OFFICE FOR SOCIAL INCLUSION – NAP/INCLUSION PROCESS

Report for Department of Health and Children

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SECTION A – REVIEW OF CURRENT SITUATION

PART A.1 – ANALYSIS OF PROGRESS TO DATE, BASED ON MATERIAL IN FIRST OSI ANNUAL REPORT

OBJECTIVE: Reducing Health inequalities and placing the health of the Population at the centre of public policy (page 27 of NAP/Inclusion)

Target 1	To reduce the gap in premature mortality between the lowest and highest socio-economic groups by at least 10 per cent for circulatory diseases, for cancers and for injuries and poisonings by 2007.
Summary Assessment	In progress
Will Target be met on time	Unknown
Indicator (s) ?	Directly standardized mortality rate ratio (DSRR); CSO Mortality and Population Data
Progress being made	National Health Strategy is the framework within which developments in health will take place over the next ten years. Policy initiatives being implemented include – Health Impact Assessment; Primary Care Strategy; Cardiovascular Health Strategy; and Cancer Strategy and Programmes.
Areas where intended implementation not being achieved	While undoubtedly many initiatives are underway which should directly impact on premature mortality, the absence of baseline data broken down by socio-economic group makes it impossible to measure how progress is being made against the stated target. The Institute of Public Health (IPH) has produced data on the NAPS target based on 2002 data and a similar analysis is being carried out on 2003 statistics. Several Regions of the Health Service Executive report that

	Community Dieticians appointed in the context of implementation of the Cardiovascular Health Strategy focus specifically on lower socio-economic groups. Nicotine Replacement Therapy is made available without charge to lower socio-economic groups. The SLÁN studies found a clear social gradient in smoking rates according to education level both in 1998 and in 2002 in keeping with international findings. There was little evidence of a narrowing of the differences over this period. There is a consistent downward trend in reported rates in those with least level of education though that was not true of younger respondents with completed second level education, the only group where the trend appeared to be upwards. Overall smoking prevalence in 2002 in the group with lowest educational status was 34% compared to 21% in those with the highest level of education. The primary care strategy is framed in terms of population health. It is aimed at effecting a change in the way in which services are delivered to all of the population, not just to lower socio-economic groups. It also seeks to shift the emphasis from diagnosis and treatment towards health promotion and rehabilitation. The strategy is a long-term project and will inform service development and reorientation over a period of ten or more years. Of the ten initial primary care teams established, the majority serve populations with a sizeable, and in some cases a large, proportion of people in lower socio-economic groups or facing other significant social disadvantage– for example, Liberties, Dublin 8; Ballymun, Dublin; West Co. Kerry; Erris, Co Mayo; Arklow, Co. Wicklow; West Co. Limerick; Lifford, Co Donegal. Specific attention has been given to ensuring that the team development process includes engagement with the population to be served, in terms for example of agreeing priority service developments and communicating key messages about the purpose of the primary care team and the benefits it is intended to bring. Significant work has also been undertaken in the National Primary Care Steering Group, which is a representative forum including the Community and Voluntary Pillar. Among the outputs of the Group are Guidelines for Community Involvement in Health, which are intended to inform the process of community involvement as the primary care strategy is implemented on a national basis by the Health Service Executive. These have a particular focus on facilitating the involvement of marginalised groups and communities. The HSE will be required, as part of the three-year corporate plan which it is required by law to prepare by mid-2005, to set out a

