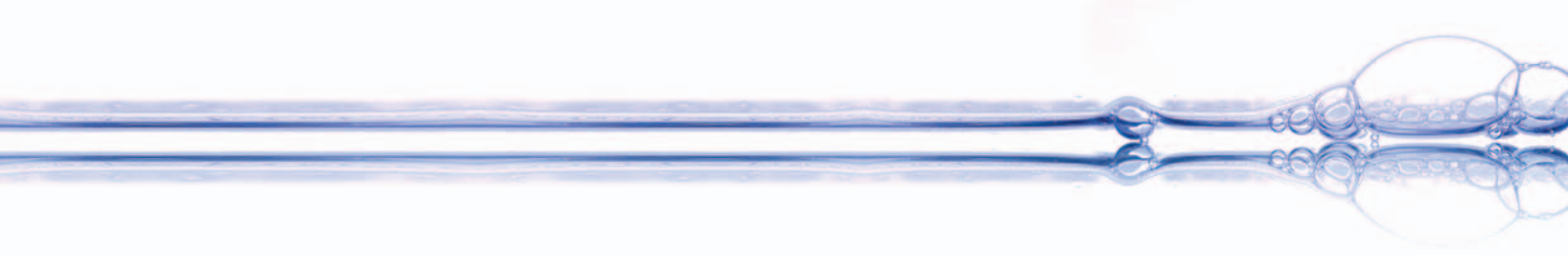


Putting the Learning to Use:
Inequalities in Health and Wellbeing





Putting the Learning to Use: Inequalities in Health and Wellbeing

Commissioned by IfH North and West Belfast Community of Interest Inequalities in Health

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for

Investing for Health Eastern Area Partnership Community of Interest - Inequalities



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Note: Report Format - The text found in the boxes at the side of the report are a series of points which a range of readers may find significant and which contribute to the recommendations.



Executive Summary

This report is based on evidence contained in hundreds of research reports and peer-reviewed journal articles about the causes of health inequalities nationally and internationally. In that large body of literature, it is difficult to find evidence, whether from the World Health Organisation, the EU, the UK or Ireland of effective interventions that work to reduce inequalities in health that are not aimed at reducing the broader inequalities in society. This confirms the validity of the approach originally taken by the *Investing for Health* Strategy and indicates that this approach should be maintained.

North and West Belfast is an area characterised by high rates of poverty and ill-health, exacerbated by the impact of over 30 years of conflict. These interact with each other to produce a population that experiences huge levels of social distress which manifests itself in high levels physical illness and of mental ill-health, particularly depression and anxiety.

As well as alarmingly high levels of disability and ill-health and particularly mental ill-health, the area also has high levels of dependence on benefits, economic inactivity and people without any qualifications. This means that for many paid employment, which is increasingly presented as the only route out of poverty, is not an option. The potential for employment is further limited by the scarcity of public services, in particular childcare, care services for people with disabilities and transport. The lack of good quality, well-paid work was also seen as an obstacle to employment providing a route out of poverty.

It is important to emphasise that the messages which we have come to accept will help to tackle health inequalities: don't smoke; eat lots of fruit and vegetables; stay active; manage your stress; use alcohol in moderation etc are backed up by research evidence only in so far as they help to improve health generally. Even when these 'lifestyle' factors are taken into account, however, living on a low income will still result in health differentials.

The international literature is clear that what works to tackle health inequalities in any society is reducing the general level of inequality in that society. While waiting for the high-level policy changes needed for that to happen, we can say that improving income adequacy does help to improve health among people experiencing poverty by reducing the stress with which they live. Methods of increasing income within the confines of present policy measures are, therefore, worth promoting. Reducing stress generally can also help to reduce health differentials between those in low-paid, low-status jobs and those in better-paid, higher-status positions.

Within North and West Belfast, there are a range of programmes and projects that are working to alleviate the worst impacts of poverty and ill-health. Some of these are described in the report. However, there is little evidence that these are likely to impact on differentials in mortality and morbidity.

Strategic Policy Recommendations

Acceptance that socio-economic inequality is the main cause of health inequalities means that policy and practice in relation to reducing inequalities in health must address the broader inequality in society. [page 7 and literature review]


Policy makers must be convinced that inequalities in Northern Ireland generally, but particularly in North and West Belfast, have to be addressed and that reducing these socio-economic inequalities must form the basis of any plan to reduced health inequalities. [pages 8-12]

The economics of healthy eating need to be addressed. Income adequacy and access to affordable, healthy food must be provided if programmes on healthy eating are to be truly effective. [pages 11-12]

Welfare reform measures introduced in Northern Ireland should include special measures which take account of the particular circumstances of the region particularly, or at a minimum, those areas that have been most impacted by the conflict. [pages 21-25]

If welfare to work measures are to have any success, they must be linked to the provision of services – such as transport, childcare and services for people with disabilities – that will facilitate paid employment. [pages 22-24]

There is a serious and urgent need to develop long-term funding strategies for community-based services that seek to address poverty and its effects on mental and physical health, education, family life etc. The particular cumulative disadvantage faced by the communities in North and West Belfast need to be taken into account in regional funding allocations. Community provision of health and health-related services must be additional and complementary to statutory services, not substitutes for services which are being cut. Funding for community-based preventative work, whether carried out by statutory or community organisations, should be ring-fenced and protected. The impact of other community work e.g adult learning, on health outcomes needs to be acknowledged and integrated funding packages provided. [pages 31-32 and passim]



An integral part of policy development must be the production of evidence on which policy can be based. This means that evaluations need to be more robust and to provide clear evidence of what works and what does not. It is recommended that, as part of policy and practice implementation, the Department of Health, Social Services and Public Safety, as the lead Department working with and across other government departments, needs to develop independent evaluation structures for community-based projects. [passim]

The interactions between poverty, conflict, disability and ill-health, a low wage economy and employability requires greater attention by policy makers. In particular, those who make policy in relation to employment and the economy need to understand the links between this range of issues. More research may be needed that focuses more clearly on the employment end of these interactions. [pages 21-25]

Practical Recommendations

One of the difficulties faced in the course of this research was the absence of evaluations for many of the health-related initiatives underway in North and West Belfast. Small, poorly-funded community organisations cannot prioritise evaluation and, when the costs of evaluation are built into a programme, there is an imperative on the part of the, usually freelance, evaluators to produce a supportive evaluation report. This suggests there is a need for independent evaluation structures that can provide baseline data and evaluate the impact of programmes, including negative as well as positive lessons learnt, in order to ensure that we can really quantify the impact of initiatives aimed at reducing health inequalities. [page 9-10 and passim]

A targeted advertising initiative and pension credit take-up campaign is needed to address the misunderstanding of the basis of pension credits as compared to other tax credits and to reassure pensioners that no clawbacks will happen.

When pilot initiatives – such as the Fresh Fruit in Schools which promoted healthy eating – are shown to work, they should receive ongoing funding and be rolled out in all areas and for all households. Throughout this report, there are models of good practice, all of which face problems in accessing long-term funding. Further, because they have been shown to work in a particular area, it would be hard for other areas to receive funding to replicate the work, since it would not be a pilot project. This 'Catch 22' situation in relation to funding has to be addressed.

Health-related information leaflets need to have more visual cues for those with literacy problems. [page 32]

GPs and diabetes' clinics should have the names of people in the area

with different kinds of diabetes who manage the disease well. They could then be asked to 'mentor' newly diagnosed diabetics until they are confident about managing the disease themselves. [page 27]

The expert patient programme needs to be better promoted and, perhaps, given a more 'friendly' title. [page 27]

Partners in the Investing for Health North and West Belfast Community of Interest Inequalities

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Introduction



Since 1978 when the WHO's Declaration at Alma-Ata stated that "the existing gross inequality in the health status of the people ... is politically, socially and economically unacceptable", the reduction of health inequalities has made its way onto the policy agenda of governments across the world, including the UK and Ireland.

The evidence is clear that it is the level of socio-economic inequality in any given society – the size of the gap between the richest and the poorest in particular – that best predicts the level of health inequalities. Thus, we find that the life expectancy among black men in the United States is 9 years shorter than for men in Costa Rica, despite the US having a median income four times as high as that in Costa Rica¹. Further, the lower down the social order one is, the greater the chance that one will be involved in 'risky' health behaviour such as smoking or not taking regular physical exercise². This evidence is presented in detail in Appendix 1.

In Northern Ireland, what that means is that the fifth of the population who are most well-off have a life expectancy among the best in Europe. For the poorest fifth, life expectancy is closer to that of people in Eastern European countries³. It has been estimated that about 2,000 lives could be saved each year in Northern Ireland if those living in the District Council areas with the highest death rates (the poorest areas) enjoyed the same level of health as those living in the District Council areas with the lowest death rates (the best-off areas)⁴.

Acceptance that socio-economic inequality is the main cause of health inequalities means that policy and practice in relation to reducing inequalities in health must address the broader inequality in society.

For example, study after study has shown that mental ill-health in particular is worsened by the stress of living with poverty and debt⁵. The main, if not only, path out of poverty offered to people with mental health problems is employment; but the possibility of becoming well enough to consider paid work may be ruined by the stress of living on meagre benefits.

It is difficult to find evidence, whether from the World Health Organisation, the EU, the UK or Ireland of effective interventions that work to reduce inequalities in health that are not aimed at reducing the broader inequalities in society. This confirms the validity of the approach originally taken by the *Investing for Health* Strategy and indicates that this approach should be maintained. Unfortunately, Our Healthier Future, the 20 year vision produced by the Dept of Health tends towards a more medical and 'lifestyle' approach.

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Investing for Health, on the other hand, encourages a more participatory approach that recognises and addresses the socio-economic determinants of health such as income inequality, substandard housing and the stress these generate.

