

HEALTH POLICY STATEMENT

June 2007



1. Introduction

People who are poor experience poorer health and die younger than wealthier people.¹ A range of factors, including poverty, determines the health of an individual. People who do not have adequate income, education or decent housing, and have limited access to quality health services suffer worse health than wealthier people.²

Experiencing poorer health means having a greater need for health services, particularly primary care,³ as these services are the first point of contact.

¹ Balanda, K. and Wilde, J. (2001) *Inequalities in Mortality 1989 - 1998: a report on All-Ireland Mortality Data*, The Institute of Public Health, Dublin/Belfast.

² Barrington, R. (2004), *Poverty is Bad for Your Health*, Dublin, Combat Poverty Agency.

³ Primary care is the first point of access to health care and is based in the community rather than in a hospital. Services include GP's, public health nurses and pharmacists, among others.

The World Health Organisation defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It also holds the view that health is a right of every human, irrespective of gender, race, religion or social condition.

World Health Organisation

The achievement of more equitable access to better quality health services for people living in poverty - in particular primary care - is a strategic objective for Combat Poverty. This policy statement sets out the actions that are required to improve the health of people experiencing poverty. Recognising that adverse social conditions affect people's health status, public policy has a key role to play in creating the conditions for people to lead healthier lives. Achieving better health requires services that are people-centred, accessible on the basis of need rather than ability to pay and delivered in an integrated manner. This implies increased co-operation between the health services and between central and local government. It also implies the participation of communities in policy development, service design, service implementation and review. It requires a focus on the social determinants of health, such as income adequacy and good quality public services, in order to prevent poor health.

Ireland has increased its spending on health in the last decade threefold. When compared to other OECD countries, in 2004 (the latest year where comparative data is available) Ireland spent a lower proportion of its Gross National Income (GNI) on healthcare: 8.4% compared to an EU-15 average of 9.1%. It lags behind higher spending countries such as Germany (10.6%) and France (10.4%).⁴ The health budget has increased since 2004, with most of the increased health budget being spent on salaries and new service developments, such as services for older people, people with disabilities and children at risk.

This policy statement makes recommendations in relation to tackling the causes of poor health among people living in poverty and providing equitable access to health services, including primary care, mental health and children's health services. Community development approaches, including community participation are central to addressing the health needs of people living in poverty.

This paper is informed by commissioned background papers,⁵ research⁶, and lessons emerging from the work of Combat Poverty's *Building Healthy Communities* Programme⁷.

4 GNI Data - Eurostat, www.europa.ec.eurostat.eu

5 Combat Poverty commissioned five background papers to inform the development of this policy statement, on the following themes: access to hospital services; access to primary health care; mental health; children's health; and community development approaches to health.

6 Layte, R, Nolan, A., and Nolan, B., (2007) *Poor Prescriptions: Poverty and Access to Community Health Services*, Dublin, Combat Poverty Agency

7 The Building Healthy Communities Programme supports community health interests to improve the health of their communities by developing good practice and documenting evidence of the process and outcomes.

Inequalities in health occur because all members of society do not have equitable access to a good standard of personal health due to social, economic, cultural and environmental factors and unequal access to primary and secondary health services.⁸

The National Development Plan 2007-2013 (NDP) acknowledges the strong social class gradient in health status. Combat Poverty recognises the recent health achievements and the current commitments to target resources to those most in need. The delivery of commitments in the NDP, the social partnership agreement, *Towards 2016* and the *National Action Plan for Social Inclusion 2007-2016* are key to tackling health inequalities.

2. Social Determinants of Health⁹

“ The social conditions in which people live and work can help create or destroy their health. Lack of income, inappropriate housing, unsafe workplaces, and lack of access to health care systems are some of the social determinants of health leading to inequalities within and between countries. ”

WHO Commission on Social Determinants of Health

Over the past decade, Ireland has experienced unprecedented levels of economic growth. It is predicted that the economy will continue to grow at a rate of 4% over the next six years.¹⁰ With economic development, Ireland has significantly reduced the numbers of people who are unemployed and those living in poverty. While the number of people living in consistent poverty¹¹ has fallen to 7% of the population (or approximately 290,000 people) the number of people at risk of poverty or ‘income poor’ (on an income of under €193 in 2005) remains high at 18.5% of the population (approximately 764,000 people).

8 Wilkinson., R., Marmot, M., (2003) *Social Determinants of Health: The Solid Facts*, 2nd edition, World Health Organisation.

9 Farrell, C., (2007), *Social Determinants of Health – The Solid Facts – An Island of Ireland Perspective*, Combat Poverty Agency and Institute of Public Health.

10 Department of the Taoiseach, (2007), *National Action Plan for Social Inclusion 2007-2016*, Dublin. Government of Ireland.

11 Income poverty is a term that refers to an income which is less than that regarded as acceptable by general society and which gives a lower than normal standard of living. It is measured as the share of persons with an equalised income below 60% of the national median income. This is also known as relative income poverty or at risk of poverty. Consistent poverty is income poverty combined with the lack of one or more of 8 basic deprivation items (e.g. warm coat, sufficient food, adequate heating).

