TARGET SETTING TO REDUCE HEALTH INEQUALITIES AND POVERTY: LESSONS FOR THE FUTURE

REPORT OF CONFERENCE PROCEEDINGS

Combat Poverty Agency *working for a poverty-free Ireland*

Report of Conference Proceedings

Target Setting to Reduce Health Inequalities and Poverty: Lessons for the Future

A Combat Poverty Agency Conference

Croke Park Stadium

December 6 2005

Contents

1. Summary

This national conference was the first in a series of seminars about poverty and health planned by Combat Poverty Agency. The aims of the conference were:

▶ to reflect on target setting to reduce health inequalities, both in an Irish and an international context, and

▶ to identify lessons from recent experience that will ultimately strengthen target setting and achievement in the future.

The conference attracted almost 100 participants from a wide range of sectors including community and voluntary organisations, health services, statutory bodies, social partners and researchers. Participants were welcomed by Combat Poverty Agency Director Helen Johnston who emphasised the strategic importance of high-level targets in the National Anti-Poverty Strategy and the Irish National Action Plan against Poverty and Social Exclusion. The conference was formally opened by Minister of State Mr Brian Lenihan TD, who noted in particular the timeliness of the event given the consultation process already underway in relation to revising the National Action Plan against Poverty and Social Exclusion.

● **Session One** of the conference was chaired by Dr Philip Crowley, Deputy Chief Medical Officer at the Department of Health and Children and comprised three papers by keynote speakers: Professor Ken Judge, Head of Public Health and Health Policy, University of Glasgow; Dr Helen McAvoy, Institute of Public Health in Ireland (IPH) and Ms Anna Lee, Manager, Tallaght Partnership. Professor Judge was unable to attend the event due to unforeseen circumstances. However Liz Sullivan of the Combat Poverty Agency delivered a detailed presentation he had provided in advance.

● **Session Two** comprised six separate workshops each of which began with a presentation. The topics covered by the workshops were: Setting Targets; Identifying Indicators; Data Collection; Involving Stakeholders; Monitoring and Evaluation; Institutional Mechanisms. The workshop presenters included Professor Brian Nolan, Economic and Social Research Institute (ESRI); Dr Sinéad Hanafin, Head of Research and Ms Ann Marie Brooks, Research Officer, National Children's Office; Dr Richard Layte, ESRI; Margaret Curtin, Northside Community Health Initiative Cork; Dr Kevin Balanda, Institute of Public Health (IPH) and Ms Marie O'Leary, Health Services Executive. This session was chaired by Dr Jane Wilde, IPH. The conference concluded with a paper from Professor Brian Nolan, ESRI, reflecting on key issues arising from the day; and with closing remarks and thanks from Liz Sullivan of the Combat Poverty Agency.

This report of the conference proceedings provides summaries of all the presentations, a brief résumé of the plenary discussion and a note from each of the workshop discussions. It also summarises the key messages and issues arising from the conference deliberations.

2. Key Messages and Issues Arising

Key Messages

- Health inequalities are defined as the 'systematic and avoidable differences in health outcomes between social groups such that poorer and/or more disadvantaged people are more likely to have illnesses and disabilities and shorter lives than those who are more affluent'. (Professor Ken Judge)

- Rates of premature mortality are substantially higher among those with lower levels of education, occupational class or income across many EU countries.

- An overview of national policies to tackle health inequalities in the EU-25 found that Ireland had a sophisticated approach and had formally outlined advanced co-ordination and monitoring and evaluation frameworks. However, the overview also found that there was little evidence of systematic evaluation of these policies across Europe.

- The inclusion of high-level health inequality targets in the National Anti-Poverty Strategy, the National Action Plan against Poverty and Social Exclusion, and the National Health Strategy is a positive development. It has helped to focus on the challenge of health inequalities and has created obligations in relation to the achievement of targets and monitoring progress towards them.

  However, while the agenda has been clearly set, the existence of these agreed targets must serve a more sophisticated purpose than agenda setting.

- While there has been monitoring of some individual targets, to date there has been no systematic monitoring of the full complement of the fifteen NAPS health inequality targets and no system for monitoring and review has yet been established. Yet it is clear that targets need to be supported by a robust, well-resourced monitoring and evaluation system if they are to be effective in bringing about change.

- Considerable data gaps exist in relation to population health status and health inequalities in Ireland. However, the emerging health information infrastructure (through the implementation of the National Health Information Strategy and the establishment of the Health Information and Quality Authority (HIQA)) provides an opportunity to help develop the required monitoring and evaluation systems and to generate more robust and relevant data.

- Reducing health inequalities is an extremely difficult and long-term process. Identifying targets is just the start. High-level outcome targets must be underpinned by specific intermediate goals and actions and a structure to take responsibility for goals and actions, from central to local level, must be put in place. The development, revision and monitoring of targets, and of actions to achieve them, must also involve the meaningful participation of people affected by poverty and health inequalities.

- Given the broad range of social and other determinants of health, multi-faceted responses are required to deal with health inequalities. Designing and delivering multi-faceted and integrated responses is a challenge for state agencies, community/voluntary organisations, faith groups, health services and local authorities; if they are to be effective the design and delivery of such integrated responses must encompass the full involvement of those affected by the problems being addressed.

- A commitment to tackling health inequalities should be encompassed in the Government's upcoming revised National Action Plan against Poverty and Social Exclusion. The development of that plan should also draw on the experience of, and lessons from, target setting and the monitoring/evaluation process in relation to NAPS health targets to date.

- It is clear that reducing health inequality is a long-term process. Currently the targets have an end date of 2007 set as a result of the review of the national Anti-Poverty Strategy (NAPS) in 2001. A ten-year strategy is being replaced by three-year NAPS Inclusions. It will be important in this new context to hold sight of a long-term vision for health.

- Although it has been difficult to monitor progress on targets, there is some evidence that, despite improvements in levels of premature mortality at population level, the degree of inequality has been fairly static over the very short time frame for which data are available.

Issues Arising

- There is a need to reassess the current set of targets; to headline outcome targets; to underpin targets with intermediate goals; to develop and specify policies aimed at each of these goals; and to clarify responsibility for goals and actions, from central to local level.

- There is also a need to develop strengthened links and communication between national targets and local action, and to generate mechanisms that will embed NAPS at local level.

- The need for resource mobilisation to ensure the implementation of NAPS at central and local levels continues to be fundamental.

- Efforts to improve population health status and health inequalities data collection are crucial. Different data may be required at central level and local levels. At central level improved data are necessary to monitor progress on headline or macro targets. At local level population health data can contribute to monitoring progress on intermediate goals and actions; but improved local data on health status and health needs are also required to support the targeting of resources, services and specific initiatives. Qualitative data, particularly in relation to the experience of service users, are also necessary to complement quantitative data.

- More thought needs to be given to how the more 'aspirational' targets, which have been agreed but which are not readily amenable to quantification, can be strengthened, and how progress on these can be measured and achieved: particularly in relation to improved equity of access to health services, an issue affecting many disadvantaged groups and individuals on a day-to-day basis.

- The need to actively facilitate the participation of those affected by poverty and disadvantage in the setting of targets and goals, in the design and delivery of integrated actions and in the monitoring and evaluation of progress towards their achievement, is an integral part of the NAPS process. However, realising the meaningful participation of those affected by poverty and building trust between relevant stakeholders requires significant commitment, time, resources, education, training and capacity building.

- While the health services have an important role to play in reducing health inequalities, they cannot do this on their own. Therefore co-ordination, integration and inter-sectoral collaboration across policies and actions in the many areas that affect people's health is essential. Health Impact Assessment offers potential as a tool for ensuring health benefits from a wide range of policies and actions.

- Achieving the NAPS health targets involves facing a number of other challenges. Reducing health inequalities for instance may potentially conflict with other health goals (e.g. increasing life expectancy across the population). In addition it is not always obvious what intermediate goals would actually push overall inequalities in the right direction and it is not often clear what policies or actions work in attaining intermediate goals.

- The question of the extent to which the emphasis should be on poverty reduction – or on the reduction of socio-economic inequalities – needs to be explored. The latter has been identified as crucial to both reducing the social gradient in health and improving the health of those who are worst off. This was an important message arising from the overview of health inequality policies in the EU-25 commissioned by the UK presidency.

3. Conference Programme

Chair: Dr Philip Crowley, Deputy Chief Medical Officer, Department of Health and Children

09.30   Registration

09.45   Welcome and Introduction
                Ms Helen Johnston, Director, Combat Poverty Agency

10.00   Opening Address
                Mr Brian Lenihan TD, Minister of State, Department of Health & Children

10.20   Poverty and Health Inequalities:
                Setting Targets to Reduce Health Inequalities – Key Challenges
                Professor Ken Judge, Head of Public Health & Health Policy,
                University of Glasgow

11.00   Questions and Answers

11.15   Tea/Coffee Break

11.30   NAPS Health Targets: Issues and Lessons
                Dr Helen McAvoy, Institute of Public Health

12.00   Social Determinants of Health: Monitoring Integrated Actions
                Ms Anna Lee, Manager, Tallaght Partnership

12.45   LUNCH

Chair: Dr Jane Wilde, Director of the Institute of Public Health in Ireland

14.00   Workshops
                1. Setting Targets
                Chair: Ms Anna May Harkin, Social Inclusion Unit, Department of Health and Children
                Input: Professor Brian Nolan, Economic and Social Research Institute

                2. Choosing the Right Indicators
                Chair: Dr Jane Wilde, Director, Institute of Public Health in Ireland
                Input: Dr Sinéad Hanafin and Anne-Marie Brooks, Research Officer, National Children's Office

                3. Data Collection and Analysis
                Chair: Mr Jim Walsh, Head of Policy and Research, Combat Poverty Agency
                Input: Dr Richard Layte, Senior Research Officer, Economic and Social Research Institute

                4. Involving Key Stakeholders
                Chair: Professor Ivan J. Perry, Chairperson, Primary Care Steering Group
                Input: Ms Margaret Curtin, Project Manager, Northside Community Health Initiative, Cork

                5. Monitoring and Evaluation
                Chair: Mr Eamonn Moran, Office for Social Inclusion
                Input: Dr Kevin Balanda, Institute of Public Health in Ireland

                6. Institutional Mechanisms – Linking National Targets and Local Delivery
                Chair: Ms Alice O'Flynn, Social Inclusion Manager, Health Service Executive
                Input: Ms Máire O'Leary, Health and Social Policy Officer, Health Service Executive

15.30   Policy Implications
                Professor Brian Nolan, Research Professor, Economic and Social Research Institute

15.50   Closing Remarks
                Ms Liz Sullivan, Head of Projects, Combat Poverty Agency

4. Background and Aims

Despite continuing economic growth, poverty and health inequalities persist within Irish society. It is widely accepted that socio-economic factors, including poverty, are key in determining health status. People experiencing poverty become sick more often and continue to die younger than those who are better off. Measures of health inequalities, including mortality rates, low birth-weight and poor nutritional status, are linked to deprivation measures such as income poverty, unemployment, inadequate housing and accommodation and poor-quality built and work environments.

