Northern Ireland Assembly

Research and Information Service Briefing Paper

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Health Inequalities in Northern Ireland

1 Introduction and Overview

This briefing paper has been prepared in response to your query regarding health inequalities in Northern Ireland (NI) and presents an introduction to the subject in terms of how health inequalities in NI are monitored, strategies and programmes to tackle them and the outcome of these.

The Institute of Public Health in Ireland (IPH) refers to health inequalities as:

> *Preventable and unjust differences in health status experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged.*[1]

Health Inequalities are observed along a social gradient – the better your social circumstances, the better your chance of enjoying good health and a longer life. The

[1] Social Determinants and Health Inequalities, Institute of Public Health in Ireland, www.publichealth.ie/service/social-determinants-health-inequalities

IPH also highlight that health inequalities also exist between genders and ethnic groups.[2]

The causes of health inequalities are complex but are strongly driven by the social, economic and environmental conditions in which people live and work. These conditions are known as the social determinants of health and are thought to be largely the result of public policy.[3]

Many of the key health behaviours significant to the development of chronic disease follow the social gradient, for example, smoking, obesity, lack of physical activity, poor nutrition, abuse of drugs and alcohol; along with other factors such as mental illness, low breastfeeding rates and poor oral and sexual health.[4]

From birth, people are exposed to a wide range of social, economic, psychological and environmental experiences which change as they go through the different stages of life. Each of life's transitions can affect health, however, people who are disadvantaged are at greater risk. Disadvantages tend to congregate among the same people, accumulate through life and can be passed on from generation to generation.[5]

In Northern Ireland, the key strategy for tackling health inequalities is the ten year cross-departmental public health strategy '*Investing for Health',* published in 2002. The Strategy contains a framework for action which is based on partnership working amongst Departments, public bodies, local communities, voluntary bodies, District Councils and social partners. The key aims of the strategy are to improve life expectancy across the population and to reduce health inequalities. This strategy was reviewed in 2009 and whilst progress has been made, challenges relating to health inequalities still remain. The key outcomes of this strategy are discussed further in section 4.

Investing for Health contained a number of lifestyle strategies, mainly led by the DHSSPS, covering a wide range of issues such as smoking, obesity, alcohol and drug misuse, suicide and sexual health. The specific work of the DHSSPS and Public Health Agency (PHA) in tackling health inequalities through these strategies and other programmes is discussed further in section 2 of this briefing.

Investing for Health sits alongside *Lifetime Opportunities*, the Anti-Poverty and Social Inclusion Strategy for Northern Ireland.[6]

[2] Social Determinants and Health Inequalities, Institute of Public Health in Ireland, www.publichealth.ie/service/social-determinants-health-inequalities

[3] Social Determinants and Health Inequalities, Institute of Public Health in Ireland, www.publichealth.ie/service/social-determinants-health-inequalities

[4] Make Healthier Choices Easier, HSC Public Health Agency, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/make-healthier-choices-easier

[5] The Annual Report of the Chief Medical Officer for the Northern Ireland 2010, Deprivation and health inequalities, page 5, http://www.dhsspsni.gov.uk/cmo-annual-report-2010.pdf

[6] *Lifetime Opportunities*, the Anti-Poverty and Social Inclusion Strategy for Northern Ireland (2006), OFMDFM, http://www.ofmdfmni.gov.uk/antipovertyandsocialinclusion.pdf

Investing for Health is to be succeeded by a new ten year public health strategy which is in development and will be launched in 2012. It will be a cross-government, outcome-based strategic framework and will take account of social, economic and legislative changes since the previous strategy was written. It will continue to focus on improving the overall health and well-being of the NI population whilst aiming to reduce evident health inequalities. It will adopt a life-course approach and will focus on those determinants which evidence shows are the most powerful in reducing health inequalities, for example, early years interventions. Particular notice is to be taken of the 'Marmot Review' – the Strategic Review of Health Inequalities in England 2010.[7]

In addition to the strategies mentioned above and the programmes of the PHA to address health inequalities, the DHSSPS has developed a monitoring system – the **Health and Social Care Inequalities Monitoring System (HSCIMS)**, to determine the nature and extent of health inequality in NI. The HSCIMS produces regular annual updates on the extent on inequality experienced by those living in the 20% most deprived areas and that experienced by those living in rural areas when compared with the regional average. A summary of results from the *Third Update Bulletin* (2009) and *Sub-regional Inequalities – HSC Trusts* (2010) is included at section 3 below. The fourth update bulletin is due to be published in June 2012.[8]