Deprivation in North and West Belfast



North and West Belfast contains several of the most socio-economically deprived areas in the UK or Ireland. 24 of its 28 electoral wards are deprived to some degree, 16 of them severely deprived. Inevitably, then, there is very poor health among some of the population, with Standardised Mortality Rates for the area considerably above the NI average. There are other reports dedicated specifically to providing information about the socio-economic and health profiles of North and West Belfast. In particular, the North and West Belfast HAZ has produced a profile of health inequalities and a socio-economic profile of the area. These are available to download on www.haz-nwbelfast.org.uk.

What the facts and figures in these profiles cannot convey is the impact on the residents of the area of layers of disadvantage resulting from poverty, ill-health and the impact of over 30 years of conflict. These layers interact with each other to produce a population that experiences huge levels of social distress which manifests itself in high levels of mental ill-health, particularly depression and anxiety.

The 2001 Census shows the area covered by the former North & West Belfast Health and Social Services Trust contains over 143,000 people, of whom one in four are less than 16 years old and one in five aged more than 60 years old. The natural geographic area of North and West Belfast, however, contains closer to 200,000 people given the community links with Twinbrook and Poleglass to the west and Newtownabbey to the east.

The unemployment rate, including the youth unemployment rate, in North and West Belfast is higher than any other part of Northern Ireland, with a large proportion unemployed for over two years. Despite growing numbers of jobs in the area, the economic activity rate remains below 50%, lower than the average for Belfast and considerably lower than the average for Northern Ireland which is around 60%. Such low economic activity rates reflect the high level of social distress. They also mean that there is a high level of dependence on state benefits in the area and, therefore, high levels of poverty and severe poverty. The North and West Belfast area contains a criss-cross of 'peace walls' dividing one community from the other and some areas can only be accessed by travelling through an area seen as 'the other side'.

There is growing evidence internationally of the impact of environmental factors on health. In particular, the quality of the air near arterial roads and motorways has been found to contribute to high incidences of some cancers, and of diabetes and heart disease⁶. In 2003, Belfast City Council, in partnership with Belfast Healthy Cities, carried out a health impact assessment of air quality in the city. Not surprisingly, it found that air quality around the M1 and Westlink was very high in pollutants that impact on health. Exposure to these pollutants shortens people's lives, increases admissions to hospital from respiratory and cerebrovascular causes, and increases asthma symptoms and the use of bronchodilators (inhalers)⁷.

The statistics that describe the difficulties faced by the residents of North and West Belfast in relation to poverty and inequality give us a better picture than is the reality for the poorest on the ground. In spite of having five of the ten most deprived wards in NI, it has some wards that are relatively well-off. So, the fact that most of these figures are averages mean that, however bad those averages seem, the reality for the bottom fifth is far worse.

This means that ways must be found to impress on policy makers that the socio-economic inequalities in Northern Ireland generally, but particularly in North and West Belfast, have to be addressed and that reducing these socio-economic inequalities must form the basis of any plan to reduced health inequalities. In the meantime, however, there is much good work underway in North and West Belfast to help people cope with the worst impacts of socio-economic, and subsequent health, inequalities.

Methodology

The initial brief for this secondary analysis of research called for a review of literature, to include international evidence as well as evidence of local practice, evaluation reports, etc from the wide range of health-related projects in North and West Belfast. In particular, the literature review was to concentrate on poverty, low income (un/employment) and fuel poverty. However, once the work started, it became clear that much of the work being carried out is not being written up, indeed cannot be due to the severe under-staffing and under-resourcing of many projects. As a result, the methodology was adapted instead to interview staff in a range of health and health-related programmes and projects, as well as collecting any literature that was available, in order to find out what is happening on the ground across North and West Belfast. The interviewees were generally the co-ordinators of their project or partnership. They were asked about the work their organisation carries out and how it impacts on health inequalities; how the need for that work was identified; the level of resources they have and what they need. They

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were also asked to signpost the researcher towards other projects that seek to impact on health inequalities.

In the course of these interviews, informants returned again and again to the impact of the conflict on the health and functioning of their communities and to the desire within those communities to protect children from the worst impacts of growing up in poverty. Almost all of the informants were working at the time to produce their area’s Neighbourhood Renewal Action Plans and clearly had invested a great deal of time, effort and hope in the Neighbourhood Renewal Strategy as a vehicle for addressing deprivation in their areas and for funding of community-based projects.

The views of four groups of people experiencing poverty were sought as part of the study. A group of parents, a women’s group, a group of young men and a pensioners’ group were consulted; two of these groups came from a Catholic area, one from a Protestant area and one was mixed. In all, 23 people experiencing poverty were consulted. They, too, raised the impact of the conflict on health inequalities in their areas.

Once the interviews were analysed, it became clear that the focus of the report would have to go beyond poverty, low income (un/employment) and fuel poverty, and their impact on health inequalities, to include discussion of the impact of child poverty and of the conflict and to examine the potential of the Neighbourhood Renewal Strategy to help in tackling health inequalities in North and West Belfast.

Poverty and Ill-health in North and West Belfast

Given the high levels of dependence on state benefits in North and West Belfast, the low educational qualifications of many of the residents and the generally low wage economy in Northern Ireland, it is not surprising that there is a general concern with the lack of adequate incomes for all residents but particularly for larger families and single people with no dependent children. Larger families are at particular risk of living in severe poverty and so have an increased likelihood of health challenges.

North and West Belfast has a high rate of long-term limiting ill-health and disability and high numbers of residents providing unpaid care to family members and neighbours. The international literature (see Appendix 1) emphasises the interaction between the financial strain caused by low incomes and caring responsibilities and the stress resulting from that interaction. The impact of this stress includes a considerably greater likelihood of being a smoker and of smoking more.

Evidence of the impact of stress on physical health, especially on heart disease and diabetes, has only relatively recently been widely disseminated in non-specialist medical journals. For example, control of blood glucose levels has been closely linked to stress in studies of type 1 and type 2 diabetes⁸. While the mechanisms for this association are unclear, they are clearly not entirely behaviour related since there is evidence that stress management can result in modest but sustained reductions in glycemic control that are not associated with changes in other health-related behaviors such as diet or exercise⁹.

As a result of the interaction of the stress of living on a low income and living in an area where the conflict was at its highest, rates of disability and ill-health are as much as double that of the NI average – which is, in itself, among the highest in the UK. That these limiting conditions are significant is illustrated by the high levels of receipt of Disability Living Allowance (DLA). DLA is a benefit awarded only after detailed and rigorous assessment. As can be seen in the table below, which details levels of ill-health in some Neighbourhood Renewal Areas of N&W Belfast it is the areas that suffer from both poverty and the legacy of the conflict that have the highest levels of disability and ill-health, and receipt of DLA.

Area	% with long-term limiting illness/ disability	% in receipt of Disability Living Allowance
Greater Shankill	35	18.2
Inner North	32.5	19.8
Upper Springfield/Whiterock	29.5	22.2
Falls/Clonard	29.4	20.1
Northern Ireland	21.3	9

Note that DLA is a benefit which has to be awarded before pension age. After pension age, the equivalent benefit is Attendance Allowance. This may explain why in some areas, despite higher levels of long-term limiting illness and ill-health, there are lower levels of receipt of DLA. For example, in the Greater Shankill 26% of the population is over 60; this compares to Upper Springfield/Whiterock where just 12.4% of the population is over 60.

Another way in which an inadequate income impacts on health is through a poor diet. There is considerable evidence that this is the case across every region in the UK and Ireland, but the cost of food in Northern Ireland is considerably higher than in Britain, even than London and the South East. The Family Spending Survey found, for example, that the average amount per household spent on food is 20% higher in the North of Ireland than in the North East of England. Even taking the larger household sizes into account, the cost of basic

foodstuffs is considerably higher in Northern Ireland.

Healthy Living Centres and SureStart provide Cook It! classes with information about cheaper, healthier cuts of meat and other ways of stretching the food budget. But research on food poverty finds that many mothers see these as unrealistic because, on a very low income, they cannot afford any waste. People experiencing poverty do not eat as well as those who are better off, but spend a larger proportion of their incomes on food.¹⁰ Research in Northern Ireland found that the type of retail outlet accessible to individuals determines the availability of the range of foodstuffs and the prices paid for food. Location of large multiple supermarkets, often on the edge of cities and towns, combined with inadequate public transport, means that those on the lowest incomes are frequently unable to access the cheaper food in such supermarkets. Instead, they have to rely on smaller, local shops which are up to 40 percent more expensive. High levels of households without access to a car in Northern Ireland exacerbate this lack of access. Those groups that are at particular risk of food poverty are also most likely not to have access to a car.¹¹ While parts of North and West Belfast are well served by the large multiples, other areas are dependent on expensive local shops.

It is important that the economics of healthy eating are recognised. Healthy Living Centres and schools can give children the opportunity to taste healthy foods but, if their parents cannot afford to buy it, the children will get mixed messages which may negate much of the good work done elsewhere. Therefore, adequate incomes are vital to promoting healthy eating and programmes to promote healthy eating are likely to be truly effective only if and when poverty is greatly reduced.

Child poverty in N&W Belfast



The boldest commitment from the current U.K. Labour Government was its determination to eliminate child poverty within a generation—defined as 20 years. Poverty leads to ill-health and together these have a devastating effect on the life chances of children and young people who live in poverty. Children born to poorer families in Northern Ireland are more likely to be smaller and to die at a higher rate than children born to better-off families.¹² Children living in poverty are 15 times more likely to die as a result of a house fire. They are five times more likely to die in accidents and four times more likely to die before the age of 20¹³.

Given such a clear commitment from government, it would be expected that all strategies that deal with poverty would have clear, interlinking, targets and 'SMART' objectives in relation to child poverty. However, an examination of a range of government Strategies from *Investing for Health*, to the *NI Strategy for Children and Young People*, the *Neighbourhood Renewal Strategy* and *Lifetimes Opportunities* reveals that only *Lifetime Opportunities* (the Anti Poverty Strategy for NI) contains any clear targets in relation to child poverty. Even there, the targets that are set are not SMART (Specific, Measureable, Achievable, Relevant and Timebound).

Thus, child poverty is an example of the lack of 'joined up' policy making which has an inevitable impact on the lack of 'joined up' work on the ground.