There is also an 8% increase in population with approximately 10% of the current population foreign born.¹² Non-Irish nationals are twice as likely to be in consistent poverty as Irish nationals.

Poverty and poor health are closely interrelated. Therefore reducing poverty is a key means to improve the health of people living in poverty. The likelihood of premature death is hugely increased by poor social conditions such as lack of income and inadequate housing. Children with low birth weight are more likely to be born to mothers who are experiencing poverty. The stress of striving to make ends meet impacts on both the physical and mental health of people in poverty, particularly women¹³. A third of those at risk of poverty (38%) and almost half (47%) of those living in consistent poverty report having a chronic illness compared to a quarter (23%) of the general population.¹⁴ Too often there is a lack of primary care services located in poor communities.

Although individuals can make choices in everyday life that may improve and protect their health, they are not completely in control of the social conditions in which they live and work. Public policy and services have a powerful influence on these external conditions and play an important role in creating a social environment that is conducive to good health. The Health Strategy *Quality and Fairness: A Health System for You* (2001) states that 'to develop an effective health system, the determinants of health, that is, the social, economic, environmental and cultural factors which influence health, must be taken into account'.

There is a need for policies which tackle the structural causes of ill-health to be formulated and implemented on a cross-departmental basis, preferably with strong inter-departmental co-ordination. Policies also need to be informed by current health research, in order to tackle health inequalities effectively. The ethnic identifier in *Census 2006* is a positive development in this regard.

12 Central Statistics Office (2006), *Census 2006; Preliminary Report*, Dublin, Stationery Office.

13 Daly M. and Leonard, M. (2002) *Against All Odds – Family Life on a Low Income*, Dublin Combat Poverty Agency.

14 Layte, R, Nolan, A., and Nolan, B., (2007) *Poor Prescriptions: Poverty and Access to Community Health Services*, Dublin, Combat Poverty Agency

Key Issues

Income

Reducing levels of poverty is the most significant way to improve the health of people living in poverty. Later advantage can make up for past circumstances, while continuing poverty perpetuates the experience of bad health. Therefore, policies need to address income inadequacy, given that the level of income available to individuals and families is the strongest determinant of differences in health.¹⁵

Housing

There is a strong relationship between neighbourhood environment, housing quality and health. People in poverty are more likely to live in poor environments and inadequate accommodation. This contributes to poorer health¹⁶. Homelessness is a major barrier to accessing a range of other services and employment. Being accommodated in direct provision has also impacted on the health of asylum seekers and refugees.

Education

The foundations for life-long health are set down in childhood. The likelihood of children experiencing long-term poverty is higher if their parents have poor health.¹⁷ Despite recent attempts to tackle educational disadvantage, a significant proportion of children living in poverty are leaving school early or without qualifications. Not only does the education system have an important role to play in providing children and young people with a greater knowledge and understanding of health. It also equips them with the necessary skills to access better employment opportunities, thus reducing the risk of poverty. Investment in pre-school education is particularly needed, given that early intervention increases people's educational attainment and subsequent job outcomes, ultimately leading to better health outcomes.

Information

Adults with low literacy levels or people who communicate in other languages (including minority ethnic groups and Deaf people) struggle with getting essential health information. This may make them unable to participate in decision-making about their health.

Transport

A lack of adequate or effective public transport systems can isolate people without cars. These are often the least well-off, the young, the old and those in rural and deprived urban locations. It can significantly hinder access to health services and thus endanger the health of those affected.

¹⁵ Layte, R, Nolan, A., and Nolan, B., (2007) *Poor Prescriptions: Poverty and Access to Community Health Services* Dublin, Combat Poverty Agency

¹⁶ Lavin T., Higgins, C., Metcalfe, O, and Jordan, A., (2006), *Health Impacts on the Built Environment: A Review*, Institute of Public Health in Ireland.

¹⁷ Layte, R, Maître, B., Nolan, B., Whelan, C.T., (2006), *Day in Day Out; Understanding the Dynamics of Child Poverty*, Combat Poverty Agency.

Policy Recommendations

- There is a need to mainstream poverty and health issues into all policy areas, as set out in the *National Action Plan For Social Inclusion (NAPinclusion)*. This can be supported through the application of poverty and health impact assessments. The Institute for Public Health plays a key role in supporting health impact assessments. Poverty Impact Assessment guidelines have been developed at national level by the Office for Social Inclusion (OSI) and are being developed by Combat Poverty for use by local authorities.
- Tackling the social determinants of health requires ‘a joined’ up approach at policy and implementation level. An inter-departmental working group led by the Department of Health and Children that involves key stakeholders, including anti-poverty groups, should be established. Within the Health Service Executive (HSE) an Expert Advisory Group on social inclusion should be established involving stakeholders, including anti-poverty groups, to co-ordinate implementation within the health services.
- Social Welfare rates and in-work supports should be adequate to keep people out of poverty.
- Standards should be set for all accommodation, but in particular for Travellers, homeless people and people living on direct provision. The enforcement of standards for people living on a low income in rented accommodation should be strengthened.
- Current policy commitments in NAPinclusion to provide pre-school education and to tackle early school leaving and promote literacy should be met.
- Information on health and welfare entitlements should be proactively promoted in a range of formats and languages, including Irish Sign Language.
- The provision of adequate public transport options and family supports are essential in addressing the health and other basic needs of people living in isolated areas.