2. Strategies and Programmes to Tackle Health Inequalities

2.1 DHSSPS Lifestyle Strategies

Investing for Health embraces a number of DHSSPS lifestyle strategies covering a wide range of issues such as smoking, obesity, alcohol and drug misuse, suicide and sexual health. Although these strategies are aimed at the general population (with specific targeted areas to tackle health inequalities), many of the key health behaviours significant to the development of chronic disease follow the social gradient, for example, smoking, obesity, lack of physical activity, poor nutrition and abuse of drugs and alcohol.[9]

The cost to the health service of **alcohol misuse** in NI may be as high as £122 million per year and £48 million to social services and there is clear evidence from around the world that there is a link between the affordability of alcohol and the level of consumption.[10] Following on from the *New Strategic Direction for Alcohol and Drugs 2006-2011* an updated five year action plan the *New Strategic Direction for Alcohol and*

[7] Developing a new Public Health Strategy for Northern Ireland- Update September 2011, http://www.dhsspsni.gov.uk/newsletter-public-health-strategy.pdf

[8] NI Health and Social Care Inequalities Monitoring System, Sub-regional Inequalities – HSC Trusts 2010 (July 2010), NISRA, DHSSPS, Foreword, http://www.dhsspsni.gov.uk/subreg_inequalities_monitoring_1.pdf

[9] Make Healthier Choices Easier, HSC Public Health Agency, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/make-healthier-choices-easier

[10] The Annual Report of the Chief Medical Officer for the Northern Ireland 2010, Alcohol and drug misuse, page 6, http://www.dhsspsni.gov.uk/cmo-annual-report-2010.pdf

Drugs Phase 2 2011-2016 was published in December 2011 to continue the work and deal with emerging concerns such abuse of over-the-counter drugs and 'legal highs'.[11]

With regards to **obesity**, the first results from the 2010/11 Health Survey NI were published in November 2011. Of 4,000 people surveyed, 59% of adults were obese (36%) or overweight (23%). A cross-Departmental Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland 2012-2022 – *A Fitter Future for All*[12] has been issued and seeks to address a number of key issues including:

- Increasing the levels of breastfeeding;
- Encouraging participation in physical activity and increased access to physical activity facilities for children and their families; and
- Active travel and the obesogenic environment.

The life course stages through which this Framework has directed its outcomes are:

- Pre-conception, Antenatal, Maternal and Early Years;
- Children and Young People; and
- Adults and General Population.

With regard to **smoking**, in NI, around 340,000 people aged 16 and over smoke. There is a strong relationship between smoking and health inequalities, with more people dying of smoking-related illnesses in disadvantaged areas of NI than in more affluent areas. In February 2012, the Health Minister, Edwin Poots, launched a *Ten Year Tobacco Control Strategy* for Northern Ireland.[13] The Strategy has three main objectives: to reduce the numbers of people in Northern Ireland taking up smoking; to encourage more smokers here to quit; and to afford greater protection for the whole population from tobacco-related harm. In launching the strategy, the Minister noted the good progress made in recent years in NI, with achievements such as the introduction of smoke-free legislation; the increase in age-of-sale requirements; and the development of smoking cessation services.[14]

With regard to promoting **positive mental health and tackling suicide**, the DHSSPS is working on a new Mental Health and Wellbeing Promotion Strategy to be published in 2012. It will focus on interventions to promote positive mental health at various stages in the life course and in various settings such as schools and workplaces.

[11] The New Strategic Direction for Alcohol and Drugs Phase 2 2011-2016 (December 2011) DHSSPS, http://www.dhsspsni.gov.uk/new_strategic_direction_for_alcohol_and_drugs_phase_2__2011-2016_

[12] Cross-Departmental Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland 2012-2022 – *A Fitter Future for All*, DHSSPS, http://www.dhsspsni.gov.uk/framework-preventing-addressing-overweight-obesity-ni-2012-2022.pdf

[13] Ten Year Tobacco Control Strategy (2012), DHSSPS, http://www.dhsspsni.gov.uk/tobacco-strategy-consultation.pdf

[14] Health Minister Edwin Poots today launched a new ten-year tobacco control strategy for Northern Ireland, 28/02/12, DHSSPS Press Release, http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-february-2012/news-dhssps-280212-health-minister-launches.htm

There will be a major focus on the early years as the evidence shows this is where greatest gains can be made.[15]

With regard to **sexual health**, many factors linked to deprivation can influence sexual health such as poverty, unemployment, poor education, alcohol and drug misuse and social exclusion.[16] The DHSSPS strategy in this regard is the Sexual Health Promotion Strategy and Action Plan 2008-2013.[17] The DHSSPS and PHA have established a multi-agency sexual health improvement network to oversee implementation of the strategy including training, prevention, education and access to services.[18]

2.2 Public Health Agency (PHA) Programmes

The PHA has acknowledged that inequalities may worsen in this difficult economic climate and, in order to make best use of its resources, the PHA has been systematically examining evidence of best practice and effectiveness. The PHA has set out four key themes to its work around health and social wellbeing improvement[19]:

1. Give every child and young person the best start in life;
2. Ensure a decent standard of living for all;
3. Build sustainable communities; and
4. Make healthy choices easier.

