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Preface by the First Minister and Deputy First Minister

Rt Hon David Trimble MP MLA
First Minister

Seamus Mallon MP MLA
Deputy First Minister

Good health is a concern for everyone: for each of us as individuals with our families, friends and neighbours; for employers with their workforces; for public services, including the health and social services; for trades unions, voluntary and community organisations. We all have a stake in Investing for Health.

The health of our population has improved steadily over the past century, partly as a result of developments in medicine and in the organisation of the health and social services, but more importantly because of improvements in public services, including education, housing, social security, and environmental health.

But too many of us still suffer from diseases and disabilities which are largely preventable. Our life expectancy, particularly for women, is below the average for European Union countries. Our death rates from heart disease are the worst in Western Europe. And there are inequalities in health and wellbeing between different groups in society which are simply unacceptable.

In the Programme for Government, the Executive outlined its vision for a cohesive, inclusive and just society. We stressed our commitment to ensuring equality of opportunity and tackling social disadvantage. We emphasised the importance of different Departments and agencies working together to improve policies and services. Health improvement is identified under the heading “Working for a Healthier People”, as one of our five overarching priorities. We undertook to develop a cross-cutting, strategic approach to better our health and reduce health inequalities, and to do so by April 2001, after full public consultation.

“Investing for Health” outlines our proposals for such an approach. It sets out the principles and values which, we suggest, should guide our actions. It demonstrates why it makes sense to pursue health improvement through a broad range of social, economic, and environmental policy areas. It highlights some of the harsh implications for health of social, environmental and economic factors. And it proposes priorities for action.
Preface by the First Minister and Deputy First Minister

We do not want "Investing for Health" to be just another document, discussed today and forgotten tomorrow. This publication is only the first step. Its purpose is to initiate a dynamic, long-term process of improvement.

The success of the "Investing for Health" process will depend on close and continuing collaboration across Departments and public agencies. The Executive has tasked the Ministerial Group on Public Health to ensure that this happens. Every Department will be open to views on the contribution which it can make.

Success will also require broad participation across society. At the political level, there is clearly an important role in the process for the Assembly and its Committees, and for the Civic Forum, all of which will be invited to contribute to the development of the strategy. At a more local level, we will be looking to health and social services agencies to stimulate and co-ordinate action. At the same time, we are calling on everyone to reflect on the strategy and to make the greatest contribution they can, whether as individuals, employers, community representatives, or service providers.

We have great pleasure in inviting you to consider this document carefully and let us have your views. We cannot succeed without your active participation.

We look forward to working with you to make a difference.

RT HON DAVID TRIMBLE MP MLA
First Minister

SEAMUS MALLON MP MLA
Deputy First Minister
I am delighted to present this consultation paper. It sets out the Executive's ideas on a new approach to public health. The Investing for Health programme, as outlined in this paper, has the potential to improve all our health, and in particular that of those groups at greatest risk. It sketches a vision for making our society both fairer and fitter. The underlying idea is that if we invest relatively small amounts now in the proposed approach, we can make substantial future gains in health and wellbeing.

Earlier this year, the Executive commissioned me as Minister of Health, Social Services and Public Safety to take forward the development of a new strategy to improve the health of all our people. Ministers agreed that the new strategy would address the wider determinants of health and wellbeing through a cross-Departmental, multi-sectoral approach. I have brought together senior officials from each Department as the Ministerial Group on Public Health, to work with me on developing this strategy.

Compared with other regions in Western Europe, we die too young and too many of us suffer unnecessarily for years from painful and disabling conditions. This need not happen.

Moreover, much of this unnecessary premature death and disease is determined by social and economic inequalities. The evidence is clear. The better off you are, the healthier you are; the longer you can expect to live; and the less likely you are to spend the later years of your life suffering from a chronic disease or disability. Poorer families have less to spend on the physical determinants of health, such as good food and comfortable housing. Their children are less likely to achieve the educational qualifications which are the key to pulling themselves up the social ladder. They live and work in more difficult conditions. They lead more stressful lives. They are excluded from the benefits of prosperity, which the rest of us take for granted. And in a culture which places so much emphasis on academic performance and material achievement, they are more likely to feel useless, helpless, and depressed. These factors all bear on the same group of people, and the damage they do to health is cumulative. This health gap - the disparities in health status between rich and poor - is an affront to equity and social justice.

We cannot ignore these facts. We can and will act. We intend to bring our health standards at least up to those of the best regions in Europe. We are determined to reduce the inequalities in living and working conditions which cause ill health.
Foreword

Some of our ideas will be familiar. We do not intend to discard programmes and arrangements which are working well. Investing for Health will not displace work already under way to strengthen treatment and care in the health and social services.

But health is too important to leave to the health service. The greatest gains in our health over the past 100 years have been achieved through improvements in other arenas, including education, working conditions, housing, food safety, water supplies, waste management, and the physical environment.

We believe that the same is true of the potential gains which now lie within our grasp. We intend to give greater priority to health and the determinants of health across the public sector, and we want you to join us. There is much to do, and to gain.

We have outlined a substantial agenda for action. Some of this is for Departments and their agencies. But the process will succeed only if it attracts widespread support and engages energies across the community. Unless the general public becomes involved in the debate, we won't make the progress that is needed.

The first step is to answer these questions:
- What are the things that we can do to make our health better than it is today?
- Who needs to take these actions?
- How will all these people work together?

We are starting a journey which will take years to complete, and in some cases years more before the results we anticipate are fully realised. We owe it to our future selves, our children and grandchildren, to start now.

The Executive is committed to developing the Investing for Health initiative through full public consultation. I want to hear from as wide a range of voices as possible. I have already written to over 600 organisations and individuals inviting initial contributions. My Department has invited more through a series of public advertisements. Already over 100 responses have been received. This consultation paper itself reflects those responses as well as contributions from over 50 people, representing a broad range of interests and areas of expertise, who came together for a workshop on 20 September to discuss what the broad approach and main themes for such a strategy might be.

The publication of this document starts the next stage in the consultation process. I hope it will stimulate thinking and discussion about how best to improve our people's health. Over the next few months, there will be many opportunities to participate in the debate. I look forward to hearing from you.* I will take carefully into account all the views and ideas that are put to me, and will use them in drawing up proposals for implementation to put to the Executive next Spring. The resulting action plan, too, will be published.
Réamhrá

Tá an-áthas orm ar an páipéar comhairleach seo a chur i láthair. Leagann sé amach barúlacha an Choiste Feidhmiúcháin ar an mhodh oibre nua do shláinte an phobail. Tá cumas iontach ag an chlár Investing for Health, a bhfuil creatloch de leogtha amach sa pháipéar seo, lenár sláinte ullig a theabhsú, agus go háirithe na grúpaí sin is mó boal. Tugann sé cuntas ar aisling chun ár socháil a dheanamh níos cothroime agus níos aclaí. Is é an bunsmaoinéama bhá má dhéanann mionfhothúchaí anois sa mhodh oibre atá á mholadh, is féidir linn gnóthú go substanstioíil i gcúrsaí sláinte agus dea-bhaile sa todhcháin.

Níos luaithe i mblíona, rinne an Coiste Feidhmiúcháin mé a choimisiúnú mar Aire Sláinte, Seirbhisí Sóisialta agus Sábháilteacha Poiblí le forbairt straitéise nua a thabhairt chun tosaigh chun sláinte ár ndaoine uile a theabhsú. D’ontaigh na hAiri go rachadh an straitéis nua i ngleic leis na fachtaíobh níos leithne a chruthaíonn nó a scrisiúnaíonn sláinte agus dea-bhail trí chuige tras-Rannóg, il-eornail a dheanamh. Thug mé feidhmeanacha shinsireachacha le chéile ó gach Rannóg, mar Ghrúpa Airí ar Sláinte Poiblí, chun bheith ag obair liom ar fhobarraí na straitéise seo.

I gcoinneálaíodh an leigíúin eile in larthar na hEorpa, faigheann muid bás ro-óg agus bionn barráocht againn ag fulaingt gan ghá ar feadh na mblianta le riochtaí píannhara a chuireann michumas orthu. Ní gá go bhfuil sé amhlaidh.

Ina theannta sin, eagothroime shóisialta agus eacnamaioch is cóis le cuid mhaith den tinneas agus den bhás análaí. Tá an fhianaise sóiléir. A shaibhre atá tú a shláintúla atá tú; thig leat bheith ag dúil le sol Máthú; agus is láu an seans go mbíodh teaghlach ná aithne amach nó mhuimhí uilig ort i mblíanta deiridh do shaol. Bionn níos luaidh le cothromach ag teaghlach bhocht ar na rudái fisciolta a chuidionn leis an tsláinte, amhail bia maithe agus tithiocht chommodrach. Is láu an seans a bhionn ag a bpaithí cailliochtaí oideachasúla a bhaint amach a chuireadh ar a gcumas iad féin a thabhairt anois an dréime láir is síosialta. Maireann siad agus oibrionn siad i gcloinniollacha níos deacra. Bionn siad níos strúmshaire orthu. Ceiltear buntaisí an rathúlaí on bhurlogh, a mblíonn an chuid eile againn ag deánadh talamh slán diobh. Agus i gcúltur ina gcurtear bheim chomh mór sin ar eachtai acaúla agus gnóthú maoine, is mó an seans go mthóidh siad gan mhaith, gan chuidiú, faoi ladar spride. Bionn na fachtaíobh seo ulig ag titim ar an grúpa óganna daoine agus tá an dochar a dhéanann siad don sláinte carnach. Is maol don chomhchomhannaíochta bos ìon siad an bhreatais síosialta ag an bhreathnú sláinte seo - an difear sa stádas sláinte idir na bocht agus lucht na tsai bíris.

Ní thig linn gan aird a thabhairt ar na firicií seo. Thig linn gniomhú agus sin a dhéanaimh uilig. Tá sé de rún ag allgair caighdeáin sláinte s’againne a ardú go dtí go bhfuil siad incheorta ar a laghad leas na reigíúin is fearr san Eoraip. Tá cinneadh déanta againn na héagothroime i gclóiníollacha beatha agus oibre a chruthaíonn drochshláinte a laghdú.

Ní bheidh íمز ar smaointí uilig ùr. Ní sé de rún againn cláracha agus socruithe atá ag obair go maith a chuirteach i gcáirte. Ní ghlaicfadh Investing for Health áit na socruithe atá ar siol cheana féin le cóir leigheas agus cúram sna seirbhísí sláinte agus síosialta a neartú. Ach tá an tsláinte ró-thabhachtach le fágail ag an tseirbhís sláinte. Na céimeanna is mó a gnóthaiodh i gcúrsaí sláinte le 100 bliain annus, is trí leasuithe in gcomhtheachasanna eile a gnóthaiodh iad, an toidreas, coinneóllacha oibre, tithiocht, sábhálteacht bia, soláthar usice, láimhseáil fuill agus an timpeallacht thhisiciúil san áireamh.
Reamhrá

Creideann muid go bhfuil an rud céanna fior maidir leis na tairbhi seo atá beagnach faoinán láimh agaín. Tá rún againn taiscocht nios mó a thabhait don sláinte agus rudai a chothaionn an tsláinte trasna na rannóige poiblí ar fad, agus ba mhaith linn go bhfuil sibhse linn. Tá a lán le déanamh agus le gnóthú.

Tá clár oibre substaintiuil chun gniomhaocha leagtha amach agaín. Tá cuid de seo do na Rannóga agus a ngníomharachtaí. Ach ní éireoidh leis an pháiséas seo muna dtarraingionn se tacaiocht leathan agus muna mbainean ní leas as fuinneamh gach coda den phobal. Muna bhfuil an pobal i gcoinne páirtreach sa diospóireacht, ní dhéanfar an dul chun cinn is gá.

An chéad cheim ná na ceisteanna seo a leanas a fhreagraí:

• Cad iad nó rudai is feidir linn a dheanamh lenár sláinte a dheanamh nios fearr ná mar atá sé inniu?
• Cé a chaithfidh na rudai seo a dheanamh?
• Cad é mar a oibreoídh na daoine seo le cheile?

Tá muid ag tosú ar thuras a thógfaidh na blianta le criochnú, agus i gcuid cásanna tógfaidh sé na blianta sula gcombhiontar go hionmáin na torthaí a bhfuil muid ag dúil leo. Tá sé dlúite féin mar a bheas muid sa todhchaí, dár bhpáistí agus do bhpáistí éf, tosú air láithreach.

Tá glactha as lámh againn an tionscmamh Investing for Health a thobarairt trí chomhairliú íomhlán poiblí. Ba mhaith liom cluinstigh ón réimse chumhanna is leithne agus is feidir. Scriobh mé cheana féin chugú níos mó ná 600 eagraíocht agus duine aonair ag tabhairt cuireadh dóibh a smaointi tosaigh a chur chugam. D’iarr mo Rannóg níos mó trí shráth d’fhográidí poiblí. Fuarthas níos mó ná 100 freagra cheana féin. Léirionn an páipéar comhairleach seo na freagraí sin chomh maith le hionchur ó níos mó ná 50 duine, ag feidhmíú ar son réimse leathan grúpaí agus speisialtaítaí, a tháinig le chéile fá choinne ceardlaíne ar 20 Meán Fómhair le modh oibre ginearálta agus téamaí móra na straitéise seo a phlé.

Cuireann failsiú an doiciméid seo tú le céim eile sa pháiséas comhairleach. Tá súil agam go spreagfaidh sé smaoineamh agus diospóireacht faoin dóigh is fearr le sláinte a dhíobh a fhéadfadh. Thuig an riocht na teacht, beidh a lán deiseanna ag daoine beith i gpríorachtaí sa diospóireacht seo. Tá mé ag dúil go mór le chuid mhíniú uait. * Glacfaidh mé son aibreachtachtaí mar gearrcaidh agus barrúachta uilig a thugtar dom agus bainfidh mé úsáid astu agus mé ag dréachtú máthú le cur i gcích a chuiríocht é m’os comhaír an Choiste Freidhmiúcháin an t-earrach seo chugainn. Failseofar an pleán gniomhaíochta a bheas mar thoradh air sin chomh maith.

Bairbre de Brún

Minister of Health, Social Services and Public Safety
Aire Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

* Details of consultation process are on page 11
* Tá sonruithe an pháiséis chomhairligh ar leathanach 11
Consultation Process and Timetable

This consultation paper sets out proposals for health and equality. Please consider them carefully, and think about how you, your family, community, and the organisations you belong to can contribute to improving our society's health. Think about how we, in government departments, can help.

Then let us know what you think.

The consultation paper is being widely circulated to key interest groups and stakeholders, and will be available in libraries and other public buildings. A summary will be provided on request in Irish, Ulster-Scots, Cantonese, Urdu, Bengali, Hindi and Punjabi. On request it can be provided on floppy disk or in accessible formats such as large print, Braille and audiotape. It will be accessible on the DHSSPS website at www.dhssni.gov.uk. Additional copies may be obtained from the Investing for Health Team on telephone 028 9052 0721 or e-mail publichealth@dhsspsni.gov.uk.

Points for consultation are highlighted throughout and for convenience are listed in Annex 5. But please feel free to comment on any other aspect of the paper.

A range of public events will be organised to engage individuals and communities in debate about the issues.

The consultation period will last until 10 April 2001.

Please send your comments to the Investing for Health Team, DHSSPS, Room C.4.22, Castle Buildings, Belfast BT4 3SJ. They may also be e-mailed to publichealth@dhsspsni.gov.uk.
Executive Summary

The health of our people

Everyone wants good health for themselves and their families. Good health helps us live life to the full. Our life expectancy is now better than ever. Yet as a population our health is not as good as it could be when compared with other European countries.

Not only is our health not good, but it is the poorest of our people who have to pay the highest price in health terms. Those of us who are worst off financially are more likely to be sick or disabled and to die at a younger age. These inequalities in health are evident in every age group.

The determinants of health

Health is mainly determined by people’s social, economic, and cultural environment, and any strategy to improve it must address these factors. This will require co-ordination of efforts across society. It will also require working with people to improve their prospects of a long and healthy life.

Aims of investing in health

Investing for Health aims to improve the health of our people and reduce inequalities in health. It sets out a broad range of areas where new and concerted action could make a significant difference to health and wellbeing.

Three priority groups are identified: the very young, children and young people, and older people. In line with best practice elsewhere a settings approach is proposed, and homes, schools, workplaces and communities are identified as priority settings.

