

Proceedings of the Public Health Policy Consultation, June 2011



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Consultation Days: Responses

Introduction

This report summarises responses to a consultation process on a public health policy framework with invited delegates across a spectrum of stakeholders at five different locations. These were: a national consultative launch in Dublin, and in four HSE regions; Cork HSE South, HSE Dublin Mid-Leinster, Galway HSE West and HSE Dublin North East (see Annexe 1 for information on attendees).

This report also includes a short summary of presentations at the Dublin national event held on 13th June 2011.

Round table discussions took place at each of these events and facilitators compiled notes under key questions:

- What would you like the public health policy to achieve?
- What is the relevance of this policy to my organisation?
- What is needed to make the policy work? (Organisational and Regional perspectives)
- What concerns do you have about the development and implementation of this policy?
- What two key messages will make Ireland's Public Health Policy first class? (See Annexe 2 for summary of all key messages)

The content of these discussions has been arranged into key recurring themes, and all comments are included though they may not be recognised from their original form due to the necessity to blend similar comments made by several delegates. Where comments were made at the local level consultation days that are specific to an area, these are mentioned in the sections that follow.

The key themes were;

- The values, or the paradigm which the policy should operate from
- What the public health policy document should aim to achieve
- What is needed to make a public health policy work
- What the public health policy document should look like

- Specific actions that should be included in the public health policy
- Concerns about the public health policy achieving what it aims to achieve

Overview

Throughout the process delegates repeatedly emphasised the necessity for the public health policy document to genuinely make a difference; to be fully implemented and for the process and outcomes/actions to be clear, tangible, accountable and time-bound. Although overall it was thought the public health policy should be aspirational, it should also be realistic, achievable and implementable. Key to this, as identified by the delegates, is the necessity to underpin the policy with an explicit acknowledgement of the influence of social inequalities on health. The policy should address the 'causes of causes', and should not only look at behaviours, but the context within which unhealthy behaviours occur.

Health equity must be at the core of the policy document serving as a moral compass and guide. The policy will require an evidence-base and considerable buy-in across the political spectrum. It will also require a more long-term view, and Finland's public health policy which takes a view beyond the length of a government was referenced in this regard.

In sum, the policy document should be:

- Aspirational and inspirational
- Achievable and realistic
- Implementable and transparent
- Underpinned by a strong commitment to health equity
- Multi-disciplinary and inter-sectoral
- Cognisant of the need for strong leadership

Key paradigms to underpin the Public Health Strategy:

- The World Health Organisation defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” and this definition should be adopted by the policy.
- The policy must emphasise that health is socially and economically determined and seek to create a wide understanding that this is the case.
- Health needs to be embedded across all sectors.
- Health must be seen as a right. The policy should take a rights based approach.
- The policy should be built on principles of fairness and equity.
- Equality of access, participation and outcome should be guiding principles.
- Community empowerment is an integral part of the process.
- A healthy Ireland is a fair and strong Ireland.
- Health is everyone’s business; from the individual through to government level.
- Prevention is better than cure – both for the individual and the exchequer.
- Unequal societies are unhealthy for everyone.

What the public health policy document should aim to achieve

The public health policy should have a long-term vision and aim to provide Ireland with an exemplary health system, where good health is as desirable as a clean environment. The public health policy should aim to take a life course approach¹ with targeted interventions for identified vulnerable groups.

However in order to deliver a public health policy that will achieve buy-in, extensive consultation is necessary. An adequate timeframe for consultation with people for whom the public health policy should serve is essential, and innovative methods for engaging with hard-to-reach communities will need to be explored. Communication and dialogue with the public are essential to ensure public ownership. The reorientation from a biomedical model to a social model of health² will require a common and clear language and a move away from a system which promotes deference to ‘experts’.

A significant achievement of the policy would be the widespread recognition of the social determinants of health. In keeping with this recognition a key aim should be to decrease the life expectancy gaps between the highest and lowest income earners. In addition key achievements of this policy should be to reverse or halt current trends that are undesirable such as trends in alcohol misuse and increased overweight and obesity among the population.

Education which was a key theme was referred to in two different ways:

Firstly, children’s education and early years interventions were particularly highlighted as desired priorities for the policy. Through education and interventions for children it is hoped that the policy would achieve longer and better quality lives for the next generation reversing the expected trend that today’s children will have shorter lives than their parents. Overall, health promotion should be embedded into curricula throughout the formal education sphere.

¹ In this context, what is meant by a ‘life course approach’ is a consideration of well-being and health across the life course from infancy upwards and not merely focussing on specific age cohorts and health amelioration that can be achieved in the short term.

² This is not to displace the importance of biomedical expertise in its appropriate setting, rather to move towards a greater holism.

Secondly, public education should support recognition of the social determinants of health, and the importance of preventative health care in both a personal and national capacity should be a central aim of the policy. The links between social and health policies should be explicit, and the public should be able to make informed decisions affecting their community as well as their own roles in protecting their health.

Key points:

- The policy should deliver Ireland as a State recognised as a role model for its public health and healthcare.
- The policy should be fit for purpose – through consultation ‘buy-in’ can be achieved and it is really important to target consultation at the entire community, not just community groups.
- A life course approach should be pursued and within this, clear and measured targeted interventions to address disparities among vulnerable groups should be established. In particular implementing the policy should achieve a reduction in life expectancy disparities between different socio-economic groups.
- Clear priority aims of the policy should be to address obesity and overweight among adults and children, and excessive alcohol consumption.
- The policy should target interventions at children taking a long term view to ensure that the next generation has better health outcomes than the current generation and reversing the expected trend whereby today’s children may have shorter life expectancies than their parents.

What is needed to make a public health policy work?

To achieve its objectives the policy document will need to have clarity and focus, a solid evidence-base, good planning, accountability and be able to distinguish between processes, outcomes and outputs. The objectives of the policy should use the SMART³ typology, as mentioned by several delegates.

In addition, the public health policy will need a practical approach to ensure these objectives are realised – through a whole-of-government approach, broadening the understanding of the health services role beyond illness management, appropriate resourcing and to be convincing, be built on a sound evidence-base.