For the first time, high-level targets to reduce poverty and health inequalities were set and policy measures to support these were identified, in the context of the government's review of the National Anti-Poverty Strategy in 2002. These were subsequently incorporated into the National Action Plan against Poverty and Social Exclusion (2003–2005) and the National Health Strategy *Quality and Fairness: A Health System for You.* This seminar provides an opportunity to reflect on progress towards implementation of these targets and to identify issues and lessons to inform future plans.

This seminar is the first in a series of five seminars on poverty and health, entitled *Poverty is Bad for Your Health*. Combat Poverty has prioritised access to quality health services within its current Strategic Plan (2005–2007). The seminar series is one of a range of initiatives being taken to highlight the importance of accessible, quality health services in reducing health inequalities and positively contributing to better health outcomes for people living on a low income.

Seminars within this series will address key aspects of policy where anti-poverty measures and health measures intersect. This first seminar in the series, *Target Setting to Reduce Health Inequalities and Poverty – Lessons for the Future,* has a practical focus on identifying issues and lessons and considering how best to overcome the challenges relating to setting, implementing and monitoring targets. It will build on experience in Ireland and internationally; and provide an opportunity for dialogue and reflection, identify lessons for policy and practice and contribute to the policy debate on poverty and health inequalities.

5. Welcome and Introductions

Ms Helen Johnston, Director, Combat Poverty Agency

Minister, speakers, ladies and gentlemen, I am pleased to welcome you here today to this conference on *Target Setting to Reduce Health Inequalities and Poverty: Lessons for the Future*.

Access to quality health services is one of the key objectives of Combat Poverty's current strategic plan, *Working for a Poverty-Free Ireland (2005-2007).* Tackling health inequalities is a priority, because despite continuing economic growth, poverty and health inequalities persist within Irish society. The conference today is just one of a series of initiatives we are undertaking with both the health sector and communities experiencing poverty and health inequalities to address these issues.

Socio-economic factors, including poverty, are central in determining health status. People experiencing poverty become sick more often and continue to die younger than those who are better off. Health inequalities, including mortality rates, low birth-weight and poor nutritional status are linked to deprivation measures such as income poverty, unemployment, inadequate housing and accommodation and poor quality built and work environments.

In 2003 (the most recent data available), 23 per cent of the Irish population, that is almost 900,000 people, were living below 185 per week (9,668 per year) (Central Statistics Office, 2005). In that same year, 9 per cent of the population or just over 350,000 people were living in consistent poverty (Central Statistics Office, 2005). Consistent poverty measures the proportion of people living on a low income (less than 185 per week) and experiencing basic deprivation, such as not having food, clothes or heat, or falling into debt because of everyday expenses. Some groups in society are particularly vulnerable. These include people who are ill or disabled, lone parents, and older women. It is important to note that children in Ireland are almost twice as likely as adults to be poor.

Findings from a Combat Poverty study, *Against All Odds,* on what life is like living in poverty showed that more than two thirds of the families interviewed had some health problems. People affected by ill-health were more likely to live on a low income because they were unable to gain employment or their employment experience was sporadic due to ill-health. The state of people's physical health was connected to their generally poor quality of life. For many, stress, isolation and depression were induced by lack on money and an inadequate income made a healthy diet difficult (Daly and Leonard, 2002).

It is vital that the policy choices we make have a positive impact on the health outcomes of people in poverty, and the targets and related indicators we set are appropriate and meaningful. This conference on *Target Setting to Reduce Health Inequalities and Poverty:*

Lessons for the Future is the first in a series on poverty and health. The series will address key aspects of policy where anti-poverty and health measures intersect.

Such a policy opportunity exists now. Ireland has both a National Anti-Poverty Strategy (NAPS) and a National Health Strategy (including a Primary Care Strategy). Combat Poverty welcomes the fact that high-level targets to reduce poverty and health inequalities were set in these strategies, as a consequence of the government's review of the National Anti-Poverty Strategy in 2002. The NAPS targets have subsequently been incorporated into the National Action Plan against Poverty and Social Exclusion (2003–2005), as NAPS and the National Action Plan have become one and the same. The National Action Plan against Poverty and Social Exclusion (NAP Inclusion) is currently being revised. It is an EU requirement to produce and submit the revised NAP Inclusion to the European Commission by September 2006. A consultative process is ongoing to inform its approach and content.

Therefore this conference is timely, as its purpose is to take stock of progress towards meeting the current set of NAPS/NAP Inclusion health targets, with a view to making recommendations on future target setting. The conference will have a practical focus on identifying issues and lessons from NAPS/NAP Inclusion and the Health Strategy to date, and in considering how best to overcome the challenges related to setting, implementing and monitoring targets. It will build on experience in Ireland and internationally. It is anticipated that the conference will provide an opportunity for dialogue and reflection, identify lessons for policy and practice and contribute to the policy debate on poverty and health inequalities.

The results of today's proceedings will be recorded and a report drafted by Clare Farrell, our conference rapporteur, and will appear on our website. We also intend to publish a paper setting out guidelines and benchmarks for target setting to reduce health inequalities and poverty going forward, which will be produced by Professor Brian Nolan of the Economic and Social Research Institute (ESRI), who is keeping a watchful eye on proceedings today.

Before I finish, I would like to acknowledge the strong and valuable working relationship that has been developed between the Combat Poverty Agency and the Department of Health and Children, the Institute for Public Health in Ireland and more recently, the Health Service Executive. I would also like to pay tribute to the communities that have engaged with us, through our *Building Healthy Communities Programme*, in putting forward the kinds of processes and mechanisms that demonstrate how health outcomes for people living in poverty can be improved, informed by their own experience in their respective communities.
I am looking forward to thought-provoking papers and challenging discussions.

Thank you for your attention.

6. Opening Address

Mr Brian Lenihan TD, Minister of State, Department of Health and Children

Introduction

I am pleased to be here this morning to open this conference. The timing is very appropriate given that the wider consultation process in relation to the next National Action Plan against Poverty and Social Exclusion is already well underway. I would like to commend the Combat Poverty Agency for their initiative in organising the event. I know that this conference fits within the wider context of Combat Poverty's own Strategic Plan which aims to inform health services planning and policy to meet NAPS objectives.

The wider consultation process is a key ingredient in helping to ensure that the health issues included in the next Action Plan reflect the views of a range of stakeholders. There still remains, however, the more specific and technical task of identifying targets which will serve as a focus for action and for measuring progress. I know this conference is a welcome opportunity for you to reflect on progress towards achieving the existing NAPS health targets and to identify issues and lessons to inform future plans.

NAPS Health Targets

The inclusion of targets specifically to reduce health inequalities is a relatively recent feature in the National Anti-Poverty Strategy. The first such targets were included in the Government's Review of *Building an Inclusive Society* published in 2002. These targets were chosen by Government from those recommended in the Report of the Working Group on NAPS and Health which also included measures to achieve the targets. This time round we have the benefit of the experience of that initial target-setting process and of working to achieve and monitor them over the last three years.

I know that some of the key targets set in 2002 do not lend themselves easily to achievement within a short timeframe. These include, for example, the targets in relation to reducing differences between socio-economic groups for low birth-weight rates and for mortality from cancer, heart disease and injuries. They are, nonetheless, important areas around which to focus action.

With my own specific brief for Children, I recognise the health gain to be achieved by reducing low birth-weight rates. Indeed, the rate of low birth-weight is included in the suite of Child Well-being Indicators published by the National Children's Office earlier this year. It is the intention to publish periodic reports on the Child Well-being Indicators and it would bring added value to the report if the data were to be provided by socio-economic group.

There are already in existence a range of national strategies and plans relevant to NAPS health targets and social inclusion issues generally in the health sector. We have, for example, the Primary Care Strategy, the Cardiovascular Health Strategy, the Traveller Health Strategy. Soon we will have the National Cancer Strategy and the Report of the Expert Group on Mental Health Services. Social inclusion-relevant aspects of the existing strategies and plans feature in the current National Action Plan against Poverty and Social Exclusion 2003–2005. Whatever targets are chosen for the next Action Plan, I think a key issue will be the degree to which people experiencing poverty and social exclusion have equity of access to, and benefit from, the health services.

Social Determinants of Health

One of the challenges facing all of us who have an interest in reducing health inequalities and poverty is the need to take into account the broad social determinants of health. While access to quality health services has an important role to play in improving health in our population and in reducing health inequalities, the health system on its own cannot do this. Income, employment, education, housing, transport, physical environment, safe and socially supportive communities and an environment that supports healthy lifestyle choices are also important ingredients.

The concept of poverty and social exclusion which Government chose to underpin the NAPS at its origin in 1997, provides an enabling policy environment for stakeholders to emerge from their 'silos' and focus on what actions, by whomsoever, are necessary to achieve the outcomes desired in reducing health inequalities and poverty. The institutional framework, which was considerably strengthened in *Building an Inclusive Society,* and which includes the Cabinet Committee on Social Inclusion, the Senior Officials Group on Social Inclusion and the Office for Social Inclusion, provides the means at national policy level whereby key crosscutting issues can be addressed. Indeed many important issues are already being addressed through these mechanisms.

A similar degree of co-ordination and inter-sectoral action is required between agencies at local level if targets to reduce health inequalities are to be achieved. I am pleased to note that both the Local Authorities and the Vocation Education Committees are represented at the conference and I also note that one of your workshops is on Monitoring Integrated Actions. City and County Development Boards (CDBs) and Revitalising Areas by Planning Investment and Development (RAPID) structures have an important role to play in promoting co-ordination at local level.

In the term 'inter-sectoral collaboration' I include the community and voluntary sector. I would like to acknowledge the contribution the sector is making not only in

implementation work on the ground but also in terms of their expertise and input at policy and planning level and in events such as this conference.

Data Issues

I note that one of the challenges you have identified relates to data collection. I am aware that data to a desirable quality standard have not always been available to facilitate target setting and reliable monitoring. A number of important initiatives are underway to improve this situation.

The National Health Information Strategy (NHIS), which was launched in 2004, sets out a phased action plan for the development of information systems to meet the requirements of improved evidence-based decision making throughout the health sector.

The lead role in many of the actions in the National Health Information Strategy will be taken by the Health Information and Quality Authority (HIQA) which is in the process of being established.

Another important development is the piloting of an ethnic identifier question on the hospital in-patient/perinatal systems in two Dublin hospitals which commenced in July 2004. Data gathering on the project has been completed. The data will be analysed and the report drawn up over the next number of months. The ethnicity question designed by the project has already been adapted by the Central Statistics Office and piloted for use in the 2006 Census of Population.

Collection of demographic and socio-economic data to standards agreed with the Central Statistics Office will be piloted within the Coronary Heart Attack Ireland Register (CHAIR, in HSE Southern Area) and in Cardiac Rehabilitation Information Systems (CRIS). The pilot in hospital settings in the HSE Southern Area has just commenced. If it proves feasible to collect data to an appropriate quality, then access to and outcomes of these cardiac services may be estimated for different demographic and socio-economic groups. The data standards may also be included in other health information systems.

