NORTH SOUTH
HEALTH SERVICES PARTNERSHIP

Employers, Trade Unions,
Service Users and Communities
working together

Creating Healthy Alliances

Reducing Health Inequalities

working together for better health services

A report from the North South Health Services Partnership based on the proceedings of a conference held on 18th May 2004 in Dundalk

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ABOUT THE ORGANISERS

North South Health Services Partnership

The North South Health Services Partnership was formed following a North South Health Services Conference held in July 2001. Addressed by both Ministers, the purpose of the conference was to address the growing crisis and challenges facing the health systems north and south and to consider what contribution partnership models and workplace initiatives could make towards strengthening the links between those delivering the health services and those using them. Members of the Committee currently include senior Departmental appointees, employer CEOs, trade union leaders and user/community representatives North and South.

Institute of Public Health in Ireland

The remit of the Institute of Public Health in Ireland is to promote co-operation North and South on public health and with a particular focus on health inequalities.

INTRODUCTION

There are unnecessary high levels of health inequalities in Ireland, North and South.

We believe that their reduction necessitates identifying, in a co-operative way, the joint needs and interests of patients, workers, management, trade unions, employers and local communities as well as the development of innovative solutions to problems. Only then can we expect to deliver effective health care in a way that ensures dignity and respect for everyone involved.

It was in this context that the North South Health Services Partnership and Institute of Public Health in Ireland joined forces to organise the conference 'Creating Healthy Alliances: Reducing Health Inequalities'.

The key objectives of the conference were:

- To stimulate discussion and action on how health institutions, trade unions and local communities can work together to reduce health inequalities and promote local anti-poverty work on the ground.
- To raise awareness of the role and potential of health institutions in reducing health inequalities.
- To create a dialogue at the conference on key issues where health institutions can reduce health inequalities, for example through areas such as health and social services, workforce development, wider procurement objectives, partnerships with local communities and their wider civic leadership role.
- To understand how partnership working between employers, trade unions, local communities and users of services can be a crucial mechanism in reducing health inequalities.

At the conference keynote speaker Anna Coote, Director of Public Health at the Kings Fund, explored the potential of health agencies for improving health through their role as an employer, purchaser/ commissioner of goods and services, landholder and manager of energy, waste and transport.

Other speakers included:

- Sarah Burke, Public Health Development Officer, Institute of Public Health
- Inez McCormack, Joint Chair, North South Health Services Partnership
- Larry Walsh, Director, Health Services National Partnership Forum
- William McKee, CEO, Royal Hospitals Trust, Belfast
- Margaret Curtain, NICHE Community Health Project, Cork

This report summarises the key themes and conclusions that emerged at the conference. These are based on presentations given by the speakers and issues and priorities fed back from a series of workshops.

These themes and conclusions are summarised and grouped into ten key areas that address the changes that need to take place in health services in order to reduce health inequalities.

A clear message coming from the conference was the need to work differently, think differently and create change both in and outside of the health care system.

The complexity of health and of health care institutions makes the task a challenging one.

The conference was also reminded of the importance of seeing health inequalities within a global context and of the importance of reflecting on international best practice.

KEYNOTE ADDRESS

Tackling Health Inequalities – The Role of Health Services

Anna Coote
Director of Health Policy, Kings Fund

This is a summary of the presentation made by Anna Coote at the conference. Anna has published widely on health, social policy and gender issues. She was formerly Deputy Director of the Institute for Public Policy Research, consultant to the UK Government's Minister for Women, Senior Lecturer in Media and Communications at Goldsmiths College, Current Affairs Producer for Channel Four, and Deputy Editor of the New Statesman. She is a member of the UK Sustainable Development Commission and the London Health Commission.

Health services can tackle health inequalities through:

- Ensuring equal and appropriate access to health services.
- Making sure disadvantaged groups and individuals get the information and advice they need to maintain and improve their health.
- Creating conditions for healthy living through
  - targeting services to needs
  - recruitment and training of low-income groups into health service jobs
  - promoting healthy working conditions within health services
  - using purchasing power of health service providers to strengthen local economies.