Government and local authorities

- To make it work, the public health policy will need a whole of government approach and endorsement, and need buy-in from all stakeholders. Long-term consistent political will and cross-party agreement is necessary for the policy to be fully implemented.
- **Fully integrated public health across policy agendas – implementable, shared budgets for inter-sectoral working**

The policy should not be a Department of Health publication, but should have the buy-in of multiple departments to ensure appropriate courses of action. This should be a ‘Trojan horse policy’; a policy that delivers health across multiple agendas. In particular, it will need to take a strategic approach to ensure that it does succeed. Therefore, the public health agenda will need to be married with other agendas, such as environment to ensure that it is adopted across the board. This will be a new approach in an Irish context, policies will need to be linked, structured and fully-implemented by multiple departments and agencies. This could include ring-fencing of proportions of budgets for evidence based prevention that extends across more than one portfolio. Formalised inter-sectoral working will need to be established at all levels, and

³ Specific, Measurable, Attainable, Relevant, Timely.

the low cost nature, compared to returns, of inter-sectoral working should be highlighted. Above all, public health should supersede sectoral interests.

- **The policy will need to be resourced and clearly targeted from the top down at all levels of the public sector hierarchy**

A cascading framework was suggested, for national, regional and local levels to ensure implementation frameworks at every level are coordinated. These should be sustainably resourced with appropriate targets. Local level recommendations included the need to identify local change agents to work across agencies and fora to secure effective joined-up cross-sectoral work.

Accountability and Implementation

- Although this policy should have a broad remit of responsibility it should also have accountability, and responsible persons for implementation should be identified.
- It is essential the implementation of the policy has identifiable targets and clear processes to achieve these.

Health Services

- The HSE will need to be reoriented to a health-driven, rather than a health services driven agency.
- Training and professional development will be needed to move health professionals towards a more holistic and preventative approach.

Evidence-base and funding

- To monitor achievements and set targets, a baseline of evidence is required to be followed by ongoing monitoring and evaluation.
- Alongside monitoring and evaluation, more extensive research is needed and not only in the area of clinical excellence.
- Although the temptation may be present to ‘shrink the vision’ in light of the recession, and there may be no impetus to be ambitious, it should be remembered that ‘quick wins’ are possible with positive and negative incentives. Actions that can be taken to modify behaviour quickly should be the first to be tackled. However, these will not necessarily have won the hearts and minds of the public, as attitudes change over a longer period of time, but eventually attitudes follow the incentives. This is not only about budgets; there is a need to be inventive and identify opportunities. Small amounts of funding can make the difference, for example, seed initiatives.

What the public health policy document should look like

Discussion around what the public health policy document should look like reflected much of what has already been discussed; for example, the need for clear leadership. New themes emerge specifically in terms of the language that should be used, what implementation should look like, what research should achieve and how it should be led. Overarching impressions of what the document should look like are dealt with in this section; however specific actions are dealt with in the following section.

Communication, language, leadership

- **Language should reflect recognition of the social determinants of health**
The policy should avoid using blame-apportioning language. It must highlight inequalities that lead to unhealthy behaviours; these are due to the social context which we all have perpetuated and cannot solely be attributed to the individual. However the aim of the policy should be to first reverse the behavioural trends as these may be easier to address than the root causes, but with the intent of doing so in the longer term.
- In a similar vein, several delegates thought it unwise to use the term 'health' in the policy document title as it was felt this could mean other sectors not feeling it was in their domain.
- The priorities of the policy, and the aims and focus will need to be clearly communicated to the general population. Health will need to be cast as an asset economically, socially and culturally to communicate the message to the broadest audience. The nation's wealth is its health and this should be particularly highlighted during the recession.

- A champion is needed but in the absence of such an individual or if deep cynicism prevails, the policy should be formulated in such a way that it is difficult for stakeholders to rescind on.
- The public health policy will need to address the challenges that may be faced when sectoral interests collide and reference a resolution mechanism for such instances.
- Clear roles need to be identified and the policy should be flexible to adapt or meet changing needs. However, it should build on existing interventions that we know work; this is cost effective and would ensure the mainstreaming of pilots and initiatives that work well but were never progressed.

Research, monitoring and evaluation

- **Translational research and courage to try in the absence of an evidence base**

Although we already know a lot in terms of research and pilot schemes which has simply never been implemented on a wider scale, it was generally agreed that in Ireland we are not good at translational research and connecting the dots. The policy will require an evidence-base to be brought together comprehensively, and further research will be required. Where there are research lacunae, the policy should address how to deal with these. There should be room to try new ideas and a mechanism for progressing ideas; in addition there should be the courage to try something where there is no evidence base and accept the risk that it might not work.

- There is a requirement to recognise that research, monitoring and evaluation are about more than producing figures. Expertise and critical thinking are also required to interpret this information. Research and evaluation should never become cynical exercises.

- Monitoring and evaluation should be embedded in the policy process, and indicators of success in health outcomes will be needed. The policy document will also need to be clear about what success will actually look like.

Implementation

- **The policy document should be accompanied by an implementation document that is time-bound, sustainable, sector specific and costed**

An implementation plan should practically outline how the cross-departmental and cross-sectoral work which is essential to this process will be rolled out in a sustainable and efficient manner. The public health policy document should provide strategic direction for organisations to bring them together through inter-linking, inclusive plans.

Key Points:

- The policy document should be drawn up to ensure that it is implemented, even if interest wanes into the future. An implementation document should accompany the policy.
- Clear roles of all parties should be framed in the document. This will assist, not only with allocating responsibility, but also accountability.
- The policy document should address conflict resolution when inter-sectoral interests collide.
- The language should recognise the social context within which behaviours occur.
- Public communication is essential – health must be marketed as the greatest asset.
- Monitoring, accounting and evaluation of the progress or lack thereof needs to be included, and flexibility is required to adjust and adapt to deal with what is not working.
- The monitoring and evaluation process should be brave enough to state when something is not working – again this is not about blame apportioning but about knowing when a different direction is needed. Courage should be acknowledged in experimentation in the absence of a solid evidence base.

Specific actions that should be included in the public health policy

There was an emphasis throughout the consultation process that delegates want the policy to move beyond rhetoric and implement the concrete changes that are needed. This would include full recognition of the social determinants of health. In addition, the language should be clear and resonate across the generations of people who will be most affected by this policy. One suggested action was to begin the process by identifying the top ten greatest areas of concern and developing an impetus around resolving these.

Key suggested actions can be grouped into:

- Organisational actions
- Actions relating to research, monitoring, evaluation and provision of an evidence base
- Actions for targeted groups

Organisational actions

- Northern Ireland and the Republic of Ireland should be working together more closely to avoid resource wastage and overall duplication should be avoided across sectors for the same reason.
- A Republic of Ireland equivalent of a Public Health Agency should be established. It should be independent, integrated but outside of the Department of Health and Children and drive the policy forward. It should be an agency of government reporting to the Taoiseach/be placed in several departments with shared targets. Either a Public Health Agency or another organisation should be proactive in responding to health inequalities.
- A National Inter-Sectoral Health Charter should be developed based on equity and agreed principles that would be signed up to by local and national partners.
- With regard to the HSE, local level consultations mentioned the need to build relationships within the Health Services Executive to give a sense of identity and common purpose across the regions.