New Social Inclusion Structures

The strengthening of social inclusion structures in the reform process both in the Department of Health and Children and the HSE bespeaks both a recognition of the importance of reducing health inequalities and a commitment to working to achieve this goal. Within the Department, we have created a Social Inclusion Unit where we are bringing together relevant elements of the Department's work in a more coherent way. In the HSE, a

National Care Group Manager for Social Inclusion has been appointed within the Primary and Continuing Care Directorate and four Local Health Officer Managers (LHOs) have been given lead responsibility for social inclusion in the regions. Within the Population Health Directorate in the HSE, a Head of Equality and Diversity has been appointed. A unified health system should facilitate the stepping down of national targets into effective implementation measures at local level. All of these developments augur well for a more unified and coherent approach and by implication greater success in reducing health inequalities.

Acknowledgements

I would like to say a special word of thanks to a number of people who have played a part in making this conference possible–to Ms Liz Sullivan and Ms Fidelma Joyce of the Combat Poverty Agency for their initiative in organising the event and to Dr Helen McAvoy of the Institute of Public Health who has been reviewing the existing targets, in particular from the point of view of the adequacy of monitoring data. I know that this conference is just one example of the many ways in which both Combat Poverty and the Institute have been working with the Department and the HSE over the past number of years to support the achievement of the existing targets to reduce health inequalities. The health sector is also having the benefit of the support of the Office for Social Inclusion.

Conclusion

Given the considerable challenges associated with setting, implementing and monitoring targets, I don't propose to detain you any longer from your task. I wish you a fruitful session and I look forward to seeing the benefit in the next National Action Plan on Inclusion.

7. Poverty and Health Inequalities

Setting Targets to Reduce Health Inequalities – Key Challenges

Professor Ken Judge, Head of Public Health and Health Policy, University of Glasgow
(This is a summary of the complete presentation. The full set of slides is available from Combat Poverty Agency.)

Presentation Outline

- Defining the problem
- Evidence from Europe
- What are the principal causes?
- Complexities related to poverty and health
- Overview of national policy responses
- Focus on targets – mainly British experience

Defining Health Inequalities

The systematic and avoidable differences in health outcomes between social groups such that poorer and/or more disadvantaged people are more likely to have illnesses and disabilities and shorter lives than those who are more affluent.

Health Inequalities in Europe: Europe in Profile

Analysed data on inequalities in mortality for 21 countries on inequalities in self-reported morbidity for 18 countries and on inequalities in smoking for 23 countries.

In Austria, Belgium, Czech Republic, Denmark, England/Wales, Estonia, Finland, France, Hungary, Ireland, Italy, Latvia, Lithuania, Netherlands, Norway, Poland, Portugal, Slovenia, Spain, Sweden, Switzerland ... rates of premature mortality are substantially higher among those with lower levels of education, occupational class or income.

Together with inequalities in mortality, inequalities in morbidity contribute to large inequalities in 'healthy life expectancy'. Typically persons with high socio-economic positions live more than 10 years longer in good health.

During the past decade, great progress has been made in unravelling the determinants of health inequalities in European countries. Health inequalities are mainly caused by the

higher exposure to material, psychosocial and behavioural risk factors in lower socio-economic groups.

Poverty and health are closely associated but…

- Relationship varies by health outcome
- Health selection has to be considered
- Permanent or transient poverty in a world of poverty churning
- Different definitions of poverty identify different groups and give different answers.

National and International Policy Responses

WHO Europe: *Reducing Inequalities in Health* 1998
  – ten recommendations made to provide an approach through which
  – inequalities in health can be reduced.

Ken Judge et al. *Health Inequalities: the Challenge for Europe* 2005
  – overview of national policies in EU-25.

Selected WHO Recommendations

- Tackle the root causes of inequalities in health in society
- Monitor the differential effectiveness of interventions on different groups
- Establish evaluation and monitoring mechanisms to assess impact
- Set equity targets … in an integrated and coherent manner.

Types of National Approaches to Health Inequality

- Legislative commitments (Greece, Germany)
- Explicit goals in national policy documents (Denmark, Sweden, Italy)
- Quantitative targets
  - WHO (Czech Republic, Latvia)
  - Fairly general (Finland, Netherlands)
  - Fairly sophisticated (Ireland and UK).

Responsibility for Action

- General commitment to equity but no formal mechanism for co-ordinating initiatives on health inequalities - *Italy, Netherlands*

- Co-ordinated action evident but not comprehensive - *Germany, Hungary, Spain*

- Advanced co-ordination mechanisms - *Ireland, Sweden, UK*

Types of Action

- No distinctive focus on health inequalities – *Cyprus, Greece*

- Some actions are in place but relatively modest – *Belgium, France*

- Health equity features prominently in public health policy – *Hungary, Sweden*

- Well integrated and co-ordinated action plans – *Ireland, UK*

Monitoring and Evaluation

Monitoring
   – very little can be observed *(many countries)*
   – some indicators (*Denmark, Latvia, Poland*)
   – extensive efforts are in place (*Ireland and UK*)
Evaluation
   – most countries can cite examples of interesting studies of interventions
   – but little evidence of systematic reviews of overall strategies anywhere

Challenges

- Real commitment needs to be commensurate with concern

- More thought needed about targets

- Think more about the gradient

- Better monitoring is essential

- Use such evidence as does exist

- Evaluation of natural experiments is key

- More comparative studies needed of the impact of health equity of different welfare models

- There is always scope for more and better international collaboration.

Targets

- What should be the focus?

- How can they be measured and monitored?

- How can they be delivered?
- What are the linkages between national and local action and targets?

Improving the Health of Poor People

- While offering policy advantages, defining health inequalities as the health penalties of poverty has limitations
- It conflates inequality and disadvantage
- It turns socio-economic inequality from a structure which impacts on everyone into a condition to which only those at the bottom are exposed.

Narrowing Health Gaps

- The focus is again confined to a small proportion of the population which can encourage perspectives that identify the lifestyles of disadvantaged groups as the cause of health inequalities
- It can obscure the pervasive effects which socio-economic inequality has on health not only at the bottom, but across the socio-economic hierarchy.

Reducing Health Gradients

- A focus on socio-economic differentials rather than on social disadvantage widens the frame of health inequality policy
- It locates the causes of health inequality not in the disadvantaged circumstances and health damaging behaviours of the poorest groups, but in the systematic differences in life chances, living standards and lifestyles associated with people's unequal positions in the socio-economic hierarchy.

Conclusions

- Targets should focus at a minimum on 'closing the gap'
- They must be feasible and not simply aspirational
- There are many traps for the unwary, and thinking through the implications of targets is essential
- The quality of the planning process at both national and local levels is critical
- Targets should be the product of theories of change
- Transparent monitoring mechanisms are vital.

8. NAPS Health Targets: Issues and Lessons

Dr Helen McAvoy, Public Health Development Officer, Institute of Public Health in Ireland

The link between poverty and health is well-established and yet we continue to grapple with the complexities of monitoring progress in tackling health inequalities. We all seek to better understand the mechanisms by which the impact of poverty on health is changing over time. We are also seeking the best possible information when faced with the challenging task of deciding on the best approach to improving the health of Ireland's poorest citizens, be that in determining policy or in designing services.

How do health inequality targets help?

In the first instance, health inequality targets help us by focusing attention on the challenge of health inequalities in Ireland. The recognition of health inequality targets within government policy brings an obligation on government departments not only to articulate actions to reach those targets, but also to monitor progress towards those targets over time.

In the longer-term I'm sure we would aspire to have our health inequality targets serve a more sophisticated purpose than 'agenda-setting'. It is the ultimate goal that the targets could 'perform' at a level where they could provide us with indications of where efforts to reduce health inequalities were succeeding and where they were failing. Such information could prove vital in instructing us as to the appropriate redirection of resources to assist those in greatest need.

The Working Group on the National Anti-Poverty Strategy (NAPS) and Health is an inter-departmental group convened by the Department of Health and Children that oversees policy-level approaches to health inequalities in Ireland. The current group includes three subgroups relating to health services, child health and research.

The purpose of my talk today is to share with you some of the learning that has been gained in terms of the setting and monitoring of health inequality targets in Ireland. This learning has been gained through the current Research Subgroup of the Working Group on NAPS and Health. This subgroup comprises representatives from the Institute, the Health Service Executive, the Economic and Social Research Institute, the Central Statistics Office, the community and voluntary sector and others. The subgroup has been overseeing the development of a paper that reviews progress with the targets set by the Working Group on NAPS and Health in 2001. This paper is being conducted by the Institute of Public Health, with funding from the Combat Poverty Agency, and is very much a work in progress.

In order to put this work in context, let me first provide you with some of the key *milestones* in the history of the development of health inequality targets in Ireland. As part of the review of the National Anti-Poverty Strategy, the Department of Health and Children convened a Working Group on NAPS and Health in 2001. This Working Group was set an important and challenging task – to have a vision of an Ireland where, as the overall health of the population improved, so would inequalities in health be reduced. From this vision, the group were then required to propose feasible targets for the reduction of inequalities in health over a relatively short time period (i.e. targets to be achieved between 2001 and 2007).

Three themes emerged from the initial deliberations of the Working Group relating to the social determinants of health and the group split into three smaller groups to achieve their task. One group developed targets relating to healthy public policy and multisectoral working and the others developed targets relating to health services, and to information and research.

To assist them in their task, a wide-ranging consultation, including the use of telephone lines and meetings, and a review of international experience in target setting, was undertaken – this is detailed in the report 'Giving People a Say on Poverty and Health' . The task of the working group was made particularly challenging in terms of the short timeline for the development of the targets and an absence of readily accessible 'real life' statistical data on which to base any quantitative targets.

For the final report, the Working Group was then requested to prioritise a small number of quantitative targets and to limit the scope of these targets to reductions in 'hard' health outcomes. Overall, the Working Group proposed fifteen targets for the reduction of health inequalities in Ireland between 2001 and 2007. These targets are detailed in the Report of the Working Group on the National Anti-Poverty Strategy and Health.

What is the nature of the targets proposed by the Working Group on NAPS and Health?

There are three 'core' targets – these seek reductions in the number of premature deaths experienced by lower socio-economic groups, improvements in the life expectancy of Travellers and a reduction in the occurrence of low birth-weight babies born to disadvantaged families.

The other targets refer to improving equity of access to health and social services, the development of governmental policy and strategy and the establishment of comprehensive systems of monitoring and review for the targets proposed. The Working Group were acutely aware of the dearth of reliable data and information on which to base national

targets and proposed the targets in the context of a first step in a process of monitoring, review and development

What happened to these targets?

The three core targets referring to reductions in 'hard' health outcomes were adopted in the revised National Anti-Poverty Strategy in 2002. A number of the targets, including those adopted in NAPS, were specifically adopted in the action plan for the national health strategy *Quality and Fairness* in 2001. The 'enshrinement' of health inequality targets within government policy is thus a recent development in Ireland and one of which we should be proud.

How have the targets been monitored?

It is fair to say that there has been no systematic monitoring of the full complement of fifteen health inequality targets. A briefing report on progress with the indicators in the three core NAPS targets is submitted by the Department of Health and Children on an annual basis to the Office for Social Inclusion. The Department also produces action progress reports in respect of *Quality and Fairness* which provide some high-level information on progress towards some of the health inequality targets.