As part of an integrated lifestyle and lifeskills programme the priority topics identified include; smoking, physical activity, eating for health, harm related to alcohol and drug misuse, mental health, sexual health and accidents.

Policy framework

We are not alone in facing the challenge of improving health. We can learn from experience elsewhere and benefit from international cooperation. Other countries are also beginning to tackle the issues we have identified, using approaches that are broadly similar to that which we propose.
Executive Summary

Programme for Government

Investing for Health is central to the Programme for Government priority "Working for a Healthier People". It complements, in particular, the overarching themes of equality, prosperity and sustainable development.

Legislative context

The New Targeting Social Need and Promoting Social Inclusion policies and the Equality and Human Rights legislation will complement and reinforce the Investing for Health process. They will do so by mainstreaming equality and human rights considerations across the public sector; reducing inequalities between the defined groups, which in themselves have health implications; opening up decision-making; and encouraging a systematic, integrated approach to social exclusion.

Interdepartmental working

We will address the Investing for Health agenda on an inter-Departmental basis and in partnership with all those whose active participation is essential to its success. Proposals are made which illustrate the contribution which can be made to health through concerted action across different Government Departments. In addition, it is recognised that there are important implications for health and health equity across a range of wider public policies. We propose therefore that arrangements should be put in place to assess the health impact of such policies.

Health and social services

The broad family of Health and Personal Social Services (HPSS) has a vital role to play in the Investing for Health initiative. The primary purpose of the HPSS is to protect and improve the health and social wellbeing of our people. It is therefore appropriate that HPSS bodies should take a lead role in co-ordinating this initiative.

Mobilising the efforts of society

It is recognised that participation and partnership are required at all levels across society. A great deal of inter-agency collaboration for health is already under way, and some structures are in place. We propose that Investing for Health should build on and mainstream this activity. It will do this by creating an integrated framework for action; by mobilising efforts across society; and by assigning clear responsibilities to the principal partners.
Executive Summary

Target setting

We propose that a limited number of high level targets should be set. These targets should be realistic but challenging and should allow for international comparisons. They should be formulated in terms of the main determinants of health and should focus on the need to redress inequalities in health.

Monitoring progress

There needs to be a strategic approach to the development of information systems to support Investing for Health. Effective monitoring and accountability arrangements need to be established to meet the inter-Departmental and inter-sectoral approach to this initiative.
Why we need investing for health
Introduction – Purpose, Values and Principles

Everyone wants good health for themselves and their families. Good health helps us live life to the full. It is essential to our happiness and wellbeing. Our life expectancy is now better than ever. Yet as a population our health is not as good as it could be.

Investing for Health recognises that our health is determined by our social, economic, and cultural environment. Any strategy to improve health and wellbeing must address these factors. This will require co-ordination of efforts across society. It will also require working with people to improve their prospects of a long and healthy life.

Importantly there is a need to reduce inequalities in health between different groups. Those of us who are worst off financially are more likely to be sick or disabled and to die younger. Social inequalities are bad for our health, and not only for the health of the poorest. Large disparities in income and opportunity weaken the fabric of society and increase rates of crime and violence.

Investing for Health is not about the treatment of disease or the care of sick people, important though these are. Nor is it about traditional health protection activities such as immunisation or improving food hygiene. It goes beyond the traditional approach to health education, with its focus on persuading people to change their behaviour. It is not confined to the professional disciplines of public health medicine, health promotion or environmental health.

This paper is intended to stimulate discussion. It seeks to engage with all those who have a part to play in improving our health. It provides an over-arching framework within which other, more detailed strategies and action plans, will be developed and implemented over the next 5 years.

The World Health Organization (WHO) defines health as ‘a complete state of physical, mental and social wellbeing and not simply the absence of disease’. Public health is therefore wide ranging, involving collaborative action by different sectors to achieve positive health and wellbeing and prevent disease and disability. Public health has been defined as ‘organised social and political effort for the benefit of populations and individuals’, while also involving health promotion and personal responsibility for health.

Investing for Health aims to improve the health of our people and reduce inequalities in health.

We also propose that Investing for Health will adopt the following values:

- health is a fundamental human right
- policy should actively pursue equity and social inclusion
- individuals, interest groups and local communities should be involved fully in decision-making on matters relating to health

Investing for Health will build on the value of equal rights to health, to health services, and to health information.
Introduction – Purpose, Values and Principles

Investing for Health will concentrate on the root causes of ill health, as illustrated in Chapter 2. The principles for such an approach might include:

• to address individuals in their social context, rather than symptoms, diseases or risk-taking behaviour
• to target social inequalities
• to tackle social exclusion
• to combat discrimination and injustice
• to focus public policies generally towards improving people’s living and working conditions, including conditions in schools and other public institutions
• to promote coping skills in individuals, families, and communities, through education, training, outreach and rehabilitation programmes
• to encourage community activity and self-help, especially in disadvantaged neighbourhoods
• to maximise opportunities for individuals, families and communities to protect and improve their own health
• to work in partnership with local and interest group communities.

The criteria for selecting priorities for action might include that they:

• show evidence of potential for saving lives, reducing avoidable ill health and disability
• show evidence of potential for reducing health inequalities and promoting social inclusion
• are practicable

We would welcome your views on the aim, values, principles and criteria, and on others which could be included.
The Determinants of Health

The determinants of health are complex and interrelated. An internationally recognised socio-economic model of health and its inequalities identifies the following major factors:

- General economic, cultural and environmental conditions
- Wider living and working conditions, food production and access to essential goods and services
- Social and community networks
- Individual behaviour and way of life
- Individuals' age, sex and constitution

Economic, cultural and environmental conditions

Poverty is the biggest risk factor for health. Even in the richest countries, the better off live several years longer and have fewer illnesses than the poor. Here, our people of working age in the poorest socio-economic groups are twice as likely to die prematurely than those in the highest group. Where gaps exist between the rich and the poor, additional social problems are likely to occur such as high rates of violence, crime and truancy. We discuss the evidence about inequalities further in Chapter 4.

The cultural environment helps shape people's values, beliefs and behaviour, and the nature of their key relationships. Culture therefore has a strong impact on how we think about our health. It also affects whether we have the motivation and the means to improve it.

Factors in the physical environment can affect health directly and indirectly. Direct risks include fast traffic near children, air and water pollution, derelict buildings, and exposure to hazardous chemicals. The physical environment also impacts on people's health indirectly; for example, cramped conditions generate conflict and stress, while fear of crime in the streets causes anxiety.

A substantial body of research evidence shows that chronic stress is bad for health. Anxiety, isolation, discrimination, the fear of violence, low self esteem, and lack of autonomy are all powerful risk factors for morbidity. Conflict, violence and the fear of violence are correspondingly damaging. The past 30 years of the Troubles have had a significant impact on the health of our people. Not only the deaths and injuries due to direct violence but the conflict has also had a huge impact on psychological wellbeing.

Good physical environments make it easier for people to develop their health potential by allowing easy access to essential goods and services and providing opportunities for relaxation, regeneration, and exercise. Play has an important role in promoting the health and social development of children and appropriate facilities need to be provided.
The Determinants of Health

Living and working conditions

Levels of educational achievement are strongly related to levels of deprivation and health status. Children entitled to free school meals (i.e. from low income families) tend to be lower achievers in terms of examination results (Figure 2.1). Education provides access to employment opportunities that influence material and social wellbeing and provide purpose, structure to life and a means of participating in society\textsuperscript{[ii]}. Conversely, the potential impact of job insecurity and unemployment is immense, including social exclusion, depression, anxiety, and a higher risk of premature death.

Figure 2.1: Qualifications of school leavers by free school meal entitlement 1998/1999

![Graph showing qualifications of school leavers by free school meal entitlement]

Source: Department of Education

Generally, those in secure employment enjoy better health than the unemployed. However, poor working conditions can contribute to ill health, high rates of absence, and reduced life expectancy. The costs to the economy and to the health and social services are substantial. Recent research has shown that the total annual cost of work-related accidents to society in Northern Ireland equals £244-307m, which is equivalent to 1.3-1.6% of the Gross Domestic Product (GDP).

Good housing is essential for good health. This has been identified clearly in the recent report "Housing and Health" issued by the Northern Ireland Housing Executive.\textsuperscript{[iii]} Dampness is associated with lung disease\textsuperscript{[iv,v]} while home accidents and falls are more prevalent in areas of disadvantage. Fires in the home are an important cause of death and injury, occurring primarily in the very young and older people. In 1999 there were 28 deaths from house fires here, the vast majority of which occurred in homes without a working smoke detector. Older people are most likely to be living in houses that are least conducive to the maintenance of good health\textsuperscript{[vi]}, often in ageing, unmodernised homes with high fuel costs (Figure 2.2). Cold housing leads directly to hypothermia and may also contribute to the excess of winter deaths seen in older people\textsuperscript{[vii]}. The highest risk of all to health is homelessness.
The Determinants of Health

Figure 2.2: Housing Conditions by Age Group

Source: Northern Ireland Housing Executive

Social and community networks

Many people relate closely to their neighbourhoods, and are likely to be healthier when they live in communities where there is a sense of belonging. Mutual support within a community can sustain the health of its members in otherwise unfavourable conditions.\textsuperscript{xiv}

However, run down communities have suffered most from the cumulative effects of poverty, the Troubles, low wages and occupational stress, unemployment, poor housing, environmental pollution, poor education, limited access to transport and shops, crime and disorder and a lack of recreational facilities.

Restricted access to public transport is a major barrier of access to health, social and recreational facilities for many people living in rural communities. This can create isolation and depression, especially for mothers at home with young children. It may be difficult for people without cars in rural areas, and in large housing estates, to reach shops with a variety of healthy foods. Lack of public transport can also be associated with drunk driving by young people in rural towns, when they travel to larger centres for entertainment.\textsuperscript{xv}

Individuals and their health

There is clear evidence that healthy early life experiences give children protection which lasts a lifetime. These begin with pregnancy and the mother's preparation for birth. The first year is especially crucial for healthy physical, mental and emotional development. Low birthweight,
The Determinants of Health

slow growth and an absence of emotional support during a child's early years are associated with an increased risk of poor health later.

Lifestyle is an important determinant of health potential. Until recently, the debate on individuals' contribution to their own health focused on their behaviour and in particular on:

- Risk avoidance (avoiding smoking, drug and alcohol misuse, unsafe sex)
- Eating and health
- Physical activity.

Smoking
Smoking is the single greatest cause of premature death and avoidable illness here. Smoking alone is responsible for approximately 15% of all deaths, killing an estimated 3,000 people annually. If parents smoke, their children are more likely to suffer from respiratory and other diseases for life. Smoking accounts for 30% of all cancers and over 80% of all lung cancers, while over 80% of chronic lung disease is a consequence of smoking. It also contributes to a number of other cancers and is a significant risk factor for coronary heart disease and stroke. Although the damage it does is well known, smoking is widely accepted and even socially approved.

Alcohol and drug misuse
Alcohol misuse has high social and economic cost. About 150 people here die each year from diseases directly linked to alcohol misuse. In a further 650, alcohol misuse has contributed to their death. Alcohol is a factor in a significant number of admissions to both acute and psychiatric hospitals. There is also an association between alcohol misuse and violence - including domestic violence - and crime.

It is difficult to estimate the number of deaths here caused by the misuse of illicit drugs. However, using International Classification of Diseases criteria, 43 deaths were attributed here to opiates and related narcotics between 1991 and 1998 - an average of 6 each year. In addition, 30 deaths were attributed to volatile substance abuse.

Eating and health
Diet plays a major role in our health. Twenty five per cent of all cancer deaths are linked to an unhealthy diet. Obesity is a significant risk factor for heart disease, high blood pressure, stroke and diabetes. Diabetes places a significant drain on health services resources as it is estimated that £1 in every £7 in the health service goes towards diabetes care. Levels of obesity here are increasing and as a result diabetes is likely to increase for the foreseeable future.

Physical activity
The contribution that physical activity makes to health cannot be underestimated. Regular exercise can reduce heart disease by one third, stroke by one quarter, non-insulin dependent diabetes by one quarter and hip fractures in the elderly by one half.
The Determinants of Health

Health promotion programs have been in place for many years, and have made a substantial contribution to raising people’s awareness of these issues. However, there are limits to what they can achieve. Health related social, economic and cultural factors such as peer group pressures, income, norms and fashions heavily influence behaviour. Advertising and marketing powerfully influence people’s choices, and the resources devoted to selling food, drink and tobacco far exceed those available for health promotion.

Investing for Health will therefore focus both on wider environmental factors, to make it easier for people to lead healthier lives; and on building self-protective attributes and coping skills. It will both give people information and help them to act on it.
The Health of Our People

Our legacy of progress

The last 100 years have seen growing prosperity, and a great improvement in living and working conditions, throughout Western Europe. Our life expectancy here has improved accordingly, from 47 years for men and women born in 1900 to 75 and 80 respectively in 1999. We have successfully controlled deadly infectious diseases such as cholera and polio. Death in childbirth is now rare, and deaths in the first year of life have fallen from 127 out of every 1000 live births in 1900 to 6 in 1000 in 1999.\(^\text{46}\)

Deaths that would once have been thought unavoidable have been prevented. Action has been taken, and lives have been saved. History shows what can be achieved when society pulls together behind a common purpose.

How we compare with other places

Despite this overall improvement, our performance compares unfavourably with other places in Western Europe. Although life expectancy has improved considerably for both men and women it has not been as great as in some other countries. We continue to rank amongst the worst in Western Europe. (Figures 3.1 and 3.2)

Figure 3.1: Life Expectancy at Birth in Selected European Countries: Females 1996

<table>
<thead>
<tr>
<th>Country</th>
<th>1996 Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>FRANCE</td>
<td>82.9 years</td>
</tr>
<tr>
<td>SPAIN</td>
<td>81.96 years</td>
</tr>
<tr>
<td>SWEDEN</td>
<td>81.83 years</td>
</tr>
<tr>
<td>EU</td>
<td>80.98 years</td>
</tr>
<tr>
<td>FINLAND</td>
<td>80.78 years</td>
</tr>
<tr>
<td>UK</td>
<td>79.71 years</td>
</tr>
<tr>
<td>NI</td>
<td>79.3 years</td>
</tr>
<tr>
<td>PORTUGAL</td>
<td>78.64 years</td>
</tr>
<tr>
<td>DENMARK</td>
<td>78.4 years</td>
</tr>
<tr>
<td>IRELAND</td>
<td>78.33 years</td>
</tr>
</tbody>
</table>

*Footnote: 1996 figure for Ireland not available so figure from previous year used.
(Source: WHO (Europe)/NI source Population Trends.)
The Health of Our People

Figure 3.2: Life Expectancy at Birth in Selected European Countries: Males 1996

<table>
<thead>
<tr>
<th>Country</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWEDEN</td>
<td>76.7</td>
</tr>
<tr>
<td>FRANCE</td>
<td>74.84</td>
</tr>
<tr>
<td>SPAIN</td>
<td>74.49</td>
</tr>
<tr>
<td>UK</td>
<td>74.46</td>
</tr>
<tr>
<td>EU</td>
<td>74.41</td>
</tr>
<tr>
<td>NI</td>
<td>73.9</td>
</tr>
<tr>
<td>FINLAND</td>
<td>73.16</td>
</tr>
<tr>
<td>DENMARK</td>
<td>73.12</td>
</tr>
<tr>
<td>IRELAND</td>
<td>72.58</td>
</tr>
<tr>
<td>PORTUGAL</td>
<td>71.17</td>
</tr>
</tbody>
</table>

*Footnote: 1996 figure for Ireland not available so figure from previous year used. [Source: WHO (Europe)/NI source Population Trends.]

The main killers

Heart disease and cancer are the two main causes of death here accounting for almost 50% of all deaths and almost 60% of deaths in those under 75 years (Figure 3.3). Stroke, respiratory disease, accidents and suicide are the other main causes of death. Many of these deaths occur prematurely (under age 65) and are potentially preventable.

Figure 3.3: Main Causes of Death in Northern Ireland 1998

For all ages

- 24% Coronary heart disease
- 24% Cancer
- 19% Respiratory disease
- 11% Injury, poisoning and suicide
- 4% Stroke
- 18% Other
- 11% Other

For under 75 year olds

- 33% Coronary heart disease
- 18% Cancer
- 10% Respiratory disease
- 7% Injury, poisoning and suicide
- 8% Stroke
- 24% Other
The Health of Our People

Not everyone who has one of these diseases dies, but many suffer years of preventable pain and disability. However by addressing their root causes we can greatly reduce their impact, particularly amongst the younger age groups.