	plan for significantly advancing the implementation of the primary care strategy in the period 2005-2008. General income guidelines for current medical cards (which entitle the holder and their dependants to a full range of services without charge) increased by on average 7.5 % effective from 1 January 2005. This aimed to enable some 30,000 additional people (over and above those with a card at end December 2004) to obtain a standard medical card in the current year. Additionally to help low income families with children particularly, the income allowance for each of the first two children has been increased by 20 per cent and the allowance for the third and subsequent children has been increased by 30 per cent. This is to give particular emphasis to helping parents and children to access primary care On 18 November 2004, the Tánaiste announced the Government's intention to introduce a doctor visit medical card. This is a supplementary initiative to enable some 200,000 additional people from lower income households to attend a doctor, free of charge. The introduction of doctor-visit cards is intended to help to overcome barriers to accessing GP services for many individuals and families who are above the standard medical card income guidelines.
Data sources used to monitor progress	CSO data on mortality analysed by the Institute of Public Health (IPH) Data available from various studies as referenced in the Report of the Working Group on the NAPS and Health e.g. All Ireland Report on Mortality 1989-1999; SLAN(Surveys of Lifestyles, Attitudes and Nutrition) 1998 and 2002
Areas where progress made/proposed to address data or indicator issues	IPH working with CSO to improve availability of data. Further "upstream" from monitoring of mortality, demographic and socio-economic data standards for health information systems are needed in Ireland in order to measure and promote equity of access to acute medical care and appropriate follow-up care in the community. In the context of the National Anti-Poverty Strategy (NAPS) Health Targets, the National Cardiovascular Information Systems (NCIS) Working Group plans to test some proposed standards for demographic and socio-economic data of cardiac patients in specific modules of the National Cardiovascular Information System currently being developed under the Cardiovascular Health Strategy. A Workshop to progress this issue took place on 18 April 2005. If the pilot study is successful the next step will be to consider their

	possible use in other health information systems, particularly in patient care settings. National Health Information Strategy, published in 2004, recommends the geocoding of routinely administered patient data. The lead role in many of these actions will be taken by the Health Information and Quality Authority (HIQA) which is in the process of being established.
Data/Indicator Deficiencies	Mortality Statistics from CSO not routinely disaggregated by socio-economic group but 2002 statistics were analysed on this basis by IPH and a similar analysis is being carried out on 2003 statistics.

Target 2	To reduce the gap in low birth weight rates between children from the lowest and highest socio-economic group by 10 per cent from the current level, by 2007.
Summary assessment	Limited
Will target be met on time?	Unknown
Indicator (s) ?	The level of low birth weights among the highest and lowest socio-economic groups based on the National Peri-natal Reporting System. (NPRS)
Progress being made	A paper commissioned by the Department of Health and Children and produced by the Institute of Public Health has quantified the effect of socio-economic status on low birthweight in Ireland and considered these findings in the light of the NAPS targets. The paper was limited in its ability to provide clear strategic direction on tackling inequalities in low birthweight, in part due to limitations in the international evidence-base and the effect of intergenerational factors. A number of key issues were highlighted that should form the focus for research, discussion, policy and practice development to tackle inequalities in the occurrence of low birthweight in Ireland.
Areas where intended implementation not being achieved	No baseline figures available from which progress towards achievement of target can be measured. The Institute of Public Health has produced data on the NAPS target based on 1999 data (see page 109 of OSI 2004 Report**)** and is working with the NPRS to derive the relevant low birthweight data for 2000 and 2001**.** The lack of clear strategic direction from the international literature and the intergenerational aspects of the issue of low birthweight make this a difficult target to achieve within the NAPS timeframe.
Data sources used to monitor progress	Data on low birth-weight by socio-economic group is collected through the National Peri-natal Reporting System (NPRS) managed on behalf of the Dept of Health and Children by the ESRI and are analysed by the Institute of Public Health.
Areas where progress made/proposed to address data or indicator issues	The Institute of Public Health has produced data on the NAPS target based on 1999 data (see page 109 of OSI 2004 Report**)** and is working with the NPRS to derive the relevant low birthweight data for 2000 and 2001**.**