1. Give every child and young person the best start in life:

International evidence from economists, psychologists, child development specialists and others suggests that priority should be given to investing in services that provide support during pregnancy and the first five years of a child's life. Economists have demonstrated that such investment brings a 9-10 fold return on every £1 invested in terms of a more educated and skilled adult workforce and avoiding the costs of criminal behaviour and a range of other poor health and social outcomes.[20]

In connection with this approach the PHA has introduced two programmes in particular to Northern Ireland – **Family Nurse Partnership (FNP)** and **Roots of Empathy**:

[15] The Annual Report of the Chief Medical Officer for the Northern Ireland 2010, Alcohol and drug misuse, page 8, http://www.dhsspsni.gov.uk/cmo-annual-report-2010.pdf

[16] The Annual Report of the Chief Medical Officer for the Northern Ireland 2009, Sexual Health, page 20, http://www.dhsspsni.gov.uk/cmo-annual-report-2009.pdf

[17] Sexual Health Promotion Strategy and Action Plan 2008-2013, DHSSPS, http://www.dhsspsni.gov.uk/dhssps_sexual_health_plan_front_cvr.pdf

[18] The Annual Report of the Chief Medical Officer for the Northern Ireland 2009, Sexual Health, page 20, http://www.dhsspsni.gov.uk/cmo-annual-report-2009.pdf

[19] Health and Social Wellbeing Improvement, Public Health Agency, www.publichhealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement

[20] Health and Social Wellbeing Improvement, Public Health Agency, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/give-every-child-best-start-life

- **Family Nurse Partnership** (first developed at University of Colorado, USA) - FNP is a voluntary preventive programme for teenage mothers. It offers intensive and structured home visiting, delivered by specially trained 'family nurses', from early pregnancy until the child is two. FNP is being tested across England, Scotland and now on one test site in Northern Ireland. The first phase of FNP is being introduced across the Western Health and Social Care Trust (HSCT) area. The PHA advocate that this programme has been shown to achieve better educational attainment, less antisocial behaviour, less child abuse and fewer young people entering the criminal justice system. Elsewhere, FNP has proven to be not only cost-effective, but cost-saving, with every £1 spent on the programme producing savings of £2.88 in the longer term[21];

- **Roots of Empathy -** This is an evidence-based classroom programme that has been shown to reduce levels of aggression among school children, while also improving social and emotional competence and increasing empathy. A parent and baby from the local community visit the classroom on a monthly basis throughout the year. A trained instructor coaches students to observe the baby's development and label the baby's feelings. The aim is to develop 'emotional literacy' so that children become more competent in understanding their own feelings and the feelings of others. The South Eastern HSCT and Belfast HSCT, together with local stakeholders, have engaged with 27 primary schools to deliver Roots of Empathy in this pilot phase, which is focused on schools serving more disadvantaged communities[22].

2. Ensure a decent standard of living for all

The PHA highlight that poverty and economic inequality are bad for health, with poverty an important risk factor for illness and premature death. It affects health directly and indirectly in many ways including - financial strain, poor housing, poorer living environments, poorer diet and limited access to employment, other resources, services and opportunities. Poor health can also cause poverty. It is well established that the poorest people live the shortest lives with the worst health[23].

Persistent poverty in Northern Ireland (21% before housing costs) is double that in Great Britain (9%) and in January 2010, 43,000 children in NI were living in severe poverty. There are a number of reasons for higher persistent poverty in Northern

[21] Health and Social Wellbeing Improvement, Public Health Agency, Family Nurse Partnership, http://www.publichealthagency.org/directorate-public-health/health-and-social-wellbeing-improvement/family-nurse-partnership

[22] Health and Social Wellbeing Improvement, Public Health Agency, Roots of Empathy, http://www.publichealthagency.org/directorate-public-health/health-and-social-wellbeing-improvement/roots-empathy

[23] Health and Social Wellbeing Improvement, Public Health Agency, Ensure a decent standard of living for all, http://www.publichealthagency.org/directorate-public-health/health-and-social-wellbeing-improvement/ensure-decent-standard-living-all

Ireland: high levels of unemployment, high rates of disability and limiting long-term illness, low wages, poor quality part-time jobs and obstacles to working mothers.[24]