Heart disease and stroke

Heart disease, stroke, and other diseases of the circulatory system kill two in every five men and women here. They are responsible for a total loss each year of over 20,000 years of life before the age of 75. They are also important causes of disability: one in 20 people reporting serious disability identifies coronary heart disease as the cause, one in 14 stroke. The major risk factors include smoking, poor diet, raised blood pressure, diabetes, and physical inactivity. A lifetime non-smoker is 60% less likely than a current smoker to have coronary heart disease and 30% less likely to suffer a stroke.xx

Although deaths from coronary heart disease have been falling since the early 1980s, we lag behind many other countries in Europe where death rates are dramatically lower (Figures 3.4 and 3.5)

**Figure 3.4: Deaths from Coronary Heart Disease per 100,000 (standardised for age): Females 1996**

<table>
<thead>
<tr>
<th>Country</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI</td>
<td>147</td>
</tr>
<tr>
<td>IRELAND</td>
<td>144.76</td>
</tr>
<tr>
<td>FINLAND</td>
<td>128.74</td>
</tr>
<tr>
<td>UK</td>
<td>116.12</td>
</tr>
<tr>
<td>AUSTRIA</td>
<td>107.26</td>
</tr>
<tr>
<td>GERMANY</td>
<td>106.5</td>
</tr>
<tr>
<td>DENMARK</td>
<td>99.06</td>
</tr>
<tr>
<td>SWEDEN</td>
<td>98.4</td>
</tr>
<tr>
<td>EU</td>
<td>77.82</td>
</tr>
<tr>
<td>NETHERLAND</td>
<td>69.17</td>
</tr>
<tr>
<td>GREECE</td>
<td>56.87</td>
</tr>
<tr>
<td>PORTUGAL</td>
<td>52.21</td>
</tr>
<tr>
<td>SPAIN</td>
<td>46.54</td>
</tr>
<tr>
<td>FRANCE</td>
<td>32.69</td>
</tr>
</tbody>
</table>

*Note: 1996 figure for Ireland not available so figure from previous year shown in figures 3.4 and 3.5 (source for figures 3.4 and 3.5: WHO (Europe)/NI rate derived from GRO (NI) mortality statistics and GRO (NI) population estimates)
Cancers

Cancers are the second most frequent cause of death here. Men have a 1 in 6 chance and women a 1 in 8 chance of dying from it before the age of 75. More than a third of us will suffer from some form of cancer at some stage in our lifetime.

The most common killers are lung, breast, colorectal and prostate cancer. Together they account for some 1735 deaths here each year, including 979 in people under 75.

Lung cancer is the most lethal. It accounts for about one in six cancer cases and one quarter of cancer deaths in people under 75. For women, our death rate is already twice the Western European average and increasing.

Breast cancer accounts for one in three cancer cases in women and almost one fifth of cancer deaths in women. Although our death rate from breast cancer is amongst the highest in Europe, it is declining, thanks to greater public awareness, screening, and earlier treatment.

Accidents

In 1998 accidents claimed 383 lives here. One third of these deaths occurred in those under 35 years of age. Falls were responsible for 127
The Health of Our People

deads, 74 of which (almost 60%) were in people age 75 and over. A further 20 deaths were as a result of fires and 13 from hypothermia.

Road traffic collisions are a major cause of death and serious injury. In 1999/00 a total of 150 people were killed on the roads. Twenty of these were children, and many of these accidents occurred when they were playing or walking close to home. In addition 1573 individuals (of whom 201 were children) were seriously injured and 12170 (1546 children) slightly injured.

Over the last five years there have been an average 23 deaths per year as a result of accidents at work. The current work-related fatal accident rate locally of 1.95 per 100,000 employees is still unacceptably high. This compares very unfavourably with a rate of 0.7 in Britain. The Labour Force Survey 1998/99 estimated that a further 17,000 people had a work related accident in the previous 12 months.

Mental ill health including suicide

Mental health problems are one of the most common forms of ill health. They place a significant burden on the community and are responsible for enormous costs to the individual and society. Approximately 1 in 6 adults, will at any one point in time, suffer from a diagnosed condition such as depression or anxiety. About 10%-20% of those aged between 10 and 19 years of age will suffer from depression, that is up to 50,000 of our teenagers.

In the 1997 Health and Wellbeing Survey, the general psychological wellbeing of respondents was assessed. Results indicated that a greater proportion of our population is at an increased risk of mental ill health when compared with England and Scotland. (Figure 3.6)

Figure 3.6: General Psychological Wellbeing, GHQ12 Score of 4 or more (Age 16-64)

Source: Health and Social Wellbeing Survey 1997
The Health of Our People

Suicide is the fourth largest contributor to potential years of life lost here, even though our suicide rate is amongst the lowest in the European Union. In 1998, there were 126 registered deaths from suicide, 95 among men and 31 among women. Of these, 28 were under 25. It is estimated that over 95% of people who commit suicide have been suffering from a mental illness.

**Long-standing sickness**

Long-standing sickness is used as a general measure of poor health in the community. Information collected through the 1998/99 Continuous Household Survey indicated that 20% of those surveyed reported long-standing sickness. Less than 20% of those with a long-standing sickness were in employment and 40% of them lived in households where the weekly income was less than £200 per week.

**Disabilities**

Disabilities (physical, sensory, and learning) are common in our society. In a 1992 report by the Policy Planning and Research Unit (DFPJ), over 200,000 adults (174 out of every 1000 adults) were reported as disabled. Significant hearing loss affected over 82,000 adults and sight loss affected over 50,000. Severe problems with mobility affected over 140,000 people.

Many disabilities cannot be prevented or cured. They can, however, be easier to live with if our environment is tailored to the specific needs of disabled individuals. Improved physical access to buildings and easy to read signs are examples of practical steps that can have huge benefits.

In 1992 there were 14,500 children (35 per 1000) with disabilities. The most common types of disability affected behaviour, mobility, personal care and intellectual function.
Inequalities

The evidence is clear: the better off you are, the longer you can expect to live (Figure 4.1). The better off you are, the less likely you are to be ill, or to spend the later years of your life suffering from a chronic disease or disability.

Figure 4.1: Life Expectancy (years) by Deprivation Category (1991)

Source: Dr D O'Reilly, Centre for Health and Social Care Research, Queen's University Belfast

Not only are differences in health evident by social class and income, but the differential between rich and poor in terms of health appears to be increasing in recent years (Figure 4.2). The health of people in the higher socio-economic groups appears to be improving while those in the lower socio-economic groups is getting worse.

Figure 4.2: Comparison of Standardised Mortality Ratios by social class, 1982-86 and 1992-96

Source: Registrar General, (NISRA)
Inequalities

Children

The differential in health status across social class can be seen in children from birth onwards. Babies in the lower socio-economic groups are much more likely to have a low birth weight and die in infancy than the children of more affluent families. The proportion of children living in conditions of poverty is unacceptable. Over a quarter of children come from households dependent on Jobseeker's Allowance or Income Support.

Inequalities in health continue to be evident throughout childhood and in young adults. Accidental injury and oral health provide examples of issues demonstrating a social class gradient.

Accidents are a major cause of death and disability among children and young people. Accidental deaths demonstrate a steeper social gradient than any other cause of death in childhood. The most deprived children are 16 times more likely to die as a result of a house fire and 5 times more likely to be injured as pedestrians than the most affluent. Deaths from accidents are by definition preventable, often by simple and inexpensive means.

Although there has been a gradual improvement in oral health over the past 5 years, the most recent surveys show that the general level of oral health here is still considerably worse than in Britain and the rest of Ireland particularly amongst children. In 1993 the average number of teeth with decay in 5 year olds here was 3, double that in the rest of Ireland.

Oral health demonstrates a stark gradient across social class, with the most deprived children experiencing four times more tooth decay than the most affluent. Children in schools in the North and West of Belfast experience more tooth decay than those in other parts of the greater Belfast area. (Figure 4.3).

Figure 4.3: Tooth Decay by School (P1 class)

![Map of Tooth Decay by School](image-url)

Source: Community dental screening data, 1998
Inequalities

There are however particular groups of individuals who by virtue of their very disadvantaged circumstances shoulder a disproportionate burden of ill health. For example teenage pregnancy is recognised as both a cause and a consequence of disadvantage. Typically, teenagers in disadvantaged areas are more likely to become teenage parents. This in turn limits their educational and employment opportunities and results in their children growing up in poverty. Thus it perpetuates a cycle of disadvantage.

We have one of the highest rates of teenage pregnancy in Western Europe. (Figure 4.4)

Figure 4.4: The percentage of all live births to mothers aged under 20 years in a number of European Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>6.93</td>
</tr>
<tr>
<td>NI</td>
<td>6.4</td>
</tr>
<tr>
<td>IRELAND</td>
<td>5.36</td>
</tr>
<tr>
<td>AUSTRIA</td>
<td>3.95</td>
</tr>
<tr>
<td>FINLAND</td>
<td>2.57</td>
</tr>
<tr>
<td>DENMARK</td>
<td>1.82</td>
</tr>
<tr>
<td>NETHERLANDS</td>
<td>1.32</td>
</tr>
</tbody>
</table>

Source: WHO (Europe)/NI percentage derived from GRO (NI) statistics

Older People

The number of older people here is increasing. Over the last 50 years the number of persons aged 75 years and over has more than doubled - an increase of more than 50,000 people. By 2013 the proportion of the population aged 65 years and over will have risen to 24%. The effects of smaller families, more women working and a more mobile population have resulted in a greater number of older people living on their own.

Rates of reported long-standing sickness among adults rise with increasing age (Figure 4.5). Health and social care needs increase as we become older.
Inequalities

Income is consistently lowest in persons aged 65 years and over.\textsuperscript{xxv} In addition many older people who are entitled to benefits such as Income Support and Housing Benefit do not claim them. Among older people there is a direct relationship between low income and reported levels of disability.

Figure 4.5: Reported long-standing sickness among adults 1996-97

![Figure 4.5: Reported long-standing sickness among adults 1996-97](image)

Source: Continuous Household Survey/NISRA

Men and women

The differences in men’s and women’s health are striking especially once they reach middle and older age groups. Death rates are much higher in men in middle age and old age than in women in the same age groups, although this gap narrows in the over 80s. However, older women are far more likely than older men to report long-standing sickness and disability (Figure 4.5).

Ethnic minorities

Travellers are an ethnic group recognised as having poorer than average health status. The life expectancy of travellers is almost 20 years less than that of the settled community here.\textsuperscript{xxvi} Infant mortality rates in travellers are three times higher than the general population.\textsuperscript{xxvi}

The Chinese community is the biggest ethnic minority group with approximately 8000 people. There is evidence that ethnic minority communities can experience difficulties in accessing services including health and social care and education.\textsuperscript{xxvii}
Inequalities

Geographical

Inequalities are also evident when we compare geographical locations. About 2000 lives could be saved each year if those living in the council districts with the highest death rates, (Figure 4.6) had the health status of those in the districts with the lowest death rates. The electoral wards with the highest death rates are also those with the highest levels of deprivation. This correlation is particularly striking for deaths from coronary heart disease.

Figure 4.6: Standard mortality ratios (all ages) by District Council 1988-94

Source: Registrar General NI (NISRA)
The Policy Context

International developments

The World Health Organization has brought together research findings and practical lessons from many places, and has used them to produce a policy framework for European countries known as Health 21.xxx Many countries in Europe have prepared or are in the process of preparing strategies which parallel Health 21. Investing for Health will build on this internationally respected framework.

EU Public Health Strategy

Since the 1993 Maastricht Treaty a number of public health programmes have been established: cancer, AIDS prevention, health promotion, health monitoring, rare diseases and communicable diseases network. In addition action has been taken in areas such as tobacco, Alzheimer's disease, blood and organ safety, women's health and children's health.

The 1998 Amsterdam Treaty changed the European Union's public health mandate and produced a stronger and more explicit emphasis on health in other policies. This led to the idea of a single programme rather than the 'topic' based programmes.

The new public health framework has three main strands:

- Improving health information
- Rapid response to public health threats
- Addressing the determinants of health

In June 2000, WHO European Health Ministers - in the Munich Declaration - agreed to strengthen public health in their own countries by enhancing the nursing contribution to health promotion, public health and community development.xxx

Other countries' public health strategies

In 1997, the Swedish Government set up a National Public Health Committee comprising politicians, experts, and representatives of the social partners, to prepare a new national strategy for health and equity. The Committee has published a series of studies and discussion papers to stimulate debate across society, with a focus on producing targets relating to health determinants (rather than health outcomes).

Public health strategies have recently been produced for Scotland (Working Together for a Healthier Scotland 1998), Wales (Better Health - Better Wales 1998), and England (Saving Lives: Our Healthier Nation 1999). These emphasise the socio-economic context for health behaviour and the need to tackle the root causes of ill health. Proposed measures include health impact assessments, area regeneration and sustainable development through social progress, protection of the environment, prudent use of natural resources and economic growth and employment. Specific target areas in all the strategies are cancer, coronary heart disease, accidents and mental health.
The Policy Context

The Irish Government’s National Health Promotion Strategy 2000-2005 similarly highlights social, economic and environmental factors as the main determinants of health. Health targets are set for three interrelated areas: settings (e.g. family, community, and school); population groups (e.g. children, sexually active people and women); and lifestyles (e.g. alcohol, smoking, substance abuse). Partnership, inter-sectoral and multidisciplinary approaches are advocated, as well as research and evaluation to bring about health and social gain in a comprehensive and equitable manner.

A summary of these strategies is at Annex 1.

The Programme for Government

The Executive Committee’s draft Programme for Government sets out five priority areas:

- Growing as a community
- Working for a healthier people
- Investing in education and skills
- Securing a competitive economy
- Developing North/South, East/West and international relations

Much of the action outlined will contribute directly to strengthening the determinants of health.

New Targeting Social Need (NTSN)

The New Targeting Social Need (NTSN) initiative aims to tackle poverty and exclusion by targeting the efforts and resources of public agencies towards the people, groups and areas with the greatest social need. NTSN includes a special focus on the problems facing unemployed people and on increasing their chances of finding a job, but also targets inequalities in health, housing, and education. The Departments’ NTSN Action Plans will be published in a single document by the Office of the First and Deputy First Minister in the Autumn, showing how they propose to implement the initiative for the 3 years from January 2000. Other public bodies must produce similar plans by January 2001.

Investing for Health will build on this experience.

Promoting Social Inclusion (PSI)

Departments have already identified and are working on an agenda for inter-Departmental action covering specific issues of social inclusion which demand an integrated approach across administrative boundaries. These will help advance the Investing for Health process. Current PSI projects include:

- meeting the special needs of minority ethnic groups
The Policy Context

- teenage pregnancy and parenthood (report recently published for consultation)
- making public services more accessible
- services for Travellers (report recently published for consultation)

More will come on stream as these are completed.

Equality Schemes

Since January 2000, all Departments and most public agencies here have been required by law to promote equality of opportunity between people of different population groups. The groups are defined by religious belief, political opinion, racial origin, age, marital status or sexual orientation; between men and women; between people with a disability and people without; and between people with dependants and people without. None of this is aimed directly at inequalities in health status, or at the main determinants of health. Neither social class nor poverty is used in defining the groups covered by the equality provisions. Nevertheless, we expect that these developments will complement and reinforce the Investing for Health process by mainstreaming equality considerations across the public sector; reducing inequalities between the defined groups, which in themselves have health implications; opening up decision-making; and encouraging a systematic, integrated approach to social exclusion.

Each Department and agency must also conduct equality impact assessments on all significant policies and programmes. There must be public consultation on each assessment, and the results must be published.

The Investing for Health process itself will be the subject of an equality impact assessment, which will be published for consultation with the strategy document itself next year.

We would also welcome comments now on the potential equality implications of Investing for Health.

The Human Rights Act

The Human Rights Act, which came into force in October 2000, requires public authorities to respect the fundamental rights set down in the European Convention on Human Rights. The Human Rights Commission is drawing up recommendations for additional legislation to further protect basic rights here, including social, economic, and educational rights. The Convention Rights do not include a right to health.