Data/Indicator Deficiencies	The paper on tackling inequalities in the occurrence of low birthweight highlighted a number of deficiencies including limited completeness of occupational/ socio-economic status data on the NPRS, a lack of data on birth outcomes for ethnic minority women and limited information on the financial wellbeing of pregnant women. The review of 'what works' in tackling inequalities in the occurrence of low birthweight, included in the paper commissioned by the Department of Health and Children, has been submitted to the National Children's Office and is under consideration. The report concludes that despite the well-established relationship between socio-economic group and poor birth outcome, there is a lack of evaluation and efficacy data on what works in breaking this link and improving birth outcomes for the poorest members of society. In particular the efficacy of multi-component strategies in preventing low birthweight is unclear from the international literature. The paper raises a number of issues for further attention in relation to tackling inequalities in low birthweight. The importance of appropriately devised surveillance of trends in low birthweight and a comprehensive research programme are emphasized. The poor birth outcomes of Traveller women are of particular concern. Sensitively and carefully designed interventions aimed at improving health behaviours in pregnancy, especially smoking, among deprived women have a role in reducing low birthweight. Antenatal care may have an important role to play in reducing the proportion of babies born with low birthweight in Ireland, particularly to teenagers. The benefits of antenatal care can only be gained by those who attend and strategies aimed at encouraging early enrolment and attendance by women in lower socio-economic group are likely to assist in this regard. The Report also suggests that social policy analysis of social welfare payments and income provision for low paid and unemployed pregnant women in Ireland would be of benefit in building healthy public policy to reduce health inequalities in birthweight.

Target 3	The gap in life expectancy between the Traveller Community and the whole population will be reduced by at least 10 per cent by 2007.
Summary Assessment	In progress
Will target be met on time	Unknown
Indicator (s)	The difference in life expectancy between the Traveller population and the whole population.
Progress being made	Implementation of Traveller's Health Strategy – a National Strategy 2002-2005 which is aimed at improving the health status of Travellers. Progress to date is as follows: ➢ Each Health Service Executive area has designated a regional Traveller health co-ordinator with responsibility for Traveller health. ➢ Travellers and Traveller organisations are involved in determining health priorities for their community and in decisions on the allocation of resources through membership of the Traveller Health Units in each Health Service Executive area ➢ Primary Health Care projects, which involve Travellers in the delivery of health services to their own community, are currently in place in all Health Service Executive areas ➢ The Traveller Ethics, Research and Information Working Group has been established and meets regularly to consider applications on research into Traveller health for ethical approval. ➢ A Sub-group of the Traveller Ethics, Research and Information Working Group has been established to progress the administration of an ethnic identifier question on the Hospital Inpatient Enquiry/Perinatal Systems in two Dublin hospitals.
Areas where intended implementation not being achieved	There appears to be little or no data available in relation to the target making it impossible to accurately measure whether progress is being made. However, progress is being made to address the data deficiencies, see below*
Data sources used to monitor progress	None – see below
Areas where progress	The Department of Health and Children and the Department of Health, Social Services and Public Safety, Northern Ireland are

made/proposed to address data or indicator issues	jointly committed to carrying out a Travellers' All-Ireland Health Study to develop and extend the indicators collected in the 1987 study of Travellers' health and to inform appropriate actions required in the area of Travellers' health. Prior Indication Notices for the tender for the Study have been published in the Official Journal of the European Communities and it is expected that the Study will commence in 2005. *The study will provide national data in relation to the target.
Data/Indicator Deficiencies	Very little data currently available.

Target 4	OLDER PEOPLE Access to orthopaedic services will be improved so that no one is waiting longer than 12 months for a hip replacement. This is an initial short-term action to improve quality of life for older people.
Summary Assessment	In progress
Will target be met on time	Likely
Indicator (s)?	Number of people over 65 waiting longer than 12 months for a hip replacement. The National Treatment Purchase Fund now has responsibility for the collection and reporting of waiting times nationally.
Progress being made	To date over 27,000 patients have had treatment arranged for them by the National Treatment Purchase Fund. It is now the case that, in most instances, anyone waiting more than three months will be facilitated by the Fund.
Areas where intended implementation not being achieved	
Data sources used to monitor progress	A new, on-line, Patient Treatment Register is being developed by the Fund. The new Patient Treatment Register will allow for more accurate identification of waiting lists, and more importantly waiting times. It is intended that the register will be implemented on a phased basis during 2005.
Areas where progress made/proposed to address data or indicator issues	The Patient Treatment Register is expected to provide more detailed information about patients who are waiting for treatment.
Data/Indicator Deficiencies	*There is no age breakdown other than children or adult, making it difficult to focus specifically on the target group (older people).* The NTPF system referred to above is being set up to record date of birth of patients on waiting lists. It should then be possible to extract data on patients over 65.