Children from poorer families are less likely to eat fresh fruit, wholemeal bread, lean meat, oily fish – all of which are recommended for healthy living¹⁴. Inability to afford a healthy diet means that young people from poorer families, especially boys, have lower intakes of energy, fat, and most vitamins and minerals.¹⁵ Children who are poorly nourished are more likely to suffer ill-health and to be obese. Children who come to school without breakfast and are hungry are less likely to benefit from school and to learn well. So, beside blighting their childhood, growing up in poverty means a child is less likely to get the most out of school, and therefore to end up spending more time out of work or in low paying jobs as an adult. The five primary schools with the highest level of entitlement to Free School Meals (FSMs) in Northern Ireland are all located in North and West Belfast. In these schools, over three quarters of the children are entitled to FSMs. Free School Meals are a good indicator of child poverty levels since they are now available only to the children of families receiving income support or means-tested Job Seeker's Allowance.

The high rates of suicide among young people in North and West Belfast have been the subject of concern and the catalyst for the NI Suicide Prevention Strategy.

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Suicide rates among 15-24 year olds are almost three times higher in the lowest income groups than in the other groups combined¹⁶.


The trajectory that leads these young people to take their own lives starts when they are little more than toddlers. Even at 22 months, children of parents in social classes I/II with higher educational levels are already 14 percentage points higher up the scale of educational development than children of class IV/V parents with low educational attainment¹⁷.

There is growing evidence that how children experience school is determined by the level of disadvantage they face. Research suggests that poorer children get used to the fact of their social position from a very early age; they accept that this will be reflected in their experience of school; that they are not going to get the same quality of schooling, or of outcomes as better off children. In short, the education system teaches them that they are worth less than better off children. As teenagers, they are blamed for hanging about the streets doing nothing when there is nothing for them to do in their areas¹⁸. Many feel the community they live in see them as a problem and place a negative value on their potential to contribute to the community¹⁹.

There is a range of activity in North and West Belfast that aims to alleviate the impact of growing up in poverty on children's lives. Much of this work is genuinely inter-sectoral. The work of SureStart is relatively well known. Sure Start Partnerships bring together community groups, childcare and statutory organisations to provide a range of services including crèches, parent and toddler groups and speech therapy to children under 4 and their families. Programmes for parents include parenting skills, child safety and Cook It. SureStart also provides services aimed especially at fathers. These services are supposed to be additional to services already provided.

SureStart services are universal and therefore open to all families but the Partnerships also provide additional support for those families who require them. All the services that are provided by SureStart across N&W Belfast can be seen to be alleviating some of the worst impact of child poverty. For example, the NI Poverty and Social Exclusion report found that 28% of children live in families that cannot afford a week's holiday each year; one in two children who live in severe poverty cannot even get away on a day trip. Clan Mór SureStart provides day trips as part of its summer scheme, which helps to overcome this.

Less visible in relation to tackling the impact of child poverty is the work of several of the Healthy Living Centres in schools in their areas to encourage healthy eating and physical activity among children. Worthy of particular mention is the self-esteem work being carried



out in primary schools by the Newlodge-Duncairn Healthy Living Partnership.

Model of Good Practice - Children's Health

Newlodge-Duncairn Healthy Living Partnership is based in an area that has higher than average levels of ill health, disability and teenage pregnancies, as well as earlier deaths due to poverty and ill-health. In 2002, it received five-year funding from the New Opportunities Fund's Healthy Living Centre Programme, as well as some funding from the Belfast Regeneration Office and Eastern Health and Social Services Board. Two of the Partnership's initial programme objectives related to children and young people. They were:

- To build on existing initiatives and develop new schemes to enable children to have a better start in life
- To enhance opportunities and develop additional schemes so that young people have the opportunity to make informed choices in respect of their health and personal relationships

Much of the work of the partnership in achieving these objectives is carried out in schools. They have a massage in schools programme that teaches children basic massage techniques to help them relax and to improve self-esteem. The Partnership produced an "Esteem Building Workbook" aimed at primary school children and deliver training to teachers in its use. The workbook helps children to talk about feelings, about friendships and about how different people can see the same event differently. It helps children to develop listening skills and approaches to solving problems, as well as to learn basic relaxation techniques. It also works to provide anger management support for teenagers who need it.

The Partnership also works with schools, community groups and summer schemes to encourage children to eat healthy food, particularly fruit. Working with the local SureStart, they run a Cook It! Programme and provide fruit to young families whose children are not yet at school. Physical activity is also encouraged through its support for Multinastics going into primary schools in the area and it funds a local community group to provide swimming classes for children.

The Co-ordinator says "work with children has the most long-term impact". However, given that any evaluation of the impact of these programmes will be available only in the long-term, we cannot yet be assured that this is the case.

Fuel Poverty



The 2001 Housing Conditions Survey found that 203,000 households (33% of all households) in Northern Ireland were in fuel poverty; 114,000 children lived in fuel poor homes. This compares with 9% of households in England and 13% in Scotland that were fuel poor in the same period. Levels of fuel poverty in Wales were similar to Northern Ireland at 31%. While by the publication of the 2004 Housing Conditions Survey, the proportion of households in fuel poverty had fallen to 24%, equivalent to 150,000 households, this was before the sharp rise in oil and gas prices in 2006 which will have sharply increased rates of fuel poverty again. Nonetheless, the 2004 figures show more than 4 in 10 of all pensioners, one in four single adults and one in five lone parents living in fuel poverty in NI. Given the high levels of deprivation in North and West Belfast, the proportions of people in the area suffering fuel poverty are likely to be considerably higher.

The 2003-4 Family Spending Survey (before the price rises) found fuel costs in Northern Ireland were 143% of the UK average at £16.90 a week, compared to £11.80 a week in the UK generally.

Fuel costs in Scotland and Wales are higher also, but the difference is nothing like as great, at £12.10 a week in Wales (102.5% of UK) and £12.40 in Scotland (105%). The NI Housing Executive estimates that if fuel prices had been the same as in England, 43,000 households would have been removed from fuel poverty in 2001.²⁰

Lifetime Opportunities, The Government's Anti Poverty and Social Inclusion Strategy for Northern Ireland includes targets to ensure that, by 2020, every child and young person and pensioner will live in a 'decent', warm home and that working age adults will have access to a 'decent fuel efficient home'. However, there is no target to ensure that the families in these decent warm homes will not have to spend an unacceptable amount of their income on fuel and, to date there are no clear 'SMART' objectives to move towards the targets set, nor the goal of eliminating fuel poverty.

The Warm Homes Scheme is the principal method through which the *Ending Fuel Poverty Strategy* sees its targets being met. The Warm Homes Scheme targets those households most vulnerable to cold-related ill-health and is available only to those who own their home or rent from a private sector landlord and who receive certain social security benefits. Thus, it excludes a large section of families with children: those who are in employment but living in poverty.

The Warm Homes Scheme has been shown to be highly effective in improving energy efficiency in the home through the provision of insulation, heating measures and energy advice. However in focus

groups with women's and pensioners' groups, the feedback on the Warm Homes Scheme while positive nonetheless pointed to the continuing difficulties people living in poverty have in keeping their homes warm. Those with oil central heating complained of the high costs of filling a tank; some gave examples of buying small amounts of heating oil at what amounted to exorbitant prices because of the premium they had to pay. This often meant paying a third more again than would be paid by someone buying a tankful of heating oil. Some who have gas meters complained that, if their meter card runs out over the weekend, they can be left with no heat until Monday.

The NIHE's 2004 Housing Conditions Survey report reinforces this point and emphasises that, even if every dwelling is given an efficient heating system and is insulated to the highest standards, it does not mean that fuel poverty will be wiped out. "Low income will remain a primary determinant of whether a household is still in fuel poverty".

Model of Good Practice - Northern Exposure

As part of Investing for Health's strategy to combat fuel poverty in Northern Ireland, a range of projects offering a variety of anti-fuel poverty measures have been developed across the region

Research into poverty levels in Belfast has consistently demonstrated that North Belfast contains a disproportionately large share of vulnerable households. The scheme developed to combat the high levels of fuel poverty within the area is Northern Exposure. This scheme is aimed at the private sector in North Belfast, both owner-occupiers and renters, and is available to those households which meet certain income or benefit requirements.

The scheme is designed to supplement the current statutory schemes in place i.e. Warm homes and Warm Homes Plus. It is able to reach more households than those schemes since the eligibility limits are more inclusive; in addition, the remedies offered are wider.

Households in receipt of any means tested benefit or living on a low income (defined as £12,000 – 15,000 p.a. depending on circumstances) qualify under the scheme and those receiving non-means tested benefits such as DLA and Attendance Allowance would also qualify.

Under the scheme, the remedies available include: installation of an entire new heating system if the applicant either doesn't currently have a central heating system or system replacement if the property in question has either Economy 7 or solid fuel. Households may also be entitled to a series of insulation measures such as cavity wall insulation, loft insulation and, uniquely to this scheme, replacement oil boilers and Thermostatic Radiator Valves, which allow each

"the NIHE's 2004 Housing Conditions Survey report emphasises that, even if every dwelling is given an efficient heating system and is insulated to the highest standards, it does not mean that fuel poverty will be wiped out. "Low income will remain a primary determinant of whether a household is still in fuel poverty"

radiator, and therefore each room, to have a separate heat and are easy to operate.

Northern Exposure is a three year project. It commenced in April 2006 with a target of 40 households in 6 electoral wards for the first year. Year 2 which commenced in April 2007 has a target of 165 households and has expanded to cover all of North Belfast.

The main challenge has been advertising the scheme; experience suggests that the most effective way of doing this is spreading the word amongst the existing local community infrastructure. The number and diversity of community groups in North Belfast is useful in this regard.