Crucially, three of the fifteen targets proposed by the Working Group refer to the establishment of a comprehensive system of monitoring and review for the NAPS and Health targets. No such system was established. This may have been due, in part, to the 'limbo' caused by substantial delays in the publication of the National Health Information Strategy. When the strategy was eventually published in 2004, the Health Information and Quality Authority (HIQA) was tasked with developing health information necessary to effectively monitor and review the NAPS health targets. As yet the HIQA is in an early stage of development. These delays have created difficulties in the monitoring of the targets and the development of the necessary information systems since 2001.

On the positive side, the mainstreaming of health inequality issues into the National Health Information Strategy, the monitoring of the action plan for *Quality and Fairness* and the functions of the HIQA are extremely positive developments. I think it is vitally important to kick-start this agenda as our health information infrastructure develops in 2006.

At this point, I trust that I have provided you with a feel for the context in which the initial targets were set and an understanding of the process by which these targets were developed. At this juncture, I would like to stress a few key points:

a) the importance of having health inequality targets in and of themselves

b) the initial targets were not considered as the definitive set of targets – rather as the beginning of a process whereby targets would be refined and developed through monitoring and review and

c) the negative impact of a lack of attention to the monitoring and review elements of the targets on one side of the coin and, on the other, the opportunity to pursue this agenda through the roll-out of the National Health Information Strategy.

So I will now move this presentation from the general to the specific by presenting some of the issues that arise in respect of reviewing progress with the NAPS health inequality targets. I hope this will enlighten you to as to some of the complexities inherent in monitoring these targets and prompt you to contribute to the debate in the workshops this afternoon.

It would not be practicable to go through all fifteen targets so I have elected to present information relating to progress with one of the NAPS targets, by way of example.

Target 1

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

Rationale for this target

Circulatory disease, cancers and injuries and poisonings account for nearly three quarters of all deaths in Ireland. There is robust evidence of inequalities in premature mortality from these causes in both international and Irish literature.

Findings from analysis of the target

Analysis on mortality and population data provided by the Central Statistics Office shows that, in 2003, there were 79% more deaths observed among men aged under 65 years in the lowest socio-economic groups for circulatory diseases than would have been observed if that group had the same death rate as the highest socio-economic group.

For cancers 70% more deaths were observed and there were four times as many deaths observed in the lowest socio-economic group when compared to the highest socio-economic group in respect of injuries and poisoning. The differences in standardised mortality rates did vary over the years 2001 to 2003, but these differences were not statistically significant.

What can we conclude?

We can reliably state that people of lower socio-economic status continue to be at greater risk of dying prematurely from circulatory disease, cancer and injuries and poisoning. Despite improvements in levels of premature mortality at population level, there is some indication that the degree of inequality is fairly static over the very short timeframe for which data are available.

This finding would seem to be roughly in line with inequalities in death rates from cancer and heart disease (presented under the heading 'the big killers') within the 2005 status report on the monitoring of the UK national health inequalities strategy *Programme For Action*.

You may gather that these conclusions are rather tentative. Going back to the original title of this talk which refers to 'issues and lessons', here are some of the issues that the Research Subgroup has faced in interpreting progress with this target.

▶ There is a large proportion of 'unknowns' (24%) recorded in the statistics in terms of socio-economic status. This raises some doubt over the accuracy of the statistics.

▶ The terms 'gap', 'premature mortality' and 'lowest socio-economic groups' within the target can be interpreted in different ways. For example, the gap can refer to an absolute reduction in rates or in rate ratios. Socio-economic group (SEG)-D comprising manual workers has been taken as the lowest socio-economic group in the analysis, but in view of the large number of unknowns, this may not be meaningful.

▶ The differences in socio-economic coding systems between census and vital statistics data are of major concern and this raises questions about the capability of the data to monitor change over time.

▶ The occupational data on women are too poor to facilitate socio-economic coding, so we have no data on women.

▶ The target refers only to premature deaths. We recognise that health inequalities also affect older people (65 years and older) and that, with an ageing population, the burden of health inequalities may increasingly affect Ireland's older citizens. We also recognise that the poor quality of occupational data on this group could hamper meaningful analysis. We are understandably concerned that existing information systems can, in fact, reinforce inequalities by their inability to provide information on vulnerable groups such as older people and women.

▶ There are time lags in accessing data in relation to the time-line of targets, so that data relating to the end-point year (2007) may not be available until 2009.

▶ There is a need to develop mortality targets and their underlying information systems so that they are in harmony with those used at European level.

Summary

I hope that this presentation has given you some idea of the issues facing us in terms of moving forward with monitoring the existing NAPS health inequality targets. The Research Subgroup will continue to consider the conceptual, statistical and policy issues raised in monitoring the targets. I hope that the input that you will provide in the workshops today will contribute to the work and, in turn, that the work of the Research Subgroup will contribute to the work of those of you addressing health inequalities at policy level and at the coal-face of service provision and advocacy.

In summary, the take-home points from my presentation today are as follows:

● Ireland's health inequality targets need to be supported by a robust, well-resourced monitoring and evaluation system if they are to develop to a stage where they can usefully redirect policy and monitor meaningful change. There is an exciting opportunity to develop this within the emerging health information infrastructure in Ireland, most notably through the HIQA and the implementation of the National Health Information Strategy. There must be clear responsibilities within the emerging infrastructure in terms of monitoring health inequalities. Existing health information systems need to be appropriately supported in developing their capacity to monitor health inequalities according to socio-economic status and also according to the nine grounds set out in the Equal Status Acts 2000 to 2004.

● We need to better understand 'who are the poor' in a health inequality sense, and define lower socio-economic groups in our health inequality targets. This must encompass aspects of gender, demography (ageing ethnicity etc) and social change. For example, the target for asylum seekers and refugees may need to be reassessed in light of the changes in Ireland's ethnic minority community with rising numbers of migrant workers.

● There is a need to integrate the health inequality targets within the wider body of knowledge in relation to the NAPS targets covering the social determinants of health such as housing, education and employment.

- Stagnation in the publication and roll-out of strategy relating to health information, primary care and specific subgroups at risk of health inequalities, has had a serious impact on effectively monitoring our health inequality targets.

Our focus on tackling health inequalities must not get lost within the shifting sands of anti-poverty and health policy. The end-date for the National Anti-Poverty Strategy, and thus for the targets, is 2007. There is no indication that another 10-year strategy will be developed from 2007 onwards. Instead, government policy on addressing health inequalities will comprise of three year action plans referred to as National Action Plans against Poverty and Social Exclusion, the next such action plan covering the period 2006 to 2008[1]. We know from the international literature, and common sense, that tackling health inequality is a long-term goal. We need to have a view on how much emphasis we wish to place on short-term, process-based targets within the three year action plans to support the reduction of health inequalities. We also need to keep our focus on where we want to go and our vision of what an Ireland without health inequalities would look like, and not lose those long-term targets within a shift to three year action plans.

We need to accept the limitations of the current targets without throwing the baby out with the bathwater.

Acknowledgements and some relevant reading

(Institute reports are available at www.publichealth.ie)

Institute of Public Health (2001) *Report of the Working Group on the National Anti-Poverty Strategy and Health*

Institute of Public Health (2001) *Equity of Access to Health Services - Some Relevant Issues in an Irish Context*

Institute of Public Health in Ireland (2001) *Setting Health Targets for the National Anti-Poverty Strategy – A Background Research Paper*

Institute of Public Health in Ireland (2002) *Giving People a Say on Poverty and Health – Learning from the National Anti-Poverty Strategy and Health Consultation Process*

Institute of Public Health in Ireland (2001) *Inequalities in Mortality – a report on all-Ireland mortality data.*

Public Health Alliance Ireland (2004) *Health in Ireland – An Unequal State*

Equality Authority (2005) Equal Status Acts 2000 to 2004 and Provision of Health Services

Department of Health UK (2005) *Tackling Health Inequalities: Status Report on the Programme for Action* (www.dh.gov.uk/healthinequalities/)

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[1] After the period 2006-2008 three year National Action Plans will be required

9. Social Determinants of Health: Monitoring Integrated Actions

Ms Anna Lee, Manager, Tallaght Partnership

In the introduction to the World Health Organisation's publication *Social Determinants of Health – the solid facts* (2003) Richard Wilkinson and Michael Marmot write:

> *Combining economics, sociology and psychology with neurobiology and medicine, it looks as if much depends on understanding the interaction between material disadvantage and its social meanings. It is not simply that poor material circumstances are harmful to health; the social meaning of being poor, unemployed, socially excluded, or otherwise stigmatised also matters. As social beings, we need not only good material conditions but, from early childhood onwards, we need to feel valued and appreciated. We need friends, we need more sociable societies, we need to feel useful, and we need to exercise a meaningful degree of control over meaningful work. Without these we become more prone to depression, drug use, anxiety, hostility and feelings of hopelessness, which all rebound on physical health.*

And we have, for some time now, understood that effective responses to poverty and social exclusion require integrated actions, with those who are the target/s of the action actively engaged with the design, delivery and implementation of the action. This paper will:

- Identify the social determinants of health

- Outline the width and range of responses that are required to impact positively on some of these determinants and the associated poverty and social exclusion

- Describe some integrated responses to improve the position of people living in poverty and their health

- Discuss some of the challenges linked to integrated actions and to monitoring such action.

Social determinants of health

- 'Rainbow' or 'layers of influence model' from Dahlgren and Whitehead.
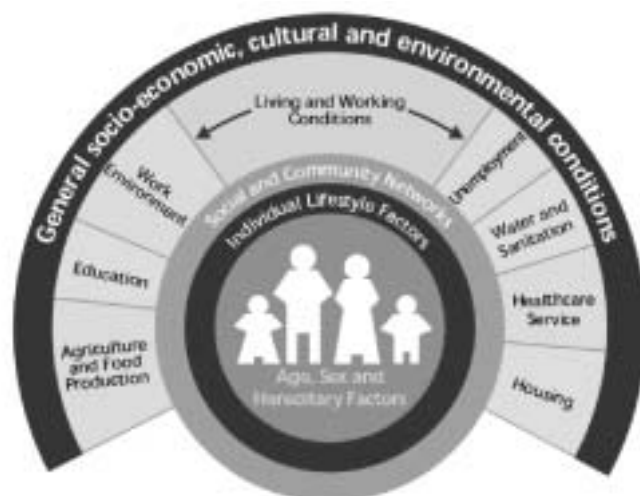
The WHO publication, referred to earlier, identifies the following

- **The social gradient/ social class** – poor social and economic circumstances affect health throughout life. Analysis of the causes of death of Irish men in the highest occupational group compared with those in the lowest occupational group show that men in the latter group have a significantly increased risk of dying from a range of causes.[2] In disadvantaged communities in Tallaght one in three people are categorised as being in social class 7.

- **Stress** – continuing anxiety, insecurity, low self-esteem, social isolation and lack of control, over work and home life. People in lower social classes more likely to experience these problems.

- **Early life** – pregnancy connections, low birth-weight and later health challenges; risks associated with insecure emotional attachment and poor stimulation.

- **Social exclusion and poverty** – associated stresses.

- **Work** – having a job better than not having one; people who have more control over their work-place have better health.

