strategies/Plans for specific diseases or groups

National Social Partnership Agreement

- Started in late 1980's
- Government, Business, Farming, Trade Unions, Community and Voluntary
- Pay restraint in return for agreed increases
- Non-pay elements including social inclusion

Ireland's National Anti-Poverty Strategy Definition of 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 which 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."

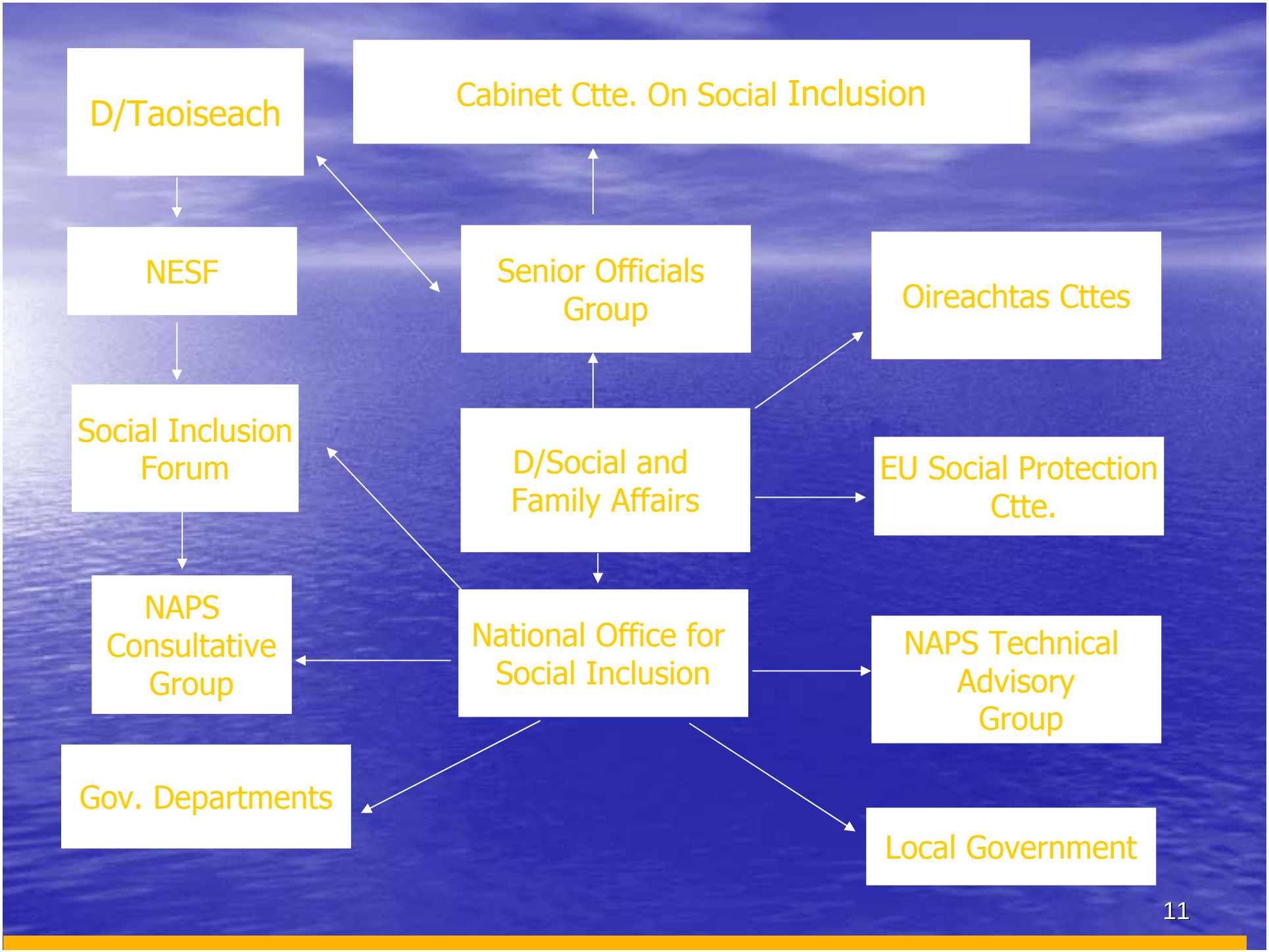
Ireland's National Anti-Poverty Strategy Areas of Focus

1997

- Unemployment
- Income adequacy
- Educational disadvantage
- Urban concentrations of poverty
- Rural poverty

2002 – additional targets set in new areas

- Health
- Housing


D/Taoiseach
Cabinet Ctte. On Social Inclusion
NESF
Senior Officials Group
Oireachtas Cttes
Social Inclusion Forum
D/Social and Family Affairs
EU Social Protection Ctte.
NAPS Consultative Group
National Office for Social Inclusion
NAPS Technical Advisory Group
Gov. Departments
Local Government

Ireland's National Anti-Poverty Strategy
Poverty Proofing

Introduced in 1998 as principal instrument for mainstreaming social inclusion at central Government level.

"the process by which government departments, local authorities and State Agencies assess policies and programmes at design and implementation stages in relation to the likely impact that they will have or have had on poverty and on inequalities which are likely to lead to poverty with a view to poverty reduction."