Promoting equal and appropriate access to health services means:

- Engaging patients and public in decisions that affect their lives.
- Ensuring that awareness of inequalities and diversity informs service design and delivery.
- Ensuring that health service premises are welcoming and located in places that disadvantaged groups can get to easily.
- Ensuring sensitivity to the language and culture of diverse groups.

- Promoting advocacy – an informal, community based resource that acts as a bridge between disadvantaged communities and the knowledge and services they need to safeguard their health.
- Developing partnerships with local government, schools, employers and other organisations to extend the scope and reach of services.

Don't put the cart before the horse

- We need more emphasis on preventing illness – as most health problems are avoidable. For example, obesity is largely a disease of poverty.
- What if we had an effective health system dedicated to improving health, preventing illness and reducing health inequalities? What would it look like?
- By 'health system' I mean a combination of organisations and relationships that are susceptible to public policy that influence health:
  - it includes health services, but is not defined by them
  - it provides advice and information to help people make healthy choices
  - it helps create conditions for healthy living.

Using information and advice to help tackle health inequalities means

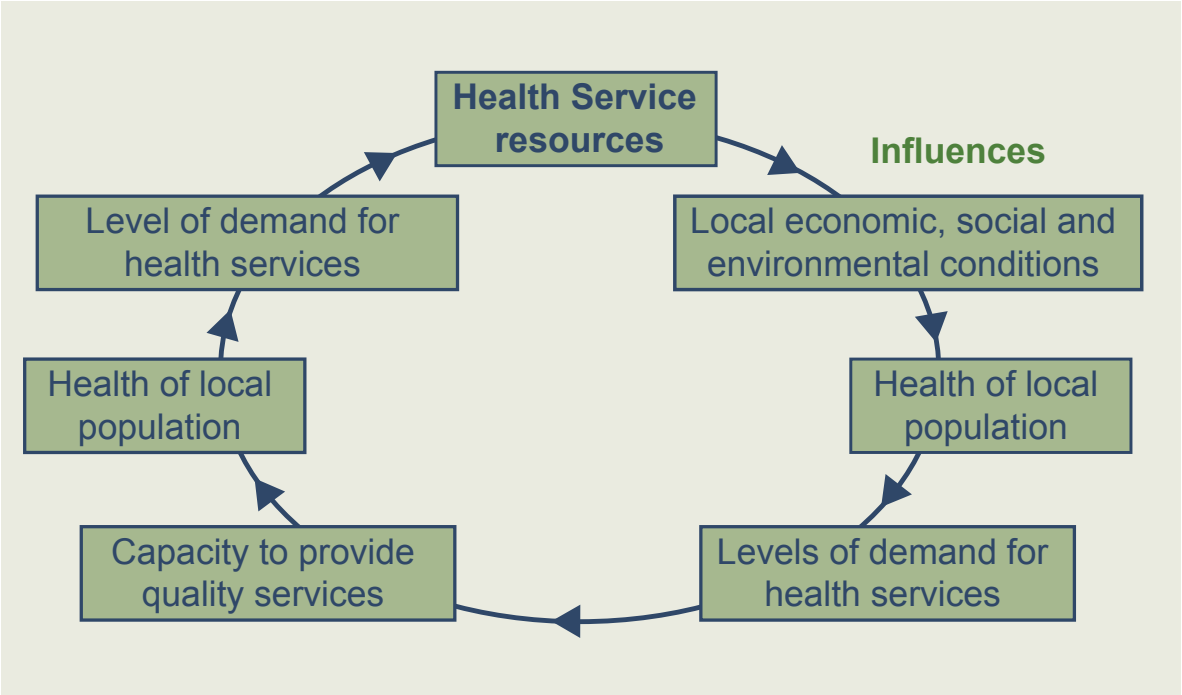
- Understanding information and advice needs of disadvantaged groups
- Designing materials in dialogue with those intended to use them
- Using formats and media that are familiar and accessible to those groups
- Ensuring appropriate dissemination, paying attention to settings and context
- Reflective practice – learn from patients and users and keep changing and improving information and advice.