3. Access to Primary Care Services¹⁸

“ Primary care is an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being. ”

The Primary Care Strategy *Primary Care: A New Direction* (2001).

Experiencing poorer health means having greater need for health services. The World Health Organisation (WHO) emphasises the centrality of primary care within the whole health system, as primary care is usually the first point of contact with the health services for most people. It should be the central component of the whole health system. Reforming primary care provision and improving access to primary care services in Ireland is central to more effective health service provision, especially for those in greatest need. The demand on hospital services could be significantly reduced if there was an adequately resourced primary care service in Ireland.¹⁹

The Primary Care Strategy *Primary Care: A New Direction* (2001) acknowledges that Ireland's primary care infrastructure is poorly developed and that services are fragmented. There is a focus on treatment at the expense of a more balanced emphasis on prevention, health promotion and well-being. The Strategy sets out a plan for primary care as the central focus for the delivery of health and personal social services. Six years after its publication, progress has been slow.

Primary care has re-emerged as a policy priority in 2006 with funding secured to roll out 200 Primary Care Teams (PCTs) in the period 2006-2007.²⁰ Furthermore, *Towards 2016* commits to 'ongoing investment to ensure integrated, accessible services for people within their own community' with the roll out of 500 primary care teams by 2011. This commitment is

¹⁸ Burke, S., (2007), *Background Paper on Access to Primary Care Services and Medical Card Eligibility*, Dublin, Combat Poverty Agency.

¹⁹ World Health Organisation, (1978), *Alma Alta*, Denmark, World Health Organisation.

²⁰ Primary care teams include GPs, nurses/midwives, health care assistants, home helps, physiotherapists, occupational therapists, social workers, administrative personnel and ideally community representatives. .

reinforced in the NDP and in the NAP inclusion. While recent financial commitments and targets are welcome, the budget allocated is still relatively small compared to that invested in hospital care.

Key issues

- National standards on access to, and quality of, primary care are required to ensure the equitable development of primary care teams.²¹ These should build on the work of the primary care steering group and the Health Boards' Executive (HEBE) who have developed standards on community participation.
- The cost of going to the GP for those on low income, who do not have access to a medical card, is a deterrent to accessing primary care services. Relatively high GP usage among medical card holders can be related to their relatively poor health status.
- **The thresholds for medical cards, while having increased recently, are not sufficient. The 2005 EU SILC²² estimates that approximately 229,000 people or 30% of people who were at risk of poverty did not have a medical card. Approximately 47,000 people or 16% of people who were in consistent poverty did not have a medical card. While 100,000 full medical cards have been issued since 2005, the income thresholds have not increased annually.**
- Fear of losing entitlement to a medical card can be a disincentive to work, particularly for families with children. The Back to Work Allowance has sought to address this but not all people access employment via this scheme.
- GP services are unevenly distributed by location. Poor areas have fewer GPs, and therefore people in those areas are more likely to use out-of-hours services and accident and emergency services. Such demands for hospital services will remain as long as primary care provision is under-resourced and unevenly distributed.
- GPs act as a gateway to many specialist and ancillary health and social services. Such essential services have long waiting lists or are an additional cost, thus exacerbating poor primary care services. Medical card holders have to wait longer for specialist care and hospital services than people who pay for them privately.
- Voluntary registration with a PCT is not the most effective way to ensure that everyone has access to a GP. Some groups such as asylum seekers, refugees, Travellers and homeless people often experience difficulty in registering with a GP, even if they have a medical card.

21 Joyce, F., (2006), *Setting Minimum Standards to Achieve Equity of Access to, and Quality of Primary Care Services*, EAPN EU Minimum Standards project www.eapn.ie.

22 Central Statistics Office (CSO), (2006) *EU Survey on Income and Living Conditions (EU-SILC)*, Cork, Central Statistics Office. (Estimation by Combat Poverty)

Policy Recommendations

Combat Poverty considers that, ideally, universal provision of free or subsidised primary care services should be a key goal of public health policy. This implies that the right to health and its benefits should be recognised through the provision of universal primary care. In the absence of universal primary care, reforming primary care and improving access to primary care services are central to more effective and equitable health service provision, especially for those experiencing poverty and health inequalities.

Primary Care Teams

Combat Poverty supports the commitments in Towards 2016 to primary care. Deprived urban and rural areas should be prioritised for the allocation of Primary Care Teams.

Standards

- The setting of national standards for primary care provision would promote greater equality in terms of access to, and provision of, services on the basis of need. The standards should be supported by mechanisms of accountability. The Health Information and Quality Assurance Board (HIQA) could play a role in developing these, building on work completed by the Primary Care Steering Group.
- Primary care services that are currently delivered free of charge should continue to be free of charge.