- In the context of interagency working, there is a need for links between hospitals and community services to be made so that everyone knows what services are available. Primary and acute care should not be pitched against each other for resources.
- Primary Care Teams should be fully developed and rolled out.
- Local authorities are often best placed to make the changes needed and should be empowered to do so.
- Funding should be ring-fenced and be multi-annual and resources need to be used in different and more creative ways. There will need to be buy-in from the workforce and unions.

Evidence and Research actions

- Research and information systems are needed to provide analysis and evidence. These should be fit for purpose and properly resourced.
- ‘Reinventing the wheel’ should be avoided. For example, there are already a lot of existing policy documents and strategies with common interests and evidence in the health domain and these should be brought together.
- An inventory of good practice should be compiled and disseminated. There is a large body of research that is not synthesised and there are information deficits. A central unit should act as a broker or clearing-house for these.
- We need to know why policies in the past did not work; we should learn what has worked, and what has not worked.
- There is a need for statistical evidence at a local level. Population level statistics are not sufficient when dealing with a particularly impoverished community.
- Value for Money – an economic case should be made for producing Irish data and long term benefits of this policy should be made explicit. However it was recognised that cost-benefit analyses are not ideal for measuring the full impacts of health promotion/prevention interventions.
- Health Impact Assessments and Child-Proofing policies may not always influence decision-making. They can be ignored and therefore should be placed on a stronger footing, similar to Environmental Impact Assessments. In particular, all policies should be health-proofed; health equity proofing should

Actions on targeted groups

- In a similar vein to avoiding ‘reinventing the wheel’ in research, there was a desire to utilise existing vibrancy in communities and supports existing structures, for example healthy living centres and the Health Action Zones.
- Volunteerism should be encouraged and access to Garda vetting and insurance for volunteers should be simplified.
- Individual responsibility is required (bearing in mind social inequities that make choices less feasible for some) and people should be asked “how can you help yourself?” Appealing to self-interest is often a good way to effect change.
- Marketing of unhealthy products should be restricted. The healthy choice should become the easy choice.
- The education system should be reframed for physical activity and the arts to give children life-long skills. In particular the school-day should be extended for physical activity.
- The recommendations of the taskforce on alcohol should be implemented
- There is a need to address why people end up in Accident and Emergency Departments.

Actions across the life course

- Quality of life for all should be at the core of addressing actions across the life course.
- In focusing on older people, the aim should be to increase the disability free years, rather than life expectancy only.
- Children were particularly highlighted by stakeholders as a priority; fully funded early childhood interventions were a desired action as well as better education and higher literacy levels more generally. A regional consultation particularly wished to emphasise not only the child, but also the family context in which that child is residing as key for intervention strategies.

- Education should prioritise mental and physical well-being to a greater extent.
- The following areas of health were particularly highlighted during regional consultations – occupational health, young mother’s health, Traveller health, with a particular emphasis on mental health.
- The policy should aim to deal with secondary and tertiary preventative health strategies or ill-health, and health inequalities experienced by people who may already have health issues, for example people with disabilities.

Concerns about the public health policy achieving its aims

The principal concerns about the policy achieving its aims can be summarised as the policy ending up on a shelf and being ignored. Some aspects of the policy could create conflict, and politicians will not want to be seen as thwarting economic interests in case it affects them in the polling booth; short term economic interests could be favoured over longer term health benefits and additionally insufficient funding could be detrimental to the policy implementation. There were concerns that health care services would be pitched against health promotion and prevention for funding; services will not see an immediate fall-off in demand once preventative actions took hold. This would be over the longer term, even with quick-wins. Therefore, the concern was how is the shrinking financial base going to be addressed in the policy?

Chief concerns under the banner of the policy being ignored included a fear that the policy would not be able to tackle the hard questions, and would not have enough buy-in and therefore would not be implemented.

Vested interests were considered a threat to the policy, particularly if the policy is not clear and direct about its intent and goals, and does not have widespread and high-level support. The policy will need to be clear who is responsible and who owns the process. However, too much regulation was also voiced as being problematic, but this could be resolved with a more flexible approach. If something is not working, and actually doing the exact opposite of the original intent; then it will need to be changed. Similarly, there were concerns that the policy could become weighed down under bureaucracy and red tape.

Key concerns:

- Will it reach the groups who need it most?
- Will it be ignored? Will it get the buy-in needed?
- Will it get lost in bureaucracy?
- How can short term economic interests win over long term health benefits?
- Where will the funding come from?

Why a Public Health Policy?

Dr. James Reilly TD

Minister for Health

Dr. James Reilly opened the day's proceedings, welcoming everyone and thanking organisers and attendees. In his address, Dr. Reilly acknowledged the need for a new focus on health and well-being that recognised the responsibility for health across all sectors, and the need for a public health policy as distinct from a health services policy. In this, Dr. Reilly noted that chronic conditions are likely to increase in the coming decades and that health problems should be addressed as early as possible in the most appropriate setting. Dr. Reilly also noted the links between ill-health and poverty, citing the statistic that half of all people in consistent poverty in Ireland have a chronic illness.

Dr. Reilly acknowledged Ireland's successes in the past; the effects on dental health made by water fluoridation, the effects on air quality through the introduction of smokeless fuel, Ireland as a world-leader in workplace smoking-bans, and how immunisation and these other preventative measures make economic sense. In this, Dr. Reilly referred to immunisation as being the "one of the best buys for public health".

Dr. Reilly noted that considering health at the lowest level of complexity makes the most sense citing preventative healthcare and health promotion as examples as to how this can be achieved. However to remove health from a silo vision of 'health services' requires political buy-in, interdisciplinary working, better cross sectoral cooperation and coordinated resource allocation.

Dr. Reilly noted the current health challenges that are everyone's responsibility, focussing in particular on smoking and obesity. These two avoidable factors occur in the majority of preventable deaths. In this, Dr. Reilly noted that new nutritional health promotion is needed and in general it needs to make "the healthier choice the easier choice...information alone doesn't always change behaviour". With regard to forthcoming challenges, Dr. Reilly noted that climate change (potential rise in

sunburns, cancers, effects of an extended pollen season, effects on mental health, floods and vector-borne diseases) and anti-microbial resistance are major issues.