How can health services help create conditions for healthy living?

- Claiming the 'health dividend' through the corporate activities of health services

- That means using the power of the service as employer, purchaser of goods and services, landholder, commissioner of buildings
- Creating a virtuous circle (see Figure 1).

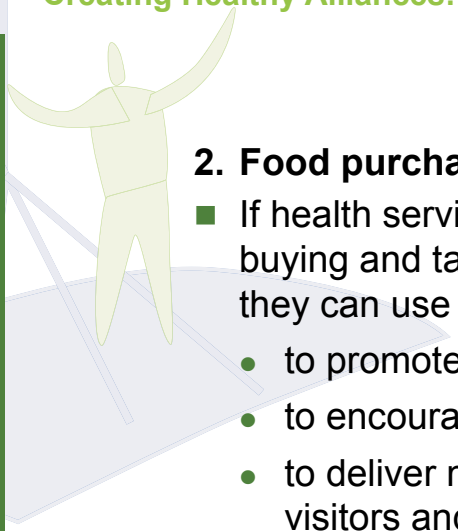
Figure 1: Claiming the health dividend – creating a virtuous circle



Here are four examples of how that might work in practice

1. Employment

- Health service providers can choose not to recruit from abroad, but to invest in local recruitment and training
- They can create a step-by-step ladder into health service jobs
- Employment combats poverty and contributes to better health
- Local recruitment more likely to produce a reliable, committed workforce
- If more people have jobs, there may be fewer demands for health care, because people in employment are likely to be healthier
- That means health service providers are under less pressure and have more capacity to provide better quality health services for those who really need them.



2. Food purchasing

- If health service providers develop a strategic approach to food buying and takes a creative approach to EU procurement rules, they can use their substantial purchasing powers
  - to promote sustainable farming
  - to encourage more local suppliers
  - to deliver more appealing and nutritious meals to patients, visitors and staff.
- This in turn will help to ensure
  - a safer, healthier environment
  - stronger local economies
  - faster patient recovery, less illness
  - less food waste
  - lower health care costs.

3. Childcare

- Health service providers need childcare for their staff. They can work with local suppliers to develop quality childcare for whole community, levering in more money from other sources.
- This will help to
  - create more jobs
  - strengthen local economies
  - improve child health
  - enable parents to combine caring and paid work
  - help recruit and retain health service staff.

4. Commissioning buildings

- Health service providers spend huge sums on capital development.
- To be sustainable and health promoting, they need to ensure
  - long-term planning, and buildings designed for flexible use
  - strategic location, to minimize car use and maximize accessibility
  - design to make maximum use of natural lighting and ventilation
  - use local workforce and suppliers as far as possible

- use sustainable materials
- minimise energy use and running costs
- create buildings that provide healthy working conditions
- create buildings that provide a healing environment.

What are the barriers to change?

- Health care targets dominating policy and practice
- Synergies between health care, health and sustainable development poorly understood
- All who work in health services suffer from initiative overload
- Incentives to innovate and change are weak.

How can we move forward?

- Give higher priority to health & inequalities
- Integrate strategies for health and sustainable development
- Promote long term planning and ‘whole life’ costing
- Take a strategic approach to health services as ‘corporate citizen’
- Focus on price of failure and prize for success.

KEY THEMES EMERGING FROM THE CONFERENCE

1. Understanding inequalities

Inequalities take a number of different forms and there is a need to develop better understanding of the causes of inequalities in health and the solutions to them. Taking account of how different groups access social, economic, civil and political rights can also help to gain insights into the impact of inequalities in the utilisation of, participation in and experiences of health care services.

It is clear that local communities experience different types of inequalities and this needs to be reflected in the planning of services and initiatives. Inequalities can be based on poverty and socio-economic status, geographic inequalities, as well as on different identities. There is often an overlap between the experience of poverty and inequality based on identity.