Impact of Conflict



In common with other conflict-torn societies, those living in poverty suffered most in the course of “the Troubles”. Most of the deaths were concentrated in fewer than ten postal code districts; over a third of those who died lived in five postal districts, all of them in North and West Belfast. In fact, a map of the areas where poverty is most concentrated matches very closely the map of areas where the conflict has been most intense²¹. In the Poverty and Social Exclusion NI (PSE NI) survey, half of all household respondents said they knew someone who had been killed in the conflict²². The impact of conflict goes beyond the question of knowing someone who was killed. The shock of witnessing a violent event; being raided by the security forces – even living close to a house that was raided regularly; being forced to move house; fear of travelling out of one’s own area: these have had a major impact on virtually everyone living in North and West Belfast.

While “the war is over”, the psychological damage of conflict continues. As the Dunlop Report commented in relation to North Belfast:

“Fear is an everyday reality with people being careful about where they walk, shop, socialise, work and travel lest they be physically or verbally attacked. For example out of a total of 136 houses in Belfast vacated due to social unrest between July 2001 and March 2002, 131 were in North Belfast. (p.21)

The psycho-social hangover of the conflict is worst in North and West Belfast, since it suffered most in the course of the conflict. Every professional and community worker interviewed kept returning to the issue. In focus groups with people living in poverty, the question of the legacy of the conflict and of ongoing high levels of fear was raised again and again. Much of this fear is perpetuated by high levels of segregation and by the ‘peace walls’ that seem to be everywhere in N&W Belfast. Segregation impacts on access to public services also,

with fear of travelling into the 'other' area leading to some people experiencing poverty saying they have difficulties accessing health and leisure centres, facilities for disabled people, childcare, even benefit offices. Nonetheless, all expressed a clear desire to move towards a more 'normal' society where there is less fear of the 'other'.

One of the insufficiently recognised legacies of the conflict is the high level of disability and ill-health, and subsequent care needs, in the population. As the table below shows, Northern Ireland generally has a high proportion of unpaid carers, with a large proportion of these providing high numbers of hours care principally to family members.

Long-term illness/disability and provision of unpaid care (%)

Region	Long-term limiting illness/disability	Providing unpaid care	Providing 50 or more hours unpaid care
United Kingdom	18.5	10.0	2.1
Northern Ireland	21.3	14.7	3.6
England and Wales	18.2	10.0	2.1
Scotland	20.3	9.5	2.3
NE England	22.7	11.0	2.7

Source: Census 2001

Levels of mental ill-health in Northern Ireland are higher than elsewhere in the UK or Ireland. The number of people in Northern Ireland receiving Disability Living Allowance (DLA) for mental health reasons in 2006 was 2.9 per cent of the total adult population. This is three times the comparable figure for GB (0.9 per cent) and has more than doubled since 1998, when 1.2 percent of the total adult population received DLA for mental health reasons. Other evidence that suggests a growth in the extent of mental ill-health in Northern Ireland is the 33 per cent rise in the number of anti-depressant prescription items issued in the five years from 2000, to 1.4 million in 2005, equivalent to 0.75 prescription items per head²³.

There is a growing body of evidence that high levels of mental ill-health are significantly related to the conflict. Variation in intensity of political violence between different areas of Northern Ireland has been linked to area differences in the level of psychological disorder²⁴. People in poorer households were found to be more likely to suffer significant health stresses and also more likely to have borne the brunt of "the Troubles"²⁵. Recent research from the University of Ulster reports that many people who were resilient during the conflict are now suffering psychological distress²⁶.

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There is a host of organizations within North and West Belfast that are trying to address the social and psychological distress that so pervades the area. Community groups, women's groups, Healthy Living Centres, all provide a range of complementary therapies to help relieve stress and most can signpost those in greatest distress to counselling or mental health services when required. Complementary therapies have tended to be seen as 'for women only'. However, several community organizations reported that the local ex-prisoners' group had started to use these services and, as a result, it has become easier for other men to use them.

It is virtually impossible to assess the effectiveness of these services since the outcomes tend to be "soft" and not subject to measurement. However, users are highly enthusiastic about the provision of complementary therapies and say their mental health would deteriorate if these were not available to them. While the value of these therapies may be more in relation to short-term relief of stress rather than addressing underlying mental health issues, they are nonetheless clearly valuable to those who use them. However, most of these projects have short-term funding and it is unclear whether they are going to be able to continue their work when this funding runs out. Given that levels of psychological distress seem to be deteriorating rather than improving, it is vital that funding is found to enable these services to continue over the next decade.

Model of Good Practice - Suicide Prevention



PIPS – Public Initiative to Prevent Suicide and Self-harm – emerged from the North Belfast Health and Social Well-being Forum in 2003. The name was originally chosen because it was recognised that "although statistics were an alarming and driving factor, they should not obscure the individual experience of tragedy. 'PIP' was the nickname of one young person who died through suicide and was chosen to keep the focus...on real people and their suffering". It works with families who have been bereaved by suicide, providing a menu of complementary therapies, art therapy and bereavement counselling. PIPS's advice workers visit the home of a bereaved family within 24 hours of a suicide and provide information and support including a link for recently bereaved families with a family that is longer bereaved. It received funding from URBAN II and N&WBHSST.

PIPS also works with people involved in self-harming behaviour and with a range of partners to help people to stop self-harming. Counselling is available through PIPS's partnership with ICPD. They also work to provide support for the carers of people who self-harm.

PIPS works with schools to train up ten mentors in each school. These mentors are “not mini-professionals” but can provide sign-posting to services for young people who are at risk of suicide or self-harm. Working with Opportunity Youth, PIPS can ensure that young people who are at risk can receive personal development courses and mentoring services to raise their self-esteem and reduce their distress.

PIPS has provided ASIST training to some 600 people in North and West Belfast. The ASIST curriculum includes suicide intervention skill development, trainer protocols to address vulnerable or at risk participants and knowledge of local resources that could be accessed to provide support for people who have thoughts of suicide or self-harm. This training used to be provided only by Community Psychiatric Nurses but through PIPS’s training for trainers is now provided by volunteers – which means that more people can be trained up to provide preventative support.

The work of PIPS has influenced policy in the area of suicide prevention, including the *Protecting Life* Suicide Prevention Strategy for Northern Ireland.

Employability in N&W Belfast

The high levels of unemployment, including long-term unemployment in N&W Belfast are an area where ‘joined up’ policy and practice is necessary. West Belfast has the lowest Jobs Density Indicator (JDI) of the four Belfast parliamentary constituencies. The JDI is the total jobs in an area divided by the resident working age population; it is an indicator of the demand for labour in a particular area. A JDI of 1 would mean that there is one job for each person of working age. The JDI in West Belfast is 0.80, compared to 1.13 in North Belfast and 1.82 in South Belfast. This reflects the numbers of people who commute to work in North and South Belfast from other parts of Greater Belfast and beyond. The low JDI for West Belfast is likely to reflect the lack of investment in the area during the conflict. There has been a marked growth in jobs in the West Belfast constituency in recent years. In 2001, the JDI was 0.56 but it had risen to 0.80 by 2004, the latest year for which figures are available.²⁷

The lack of jobs within West Belfast cannot explain the high levels of unemployment, however, since parts of the area are within easy walking distance of the city centre where there are jobs available. For example, the Shankill and Clonard wards are two of the ten wards in NI with the highest proportion of Job Seekers’ Allowance claimants in July 2006.²⁸ Further, despite the relatively high JDI in North Belfast, there are nonetheless high levels of unemployment in the area. Almost all of the wards experience higher levels than the N.I. average, with two having over 10% unemployed. There are very low

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“the level of disability and ill-health in Northern Ireland generally, but particularly in the areas most affected by the conflict, has a huge impact on employability. Similarly, the conflict’s legacy of fear impacts on job seeking activities”

levels of economic activity in parts of North Belfast. Four of its eleven wards have less than 50% of the working age population in paid employment. Only one of the 11 wards exceeds the NI average for economic activity. There are 37 Super Output Areas in North Belfast; 18 of these rank in the worst 20% for employment deprivation in Northern Ireland.

There are a wide range of reasons why people in the most disadvantaged parts of North and West Belfast have such low levels of economic activity. Those reasons are interlinked and each exacerbates the other. Among them are: stress and anxiety caused by struggling to make ends meet; mental ill-health in the wake of the conflict; high ongoing levels of fear across North and West Belfast; low educational qualifications, including literacy problems; the low quality of jobs that are available at the bottom end of the labour market; lack of accessible and affordable childcare and of services for adults with care needs due to disability and ill-health, and poor public transport. This list is not complete but it does point to the extent of the problems that have to be addressed if economic activity rates in North and West Belfast are to be significantly increased. See the Employability Access Project model of good practice below for an example of what can help to improve employability. It is worth noting, however, that half of those who gained employment through EAP had to leave work due to domestic/caring responsibilities. This emphasises the need to tackle structural as well as personal issues in improving economic activity rates.

As noted above the level of disability and ill-health in Northern Ireland generally, but particularly in the areas most affected by the conflict, has a huge impact on employability. Similarly, the conflict’s legacy of fear impacts on job seeking activities. A large-scale survey of the impact of fear on North Belfast’s ‘interface’ communities collected data on over 4,500 individuals. It revealed that just one in twelve worked in areas dominated by the ‘other’ religion. 48% would not travel through an area dominated by the other community during the daytime, due to fear. Between a third and two thirds said their job seeking activities are limited by fear²⁹.

Low educational qualifications are a problem across North and West Belfast. The 2001 Census revealed that almost half of 16-24 year olds had no qualification at all; five wards in both North and West Belfast had over 60 per cent of people with no educational qualifications; in Crumlin ward 75 per cent of the population was without any educational qualifications. Again, the interaction of the impact of poverty and the legacy of the conflict cannot be ignored here. Children growing up in poverty are more likely to leave school without any qualifications. While educational disadvantage remains a problem in all disadvantaged areas, in those areas that suffered most from the conflict, those in the 30 – 44 and 45 – 59 age brackets

will have seen much of their school years dominated by the conflict around them. Across NI, 31.2% of 30 – 44 year olds and 58% of 45 – 59 year olds have no qualifications. As can be seen in the table below, which details qualifications in some Neighbourhood Renewal Areas of North and West Belfast, the proportions in areas impacted by the conflict are much higher.