In conclusion, Dr. Reilly stated his intent is to strengthen inter sectoral working and to make Ireland healthier. He noted that there are occasions on which this objective might result in indicating that business and the private sector will have to play their part and be challenged when products or activity are counter productive to health.

Address by the Minister for Children

Frances Fitzgerald TD

Ms. Fitzgerald opened her address by noting how crucial public health is to the Irish economy, and how children are essential to Ireland's future. Children comprise a quarter of the total Irish population; there are 1.1 million children under age 18 living in Ireland. There is a lot of media attention on how future generations have been condemned to debt in the current economic circumstances and this will in turn undoubtedly have health impacts, but Ms. Fitzgerald stated that on this occasion she wished to focus her address on three pertinent issues relating to children's health – tobacco, alcohol and obesity. A new framework for public health is essential and we must take this opportunity that has been presented to ameliorate these health issues.

Ms. Fitzgerald noted that young people are drinking more and from an earlier age. The average age for consumption of first alcoholic drink has declined from age 16 in the 1980s to 14 in the 1990s. Alcohol is a risk factor in three-quarters of admissions to care and early abuse is linked to problematic alcohol consumption in later life. It is important that alcohol is recognised as a gateway drug. Ms. Fitzgerald is also hoping for more research into foetal alcohol syndrome. With regard to tobacco, Ms. Fitzgerald noted the positive outcome of a decline in smoking since 2005 but recently this decline has ceased and further reductions are desirable.

Ms. Fitzgerald voiced her concern about the “obesity epidemic” across Europe which is costing €4 billion per annum. Ms. Fitzgerald said health and social costs include threats to mental health and self esteem. Ms. Fitzgerald is particularly concerned about the trends within Ireland and the long term impacts as being overweight before puberty is a risk factor for being an overweight adult. ‘Growing Up in Ireland’ results show that one quarter of all 7 year olds are overweight/obese and preliminary analysis demonstrates similar trends among 3 year olds. Obesity will need to be tackled through community facilities such as signalised crossings to encourage children to walk in a safer traffic environment, smarter travel will have to be a priority and sporting clubs will need increased participation.

These are serious public health challenges but they can be addressed and “today we start progressing.”

Address by the Minister of State with responsibility for Primary Care

Roisin Shortall TD

Ms. Shortall's address focused on a reorientation of health services to the community and how these services could provide many add-on benefits. Ms. Shortall also concentrated on alcohol and substance misuse as growing concerns. Ms. Shortall's address included the promise of free primary health care within the government's lifetime.

Ms. Shortall discussed how the focus of health should be placed back into communities as in 95% of care situations, this is the most appropriate location and it is where patients want to be treated. At that level, primary care can interface with prevention, for example when patients are attending for immunisation or cervical screening, advice on lifestyle issues such as exercise or referral to appropriate services can be raised.

Primary Care Teams are valued within local communities and are an excellent model of multi-disciplinary working providing care from before birth through to end of life. In addition, Primary Care Teams can act as advocates within communities with regard to housing, education and health problems associated with (un)employment.

Referring to the "alcohol epidemic", Ms. Shortall stated that Ireland has exceptionally high rates of alcohol consumption and there are 100 deaths per month that can be attributed to alcohol. Three in every ten accident and emergency department attendances are due to alcohol and all are avoidable and preventable. Ms. Shortall stated that alcohol may be a bigger killer than cancer or circulatory diseases. Ms. Shortall believes we need to change our attitudes, our pricing and other regulatory mechanisms, reduce supply and try to raise the age at which first drink consumption occurs.

Ms. Shortall reiterated Ms. Fitzgerald's point that alcohol is a gateway drug and that the links between alcohol and illegal drugs needs to be made explicit and addressed in tandem. In the case of illegal drug use it is a necessity to prevent any first use with a focus on the most at risk; homeless people, early school leavers, and children of drug

users. This will require sustained action across multiple sectors and she referred to the national substance misuse strategy which is due to be published in the coming months.

**Address by the Minister of State with responsibility for Mental Health, Disability
and Older People**

Kathleen Lynch TD

Ms. Lynch spoke briefly about her three briefs, which she feels are well suited to addressing issues of equality and she outlined what she perceived as the biggest challenges in each of these areas;

Mental Health: Mental ill-health must be normalised, the way other illnesses such as cancer have been de-stigmatised in the past. Mental ill-health or the experience of a mental illness frequently occurs in parallel to issues such as poverty and unemployment.

People with Disabilities: Ms. Lynch emphasised that for people with disabilities it is frequently the environment that disables and excludes. Ms. Lynch called for universal design to become part and parcel of our aesthetic. It is no longer acceptable to compound health issues with social exclusion.

Older People: Ms. Lynch stated that all health planning must have delivery of care across the life cycle at its core and that it must be consistent across the population. Ms. Lynch was disappointed that “we’re in love with institutions in this country” and this is a model of care that we must move away from.

Ms. Lynch noted there were inherent contradictions in Ireland, for example, Ireland is a nation that both loves sport, but also has a love affair with alcohol. Ms. Lynch ended by remarking how embedded environmental issues are in our education system and this is where health promotion must also locate itself.

Public Health – A Cornerstone of a Healthy Society

Zsuzsanna Jakab

Regional Director for Europe, WHO

“Public Health is the science and art of preventing disease, prolonging life and promoting health through organized efforts of society”

Sir Donald Acheson, 1988

Sir Acheson’s definition of public health was the backdrop for Ms. Jakab’s presentation in which she promised the support of the World Health Organisation (WHO) to Ireland in developing a new public health strategy. The WHO is currently developing a new European policy *Health 2020 – a new policy for better health in Europe* and therefore Ireland’s public health policy will be part of a broader momentum to improve public health and its infrastructures across Europe.

Ms. Jakab used the WHO 1948 definition of health (*a state of complete physical, mental and social well-being and not merely the absence of a disease or infirmity*) to note that overall European life expectancy is growing, however when considered in terms of individual countries the compounding effects of non communicable diseases and the associated poverty traps are apparent. In September 2011, the WHO ‘European Review on Social Determinants and the Health Divide’ will be presented. There are new challenges and opportunities alongside old problems; there are ongoing and new challenges to health as a human right, a ‘public good’ and an asset to development. Ms. Jakab noted that we are in a new era with rapidly developing global and European trends with increasing complexity shaping health and determinants of health inequalities.