Across NI the PHA is working in partnership with voluntary and statutory sector partners on a range of initiatives to support vulnerable groups. Its work includes the Advice 4 Health project, a collaboration between the Northern Investing for Health (IfH) Partnership and the Citizens Advice Bureau with four specialist workers supporting vulnerable groups across a range of Health and Social Care settings. Another programme coordinated by the PHA aims to improve the health and wellbeing of people living in the top 30% of rurally deprived super output areas by making them aware of, or helping them access, local services, grants or benefits.[25]

In terms of fuel poverty, the PHA have established a regional fuel poverty and health network to develop a more strategic approach to fuel poverty and health across the region. Benefit maximisation schemes across Northern Ireland have also improved household incomes. These schemes take referrals from HSC.[26]

3. Build sustainable communities

Building sustainable communities is one of the core themes proposed by Sir Michael Marmot in his 2010 report *Fair society, healthy lives*. Community development is the key component of the PHA's approach to building sustainable communities. In all areas of the PHA's Health and Social Wellbeing Improvement Division, more than 50% of the programme budget is devoted to enabling the community and voluntary sectors to provide a range of services. Significant investment goes towards services that address[27]:

- Mental health promotion and suicide awareness and prevention;
- Prevention of obesity;
- Smoking cessation;
- Reducing drug and alcohol misuse;
- Reducing teenage pregnancy.

[24] Health and Social Wellbeing Improvement, Public Health Agency, Ensure a decent standard of living for all, Poverty, http://www.publichealthagency.org/directorate-public-health/health-and-social-wellbeing-improvement/poverty

[25] Health and Social Wellbeing Improvement, Public Health Agency, Ensure a decent standard of living for all, Poverty, http://www.publichealthagency.org/directorate-public-health/health-and-social-wellbeing-improvement/poverty

[26] Health and Social Wellbeing Improvement, Public Health Agency, Ensure a decent standard of living for all, Fuel Poverty, http://www.publichealthagency.org/directorate-public-health/health-and-social-wellbeing-improvement/poverty

[27] Health and Social Wellbeing Improvement, Public Health Agency, Building sustainable communities, http://www.publichealthagency.org/directorate-public-health/health-and-social-wellbeing-improvement/build-sustainable-communities

4. Make healthier choices easier

Many of the key health behaviours significant to the development of chronic disease follow the social gradient, for example, smoking, obesity, lack of physical activity, lack of nutrition, drug-taking, alcohol abuse and mental illness, along with other factors such as breastfeeding and poor oral and sexual health. The PHA commissions a range of programmes to address these concerns. A brief outline of the PHA's work in some of the key areas is outlined below:

- **Tackling childhood obesity** - During 2009–10, the PHA developed an action plan for obesity to ensure evidence-based approaches. A public information campaign on physical activity, which aims to encourage children to be more active, was launched in September 2010. The PHA continues to work in partnership with primary and secondary care, leisure services and healthy living centres to provide physical activity/exercise referral schemes. In partnership with Safefood, the DE and the DHSSPS, the PHA produced a new leaflet Are you packing a healthy lunch?, which was distributed to every child in primary school.[28]
- **Improving wellbeing through peace of mind** - The PHA campaign to promote Lifeline, the free helpline for those in distress or despair, has led to increased public awareness of the Lifeline number 0808 808 800. A website www.lifelinehelpline.info was also launched. An award-winning PHA public information campaign encouraging young men to open up and talk about their feelings was re-run during 2010. The next phase of the PHA campaign will include a focus on issues that can have a negative impact on the mental health and wellbeing of individuals, families and communities, including the economic downturn.[29]
- **Stopping smoking** - The PHA highlights that it has been at the fore in ensuring that smoking cessation support is available to smokers who want to quit; ensuring that young people don't start smoking, through programmes like 'Teenage Kicks' and 'Smokebusters'; protecting non-smokers from the dangers of second-hand smoke; and through the 'No Smoking Day' campaign, it also encourages smokers to use it as an opportune time to quit.[30]
- **Highlighting the dangers of emerging drugs** - The emergence of legal highs in the latter part of 2009 and 2010 presented challenges for the PHA in ensuring accurate information was available. The PHA developed a legal highs factsheet for parents and those working with young people; produced a bulletin on mephedrone; issued regular press statements on emerging drugs of concern; supported local communities, groups and schools by providing information and advice through its

[28] Health and Social Wellbeing Improvement, Public Health Agency, Tackling childhood obesity, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/tackling-childhood-obesity

[29] Health and Social Wellbeing Improvement, Public Health Agency, Improving wellbeing through peace of mind, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/improving-wellbeing-through-peace-

[30] Health and Social Wellbeing Improvement, Public Health Agency, Stopping smoking, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/stopping-smoking

range of additional drug and alcohol services; developed materials for young people on legal highs; and funded specific training programmes on legal highs and other emerging drugs of concern.[31]