Key policy areas impacting on health

Ministers and their Departments have recognised the important implications for health and health equity of wider public policies. These policies both impact on health directly, and contribute to creating conditions which make
The Policy Context

It easier for people to lead healthy lives. Most of the determinants of health outlined in Chapter 2 lie beyond the remit of the health and social services and will require a sustained commitment at the highest level across all Departments.

Key policy areas impacting on health and the Departments primarily responsible for them are listed at Annex 2.

Over the last decade there has been an increasing commitment to tackling the root causes of ill health through a range of interagency approaches. The Ministerial Group on Public Health has already demonstrated that much can be achieved through a co-ordinated effort across Departments. Inter-Departmental structures are already in place to address drug and alcohol misuse, smoking and domestic violence, and to develop child care and family support. Inter-agency strategies are in place on diet and physical activity.

Special initiatives are already under way to break down the obstacles to collaboration between agencies and sectors, and to broaden participation in action for health. These include Healthy Cities projects in Belfast and Derry; Health Action Zones in North and West Belfast, Armagh and Dungannon (with two more in the pipeline).

There are also several new initiatives on the horizon, such as After School Clubs and Healthy Living Centres, which will impact on health throughout schools and local communities. Both are funded through the New Opportunities Fund. The involvement of 24 schools here in the European Network of Health Promoting Schools has provided a context and environment for demonstrating, as well as learning about, healthy lifestyles, by all members of the school community.

The forthcoming Regional Development Strategy acknowledges the impact which spatial planning can have on the health and wellbeing of our citizens; it will promote a social, economic and environmental approach to planning and will include guidelines which will promote healthier lifestyles.

The Department of the Environment (DoE) is charged, in collaboration with the other Departments with developing a strategy for implementation of Sustainable Development, taking as the definition "Development that meets the needs of the present without compromising the ability of future generations to meet their own needs". Early sustainable development strategies tended to concentrate on promoting economic growth that was sustainable in terms of meeting objectives on environmental protection and the use of finite natural resources. The latest thinking adds economic and social objectives and clearly has significant potential implications for the health of the public.

The Investing for Health process will learn from and build on these experiences.

We would welcome your views on how best to develop existing inter-agency strategies and initiatives to improve our health.
Agenda for Change

Investing for Health is a continuing, long-term process. We are proposing to take the first steps on a long road. There is much to do, and we will have to set priorities. In so doing, we suggest that it would be sensible to think in terms of what we might realistically hope to achieve within the next ten years. This Chapter proposes priority areas for attention and an agenda for action.

Priorities

The imperative is to strengthen the determinants of health and reduce the risks of premature death, disease and disability, as identified in Chapter 3. This ambitious agenda will need to focus efforts on several groups of individuals and at several different societal levels if it is to be successful. Addressing inequalities will be a key theme for all of the proposed action.

To achieve this we must focus on tackling the underlying causes of disease such as poverty, smoking, inactivity, poor diet and alcohol and drug related problems. The existing lifestyle programmes target some of the key risk factors. However, we need to achieve more effective co-ordination of these programmes and transform them from a series of parallel processes to an integrated programme focusing on the health of specific target groups.

Investing for health proposes to target key priority groups, including the very young, children and young people, and older people. Across all groups, the specific needs of those who have a physical, mental or sensory disability will require particular attention and targeted action.

We also need to achieve a better co-ordination of the delivery of programmes in specific settings. In addition to the age related priority groups, we propose to promote action in a number of settings where people spend much of their time. Examples include homes, schools, workplaces and communities.

Fundamentally, the success of healthy lifestyle programmes depends on people embracing the messages and changing their behaviour. A well-informed public can do much more to protect or improve their health but individuals, families and communities need to be supported by an environment that makes it easy for them to choose a healthier lifestyle.

Overarching themes aimed at protecting the health of the public, ensuring environmental safety and promoting a vibrant economy will complement the targeted action described above.

What are the key issues that need to be addressed in taking forward this agenda?
Agenda for Change

Priority Groups

• **The very young** - we need to ensure that babies and young children get the best possible start in life

• **Children and young people** - we must equip children and young people with the knowledge and the self-esteem to make responsible choices in their lives

• **Older people** - as well as extending the length of life we need to improve the quality of life of those added years

Priority Settings

• **Homes** - the home is the setting in which people spend most of their time. Homes should be designed and built to sustain health and the environment. People can create healthy home conditions

• **Schools** - pupils, teachers and parents can work together in health promoting schools to enhance the health of students, staff, families and communities

• **Workplaces** - workplaces should aim to reduce exposure to risks and increase the participation of employees in promoting a safer and healthier working environment and reducing stress

• **Communities** - communities need to build health plans, with commitment from different sectors to creating sustainable, healthy living environments for local people.

Priority topics

We propose to prioritise the following topics as part of integrated lifestyle and lifeskills programmes:

- smoking
- physical activity
- eating for health
- harm related to alcohol and drug misuse
- mental health
- sexual health
- accidents

In each case, the approach would focus on community support, self-help, strengthening protective attributes, and building coping skills

The following sections show some of the multi-sectoral programmes targeting these priorities which are already in the pipeline or planned.
Agenda for Change

Smoking

We will do our best to prevent young people from starting to smoke, make it easier for people to quit smoking, and to protect everyone from the dangers of passive smoking\textsuperscript{xxx}. We will introduce legislation to ban tobacco advertising and sponsorship.

We will continue to publicise the dangers of smoking; will support smoking cessation projects in local communities, workplaces, and elsewhere; and will expect primary care teams and others in the health service actively to encourage and help people to quit.

The Department of Education (DE) will help in teaching children of the dangers of smoking. The Department of Enterprise, Trade and Investment (DETI) is drawing up an Approved Code of Practice on Passive Smoking. The Department of Finance and Personnel (DFP) is reviewing smoking policies in government buildings.

Tackling the problem of tobacco dependence requires a co-ordinated plan. An inter-agency working group will be convened to take forward an action plan on tobacco dependence in 2001.

Physical activity

Cross-departmental cooperation on promoting the importance of physical activity will build on the work of the NI Physical Activity Implementation Group and be strengthened.\textsuperscript{xxxii} The Department for Culture, Arts and Leisure (DCAL) aims to increase health-related physical activity across all sections of the population, especially through promoting life-long participation in sport and exercise. The Department for Regional Development (DRD) and DoE are developing or implementing integrated strategies on cycling\textsuperscript{xxxiii}, walking (including safer routes to schools) and the natural environment. The education departments are working to promote physical activity in schools and colleges. The Department of Agriculture and Rural Development's (DARD) contribution to opportunities for exercise will continue through the recreational facilities provided by the Forest Service Executive Agency.

Eating and health

An inter-Departmental food and nutrition strategy is already in place\textsuperscript{xxxiv}, which will be reviewed in the light of the Investing for Health consultation process. DHSSPS co-ordinates action to strengthen public awareness of healthy eating issues, in partnership with the Health Promotion Agency, the Food Standards Agency, the Food Safety Promotion Board and the community and voluntary sectors. We will maintain and encourage the consumption of school milk through the restoration of the subsidy to its former level. We strongly support the early exposure of young children to milk in the diet as we recognise its importance in the development of
strong bones and teeth and also to provide children with a healthy alternative to carbonated drinks. The education departments act to ensure that all those involved in nutrition education are equipped with current knowledge and skills; that awareness of healthy eating is included in the school curriculum; and that education and training environments support good nutrition. DETI and DARD work in partnership with the food sector to make it easier for people to make healthier food choices.

Alcohol and drug misuse

To reduce the harm caused from alcohol misuse, the DHSSPS strategy aims to encourage a responsible approach to drinking, from those who choose to drink; promote effective treatment services; protect individuals and communities from alcohol related harm and develop a research and information programme. It emphasises the need for cross-community, multi-sectoral and inter-departmental working to deliver the published targets. DHSSPS will act in partnership with the education departments and DETI on public awareness, with DoE on road safety, and with DETI and the Department of Higher and Further Education, Training and Employment (DHFETE) on staff training for the drinks industry.

The inter-Departmental Drug Strategy identifies four cross-cutting areas for action: young people; treatment; communities; and supply. DHSSPS is responsible for overall co-ordination, health promotion and treatment. The education departments have developed action plans for work with young people, and the Department for Social Development (DSD) for regeneration and community development.

Promoting mental health

Mental and emotional health is fundamental to our wellbeing and quality of life and must be addressed as part of improving our health status. Mental health promotion aims to enhance ability of individuals, families and communities to cope with stresses that occur in our everyday lives. It also aims to minimise the risk factors for poor mental health by, for example, reducing anxiety and distress, substance abuse and social isolation.

Already a number of initiatives have been taken forward locally, including the issue of a draft strategy for promoting mental and emotional health “Minding our health” which contains a specific section on suicide prevention. Other initiatives have included guidelines on managing the issue of suicide in schools and guidelines on bullying in schools.
Agenda for Change

Sexual health

This priority includes HIV/AIDS and other infectious diseases, and other aspects of sexual relationships. A multi-sectoral working group has produced a consultation document on teenage parenthood and pregnancy, which emphasises the particular needs of young people in relation to sexual health services.

DHSSPS and DE will be working to improve relationship and sex education and access to information.

Accidents

We will take action to reduce road traffic casualties as well as home and workplace accidents. Specifically, we will build on the multidisciplinary work already underway, led by ROSPA, to produce a framework for home accident prevention. In partnership with employers, Trade Unions and District Councils the Health and Safety Executive for Northern Ireland will continue to direct resources at reducing the incidence of workplace accidents.

We would welcome comments on the priority groups, settings and topics, and in particular on what additional action we might take for each.

Departmental contributions to Investing for Health

The following provides an illustration of which Departments may contribute to Investing for Health objectives, by target group and settings. Objectives that will require a collaborative approach to improving the infrastructure of our community are also included. The lists are not intended to be exhaustive but to demonstrate what can be achieved through a multi-sectoral approach and the Departments listed may only be involved in one or two of the items.

Age groups

The very young [DHSSPS, DE, DSD, DCAl]

• Reducing child poverty by ensuring that parents have access to the social and economic resources and information they need, when they need it
• Improving the health of babies and toddlers
• Improving parents’ understanding of their children’s health
• Extending high quality pre-school programmes, including Sure Start
• Extending and developing family support programmes
• Protecting children from passive smoking
• Establishing community play facilities
• Improving young children’s diet
• Safeguarding young children’s oral health
Agenda for Change

- Improving the health of pregnant women
- Supporting vulnerable parents through pregnancy and after childbirth
- Reducing smoking during pregnancy
- Promoting breastfeeding

Children and young people [DE, DHFETE, DHSSPS, DSD, DCAL]
- Reducing child poverty by ensuring that parents have access to the social and economic resources and information they need, when they need it
- Encouraging healthy lifestyle choices
- Targeting underachievement, particularly in areas of social disadvantage, to enable all young people to achieve their best
- Equipping young people with the skills needed for adult and working life, including protective coping skills
- Equipping young people with information about health
- Equipping young people with the skills needed to take a full and active part as citizens in the community

Older people [DHSSPS, DSD, DRD, DCAL, DHFETE]
- Encouraging older people's personal independence through maintaining and restoring physical and mental capacity
- Supporting older people to enable them to live in their own homes and communities
- Promoting the active participation of older people in the community and their active use of services
- Recognising the rights and values of older people
- Making public transport more accessible for older people
- Encouraging libraries to meet the special needs of older people
- Encouraging lifelong learning

Settings

Homes [DSD, DoE, DFP, DHSSPS, DCAL]
- Reducing homelessness
- Reducing the proportion of housing which is unfit
- Improving space and amenity standards
- Improving insulation and heating systems
- Reducing home accidents
- Improving indoor air quality
- Supporting family relationships through difficult transitions
- Tackling violence in the home (including violence against children)
- Improving access to cultural and leisure activities
- Reducing deaths and injuries from fires
- Tackling fuel poverty

Schools [DE, DSD, DHSSPS]
- Reviewing the school curriculum to focus on the personal health and social needs of young people as well as their academic development
- Targeting improvement strategies and resources on the lowest achieving schools in disadvantaged areas
Agenda for Change

- Examining ways of lowering rates of multiple suspension, expulsion and persistent non-attendance
- Tackling bullying and abuse in schools
- Encouraging healthy choices in school meals
- Improving the uptake of free school meals
- Improving access to pre-school education
- Helping school-age mothers in completing their education

Workplaces [DETI, DARD, DHFETE, DFP]
- Ensuring safe and healthy workplaces
- Reducing occupational ill-health and injury
- Developing an occupational health strategy
- Preventing discrimination, harassment, and chronic stress
- Creating job security and satisfaction
- Promoting personal development and training opportunities at work
- Building on opportunities for health promotion in the workplace
- Encouraging family friendly employment practices
- Building on opportunities for recognition and advancement

Communities [DSD, DARD, DHSSPS, DCAL]
- Strengthening local community networks
- Developing local advice and information services
- Developing structures for community participation in local planning and policy development
- Strengthening cross-Departmental collaboration in the most disadvantaged areas
- Developing partnerships between the community, the public and the private sectors to produce sustainable renewal
- Securing sustainable funding for community projects
- Supporting the social and economic development of rural communities. The Rural Development Programme plays a major role in this area.

Infrastructure

Economic development [DETI, DHFETE, DSD, DARD]
- Increasing the competitiveness of companies
- Developing a fast-growing and enterprising economy
- Encouraging sustainability, enterprise and self-help
- Ensuring a properly maintained and regulated business environment
- Reducing long-term unemployment
- Enhancing educational opportunities and removing obstacles to lifelong learning, employment and training, including the contribution of the Agricultural Colleges with regard to those involved in the agri-food sector
- Encouraging business investment, including investments with health improvement potential (e.g. exercise facilities, high quality food production)
Agenda for Change

The environment [DoE, DRD, DARD, DCAL, DETI, DFP]
- Meeting air quality standards
- Promoting the development of a natural gas market
- Promoting an increase in electricity generation from renewable sources
- Making enclosed public environments smoke-free
- Meeting water quality and effluent treatment standards
- Making roads safer for pedestrians, cyclists, and drivers
- Making public spaces safer (freedom from crime and the fear of crime)
- Improving public transport and developing integrated transport systems
- Improving access to opportunities for exercise (walking, cycling, sport, dance, play)
- Improving access to essential facilities and services (shops, schools, health services)
- Increasing protection against the hazards associated with waste disposal, sewage disposal, and radiation

Standards and Safety [DHSSPS, Food Standards Agency, DARD, DETI, DFP]
- Improving food safety standards
- Increasing the availability and accessibility of safe healthy food
- Controlling drugs and medicines, tobacco and alcohol
- Preventing misleading and harmful advertising
- Controlling infectious diseases in humans and farm animals
- Action to tackle resistance of micro-organisms to anti-microbial agents
- Building regulations

We would welcome comments on the examples of Departmental contributions to the Investing for Health objectives, including deletions, additions, and more specific suggestions.

We would be particularly grateful for information on actions which have successfully improved health here or elsewhere, and which could be made to work more widely.
Reducing Inequalities

Chapter 4 described the social gradient in health and noted how negative factors tend to cluster together and reinforce one another in damaging the health prospects of the least well off people. This Chapter looks specifically at ways of reducing inequalities in health.

Targeting the most disadvantaged

The Investing for Health approach will reduce inequalities in health by improving the social and economic circumstances, living and working conditions, and coping skills of the least well off. It would be appropriate to target many of the measures to be taken at the poorest families, at the most disadvantaged neighbourhoods, or at priority population groups. The process of targeting would have to be supported by improved information systems, to which we will return in Chapter 12.

Healthy public policies will aim to reduce the experience of educational failure, income differences, and job insecurity. They will aim to improve working conditions so as to diminish the social class gradient in risks at work; lack of control; and lack of job satisfaction. They will make it easier for citizens to participate in social and community life.

There are a number of key themes of relevance to health which apply across the New TSN Action Plans of Departments. Some examples from specific Departments follow by way of illustration.

In DSD's New TSN Action Plan, tackling poverty is a major theme and this includes providing an integrated social welfare system which encourages work for those who can, provides security for those who cannot and encourages provision for income in retirement and for reducing child poverty, as well as action on housing, addressing fuel poverty and encouraging preparation for employment. A second main theme is addressing social exclusion. This occurs when people or areas suffer from a combination of linked problems or disadvantage. The need to promote social inclusion applies across all areas of the Department's business. A third key theme deals with working in partnership with communities to deliver the Departments services in the most coherent and responsive way.