Health inequalities can be influenced not only by the social determinants of health but by the context; the political system, social policies and programmes and the physical environment in which they are experienced. Ms. Jakab referred to alcohol, tobacco and obesity as major twenty-first century public health challenges. In the case of these latter two we know what we have to do and the next challenge is anticipated to be alcohol. The challenge is to make the healthy choice the easy choice.

Ms. Jakab outlined the “backbone” of public health operations in Europe within the last four years. Although these points are interpreted in different ways in different countries they constitute the core activities for public health:

1. surveillance and assessment of the population’s health and well-being
2. identification of health problems and health hazards in the community
3. health protection services (environment, occupational, food safety)
4. preparedness for and planning of public health emergencies
5. disease prevention
6. health promotion
7. assurance of a competent public health and personal health care workforce
8. leadership, governance, financing and evaluation of quality and effectiveness of public health services
9. health-related research
10. communication for public health

Ms. Jakab concluded with an overview of how a ‘health in all policies’ approach has been applied using examples from Scotland’s whole of government approach as well as of the Promurje Region, Slovenia’s integrated health and development plans.

Determining Health – Determined to make a difference

Professor Sir Michael Marmot

Director, UCL Institute for Society and Health

This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries.

'Closing the Gap in a Generation', Commission on Social Determinants of Health

Sir Michael briefly outlined his work on the Commission on Social Determinants of Health with the WHO, and his work on the 'Marmot Review'⁴, and how these ideas and concepts are all evidence-based. Being able to close this gap in a generation requires "evidence based optimism"; the knowledge and means are known and possible but the will is lacking. According to Sir Michael, this is a matter of social justice, and social injustice is killing on a grand scale. The social determinants of health establish "the causes of causes", focussing solely on the most disadvantaged will not reduce inequalities sufficiently; action is needed across the social distribution. 'Health in all policies' is insufficient 'health equity in all policies' is what is required to ensure fairness is at the heart of all policies. In this vein, Sir Michael warned against the misuse of the word 'fair'. For example, VAT is a regressive tax; it cannot be called fair as it has an unequal impact. A fair society is one in which circumstances and conditions exist whereby individuals and communities have control over their lives and can participate fully in society.

Sir Michael said the principle argument for addressing health inequalities was a moral argument but there are economic dimensions in support of the perspective. He referred to a policy decision to raise the retirement age to 68 where three-quarters of the population do not have disability free lives up to age 68, therefore policies like this make little sense as people will be moved from being on pensions to being on disability allowances. There should be health equity built into these forms of fiscal policies and these should be evidence based. However, Sir Michael warned that

⁴ www.marmotreview.org/

policies may need to go beyond an evidence base which could limit arguments to being purely economic; “the bottom line” is not what government should be about, there is a moral argument for valuing all citizens.

Therefore “every sector is a health sector, every minister is a health minister”. Sir Michael traced the discrepancies between health status and the social determinants of health in a series of graphs. Sir Michael outlined the experience in Birmingham, one of the most deprived areas in the UK, and the West Midlands in particular. Birmingham placed a champion on each Marmot objective (outlined below) and significant improvements were attained. It was not possible to change the income levels, but other changes could be made to lessen the effects of the social gradient.

Policy Objectives of ‘Fair Society, Healthy Lives: The Marmot Review’ (2010)

- 1) Give every child the best start in life
- 2) Enable all children, young people and adults to maximise their capabilities and have control over their lives
- 3) Create fair employment and good work for all
- 4) Ensure a healthy standard of living for all
- 5) Create and develop healthy and sustainable places and communities
- 6) Strengthen the role and impact of ill health prevention

Sir Michael also provided evidence that the current accepted method of calculating consistent poverty as below 60% of the median income is insufficient in many cases. For example, a lone parent with two children will need at least 80% of the median income. Sir Michael also demonstrated the complexity behind the statistics; more alcohol is drunk by the higher social classes but the negative health effects of alcohol consumption are experienced to a greater degree among the lowest social classes. This may be attributable to lifestyle factors such as being able to have a few glasses of wine each night with dinner rather than binge drinking in one evening. Sir Michael displayed the image of the US President and his wife drinking Guinness during their recent trip to Ireland and referred to this as Ireland’s “self abuse”.

Sir Michael noted that the NHS spends just 4% of its budget on prevention. However, there was better news with regard to the NHS when compared with other countries.

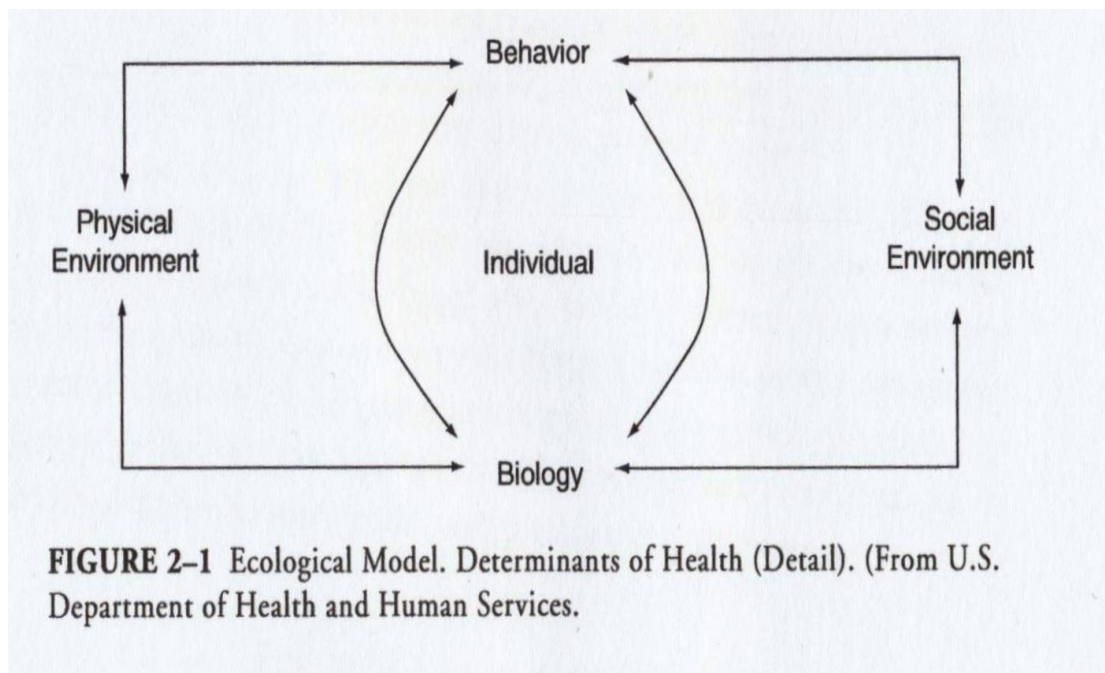
Sir Michael presented a graph of cost related problems accessing healthcare in the past year by income. In the US, 20% of people above the average income had problems accessing healthcare due to cost while this was the case for 39% of people below the average income. In the UK the figures for problems accessing healthcare due to cost stand at 4% both for the group above the average income, and the group below. However, Sir Michael was also able to demonstrate how the wealthy pay proportionately less tax than the poorest in the UK and he advocated for a proportionate income tax rather than a progressive income tax.