- Averting an alcohol crisis – The focus of the PHA currently is to support the measures proposed by the NI Assembly to introduce a minimum per unit price for alcohol and banning irresponsible drinks promotions.32

3. DHSSPS – Monitoring Health Inequalities in NI - Health and Social Care Inequalities Monitoring System (HSCIMS)

As previously mentioned, the **Health and Social Care Inequalities Monitoring System (HSCIMS)** comprises a basket of indicators which are monitored over time to assess area differences in mortality, morbidity, utilisation of and access to health and social care services in NI. Inequalities between the 20% most deprived areas (using NISRA 2005 NI Multiple Deprivation Measure) and NI as a whole are measured. Results for the most rural areas are also compared against NI overall.[33]

The HSCIMS third update bulletin (2009) demonstrated that overall health outcomes in deprived areas continue to be generally worse than in NI as a whole, although there have been relative improvements across a number of indicators. For example, the relative inequality gaps for infant mortality and cancer incidence more than halved over the period measured[34] and there were improvements in the gaps for hospital admissions. However, while a reduction in hospital admissions in deprived areas might indicate improved health outcomes, as other health outcome indicators have remained relatively worse in deprived areas, it probably indicates poorer access in these areas.[35]

There have also been improvements in the inequality gaps for self-harm admissions, smoking during pregnancy, breastfeeding on discharge from hospital and dental registrations, however, the health gaps in a number of these areas still remain large.[36]

[31] Health and Social Wellbeing Improvement, Public Health Agency, Highlighting the dangers of emerging drugs, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/highlighting-dangers-emerging-drug

[32] Health and Social Wellbeing Improvement, Public Health Agency, Averting an alcohol crisis, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/averting-alcohol-crisis

[33] NI Health and Social Care Inequalities Monitoring System, Third Update Bulletin 2009, DHSSPS, Project Support Analysis Branch, Information Analysis Directorate, Introduction and Methodology, page 1, http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-october-2009/news-dhssps-29102009-third-update-bulletin.htm

[34] 'The period' referred to varies for the indicator being considered and is that defined in Table 1.2 of the NI Health and Social Care Inequalities Monitoring System, Third Update Bulletin 2009, http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-october-2009/news-dhssps-29102009-third-update-bulletin.htm

[35] NI Health and Social Care Inequalities Monitoring System, Third Update Bulletin 2009, DHSSPS, Project Support Analysis Branch, Information Analysis Directorate, Executive Summary, http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-october-2009/news-dhssps-29102009-third-update-bulletin.htm

[36] NI Health and Social Care Inequalities Monitoring System, Third Update Bulletin 2009, DHSSPS, Project Support Analysis Branch, Information Analysis Directorate, Executive Summary, http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-october-2009/news-dhssps-29102009-third-update-bulletin.htm

Male and female life expectancy were 4.4 years and 2.6 years lower in deprived areas compared to NI overall.

The most sizeable inequality gaps between deprived areas and NI overall were in[37]:

- **Alcohol-related deaths** (121% higher) – the alcohol-related death rate rose by around 10% between 2005 and 2008 across NI as a whole, despite some minor fluctuations in the gap, the deprived death rate has remained around 120% higher than the NI rate;
- **Drug-related deaths** (113% higher) – Although the number of such deaths is relatively low, the standardised death rate increased steeply (by almost 40%) across NI between 2005 and 2008 and the rate in deprived areas was consistently more than twice the NI rate during the period;
- **Admissions for self-harm** (94% higher) – although the standardised admission rate for self-harm has improved in deprived areas over recent years it still remains almost twice that in NI overall (inequality gaps for male and female in 2008/09 stood at 117% and 76%);
- **Teenage births** (80% higher) – the teenage birth rate to girls aged under 20 dropped in both deprived areas and NI generally, with a larger decrease in deprived areas which led to an inequality gap decrease from 92% in 2001 to 80% in 2008;
- **Suicide** (73% higher) – Since 2005 the number of registered suicides has grown substantially in NI as a whole, between 2001 and 2005 the gap between deprived areas and NI narrowed from 65% to 39% but since then the gap has risen again to 73% higher in 2008;
- **Respiratory death rates** (66% higher) – Although respiratory mortality in deprived areas fell by 28% from 2001 to 2008, the gap between the deprived rate and NI as a whole rose from 58% to 66% with some evidence of a levelling off since then; and
- **Lung cancer incidence** (65% higher) –the difference in lung cancer incidence rates as a whole has narrowed from being 81% higher in 1999 to 65% higher in 2006. The female lung cancer rate in deprived areas was 76% higher than in NI and the male rate was 58% higher.