DETI's New TSN Action Plan sets out a range of measures to increase employment opportunities for disadvantaged individuals such as the unemployed and long-term unemployed and in disadvantaged areas with higher levels of unemployment.

DHFETE will contribute to working for a healthier people through a number of initiatives aimed at removing people from economic deprivation and through raising poor self esteem, thus contributing to both their physical and mental wellbeing. It will help people improve their employability and find work. It will also promote a policy of lifelong learning in order to support personal development and encourage social inclusion. In all its areas of employment and training activity, DHFETE will
Reducing Inequalities

promote wider access for the disadvantaged and socially excluded members of society.

Examples of DRD’s contributions include the support and development of rural public transport services through the Rural Transport Fund and increased provision of a public water supply to isolated rural houses.

The DoE’s Plan includes a commitment to encourage District Councils to re-direct resources towards those in greatest social need and for Environment and Heritage Service to target disadvantaged groups for environmental education and awareness activities.

DFP’s examination of its equality obligations focuses:

- on the way its central contribution to decision making on the funding of public services can ensure that equality of opportunity is promoted;
- on its role and responsibility for personnel policy and how, in exercising them, it will meet its equality obligations to Civil Service employees and to the wider population
- on the contribution of the services it provides directly to the public through its agencies.

Community involvement

The report on “Mainstreaming Community Development in the Health and Personal Social Services” highlighted the role of community development in reducing inequalities in health and social wellbeing and fuller participation by individuals and communities in tackling identified inequalities on the basis of empowerment, equity, partnership and collective action.

The Active Community Initiative was launched in 1999 with the aim of helping to build a sense of community by encouraging and supporting all forms of community involvement. Locally a draft Action Plan was issued for consultation in June 2000. This set out a range of actions - for the public, private and community sectors - so that the aims and objectives of the Active Community Initiative can be delivered here.

Practical tools

We propose to adopt the following practical tools to reinforce the systems already in place:

- arrangements for health impact assessment which will include health equity impacts (further discussion in Chapter 8)
- arrangements for monitoring inequalities in health and evaluating the effectiveness of measures taken to reduce them (further discussion in Chapter 12)
- benchmarks based on international good practice.
Reducing Inequalities

Others' contributions

We have outlined some of the ways in which the public sector will contribute towards reducing the health gap. Others also have an important potential contribution. For example, employers can make a substantial difference by improving working conditions for unskilled and semi-skilled employees. These categories are most likely to be exposed to health and safety risks in the workplace; to have routine and unfulfilling jobs which offer them little scope for autonomy and personal development; and to suffer from job insecurity and low self-esteem. Departments already promote good practice through policies and initiatives such as Investors in People.

We would welcome comments on reducing health inequalities, including ideas for what more realistically be done and by whom.
3 making it happen
Working Across Government

Structures in Government

Investing for Health will build on and complement the Executive's Programme for Government. The Minister of Health, Social Services and Public Safety will be accountable to the Executive for co-ordinating and steering the Investing for Health process in Government, so that the agreed agenda is addressed coherently and effectively. Other Ministers and their Departments have undertaken to ensure that health factors are given due consideration in developing and implementing their policies and programmes and allocating resources within their respective areas of responsibility.

The Minister of Health, Social Services and Public Safety chairs and will be supported by the Ministerial Group on Public Health, consisting of senior officials from all Departments. The Ministerial Group is in turn supported and serviced by the Investing for Health Team in DHSSPS.

The Minister of Health, Social Services and Public Safety and her Department will continue to be responsible for co-ordinating and steering inter-Departmental action in specific areas within the Investing for Health framework, including drug and alcohol misuse, smoking, physical activity, food and nutrition, child care, and domestic violence. Other Departments will take the lead in areas for which they have the principal responsibility (see Annex 2).

We would welcome views on the arrangements for co-ordinating and steering inter-Departmental action on Investing for Health.

The Department of Health, Social Services and Public Safety

The DHSSPS will have lead responsibility within Government for the Investing for Health initiative. This will include providing the necessary resources to coordinate the process at the regional level. Within the agreed Investing for Health framework, DHSSPS will also be responsible for:

- preparing new public health legislation, including legislation to control tobacco advertising
- providing guidance to the Health and Personal Services (HPSS) on the implementation of Investing for Health
- implementing and developing its own Equality Scheme and New TSN Action Plan
- coordinating the development and implementation of specific inter-agency strategies
- policy on and structural arrangements for the control of communicable diseases, including immunisation
- policy on and structural arrangements for health promotion
- monitoring and overseeing the performance of the health and social services, including changes in the roles of Boards, Trusts, and the Health Promotion Agency
Working Across Government

- developing human resources policies for the HPSS to support Investing for Health
- arranging for the introduction of any new planning, training, information and monitoring systems required to support the HPSS contribution to Investing for Health
- supporting regional voluntary organisations working for health improvement
- co-ordinating cross-border and international co-operation for public health

The Department intends shortly to review and report on the public health function.

In making decisions on priorities and allocations, DHSSPS will be guided by the priorities and targets set by Investing for Health.

Encouraging wider participation

The Minister and the Ministerial Group will wish to work as closely as possible with the Assembly and its Committees, and with the Civic Forum, and will be exploring with them how best to structure this work during the consultation process.

In line with the values and principles set out in Chapter 1, we are keen also to encourage wider participation in the process of inter-Departmental policy development. This might be done, for example, by establishing a regional Investing for Health network. Such a group might bring together people with an active interest in and day to day experience of the field of health, who would meet together to provide a continuing focus for carrying forward the Investing for Health agenda.

The role of such a network might include:

- to raise awareness and understanding of Investing for Health across society
- to encourage full participation in the process by all potential partners
- to identify issues of concern which might be addressed within the Investing for health framework
- to share and disseminate relevant experience and information, including research findings
- to help identify obstacles to full implementation and overcome them.

In view of the great importance which we attach to building the capacity of local community networks to strengthen their own sources of health, we propose that, in addition, special attention should paid to this element in the proposed structure.

We would welcome views on the proposals for encouraging wider participation in Investing for Health.
Health impact assessment

The success of much of the proposed agenda for action will depend on the impacts on health of all Departments' policies and programmes. We therefore propose to introduce a systematic approach to the assessment of health impacts. This would enable us to identify and evaluate the health implications of significant new policy developments as they emerge. It would include an assessment of impacts on health inequalities. As with equality impact assessments, alternative options would be considered which would produce better health outcomes, and consideration would be given to special measures to mitigate any negative impacts.

Health impact assessment is a relatively new tool to facilitate working together across Government. As a minimum, health impact assessment will ensure the health consequences and effects of future decisions are not overlooked. Opening up the process of health impact assessment and engaging with the public is important as many of the judgements to be made within a health impact assessment are value based.

Health impact assessment must also be tailored to the policies, programmes and proposals for change under scrutiny. As a decision tool it ought not to be academic or bureaucratic; just “fit for purpose”. To be successful health impact assessment should not deter decision-makers from using it. Often a simple matrix of perceived health impacts, their magnitude and probability of occurrence is enough to inform and allow a decision to be made between competing options.

Likely policy areas for health impact assessment in future could include:

- the new Regional Transportation Strategy, Gas to the North West, fluoridation of the water supply, new housing initiatives / developments, and proposals emanating from the Executive Programme Funds;
- healthcare resource decision makers (Department, Boards and Trusts) might use a refined health inequality impact assessment to target public health improvements towards those groups suffering from existing health disadvantage.

There is a need to develop methodology for health equity impact assessment.

The Investing for Health Team would be responsible with others in DHSSPS for carrying forward work on methodological aspects of health impact assessment, and for advising Departments and other bodies on its application. DRD will undertake an assessment of health impacts in the preparation of the Regional Transportation Strategy.

We would welcome views on the proposal to introduce health impact assessment across all Departments; on the methodology to be used; and on significant policy areas for assessment.
The Health and Social Services

The mission of DHSSPS is to improve the health and wellbeing of the population. This role is reflected in the responsibilities of the bodies which constitute the Health and Personal Social Services (HPSS). It is expected therefore that HPSS bodies and personnel will take a lead role in co-ordinating the Investing for Health programme at local level.

This will involve:

- DHSSPS supporting the Minister of Health, Social Services and Public Safety and the Ministerial Group on Public Health and leading the overall programme
- DHSSPS setting strategic priorities for the HPSS and associated decisions on resource allocation
- the four Health and Social Services Boards planning and co-ordinating the contributions of the other statutory voluntary and community agencies at local level
- HSS Trusts and primary and community care staff engaging with local communities to identify needs and produce local solutions for local problems.

The DHSSPS will establish a framework to allow Boards to produce Health and Wellbeing Investment Plans (HWIP). These plans will cover all the Boards’ activities but will be expected in particular to focus on the implementation of Investing for Health. The Department will monitor Boards’ progress, particularly in engaging and empowering local communities.

We would welcome views on how the DHSSPS should progress and monitor the Investing for Health programme within the HPSS.

Health and Social Services Boards

We propose that HSS Boards, which have the overarching responsibility for improving health and social wellbeing, reducing inequalities and ensuring effective health and social services for their local population, should take the lead in steering and co-ordinating the Investing in Health process at local level.

Each board will be asked to produce a HWIP, which will be the local plan for improving health and social wellbeing, tackling inequalities and developing high quality, efficient, effective and responsive services. Each Plan would set out:

- proposals to protect the public health, and in collaboration with other agencies, measures to safeguard the public from communicable disease;
- proposals to promote health and social wellbeing;
- proposals to analyse and tackle inequalities; and
- a programme to improve clinical and social care effectiveness.
The Health and Social Services

To achieve this, boards will need to work closely with their partner organisations and with a wide range of local interests including those who use local services (e.g. service users and carers), those who provide services (e.g. clinicians), and others with an interest or contribution to make (e.g. education and library boards, district councils). Each board will establish in its area an Investing for Health Partnership drawing together the key statutory, voluntary and community organisations. Boards will be asked to ensure that all concerned have the opportunity to contribute to identifying needs and priorities, assessing options and setting realistic timescales for the objectives and targets to be met. There is considerable existing good practice on which to build; for example, focus groups and citizens’ jury initiatives, joint planning and working between the HPSS and the voluntary sector, and the experience gained in the development of Health Action Zones. The effective involvement of all interests in the development of the HWIP will help to build public confidence.

The HWIP will represent a public commitment by all partners to improve not only health and social services but also the health and social wellbeing of local communities. Annual public reporting of progress, as measured against the HWIP objectives and targets, will be a critical component of accountability. The Department will hold Boards and Trusts to account for their roles and responsibilities in HWIP and will monitor progress through an annual accountability review process.

Successful development and implementation of HWIP will be critical if the goals of reducing inequality, improving health and social wellbeing, and delivering better health and social services are to be achieved. The Department will work with the HPSS and its partners to ensure that the process develops effectively, good practice is spread, and problems are tackled.

Views are sought on the key role in the strategic planning and pursuit of Investing for Health envisaged for boards and on the proposed Investing for Health Partnerships.

HSS Trusts

Trusts will be expected to work in partnership with boards to deliver the implementation as appropriate of HWIPs. They will be required to prepare an Implementation Plan consistent with the HWIP. These should:

- show how the HWIP is to be put into effect within the Trust

- identify the consequences and risks for the Trust in relation to: current and future clinical support services, funding sources (both capital and revenue), costs, human resources, capital assets and information and management technology.
The Health and Social Services

Trusts will be key players in the Investing for Health Partnerships. Through their links at operational level with voluntary and community groups they will be expected to promote, stimulate and facilitate initiatives at local level to enable communities to decide how to invest in their own health.

Primary Care

Primary Care is the front line of the HPSS and usually the first port of call for patients. Primary Care therefore has an important role to play in pursuing the Investing for Health programme. It can also help to promote greater identification with the Investing for Health programme by front-line staff and greater ownership by local communities.

This can be at 3 levels:

- Primary Care professionals can convey key messages on health and lifestyle on a one-to-one basis
- Primary Care can engage in Investing for Health Partnerships with local communities and HSS Trusts
- GP practices or groups of practices, working with other primary care professionals, can assess population health and social care need at a more local level than Boards or Trusts. This can facilitate the delivery of more local solutions which take account of communities' characteristics.

How can the potential contribution of HSS Trusts and primary care to Investing for Health be maximised?

Special Agencies

There are 5 Special Agencies in the HPSS:

- **Central Services Agency:** responsible for the registration of patients and payment of doctors, dentists and pharmacists
- **Blood Transfusion Service Agency:** responsible for the supply of blood and blood products to hospitals
- **Regional Medical Physics Agency:** providing scientific measurement and control of high technology equipment
- **Guardian ad Litem Agency:** responsible for presenting and safeguarding the interests of children appearing in Court
- **Health Promotion Agency:** has a key role in identifying health promotion priorities and developing public information programmes, in consultation with HSS Boards.
The Health and Social Services

The Health Promotion Agency

The Health Promotion Agency provides a regional focus for health promotion. It has a key role in identifying health promotion priorities, and in developing and implementing public information programmes to improve health. It has an annual core budget of £1.3m and employs 30 staff. DHSSPS is about to begin a review of the Agency.

Clearly the Health Promotion Agency has a very direct role in ensuring that key messages within Investing for Health are targeted and delivered to all those who could benefit from them. However the other Agencies can also provide information and advice on public health matters from their own perspectives.

How can the HPSS Agencies, each with a specialist focus, maximise their contribution to Investing for Health?

Health and Social Services Councils

There is a HSS Council in each HSS Board area. They monitor the operation of the health and personal social services in their area, provide advice to members of the public, make recommendations on how services might be improved.

We would expect HSS Councils:

• to contribute to HWIPs and monitor closely their outcomes
• to report annually on the practical difference that the HWIP is making from their local populations' perspective
• to participate in Investing for Health Partnerships and have a key role in promoting greater participation and involvement by local communities.

Voluntary Sector

The voluntary sector plays a significant role in the HPSS, not only in the provision of care but also as very active advocates for the needs of many groups throughout the community.

It is envisaged that the voluntary sector will be an important participant in the partnership with Boards when producing HWIPs and that they too should expect to provide health and or social care identified by those Plans. The voluntary sector can provide a credible link with the groups and communities targeted by Investing for Health. They can also use their well established lines of communications to ensure that key messages within Investing for Health are passed on.
The Health and Social Services

The HPSS Workforce

Over 40,000 people work in the health and social services here. Every one of them has the potential to contribute to improving the health of the community. The contribution which professional staff such as GPs, health visitors, district and school nurses, the Professions allied to Medicine (such as physiotherapists), pharmacists and dentists make in promoting health is well recognised and, in the case of community nursing, has been demonstrated in recent research. They provide support and advice to people on how to look after their own and their family’s health, and provide treatment where this is needed.

• Social workers and home helps are often the main point of contact for vulnerable people and can provide advice or identify potential health problems. Community staff are also ideally placed to identify and deal with wider issues - for example, poor housing, poverty or social exclusion.

• The role of hospitals in contributing to wider health has been recognised in the WHO’s Health Promoting Hospitals initiative. We would encourage all hospitals to become a part of the Health Promoting Hospital Network.

• Like all employers, HPSS organisations have responsibilities for the occupational health and safety of their staff. They should seek to set an example to other organisations.

How can we better harness the skills, experience but above all commitment of the workforce in the HPSS to champion and progress the Investing for Health programmes?
Mobilising the Efforts of Society

Departments and their agencies alone cannot expect to achieve the substantial improvements in our health status which, from experience elsewhere, we know are possible. The Investing for Health process will need to engage with a range of partners, including the general public, community groups, District Councils, trade unions, employers, the business community, statutory and voluntary organisations, and the media. This chapter sets out our proposals for each of the main stakeholders whose participation will be essential to the success of the proposed approach and outlines our vision for Investing for Health partnerships.

We would welcome comments on each of the sections in this chapter. What should be the contribution of each key partner to the Investing for Health process? How can we maximise it? What should be done to strengthen the capacity of each partner to play a full part? What are the barriers to success and how can we ensure effective partnerships, commitment and implementation?

Individuals and families

Individuals have a clear responsibility for their own health, which nobody else can take from them. But families and friends can help enormously. People do a great deal to support one another in everyday life.