Community Participation

- Local communities should be involved in the development of health needs assessments and in the design and delivery of primary care services. This would lead to more efficient and cost effective services.
- Mapping exercises are being undertaken by the HSE to inform the location of PCTs. Communities of greatest need should be prioritised for the location of PCTs. For example, communities in RAPID and CLAR areas could be targeted, or local deprivation indicators could be used to identify areas of greatest need. GPs could be provided with an incentive to locate there, for example by providing tax relief on buildings.
- Needs assessments should inform the composition of PCTs. PCTs should be sufficiently resourced to ensure that all ancillary services are available to those in need. These ancillary services should also be 'fit for purpose'. For instance, in areas with high drug misuse there should be access to drug treatment and mental health services.
- Compulsory universal patient registration with PCTs should be introduced. This would ensure that everybody including vulnerable and disadvantaged people and/or those with greatest medical need has access to a GP. Such registration procedures would ensure that Travellers, asylum seekers, refugees and people who are homeless or in temporary accommodation are not excluded.

Medical Card Eligibility

The cost of GP services and subsequent medication costs can be a deterrent for low income families to go to their GP, particularly in the early stages of illness. Combat Poverty welcomes the recent increases in thresholds for medical cards and the current review of medical card thresholds, which is currently being undertaken by the Department of Health and Children, as agreed in *Towards 2016*. Increasing access to medical cards is the most effective immediate measure to provide greater access to a GP and other primary care services for those on low incomes, in the absence of universal health care provision. Thus, we recommend:

- The medical card income thresholds should be set above the poverty line so that everyone living in poverty is eligible for a full medical card.
- Additional adjustments should include:
 - The thresholds for adults should be individualised and equal.
 - The threshold for children should be based on social welfare equivalence scales.²³
 - Medical card thresholds should be index-linked so that the level is set automatically, and up-rated annually, to ensure that cost of living increases are taken into account.²⁴
 - More generous tapering of withdrawal of the medical card should be considered, particularly for lone parents entering or re-entering employment.
- The types of service covered by the medical card should be flexible in order to meet the needs of excluded groups. For example, these services should include mental health services and treatment for illnesses new to the Irish health landscape.

4. Accessing hospital services²⁵

“ The overall policy objective for the reform of acute hospitals is improved access for public patients. The reforms involve increasing capacity through further investment, strengthening efficiency and quality of services, and working in closer partnership with the private hospital sector.”

Quality and Fairness: A Health System for You, 2001.

²³ Social welfare equivalence scales estimate income for dependent children at 33% of the main householder

²⁴ This should be in line with the consumer price index or preferably with minimum wage increases.

²⁵ Burke, S., (2007) *Background Paper on Access to Hospital Services*, Combat Poverty Agency.

Everyone in Ireland is entitled to public care in hospitals. Yet there is a two-tiered health service whereby those who can afford to pay for private health insurance have faster access to hospital and specialist services. 52% of the population purchase private health insurance, enabling them quicker access and treatment.²⁶ People who depend on public care, such, as those living in poverty and/or on low incomes, have to wait longer to access hospital care.

The current mix of public and private healthcare has resulted in the treatment of private patients in public hospitals. This is heavily subsidised by public money, at the expense of public patients. Private patients pay on average up to 60% of the full costs of their care with the rest covered by public funding. The two separate waiting lists for public and private patients ensure that the priority attached to access to hospital and specialist care is determined more by ability to pay than medical need.

The 2001 Health Strategy *Quality and Fairness – A Health System for You* outlines broad and specific commitments in relation to hospital services. These commitments include the provision of all services on the basis of need, 3,000 additional beds, and significant developments in a range of services requiring extra staffing. While Ireland has trebled its spending on health between 1997 and 2004, the recent increases have not yet made up for previous under-spending. Even though 1,200²⁷ additional beds have been recently provided, there still remains a shortfall. In addition to this, the public service staffing ceiling has hampered the recruitment of essential staff.

While these shortfalls impact on the health of the entire population the key issues for those on low incomes, who are mostly public patients, are:

Key Issues

- For medical card holders hospital services are free, but two separate waiting lists exist - one for public patients and one for private patients. As a result, those with a medical card and those on low incomes, without a medical card or health insurance, wait longer for treatment. For those public patients who are on low incomes and do not have health insurance or a medical card there is a fee of €60 per day in hospital, with a maximum payment of €600.
- Access to, and treatment for, public and private patients differ. Public patients wait longer to see a specialist and to receive treatment thereafter. Though a consultant may treat public patients it is more likely to be a non-consultant hospital doctor.
- While there has been recent investment in health services this will need to continue alongside a programme of reform, whereby services are provided on the basis of need, not ability to pay. The cost of providing services is rising; medical advances are being made which are more costly to provide; and there is a growing and ageing population. The current lack of well resourced primary, community and continuing care provision exacerbates pressures on Accident and Emergency services and hospital beds.

²⁶ Burke, S., (2007) *Background Paper on Access to Hospital Services*, Combat Poverty Agency.

²⁷ 720 inpatient and 480 day beds

- There is a need for more consultants working in public and voluntary hospitals.
- The National Treatment Purchase Fund (NTPF) was set up to deal with the issue of long waiting times for elective procedures. It has been successful in reducing waiting times for some patients by buying private care for public patients to reduce public patient waiting lists. While the NTPF reduces immediate pressures, it does not address the reasons behind the public system's inability to provide timely treatment in the first place, which should be the long-term focus.