Area	% 30-44 with no qualifications	% 45-59 with no qualifications
Upper Springfield/Whiterock	62.3	82.3
Greater Shankill	61.4	85.5
Inner North	59.2	83.4
Falls/Clonard	48.7	79.1
NI average	31.2	58.1

These high proportions of the population who have no qualifications will have a huge impact on the proportion likely to gain paid employment. Even low-level vocational qualifications have been shown to have a dramatic effect on the probability of gaining employment. For example, men who leave school without any qualifications and who do not go on to acquire qualifications have an employment rate of 68 per cent. If they later achieve vocational level 2 qualifications, however, their employment rate rises to 89 per cent³⁰.

A recent survey of Incapacity Benefit Claimants in the Falls and Shankill wards found that the mean age of these claimants was 48, an age which is perceived as being an obstacle to employment. Respondents to the survey saw the local labour market as a harsh environment with few jobs and dominated by low paid, insecure work demanding irregular hours, with poor transport to help access employment³¹. Many claimants question the point of working in such low-paid, low quality jobs.

The viability of taking up low-paid, low quality jobs when public services such as transport and childcare are scarce is an issue that further depresses the possibilities of people in North and West Belfast accessing employment. Research commissioned by the Equality Commission on the demand for and supply of childcare in Northern Ireland found evidence that affordability and availability were the main problems in relation to childcare for working parents. As a result, relatives and friends play an important role in providing childcare. Grandparents were found to be particularly important. Around one in five of the children of working parents, and over one in three of children aged 5-11, are cared for entirely by a relative or friend. Analysis of the costs of childcare revealed that an important reason for this reliance on informal childcare was cost. Lone parents in NI face a specific disadvantage as their earnings are about one third lower than

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the UK average for lone parents³².

In spite of these multiple obstacles, there is considerable work underway in North and West Belfast to improve employability and help people into the workforce. There is a range of targeted initiatives provided by a range of organisations. These include excellent initiatives which support people with learning disabilities into employment.

Given the above, it is important that welfare reform measures introduced in Northern Ireland should include special measures which take account of the particular circumstances of the region particularly, or at a minimum, those areas that have been most impacted by the conflict. Further, if welfare to work measures are to have any success, they must be linked to the provision of services – such as transport, childcare and services for people with disabilities – that will facilitate paid employment.

Model of good practice - Employability Access Project



The Employability Access Project (EAP) focuses on North Belfast and seeks to close the gap between employers in the health sector and those seeking employment. It was perceived by people working in North Belfast Partnership and in the Health Trusts that there was a difficulty, on the demand side, in relation to filling posts in certain grades and, on the supply side, accessing work in the health sector, despite a range of work undertaken in the past to address this. The health sector employers had found it difficult to fill vacancies in service type posts (cleaners, home-helps, domestics, catering, laundry, etc.) and were open to looking at ways to better access the available pool of unemployed people from North Belfast. Given the nature of the posts that were vacant, very often these suit unemployed people who live locally. Both the Mater Hospital and the North and West Trust were open to reviewing their recruitment policies and practices to test how these present barriers to those who are unemployed.

The EAP is funded through Equal, a programme administered through the European Social Fund which aims to test new ways of tackling discrimination and inequality in the labour market, with a view to developing new ideas to change policy and practice in employment and training. E.A.P. brings together organisations from the public, voluntary and community sectors in North Belfast with the aim of developing new and innovative training and employability programmes and policies for people furthest from the labour market in a very disadvantaged area.

The EAP offers a pre employment, personal skills development programme incorporating one to one mentoring support, job

shadowing and guaranteed interview. The programme is available to any long term unemployed or economically inactive resident of North Belfast.

The training programme provides four weeks training (it was initially six weeks) followed by two weeks work experience in either the Mater Hospital or in N.W.B.H.S.S.T. The training provides essential skills and personal development and pre-employment skills. Training takes place on three days per week over the four week period. The training runs from 9.30 a.m. until 2.30 p.m, i.e. during school hours. A key part of the process is that applicants are advised to take a finance check to look at their financial circumstances, and advice on how gaining employment will affect them financially, in terms of benefits.

Each of the participants has the opportunity to job shadow for a two week period. The job shadowing placements are either at the Mater Hospital or N.W.B.H.S.S.T. During the job shadowing, the participant will work alongside one of the Trust staff and will have the opportunity to experience the reality of working in a post that they will then have the opportunity to be interviewed for. During this period, the participant is supported by EAP staff, the member of staff being job shadowed and line management within each Trust.

To date, the project has been very successful with about half of all participants that start the programme obtaining employment in the health sector. The other half have tended to drop out of the training programme due to ill-health or to domestic responsibilities.

Neighbourhood Renewal Strategy and 'Joined Up' Thinking

It seems that most community and voluntary organisations in N&W Belfast have accepted that future funding for their activities is likely to come through 'Neighbourhood Renewal'. The Neighbourhood Renewal Strategy presents itself as being concerned with a 'joined up' approach to regeneration and tackling disadvantage, including disadvantage in health. A fundamental question for this paper is whether changes produced by urban renewal will also change population health. There is a growing body of work in Britain that questions the general presumption that urban renewal is beneficial for health (see Appendix 1). That assumption is because such renewal schemes act on working and living conditions which are, in turn, determinants of health. It may appear self-evident that improvements in health determinants for disadvantaged groups will lead to health improvement and so reduce health inequalities in society. However, this view must be considered in the light of the evidence from research on health inequalities. Otherwise, this assumption becomes a 'given' based on a perspective that is not rooted in evidence³³.

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Researchers who analysed 140 studies relating to regeneration programmes found that such programmes target specific areas and populations and are not designed to change the wider structural factors in society that contribute to social, including health, inequalities. Health is affected by many different factors, whereas neighbourhood renewal schemes often aim to tackle a more limited range of conditions that affect health. It is therefore important to be realistic about the potential for regeneration programmes to reduce health inequalities. On the other hand, they also found evidence that, in the right conditions, regeneration can make a positive contribution to health improvement and the reduction of health inequalities³⁴. Unfortunately, few regeneration programmes have been evaluated for their direct impacts on social determinants of health (measures of deprivation) or for indirect health impacts (self-reported health, morbidity, mortality)

The messages coming from the experience of neighbourhood renewal in Britain are not as positive as we might hope. Given the considerably larger budgets that were attached to such regeneration schemes in Britain, the possibility is slight of neighbourhood renewal here, which has a considerably smaller budget, making a real difference. Despite rhetoric about the 'joined up' nature of Neighbourhood Renewal action plans, the reality is that although the plans cover most relevant areas – health, education, employment, transport etc – they are divided up into separate themes and their interactions are not addressed.

It is worth noting that the parts of Britain where urban regeneration was most successful were Sheffield and Liverpool where there was effectively city governments which meant that there could be one partnership dealing with most of the main issues for poorer areas. In N&W Belfast, communities have to deal with a range of statutory agencies led by government departments that have a 'silo' attitude, each seemingly more concerned with protecting its own narrow interests than engaging in 'joined up' work and thereby merging some of its power with other departments.

Government departments need to adopt a real 'joined up' approach to tackling poverty and disadvantage if they are to promote real 'joined up' working on the ground.

The views of people experiencing poverty

All the groups of people experiencing poverty emphasised the impact of living on a low income on every aspect of their lives. With the exception of the young men's group, it was difficult to move the groups away from talking about the inadequate level of their income.

The stress caused by trying to make ends meet, and how 'low' this can make one feel, was a recurring theme. The high cost of fuel including oil, gas and electricity and the subsequent difficulties in heating the house was a particular issue with all the groups apart from the young men.

All the groups talked a lot about the conflict and its legacy in their communities; for the young men, this was mainly in relation to the impact of segregation on their lives. This was the case even for the groups that would not be perceived as from an 'interface' area. The pensioners' group did not express the same concerns about going into or through 'other' areas; rather they expressed dismay at how segregated Belfast had become compared when they were younger.

The women's group was the most aware of health inequalities and health related behavioural issues generally. They expressed enthusiastic support for community-based services that help relieve stress and reduce anxiety through the provision of complementary therapies like aromatherapy, relexology, massage and reiki. They had concerns about the scarcity of counselling services and wanted to see more such services staffed by well-qualified therapists.

There were people with diabetes in both the women's and pensioners' group. Each expressed concerns about the accessibility of information about management of diabetes. They said that they themselves were able to read and understand the literature and instructions they received. However, they had personal experience of friends or neighbours with diabetes who did not understand the basics about managing diabetes. As one woman said "it'd be easy to kill yourself by getting things wrong when you have diabetes". It was suggested that information needs to have more visual cues for those with literacy problems. It was also proposed that GPs and diabetes' clinics should have the names of people in the area with different kinds of diabetes who manage the disease well. They could then be asked to 'mentor' newly diagnosed diabetics until they are confident about managing the disease themselves. No one in the groups had heard of the expert patient programme but support was expressed for the general concept.

The young men complained that the only work available to them is in construction or call centres. They didn't hold out 'any chance' of getting an interview, still less a job, in a call centre. 'They can get fellas with degrees in the call centres, why would they take the likes of us?'. Several of them had done the one day health and safety course which is necessary to be able to work on a construction site. Their attendance on this course had been funded by one of the local employability schemes. However, they said that the only work available is 'on the lump' – which means the worker is self-employed and paid by the day. They said the daily rate is £40 a day, which is just about the minimum

"information needs to have more visual cues for those with literacy problems"

wage. They were not sure whether they would be insured against accidental injuries as a self-employed worker for a sub-contractor.

Asked about the high suicide rates among young men, the young men's group said that they thought lack of hope for their future and lack of respect in the present were among the main reasons young men killed themselves. This view was echoed in the women's group where the women said, in relation to suicide, that young people needed support to become more assertive and to value their lives. The women said that part of this had to be the older generation letting the young ones know that they valued them and that they had a part to play in the community. Instead, they said, young people get 'a hard time' from the community and are often 'made to feel like dirt' for hanging around, instead of being offered the chance to participate in community activity.