Target 5	YOUTH HOMELESSNESS The incidence of youth homelessness will be reduced significantly through the implementation of the Youth Homelessness Strategy, which provides for increasing family and community based supports to prevent homelessness and providing appropriate emergency responses so as to prevent young people staying homeless and to facilitate their reintegration into the community.
Summary Assessment	In progress
Will the target be met on time	Likely
Indicator (s)?	Number of young people becoming homeless, as monitored by new information systems of the Health Service Executive.
Progress being made	Implementation of the Youth Homelessness Strategy (YHS) by the NCO, Departments of Health and Children and Education, Local Authorities and former Health Boards (now Health Service Executive) is monitored and co-ordinated by a monitoring committee, which is chaired by the National Children's Office and is representative of the relevant stakeholders. The Health Boards prepared detailed action plans with regard to implementation, to be phased in over 2002-2004. The Department of Health and Children has requested that the HSE undertake a review of these action plans to ascertain the extent of their implementation. This will be completed later this year. Since the publication of the YHS other significant progress has been made, including: • Approximately 12 million Euro has been allocated by the Department of Health and Children to the health boards for the development of youth homelessness services since 2001 €1.5m of this funding allocated since 2003 to date ; and • 195 new whole-time equivalent posts (including Management Staff, Project Workers, Social Workers, Family Support Workers, Aftercare Workers and Public Health Nurses) have been filled across the 10 former Health Board regions up to 31st December 2004. Although these posts impact on youth homelessness services, they are not all exclusively dedicated to youth homelessness services. • 11 new units have opened nationwide and 42 new/extended services have been developed around the country Considerable investment in recent years has enabled many services to be developed to counter the problem of youth homelessness which is **mainly** concentrated in the Dublin area. It is considered that there is sufficient emergency night-time accommodation for

the current youth homeless population of Dublin*.*The* provision of additional emergency accommodation is not a priority service need in other parts of the country and therefore the HSE continue to implement other preventive objectives of the Strategy in these areas e.g. development of family support services, Springboard, Aftercare Services etc.

The Youth Homelessness Strategy Monitoring Committee has established a series of sub-groups to tackle persistent obstacles to implementation or areas of slow progress.
The Aftercare sub-group of the Youth Homelessness Strategy Monitoring Committee drafted National Guidelines on Leaving and Aftercare, which were approved by the YHS Monitoring Committee and were circulated by the Department of Health and Children to the former Health Boards in July 2004. The purpose of the Guidelines is to assist Health Boards/HSE in developing their leaving and aftercare policies.

A Statistics sub-group recommended the introduction of a new Youth Homeless Contact Form as a way of gathering more reliable and consistent statistics. The Department of Health & Children circulated the form to the Health Boards in December 2003 for introduction on 1st January 2004.

A sub-group was established to look at the education and training objectives of the Youth Homelessness Strategy. Membership of the group includes representatives of the statutory and voluntary education and health sectors. It was agreed that there was a need to look at a broad understanding of the Homelessness Process to understand the potential impact of education and training elements as part of the solution for young people who are Homeless. Consideration is being given to:

(i) The preventive aspect of educational and training interventions;

(ii) Processes to ensure that education/training elements form part of the ongoing support of children and young people who are homeless; and

(iii)The role of education/training in the prevention/ reintegration of children in the care or detention systems.

The group is expected to finalise its report by the end of June 2005.