With regard to rural areas, the bulletin shows that health outcomes in rural areas tend to be better than in Northern Ireland as a whole and this is most evident in[38]:

- Drug related deaths (49% lower in rural areas);

[37] NI Health and Social Care Inequalities Monitoring System, Third Update Bulletin 2009, DHSSPS, Project Support Analysis Branch, Information Analysis Directorate, Executive Summary and pages 4-11 http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-october-2009/news-dhssps-29102009-third-update-bulletin.htm

[38] NI Health and Social Care Inequalities Monitoring System, Third Update Bulletin 2009, DHSSPS, Project Support Analysis Branch, Information Analysis Directorate, Executive Summary and pages 14-20 http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-october-2009/news-dhssps-29102009-third-update-bulletin.htm

- Admissions to hospital for self-harm (47% lower);
- Alcohol-related mortality (45% lower); and
- Teenage births (41% lower).

Life expectancy in rural areas was 1.3 and 0.6 years higher for males and females respectively than in NI generally.

There has been a relative narrowing of the gap for all cancer incidence rates. In 1999 the cancer incidence was 13% lower in rural areas than in NI as a whole but due to incidence rising faster in rural areas than in NI generally the gap stood at 9% in 2006.

Conversely, rural areas fared worse than NI overall for ambulance response times (almost double the regional average) - as the improvement in response times in rural areas has been modest compared to overall regional improvement, meaning that rural response times have increased relatively from being 67% higher than NI generally, to being 95% higher than NI generally.

Over the period 2001/02 to 2008/09 elective hospital admissions increased by 42% in rural areas compared to 22% increase across NI generally. Given the better health observed in rural areas this relative increase probably represents decreasing access to elective care within urban areas.[39]

With regard to specific HSC Trusts, the report entitled *NI Health and Social Care Inequalities Monitoring System, Sub-regional Inequalities – HSC Trusts 2010*, outlines the subregional inequality gaps between the health outcomes experienced in the most deprived areas of each HSC Trust and the HSC Trust as a whole. Health outcomes were generally worse in the most deprived areas within a Trust than the overall Trust itself. The Executive Summary from the subregional report is included in its entirety in Appendix 1.

4. Review of Investing for Health – Outcomes/Impact and Emerging Themes

The *Investing for Health Strategy Review, Final Report* was published in September 2010.[40] Subsequent to the Review of the Strategy, and as stated in the introduction, *Investing for Health* (IFH) is to be succeeded by a new ten year public health strategy which is in development and will be launched in 2012.

[39] NI Health and Social Care Inequalities Monitoring System, Third Update Bulletin 2009, DHSSPS, Project Support Analysis Branch, Information Analysis Directorate, Executive Summary and pages 14-20 http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-october-2009/news-dhssps-29102009-third-update-bulletin.htm

[40] *Investing for Health Strategy Review, Final Report*, FGS McClure Watters, September 2010, http://www.dhsspsni.gov.uk/health_development-final_report_-_september_2010.pdf

The original IFH Strategy was published in 2002 and contained two wide ranging goals and seven objectives. The two goals sought to improve the health of people and to reduce inequalities in health through the achievement of the seven objectives that focused on the wider determinants of health including poverty; education; the environment; reducing deaths and injuries from accidents; promoting positive mental health and well-being; and encouraging people to make healthy choices. Priority was given to initiatives which would also help to reduce inequalities in health.

Given the cross-Departmental nature of IFH, structures were established to support its delivery both across Departments and at a local level. Following reform of health and social care structures the functions and responsibility for all IFH Partnerships and the four Health Action Zones was transferred to the PHA in April 2009.

The DHSSPS allocated £2.5-2.9m per annum between 2002-03 and 2008-09 for the operation of the *Investing for Health Partnerships* and the delivery of local actions plans. The Partnerships also successfully levered in funds from other organisations.[41]

The Review noted that since the publication of IFH, a considerable amount of evidence has emerged to support the rationale for tackling the social determinants of health as the key to addressing health inequalities and improving outcomes for society as a whole. These societal influences, such as early childhood care, education, employment and working conditions, access to health services, housing, income, social exclusion and unemployment, all impact on health. It is envisaged that this increased emphasis on the social determinants of health will enhance the traditional public health focus on disease prevention and behavioural risk factors. Early childhood interventions are now seen as a particularly important area that can help reduce societal inequalities rooted in poverty.[42]

With regard to the effectiveness of Investing for Health, the Review highlighted that improvements had been made to the levels of life expectancy in Northern Ireland since 2002 and in addition, significant progress had been made towards achieving the 14 targets set out in IFH.