- **Unemployment** – higher risk of premature death

- **Social support** – social isolation and exclusion are associated with increased rates of premature death.

- **Addiction** – social links.

- **Food** – impact of good diet and adequate food supply.

- **Transport** – exercise.

It is useful to add to this list from the 'rainbow' diagram above, especially education and housing. It is important to note the interrelationship of these factors and the negative impact on individuals when, for example, low social class, unstable work interfaced with unemployment and poor social supports, in a badly maintained environment, come together.

Responding to the social determinants of health

The WHO document outlines policy changes required to reinforce positive determinants of health and to address those that are negative. The changes are frequently complex; would, in many instances, require a significant shift in current social and economic policy; and require a clear implementation strategy across many organisations and interests, that is integrated actions. It is useful to reflect on some of these in an Irish policy context:

- **Social class**: little discussion about social class in Ireland. Evidence-based analysis of the impact of social class on health outcomes is available. Important articulation

from some interests of the benefits to be gained from a more equal society in health and other areas – limited evidence of the radical policy shifts and integrated responses needed to achieve this. Policy focus on reducing absolute poverty – very important progress and related impact on health clear.

- **Stress**: Wilkinson and Marmot identify the key contributors to stress-related ill-health – continuing anxiety, insecurity, low self-esteem, social isolation, and lack of control over work and home life. Effective responses to these factors cross a range of interests. Need to improve the social environment – more places for positive social interactions; material security – adequate income levels; good quality built environment – clean, safe. Multi-faceted responses are required – challenge for state agencies, community/voluntary organisations, faith groups, local authorities.

- **Early life**: Recognition of the importance of preventive health care in achieving positive health outcomes for mothers and children. Requires response of range of health professionals – ongoing challenges for intra-agency/sector working. Also requires contribution of education interests, growing body of childcare services.

- **Social exclusion and poverty**: Establishment of area-based partnerships, RAPID programme – acknowledgement of complex nature of poverty and social exclusion and the need for complex and integrated responses including health actions. Some concern that geographic focus is masking need for income redistribution policies and those demonstrably effective actions are not impacting on mainstream policy.

- **Unemployment**: Important focus of public policy in last 15 years. Need to develop effective responses to those who remain unemployed, the non-progression ready – many of whom have difficulties linked to addictions including alcohol, and those who are distant from work, in particular other groups of people who are social welfare dependent. Requires integrated focus of FÁS, education organisations, health services and employer sector.

- **Social support**: Increasing policy discourse – social capital and active citizenship. Need actions to respond to increased urbanisation, reduced time for association, particular needs of migrant workers and their families, refugees and asylum seekers, isolated elderly, people with disabilities. Cross-society response needed.

- **Education**: Education an important determinant of health. Optimising participation in education and the putting in place of compensatory educational opportunities is also a complex matter requiring the effective cooperation of a number of organisations and bodies.

Target Setting to Reduce Health Inequalities and Poverty: Lessons for the Future

Integrated responses to improve the position of people living in poverty and their health

The majority of actions undertaken by the Tallaght Partnership are planned to impact on the social determinants of health and to improve health outcomes for people.

- **Flexible Training Unit:** project to assist older, long-term unemployed men to access the labour market. Started with focus on working with the participants to address social exclusion and poverty, unemployment, social supports and low levels of educational attainment. Majority of project participants have high stress levels and a significant number have addiction to tobacco, alcohol and to a lesser extent illicit drugs. Health profile of the participants is poor. Project operates on a number of levels and is funded/supported through a number of sources – FÁS, Co. Dublin VEC, Department of Social and Family Affairs, Partnership, HSE. Activity focuses on improving education and skills levels; development of participants' self-confidence, awareness and relationships with others including their children and partners; improving physical and mental health. Project has strong links with the HSE health promotion team and the community alcohol services. Increased participation opportunities, social supports and achievement of key milestones have challenged the participants to manage their health better. Improved health, psychological and physical, has improved employment chances. But smoking cessation programme has not been effective – there were no reference points for the participants.

- **Food project:** to develop a programme to address food poverty in a disadvantaged community; acknowledging the inability to access food of sufficient quality and quantity due to issues of access and affordability. Building on work of CPA, Crosscare and SVP. More specifically the programme aims to increase the amount of fresh fruit and vegetables bought, prepared and eaten by people living in this community. Low-income households spend a large proportion of its budget on food and find it harder to buy healthy food within the budget, retail options in disadvantaged areas are limited, transport issues impinge and cultural norms, social skills and knowledge play a role in buying, preparing and eating food. Project actions to focus on health/nutrition awareness; influencing retail provision, developing cooking skills, increasing possibilities of people eating together; growing food; school meals and the building of social capital. Project will need participation of HSE, South Dublin County Council, Co. Dublin VEC and Department of Education and Science. Most crucially it will need the participation and ownership of the local community.

Challenges linked to integrated actions and to monitoring such actions

The following are challenges arising in relation to integrated actions such as those that might be used to impact on the social determinants of health and the monitoring of those actions.

- Clarity regarding purpose of action and planned outcomes

- Ensuring that the integrated action has everyone it needs to work successfully and in particular the active participation of those who are the target of the action

- Ability of partners to work together at project level while ensuring that their own particular contribution is delivered in a timely and effective way

- Understanding, agreeing and implementing the sequence of actions

- Building trust – that everyone will do what they say they are going to do and will do it to the best of their ability

- Respect for partners and their possible limitations – effective communication.

Integrated actions, like all actions, should be monitored in relation to the effectiveness of:

- the integrated process; *and*

- outcomes

  ▶ Process monitoring needs to take place on a continuous basis.

  ▶ Monitoring of outcomes requires good baseline data.

  ▶ Need evidence that the integrated actions are producing more successful outcomes and/or a wider range of successful outcomes than if any one organisation was acting alone. Also need capacity to identify impact of particular aspects of integrated strategy and to make changes as required.

Given the determinants of health, and the fact that responsibility for addressing the determinants is not the responsibility of health professionals, integrated working may be disproportionately important to the achievement of positive outcomes.

References

Health in Ireland – an unequal state. Public Health Alliance Ireland, 2004

Social Determinants of Health: The Solid Facts, 2nd ed. World Health Organisation, 2003

10. Brief Note of Plenary Discussion

The presentations were followed by a lively plenary discussion. The points raised by conference participants in response to the speakers in the morning session can be summarised as follows:

- The EU research/overview of health inequality policies said that Ireland had advanced co-ordinated mechanisms. This view was based on research undertaken outside Ireland, and might surprise people working on the issues here, so speakers were invited to comment on the report's view of the Irish situation.

  [In response speakers explained that the report was based on a review of documented policy frameworks and that it did in fact identify as problems the gap between policy commitment and implementation/action and the absence of systematic evaluation of policies. It was noted that this gap can be considerable, and that it underlines the need for political commitment and resource mobilisation to ensure the implementation of formal policies.]

- Trying to support the involvement of those living in poverty and experiencing health inequalities is vital and remains a challenge.

- The importance of involving people who are socially excluded was raised again, and attention was drawn to a piece of research in the north inner city of Dublin called 'We're People Too: the views of drug users on health services'. This report is the result of a collaborative effort of the Participation and Practice of Rights Project, the Union for Improved Services, Communication and Education and the Mountjoy Street Family Practice; and gives voice to drug users about their experiences of health services.

  [In response Liz Sullivan of Combat Poverty Agency agreed that the involvement of people affected by poverty was crucial and that there was a strong focus on strengthening the involvement of people in poverty in the Combat Poverty programme Building Healthy Communities.]

- The importance of being loved and nurtured from an early age is very important for health and well-being and implies a responsibility for the Department of Education. The current debate about childcare is driven by middle-class concerns about the costs of childcare rather than the needs of children, and yet all of our small children in infants and senior infants continue to be in primary school classes of 30-35.

[In response Anna Lee agreed and added that in particular we need to focus on the needs of people who have not gained from the current boom; this investment has not been made.]

- A speaker who had direct experience highlighted the need for frontline staff in some health/welfare and local authority services to treat people who come to them for help with respect and dignity. The speaker had felt 'looked down on' and felt that many people on welfare or seeking housing had this negative experience with officials.

[In response Dr Phillip Crowley said this experience highlighted the need to go back to the issue of rights and the need for people receiving services to have rights and entitlements rather than having to rely on discretion. A speaker from the floor said that his experience in MABS of working with frontline staff had been very positive. Another speaker made the point that many people who are involved in delivering services have never experienced poverty.]

- A speaker working within the Health Service Executive said that one of the challenges for staff delivering services is to ensure that there are systems in place to receive feedback from people on they are doing their job.

- The problem posed by limited health data was reiterated, particularly in relation to local data and mortality statistics at the small area level.

11. Conference Workshops

Workshop 1: Setting Targets

Input: Professor Brian Nolan, Economic and Social Research Officer
Chair: Ms Anna May Harkin, Social Inclusion Unit, Department of Health and Children
Notetaker: Ms Barbara Walshe, Combat Poverty Agency

1. 1 Workshop Input

How Can Targets to Reduce Health Inequalities Help?
▶ a public declaration that current inequalities are unacceptable and
▶ a commitment to address them by developing/implementing policies
▶ targets can provide a rallying point for mobilising a multi-sectoral, multi-agent response
▶ targets can act as benchmarks against which overall progress can be measured.

The Downside of Target-Setting
▶ Setting targets can be a substitute rather than a spur for action
▶ High-level targets may fail to capture core concerns and can take on a life of their own – failure to reach them can de-motivate
▶ Micro-level targets can distort behaviour while high-level targets are no help in evaluating the impact of particular policies
▶ It is still hard to frame a meaningful strategy without them.

What Makes a Useful Target?
Targets should be:
▶ Specific, quantified and unambiguous – depending on available indicators
▶ Ambitious but attainable
▶ Actionable – but only in broadest sense for high-level outcomes.

Setting Policy-Relevant Targets
▶ Set headline targets for the outcomes we care most about (and can measure)
▶ Underpin these with intermediate-level policy goals/performance targets
▶ Develop a set of policies aimed at attaining these specific goals
▶ Make clear who is responsible for delivery of these targets.

Learning from Irish Experience with Poverty Targets

▶ Primary focus has been on single 'global poverty reduction target', framed in terms of 'consistent poverty' measure

▶ Desirable to move towards tiered set of headline targets:
  – Real incomes rising and deprivation levels falling for those on low incomes
  – Consistent poverty falling (with both fixed and slowly changing set of items)
  – Relative income poverty falling.

Learning from EU Experience

▶ Social Inclusion process adopted Laeken indicators – multidimensional

▶ Member states invited to set targets for significantly reducing poverty by 2010

▶ Health inequality indicators unsatisfactory:
  – Life expectancy
  – Differential in self-assessed health by income

▶ Capturing premature mortality by socio – economic status in a common framework now a key priority.

Overall Aims

Health Strategy: Better health for everyone, including a reduction in health inequalities. Fair access – equitable access for all categories of patient

NAPS Review: Reduce inequalities in health by making health and health inequalities central to policy, acting on social factors, improving access for poor, improving information and research base

NAPS Health Targets: Reduce gap in premature mortality between lowest and highest SEGs by at least 10% for circulatory diseases, cancers and injuries by 2007. Reduce gap in low birth-weight rate between lowest and highest SEGs by 10% by 2007. Reduce gap in life expectancy between Traveller Community and population by at least 10%. Develop guidelines for respite care for carers, improve respite care for disabled, reduce waiting for hip replacements, reduce harm caused by misuse of drugs, improve services for families, improve access for rural dwellers.