Policy Recommendations

Despite progress being made, there remain considerable inequities in the provision of Ireland's hospital services, as outlined above. The key recommendations to address these issues from a low income perspective are:

A common waiting list

- To make the system more equitable we recommend a common waiting list for all patients with no differences in timing or type of medical care provided.

Investment in health

- To deliver high quality health services on the basis of need, the Health Strategy should be fully implemented. Meeting the health strategy's major targets will require continued investment in health care facilities over the next ten years, with increased day-to-day spending on health. Combat Poverty welcomes commitments outlined in the NDP regarding planned investment in health.
- To maximise efficiency, and ensure equity and fairness, private health care should not be subsidised by public funds.
- Investing in public health services would gradually reduce the need for the NTPF to operate on its present scale.

Investment in hospitals

- The Health Strategy has promised 3,000 more hospital beds over a ten year period from 2001. Alongside this there is a need for a comprehensive primary and community care service. This would relieve pressures on accident and emergency departments. It would also lead to a reduction in public patient waiting lists and ensure that the public health system is more accessible to people living in poverty.

5. Community Development and Community Participation

“ Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support. ”

World Health Organisation

Community development is an anti-poverty intervention that supports communities to identify and address the underlying issues that cause inequalities, including health inequalities. It empowers communities to participate in the decisions that affect their lives in order to bring about positive change for their communities.²⁸

A community development approach promotes the right to health and to tackling the underlying structural causes of health inequalities. At its core is the empowerment of groups of people to become involved in social change. It is about widening participation in the development, planning and delivery of health services and ensuring that the community is actively involved in these decisions.²⁹ It seeks the fulfilment of the right to the highest attainable physical and mental health.³⁰

Community development health projects are driven by community groups, often with the support and involvement of health professionals and health service staff. There is an increased awareness of the advantages of this approach in tackling poverty and health inequalities, as it supports the participation of those experiencing health inequalities.³¹ Participation leads to an improvement in services, as they are designed to meet and incorporate community needs.

Public policy recognises that communities should be centrally involved in shaping health services, including primary care services. The NAPinclusion promotes the application of

28 Houlihan, E., (2007), *Background Paper on Community Development and Community Participation*, Dublin: Combat Poverty Agency.

29 CLES Consulting, (2006), *Policy Paper on Developing Community Infrastructure in the Building Healthy Communities Programme*, Dublin, Combat Poverty Agency.

30 Community Action Network, (2006), CAN Comment; *Community development is good for your health*, Dublin, CAN,

31 CLES Consulting, (2006), *Policy Paper on Developing Community Infrastructure in the Building Healthy Communities Programme*, Dublin, Combat Poverty Agency.

community development approaches in the achievement of more people-centred health services. The Health Strategy *Quality and Fairness: a Health System For You* makes a commitment to the participation of communities in policy and service development.

The Chief Medical Officer sees community participation as 'an essential component of a more responsive and appropriate system of care which is truly people-centred'.³² The Primary Care Strategy considers that 'community participation in primary care will be strengthened by encouraging and facilitating the involvement of local community and voluntary groups in the planning and delivery of primary health care services'.

The development of the *Community Participation Guidelines* (2002)³³ and the *Community Involvement in Primary Care Guidelines* (2005)³⁴ are welcome steps. Also positive is the support of the Department of Health and Children and the HSE for the work being carried out by community groups with PCTs through the *Building Healthy Communities* Programme³⁵. This values the experience and perspective of these groups.

The participation of groups representing the interests of Travellers and minority ethnic groups in the consultation process on the HSE's Intercultural Health Strategy is a good example of this policy being put into practice.

Many challenges remain, however in ensuring that community participation, informed by community development approaches, becomes a reality, particularly in the roll out of the Primary Care Strategy.

32 Chief Medical Officer, [2001], *Better Health for Everyone: A Population Health Approach for Ireland*, Annual Report of the Chief Medical Officer 2001, Dublin, Department of Health and Children.

33 Health Boards Executive, [2002], *Community Participation Guidelines*, Health Boards Executive.

34 Department of Health and Children, [2005], *Guidelines for Community Involvement in Primary Care*, Department of Health and Children.

35 Launched in 2003 by Combat Poverty and the Department of Health and Children. Further information available at www.combatpoverty.ie/health.

Key Issues

- Some community development health projects are involved in the implementation of the primary care strategy and the roll out of PCTs in an ad hoc way. However, there is limited participation of communities in the roll-out of the strategy at local and national level.
- The reform of the health service is impacting on communities. There have been changes in the personnel working with communities. Some of the local structures, enabling groups and communities to participate at local level, have been abolished as the health services become streamlined. In the new national structure there are few mechanisms in place yet for communities to meaningfully participate in decision making at a local, regional and national level.
- Embedding understanding and awareness of poverty, human rights and community participation is important in the new health service structures. Similarly, the role that community development approaches, such as the *Building Healthy Communities* Programme, have to play in tackling health inequalities needs to be understood and promoted.
- Communities need resources and supports to participate in the new health service structures in order to identify and articulate the needs of the communities in which they operate.
- Tackling health inequalities caused by poverty requires a 'joined up' approach. Community development health projects can support a broad range of interests to participate in tackling health inequalities. However, the support these projects can offer needs to be fully utilised.