Does the Literature Tell Us What Works to Tackle Health Inequalities?



The international literature is clear that what works to tackle health inequalities in any society is reducing the general level of inequality in that society. While waiting for the high-level policy changes needed for that to happen, we can say that improving income adequacy does help to improve health among people experiencing poverty by reducing the stress with which they live. Methods of increasing income within the confines of present policy measures are, therefore, worth promoting. Reducing stress generally can also help to reduce health differentials between those in low-paid, low-status jobs and those in better-paid, higher-status positions.

Evidence is now emerging that the provision of advice services in healthcare settings can help provide solutions to patients' problems, thereby also improving patients' health. The role of welfare benefits advice in healthcare settings, through increasing benefits take-up, can be substantial in helping to reduce stress and so improve both physical and mental health.³⁵ Britain has seen an increase in the number of Citizens Advice Bureaux situated in hospitals³⁶ and the development of partnerships between health centres and advice agencies.³⁷

Successful interventions that improved psychological health and levels of sickness absence used training and organisational approaches to increase participation in decision making and problem solving, increase support and feedback, and improve communication. It is concluded that many of the work related variables associated with high levels of psychological ill health are potentially amenable to change. This is shown in intervention studies that have successfully improved psychological health and reduced sickness absence³⁸.

Overall, the messages which we have come to accept will help to tackle health inequalities: don't smoke; eat lots of fruit and vegetables; stay active; manage your stress; use alcohol in moderation etc are backed up by research evidence only in so far as they help to improve health generally. Even when these 'lifestyle' factors are taken into account, however, living on a low income will still result in health differentials. The Townsend Centre for International Poverty Research at the University of Bristol summed the research evidence up well in a series of Alternative Tips for better health in response to the ten tips promulgated in 1999 by Liam Donaldson, England's Chief Medical Officer at the time.

	The Chief Medical Officer's Ten Tips for better health*	Alternative Tips Based on Research Evidence*
1.	Don't smoke. If you can, stop. If you can't, cut down	Don't be poor. If you are poor, try not to be poor for too long
2.	Follow a balanced diet with plenty of fruit and vegetables	Don't live in a deprived area. If you do, move
3.	Keep physically active	Don't be disabled or have a disabled child
4.	Manage stress by, for example, talking things through and making time to relax	Don't work in a stressful low-paid manual job
5.	If you drink alcohol, do so in moderation	Don't live in damp, low quality housing or be homeless
6.	Cover up in the sun, and protect children from sunburn	Be able to afford to pay for social activities and annual holidays
7.	Practise safer sex	Don't be a lone parent
8.	Take up cancer screening opportunities	Claim all benefits to which you are entitled
9.	Be safe on the roads: follow the Highway Code	Be able to afford to own a car
10.	Learn the First Aid ABC – airways, breathing and circulation	Use education as an opportunity to improve your socio-economic position
	Source: DoH (1999) Saving Lives: Our Healthier Nation. London: The Stationery Office	Source: Townsend Centre for International Poverty Research, University of Bristol


Other messages from the research



This report has one main message: if health inequalities in North and West Belfast are to be reduced, the evidence nationally and internationally is clear: partnership working is not enough, only a 'joined-up' approach by policy makers and professionals across a range of disciplines, not only in health, can have a significant impact. The lack of a 'joined up' approach can be seen in the way in which community based services are often the first to be cut when the NHS needs to reduce costs. As a result, there is a scarcity of social care services, physiotherapists, OTs, CPNs and especially counselling services. The community often has to plug those gaps, substituting itself for, instead of complementing, the statutory sector. And the statutory professionals are caught in the middle, expected to work in an ever-growing range of roles.

An example of this is the important role played by Health Visitors (HVs) in the community. SureStart's national evaluation emphasised the importance of outreach as a way of bringing more 'hard to reach' parents into SureStart activities. Health Visitors are a vital, universal, link into every home where there is a child under the age of 4. Their role in telling more disadvantaged and isolated mothers about their local SureStart is vital. Yet, there are falling numbers of Health Visitors being employed. Health Visitors play a vital role in early years' development and if there are ever fewer of them, then even more of the work that they used to carry out will be left to the community and voluntary sector. On the other hand, community organisations that have an early years' remit depend on the expertise of HVs on their management committees and this can be perceived by statutory agencies as over-dependence. Thus, there is pressure on community organisations to develop sustainable programmes based on the community perspective. However, to secure funding for those programmes, they need to dovetail with statutory priorities. Many groups feel they need the involvement of statutory professionals to inform them of those priorities and to act as advocates for the programmes they have developed. These differing approaches to the same issues can cause tensions in relationships between the two sectors, but the tensions arise from the same source: scarce funding.

Most health-related funding continues to be channelled towards medical provision for treating disease while community-based work that works towards preventing such disease is under-funded, insecure and often the first area to have its funding cut. There needs to be more transparent information on the different levels of funding for prevention as opposed to treatment. Policy makers need to ring-fence funding for community-based preventative work if morbidity differentials, and ultimately mortality differentials are to be reduced.



Community provision of health and health-related services must be additional and complementary to statutory services, not substitutes for services which are being cut. Funding for community-based preventative work, whether carried out by statutory or community organisations, should be ring-fenced and protected.

Statutory provision for those with mental health problems that are serious but not severe is scarce. People with such difficulties are usually referred to one of the community groups supplying support to people who require stress relief and anxiety reduction. These groups can make a big difference for people who are not yet seriously ill but there is a clear gap between the needs that the community groups can meet and those provided by statutory mental health services. That gap is for people too ill to be helped by the community groups but not so severely ill to need hospitalisation. Yet, community-based groups report that they frequently receive referrals for people who are very seriously ill and need psychiatric support. Further, while there is a recognition that there are particular mental health needs among the children and young people of N&W Belfast, there is little statutory provision for them. Mental Health Promotion within EHSC Trust are involved in innovative work in this regard; for example, with the provision of a self-harm prevention team in the Mater Hospital's A&E Department or the provision of the "Turn It Around" resource pack promoting mental and emotional well-being of young people to all post-primary schools in the area. However, there is no community-based child psychiatrist in the former N&WB Trust area and has not been for some years. This is despite children's and young people's organisations lobbying for such provision. Further, it is unclear how long the community groups can continue to provide the services they do. Some of the community groups, especially the Healthy Living Centres, are training up local volunteers to ensure that there will still be some services available if the funding runs out. But, while admirable, this cannot be viewed as the only option for long-term provision of services to such a vulnerable population. Few of their services receive statutory funding; rather, the Trust supports funding proposals made by community groups. However, most funders will not provide ongoing support but expect groups to move to statutory funding or to self-financing.

There is a serious and urgent need to develop long-term funding strategies for community-based services. The particular cumulative disadvantage faced by the communities in N&W Belfast need to be taken into account in regional funding allocations.


Another example of the need for a 'joined up' approach is in relation to employability. The evidence for high levels of social distress and mental ill-health in those areas most impacted by the conflict is overwhelming. So, for those people in N&W Belfast affected by such distress to think about moving towards paid employment is

not a simple matter. To begin with, they need to feel less anxious or depressed. Community based programmes that bring them out of the isolation of the house can be vital in this regard. Courses that are not demanding but which help to rebuild their self-esteem and self-confidence have been shown to be useful in this regard. Yet, funding for courses that are not work-path oriented is becoming increasingly difficult to get either from DEL or other funding bodies. Yet, if that first step out of isolation, anxiety and depression is not taken there is no hope of putting that person on a work path.

For those who are well enough to take advantage of employment opportunities, the lack of 'joined up' thinking means that they remain locked in poverty traps. Community workers and the young men living in poverty explained about the low levels of wages available for the jobs that would be open to them. Such low wage levels are seen by the Dept of Enterprise, Trade and Investment as a 'selling point' for foreign direct investment. For example, the Invest NI website tells overseas companies that wages are "up to 32% lower than in the US and 25% lower than the EU average".³⁹ Yet, studies with people experiencing poverty and considering employment as a route out of poverty have consistently showed that there is a link between the quality of employment available, particularly wage levels, and willingness to take the risk of coming off benefits. The additional costs of paid work: travel costs, lunches, clothing and the loss of benefits, particularly housing benefit, the stress of working in a low quality job with little or no control and perhaps increased financial strain, can cause people with pre-existing mental health problems to regress⁴⁰. For lone parents who have additional strains in achieving the coordination of work and childcare, the issue of wage levels has been found to be a crucial factor.⁴¹ Community workers and groups of people experiencing poverty suggested that allowing people working in low paid jobs to retain housing benefit would make the biggest difference in terms of helping people to escape the benefits trap.

The interactions between poverty, conflict, disability and ill-health, a low wage economy and employability requires greater attention by policy makers. In particular, those who make policy in relation to employment and the economy need to understand the links between this range of issues. More research may be needed that focuses more clearly on the employment end of these interactions.

Poverty, the isolation that goes with it, and subsequent ill-health among older people certainly contributes to differentials in health outcomes. The importance of community groups' provision of breakfast clubs, coffee mornings, lunch clubs, bingo etc for alleviating isolation, encouraging social and physical activity and maintaining good mental health cannot be over-estimated. Yet, these services are poorly funded and often forgotten when it comes to describing health-related activity in an area. Although many pensioners continue



to live in income poverty, and NI's rate of take-up of pension credits is relatively high, there still remain a large proportion of eligible pensioners who do not claim this extra income. Community workers and the pensioners' group reported that many pensioners are afraid to claim pension credits because of fear of overpayment and clawback similar to that seen in relation to working and child tax credits.

A targeted advertising initiative and pension credit take-up campaign is needed to address the misunderstanding of the basis of pension credits as compared to other tax credits and to reassure pensioners that no clawbacks will happen.

As can be seen in Appendix I, much of the literature continues to focus on describing levels and nature of health inequalities and examining the pathways through which different factors impact on health. While this is important baseline information that we need to measure the impact of initiatives, it is important that we start to develop a literature on what works and what does not work in reducing health inequalities. Further, when pilot initiatives – such as the Fresh Fruit in Schools which promoted healthy eating – are shown to work, they should receive ongoing funding and be rolled out in all areas and for all households.