Many of the determinants of health are beyond individuals' direct control. Public bodies should work in partnership with individuals and their personal support networks to maximise their capacity for health, and to make it easier for them to make healthy lifestyle choices. This applies particularly to people and communities living in greatest poverty and deprivation.

Individuals should be able to contribute directly to the development of policies and programmes which influence their health at both regional and neighbourhood levels. They should continue to have the chance to shape the Investing for Health agenda, register concerns, suggest changes, and participate in the design and management of local projects.

Local community networks

Community capacity-building should be an important strand in the Investing for Health approach. This in turn implies that statutory agencies and professional workers will act in partnership with local communities.

Investing for Health will work to build strong and cohesive local communities which will protect and improve their members' health and reduce social exclusion.
Mobilising the Efforts of Society

Community development approaches to health have emerged in recent years, often with European or other short-term funding. They have been extensively monitored and evaluated. We propose that those approaches that have demonstrated their success should now be extended, put on a more sustainable footing, and supported by public sector partners. A recent example is contained in the report issued by DHSSPS, ‘Building the Community-Pharmacy Partnership’.

We recognise that to achieve the goal of increasing community participation in the Investing for Health process, it will be necessary to provide at least a threshold level of organisational and technical support. Participants from the community will need access to information and training, and will quite reasonably expect to contribute to partnership decisions on a basis of equality and mutual respect.

The voluntary sector

Voluntary organisations have played and will continue to play a particularly strong role here in advocacy, interest group representation, community development, information and advice, and service provision and the provision of special needs and general housing. Regional voluntary agencies provide essential infrastructural support for community and self-help projects, and are well placed to facilitate public participation in decision-making.

The Government has already established its commitment to stimulating and supporting a dynamic and innovative voluntary sector, and will continue to work to the principles and values set out in the 1998 Compact. Within the general framework of partnership already established, Investing for Health will work with the many regional and local voluntary organisations which have a contribution to make to improving health and strengthening the determinants of health.

District Councils

District Councils currently have a number of functions which bear directly on health and the determinants of health, including environmental health, consumer protection, building control, waste management, community services, parks and playgrounds, leisure amenities, local economic development planning, and regulating the sale and consumption of alcohol and tobacco.

As local elected representatives, District Councillors have an important potential contribution. Their role could include articulating concerns related to their districts’ particular circumstances, animating interest in health and health equality issues, and stimulating public participation in the Investing for Health process.
Mobilising the Efforts of Society

We would welcome views from the political parties, Councillors, and Council officers, in particular, on how best to build on Councils’ experience in these areas. How can we maximise their contribution to the Investing for Health process, and to the development of health improvement planning in particular? Should Councils have a role in preparing health impact assessments for significant policy proposals affecting their Districts (such as regeneration schemes, shopping centres, and large-scale building projects?)

Other public sector bodies

The Health and Safety Executive (HSE) is the lead body responsible for the promotion and enforcement of health and safety at work standards here. HSE recognises the value in developing effective working partnerships and has done so with many other private and public sector organisations which have a shared interest in improving health and safety standards.

The Housing Executive has an important part to play, as the assessor of housing needs, including those which are health related. Its adaptation and private sector grant programmes help meet the needs of people with disabilities and those living in unfit housing. In addition, its role as the Energy Conservation Authority has potential to assist those in poor health and those suffering fuel poverty.

The Education and Library Boards, the Council for the Curriculum, Examinations and Assessments, Council for Catholic Maintained Schools, schools, colleges and universities are clearly important partners. In addition, organisations within the wider cultural sector such as the Arts Council, Sports Council, and museums have an important contribution to make.

The business sector

There is an undeniably clear link between the effective management of health and safety at work and improved business competitiveness.

Employers have a statutory responsibility to protect the health and safety of their workforce. We believe that it is in their interests also to promote the health of their workers, and to provide good working conditions. This is not only because the cost to employers of workplace injuries and work-related ill health. Healthy and satisfied workers with greater security and autonomy, facing less monotony and chronic stress, will be both more creative and more productive. Successful businesses will be aiming to improve working conditions which makes healthier employees, which in turn increases productivity. The workplace is also a promising location for health promotion, for example through smoking cessation groups, healthy eating options, and exercise facilities.
Mobilising the Efforts of Society

Trades unions have campaigned down the years for better working conditions for their members, including psychosocial conditions. We hope that they will join us in an Investing for Health partnership. Investing for Health will also seek to form partnerships with specific business sectors that have a particular contribution to make. For example, the retail food sector is now active in publicising aspects of healthy eating, and we will wish to work with them to ensure consistency in the messages which they and the health promotion agencies are putting out.

Other potential partners in the business sector include the media, architects and town planners, farmers and food producers, alcohol retailers, sports and leisure businesses, and transport undertakings.
Working Together - North/South, East/West and Internationally

Where societies face similar challenges, it is sensible to share ideas and to learn from one another’s experience. International co-operation also opens up opportunities to pool resources, for example in the search for new measures to prevent disease. We have historically benefited from pioneering work elsewhere, and as the pace of progress increases must ensure that we are well placed to apply new discoveries here without undue delay.

We would welcome views on new ways of developing co-operation through North/South, East/West and international partnerships

North/South

The Belfast Agreement introduced new and special arrangement for co-operation. The North/South Ministerial Council provides a structure for Ministers of all Departments in both jurisdictions to:

• exchange information, discuss and consult with a view to cooperating on matters of mutual interest
• reach agreement on the adoption of common policies in areas where there is a mutual cross-border and all-island benefit
• take decisions by agreement on policies for implementation separately in each jurisdiction
• take decisions by agreement on policies and action at an all-island and cross-border level to be implemented by the new cross-border implementation bodies

Six cross-border implementation bodies have been established, including the Food Safety Promotion Board.

The Food Safety Promotion Board

The key function of the Food Safety Promotion Board is the promotion of food safety and to ensure that producers, processors, distributors, caterers and general public take responsibility for the provision of safe food. Other functions include:

• promoting research in all aspects of food safety
• ensuring prompt, accurate and complete dissemination of information on national and international food alerts
• promoting cross-border co-operation in the microbiological surveillance of food borne diseases
• promoting scientific co-operation and linkages between laboratories under relevant EU directives
• developing a strategy for the island of Ireland for the delivery of specialised laboratory services.
Working Together - North/South, East/West and Internationally

The Board will consult widely where appropriate and will work closely with the Food Standards Agency here and the Food Safety Authority of Ireland (FSAI) in the South.

Co-operation under Health

In addition the North South Ministerial Council (NSMC) identified health as one of the six areas for co-operation and collaboration. The five areas identified for co-operation under Health are:

- Accident and Emergency services
- Planning for Major Emergencies
- Co-operation on High Technology Equipment
- Cancer Research
- Health Promotion.

Specifically with regard to health promotion, the NSMC has agreed to:

- share information and discuss opportunities for co-operation in relation to health promotion on an all Ireland basis
- collaborate on public information campaigns, particularly major media campaigns. For example the recent joint initiative to promote the use of folic acid by women intending pregnancy, to prevent the incidence of neural tube defects such as spina bifida in babies
- share information on research and good practice for mutual benefit
- examine the scope for research and public information/education in the areas of heart disease, cancer and smoking.

The Institute of Public Health in Ireland

The Institute of Public Health in Ireland, whose establishment predates the Agreement, is working to promote North/South co-operation for public health in the following areas:

- tackling health inequalities
- strengthening partnerships for health
- contributing to public health information and surveillance
- develop public health capacity and leadership
- networking internationally and nationally.

We propose that the Institute should enhance its capacity to include:

- comparative monitoring of trends in health, the determinants of health, and health inequalities North and South, and relative to other EU countries
- highlighting new areas of concern as they emerge
- advising on the methodology for health and health equity impact assessments
- disseminating throughout Ireland information from international research and experience.
Working Together - North/South, East/West and Internationally

Co-operation and Working Together

With support from European funding programmes, adjacent health boards are working across the border in the framework of the Co-operation and Working Together initiative. Their work already includes a project to prevent home accidents.

European and international programmes

European and international money has also been used to support cross-border programmes in the voluntary and community sector, for example in the area of early years and family support. We anticipate that there will be scope for drawing on the new EU Peace Programme in particular for specified cross-border purposes over the coming five years. This will involve a competitive process but we will be making every effort to ensure that the maximum possible funding is earned by health-related projects.

Another area to be addressed is the development of common data systems to allow meaningful comparisons to be made on a North/South basis. Ideally, these would extend across the European Union.

East/West

The British-Irish Council provides a structure for co-operation between Britain and Ireland. It has identified a range of issues for co-operation, including social exclusion, drug misuse, the environment, transport, and other issues in health and education.

A Concordat provides a more specific framework for co-operation between the Department of Health in England and Departments concerned with health and social care in each of the devolved administrations. There is regular contact between DHSSPS officials and their counterparts in Britain to obtain and exchange information, including information on health promotion and public health issues. DHSSPS is also included in discussions which feed into the European Health Council.

There are a number of Joint Committees which advise Health Departments such as the Joint Committee on Vaccination and Immunisation and the National Screening Committee.

There are similar arrangements across other Departments.
Working Together - North/South, East/West and Internationally

**Joint Ministerial Committee**

There is a Joint Ministerial Committee on health issues. This Committee provides an opportunity for the separate administrations to share information, experience and best practice on a wide range of policy issues. These include developing common measures of performance, learning from each other’s experiences, and sharing ideas on incentives and best practice.

**Inter-Departmental Group on Tobacco**

An interdepartmental group on tobacco was convened at the time of publication of the White Paper “Smoking Kills” (December 1998). The membership of this group now includes representatives from DHSSPS and the health departments in London, Edinburgh and Dublin. The purpose of this group is to provide strategic direction and share information on action against tobacco. Where appropriate, it endeavours to promote a co-ordinated east/west approach to tackling tobacco dependence. The group meets on a regular basis.

**Anti-Drugs Co-ordination**

Strong links exist between the devolved administrations and the Anti Drugs Co-ordination Unit in the Cabinet Office. There is frequent contact on a range of issues relating to drug misuse, including progress with the implementation of strategies for action.

**Food Standards Agency**

The Food Standards Agency (FSA), operates here and in Britain. It has assumed responsibility from DHSSPS and DARD for:

- policy advice to Ministers on food safety, food standards and aspects of nutrition
- preparation of draft subordinate legislation
- representation in negotiations in the EU
- operation of the Food Hazards Warning System
- commissioning research
- setting standards for enforcement of the legislation and monitoring the performance of the enforcement authorities against these standards
- issuing/refusing/revoking/suspending licences, approvals and authorisations in accordance with the relevant legislation.

The Agency will exercise its role in partnership with the Food Safety Promotion Board, so combining an East/West with a North/South dimension.
Information, Monitoring and Research

Information

Investing for Health should be based on the best available evidence of our population's health status, relative to other regions. Policy development, implementation and monitoring need support from a strategic approach to gathering and using information. This should include information on the determinants of health, and on people's health beliefs and concerns. While there may be gaps in the current information base, and the availability of information sources, there has, over the past decade, been considerable progress in the development and implementation of information systems. Some of these information sources are outlined in Annex 4. While this may not be an exhaustive list, it does show the range of information and information sources that are available to inform the decision-making process. However, while a wide range of information is collected, it is not always available in the most useable form (eg geographical area), or suitable for international comparisons.

The pressure for electronic dissemination of information is increasing and has raised expectations regarding the availability and accessibility of information. The “Statbase System” offers direct access to key economic, social and health related statistics via the Internet.

The Northern Ireland Statistics and Research Agency (NISRA), one of DFP’s agencies, is leading work in conjunction with the office of the First Minister and Deputy First Minister (OFMDFM) to develop data systems and methodologies to help all Departments to identify disadvantaged people, groups and areas, to target resources and to monitor progress. Planning is at an advanced stage for the 2001 Census, which will provide an extensive range of information on the characteristics of the population. In addition, NISRA has commissioned consultants to undertake a review of the geography of deprivation locally and to produce a new measure of deprivation based on more timely administrative data.

A Geographical Information System (GIS) Unit has been set up within NISRA to collate geographically referenced data. This will be updated regularly and key information will be made available via the Internet.

We would welcome comments on the scale and nature of the information gaps and the best way to fill them.

Standards and monitoring

High standards, clear goals, effective monitoring and accountability arrangements are essential to the success of the strategy. Arrangements are already in place for accountability and monitoring in relation to the last DHSS Regional Strategy. However additional arrangements will be needed for the new inter-Departmental approach. The Ministerial Group on Public Health will consider how best this should be done in the light of experience both with previous strategies and elsewhere.
More detailed information on inequalities in health and social wellbeing is required. There are a number of actions and targets within the New Targeting Social Need (TSN) Action Plan for DHSSPS which may help meet this need. These include:

- monitoring and evaluation of specific public health strategies, including those dealing with tobacco, alcohol misuse and mental health promotion, for their ability to reduce inequalities and to take appropriate consequential action

- building into all Departmental New TSN-related interventions an effective method of monitoring and evaluating the impact on inequalities.

We would welcome views on the most appropriate arrangements for setting standards and monitoring progress in implementing Investing for Health.

Targets

Targets give all the partners a common set of improvements to work towards, and allow progress to be measured meaningfully and regularly.

The emphasis on the past has been on the incidence of diseases and on individual behaviour. This has deflected attention from the determinants of health. We consider that the targets for Investing for Health should be formulated in terms of the main determinants of health, and should reflect the principles set out in Chapter 1. For example, tackling the main determinants of ill health with the objective of achieving a level of health and wellbeing that is at least as good as the best of our European neighbours.

We propose to set a limited number of high level targets. They should be challenging but attainable. They should realistically take account of constraints and obstacles. They should include process as well as substantive targets. They should measure progress towards reducing health inequalities (but by levelling up, not down!). They should be based on robust evidence, but should not be selected simply for convenience in information-gathering. They should allow for international comparisons, drawing on World Health Organisation (WHO) guidelines. There should not be too many of them (we suggest between 5 and 10).

By way of example, WHO Europe has set a target of reducing the health gap within each member country by at least a quarter by 2020 (“Health 21, 1999”). After extensive consultation across society, Sweden has provisionally set targets for 2010 which include:
Information, Monitoring and Research

- to reduce the proportion of poor people (according to the EU definition) from 4.8% to 4.0%
- to reduce the proportion of families with children who are dependent on social welfare by 50%.

We would welcome views on our proposed approach to target setting, and ideas for specific targets which meet our proposed criteria.

Research

Investing for Health will need a complementary programme of research and evaluation. The Research & Development Office for the HPSS recognizes the importance of public health research. As a first step it has set up number of mechanisms to strengthen the research base for population health. It intends working collaboratively with the Health Research Board in Dublin to look at public health issues on the island of Ireland.

We will be participating in two longitudinal studies (tracking the same people over a number of years) - the British Household Panel Study and the UK Millennium Cohort Study. Both of these will provide a rich source of relevant information.

Commitment has been made in the New TSN Action Plan for DHSSPS, to agree, by March 2001, a programme of New TSN-related research in consultation with the Research and Development Office for the HPSS. Also a review will be undertaken of how best to secure the effective co-ordination and support of New TSN research, the evaluation of New TSN interventions and dissemination of related information.

We will wish to discuss priorities and arrangements for research with our partners in the light of the consultation outcome.

We would welcome views from researchers and others on the priorities that we might set for a research programme to support Investing for Health.
Saving Lives: Our Healthier Nation - (England)

The Department of Health published a public health strategy in July 1999. "Saving Lives: Our Healthier Nation" is an Action Plan to tackle poor health. It aims to improve the health of everyone and the health of the worst off in particular. It stresses that in securing better health the social, economic and environmental factors tending towards poor health are very important, and that people can make individual decisions about their health which can make a difference. It seeks to find a new balance in which people, communities and Government work together in partnership to improve health.

It highlights that health inequalities are widespread and that the most disadvantaged have suffered most from poor health. Government is addressing inequality with a range of initiatives on education, welfare-to-work, housing, neighbourhoods, transport and the environment which will help improve health.

It focuses on the main killers: cancer, heart disease and stroke, accidents and mental illness. It also covers other important health issues like sexual health, drugs and alcohol misuse, food safety, fluoridation and communicable diseases.