Policy Recommendations

- Combat Poverty will seek to work with the Health Information and Quality Assurance Board (HIQA) to set national standards for community participation in primary care.
- Combat Poverty will seek to work with the HSE to support community development approaches to health. This will require resourcing and mainstreaming within the reformed health services, with a dedicated budget line. This should take the shape of programmes such as the *Building Healthy Communities* Programme. This aims to support disadvantaged communities to tackle poverty and health inequalities.
- Communities need resourcing to participate in the roll-out of the primary care strategy. In order for new primary care services to be cost effective and to target need, PCTs should include local community development interests in their governance structures. The employment of community development workers and the establishment of local health fora, resourced accordingly, could support this work.

- A national community development and health network would provide a mechanism for consultation, participation, sharing good practice and monitoring in the reformed health services. Combat Poverty will start to work with the HSE to support its establishment.
- Combat Poverty will seek to work with the HSE to provide training on community development approaches, especially as staff take up new roles. In conjunction with community development health projects, training could be developed for staff in how to engage and support community interests, using resources developed through Combat Poverty's local government programme.

6. Mental Health³⁶

“Poverty and mental illness form a vicious circle. Poverty is both a major cause of poor mental health and a potential consequence of it.”
WHO Regional Committee for Europe

People living in poverty experience poorer mental health and have a higher dependency on mental health services than people in higher socio-economic groups³⁷. Likewise, people with mental illness are more likely to experience poverty. Promoting good mental health among people who are poor, and improving access to quality mental health services, is central to reducing poverty and promoting social inclusion.³⁸

In 2006 an expert group on mental health, established by the Government, produced a new mental health policy: *A Vision for Change*. This policy outlines a seven to ten year reform programme aimed at providing a quality mental health service. It also commits to strengthening the capacity of individuals and communities and reducing the structural barriers to mental health by reducing discrimination and promoting access to employment.

People living in poverty have lower self-esteem and higher stress rates. Without adequate and appropriate responses these issues can lead to further and more serious problems. People from lower socio-economic groups have higher admission rates to psychiatric hospitals in Ireland than people from higher socio-economic groups.³⁹ Research from mental health service users in the consultations for *A Vision for Change* found that 68% of

36 Burke, S., (2007), Background Paper on Mental Health, Dublin, Combat Poverty Agency.

37 World Health Organisation (2003) Mental Health Programme for Europe, WHO Regional Committee for Europe.

38 Rankin, J., (2005) *Mental Health and Social Inclusion*, London, Institute of Public Policy Research.

39 Battel-Kirk, B., Purdy, J., (2007), *Health Inequalities on the island of Ireland*, Public Health Alliance for the island of Ireland, Belfast and Dublin.

people with mental health issues were dependent on some form of social welfare; 27% had the junior certificate as their highest qualification; 58% were single; and 30% were in some form of employment. In 2002, only one in five people with mental health difficulties were employed.⁴⁰ The National Disability Authority states that people with mental and emotional disability have the lowest rates of participation in the workforce.⁴¹

According to EU estimates 3-4% of GDP is lost through the economic and social cost of mental illness ⁴², while 60-80% of all costs associated with mental health problems are experienced outside the health system. ⁴³

Key Issues

- There is a strong link between poverty and mental health. The link between poverty, ethnicity and gender inequality, and mental health is demonstrated in international research⁴⁴ In Ireland, research at the Central Mental Hospital in Dublin found that more women than men had psychiatric illnesses⁴⁵ However, death by suicide is significantly higher among men, particularly young men.
- Some of Ireland's most excluded groups experience particularly acute mental health difficulties. These include prisoners, Travellers and asylum seekers. For example, research with asylum seekers demonstrated high levels of poor mental health experienced by those living in direct provision⁴⁶. Not being able to work, to purchase or cook one's own food, combined with a long stay in often confined spaces, all contribute to poor mental health.
- Lone parents experience high levels of depression. A recent study showed that 76% of lone parents believe that anxiety, stress and depression affects the quality of their parenting⁴⁷ Lone parents identify poverty and stigma as contributing to poor mental health.

40 Conroy, P. (2005) Mental health and the workplace. In S. Quin and B. Redmond *ibid*

41 NDA (2005) *Disability and Work – The Picture We Learn From Official Statistics*, Dublin, National Disability Authority

42 European Commission (2005) *Green paper: Improving the Mental Health of the Population: Towards a Strategy on Mental Health for the European Union*. Brussels: Health and Consumer Protection Directorate, European Commission.

43 McDaid, D. (2004) Mental health and social exclusion: An overview. In Thompson Coyle, K. (Ed) *Public Policy, Poverty and Mental Illness: Opportunities for Improving the Future*. Occasional Paper No. 1. Dublin: Schizophrenia Ireland.

44 MIND (2006) *Statistics 6: The Social Context of Mental Distress*. London, Factsheet.

45 Kennedy et al,(2005), *Mental Illness in Irish Prisoners: Psychiatric Morbidity in Sentenced, Remanded and Newly Committed Prisoners*. Dublin: National Forensic Mental Health Service.