Three of the four targets set to be achieved by 2004 were achieved within the timescale. Of the 10 targets to be achieved by 2010, two were on track to be achieved, four were not on track to being achieved and four were not directly comparable to the baseline as the method of recording data had changed since 2002. The targets set were considered to be challenging so the Review concluded that IFH had achieved a considerable amount in many areas in a relatively short time scale, while challenges remained in relation to health inequalities.[43]

[41] *Investing for Health Strategy Review, Final Report*, FGS McClure Watters, September 2010, paragraph 2.1, http://www.dhsspsni.gov.uk/health_development-final_report_-_september_2010.pdf

[42] *Investing for Health Strategy Review, Final Report*, FGS McClure Watters, September 2010, paragraph 2.2.6, http://www.dhsspsni.gov.uk/health_development-final_report_-_september_2010.pdf

[43] *Investing for Health Strategy Review, Final Report*, FGS McClure Watters, September 2010, paragraph 2.5.4, http://www.dhsspsni.gov.uk/health_development-final_report_-_september_2010.pdf

Five of the targets were impact targets with short timescales[44]:

- The target to reduce the percentage of pupils who achieve no GCSEs in the 25% of secondary schools with the highest percentage FSME[45] from 8.5% to 5% by 2005-06 was successfully achieved.
- The target set for the percentage of children achieving the expected level in Key Stage 2 English and Maths was not met by 2005-06, although improvements were made compared to the baseline figures;
- The target to reduce the level of fuel poverty by 2004 was achieved.
- The target on the number new dwelling starts by housing associations fell short of the target by a small amount (239 new dwelling starts).
- The target to reduce the concentrations of the seven main air pollutants by 2005 was not achieved. The margin by which it failed was small and considerable improvements had been made over the time period.

The outcome targets with longer timescales looked likely, at the date of publishing of the Review, to have varied levels of success[46]:

- The target to increase life expectancy for men 77.5 years and for women to 82.6 years, was on track to being met by 2010 if the trends in improvements continued;
- The target to reduce the proportion of people with a potential psychiatric disorder to 19% by 2010 was on track to be achieved, based on data for 2006;
- The level of obesity was unlikely to be reduced below the baseline figures by 2010. However, the Review noted that the rise in obesity levels is a global problem;
- The gap in life expectancy between the most deprived areas and the Northern Ireland average at 1998-00 was 3.1 years for men and 2.5 years for women. It was predicted to be to 3.6 years for men and 2.2 years for women in 2009-11, suggesting that gaps in life expectancy are forecast to narrow for women but widen for men (the actual figures, already mentioned above, published by the HSCIMS third update bulletin (2009) were 4.4 years for men and 2.6 years for women)
- In 2003, the proportion of children living in low income households (after housing costs) was 26%. In 2009, this proportion remained unchanged at 26%.

The Review analysis at a Departmental level highlighted that a significant number of areas only started to progress from 2006. There had also been a significant level of strategy and policy work in 2009 which had not had time to work through into outputs or

[44] *Investing for Health Strategy Review, Final Report*, FGS McClure Watters, September 2010, paragraph 2.4.1, http://www.dhsspsni.gov.uk/health_development-final_report_-_september_2010.pdf

[45] FSME – Free school meal entitlement

[46] *Investing for Health Strategy Review, Final Report*, FGS McClure Watters, September 2010, paragraph 2.4.1, http://www.dhsspsni.gov.uk/health_development-final_report_-_september_2010.pdf

impacts at the time of the Review. The Review noted that Departments had a strong focus on reporting activities rather than achievements or outcomes.[47]

In summary, the causes of health inequalities are complex but it is known that they are strongly driven by the social, economic and environmental conditions in which people live and work. These conditions are known as the social determinants of health.[48] Alongside these determinants, many of the key health behaviours significant to the development of chronic disease follow the social gradient, for example, smoking, obesity, lack of physical activity, poor nutrition, abuse of drugs and alcohol; along with other factors such as mental illness, low breastfeeding rates and poor oral and sexual health.[49]

In NI the overarching policy driver in this area is *Investing for Health* and it is to be succeeded by a new ten year public health strategy to be launched in 2012. It will be a cross-government, outcome-based strategic framework and will take account of social, economic and legislative changes since the previous strategy was written. It will continue to focus on improving the overall health and well-being of the NI population whilst aiming to reduce evident health inequalities. This briefing has aimed to give an overview of how health inequalities are being monitored and measured in NI; how the current *Investing for Health* Strategy has performed over the past decade; and the DHSSPS strategies to tackle some of the key lifestyle areas and related activities of the PHA.