Poverty Proofing continued

A review in 2001 found high level of formal compliance but need for further clarification of objectives and operation of scheme.

Revised Guidelines being launched, October 2005 and being rolled out early 2006.

Available on www.socialinclusion.ie

Health Aim of NAPS

In relation to health, the overall aim of NAPS is to reduce the inequalities in the health of the population by:

- making health and health inequalities central to public policy
- acting on the social factors influencing health
- improving access to health and personal social services for those who are poor or socially excluded
- improving the information and research base in respect of the health status and service access for the poor and socially excluded.

Source: Building an Inclusive Society 2002

Key NAPS Health Targets set in 2001/2

- Reducing differences between socio-economic groups in
  - premature mortality
  - low birth weight
- Improving Traveller life expectancy

Key Targets (continued)

- To reduce the gap in premature mortality between the lowest and highest socio-economic groups by at least 10% for circulatory diseases, for cancers and for injuries and poisoning by 2007.

- To reduce the gap in low birth weight rates between children from the lowest and highest socio-economic groups by 10% from the current level by 2007.

Key Targets (continued)

- The gap in life expectancy between the Traveller Community and the whole population will be reduced by at least 10% by 2007

Targets and measures included in National Health Strategy: Quality and Fairness (2001)

Report of Working Group on NAPS Health 2002

Set out Measures and Actions

- Improved access to services and eligibility for them
- Wider Public Policy
- Health impact assessment and inter-sectoral work
- Monitoring and Research re. targets and indicators

Approaches 1

We have been trying to:

- Mainstream social inclusion into existing/ upcoming health policies e.g. Primary Care Strategy, CVD, Cancer, Obesity, Food and Nutrition, Mental Health

Secure better integration of policy and implementation

- Within health sector
- Across other sectors

Approaches 2

Involve the Community and Voluntary Pillar

Build capacity for HIA

Work with support agencies such as Institute of Public Health, Combat Poverty Agency

Working Group on NAPS and Health

Cardiovascular Strategy

- Concentrated initially on improving infrastructure and staffing
- Improving regional access for cardiac procedures
- Now plan to target lower SEG more
- Food/nutrition initiatives for low income groups – community dieticians, peer led approaches, some food co-ops
- Nicotine Replacement Therapy available free to lowest income group
- Ban on smoking in Pubs and Restaurants

Strategies for Vulnerable Groups

- Travellers
- Homeless
- Drug Users
- Disability
- Ethnic Minorities

All require better "joined up" working

Data Developments

- Pilot on SEG variablies in National Cardiac Information System (NCIS)
- Ethnic Identifier Pilot
- National Health Information System
- Health Information and Quality Authority (HIQA)
- Population Health Observatory (INIsPHO)

Initiatives beyond the health sector

Examples

- Special Initiative on Ending Child Poverty
  - Increasing child benefit payments
  - Facilitate employment for lone parents
- Educational disadvantage
- National Children's Play Policy
- Office of the Minister for Children (established end 2005) to ensure better co-ordination across ministries. Under remit of Ministry of Health and Children
- Support for ex prisoners

Geographically targeted investment 1

- Government programmes prioritising investment into geographic areas of disadvantage
- Mainly capital – improving playgrounds, CCTV for safety, day care centres, improving kitchens in schools

Geographically targeted investment 2

- RAPID (Revitalising Areas through Planning, Investment and Development)
  - Urban areas and some provincial towns
    - 45 areas in all
- CLÁR (Ceantair Laga Árd-Riachtanais)
  - Isolated rural areas

Achievements outside the health sector

Consistent Poverty

15.1% in 1994 to 5.2% in 2001 to 6.8% in 2004*

Unemployment

4.3% in January 2006

Long-term unemployment under 2%

Education

Increasing participation of low income groups in 3rd level

*Methodology changed in 2003: not possible to draw conclusions from 2001 onwards

What we have learned 1

- Key Health Status Targets valid but need longer time frame

Some success in measures e.g.

- Improved regional access for cardiac procedures
- Reduced waiting time for hip replacements
- Improved respite for carers
- Increase in family support projects (at risk children)
- Income guidelines for medical card increased (for free health care)

However improvements still needed in all the above

What we have learned 2

- Multi-sectoral approach is best way to proceed but needs improved structures
- It is possible to mobilise actors
- More emphasis now on community involvement
- Health reform programme has strengthened structures for social inclusion in Ministry and Health Service Executive (HSE)
- Inadequate data for monitoring

Some Challenges

- Need to extend good practice and make more systematic
- Improve integration of policy at national level and service delivery at local level
- Roll out poverty proofing as a way of mainstreaming
- Get buy-in from other Government Departments to HIA
- More support for staff by way of networking and training
- Address inadequacies of socio-economic data for monitoring
- Support capacity building for community involvement

What we are planning 1

- Negotiating new Social Partnership Agreement
- Extending time frame of key health inequalities targets
- Short term targets/actions for 2006-2008

What we are planning 2

- Considering new mechanisms for cross sectoral working among Ministries
- Improved linkages within Ministry and with Health Service Executive

Useful Websites

- www.publichealth.ie
- www.socialinclusion.ie
- www.combatpoverty.ie
- www.dohc.ie