46 Pieper, Dr.H., (2006) *The Mental Health Promotion Needs of Asylum Seekers and Refugees in Direct Provision Centres in Galway*. Galway City Development Board/HSE

47 OPEN (2007) *Lone Parents' Experiences of Isolation and Stigmatisation*. Submission to NESF Team on Mental Health and Exclusion, Dublin, OPEN

- Mental health services have generally been under-funded. In 2006, 7.1% of the health budget was allocated to mental health services, whereas in the UK and Northern Ireland it was 10% of the overall health budget.⁴⁸
- People with mental health issues often have difficulty in accessing housing, social supports and employment. This leads to further exclusion.⁴⁹
- As a result of the stigma associated with mental illness people find they are discriminated against, and have few opportunities to challenge this discrimination.⁵⁰
- There is a lack of Irish data on the links between poverty and poor mental health.
- Over one in four people with a mental health difficulty live alone and many feel isolated.⁵¹

Policy Recommendations

- A range of measures, including increasing opportunities for work; providing social housing; and ensuring participation in education and training are needed to support people with mental health difficulties, many of whom experience poverty. Combat Poverty supports the recommendation by the Mental Health Commission that multi-disciplinary teams are needed to support the range of needs for people with mental health issues.
- For those who experience mental illness, there is a need for better services and social support networks, especially for those at risk of poverty. These include a range of services such as access to exercise, health promotion, home-visiting, mentoring, befriending and other social networks.
- Protection against discrimination on the grounds of mental ill health should be provided for under the Equal Status Act.
- The participation of people with mental health difficulties in the design and delivery of the range of services targeted at them would lead to service improvements.
- Research is needed to investigate further the complex links between poverty and mental health. Combat Poverty welcomes the work on this issue by the National Economic and Social Forum.
- Child and adolescent mental health teams should be rolled out in line with the recommendations in *Vision for Change*.

48 Mental Health Commission (2006) Mental Health Commission Annual Report 2006 including the Report of the Inspector of Mental Health Services, Dublin Mental Health Commission

49 Rankin, J., (2005) *Mental Health and Social Inclusion*, London Institute of Public Policy Research,

50 Expert Group on Mental Health Policy (2004) *What we Heard. A Report of Service User Consultation Process*. Dublin, Department of Health and Children

51 Expert Group on Mental Health Policy (2004) *What we Heard. A Report of Service User Consultation Process*. Dublin, Department of Health and Children

7. Children's Health⁵¹

“ If you're [living] in poverty, you can't get better. You can't get better if you've not got a good diet to build you up...or if you can't pay for heating to keep you warm if you're getting over pneumonia or whatever. Health and poverty are really closely linked⁵². ”

Childrens Rights Alliance 2002

Children born into poverty experience an increased risk of ill health. Poverty impacts on a child's physical, mental and emotional health and development, and affects a child's health from before their birth through to adolescence.

The Department of Health and Children and the Office of the Minister for Children have lead policy responsibility for child health. Inequalities in child health and the social determinants of child health are considered within the Children's Strategy.

The Department of Health and Children has a number of targets relating to the reduction of inequalities in child health, including targets to reduce inequalities in low birth weight and to improve breastfeeding rates among lower socio-economic status groups.

The impact of poverty on child health is often measured by assessing the different levels of illness, disability and death reported for children born into families from different socio-economic backgrounds. Examples of this include the differences in health status of children born to professionals compared to unemployed parents, or children living in advantaged areas compared to deprived areas. However, levels of childhood illness represent only the tip of the iceberg. Consideration must also be given to the loss of 'health and well-being potential' of the child living in poverty and the diminished health of the child, not only as a child, but also throughout the rest of his or her life.

In order to get the best possible start children need a nutritious diet; a positive and attentive child-parent relationship; a safe family and community environment; opportunities for more play; and freedom from illness and disability.

Combat Poverty welcomes the role that initiatives under the Family Support Agency plays in supporting families. Access to affordable, flexible and high quality childcare for poor families is important and Combat Poverty welcomes the National Childcare Investment Programme (NCIP) 2006-2010.

⁵¹ McAvoy, Dr. H., (2007), Background Paper on Child Health and Poverty, Dublin, Combat Poverty Agency.

⁵² A. Ritchie. *Our Lives Consultation: Final Report* (Edinburgh: Save the Children Scotland, 1999) p. 27 quoted in McAuley, K & Brattman, M. (2002) *Hearing Young Voices: Consulting Children and Young People*, Dublin: Children's Rights Alliance and the National Youth Council of Ireland, p.11. available at www.childrensrights.ie.

