5 Inequalities in Health and Social Care

The World Health Organisation has defined health as a "state of complete physical, mental and social well being and not merely the absence of disease or infirmity". Poor health limits people's ability both to develop their skills through education and to contribute to society by means of employment and involvement in public life. A study by the Institute for Public Health[52] found that health was strongly linked with education, employment, income and housing. Improving equality in health services and outcomes is therefore essential to creating a better Northern Ireland in terms of addressing past legacies and future needs.

Migrant workers and new residents experience difficulties in accessing health and social care services. As our economy grows, reflecting a new era for Northern Ireland's prosperity, it is critical that old inequalities are not replaced by new ones. There is an emerging pattern of inequalities experienced by migrant workers and new residents here, in particular unequal access to basic health care. For example, projects such as STEP and Animate have reported difficulties for those from minority ethnic communities trying to avail of public health provision. The importance of service delivery and of removal of barriers for migrant workers and their families is supported in recent research[53].

Approximately one in five (18%) individuals living in private households in Northern Ireland has some form of **disability** (21% for adults and 6% of children)[54].

Despite disabled people being major users of health care in Northern Ireland[55], there are often many unmet needs. For example, research by the Equality Commission for Northern Ireland highlighted that many disabled women have particular difficulty in accessing key services such as reproductive health care and screening[56].

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[52] Balanda, K.; Wilde, J.; (2003). *Inequalities in Perceived Health: A report on the All-Ireland Social Capital and Health Survey*.
[53] Centre for Cross Border Studies et al (2006) *Improving Government Service Delivery to Minority Ethnic Groups.*
[54] Northern Ireland Statistics and Research Agency (2007) *The Prevalence of Disability and Activity Limitations amongst Adults and Children Living in Private Households in Northern Ireland.* – First Report from the Northern Ireland Survey of people with Activity Limitations and Disabilities, Bulletin No 1.
[55] DHSSPS (2004) *Equalities and Inequalities in Health and Social Care in Northern Ireland: A statistical overview*.
[56] Equality Commission (2003) *Disabled Women in Northern Ireland: Situation, Experience and Identity*.

While we await the detailed output of the Northern Ireland Survey of Activity Limitation and Disability to update knowledge across a range of relevant themes, previous research reported that almost half (48%) of disabled people, compared with under two fifths (39%) of non-disabled people identified transport, when asked unprompted about their concerns[57]. Public transport is highly relevant to health inequality among disabled people – "households which contain a person with a limiting long-term illness are less likely to have access to a car than other households" (68% vs. 82%)[58]. A recent report[59] illustrated that, at the time of the report, 71% of Citybus vehicles were accessible and 18% of Ulsterbus vehicles were accessible. A recent DRC study[60] found that one third (35%) of disabled people found it difficult to go to their local hospital and one fifth (20%) found it difficult to get to their GP[61]. This accessibility differential may be producing a profound effect on those in rural areas, and on **older people** and **disabled people**.

In addition, initial output from the Northern Ireland Survey of Activity Limitation and Disability suggested that, while the majority reported satisfaction, of the approximately one in ten disabled people who noted they were dissatisfied with one or more primary or secondary health services, 40% were dissatisfied with the general attitude of professional medical staff.

The Bamford Review of **Mental Health and Learning Disability** found that mental ill-health affects one in every four citizens. The Review concluded that there was "clear evidence of inequalities in the investment associated with mental health and learning disability over many years compared with the other countries within the UK", despite higher levels of ill-health in Northern Ireland[62]. Describing the costs of failing to address these issues as far reaching, the Review drew attention to impacts on "the quality of life of individuals and their families, their physical health and capacity to make effective use of health services, their employment and

[57] MORI (2002) *Attitudes of Disabled People to Public Transport*. Available at http://www.dptac.gov.uk
[58] NISRA. 2001 Census of Population. Available at www.nisra.gov.uk
[59] DRDNI (2005) *Regional Transport Strategy (RTS) for Northern Ireland 2002-2012 Annual Monitoring Report 2004-2005*.
[60] DRC (2006) *Secondary Analysis of Existing Data on Disabled People's Use and Experiences of Public Transport in Great Britain.*
[61] The Equality Commission has published a series of case studies on a similar theme - Equality Commission (2003). The Experience of Disabled People using Transport in Northern Ireland.
[62] DHSSPS (2006) *The Bamford Review of Mental Health and Learning Disability (Northern Ireland)*. Available at www.rmhldni.gov.uk

productivity and the general economic capital of the entire community"[63]. People with mental health and learning disabilities face particular barriers in society which can impact on outcomes and life chances[64].

Recent research commissioned in Great Britain highlighted the failures of the NHS in addressing the mental health needs of **older people**[65] complementing the findings of the Bamford Review in Northern Ireland. Research carried out by the Northern Ireland Human Rights Commission in 2004 also indicated that there were serious concerns over breaches of older patients' human rights in the level and nature of care they were receiving in the NHS across palliative, acute and ongoing care programmes[66].

In considering equality of health and social care for **women and men**, research commissioned by the Equality Commission[67] found that most health and social care strategy and policy is written in gender-neutral language with general targets set for the whole population. Women and men, however, differ in their specific health and social care needs throughout their lifetime. This research noted that there were particular groups who may be vulnerable when it came to health and well-being, eg, older women, women from minority ethnic communities, women living in rural areas, men who had experienced sexual abuse, men who had experienced domestic violence and men in their role as fathers.