A sub-group was established in 2004 to examine Information and Advocacy in the context of the Youth Homelessness Strategy, with particular focus on making relevant information more accessible to young homeless people or young people at risk of becoming

	homeless. The group is expected to report back to the Monitoring Committee at the end of June 2005. The Programme of Action for Children Office (a unit within the health board/HSE structure with a co-ordinating function across all health board/HSE regions) has agreed to take on the co-ordination and linkages functions within the health board/HSE arena. The NCO will continue to deal with cross-sectoral co-ordination issues.
Areas where intended implementation not being achieved	
Data sources used to monitor progress	After extensive consultation with Health Board representatives and Government agencies, the Steering Group of the National Child Care Information System Project recommended that the Department of Health and Children and the (former) Health Boards conjointly commission the development of a single national child care information system. The NCCIS is a project within the Programme for Action for Children (PAC) and was established in March 2004 with a Project Manager has been appointed. The project is in its second phase of completing a Statement of Requirements (SOR) for sign-off process in May 2005. Consultation and requirement gathering exercises in the form of workshops, interviews, meetings etc are currently taking place in all regions and will continue until May of this year to agree on : Definitions Project – a standard set of definitions A Single National Business Process A census methodology for staffing, financial and family support data Review and/or leverage requirements against the current enterprise system It is planned to prepare tender documentation to procure/design the information system by the fourth quarter of 2005. The new Youth Homeless Contact Forms are being used for the quarterly returns from the Health Service Executive areas since 1st January 2004 and in the annual returns submitted for 31st December 2004 with the Interim Dataset. The Interim Dataset figures for 2004 are returned in April 2005 for publication in September 2005.

Areas where progress made/proposed to address data or indicator issues	A Statistics sub-group recommended the introduction of a new Youth Homeless Contact Form as a way of gathering more reliable and consistent statistics. The Department of Health & Children circulated the form to the Health Boards in December 2003 for introduction on 1st January 2004. Included in these forms is an agreed interpretation of youth homelessness definitions to ensure that statistics on Youth Homelessness are collated consistently across all health boards.
Data/Indicator Deficiencies	Data re youth homelessness outside Dublin (statistics from the new data forms mentioned above) are being examined.

Target 6	Aim to improve access to planned respite care for carers of disabled people by 2003
Summary Assessment	In progress
Will Target be met on time	Has been met
Indicator (s) ?	Level of access to respite care.
Progress being made	In recent years there has been a continued expansion of residential support services (respite) for people with intellectual disabilities, in particular planned or emergency centre based respite services. Additional funding is being provided in years 2005-2009 to further enhance these services. The current figures for people availing of or requiring a respite place are as follows: • Intellectual Disability Database Report 2004 shows 3, 978 receiving a service, an increase of 357% in number of individuals since 1996. 1,763 new places are required in the period 2005 to 2009. • Physical and Sensory Disability database report 2004 shows 2,838 people in receipt of a respite service. 8041 require a service from 2005 to 2009 but this includes summer camp and holiday respite. Figures on database are preliminary and incomplete as two former health boards in the eastern region are not included and the database is not complete in all HSE areas. The statistics for physical and sensory disability are the first available statistics and so there is no existing baseline against which to compare them. • Budget 2005 provided for o The Respite Care Grant extended to all Carer's providing full-time care to an older person or a person with a disability, regardless of means, subject to certain employment related conditions. (June 2005) o Respite Care Grant increased by €165 from €835 to €1,000 in respect of each care recipient. (June 2005) o Limit of payment of Respite Care Grant to only two care recipients abolished. (June 2005)
Areas where intended implementation not being	

achieved	
Data sources used to monitor progress	Number of people availing of the service.
Areas where progress made/proposed to address data or indicator issues	**See progress being made above**
Data/Indicator Deficiencies	

Target 7	By 2003, national guidelines will be put in place for the provision of respite care services to carers of older people.
Summary Assessment	Insufficient
Will Target be met on time	No
Indicator (s) ?	National Guidelines
Progress being made	The issue of guidelines for the provision of respite services to carers of older people will be referred to the Health Information and Quality Authority (HIQA) which is in the process of being established. The Board of the Interim Authority had its first meeting in March.
Areas where intended implementation not being achieved	No guidelines to date.
Data sources used to monitor progress	Published guidelines
Areas where progress made/proposed to address data or indicator issues	
Data/Indicator Deficiencies	