Key Issues

- Babies from families of lower socio-economic status face a greater risk of low birth weight, because they are born earlier and/or born smaller.⁵³ These babies are more likely to be stillborn or die in infancy. For babies who survive there is an increased risk of disability and behavioural problems, which can limit their educational achievement and continue the cycle of poverty. Interventions to tackle inequalities in child health must begin during pregnancy.
- In 2003, 26.6% of unemployed mothers breastfed compared to 67.1% of babies born to 'higher professional' mothers. Breastfeeding offers particular benefits for infants born into poverty by providing increased protection from infectious disease, promoting development and saving money by eliminating the cost of formula-feeding and lowering health-care costs. However, there is a considerably lower uptake of breastfeeding among poorer mothers in Ireland. The achievement of the specific targets to reduce this inequality in *Breastfeeding in Ireland; A 5-Year Strategic Action Plan 2005*, will make a substantial contribution to reducing inequalities in children's health.
- Healthy food habits are established within the first few years of life. Children's diets that are high in fat and sugar and low in fruit and vegetables, at this time, are likely to remain so in the future. As childhood obesity is far more prevalent in poorer communities, it is vital that poorer families are provided with access to affordable nutritious food and the skills to prepare it.
- Immunisation makes a very significant contribution to reducing the risk of serious infectious disease in early childhood. While progress has been made towards the national target of 95% uptake in the primary childhood immunisation programme, there is no information on whether the lower uptake among disadvantaged communities has been improved.
- Irish school children from poorer backgrounds experience higher mortality levels and greater likelihood of mental ill-health and obesity. Exceptionally high levels of ill-health are recorded for children in care and homeless children.
- Childhood illness creates poverty traps for children and their families. When illness is associated with school absenteeism, academic achievement suffers, as can a child's mental and emotional development and friendships. Sick children place a financial and emotional strain on families, with many parents opting for unpaid leave from employment, in addition to meeting the costs associated with health care. The centralisation of acute services for children often places an extra financial burden on families.
- Poverty compromises the mental health of teenagers living in deprived communities, where there are higher levels of drug use and suicide.

53 McAvoy., Dr.H., Sturley, J., Burke, S., Balanda, Dr. K., [2006] *Unequal at Birth*, Institute of Public Health in Ireland.

- Promoting the sexual health of teenagers and preventing teenage pregnancy is of particular importance in tackling health inequalities in poorer areas.
- The longer a child is in poverty, the more he or she is at risk of behavioural problems⁵⁴ The duration of child poverty is longer among welfare dependent and unemployed families, lone parent households and families where parents have lower levels of education⁵⁵
- Households with children generally have higher poverty rates than those without children. In 2005, persons in households comprising a single adult with children had a consistent poverty rate of 27%⁵⁶.
- More than one in three (34.8%) of post primary school students in the most disadvantaged schools missed 20 or more school days, compared with less than one in ten (9.2%) students in the least disadvantaged schools⁵⁷

Policy Recommendations

- To improve children's health there is a need to reduce child poverty. Policies targeted at reducing child poverty should be fully implemented.
- The Office of the Minister for Children (OMC) could lead on an inter-agency agenda to tackle health inequalities, drawing on a range of strategies designed to impact on child health. The OMC could play a key role in supporting County and City Development Boards to reduce child health inequalities.
- Maternity/ante-natal services should be designed to reduce inequalities in birth outcomes.
- Policy commitments to tackle child health inequalities, such as the breastfeeding and obesity strategies, should continue to be monitored to ensure that they effectively contribute to the reduction of child health inequalities.
- Early childhood screening and immunisation should be delivered on an equitable basis. The school health service should be equipped to provide high quality services in areas where there are high levels of school absenteeism. Hot school dinners (or equivalent) should be provided to all children from low income families under the School Food Programme.
- A number of measures are needed to assist low income households to access good quality nutritious food. Welfare payments need to meet the cost of a healthy diet. There should be greater access to food retailers in disadvantaged areas.⁵⁸

54 Health Service Executive (2006), *Child Mental and Emotional Health - A Review of Evidence*, Programme of Action for Children.

55 Layte, R, Maître, B., Nolan, B., Whelan, C.T., (2006), *Day in Day out, Understanding the Dynamics of Child Poverty*, Dublin, Combat Poverty Agency.

56 Central Statistics Office (CSO), (2006) *EU Survey on Income and Living Conditions (EU-SILC)*, Cork, Central Statistics Office.

57 Office of the Minister for Children (2006) *State of the Nation's Children*, Dublin, the Stationery Office, Dublin.

58 Combat Poverty Agency (2006) Pre-Budget submission, Dublin.

- A number of child health inequality indicators could complement the current set of national child well-being indicators, monitored through the *State of the Nation's Children* report.
- A children's research programme to monitor inequalities in child health should form a key component in the national children's longitudinal study.

8. Conclusions

Poverty is bad for your health. The policy statement sets out current issues and recommendations for improvement. In summary these are:

- The need to address the broader issues outside the health service including income, housing, education, transport and information
- The need for up-to-date health intelligence in order to target policies and strategies accurately
- The need to promote primary care and community participation and to improve entitlement to medical cards, as the primary care strategy is being rolled out
- The need to enhance public provision in the area of hospital services
- The need to invest more in the mental health service
- The need to address children's health. Poverty impacts on a child's future well being and hence it is important to address child poverty.

Combat Poverty will seek to work with the main stakeholders, including the Department of Health and Children, the Health Service Executive, the Institute of Public Health, the Office for Social Inclusion, Community Development and Health Projects and health service professionals, in order to take forward the recommendations in this policy statement.



**Combat Poverty
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