Healthy Children – Getting the First Steps Right

Professor Sheila Greene

Director, Children's Research Centre, TCD

Professor Greene began by stressing the need to acknowledge the diversity in children's experiences and needs. 'The Child' or a 'standard childhood' does not exist. Professor Greene demonstrated the complexity and multitude of factors that influence the experience of childhood and the formation of the individual using a complex ecological model from the US Department of Health and Human Services, simplified below.



In addition, Professor Greene also outlined how children develop and what influences these developments:

- Development is influenced both by heredity and environment, involving many complex transactional processes
- At individual level, there is interconnectedness of the physical, the psychological and the behavioural
- There are multiple influences on health: biological, psychological and social; proximal and distal

While Professor Greene acknowledged huge advances in medical knowledge and epidemiology; social and developmental sciences emphasize the following insights:

- Very early events and exposures can create problems that carry forward into later life
- Poor children have higher likelihood of poor outcomes
- Health outcomes for children are socially structured
- Many of these poor outcomes are preventable
- Respectful treatment of children enhances their health outcomes (Coyne et al, 2006; Donnelly & Kilkelly, 2006)

Taking a life course perspective, longitudinal research confirms the links between events in the prenatal period and early years and adult health outcomes. In 2006, one in five children was at risk of poverty and this situation may have become more acute during the recession. Ireland has high levels of income inequality and children living in consistent poverty. These situations are compounded by Ireland's two-tier health system and two-tier education system at second level. The 'Growing-Up in Ireland' longitudinal study which Professor Greene is involved with recently revealed that a quarter of nine-year olds are overweight or obese and the preliminary data on 3 year olds is similar, though further analysis is required. Professor Greene went on to discuss the links between chronic illness, breast feeding and maternal education levels, but with the caveat that non-Irish national mothers far outstrip the percentages of all women in Ireland breastfeeding.

Professor Greene stated that early intervention programmes are often targeted at disadvantaged children. These are intensive, comprehensive, long-lasting, expensive and contextually sensitive, but it is not possible to rely on early intervention programmes alone to adjust social inequalities and prevent their ill-effects. Professor Greene called for a child health policy within the public health policy that will be developed to address the following -

A child health policy should:

- Be premised on a multi-dimensional definition of health
- Be situated within a life course perspective (Kuh et al, 2003)
- Be ecological, recognising the many layers and types of influence
- Adopt agreed, well-defined outcomes

- Respect children's rights and agency
- Recognise the importance of supportive relationships and a strong family life
- Be embedded in and associated with a commitment to reduce child poverty and social inequalities (See, e.g. Tackling health inequalities, CPA/IPH 2008)
- Employ evidence-informed public health programmes and services that are universal and targeted
- Adhere to clear objectives and implementation strategies at national and local levels
- Encourage cross-departmental collaboration and commitments and inter-agency working

Professor Greene concluded by stating that children are not just about the future, they are living now and it is necessary to invest early and to keep investing across childhood.

Developing and Implementing a Public Health Policy – Learning from *Investing for Health*

Dr. Michael McBride

Chief Medical Officer, DHSSPS, Northern Ireland

‘Investing for Health’ is by far the best health policy document at national level from a country in the English-speaking world I’ve ever seen

Sir Donald Acheson

‘Investing for Health’ (2002), Northern Ireland’s public health strategy was developed by the first Stormont Executive and recognised the social determinants of health. It is a cross-departmental document requiring a partnership approach, a comprehensive document for policy-makers, and very little new funding was available for it.

In developing ‘Investing for Health’ extensive consultation processes were undertaken to include people across the Northern Ireland population. The three priority groups in the consultation paper – the very young, children and older people – did not attract widespread support and it was widely suggested that the focus should be on the most disadvantaged in society whatever their age group.

Seven cross-cutting objectives were identified to reflect cross-departmental cooperation:

- To reduce poverty in families with children
- To provide education and skills for people to achieve their full potential
- To improve living and work environments
- To prevent and reduce accidents at work, home, and on the road
- To improve neighbourhoods and the wider environment
- To enable healthier choices
- To promote mental health and emotional well being at individual and community level

Dr. McBride outlined the implementation process whereby a ministerial group on public health had strategic oversight and facilitated cross departmental working. Boards and ‘Investing for Health’ partnerships were established and the Public Health Agency is now responsible for regional and local implementation.

A recent review of 'Investing for Health' took place, although overall positive some updating was required for new contexts. Positive results included:

- A key area of success was local ownership and commitment
- There is an inclusive approach to development and delivery
- There is a focus on the wider determinants of health
- There is a purpose and sense of direction to those within and outside of health.

However, variations in life expectancy has not improved for women, has gotten worse for men and there are great differences within gender based on income.

Dr. McBride concluded by noting three things that worked and four things learned by the process, and plans going forward.

Three things that worked:

- Greater awareness of the complexity of factors that influence health and the need to work together
- Mobilisation at a local level
- Engagement and involvement of communities/third sector

Four things learnt:

- Need to ensure connection between local and regional levels, particularly at regional level
- Strengthened direction, structures and monitoring at a strategic level and need to better inform other government strategies at development stage
- Courage when determining priorities
- Levering funding advantages and disadvantages – the advantage being getting the buy-in from key partners, but a lot of time and energy was used in leveraging this money.

Looking to the future, Dr. McBride noted how work must continue within health as well as focussing on influences external to healthcare services. In this vein, there has been a focus on the major causes of morbidity and mortality. In 2009, the Cardiovascular Health and Well-Being Service Framework was launched for

implementation and sets in place 45 standards for good practice in the prevention and treatment of cardiovascular diseases. In parallel to their responsibility for this, the Public Health Agency undertook a Health Impact Assessment (HIA) which concluded that if fully implemented that the service framework will positively influence the wider health determinants of health such as economic productivity, health lifestyles, and the environment. It also concluded that the HIA has produced results that will help to implement the service framework in ways to improve equity in access to services and ultimately reduce inequalities. This was Dr. McBride's concluding example of mainstreaming public health intervention into shaping health service activity.