Finally, policy makers need not only to acknowledge but also to act upon the fact that socio-economic inequality is the main cause of health inequalities. So, for example, here are innovative programmes working within North & West Belfast to promote self-esteem among primary school children living in the most disadvantaged areas. These programmes offer the potential to address behaviours that impact on health inequalities from early childhood and to reduce the social alienation that young people in such areas often experience in their teenage years and which has led to high levels of suicide and parasuicide among young people in the area. The effectiveness of these programmes in reducing some of the differentials in mortality and morbidity caused by socio-economic inequality can be evaluated only over the long-term. It must be remembered, however, that the evidence is unambiguous that even when behavioural determinants of health are taken into account, levels of socio-economic inequalities remain the main predictor of differentials in population health.

Even if long-term evaluation of these programmes find they are successful in helping children reach their full potential, develop self-esteem, learn stress management and anger control techniques from an early age and promote healthy eating across the entire generation of children, health inequalities would still remain.

Recommendations



The recommendations are collated under two themes those relating to

- a) Practice
- b) Policy

Practice

One of the difficulties faced in the course of this research was the absence of evaluations for many of the health-related initiatives underway in N&W Belfast. Small, poorly-funded community organisations cannot prioritise evaluation and, when the costs of evaluation are built into a programme, there is an imperative on the part of the, usually freelance, evaluators to produce a supportive evaluation report. This suggests there is a need for independent evaluation structures that can provide baseline data and evaluate the impact of programmes, including negative as well as positive lessons learnt, in order to ensure that we can really quantify the impact of initiatives aimed at reducing health inequalities.

Health-related information leaflets need to have more visual cues for those with literacy problems.

GPs and diabetes' clinics should have the names of people in the area with different kinds of diabetes who manage the disease well. They could then be asked to 'mentor' newly diagnosed diabetics until they are confident about managing the disease themselves.

The expert patient programme needs to be better promoted and, perhaps, given a more 'friendly' title.


Policy

Acceptance that socio-economic inequality is the main cause of health inequalities means that policy and practice in relation to reducing inequalities in health must address the broader inequality in society.

Policy makers must be convinced that inequalities in Northern Ireland generally, but particularly in North and West Belfast, have to be addressed and that reducing these socio-economic inequalities must form the basis of any plan to reduce health inequalities.

A targeted advertising initiative and pension credit take-up campaign is needed to address the misunderstanding of the basis of pension credits as compared to other tax credits and to reassure pensioners that no clawbacks will happen.

The economics of healthy eating need to be addressed. Income



adequacy and access to affordable, healthy food must be provided if programmes on healthy eating are to be truly effective.

When pilot initiatives – such as the Fresh Fruit in Schools which promoted healthy eating – are shown to work, they should receive ongoing funding and be rolled out in all areas and for all households.


Welfare reform measures introduced in Northern Ireland should include special measures which take account of the particular circumstances of the region particularly, or at a minimum, those areas that have been most impacted by the conflict.

If welfare to work measures are to have any success, they must be linked to the provision of services – such as transport, childcare and services for people with disabilities – that will facilitate paid employment.

There is a serious and urgent need to develop long-term funding strategies for community-based services. The particular cumulative disadvantage faced the communities in N&W Belfast need to be taken into account in regional funding allocations. Community provision of health and health-related services must be additional and complementary to statutory services, not substitutes for services which are being cut. Funding for community-based preventative work, whether carried out by statutory or community organisations, should be ring-fenced and protected.

The interactions between poverty, conflict, disability and ill-health, a low wage economy and employability requires greater attention by policy makers. In particular, those who make policy in relation to employment and the economy need to understand the links between this range of issues. More research may be needed that focuses more clearly on the employment end of these interactions.

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Appendix I

Literature Review: Poverty and Inequality in Health with particular regard to North and West Belfast

Introduction

The World Health Organisation set up an independent Commission on Social Determinants of Health in order to better understand the social determinants of health, how they operate, and how they can be changed to improve health and reduce health inequalities. The Commission's mission is to link knowledge with action and to try to get public policy – both national and global – to change to take into account the evidence on social determinants of health and interventions and policies that will address them.

In a report to set the out the tasks facing the Commission, Marmot (2005) described its aim as “within three years, to set solid foundations for its vision: the societal relationships and factors that influence health and health systems will be visible, understood, and recognised as important. On this basis, the opportunities for policy and action, and the costs of not acting on these social dimensions will be widely known and debated”. He argues that the Commission will know it has been successful “if institutions working in health at local, national, and global level will be using this knowledge to set and implement relevant public policy affecting health”. This is an ambitious aim since, so far, politicians and policy makers have been unwilling to act on the knowledge we have had for over four decades now about the factors that influence health inequality.

In the UK, the 1979 Black Report produced convincing evidence that poverty and ill-health are inextricably linked and that material deprivation is a major determinant of ill-health and death. The Black Report suggested that these inequalities in health did not result from failures in the health care system, but were due to other social inequalities that influence health: income and employment, education, quality of housing, diet and the working environment. Further, Black concluded that health inequalities cannot be blamed on people's behaviour since their behaviour is limited by structural and environmental factors over which they have no control. Black recommended a raft of social policy measures to tackle inequalities in health, but these were dismissed by the government of the day¹. The then Secretary of State for Social Services, in a foreword to the report, recognized that the report recommended “a major and wideranging programme of public expenditure”. However, he concluded that such a programme was “quite unrealistic in present or any foreseeable economic circumstances”. However, the report inspired similar national enquiries into health inequalities in a number of countries including the Netherlands, Spain and Sweden. Public health specialists and political leaders in several countries began to explore policy options to address the troubling patterns the studies revealed. In


Britain, the pervasive effects of social gradients on health were further confirmed and clarified by data emerging from the Whitehall studies of comparative health outcomes among British civil servants, led by Sir Michael Marmot².

The 1998 Independent Inquiry into Inequalities in Health Report by Acheson, also concluded that “Socio-economic inequalities in health reflect differential exposure from before birth and across the life span, to risk associated with socio-economic position”. He found that although prosperity has increased in England, the health gap between social classes had widened since the 1980s – primarily because of the faster rates of improvement in health of more affluent groups.

The Social Determinants Of Health

The term “social determinants of health” came into increasingly wide use beginning in the mid-1990s. Tarlov (1996) was one of the first to employ the term systematically. Tarlov identified four categories of health determinants: genetic and biological factors; medical care; individual health-related behaviours; and the “social characteristics within which living takes place”. Among these categories, he argued, “the social characteristics predominate”³. A series of important publications generalized the use of this vocabulary and explored how social conditions and processes might translate into individual experiences of disease⁴ and much work has been carried out to establish whether there is another major explanation of health inequalities besides the scale of a society’s income inequality. Two major factors that have been suggested to explain away the effect of income inequality on health are per capita income and educational attainment. It has been argued, for example, that the relation between income inequality and mortality is an artefact of the nonlinear relation between income and mortality at the individual level⁵. In relation to educational achievement, it has been argued that the level of education in a population accounts for the income inequality effect. De Vogli and others (2005) measured the correlation between income inequality and life expectancy at birth within Italy and across the top 21 wealthy countries and found that within Italy, income inequality had an independent and more powerful effect on life expectancy at birth than did per capita income and educational attainment. The cross national analyses showed that the relation between income inequality and population health remains strong⁶. Despite such findings, other determinants, particularly those which can be seen as an individual’s own responsibility, such as diet, exercise and smoking, tend to be highlighted ahead of the question of income inequality. Indeed, the idea that the level of income inequality in a particular country being the main predictor of population health is still regarded as a controversial issue.

Wilkinson and Pickett (2005) reviewed the evidence by examining the research findings of 168 analyses in 155 papers reporting on the



association between income distribution and population health. They found consistent evidence to support the thesis that the social gradient in health within countries is primarily a gradient in relative income, or social status, rather than a reflection of absolute material living standards. This view was strongly supported by the fact that, in a number of studies, the international relation between Gross National Income per capita and life expectancy was shown not only to grow progressively weaker as countries get richer, but disappears altogether among the richest. This review shows income inequality matters not only in relation to the health of the poorest, but to the health of all in unequal societies⁷.

The international literature on health inequalities is divided in its explanation of the reasons for differentials in health outcomes. Experts tend to identify the problem as inequality in access to material resources in society⁸ or to see the problem as one of behaviour by individuals and focuses on the responsibility of individuals and societies in ensuring their health and welfare⁹. More recently, psycho-social and social cohesion explanations, which concentrate on the effects of social cohesion on the health of different groups, have come to the fore¹⁰. It is important to emphasise that all of these explanations for health inequalities have some validity, but it is the interaction of them all that helps to produce high levels of differentials. For example, there is considerable evidence that the impact of psychosocial circumstances on health is related to material circumstances¹¹ and that health behaviours are highly influenced by material conditions¹². There is also increasing emphasis in the literature on the life course perspective to health inequalities; this is based on an understanding that investment in the well-being of mothers and children has a double advantage in improving early life status and influencing life trajectory opportunities¹³. However, it is important to say that virtually all researchers agree that the best approaches to tackling health inequalities focus on addressing the underlying structural determinants of social and economic inequalities in society¹⁴. In other words, to reduce inequalities in health demands the reduction of inequality in society generally.

Poverty and Mental Ill-health

The link between depression and living on low incomes has been well established by a series of large-scale quantitative studies¹⁵. In 2003, a comprehensive metaanalysis of the research on socio-economic position and depression concluded that both prevalence and incidence studies show that people living in poverty and with lower levels of educational qualifications are at a higher risk of depression¹⁶. Further, national and regional studies have found that higher levels of socio-economic inequality are associated with higher levels of depression, particularly among women¹⁷. These quantitative findings have been confirmed by a range of qualitative studies with people experiencing poverty, particularly with women and lone parents¹⁸.