[47] *Investing for Health Strategy Review, Final Report*, FGS McClure Watters, September 2010, paragraph 2.4.1, http://www.dhsspsni.gov.uk/health_development-final_report_-_september_2010.pdf

[48] Social Determinants and Health Inequalities, Institute of Public Health in Ireland, www.publichealth.ie/service/social-determinants-health-inequalities

[49] Make Healthier Choices Easier, HSC Public Health Agency, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/make-healthier-choices-easier

Appendix 1 - NI Health and Social Care Inequalities Monitoring System, Sub-regional Inequalities – HSC Trusts 2010, Executive Summary

Health outcomes were generally worse in the most deprived areas within a Trust than the overall Trust area itself.

Belfast HSC Trust

- The largest subregional inequality gaps between the health outcomes experienced in the most deprived areas in Belfast Trust and the Trust itself occurred in alcohol related mortality (103%), self-harm admissions to hospital (96%) and teenage birth rates (93%).
- In addition, there were still other relatively large inequality gaps cross many areas (14 of all 33 indicators examined for the Belfast Trust showed gaps of 40% or greater).
- More encouragingly, gaps were relatively small for mood and anxiety disorders, cancer incidence, elective admissions (although this might be an indication of worsening access in the most deprived areas) and infant mortality rates.
- There were a number of noticeable improvements over recent years in the gaps that existed in Belfast Trust – the size of the infant mortality, hospital admission rates (all, emergency and elective), cancer mortality, cancer incidence, mood and anxiety disorders and dental registration rates inequality gaps all declined.
- Conversely some inequality gaps widened over time, most notably for male life expectancy, respiratory mortality, self-harm admissions, smoking during pregnancy and breastfeeding on discharge from hospital.

Northern HSC Trust

- The largest inequality gaps in the Northern Trust occurred in teenage births (86%), alcohol related deaths (76%) and admission rates to hospital for self-harm (67%).
- Of the 33 health indicators analysed, 7 showed relatively large gaps (i.e. greater than 40% in magnitude) between the 20% most deprived areas in the Northern Trust and the Trust itself.
- More than two-thirds of the health indicators analysed showed only relatively small inequality gaps (i.e. less than 20% in magnitude).
- There were improvements in most of the Northern Trust inequality gaps over time, for instance, the gaps for infant mortality and cancer mortality virtually disappeared. However the relative gaps for male life expectancy, lung cancer incidence, ambulance response times and mood and anxiety disorders all remained fairly consistent over time, while the gaps for suicide and teenage births both increased over the period under review.

South-Eastern HSC Trust

- The largest health inequality gap occurred in alcohol related mortality where the death rate in the most deprived South Eastern Trust areas was almost double (98% higher) that in the wider Trust.
- There were also large differences in health outcomes for teenage births (77%) and smoking during pregnancy (75%).
- In all, 6 of the 33 indicators analysed showed relatively large inequality gaps (of greater than 40%). Conversely 20 indicators had relatively small gaps of less than 20% in magnitude with the smallest gaps occurring in outcomes for life expectancy (for bo*th males and females), mood and* anxiety disorders, cancer incidence, elective admission rates and childhood immunisation.
- For most of the indicators, the inequality gap in the South Eastern Trust area remained broadly constant over time. However there were improvements in the gaps for infant mortality, hospital admission rates (all admissions, emergency admissions, circulatory disease and self-harm), cancer mortality, smoking during pregnancy and breastfeeding on discharge from hospital.
- Gaps for teenage births and amenable mortality actually increased over the period.

Southern HSC Trust

- The largest inequality gaps in the Southern Trust area occurred in alcohol related mortality (94%), self-harm admissions (68%) and smoking during pregnancy (64%).
- Overall 6 of the 33 indicators analysed in this report showed relatively large inequality gaps of 40% or more whereas two-thirds of the indicators showed relatively small gaps (i.e. less than 20% in magnitude).
- Over time notable improvements in Trust inequality gaps within the Southern Trust Area occurred in teenage births, suicide and self-harm admissions to hospital. In fact, most of the inequality gaps improved with the exception of female life expectancy, cancer incidence, hospital admissions for circulatory disease, smoking during pregnancy, smoking related mortality and dental registrations which remained fairly constant.
- Gaps widened for circulatory deaths, alcohol related deaths, amenable deaths and ambulance response times.

Western HSC Trust

- The largest Western Trust inequality gaps occurred in alcohol related mortality (112%) and self-harm admissions (89%), teenage births (76%) and smoking during pregnancy (71%).
- Overall 7 of the 33 indicators had gaps of 40% or greater. Irrespective of the direction, gaps in 19 of the indicators were of a magnitude of less than 20%.

- Within the Western Trust, there was a narrowing of the gaps for most of the indicators over time. The most notable reduction (proportional terms) in Trust inequality gaps occurred for circulatory admissions, cancer mortality and lung cancer incidence.
- The gaps for male life expectancy, elective hospital admissions and alcohol related mortality all remained broadly similar, while those for ambulance response *times and suicide widened over* their respective periods.