Disability and Population Health Discussion Paper

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FOREWORD

People with disabilities, their families, carers and advocates have traditionally focused on striving to develop adequate and responsive specialist support services to meet their needs. This work continues today. However, the mechanisms and channels through which this can happen are changing. Changes are occurring in the health services and other state agencies that have a responsibility to provide services that meet the needs of people with disabilities. The voluntary disability sector has continuously responded to this change in a timely and professional manner. This Discussion Paper on Disability and Population Health is another example of how the disability sector is responding to that change.

Health policy was once thought to be about little more than the provision and funding of direct medical care and intervention. With the emergence and development of the social model of health this is now changing. The concept of Population Health is taking centre stage, internationally and nationally, in the strategic development of health and social care services. The Irish health care system is experiencing a time of change, not only in terms of service design and delivery, but, perhaps more fundamentally, in relation to underlying values, core principles and strategic thinking. The establishment of a designated Population Health Directorate within the Health Service Executive and the primacy of the approach within the Department of Health and Children should further energise and promote the concept at national level. It is envisaged that the approach will be central to the developing structures and consequently service design at national, regional and local delivery level.

People with disabilities are living longer. Many are surviving into old age who in the past would not have survived. The general population is also living longer. What can our society do to reduce the incidence of disability, and to ameliorate its impact? Increased capacity in the diagnostic, genetic and information provision areas will meet up with the moral, ethical, behavioural and social issues that mainstreaming will throw up. We must not simply content ourselves with only sorting out the current levels of unmet specialist needs and presume that disability as an issue has been dealt with once and for all. We must develop a disability plan looking forward to the next fifty years. The Population Health approach is key to any such plan.

This Discussion Paper is therefore very timely and relevant. It provides the cornerstone to our National Conference, 'Disability and Population Health', (Portlaoise, 5th and 6th October, 2005). It outlines DFI's current position regarding disability and the Population Health approach to health policy. It sets out to define the concept, particularly within an Irish context, proceeds to develop key determinants for the disability sector and finally makes recommendations for policy development.

I wish to thank all those who contributed to the development of the Paper, in particular those individuals and organisations who commented on and submitted responses to earlier drafts.

I am particularly grateful to Maria Fox, author of the Paper and to all the staff of DFI for their input. I would expect that the proposals contained in the Paper will contribute to the development and expansion of public health initiatives which will benefit not only the disability sector, but all groups in the population.

John Dolan
Chief Executive
September 2005

SUMMARY OF RECOMMENDATIONS

Income and Social Status

- Social Policy interventions should provide not only safety nets and basic entitlements, but also spring-boards to tackle early and recurrent disadvantage, (e.g. housing, income, education etc.).
- Public health policies should remove barriers to health care, social services and social and affordable housing.
- Introduce and pay a Cost of Disability Allowance at a base rate of €40 per week.
- Disability Allowance to be increased by €17 to €165.80 in Budget 2006 in line with the commitment in the NAPS Review.

Social Exclusion

- Increased support and legal enforcement of existing Equality Legislation to protect people with disabilities from discrimination and social exclusion.
- There should be a statutory duty on all Government Departments, public bodies and publicly funded bodies and services to 'disability proof' their activities from policy to operational matters. This is to ensure the inclusion of people with disabilities in all public policies and services.
- Government should continue to develop its policy of Mainstreaming of Disability Services as committed to in the 1997 Programme for Government and the National Disability Strategy.
- Improved supports for a Community Development approach within the voluntary disability sector to enhance the social inclusion of people with disabilities in mainstream society.
- Support voluntary disability organisations to further engage in social inclusion initiatives for people with disabilities.

Early Child Development

- Increased and earlier screening, detection and intervention programmes contribute to prevention of conditions and positive health and financial outcomes for all.
- Develop improved preventative health care (including health education, care facilities) before the first pregnancy.
- Continued promotion of folic acid intake among all women of child-bearing age.
- Examination and development of other methods of folic acid intake promotion, particularly for hard to reach groups, eg disadvantaged young women, ethnic minorities and young women with disabilities.
- Provide improved pre and post-natal care for mothers and babies.
- Increase Child Allowance as a direct universal financial intervention for mothers and children.
- Increase the general level of, and access to, education to improve the health of mothers and babies in the long run.
- Strategic Task Force on Alcohol to address the issue of alcohol related harm to the foetus and developing child.

Unemployment, Employment and Working Conditions

- Employment Policy should have as its goals:
  (i) to prevent unemployment and job insecurity,
  (ii) to reduce the hardship associated with unemployment and
  (iii) to restore people to secure jobs.
- There is a need to further develop training and employment opportunities, in both the public and private sector, for people with disabilities.
- Tax relief, employment grants and other financial incentives to be provided to employers to increase the participation of people with a disability in the workforce.
- The 3% target (of employment of people with disabilities) within the public sector needs greater monitoring and adherence.
- All workers should be protected by minimum income guarantees, minimum wages legislation and access to work related services, (e.g. employee assistance programmes).
- To reduce musculoskeletal disorders workplaces must be ergonomically designed.
- There is an ongoing need to protect people from exposure to toxic materials at work, by increased adherence and enforcement of health and safety and other worker protection legislation, including the workplace smoking ban.
- Workplace health protection should encompass legal aspects, including health and safety legislation and powers of inspection, and workplace health initiatives such as employee assistance programmes and work/life balance programmes.
- Limitations on working hours must be enforced as a matter of priority.
- Appropriate involvement in decision-making benefits employees at all levels in an organisation.
- Good management involves ensuring appropriate rewards – financial, status and self-esteem – with a subsequent positive health impact for all employees.