It stresses the need for action across a number of fronts:

- in the NHS, building a health improvement approach into the routine delivery of health care
- ensuring that local authorities work in partnership with the NHS to plan for health improvement
- introducing new Healthy Citizens' programmes to support individuals in improving their own health potential
- raising standards in public health information and research

The strategy sets targets in the main priority areas. By the year 2010:

**Cancer** - to reduce the death rate in people under 75 by at least a fifth

**Coronary heart disease** and stroke - to reduce the death rate in people under 75 by at least two fifths

**Accidents** - to reduce the death rate by at least a fifth and serious injury by at least a tenth

**Mental illness** - to reduce the death rate from suicide and undetermined injury by at least a fifth

Achieving these targets would prevent up to 300,000 untimely and unnecessary deaths in England.
Towards a Healthier Scotland

A new public health strategy for Scotland was published in February 1999. "Towards a Healthier Scotland" calls for a coherent attack on health inequalities, a special focus on improving children and young people's health, and major initiatives to drive down cancer and heart disease rates.

The strategy commissions linked action at three levels and sets national priorities to improve Scotland's health. The first level means improving life circumstances - social inclusion, job, income, housing, education and environment - that impact on health. The second level means tackling lifestyles like poor diet and lack of exercise, tobacco, alcohol and drug misuse, that lead to illness and early death. The third level means direct work to tackle what can be prevented - such as heart disease, cancer and accidents - and to improve child, mental, oral and sexual health.

At all three levels, tackling inequalities is the overarching aim. Central to this approach is cross-departmental work to focus social and economic policy on positive health impacts.

The document describes how the many agencies that can help improve Scotland's health will work better together. Health Boards will lead and encourage health promotion and health improvement throughout their services, demonstrating clear reductions in health inequalities and offering support to other bodies, including local authorities, who are in a strong position to influence health.

The document establishes headline targets and second rank targets. The headline targets are:

- Coronary heart disease - reduce by 50% between 1995 and 2010
- Cancer - reduce by 20% between 1995 and 2010
- Smoking - reduce smoking among young people from 14% to 12% and the proportion of women who smoke in pregnancy from 29% to 23%
- Alcohol misuse - reduce the incidence of adults exceeding weekly limits from 33% to 31% for men and from 13% to 12% for women
- Teenage pregnancy - reduce by 20% between 1995 and 2010
- Dental health - by 2010 60% of five year-olds should have no experience of dental disease
“Better Health, Better Wales”

“Better Health, Better Wales” aims to improve the health and wellbeing of people in Wales through strategies which promote and protect health, reduce inequalities in health and inequities in access to health services, and to provide effective and efficient health services.

The Welsh strategy recognises that health is influenced by a complex interaction of lifestyle and environmental factors which must be taken into account if real improvement is to be achieved. This is a long term challenge, which will involve collaboration across public services, voluntary and private sectors, and communities.

It is structured around five areas, as follows.

**Sustainable health**

At the local level, each of the determinants of health affected by public policy - environment, employment, housing, access to leisure, health and social care, education and other services - should be considered together rather than as separate policies, taking into account their potential impact on health. A 5 year sustainable health action research programme is proposed to break the cycle of poor health by learning lessons about what works in addressing the effects on health of housing, unemployment, social distress and access to services.

**Healthy Lifestyle**

Lifestyle is not only a matter of knowledge and choice, but is strongly influenced by wider factors related to local and personal situations, including educational level, personal skills, peer pressure, and social, economic and cultural factors. Schools and workplaces are identified as settings with potential for health improvement. At the same time, information should be readily available to enable individuals and families to make informed choices about their health.

**Healthy environment**

Damp, cold and poorly ventilated houses generate ill health, while good social housing can make an important contribution to health. People sleeping rough are particularly at risk from ill health. Clean air, safe water and effective land use are prerequisites for good health.

Community safety - an environment free from crime, or fear of crime - contributes significantly to an individual's sense of wellbeing.

**Partnerships for Health**

Action is needed across a broad front extending well beyond the NHS to tackle inequalities in health. Individuals, community and voluntary organisations, Local Authorities, the NHS and local health groups need to work together. The Government is proposing a new duty of
collaboration on local authorities and health bodies, while health impact assessments will be conducted for major new service developments, including those which are the responsibility of local government. This will ensure, for example, that economic development projects do not jeopardise the environment.

Measuring progress

The Welsh Office has published a set of 15 health gain targets on topics such as lung cancer, heart disease, strokes, accidents, mental health, smoking and tooth decay. Health Improvement Programmes are to be drawn up in each Health Authority and these will be used as a benchmark for measuring progress.

The National Health Promotion Strategy 2000/2005 - (Ireland)

The Irish Government’s Health Promotion Strategy sets out the broad policy framework to promote a holistic approach to health.

The strategic starting point is an acknowledgement that health improvement cannot be achieved solely by the healthcare sector - rather, it will require inter-sectoral and multi-disciplinary effort.

This is because the determinants of health in Ireland include social, economic and environmental factors, as well the lifestyles of individuals. Poverty, unemployment and income inadequacy are identified as the main influences on health. Also important are education, access to health services and environmental factors such as water supplies, roads and housing. The most significant lifestyle factor is smoking. Food and nutrition, alcohol, exercise, dental care/oral hygiene, drug use and sexual behaviour are also highlighted.

The main causes of illness in Ireland are cardiovascular diseases, cancers, road traffic accidents and mental health problems.

The strategic framework for health promotion focuses on

- Population groups: children, young people, women, men, older people and other groups within the population such as the Traveller Community
- Settings: schools and colleges; the youth sector; community (cities, towns or villages); workplace; and health services. It is proposed that a National Community Co-ordinator is appointed to support the development of community based health promotion initiatives, and a National Workplace Health Co-ordinator to perform a similar function for work settings
- Topics: positive mental health; being smoke free; eating well; good oral health; sensible drinking; avoiding drug misuse; being more active; safety and injury prevention; and sexual health.

Specific goals and outcomes are set for each of these areas.
Strategic direction is based upon commitment to infrastructure. Key to this is "health proofing" relevant policies so that their impact on the physical, mental and social well-being of the population is positive. A National Health Promotion Forum will be established and the health services reoriented to achieve a better balance between the curative services and those which promote health. Regional health promotion structures are to be strengthened. It is intended that adequate funding should be earmarked to support and sustain research, planning, implementation and evaluation, and that there should be a stronger emphasis on consumer involvement.
THE KEY RESPONSIBILITIES, IMPACTING ON HEALTH, OF EACH DEPARTMENT

Department for Social Development

MGPH representative: Dr J Harbison (Telephone No: 028 90569206)

The Department for Social Development's overarching mission is to promote individual and community wellbeing through integrated social and economic action. Many of its policies impact on health and wellbeing. It interacts on a regular basis with many of the poorest in our society. It has a key role to play in Targeting Social Need and it is tasked with tackling disadvantage, and has responsibility for improving housing, delivering social security benefits, providing child support services, strengthening and developing the community infrastructure, and regenerating the most disadvantaged urban neighbourhoods. Key elements of current DSD strategies include:

- Introducing comprehensive strategies to address the problems of multiple disadvantage in urban areas, which will:
  - target action on the most disadvantaged neighbourhoods
  - establish Neighbourhood Regeneration Taskforces, partnerships of the community, voluntary, private and public sectors
  - commit Government to long term support for these neighbourhoods
  - include action to improve health.

- Providing high quality affordable social housing for those on low incomes and in greatest need including:
  - remedying unfitness in social and private sector housing
  - assisting homeless people
  - increasing adaptations to existing houses to make them accessible to people with disabilities
  - providing more special needs housing for disabled people and other vulnerable groups
  - developing appropriate permanent accommodation which meets the special needs of Travellers
  - improving energy conservation and reducing fuel poverty
  - designing safety into housing provision.

- Promoting policies to sustain and enhance local communities, particularly those in the most disadvantaged areas by:
  - rebuilding a sense of community by encouraging and supporting all forms of community involvement
  - strengthening areas of weakest community infrastructure
  - introducing community support plans through District Councils to underpin the work of local voluntary and community groups.

- Implementation of the Welfare Reforms and Modernisation Programme, including:
  - Child Support Reforms, which puts the interests of children first and will make a significant contribution to eliminating child poverty
THE KEY RESPONSIBILITIES, IMPACTING ON HEALTH, OF EACH DEPARTMENT

- assisting the Inland Revenue to implement the integrated child credit to provide increased financial support for people on low incomes
- implementing fully the ONE Initiative across Departments and agencies to provide joined up welfare and employment services.

In areas such as social security, where policies are determined at Westminster, the Executive will seek to ensure that they protect our interests and advance our health improvement objectives.

Department of Education

MGPH representative: Mr S Peover (Telephone No: 028 9127 9313)

The Department of Education is taking active steps to provide, for all children and young people, opportunities to acquire:

- the critical skills to evaluate realistically the situations and decisions they face in life
- the information necessary for them to make informed decisions about their personal behaviour, be it on diet and hygiene, care of their environment, alcohol or other drug-taking, smoking or danger of abuse by others
- the confidence and self-esteem to be able to make the decisions which are in their own best interests, even where this may mean temporary unpopularity.

These skills are already an integral part of most schools' pastoral care and personal development programmes, and are intrinsic to the new revised statutory curriculum which is currently being consulted upon. They are also integral to the purpose and curriculum of the youth service, where they can be reinforced in informal settings.

Teaching about health matters and healthy lifestyles, including how the body works, and education specifically on the harmful effects of alcohol, smoking and drugs misuse, is already a statutory requirement in all schools, and has been so for the past 8 years.

The revised curriculum will take particular account of the need for improved health education, including sex education, which young people themselves, in a survey, have identified as a priority. The Department will shortly be issuing revised guidance on Relationships and Sexuality Education, supported by guidance to teachers prepared by the Northern Ireland Council for the Curriculum, Examinations and Assessment.

The involvement of 24 schools here in the European Network of Health Promoting Schools has provided a context and environment for demonstrating, as well as learning about, healthy lifestyles, by all members of the school community.
THE KEY RESPONSIBILITIES, IMPACTING ON HEALTH, OF EACH DEPARTMENT

In the area of teenage pregnancy, with partners in the statutory and voluntary sectors, we are investing in a pilot project designed to help school-age mothers in completing their education.

We need also to update the guidance for nutritional quality in school meals and encourage whole school approaches to healthy nutrition through mechanisms such as School Nutrition Action Groups.

Department of the Environment

MGPH representative: Mr J Lamont (Telephone No: 028 9054 6625)

The Department of the Environment has amongst its strategic objectives:

- to protect, conserve and enhance the natural and built environment for the benefit of present and future generations
- to improve and promote road safety and ensure the proper regulation of drivers, vehicles and operators with a target to ensure continued reduction in road casualties
- to support a system of local government which meets the needs of citizens and ratepayers.

Other specific key DoE policies include:

- Air Quality Strategy which include plans to improve and protect ambient air quality with particular focus on eight main air pollutants which affect health
- Waste Management Strategy which seeks to encourage the sustainable management of waste
- Nature Conservation and the Countryside: caring for the countryside and wildlife extends to safeguarding a range of sites and species but also encouraging and promoting enjoyment and helping others to conserve nature
- Protecting and Recording the Built Heritage in its wider sense contributes to the quality of the environment and plays a significant part in a sense of heritage and wellbeing.

The Department of the Environment is charged, in collaboration with the other Departments with developing a strategy for implementation of Sustainable Development, taking as the definition "Development that meets the needs of the present without compromising the ability of future generations to meet their own needs". Early sustainable development strategies tended to concentrate on promoting economic growth that was sustainable in terms of meeting objectives on environmental protection and the use of finite natural resources. The latest thinking adds economic and social objectives and clearly has significant potential implications for the health of the public.
THE KEY RESPONSIBILITIES, IMPACTING ON HEALTH, OF EACH DEPARTMENT

Department of Agriculture and Rural Development

MGPH representative: Mr P Toal (Telephone No: 028 9052 4628)

The Department of Agriculture and Rural Development (DARD) makes a major contribution through its Veterinary and Science Services to the improvement of food safety standards in Northern Ireland and through the advisory function of the Agri-Food Development Service to increasing the availability and accessibility of safe and quality food. DARD provides information on diet and nutrition through the National Food Survey and is currently looking at the possibility of merging the National Food Survey with the Family Expenditure Survey. This would mean that data on meals eaten outside the home could be included in the Surveys which would provide a better and more complete picture on the Northern Ireland diet. DARD also has a significant role in the safeguarding of public health with particular reference to the detection and control of zoonotic diseases. Mandatory programmes exist for the control of both bovine tuberculosis and bovine brucellosis. DARD also makes a major contribution to public health and food safety through its work on meat hygiene inspections, ante and post mortem inspections at slaughterhouses, research and development, analytical/diagnostic work and advice and education in both the food and animal disease fields.

It is also one of the Department's major objectives to contribute to the development of rural communities, helping to combat rural poverty and promoting social inclusion. DARD's contribution to public health is acknowledged in the Programme for Government.

The Department conducts a range of surveillance for the more important zoonotic diseases and carries out work on both chemical and microbiological food safety which includes all the major food borne pathogens. DARD would be anxious to improve and develop that surveillance as well as identifying new and novel diseases so that their implications for human and animal health can be assessed at the earliest possible opportunity.

Department of Enterprise, Trade and Investment

MGPH representative: Mr J Keyes (Telephone No: 028 9054 6857)

The Department of Enterprise, Trade and Investment's (DETI) vision is to see a fast growing, competitive, innovative, knowledge - based and balanced economy where there are plentiful opportunities and a population equipped to grasp them.

Increasing competitiveness and promoting enterprise is done in concert with the development and maintenance of a conducive equality, policy and regulatory environment.

In regard to the regulatory environment the role played by the Health and Safety Executive for Northern Ireland is pivotal.
THE KEY RESPONSIBILITIES, IMPACTING ON HEALTH,  
OF EACH DEPARTMENT

HSENI is working to develop an occupational health strategy for Northern Ireland that will tackle, in partnership with all the key stakeholders, the burden of ill health brought on by work or made worse by work.

In addition it will work with the Health Promotion Agency in using the workplace as arena to promote better health and lifestyle practices. It will also focus attention on the risks presented by passive smoking.

HSENI is planning to open an ICT based information and advice centre with regional outlets that will help, those responsible for worker’s health and workers themselves, make informed choices and decisions about workplace health strategies.

In addition DETI is working with other Departments and agencies to raise public health awareness in areas such as healthier food choices and encouraging a responsible approach to alcohol.

Department of Health, Social Services and Public Safety

MGPH representative: Mr J McGrath (Telephone No: 028 9052 2733)

The primary purpose or mission of the Department of Health, Social Services and Public Safety (DHSSPS) is:-

“To improve the health and social wellbeing of the people of Northern Ireland”.

DHSSPS has a clear responsibility for setting the strategic direction and overseeing the delivery of the health and personal social services. It also promotes voluntary activity and community development in the health sector.

DHSSPS also has responsibility for promoting health and social wellbeing. In this regard, we are developing and implementing a range of lifestyle strategies on smoking, physical activity, nutrition, alcohol, and drugs. Work is underway to take forward strategies dealing with home accidents and workplace health. Action is being taken to promote positive mental health, particularly targeting suicide in young men. DHSSPS has recently published Children First, an integrated strategy for the development of child care and family support. The first local oral health strategy was published in 1995. Although there has been a gradual improvement in oral health over the past five years, the most recent surveys show that the general level of oral health here is still considerably worse than in Britain and in the South particularly amongst children.

DHSSPS has an important health protection and disease prevention role. Communicable diseases such as meningitis and influenza continue to present a danger. Immunisation programmes have made an important contribution to improving health protection this century and our childhood immunisation rates have improved over the past decade. However, there are still some areas with low uptake rates where is the potential for
epidemics to occur. We need to do more to ensure awareness of the benefits of immunisation and to improve uptake. Similarly, among high-risk groups of all ages, but in particular the elderly, annual flu and pneumococcal immunisations reduce the risk of illness, during winter months but the current uptake rates need to be improved with co-ordinated effort, appropriately resourced. Screening programmes for breast and cervical cancer are already in place, as are a range of antenatal and neonatal screening programmes.

Department of Higher and Further Education, Training and Employment

MGPH representative: Ms A Flanagan (Telephone No: 028 90257851)

DHFETE's key strategy will be to help people without employment find work and also to promote a policy of lifelong learning.