Access to social care presents an obstacle to both **women and men.** Women, for example, may be more likely than men to find their access to health care limited by caring responsibilities and by a lack of transport while, for men, obstacles are more likely to include reluctance to go to a doctor, combined with the limited access associated with the inconvenience of opening times of health care facilities.[68] It is also represented that women have a more restricted access to particular

[63] Bamford Review of Mental Health and Learning Disability (Northern Ireland), Reform and Modernisation of Mental Health and Learning Disability Services – Strategic Priorities for the First Phase of Review Implementation, Briefing Paper (October 2006).
[64] Equality Commission (forthcoming) *A formal investigation under the Disability Discrimination Act to evaluate the accessibility of health information in Northern Ireland for people with a learning disability*.
[65] ACE (2007) *Improving Services and Support for Older People with Mental Health Problems.* (The UK Enquiry into Mental Health and Wellbeing in Later Life).
[66] NIHRC (2004) *Older People's Experience of Health Services in Northern Ireland.*
[67] Equality Commission (2002) *Gender and Health in Northern Ireland: Implications for Statutory Duty.*
[68] Equality Commission (2002) *Gender and Health in Northern Ireland: Implications for Statutory Duty.*

services in Northern Ireland compared to elsewhere in the UK, specifically to reproductive health services[69].

The experience of a person facing multiple inequalities is different from those facing inequality on a single ground. For example **women** are more likely to display signs of a possible mental health problem (21%) than men (16%)**[70]** and other research[71] in Northern Ireland has shown that the experiences of disabled women differ from those of disabled men or of women who are not disabled.

The *Promoting Social Inclusion Working Group*[72] drew attention to significantly poorer levels of health amongst **Travellers** than amongst the majority population. Connolly and Keenan[73] have also highlighted the poor health status of the Traveller children, with mortality rates among Traveller children up to ten years of age having been found to be ten times that of children from the 'settled' population.

Carers are important in our society providing support, often on an unpaid basis, for thousands of older people and those with disabilities[74] and they suffer higher levels of ill health. Almost one in five (19%) of those providing substantial care (50+ hours per week) feel they are in poor health. This compares with 14% of the non-carer population[75]. One in five carers (21%) are aged 60 years or over. Women are more likely to be informal carers than men and over one third (34%) of female carers report that they spend at least 30 hours per week caring[76]. Providing such caring throughout life can result in multiple disadvantages in later life - it can impact on income, pension accumulation and the development of social networks[77]. These impacts of care giving on pensions, earnings, savings and career all multiply over time and impact substantially on middle aged

[69] Women's National Commission of Great Britain and Northern Ireland (March 1999 and March 2005), Submission to the UNCEDAW Committee on the 5th and 6th Periodic Reports of the United Kingdom, Great Britain and Northern Ireland;
Northern Ireland Women's European Platform (2007) Submission to the UNCEDAW Committee on the 5th and 6th Periodic Reports of the United Kingdom, Great Britain and Northern Ireland;
DHSSPS (2007) Draft Guidelines on the Termination of Pregnancy in Northern Ireland.
[70] NISRA (2005) *Health and Well-Being Survey*.
[71] Zappone, K.; (ed.) (2003) *Re-Thinking Diversity*, Dublin: Joint Equality and Human Rights Forum.
[72] OFMDFM (2000) *The Final Report of the Promoting Social Inclusion Working Group*
[73] Connolly, P.; Keenan, M.; (2002) *Consultation with Travellers on the Recommendations of the Final Report of the Promoting Social Inclusion Working Group on Travellers*. Belfast: OFMDFM.
[74] Evason, E.; (2004) *Who Cares? Changes in Informal Caring 1994 to 2006.*
[75] Carers UK (2004) *In Poor Health: The Impact of Caring on Health.*
[76] Evason, E.; (2007) *Who Cares Now? Changes in Informal Caring 1994 to 2006.*
[77] DHSSPS (2006) *Caring for Carers.*

women. 17% of women aged 60 to 74 provide care in their own household and 1 in 4 (25%) children provide informal care for a person not living with them[78].

The social inclusion of **older people** is inextricably linked to their well being and access to services. Over 80,000 older people live alone in Northern Ireland and recent work by Help the Aged indicates that 53% of older people feel that loneliness is the major issue facing older people today[79]. Social isolation is caused by a number of factors, including differential access to and availability of health and social care alongside lack of affordable public transport, and differential access to financial services. Inclusion, however, must go beyond the provision of health and social care services. For **older women**, participation is also constrained by pensioner poverty. Most of the existing pension schemes are based on the traditional model of work, that is, continuous contribution whilst in full-time work in a lifetime job. This model fails to take account of the fact that women are more likely to take career breaks for child or family related reasons, to be economically inactive outside the household, or to be in part-time employment for periods[80]. Gender differences in the labour market have a particular impact on women's situation in later life and their access to pensions, savings and benefits is thereby restricted.

[78] ARK (2006) *Northern Ireland Life and Times Survey.* The definition of 'informal care' as used in the NILT survey included tasks such as going to the shop, giving medicine, etc.
[79] NOP/GfK Spotlight survey for Help the Aged (Unpublished, January 2006)
[80] Evason, E.; Spence, L.; (2002). *Women and Pensions in Northern Ireland*. Belfast. Equality Commission.