Moving Forward

▶ Reassess current set of targets

▶ Headline outcome targets – improving health of disadvantaged, faster

▶ Underpin with intermediate goals (e.g. improve access, reduce smoking for lower SEGs)

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- Develop and specify policies aimed at each of these goals (e.g. availability, health promotion)
- Clarify responsibility for goals and actions, from central to local level

Some Challenges
- Reducing inequalities potentially conflicting with other health goals – including increasing life expectancy
- Not always obvious what intermediate goals would actually push overall inequalities in the right direction (e.g. reducing deprivation?)
- Not always obvious what policies work in attaining those intermediate goals (e.g. changing behaviour with respect to smoking, drinking)

Achieving Health Inequality Targets
- Likely contribution of health services modest
- Emphasis on poverty reduction, disadvantaged areas in UK
- But reducing socio-economic inequalities is key
- Who 'owns' the targets? Office for Social Inclusion, Department of Health and Children
- Note: Treasury in UK has key role in PSA process

Conclusions
- Reducing health inequalities is extremely difficult
- High-level outcome targets must be underpinned by specific goals and actions
- Structures must be put in place to take responsibility for goals and actions, from central to local level.

Targets are just the start!

2. Note of Workshop Discussion

Key Feedback points
- Health targets involve cross - cutting departments and a collaborative approach to their delivery.
- Targets set must be explicit and be owned and have buy-in from staff internal to the HSE.
- They are set in conjunction with the groups that are supposed to benefit from them and with the frontline staff who need to understand the context in which they are operating.

- Headline targets need to have sets of medium - term goals, which encourage people to track their progress towards meeting those targets.
- Need to have greater understanding of the social determinants of health by a range of stakeholders; this will involve having this information available in a style that is clear and clear accessible to all.
- Need to have strong links between national and regional levels and an understanding of what the national targets mean at both county and regional level in terms of being able to meet them.

Initial response to the presentation

- Policy levers have indirect impacts on health inequalities. Big time lag between intervention and outcomes. Need for medium - term goals and policies to target those goals. Targets need to be clearly owned, with clear responsibility for achieving those targets at the level of both personnel and department.

Experiences and challenges

- Process needs to be right. Needs to have the input and involvement of both service deliverers, frontline staff and people experiencing poverty.
- Lots of work on health inequalities going on but little evidence of integration between the work at policy or operational level.
- Consultation with all stakeholders takes time.This poses challenges in terms of meeting the deadlines in the context of the National Action Plans for Poverty and Social Inclusion.

Workshop 2: Choosing the 'Right' Indicators

Input: Dr Sinéad Hanafin and Anne Marie Brooks, National Children's Office
Chair: Dr Jane Wilde, Director, Institute of Public Health
Notetaker: Ms Bevin Cody, Head of Information, Combat Poverty Agency

2.1 Workshop Input

Dr. Sinéad Hanafin and Anne Marie Brooks made a presentation on the approach taken by the National Children's Office to develop a set of well-being indicators for children. (Slides of the presentation are available.) Some of the key points to emerge from the input were as follows:

Developing Indicators

Indicators are statistics that seek to capture developments in areas of significant concern. They aim to provide empirical, valid measurements of key dimensions of human well-being. (National Statistics Board 2003)

- Establishing the definitions of 'indicators' and 'well - being' at the outset was important.
- In developing the indicators, certain principles were adopted, including the following:
    - ✓ Go beyond basic survival in its representation of well-being
    - ✓ Focus on positive as well as negative aspects of children's lives
    - ✓ Take account of the experience of childhood in itself
    - ✓ Go beyond traditional domains to a broader conceptualisation of well-being
    - ✓ Each set to have between 25 and 30 indicators.

Definition of well-being

Healthy and successful functioning, positive social relationships and a social ecology that provides safety, human and civil rights, social justice and participation in civil society
(Andrews et al 2002)

- Having an indicator set is not about having huge numbers of indicators, it is about being able to filter down the huge number into a meaningful set of good indicators.
- Finding the right indicators is difficult because of the fact that there are multiple indicators, multiple positions and standpoints, different aspects depending on professional perspectives.
- Children (i.e. the people whose experience is being measured) need to be included in the development of indicators.

- In developing indicators for NAPS, the first question is to identify how NAPS should be conceptualised (i.e. to measure poverty, at a programme level, to measure well-being etc).

- Need to consider who the stakeholders are (i.e. policy makers, NGOs, children)

- National Children's Office assessed the issues relating to group development of indicators, and for various reasons, including group effect, logistical problems etc, opted for a 'multi-stage incremental approach'. This involved:
  - ✓ Background review to compile inventory of indicators
  - ✓ Feasibility study of data sources (in doing this they found many data sources – admin and survey data – that currently are not used)
  - ✓ Study of children's understanding of well-being (this involved giving children cameras to take pictures of 'makes them feel good')
  - ✓ A consensus process referred to as a Delphi technique.

The 'Delphi Technique', a research approach

This was used to gain consensus through a series of rounds of questionnaire surveys, where information and results are fed back to panel members between each round.

Uses
- Where a problem does not permit the application of precise analytical techniques but can benefit from subjective judgments on a collective basis

- Where the experts are in different fields and occupations and not in direct communication

- Where the number is too large to effectively interact in a face-to-face exchange

Main features
- Structured communication
- Anonymity
- Iteration and feedback
- Statistical group response

Stakeholders
- Small advisory group
- Panel of expertise: parents, policy makers, researchers, service providers
- Children and young people

Round 1
What are the main elements of child well-being?
- Event list with 56 broad areas

- Findings from a pilot study on children's understandings of well-being
- Participants asked to rate the importance of each area and provide rationales
- Demographic information

Round 2

How much agreement is there?
- Prioritised list of indicator areas (26)
- Key areas from children's understandings
- List of excluded areas
- Feedback
- Request to choose three additional areas

Round 3

Satisfaction overall with indicator set; comments on the Delphi technique.

Results
- 42 child well-being indicators
- 7 socio-demographic indicators
- 4 to be developed
- 96% very satisfied or satisfied with indicator set, 96% very satisfied or satisfied with process.

Evidence shows that Delphi approach leads to more effective outcomes

Benefits:
- ✓ Inclusive and consultative
- ✓ Comprehensive
- ✓ Rigorous and systematic
- ✓ Efficient

Disadvantages:
- ✓ Incomplete understanding of rationale of others
- ✓ Lack of group effect
- ✓ ack of transparency of different perspectives of key stakeholders.

Moving Forward for NAPS
- What are you measuring?
- Who should decide?
- How should decisions be taken?
- When will you know you are there?

2.2 Note of Workshop Discussion

The workshop discussion highlighted the following points:

Feedback

- There is a long time-lag between performance indicators being set for health and any progress/feedback being reported back to service providers (if at all). This results in a loss of momentum. It is often not clear what progress is being made, how progress is being monitored and how good practice is being captured. An effective feedback and action loop is a critical element in any set of indicators and is vital for achieving sustained buy-in.

- The process itself of developing indicators helps to build awareness and buy-in to indicators, but this momentum wanes if there is no feedback.

- Greater clarity is needed regarding what people are measuring and what data are being used for. Communication tools such as reports, cascade processes etc, should be used to feedback on indicators.

Timing

- Allowing adequate time to set indicators is important to getting indicators right. Often this time is not available. The rushed timeframe to develop indicators can undermine them. Time and thought are needed to figure out what actually needs to be measured.

- Improvements in health take time, so long-term health targets are needed. This was the case under NAPS, but the 2-year timeframe of the NAP/incl does not allow for this. 'What framework for long-term targets will replace NAPS?'

Linking Indicators to Actions

- Enforcing observations from indicators should be built into the process (i.e. implementing actions in response to indicators).

- Indicators should be used to inform specific approaches (e.g. in schools). There must be a link between national indicators and activities at a local level.

- The Delphi approach is a good way of linking indicators to actions because it delivers a high level of buy-in among stakeholders at both national and local level.

Target Setting to Reduce Health Inequalities and Poverty: Lessons for the Future

Health Needs of Specific Groups

- Health indicators should be comprehensive and inclusive. For example, indicators relating to ethnic communities are important. Need to ascertain what data are available regarding this, and what the particular health needs of ethnic communities are. 'Now is the time to develop research on the specific health needs of immigrants.'

- With regard to the NAPS targets on Travellers' Health, it is virtually impossible to relate the target with local performance indicators. Often the wrong indicators are being used to measure targets and there is a gap between the indicators and the targets. 'How do you know the gap isn't a chasm?'

- Indicators need to be developed to measure improvements in the health deficit of the Traveller Community.

- State officials should be trained to recognise they are dealing with real people, not just statistics or forms. The requirements of specific groups need to be considered.

- The accessibility of the health service is a key issue for immigrants. Indicators are needed to monitor how well an understanding of accessing the health services is promoted among ethnic communities.

Approaches to Setting Indicators

- Participation of service users in the process of setting indicators is important in order to ensure that their voice is heard.

- A building block approach is needed. A different range of indicators is needed at each level to build towards an outcome indicator. A combination of indicators is needed to inform the process.

- Targets are fine in theory, but in reality there are contradictions between different agencies/government departments in how well they can be met (conflicting policies etc). A cross-agency approach to developing indicators is needed.

- More qualitative indicators are needed. NAP/Incl mainly focuses on quantitative data, but it is necessary to look at the subjective experience of service users.

Linking Indicators to what is being Measured

- NAPS needs different sorts of indicators around processes, partnerships, services etc. Measurement around what is happening at the coal-face is important as this is the experience that people in poverty are exposed to.

- The quality of the interface between service provider and client needs to be monitored (i.e. need to measure respect, etc).

- This approach measures performance. It is not target measurement. Whether this is appropriate depends on what the targets are (e.g. performance or poverty reduction). Otherwise, there is a risk of measuring things that are not important.

- The performance of the system needs to be measured. Currently it is a middle-class system and everyone else needs to be able to work around this. The system currently reports on itself. Objective performance indicators based on service user experience needs to be developed to stop collusion.

- Services should be delivered by a more diversified provider i.e. more people who understand poverty, or come from ethnic minority backgrounds. The service provider should reflect the nature of the clients (similar to concept of community policing where people who understand and have grown up in a community should be the people to police it).