Associations have been found also between debt and various aspects of ill-health. For example, studies have shown a relationship between debt and maternal depression among lone parents¹⁹ and credit card debt and ill health²⁰. Moreover, there is growing evidence that when those already living in poverty take advantage of the 'right to buy' their public sector housing from the state, the stress caused by mortgage arrears and repossession can have a major impact on health²¹. A recent study of those seeking debt advice from Citizens Advice Bureaux found two out of three reporting that their problem led to stress, anxiety or depression, with a significant minority requiring medical intervention as a result of these²².

While most literature relates poverty and depression to unemployment, there is now emerging a body of literature that suggests that low quality work can contribute to the development of psychological ill-health or exacerbate existing mental health problems. A literature review which included over 40 studies of psychological ill-health among employees revealed that key work factors associated with psychological ill health and sickness absence in staff were long hours worked, work overload and pressure, and the effects of these on personal lives; lack of control over work; lack of participation in decision making; poor social support; unclear management and work role; interpersonal conflict; and conflict between work and family demands. Long hours were found to be associated with depression in women, but not in men²³. Employment in occupations involving potential exposure to work related threats and violence has also been shown to be a risk factor for psychiatrically diagnosed affective and stress related disorders in both sexes²⁴.

How much is poverty a geographical or area-based phenomenon?

There is little evidence to suggest that concentrations of poverty in particular areas actually cause poverty. For example, a study of income inequality and residential segregation in the United States found that segregation within urban areas is associated with an additional mortality burden. However, the association between income inequality and mortality in these areas was found to be independent of the degree of economic segregation between their constituent neighbourhoods.

A British study of geographical variation in life expectancy at birth found that such variation is "largely explained by deprivation" Regional estimates of life expectancy revealed a clear north-south gradient, but the multivariate analysis carried out by the researchers showed the geographical pattern to be predominantly attributable to the distribution of income deprivation²⁵.



The Impact of Conflict on Health Inequalities

One way in which area does have an impact on health inequalities is in relation to the continuing impact of decades of conflict on those areas that suffered most in the course of the conflict. The evidence is clear that levels of mental ill-health are higher than elsewhere in these islands and significantly related to the conflict²⁶. Variation in intensity of political violence between different areas of Northern Ireland has been linked to area differences in the level of psychological disorder. A report from the 1997 Northern Ireland Health and Social Wellbeing Survey indicates that people in poorer households were more likely to suffer significant health stresses and also more likely to have borne the brunt of “the Troubles” either in their areas or on their lives.

The Department of Health Social Services and Public Safety’s statistical overview of equality and inequalities in health and social care in Northern Ireland has a full chapter on the impact of the conflict on health inequalities in the region. This includes information on all relevant studies to 2003. More recent research suggests that many people who were resilient during the conflict are now suffering psychological distress. Professor Ed Cairns told a conference on London’s July 7th bombings that “Resilience is achieved through a combination of habituation, denial and distancing”²⁷. The growth in the extent of mental ill-health in Northern Ireland is further illustrated by the 33% rise in the number of anti-depressant prescription items issued in the five years from 2000, to 1.4 million in 2005, equivalent to 0.75 prescription items per head²⁸. While there is evidence of a significant growth in the prescription of anti-depressants across the UK, the rapid rise in NI since 2000 is not matched elsewhere.²⁹

The international literature relating to the impact on health of trauma, violence and conflict on populations in developed countries is only starting to emerge. What there is, however, makes it clear that those at the bottom of society suffer most as a result of such trauma. For example, a study of depression in post-911 New York found that people living on low incomes in neighbourhoods characterised by an unequal income distribution had higher levels of depression than those living in neighbourhoods that were more homogenous in terms of income levels³⁰.


Some of the most relevant literature about the impact of conflict on health inequalities in developed countries is the literature on psycho-social healing in the former Yugoslavia³¹. There, health care professionals have been keenly aware of the ‘social trauma’ caused by the conflict; they have questioned the validity of simply treating victims of the conflict as suffering from post-traumatic stress disorder (PTSD). Rather, they argue, since such trauma is not inflicted in social isolation, the high levels of social distress that follow civil conflict need to be acknowledged and addressed as part of psycho-social healing.

...the search for the meaning of what has happened is extremely difficult. People who have been exposed to such events feel that gross injustice has been done to many of them and that their basic rights as human beings have been violated...At the community level, collective violence disrupts normal patterns of social activities, fractures social relationships, and damages social structures. People feel betrayed, and both value systems and moral norms are disturbed. Disempowerment is not only individual but also collective, adding to the questioning of basic assumptions about the world around³².

Clearly, the relatively brief but intense nature of the conflict in the countries of the former Yugoslavia makes it different to Northern Ireland. However, the fact that the conflict here was 'normalised' and less intense over the decades does not detract from its impact. As Hayes and McAllister point out, what we euphemistically call "The Troubles", when viewed proportionately to population size, could be characterised as a war in scale, intensity and duration. 3,352 had died in the North's political conflict by the end of 2002. In addition, at least 50,000 people were injured, representing just over 3 per cent of the population. Hayes and McAllister extrapolated these numbers to Britain, where some 126,000 people would have died, with 1.8 million people injured. Further extrapolating the deaths to the United States, they estimated some 608,000 would have died, nine times the American war dead in Vietnam³³. This is clearly an area which needs further research in Northern Ireland. In particular, the interaction of poverty and conflict and the way in which each exacerbates the other needs to be further explored³⁴.

Environmental determinants of health

Another way in which area has an impact on health inequalities is in relation to environment harm. There is a reason why the areas where better off people live are known as 'leafy suburbs': they are more likely to be environmentally relatively healthy areas, with cleaner air, fewer arterial roads passing through them and better quality housing. There is a growing literature confirming that exposure to harmful factors in the environment is an important contributor to ill health, especially among children. And there is considerable evidence of the damage caused to the developing foetus by the exposure of prospective parents before conception and during pregnancy. While major gaps remain in knowledge about the extent and distribution of the environmental impact on the well-being of children, environmental conditions clearly influence the health and development of young children. Those at most risk are among the most disadvantaged; poverty is closely associated with environmental degradation. Exposure to lead and other pollutants, substandard housing, poor air quality and poor nutrition are some of the challenges faced by children living in poverty, especially those in the most disadvantaged areas.



In 2004, the WHO Regional Office for Europe carried out a study of the environmental burden of disease, the first attempt to assess the impact of the environment on child health in the European Region³⁵. The study concentrated on hazards with well-documented health effects from four major environmental risk factors (outdoor and indoor air pollution, unsafe water and sanitation, and lead) and injuries. It aimed to estimate the health gains achievable from reducing the exposure of the child population in Europe to these hazards.

Using 2001 as the reference year, the study showed that the environmental risk factors and injuries accounted for one third of the total burden of disease in people aged 0–19 years. In absolute terms, the data showed that, in 2001, up to 13 000 children under 5 died from outdoor air pollution with particulate matter; 10 000 died as a result of solid-fuel use at home; and lead poisoning was responsible for over 150 000 Disability Adjusted Life Year (DALYs)³⁶. Poor water and sanitation accounted for 13 000 deaths in children under 15 years of age. The burden of disease is much higher in non-EU countries and new EU member states, due to varying combinations of poor housing conditions, a polluted environment and less access to programmes for disease and injury prevention and health care.

In 2003, Belfast City Council, in partnership with Belfast Healthy Cities, carried out a health impact assessment of air quality in the city. Not surprisingly, it found that air quality around the M1 and Westlink was very high in pollutants that impact on health. The HIA predicted that Draft Air Quality Action Plan for Belfast's objective for annual mean levels and hourly mean levels of nitrogen dioxide and for annual and daily mean levels of particulate matter will be breached in the M1/Westlink Corridor AQMA. Exposure to nitrogen dioxide and particulate matter shortens people's lives, increases admissions to hospital from respiratory and cerebrovascular causes, and it increases asthma symptoms and the use of bronchodilators (inhalers)³⁷.

Diabetes – an example of the interaction of social determinants of health


Diabetes is more prevalent among people living in poverty and those in the lowest social classes are three and a half times more likely to die as a result of diabetes than are those in the highest social classes³⁸. There has been a considerable amount of research into how control of diabetes is affected by various of the social determinants of health. How they all interact provides a good illustration of why a holistic or 'joined up' approach is necessary to reduce health inequalities.

Stress seems to be one of the principal mechanisms through which poverty and inequality impact on diabetes. Control of blood glucose levels has been closely linked to stress in studies of type 1 and type 2 diabetes³⁹. There is evidence that stress management can result in modest but sustained reductions in glycaemic control that are not associated with changes in health behaviors such as diet or exercise⁴⁰. Much of the research to date has focused on the acute effects of stress on diabetes management and glycaemic control, while the long-term impact of sustained exposure to socioeconomic deprivation and its association with detrimental health behaviors and physical mediators has only begun to be investigated.


However, people experiencing poverty themselves have identified the question of functional health literacy – the ability to read and understand instructions relating to medication, letters about appointments, information leaflets etc as a barrier to the management of diabetes for some. Poor health literacy has been shown to lead to poorer management of the disease and more hospital admissions. People with diabetes who have poor literacy are less likely to know the symptoms of hypoglycaemia, and they have higher hemoglobin A1c levels and higher rates of retinopathy even when they have received ‘traditional’ diabetes education⁴¹.

People with diabetes are more likely than the general population to have depression and other psychological conditions⁴²; in fact, people with diabetes are twice as likely as the general population to have depression and in the general population there is a consistent inverse relation between income and depression⁴³.

There are a range of other determinants of health that people living in poverty and at risk of, or with, diabetes are more likely to experience. These include higher-priced but poorer-quality foods, poor public transport, and poor air quality. The question of food poverty and toxic environments are dealt with elsewhere but it worth looking at the issue of public transport as a health issue, not only in relation to improving employability but also in enabling people to manage their illnesses. The international literature suggests that lack of transport is an important barrier to accessing appropriate health services and it may influence other environmental factors, such as access to food, health care, and social networks⁴⁴.

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