Government Departments Addressing the Health Agenda –

Health: Everybody's Responsibility

Tom O'Mahony

Secretary General, Department of Transport, Tourism and Sport

Mr. O'Mahony discussed his roles in different departments and in developing *Shaping a Healthier Future* and how a strong multi-sectoral approach to the health agenda would pay great dividends. Mr. O'Mahony focussed on the relationship between 'active travel' as having positive outcomes for health, the environment, road safety and congestion. The promotion of road safety in particular supports the health agenda as road traffic accidents not only cause deaths, but create limiting disabilities for otherwise mobile and active younger people. In addition, securing accessible, affordable and acceptable transport for all is recognised as making a difference to health and quality of life.

Mr. O'Mahony offered practical advice on how to encourage others to work cross-sectorally to promote an agenda that is common to all, but being particularly championed in one sector. Mr. O'Mahony stated that others can be persuaded to take on these other agendas but sustaining this buy-in can be the difficult part. Mr. O'Mahony recommended consistent reinvention, particularly during a time of funding cuts. There is an inherent need to identify shared agendas and share budgets when there is less money available. For example, encouraging physical activity among children can mean a reduction in long term healthcare costs, a greater involvement in sport and in the classroom more alert children are better equipped for learning. These benefits can already be seen in the Green Schools programme.

Mr. O'Mahony focussed on his current department's Smarter Travel Strategy which aims to have over 200,000 additional people walking and cycling to work by 2020; a great challenge in which inter-sectoral working is essential and one in which other sectors receive great benefits. The health benefits in terms of mental well-being, reduced levels of heart disease, reductions in obesity and diabetes are accompanied by economic benefits such as reduced congestion and freeing up money from imported petrol purchasing for other consumer goods. In addition, there are the environmental targets and goals that can be addressed through this Strategy's success. The Smarter

Travel Strategy took a holistic approach with 49 actions many of which lie outside the direct responsibility of the Department of Transport. While the policy development included a high level of interdepartmental work the challenge will be the implementation, but Mr. O'Mahony believes that the current circumstances will require more efficient ways to work together as a necessity which should assist this process.

Mr O'Mahony concluded that many of our most important national policies are interdependent, and this message needs to be promoted across sectors.

Panel Discussion

The question and answer session at the national consultation day focussed primarily on one specific area – achieving buy-in; from the politicians and policymakers – the leaders, the public and the healthcare sector. The panel also briefly addressed the difficult question of what to do when policies conflict.

Leadership buy-in and conflicting policies

- There is a need to acknowledge interdependencies across government departments and a programme for government needs to be developed that is cross-cutting otherwise there is a danger that departments will retreat into their corners.
- An economic argument is often a good way to convince leaders who otherwise might be sceptical about the necessity of inter-departmental working. Although economic rationale may make sense in the long term, often returns are not seen within the lifetime of a government. Leaders need to be convinced that a long-term view rather than a four-year term is essential to policy development.
- Trade-offs are almost always necessary between policies, and conflict is about finding the best compromise. If the public are well-informed and engaged, they should be able to guide the ‘moral compass’ that is necessary to negotiate the best solution.

Public buy-in

- There is a need to educate the public to extend their view of health as being more than access to a G.P.
- At EU level, there has been a good deal of consultation to develop public health policy to promote ownership at every level of society.
- There is a need to focus on research that will highlight the interdependencies across government departments. Research should clearly demonstrate to the public the logic of more inter-departmental work, particularly in light of providing better value for money.

- This may require inventive ways of engaging the public to think about what is most important to them reframed in terms of health.
- However, education of the public may not always be enough. More must be done to broach culturally-accepted behaviours such as binge drinking which is not restricted to one socio-economic group.

Healthcare sector buy-in

- Every hospital needs to be a health promoting hospital and this will require better coordination between public health and health promotion strategies. A cultural shift is required to make prevention everyone's business.
- To achieve this cultural shift within the healthcare sector it will be necessary to get healthcare workers thinking of their role as ensuring good health for their patients beyond the hospital door; to become advocates for good health.

Annexe 1: Numbers in attendance

Dublin 13th June 2011 (National)

Over 330 were invited, 12 declined, those in attendance included representatives from the following:

45 from Departments of Health & Children and Youth Affairs

163 HSE employees (public health, health promotion, primary care and healthcare providers) or research based. Plus one person from HIQA.

12 people from other government departments

5 people from youth/children's groups

9 from NGOs

3 from religious groups

3 from broadcast media

5 from environment-focussed groups

5 from business interests

3 from pharmaceutical groups

3 from disability groups

3 consumer and food safety

11 representatives covering poverty, homelessness, unemployment, Unions, equality, Travellers, women's groups

13 healthcare interest groups (e.g. patients', cancer, heart, anti-smoking, suicide/mental health)

2 government policy advice groups (NESF, ESRI)

4 sporting organisations

1 older person's group

2 public protection representatives (Garda and Road Safety Authority)

1 representative from a local authority and 1 representative from a regional development organisation

Cork 16th June 2011 (HSE South)

87 attendees

63 were direct HSE employees (to include: Health Action Zone staff, social inclusion, community workers, health promotion, environmental health, communications and operations, Traveller health workers, childcare, drug and alcohol workers) plus one person from the 'GP unit'

8 were third level educators

5 worked for DOH

3 worked for Local Authorities

1 person each from a regional health office, Cork city partnership, SafeFood, Healthy Cities (Waterford), a sports partnership and the Gardai.

Dublin 17th June HSE Dublin Mid-Leinster

90 people were invited

69 accepted the invitation

48 attended

Local authority: 3

Child care committees 2

Partnership companies 2
Education 2
Sports 1
IPH 1
DOH 2
Politician 1 (HSE Regional Forum)

HSE:

Ambulance 2
Environmental Health 4
Health Promotion 6
Public Health 12 (4 DoH group and 2 speakers)
Integrated services area 10

Galway 23rd June 2011 (HSE West)

The Public Health Department issued approximately 180 invites. Ninety-eight attended on the day, organisations of which included:-

- HSE
- Nursing Homes Ireland
- Baby Friendly Hospital Initiative in Ireland
- Galway & Tuam Traveller Movement
- An Garda Síochana
- ASTI
- County Councils
- Muintír na Tíre
- AIDS West
- Sports Partnerships
- Disability Services
- AWARE
- Mental Health Services
- Childcare Services
- Carers Support Group
- Education
- Youth Work Ireland
- Healthy Cities
- CAVA (community and voluntary association)
- Patient Focus

Dublin 24th June 2011 (HSE Dublin North-East)

The Public Health Department in Dublin issued approximately 120 invites. 68 people attended.