Factors to address:

- Highlight issues of social class, poverty, deprivation, as well as identity e.g. Race, age, disability, sexual orientation, gender etc.
- Carry out poverty and equality impact assessments of all services so that the planning, delivery and monitoring of services are assessed for their impact on specific groups that experience exclusion, disadvantage or discrimination.
- There is a need to replicate good practice by placing duties on public service providers to provide services within a framework of equality.

2. Multifaceted and multi-agency strategies

This is relevant to improving the organisation and delivery of services so that they are more able to work in co-ordinated and integrated ways. It is clear that much ill health can be prevented by addressing the causes of ill health related to areas such as poverty, deprivation and poor housing.

Factors to address:

- Shift the delivery and focus of health services to enable more co-ordinated approaches.
- Identify determinants/causes of ill health and how the co-ordination of services can tackle these.

3. A dynamic change process

Reforms in health services should locate inequalities in health at the core of their role and purpose. This should reflect a culture of health improvement, with a shift of priorities towards health prevention and promotion. This should include whole life and lifetime approaches to planning and providing services. More holistic approaches should be built into this change process.

Factors to address:

- Address health inequalities as a core aspect of the change process.
- Build health promotion and health education into all health provision, including acute and community based care.
- Plan services so that are provided in more holistic ways.
- Health proof all activities and services so that health impacts are addressed.

4. Structure of health services

The institutional and historic reliance on the medical model of health needs to be refocused to ensure that health includes social, environmental, economic and other factors impacting on health status. This means developing a better understanding of how health inequalities can be addressed through improving and promoting health (health status) and by addressing access to health care (health services).

There is a real need for additional funding to address the promotion of good health and to address the social and economic causes of ill health. More resources for health services do not necessarily lead to better health, since the focus is usually on the treatment of ill health. However, improvements in living standards, health promotion and health education have an important role to play in preventing ill health. Preventing ill health will save resources in the longer term for health services. More co-ordination between acute and community based services is also needed.

Factors to address:

- Provide more resources and give a bigger focus to health promotion and health education.
- Improve access to health services for groups experiencing disadvantage and discrimination.
- Address the social, economic and cultural determinants of health when planning, providing and monitoring services.
- Take a whole system approach to tackling health inequalities.

5. Community based approaches

A shift in the boundaries of health services needs to take place, including a greater focus on primary health care, community action, community development, the targeting and supporting of people from local communities to work in the health sector and health education and promotion to take place in schools and other community settings, and by utilising the skills of local people and investment in workforce development.

Factors to address:

- A greater focus on community development and community action.
- Shift the focus of services towards the development of multidisciplinary and community based primary health care models.
- Take acute services out to local communities and involve them more fully in the planning and provision of local services.
- A new focus is needed for the development of community based health education and health promotion, including actions in schools.

6. Engagement and empowerment of local communities

There are already good examples of consultation taking place with service users, representative groups and local communities. However, a clear message is the need to ensure that consultations result in real changes in policy and practice. In some cases consultation overload has not resulted in change and this has led to scepticism about the intentions of health services consultations with local communities.

In other cases, effective community engagement has led to real health promoting changes in local communities. Community development approaches can help to challenge existing resource allocations and structures.

Factors to address:

- Local communities should be resourced and empowered to identify what their local needs are.
- Health service organisations need to translate feedback from consultations into effective change.
- Resource and put in place models of advocacy and community development to improve health in community settings.
- Enhance the engagement between local communities and health services, especially in acute settings.

7. Capacity building

Capacity building is as important for local communities as it is for health service organisations. This includes empowering and building the capacity of local communities to act for themselves and engage in health related activities and in influencing and informing health service developments. Building the capacity of health service organisations means changing the style of leadership and management so that organisations are able to be more reflexive and responsive to the groups that face the greatest barriers in accessing services.

This means moving to the development of more responsive organisations, for example, through the development of learning organisations, and learning circles involving staff and service users. Workforce development should focus on empowering and developing staff, and ensuring that low paid staff have access to better paid jobs.