Workshop 3: Data Collection and Analysis

Input: Dr Richard Layte, Senior Research Officer, Economic and Social Research Institute
Chair: Mr Jim Walsh, Head of Policy and Research, Combat Poverty Agency
Notetaker: Ms Caroline Corr, Research Officer, Combat Poverty Agency

3.1 Workshop Input

NAPS Targets
Three targets currently included in NAPS:
10% decrease in mortality for three causes between top and bottom
10% decrease in life expectancy gap between Travellers and average
10% decrease in gap in low birth-weight between top and bottom

Additional Proposed Targets
Working Group on NAPS and Health also proposed:
5 additional targets on equity of access (and utilisation)
3 targets on government policy (income, medical cards, equality proofing)
4 targets on to improving research, monitoring and review
15 targets in all, 3 of which are quantitative

Issues with Existing Quantitative Targets
Data from 'unlinked' register of deaths and census
'Denominator' problems – move toward linked registers with personal identifiers?
Quality of occupational data suspect in death certificates
Mortality and census use different occupational codes
Occupational status – an issue for women
No ethnic identifiers (Travellers)

Data Collection and 'Equity' Targets
'Equity' in what? – access, utilisation, other specific measures (waiting times?)
Waiting period begins after consultation
National Treatment Purchase Fund (NTPF) Register does not record socio-economic data from which to assess equity
NTPF data do not include private patients
Total 'Population' measures of utilisation with health and socio-economic indicators are needed (problems with Hospital In Patient Inquiry (HIPE) and Survey Living and Income Conditions (SILC))

Problems Analysing 'Equity'
'Equity' usually defined in relation to need

Yet measuring 'need' is problematic, particularly in social surveys
'Medical', 'functional' and 'subjective' measures give different results
Should equity be assessed across the whole population or between sub-groups?

3.2 Note from Workshop Discussion

People's experiences in relation to collecting and analysing data within the health domain

- The Health Information Strategy identified many of the problems. However, there was a 3-year delay with the Strategy and a further delay with the establishment of HIQA.

- There may be differences between data needs at a national level and local level.

- There was a challenge in relation to making valid choices around conceptual issues (e.g. perinatal data–choosing occupational class of mother or father).

- Another challenge was identifying the most appropriate data sets (e.g. should researchers use social welfare data, medical card data, rent allowance data, etc?).

- Main problem with HIPE data is that it does not contain information on socio-economic status.

- Medical card status is collected in HIPE and was perceived as a potential proxy for disadvantaged socio-economic status – but this may become less useful with doctor-only medical cards and over-70s medical cards.

- Difficulties were cited getting in relation to getting ethnic identifier mainstreamed. There is a challenge for health services in relation to number of nationalities and languages. However, ethnic identifier was piloted in Tallaght and Rotunda and there was 100% compliance.

- Main challenges for health services in relation to data collection are resources and staffing.

- Data systems not linked or co-ordinated.

- Occupational data measures higher professionals better than lower socio-economic groups.

- Income is a useful measure but is complicated to collect. Income alone was not considered adequate as an indicator of class.

Procedures that need to be put in place at different levels to enable good practice in relation to data collection and analysis

- The main need is to identify most appropriate data systems that can be used now and design data sets that could be used in the long term. Large-scale surveys may be useful.

- There is also a need for a dedicated funding system to forward the data collection agenda.

- There is a need to agree a standard identifier for socio-economic classes and groups.

- It was generally understood that the HIQA would monitor data but more clarification was needed on the HIQA's role in population health statistics and clarification on who is responsible for the collection of data.

- A need was identified for more up-to-date and readily available data.

- It was also recommended that data be pooled from different data sources and that different data sets be linked.

- Community groups should be involved more in data collection and analysis. Community workers in some areas have been trained to collect data.

- Codes of practice should be introduced (particularly addressing confidentiality issues and sharing of data).

Workshop 4: Involving Key Stakeholders

Input: Ms Margaret Curtin, Project Manager, Northside Community Health Initiative, Cork
Chair: Professor Ivan J. Perry, Chairperson, Primary Care Steering Group
Notetaker: Ms Elaine Houlihan, Projects Officer, Combat Poverty Agency

4.1 Workshop Input

NICHE: The Northside Community Health Initiative (Cork)

- Founded in 1998 with EU funding through the URBAN programme – now funded by the Health Service Executive
- Managed by an independent board of management drawn primarily from the local community
- Serves the Knocknaheeny/Hollyhill area of Cork City
- Works at both practical and policy levels
- The goal of NICHE is: to see the quality of life in Knocknaheeny/Hollyhill as good as that enjoyed in any other area of Ireland
- Purpose: to institutionalise a holistic and social model of health within the area.

Underlying Principles

- Health issues are an important aspect of quality of life in local areas
- 'Social Model of Health'
- Community development approach to promoting health and well-being
- Locally-led, locally managed, local Community Health Workers

Areas of Work

- Community health worker-led support
- Developing mechanisms for community consultation
- Bringing health services into areas
- Inter-agency collaboration
- Improved access to health information
- Consolidation of the role of the community health worker

Community Health Workers (CHWs)

WHO define CHWs as

> *workers who live in the community they serve, are selected by that community, are accountable to the community they work with, receive a short defined training and are not necessarily attached to any formal institution.*

What is unique about the Community Health Workers?

- Deeply connected with the local community
- Non-medical
- Local skills and talent
- Support people to become involved
- Act as a link between local people and services/activities
- Work with people and not for or to them
- Equality with the community

Involving Stakeholders

Community Health Planning 2003

NICHE Strategic Planning

Response and Feedback 2004

Knocknaheeny/Hollyhill Healthy Community Partnership Launched 2005

Community Health Planning

Purpose:

- To ensure that NICHE stays in touch with changing community health needs
- To identify the steps needed to make further progress in the promotion of health in Knocknaheeny/Hollyhill
- Based on Rapid Participatory Appraisal
- Principle of Respect for Local Knowledge and Local Preferences
- Group Survey followed by Group Planning and Analysis*Process:*
- Training of fifteen local people in Community Health Planning techniques
- Two Community Health Workshops run by trained group:
  – Health Survey Meeting
  – Health Planning Meeting

Health Survey Meeting

Local people only; all ages

  – Over seventy people attended
  – Local health priorities identified
  – Charts and maps on social, environmental and economic issues
  – Issues raised were identified as *Themes for Action*

Themes for Action

- A clean and beautiful environment
- Health and well-being

- Medical facilities and health services
- Children, young people and education
- Safe environment
- Housing
- Social, personal and community development
- Recreation, sports and amenities

Health Planning Meeting

– Community and agency stakeholders also included

– Groups worked on 'Themes for Action' identified at first meeting

– Constructive planning approach.

Causes and Effects in Relation to Health: Residents' views

Health pressures
- Low income
- Unemployment
- Lack of education opportunity
- A dirty and bleak environment
- Traffic hazards
- Isolation
- Poor nutrition
- Lack of support for young people
- Lack of medical facilities
- Lack of recreational facilities

Health Impacts
- Asthma
- Young pregnancy
- Suicide
- Road deaths/injuries

Negative Responses
- Drinking
- Crime
- Dangerous driving
- Depression
- Violence
- Stress
- Smoking

Positive Responses
- Socialising
- Exercise and sports
- Healthy diet
- Gaining an education
- Finding employment
- Good support

Response and Progress Report

- Analysis of Progress on Themes by relevant groups
- Feedback and Response from Community
- Analysis of Census 2002 Small Area Statistics relative to Community Issues

Knocknaheeny/Hollyhill Healthy Community Partnership

Endorsement by City Manager and HSE Local Health Manager of Partnership formed by the HSE and City Council in conjunction with NICHE and the local Community on a Social Model of Health

Partnership Themes

Environment / Primary care / Mental well-being / Youth

4.2 Note from Workshop Discussion

Initial response to the presentation

- Viewed as an interesting project with a clear working model of community health worker.
- Lots of questions for NICHE about the project.

What experience do people have in relation to involving stakeholders?

- Community health workers are good at engaging people who are most vulnerable and marginalised, as they play a key role in outreaching to the communities in which they are located. CAIRDE is at the beginning of a similar project and involving local people is key to the work.
- It is important to complement representative democracy with participatory democracy at local level.
- There can sometimes be tensions at local level between organisations with a participatory ethos and organisations with a hierarchical structure.
- Agencies need to commit to work in a different way and commit to action. This commitment can still be dependent on individuals.
- Consultation takes time and resources.
- Engaging and consulting with communities can raise expectations. People want to be consulted and need to receive feedback but participation and consultation are different activities. Participation implies an ongoing process and being active in decision-making. Participation supports people's health.

What needs to be in place at different levels to enable good practice in relation to involving stakeholders?

- Delivery of health services depends on staff. Social inclusion staff tend not to be involved in direct service delivery. There is a perception among community and voluntary organisations that mainstream staff tend not to work from a participatory perspective and do not hold a social view of health. There is a need for training and education around these issues and for cultural shifts in the statutory sector. It was perceived that senior managers do not see communities as experts.
- Building trust takes time.

- Resources are needed on an ongoing basis and over longer-term cycles.

- It is important to resource local community health workers. The model in Cork works.

- Education is key to empowering communities.

- It is important to set standards and measurable outcomes.

- Planning systems in the HSE need to embrace the participation of communities.

- There is a need for good baseline data and a targeted approach at local level.

- Dialogue/partnership and building capacity are essential.

Workshop 5: Monitoring and Evaluation: How should We Frame it?

Input: Dr Kevin P. Balanda, Institute of Public Health in Ireland
Chair: Ms Liz Sullivan, Head of Projects, Combat Poverty Agency
Notetaker: Ms Izabela Litewska, Combat Poverty Agency

5.1 Workshop Input

At the Same Time ….
- Full review of the NAPS
- National Health Strategy and Primary Care Strategy
- National Health Information Strategy
- National Health Research Strategy

The Mood at the Time
- Very broad agenda
- High expectations
- Participatory approach
- Strong demand for action
- Paucity of reliable information

What came out of it?
- Implementation Strategy
- Three levels of targets ('exact' targets, 'aspirational' targets and indicators)
- Research Monitoring and Review Framework

The Targets …
- Four health status targets
- Seven equity of access to health service targets
- One public policy target
- Three research, monitoring and review targets

Research, Monitoring and Review Targets
- System to monitor targets and indicators
- Research to develop further targets and indicators
- Process to review and revise targets

Research, Monitoring and Review Framework
- Three-pronged approach:

      – Three levels of targets including research and information targets

      – Research, monitoring and review framework

      – Implementation strategy

- Conceptualised as a continuing process
- Commitment to inequality targets
- Active follow-up

What has Happened Since?

- Health services reform and information infrastructure developments
- NAP/Incl. and National Action Plans
- Policy commitments to NAPS
- Particular projects (ethnicity data, Low Birth-weight project, quality of mortality data, etc)
- Reconstituted Working Group

In Summary

- Big changes in health services and information infrastructure
- Policy commitments are there
- There are significant opportunities
- Framework provides a good start
- Let's get on with it

Some Questions

- What should we monitor/evaluate?
- What sort of data are needed?
- What methods are required?
- Does the framework need updating?
- How do we implement it in the new environment?
- Who should be involved?

5.2 Note from Workshop Discussion

Initial response/key points:

- The thinking of the NAPS Health Working Group was to involve a wide range of stakeholders in the development of information systems. This can only happen through participation of these stakeholders at the beginning of the process and further through implementation and evaluation.

- Only through such involvement can policymakers gain an understanding of factors that contribute to health inequalities.

- Qualitative data are needed, so that personal stories/histories can be taken into account. Indicators of people's experiences of poverty and of access to the health services are needed to complement other health indicators (e.g. mortality and morbidity rates).