In education and lifelong learning DHFETE aims to widen access to under-represented sections of society and to increase participation across all age groups. In further education, the Department's aim is to review and enhance the provision of basic skills education and reduce the number of adults with low basic skills. A review of basic skills education and under-representation of sections of society will be completed. The Department will increase the number of places available in further and higher education. In employment DHFETE aims to provide an efficient and effective employment service matching people with jobs or appropriate training opportunities. In training programmes, the Department will aim to extend help to the unemployed, particularly disadvantaged groups, to improve their opportunities to gain suitable employment. In addition, the Department will also aim to provide young people with new training opportunities, to improve skills and motivation and enhance employment prospects.

Work-Life Balance is the term given to DHFETE's promotional campaign to encourage employers to consider the business benefits of enabling their employees to achieve and maintain a better balance between their work and the other aspects of their lives. The basis of the 'Work-Life Balance' campaign is that everyone benefits from good practice in Work-Life Balance and businesses particularly will find it easier to deliver services, easier to recruit, retain and motivate their staff and easier to reduce stress, sick leave, staff turnover and absenteeism. DHFETE has been working in partnership with the Northern Ireland business community in developing the campaign which will provide practical advice and guidance to employers and employees on Work-Life Balance practices.

Further Education Colleges and Higher Education establishments have a major preventative role to play in addressing the problems of the misuse of drugs and other substances. All Higher Education establishments have their own drug policies and strategies in place and the Further Education sector has established a Curriculum Development project which aims to develop a healthy living programme. Training organisations are also aware of the need to address alcohol, drugs and solvent abuse problems and initiatives are being considered through a number of programmes.
THE KEY RESPONSIBILITIES, IMPACTING ON HEALTH, OF EACH DEPARTMENT

Department for Regional Development

MGPH representative: Mr Alan McArthur (Telephone No: 028 90541195)

DRD’s objectives from a health perspective include:

• Formulating a strategy, the Regional Development Strategy, which will set out how Northern Ireland might develop over the next 25 years. The Strategy, which has been a subject of wide public consultation, provides a spatial framework for action addressing a range of social, environmental and community issues which are relevant to promoting sustainable development and social cohesion in Northern Ireland.

• Developing and maintaining an integrated, sustainable and safe transport network which supports the Regional Development Strategy and facilitates the rapid, predictable and efficient movement of people and goods. A 10-year Regional Transportation Strategy is being prepared which will provide a strategic framework to facilitate the future development of the region’s roads and railways. The emphasis in future will be more directed to movement of people and goods in a sustainable, integrated transport system and a more responsible use of the car. Support for public transport will continue and the Department will seek ways of ensuring that public transport services are a safe, attractive option for both those who use cars and for those who do not have access to them. This will include, for example, support and development of rural public transport services through the Rural Transport Fund.

• Contributing to the health and wellbeing of the community and the protection of the environment through the provision of cost-effective water and sewerage services. This will be achieved by developing water and sewerage services to meet required quality and environmental standards. We will also be endeavouring to increase provision of a public water supply to isolated, rural houses.

Department for Culture, Arts and Leisure

MGPH representative: Dr E Rooney (Telephone No: 028 90258821)

DCAL’s potential contribution to improving health and well-being is encapsulated within two of the Department’s strategic goals:

• to increase participation in culture, arts and leisure through enhancing access to, and the quality of, facilities and services

• to preserve and make available our cultural and information resources to the widest possible audience.

Progress made towards achieving these goals will help to promote public health by:
THE KEY RESPONSIBILITIES, IMPACTING ON HEALTH, OF EACH DEPARTMENT

• increasing health-related physical activity across all sections of the population, especially through promoting life-long participation in sport and exercise

• helping to increase social inclusion and build self-esteem through participation in culture, arts and leisure activities

• contributing to therapeutic services in collaboration with health and social care agencies

• establishing new ways to enable the public to access health information through, for example, maximising the use of the public library service's ICT developments.

DCAL has a particular role to play in the development of policy on linguistic diversity and in ensuring that language does not act as a barrier to accessing health information and advice.

Department of Finance and Personnel

MGPH representative: Mr D Sterling (Telephone No: 028 91858204)

DFP should be able to make a positive contribution by:

• giving appropriate Ministerial and top management commitment to the strategy

• at a practical level, through the promotion of healthy working environments

• through the public expenditure process.

More specific contributions would be provided from the following Divisions.

Accommodation and Construction Division is responsible for the provision of office accommodation for civil servants and the making of Building Regulations. Through compliance with Health and Safety legislation in its buildings the department makes a continuous contribution to the health and wellbeing of staff. Buildings Regulations make an important, and continuous contribution to public health and safety in a wide range of areas:

• safety glazing in homes and in public buildings to help reduce cutting injuries

• requirements for smoke alarms in domestic property, and fire prevention and safety measures in other buildings to reduce deaths or injury by fire

• regulations on the structure and design of stairs to reduce accidents
THE KEY RESPONSIBILITIES, IMPACTING ON HEALTH,
OF EACH DEPARTMENT

• requirements for clean water supply and the proper disposal of foul water to maintain public health

• measures to prevent the ingress of radon, water and damp

• minimum ventilation standards for domestic building.

Central Personnel Group (CPG) has general responsibility for management issues associated with occupational health policies in the Civil Service working in close co-operation with the Occupational Health Service (OHS) which is based in DHSSPS and the Office Accommodation Branch of DFP's Central Support Group.

One of the main roles of Central Finance Group (CFG) is to advise Ministers on the allocation of resources to Departments from the Public Expenditure Block agreed with the Treasury. In its advice to Ministers, CFG incorporates information on a variety of issues including for example the New TSN implications of public expenditure options. This allows Ministers to consider New TSN objectives together with other priorities, bearing in mind that economic and social issues are cross-cutting themes in the public expenditure process.
LIST OF PEOPLE AND ORGANISATIONS WHO RESPONDED TO THE PRE-CONSULTATION LETTER AND ADVERTISEMENT

Philip Newton, Enniskillen
Antoinette McKeown, PlayBoard
Nicola Nicholls, Action Cancer
Susan Reid, RNIB
Jennifer Loughridge, Arthritis Research Campaign
Peggy Flanagan, Community Work Education & Training Network
Jacqui Erwin, Northern Health & Social Services Council
M. Ni Chionnaith, Nadnerb
Kathleen Feehan, Women’s Information Group
Audrey Simpson, Family Planning Association
B P Cunningham, Southern Health & Social Services Board
Heather Moorehead, Sustainable Northern Ireland Programme
Mary Stewart, Central Council for Education and Training in Social Work
Stuart MacDonnell, Northern Health & Social Services Council
D R D Mitchell, Armagh City and District Council
T J Frawley, Western Health & Social Services Board
John McCardless, Southern Group Environmental Health Committee
Sheila Jones, National Alliance for Equity in Dental Health
James T Kilpatrick, North Down Borough Council
J Prentice, Aughnatrisk Action Group
Anonymous, Londonderry
George Lunn
Liam Steele, Belfast City Council
Jo Marley, Bryson House
Ballymena Borough Council
Walter Rader, New Opportunities Fund
J Sloan, Ballyclare
Lynne Harrison, Love for Life
Seamus Magee, Southern Health & Social Services Council
Maura Sophia Harbinson, Annaghorn
Mr McKeever, Family Information Group
Mr Kinghorn, Ballymena Borough Council
Arelene Spiers, Ulster Cancer Foundation
Gerry Cunningham, Newry & Mourne Health & Social Services Trust
Paul Laughlin, City Partnership Board, Derry, Londonderry
Gerry Doherty, South Belfast Partnership
Pip Jaffa OBE, Parents Advice Centre
Mary Cunningham, Child Care NI
Fiona Boyle, Simon Community
Janet Muller, POBAL
J K Stevenson, Limavady Borough Council
Aine Meehan, Altnagelvin Hospitals Trust
M McCourt, Portadown
Andrew Murdock, The Guide Dogs for the Blind Association
Health Promotion Department, Southern Health & Social Services Board
Marie Crossan, C.A.U.S.E. for Mental Health
S Rainey and B Robinson, Women’s Forum
Christine Acheson, East Belfast Health Issues Working Group
Deidre Stewart, CBI
R G Black, North & West Belfast Health & Social Services Trust
M Keenan and Dr K P Kerr, University of Ulster
Anonymous, Senior Community Nurse
A D Gowdy, North Down Primary Care Organisation
Carole McIlwraith, Royal College of Nursing Mental Health Nurses
Eastern Area Health Promotion Forum submitted by Bryan Nelson
K M McLean, Northern Ireland Sports Forum
LIST OF PEOPLE AND ORGANISATIONS WHO
RESPONDED TO THE PRE-CONSULTATION LETTER AND
ADVERTISEMENT

Sr Kathleen Savage, New Life Counselling Service Ardoyne
Jim Shannon MLA,
Joan Carson MLA,
Mick Murphy MLA
John Dallat MLA,
Joan Devlin, Belfast Healthy Cities
Maggie Beirne, Committee on the Administration of Justice
Eila MacQueen, Museums Council
Rosie Mercer, Child Accident Prevention Trust
Christine Hagen, CAREW II
Frances McReynolds, Co-operation and Working Together
Ulster Community & Hospitals Trust
Hilary Boyd, Greenpark Healthcare Trust
Angela McCourt, Women’s Aid Federation
Professor John Wilson, University of Ulster
R McKay, Association of Local Health Authorities
Lorraine Crawford, Craigavon Borough Council
Professor Watson, NI Affairs Committee
Gordon Topping, North Eastern Education & Library Board
R C Dunn OBE, Arts Care
Kenneth D Forbes, Local Government Training
Frances Donaghy, Royal College of Nursing
Janice Bisp, ROSPA
R H Whitford, Southern Education & Library Board
Hilary Boyd, Green Park Healthcare Trust
Ruth Sutherland, Community Development & Health Network
Dr O’Neill, Chairman Area Medical Advisory Committee NHSSB
Niall Fitzduff, Rural Community Network
North & West Belfast Health Action Zone: Accommodation and Health
   Improvements For Travellers Action Group
Brieger Coyle, Community Practitioners’ & Health Visitors’ Association
Jim McCambridge, National Addiction Centre, London
Anna Leech, Sinn Féin Cumann
Alan Burke, Dungannon & South Tyrone Borough Council
Professor Stout, Queen’s University of Belfast
Noel Muddiman, Motability
Dr Johnston, Maine Medical Practice
Dr Kilbane, Eastern Health & Social Services Board
Alison Laird, Care for Northern Ireland
Dr McConnell, Western Health & Social Services Board
Dr MacLeod, Antrim Hospital
Mr Boreland, Ards Borough Council
Ms McGuinness, Lifestart Foundation
Mrs Marshall, Causeway Health & Social Services Trust
Ms Geraghty, Children’s Law Centre
Dr Cooke, GP/Travel Health Adviser
G J McFarlane, The Chartered Institute of Environmental Health
Western Education & Library Board
Dr Vinod K Tohani, British Medical Association
Dr W Henry, Belfast City Hospital
Eamon McCartan, Sports Council
John Meehan, Chief Environmental Health Officer, Derry City Council
Dr F W Browne, Royal College of Psychiatrists
LOCAL INFORMATION SOURCES FOR HEALTH

Routinely collected data:

- Census of Population - includes a question on long standing illness
- Child Health System - provides information on the child population
- Patient Administration System (PAS) - produces information on discharges and deaths from hospitals
- General Register Office - produces information on births and deaths and population estimates
- Northern Ireland Cancer Registry - can provide data on cancer incidence and mortality as well as survival

Special surveys:

- The Health Behavior of School Aged Children - part of a WHO survey conducted in 1997-98.
- European School Survey Project on Alcohol and Drugs 1999, this was a UK wide survey of 15 year olds in which 76 local schools participated.
- Life and Times Survey - annual survey carried out by the University of Ulster and Queen's University, includes questions on health, including alternative medicine, public access to information on health and views on involvement in service.
- The Continuous Household Survey, carried out by NISRA includes a health section including sight, hearing, use of services, smoking, drinking, chronic illness and contraception.

Other sources of information:

- A Drug Information and Research Strategy is being developed by the Drug Information and Research Unit (DIRU). The primary purpose is to inform the implementation of the Northern Ireland Drug Strategy. A number of surveys are proposed.
- Administrative data - routinely collected data (e.g. unemployment data) can be used to supplement data derived from other sources, such as surveys, to shed further (indirect) light on the health of the population
- DARD provides information on diet and nutrition through the National Food Survey and is currently looking at the possibility of merging the NFS with the Family Expenditure Survey. This would mean that data on meals eaten outside the home could be included in the surveys which would provide a better and more complete picture of our diet.
CONSULTATION POINTS

For convenience, we have reprinted below each of the consultation points highlighted in the paper, with their page reference.

But please feel free to comment on Investing for Health more generally.

**Chapter 1. Introduction - Purpose, Values and Principles**

We would welcome your views on the aim, values, principles and criteria, and on others which could be included. (Page 18)

**Chapter 5. The Policy Context**

We would also welcome comments now on the potential equality implications of Investing for Health. (Page 43)

We would welcome your views on how best to develop existing interagency strategies and initiatives to improve our health. (Page 44)

**Chapter 6. Agenda for Change**

What are the key issues that need to be addressed in taking forward this agenda? (Page 46)

We would welcome comments on the priority groups, settings and topics, and in particular on what additional action we might take for each. (Page 50)

We would welcome comments on the examples of Departmental contributions to the Investing for Health objectives, including deletions, additions, and more specific suggestions. We would be particularly grateful for information on actions which have successfully improved health here or elsewhere, and which could be made to work more widely. (Page 53)

**Chapter 7. Reducing Inequalities**

We would welcome comments on reducing health inequalities, including ideas for what more might realistically be done and by whom. (Page 57)

**Chapter 8. Working across Government**

We would welcome views on the arrangements for co-ordinating and steering inter-Departmental action on Investing for Health. (Page 61)

We would welcome views on the proposals for encouraging wider participation in Investing for Health. (Page 62)

We would welcome views on the proposal to introduce health impact assessment across all Departments; on the methodology to be used; and on significant policy areas for assessment. (Page 63)
CONSULTATION POINTS

Chapter 9. The Health and Social Services

We would welcome views on how the DHSSPS should progress and monitor the Investing for Health programmes within the HPSS. (Page 65)

Views are sought on the key role in the strategic planning and pursuit of Investing for Health envisaged for Boards and on the proposed Investing for Health Partnerships. (Page 66)

How can the potential contribution of HSS Trusts and primary care to Investing for Health be maximised? (Page 67)

How can the HPSS Agencies, each with a specialist focus, maximise their contribution to Investing for Health? (Page 68)

How can we better harness the skills, experience but above all commitment of the workforce in the HPSS to champion and progress the Investing for Health programmes? (Page 69)

Chapter 10. Mobilising the Efforts of Society

We would welcome comments on each of the sections in this chapter. What should be the contribution of each key partner to the Investing for Health process? How can we maximise it? What should be done to strengthen the capacity of each partner to play a full part? What are the barriers to success and how can we ensure effective partnerships, commitment and implementation? (Page 71)

We would welcome views from the political parties, Councillors, and Council officers, in particular, on how best to build on Councils’ experience in these areas. How can we maximise their contribution to the Investing for Health process, and to the development of health improvement planning in particular? Should Councils have a role in preparing health impact assessments for significant policy proposals affecting their Districts (such as regeneration schemes, shopping centres, and large-scale building projects?) (Page 73)

Chapter 11. Working Together - North/South, East/West and Internationally

We would welcome views on new ways of developing co-operation through North/South, East/West and international partnerships. (Page 76)

Chapter 12. Information, Monitoring and Research

We would welcome comments on the scale and nature of the information gaps and the best way to fill them. (Page 81)
CONSULTATION POINTS

We would welcome views on the most appropriate arrangements for setting standards and monitoring progress in implementing Investing for Health. (Page 82)

We would welcome views on our proposed approach to target setting, and ideas for specific targets which meet our proposed criteria. (Page 83)

We would welcome views from researchers and others on the priorities that we might set for a research programme to support Investing for Health. (Page 83)
REFERENCES

REFERENCES

xxvii North and West Belfast Health Action Zone 1999.
Issued by the Department of Health, Social Services and Public Safety on behalf of the Ministerial Group on Public Health.

Éisithe ag An Roinn Sláinte, Seirbhisí Sóisialta agus Sábháilteachta Paibhi ar son an Ghrúpa Airú ar Shláinte Paibhí

November 2000