Factors to address:

- Resources and mechanisms for capacity building in local communities that takes decisions, planning, monitoring and prioritising of resources into local communities.
- Improve the capacity of organisations to engage with local communities and ensure that consultations result in meaningful changes and with the operation of a feedback loop.
- Create and resource a learning organisation approach.
- Ensure that health services reflect the diversity of local communities.
- Enhance the capacity of organisations to skill up and employ local people in health service employment.

8. Create healthy living and working environments

Many working and living environments cause ill health. Creating workplaces that are healthy, commissioning new health service buildings and contracts that are health promoting, can have long-term health gains for employees, patients and local communities. Healthy living conditions, good housing and healthy environments are all conducive to good health.

Factors to address:

- Build healthy living/working into purchasing and commissioning.
- Improve working environments so that they are health promoting.
- Create healthy environments for patients.
- Clearly identify who will improve the living environments of people experiencing poverty and disadvantage, through better housing, improved community facilities and local environments.

9. Evidenced based practice

There is a real need identify and share learning from good practice. This includes information sharing across health service and community organisations, reflecting on what works, and mainstreaming successful pilots and initiatives.

Factors to address:

- Mechanisms for sharing and mainstreaming good practice.
- Learn from international best practice.
- Share experiences and learning between health and community settings.

10. Sustainability

It is crucial that work on health inequalities is sustainable in the longer-term. Much work on health inequalities requires a long-term approach to planning and change. There is also a need for policy and practice to be linked in sustainable ways.

Factors to address:

- Put in place mechanisms for sustainability of work on health inequalities over the short, medium and long term.
- Ensure that there is a link between policy and practice, including a budgetary link between the two.

CONFERENCE REGISTRATION

1.	Armstrong	Claire	Royal Hospitals
2.	Bailey	Avril	Age Action Ireland
3.	Bates	Evan	Royal Hospitals
4.	Benner	Thomas	NICEM
5.	Bergin	Sadie	Cooperation and Working Together (CAWT)
6.	Bloomer	Stephen	Community Foundation for Northern Ireland
7.	Bloomfield	Caroline	SPEAKER
8.	Boyle	Rosaline	Western Education and Library Board/UNISON
9.	Bradley	Martin	Royal College of Nursing
10.	Broderick	Katherine	Northern Eastern Health Board
11.	Burke	Sara	SPEAKER
12.	Caddell	Mary	Royal College of Midwives
13.	Caldwell	Sandra	Central Services Agency
14.	Campbell	Maria	Tallaght Hospital
15.	Camplisson	Seamus	DHSSPSNI
16.	Cleary	Mary	AMEN
17.	Coogan	Tara	Equality Authority
18.	Coote	Anna	SPEAKER
19.	Cowan	Hugh	Royal Hospitals Trust/UNISON
20.	Culbert	Michael	Coiste Na N-Iarchimí
21.	Cullen	Caroline	Southern Health and Social Services Board
22.	Curley	Dympna	Royal Hospitals
23.	Curtain	Margaret	SPEAKER
24.	D'Arcy	Esther Mary	Facilitator
25.	Dillon	Annie	UNISON
26.	Donnelly	Anne	UNISON
27.	Doole	Mable	Job Assist Centre
28.	Dooley	Pamela	UNISON
29.	Doyle	Jacinta	CORI - Nazareth House Care Village
30.	Elliott	Iris	National Disability Authority
31.	Fantini	Alessandra	The Women's Health Council
32.	Ferguson	Brian	Down & Lisburn Health Trust/ UNISON
33.	Ferris	Mary	Royal Hospitals Trust/UNISON
34.	Fraser	Agnes	Job Assist Centre