- There is a gap between setting targets and actions to achieve targets. There is also an issue of accountability: who is responsible for what – what is the local/delivery level responsibility in anticipated actions and monitoring actions?

- Greater co-ordination of various policies, such as disability, housing, employment etc. is required. The use of Health Impact Assessment in this process offers potential.

- Targets/actions established at the central level need to be meaningful to both service providers and service beneficiaries. National/local feedback, communication mechanisms need to be developed. There is also a need for capacity building at local level so that groups can engage, and for more training in evaluation and monitoring.

- Having access to good baseline data is important for the implementation of effective action and for monitoring and evaluation. Disaggregated data are also necessary so that the needs of specific groups can be addressed. _

- There is a need to focus on equity of access and a need for improved awareness and training among frontline health services staff.

What needs to be put in place?

- *Partnership* among service providers and other stakeholders, based on respect and trust. Once there is respect and trust there is feedback to and from local level.

- *Quality assurance* indicators. However, we should not create unrealistic expectations. They must be translated into viable action (for example, by establishing conditions for funding we can engage but at the same time set obligations).

- *Engagement* of service beneficiaries at the very beginning of the policy cycle in setting mechanisms for data design, collection and monitoring.

Workshop 6: Institutional Mechanisms – Linking National Targets and Local Delivery

Input: Ms Máire O'Leary, Health and Social Policy Officer, Health Service Executive
Chair: Ms Alice O'Flynn, Social Inclusion Manager, Health Service Executive
Notetaker: Ms Sharon Keane, Combat Poverty Agency

6.1 Workshop Input

Outline of presentation
- Current situation regarding national targets
- Local anti-poverty and social inclusion work within the health sector NW – examples
- Issues, challenges, concerns
- How can we strengthen the link between national targets and local action?
- Suggested approaches

Current National Targets
NAPS Health Targets 2002:
- To reduce the gap in premature mortality between the lowest and the highest socio-economic groups by at least 10% for circulatory diseases, cancers and injuries and poisoning by 2007
- To reduce the gap in low birth-weight rates by 10% for children from the lowest and highest socio-economic group by 2007
- To reduce the gap in life expectancy by at least 10% between the Traveller Community and the whole population by 2007
- General NAPS targets have significant health impacts.

Current National Targets
NAPS and Health Working Group:
- Monitoring health status of Travellers, asylum seekers and refugees
- Greater access to Primary Care, Community and Continuing (PCCC) services
- Greater access to acute hospital services
- Community supports
- Equality within cardiovascular and cancer strategies
- Targeted injury prevention strategy
- Increase medical card eligibility
- Equality dimension in service delivery
- Multi-sectoral work and Health Impact Assement
- Monitoring systems
- Research programme
- Review and revision

Current National Targets

Quality and Fairness:

- Supports 3 key NAPS targets
- Multi-sectoral approach
- Equity of access
- Research/data
- Barriers to healthier lifestyles for disadvantaged groups eliminated
- Actions to improve the health of Travellers, homeless people, drug misusers, asylum seekers, refugees and prisoners.

Current National Targets

NAPs/Incl.

- Make health and health inequalities the centre of public policy
- Act on the social factors influencing health
- Improve access to services
- Improve the information and research base re: health status and service access
- Implement Quality Customer Service principles
- Develop Performance Indicators for vulnerable groups

Examples of local anti-poverty, equality and social inclusion work

(NW Area)

- Community-Focused Health Projects
- Primary Health Care Projects for Travellers
- Primary Care Implementation Project
- Under the Spotlight: A Growing Family in a Growing Town
- Active Age Projects
- Social inclusion of older people: Voice of older people
- Local Area Teams

Local anti-poverty, equality and social inclusion work

- Inter-sectoral working
- The County Development Boards (CDBs)
- Social Inclusion Measures Groups
- Donegal Health Forum
- Donegal Youth Council
- Traveller accommodation and health – HIA
- Action on Alcohol in the North West
- Integrated Homeless Action Plan

Local anti-poverty, equality and social inclusion work

Tailoring services to meet needs:

- Equal Status Review and Action Plan
- Diversity Management Training
- Participation by Young People in Service planning, delivery, monitoring and evaluation through NW Children and Young People's Committee
- Research into the health needs of the lesbian/gay/bi-sexual community

Issues, Challenges, Concerns

- Low priority for anti-poverty work
- Low awareness levels of NAPS and anti-poverty work
- Integration within the health service
- Lack of dedicated resources – sourced externally
- Issues relating to access to services
- Community participation needs strengthened
- Need for research and data – disaggregated
- Inter-sectoral work is challenging.

Links between National Targets and Local Actions

- Existing targets still relevant
- Gap between national targets and local actions
- Lots of good work going on but like 'stabbing in the dark'
- Clearer link where there is a focused strategy
- Inter-sectoral work needs a national framework
- Little monitoring of how local work impacts on the national targets
- Need for implementation plans which are evidence-based, supported, integrated, resourced and monitored.

Linking national targets and local delivery

Two proposed approaches:

- NW Social Inclusion Action Plan
- The Power of Outcomes – working towards a common purpose.

Social Inclusion Action Plan –
A Proposed Framework for Anti-Poverty/Social Inclusion Work in Health
Key National Actions

1. *Awareness and Understanding of Social Inclusion*
    – Build knowledge
    – Enhance staff participation

      – Improve data

      – Set up Learning Networks

2. Participation

      – Range of methods of participation

      – Role of community development in promoting and protecting health

      – Key National Actions.

3. Action on Health Inequalities

      – Develop comprehensive National Strategy to tackle health inequalities including new NAPS and health targets based on consultation and evidence

      – Develop local implementation plans, e.g. Traveller Health Strategy

      – Monitor progress – data

4. Equal Access to Services

      – Increase eligibility

      – Mainstream in-service planning and delivery

      – Professional training and development

      – Key National Actions

5. Prevention and Early Intervention

      – Focus on work with children and families

      – Address link between educational attainment and health inequalities

6. Co-ordination/Integration/Partnership

      – Health at centre of public policy

      – Inter-departmental agreements as foundation for local inter-agency work

      – Develop and sustain work with County Development Boards

      – Make HIAs a requirement in larger developments

7. Develop, Implement and Evaluate Pilot/Demonstration Projects

      – Socially Inclusive Local Health Office

      – Socially Inclusive Hospital

      – Extend Primary Health Care model

The Power of Outcomes – Vermont

- High-level outcomes which all sign up to – common purpose – powerful statements – emotional resonance

- Related Indicators – track progress

- Actions linked to these at local level, between and within agencies

- Agencies, users and communities involved

- Everything is connected – doesn't matter where you start

- Ten-year process – strategic view
- DATA, DATA, DATA!
- Show results/Give credit/Build credibility and confidence
- Economic benefits result in further investment

Examples of Powerful Outcome Statements
- Young people choose healthy behaviours
- All children succeed at school
- All families and individuals live in safe supportive communities
- Older people and people with disabilities live with dignity and independence in their preferred place

Outcomes Model – what's different
- Not so much emphasis on structure and process – more on results
- Shift from activity and input indicators to well-being and outcome indicators
- Not hierarchical – focus on teams and partners
- Self-directed motivation
- Long-term view
- Not so much about integrated services as integrated actions and results
- Families and institutions must fulfil basic human needs for affection, appreciation and achievement

Summary of Key Proposals to improve linkage
- National outcomes and targets agreed
- National frameworks and agreements to support local delivery
- Implementation plans to be delivered at local level
- Dedicated resources
- Research and data for evidence-base, monitoring and evaluation
- Integration: *NAPS, Social Inclusion, Equality, Community Involvement, Performance Indicators, Population Health, Hospital, PCCC Directorates, HIQA*

6.2 Note of Workshop Discussion

Initial Response
- Very focused presentation

What experience do people have in relation to local delivery on the NAPS targets – what have been the successes/challenges?

- Internally a challenge for health services is communicating effectively with staff working at a local level. There needs to be a distilling of documents, strategies, language and encouragement of ownership.

- Social inclusion has been sidelined to certain areas within the health sector and it needs to be embedded within others.

- Quite a high degree of representation sought from the HSE to sit on committees. This requires staff and in turn resources to support these staff.

- Staff sitting on committees should have decision-making ability.

- If people don't see outcomes from structures participation drops; structures are seen as talking shops and become discredited.

- At a local level relying on individuals to push agendas; need for a few 'evangelists' at national level.

- Assumptions made about what people understand as community participation; it is about more than consumer involvement.

- Strategies to encourage participation of ethnic minorities usually stay at the level of inter-culturalism.

- Participation is a right.

- Building the capacity of people to participate to the actual point when there are outcomes from a project takes a long time and is resource intensive – this needs to be acknowledged.

- Pace of change is slow and there is a lack of understanding by people outside the HSE regarding the complexities.

- Inter-sectoral working appears to be a lot more common at local than at national level.

What needs to be in place to enable good practice in relation to meeting current and future NAPS health targets? Who needs to be involved? What mechanisms need to be in place?

- Need to create spaces for people within the HSE to develop their skills, leadership, etc–away from operational issues.

- Intersectoral working is a process that needs to be acknowledged, facilitated and supported. Training should be provided to encourage and support this type of working.

- Inclusion, partnership and participation: there should be a shared understanding of these terms by all agencies.

- Need for real inter-agency work where people are clear about their responsibilities and what they are to deliver on.

12. Reflections on the Conference

Professor Brian Nolan, Economic and Social Research Institute

Key Conclusions

- **Targets can help – don't throw out the baby with the bathwater – but they are not a substitute for co-ordinated, well-planned and well-resourced action**

- **Structure to take responsibility for goals and actions, from central to local level, must be specified.**

How Can Targets to Reduce Health Inequalities Help?

- Targets can represent a public declaration that current inequalities are unacceptable, and of commitment to address them by developing/implementing appropriate policies
- They can provide rallying point for mobilising a multi-sectoral multi-agent response, and benchmarks against which overall progress can be measured

The Downside of Target-Setting

- Setting targets can be a substitute rather than a spur for action
- High-level targets are not a very accurate way of capturing core concern
- They take on a life of their own – and failure to (be seen to) reach them can de-motivate
- Micro-level targets can distort behaviour, but high-level ones are no help in evaluating the impact of particular policies
- It is still hard to frame a meaningful strategy without them.

Setting Policy-Relevant Targets

- Set headline targets for the outcomes we care most about (and can measure)
- Underpin these with intermediate-level policy goals/performance targets and a set of policies aimed at attaining these specific goals
- Make clear who is responsible for delivery of these targets

Are Health Inequality Targets Different?

- The policy 'levers' available to policy-makers mostly have only indirect effects on health inequality outcomes
- The time-lag between intervention and impact on measured health inequalities may be very long

From this Starting-Point, How Do We Achieve the Following?

- Reassess current set of targets
- Underpin with intermediate goals
- Develop policies aimed at each of these goals (which disproportionately impact on lower SEGs)
- Clarify responsibility for goals and actions, from central to local level

Process: Framing Targets

- Who should be consulted on framing the targets and how?
- Those most affected
- Those expected to deliver
- Need a broad understanding of the thinking behind the targets
- And shorter-term indicators of whether moving in the right direction.

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