Attendees included HSE employees:

- Departments of Public Health
- Health Promotion Departments
- Environmental Health Departments
- Emergency Management
- Health Intelligence
- Health Protection Surveillance Centre
- Communications
- Nominees of Integrated Service Area Managers
 - Including representatives from Nursing, Senior Management, Occupational therapy, Physiotherapy, PCCC (Primary Community and Continuing Care), Disability services, Dietetics, Social work, Clinical directors, Mental health services, Health promoting hospitals network

Non- HSE attendees included representatives from:

- Primary Care- General Practice
- Healthy Cities
- Local Authorities (environmental, planning and water services)
- County Development Boards
- National Youth council
- Education centre
- Local Sports partnership
- Chamber of Commerce
- Border counties childcare network

Annexe 2:

What two key messages will make Ireland's Public Health Policy first class?

Dublin 13th June 2011 (National)

- Prevention is better than cure. Early intervention is key.
- Well-being/health as an asset
- A healthy Ireland is a fair and strong Ireland.
- To make it happen everyone needs to be involved – community, business, state – all sectors.
- I want my children to bury me; I don't want to bury them.
- Be a society that aspires to having educated healthy children.
- Fairness is social justice – a more equal and responsible society on an evidence base.
- Unequal societies are unhealthy for all.
- Owned by the whole of government, with a sustainable long term view.
- Make positive health as desirable as a clean environment.
- Adequate timeframe for the consultation. Full and meaningful participation across all sectors. Process is equal in importance as the outcome.
- Health is to be seen as an investment for the future. Health is an economic good.
- Policy should be long term with a whole of government support, underpinned with legislation.
- Sustainable and enduring based on evidence and is measurable and with clear accountability and a clear implementation framework which clearly shows cross departmental collaboration.
- Empowered community that has a well supported capacity to engage and advocate for fairness with a shift towards recognising the importance of prevention and promotion.
- Health equity and fairness at the core of the policy.
- Ensure public ownership, participation and under collaboration from development to implementation.
- Help us to help you to look after your health
- This is a health policy for Ireland for the long haul.
- Based on informing, developing and implementing the evidence with in-built real time evaluations.
- Be ambitious – don't shrink the vision. Be understandable, readable for all.

Cork 16th June 2011 (HSE South)

- Should use SMART objectives and be evidence based
- Should engage all sectors in development and implementation
- Healthy population is a wealthy population. In recessionary times the wealth of the country is the health of the people.
- Health is about well being as distinct from services
- Give it the commitment it deserves – learn from previous policies and have a plan for implementation and look at what works well and why things didn't happen previously

- Harness the public health resource within the health sector
- Get the various departments within the HSE to work together and aware of each other
- National inter sectoral health charter based on equity and agreed principles signed up to by all partners at national and local level to include health proofing of policies
- Shift to social model will place emphasis on communities; involvement, prevention and early intervention support.
- Offering behaviour change but only in a supportive environment – all sectors working together
- What have other countries done to improve public health – encourage active citizenship and media driven
- Resources and outcomes should be evident to keep the momentum up
- Engage all sectors in development and implementation
- Connecting health and wealth in a time of recession is important.
- Education of the population: Building our Nation - Our health in our Wealth. Meaningful consultation – ownership of policy by voluntary and statutory sectors. Government will ensure that departments will have to work together openly and honestly - training on partnership and inter sectoral working.
- We need a minister of public health and a unit to champion public health to make sure it happens and complements other policies
- Ensure it happens; realistic, achievable, clear – that people will understand.
- Strategy needs to evolve to a framework for Public Health with an incremental to implementation with measurable outcomes and tangible results.
- Integration of the public health policy into all sectors and associated strategies, particularly primary care/prevention and early intervention.

Dublin 17th June 2011 (HSE Dublin mid-Leinster)

- Has to appeal to every individual. Message should reach all.
- Is Feidir Linn – improve our public's health.
- Health is everyone's business, and quality of life should be the target
- A child born today should enjoy optimal quality of life into old age
- Public Health is everybody's responsibility
- Think healthy, be healthy
- Long term commitment to a long term approach
- Put health on your agenda, communication is key
- Everyone has to work together, maximum gain for shared working under the direction of policy
- Equitable for all the population, everybody wins – needs to be accepted by all agencies that they will benefit from implementation. Public health is everyone's business.

Galway 23rd June 2011 (HSE West)

- Bring it back to basics – use existing resources, harness people and ideas
- Leadership, direction, clear focus taking ideas and issues from the public
- This policy will be implemented in a fair and inclusive way
- This policy is achievable – recognise the real situation we are in.
- Healthy public policy must be based on quality of life

- Healthy community = healthy life = healthy community
- Own your own future, your health your future, your health is in your hands
- Be passionate about your health, be passionate about yourself
- Take bold action with major risk factors
- Clear and explicit focus on inequalities in health
- Inter sectoral respect, one voice, one message
- Meaningful consultation. Stop being reactive and become proactive
- Prevention is better than cure – all sectors need to be involved to ensure that everyone’s health matters. Policy needs to be implemented and have leadership so that it is not just another document on the shelf.
- Equity
- Quality of life as defined by health and well being

Dublin 24th June 2011 (HSE Dublin North-East)

- Ireland’s health – your call
- Public Health concerns every organisation in the state.
- That all groups in society should be able to maximise quality of life and health.
- “Slainte – Is feidir linn”
- Across all departments, measure all decisions against health impact.
- Involve all stakeholders including talking to vested interests and de-vestment of what does not work.
- Prevention is better and cheaper cure.
- Tosach maith, leath na hoibre – supporting families in the early years.
- Title should leave out ‘public health’ term.
- We’re all in this together – Inclusivity is key.
- Recognition of the multi-dimensional nature of health (physical, mental, emotional, spiritual, societal etc.) is of paramount importance. The views of all socio-economic groups should be included.
- Just improving health services will not improve nation’s health.
- Providing all children with the best start in life by empowering them to achieve full potential by a programme similar to SureStart in the UK.