35.	Gillgun	John	UNISON
36.	Gravador	Charlotte	Royal Hospitals
37.	Griffin	Ciara	Department of Health and Children
38.	Hanley	Teresa	Facilitator
39.	Hardy	Charlie	Department of Health and Children
40.	Harkin	Anna May	Department of Health and Children
41.	Harvey	Elaine	Galway People's Resource Centre
42.	Hayes	Catherine	Eastern Regional Health Authority
43.	Heaney	Donna	Equality Commission for Northern Ireland
44.	Hegarty	Ita	North Eastern Health Board
45.	Henderson	Alez	Down Lisburn Trust
46.	Heuston	Leslie	Facilitator
47.	Iran	Alma	Royal Hospitals Trust/UNISON
48.	Keatings	Denis	Mater Hospital Trust/UNISON
49.	Kelly	Michael	Facilitator
50.	Lafferty	Mary	Altnagelvin Hospitals HSS Trust
51.	Largey	Gerry	North and West Belfast HSS Trust
52.	Long	Stiofan	Sinn Fein
53.	Mahaffy	Thomas	UNISON
54.	McAdam	John	Health Services National Partnership Forum
55.	McAvoy	Helen	National Council on Aging and Older People
56.	McCambley	Derek	Community Foundation for Northern Ireland
57.	McCartney	Suzanne	Lagan Valley Hospital
58.	McCaughey	Kate	Royal Hospitals Trust/UNISON
59.	McConnell	Paul	Down Lisburn Health & Social Services Trust/UNISON
60.	McCormack	Inez	SPEAKER
61.	McCullough	Theresa	Royal Hospitals
62.	McDonald	Bernard	North Eastern Health Board
63.	McKee	William	SPEAKER
64.	McKeever	Lucia	Armagh & Dungannon Trust
65.	McKelvey	Siobhan	Dept of Health, Social Services & Public Safety NI
66.	McKenna	Maura	North & West Belfast Health & Social Services Trust/UNISON
67.	McKenna	Peter	UNISON
68.	McKeown	Patricia	UNISON
69.	McLaughlin	Paul	Foyle Health Trust/UNISON

70.	Mernagh	Michael	South Inner City Community Development Association
71.	Millar	Jacinta	Open University of Ulster
72.	Milner	Yvonne	Northern Area Health Board
73.	Morgan	Brendan	NASUWT
74.	Muldoon	Noel	Armagh & Dungannon Trust
75.	Mulvenna	Anne	Royal Hospitals
76.	Newell	Nora	Letterkenny Women's Centre
77.	O'Connor	Tim	North South Ministerial Council
78.	O'Dowd	John	Sinn Fein
79.	O'Keefe	Bernadette	North Eastern Health Board
80.	O'Neill	Eileen	Health Boards Executive
81.	O'Neill	Léonie	East Coast Area Health Board
82.	O'Neill	Mary	Homefirst Trust
83.	O'Rawe	Angela	Northern Ireland Council for Ethnic Minorities
84.	O'Reilly	Carol	Facilitator
85.	O'Reilly	Fiona	Royal College of Surgeons
86.	O'Riordan	Ann	Irish Health Promoting Hospitals
87.	O'Rourke	Jo	Northern Area Health Board
88.	Patterson	Eddie	Mater Hospital
89.	Pentony	Thelma	North Eastern Health Board
90.	Phelan	Richard	North Eastern Health Board - Traveller Health Unit
91.	Pillinger	Jane	SPEAKER
92.	Porter	Barbara	The Health Promotion Agency Northern Ireland
93.	Ritchie	Marion	Down Lisburn Health & Social Services Trust/UNISON
94.	Rooney	Bernadette	Northern Area Health Board
95.	Ruddy	Gerry	North Eastern Health Board
96.	Shaw	Bill	174 Trust
97.	Smith	Oliver	Facilitator
98.	Smyth	Deirdre	Northside Centre for the Unemployed
99.	Spears	Madeleine	INO
100.	Stephenson	Joanne	RCN, Down Lisburn Trust
101.	Sullivan	Liz	Combat Poverty Agency
102.	Thunhurst	Colin	Dept of Epidemiology & Public Health, University, College Cork
103.	Tynan	Mary	Facilitator
104.	Walsh	Larry	SPEAKER
105.	Walsh	Úna	Mullaghbawn Community Association
106.	Woods	Sharon	Down Lisburn Trust

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