Stress

- Social policy needs to address both psychosocial and material needs, as both are major causes of stress.
- In association with the medical response to treating stress, more attention should be focused upstream on reducing the major causes of chronic stress (insecurity, low self-esteem, working environment, poverty etc.).
- Increased financial and other support systems for carers as an acknowledgement of the vital role this group provides in responding to the care needs of people with disabilities.

Health Services

- The Health Service Executive in partnership with the Department of Health and Children, the voluntary disability sector and other stakeholders should develop as a priority a comprehensive, targeted, National Population Health Strategy.
- A National Assessment of the Health Needs of People with Disabilities should be undertaken to compile baseline data. This data will determine needs, priorities and targets for the planning and development of all health services for people with disabilities.
- All health screening and protection initiatives (e.g. cancer screening programmes) be made available and accessible to people with disabilities including those in all residential settings.

- Population Health programmes and interventions need to be specifically targeted and delivered in partnership with disability organisations if take-up is to increase past its current unacceptably low levels.

Physical Environment

- The Departments of Health and Children and Environment, Heritage and Local Government to develop a joint national accommodation and support strategy for people with disabilities.
- The principle of Universal Design is the target in relation to the built environment.
- Local Authorities should encourage and require, by legal means if necessary, that all building developments, as a minimum, comply with Part M of the Building Regulations.
- Local Authorities should employ an Access Officer to inspect planning applications and building developments.
- All Local Authorities to implement and deliver on the commitments of the Barcelona Declaration.
- The Department of the Environment, Heritage and Local Government should 'design in' the issues and needs of people with disabilities in line with the Government's commitments in the National Disability Strategy and to Mainstreaming, particularly with regard to the housing and accommodation needs of people with disabilities.
- The six Government Departments mandated to implement the National Disability Strategy through the development of Sectoral Plans to develop a partnership approach to the development, implementation and monitoring of these initiatives.
- Government Agencies and Partner Groups to continue the promotion and enforcement of the Workplace Tobacco Ban.
- There should be continued improvement and development of an accessible public transport network, to include rural and other hard to reach communities.
- Increased implementation and enforcement of the penalty points system as a proven road safety measure.
- Reduction of the blood alcohol concentration level to zero in line with that of most other EU countries.
- Continued promotion of designated driver schemes, such as free soft drinks, through licensed premises.

INTRODUCTION

This Paper outlines DFI's current position regarding the Population Health approach to health policy. It first defines and outlines the concept, particularly within the Irish context, then proceeds to develop some key determinants for the disability sector and subsequently make recommendations for policy development. DFI member organisations and the broader voluntary disability sector have traditionally been active in health promotion, education and early intervention. This work emphasis draws parallels with the Population Health concept and its relevance to the sector will be developed in the course of the Paper. Throughout the text the WHO definition of health, which states that, '*health is a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity*', is adopted. In 1986 this was redefined to include health as '*a resource for everyday life, not the objective of living.*'

It is important to note at the outset that the purpose of this Paper is to develop and set out priorities for the disability sector within the parameters of a Population Health approach to health and social services. Prevention is the cornerstone of any rational health policy. As a result issues of health promotion, disease and disability prevention are discussed. This is by no means contrary to the social and rights based model of disability to which DFI is committed. Rights and responsibilities are not substituted or diluted through the exploration and promotion of improved health status, reduced inequalities and greater social participation for all, including people with disabilities.

The Concept of Population Health

Health policy was once thought to be about little more than the provision and funding of direct medical care and intervention. With the emergence and development of the social model of health this is now changing. The concept of Population Health is taking centre stage, internationally and nationally, in the strategic development of health and social care services. Population Health is an approach to health that aims to improve the health and wellbeing of the entire population and to reduce inequities in health status among particular population groups. In order to do this it works at, and acts on, the broad range of factors and conditions that have a strong influence on our health, known as the determinants of health. Multiple factors and conditions contribute to our health. These range from biological and hereditary factors to lifestyle and community factors through to general socio-economic, cultural and environmental conditions.

Subsequent action is directed at the health of the entire population, or sub groups of the population, rather than the individual. A healthier population makes more productive contributions to overall societal development, requires less support in the form of health care and social benefits, and is better able to support and sustain itself over the long term. An underlying assumption of the approach is that reductions in health inequities require a reduction in material and social inequities. There is broad agreement in the research that the best approaches to tackling health inequalities focus on addressing the underlying structural determinants of social and economic inequalities in society, (in Burke, S et al 2004). The outcomes or benefits of a Population Health approach therefore extend beyond improved Population Health outcomes to include a sustainable and integrated health care system, increased net growth and productivity, strengthened social cohesion and improved quality of life, (Health Canada 2001).

The concept of Population Health builds on a long tradition of public health, community health and health promotion policy and practice. It has its foundations in Canadian

health policy dating from the early 1970s. The theoretical framework for health promotion and Population Health are similar, both are concerned with improving health and reducing health inequities. They both regard health as *'a capacity or resource for everyday living, that enables us to pursue our goals, acquire skills, satisfy personal aspirations and cope with life's challenges', (WHO 1986).* However certain sectors in society are at a disadvantage in this regard, these include homeless persons, ethnic minorities and people with disabilities.

An underlying principle is that all people should have an equal opportunity to develop and maintain their health, and it acknowledges that certain population groups have unique requirements for health, e.g. people with disabilities. The approach assesses needs and develops strategies that accommodate the distinctive characteristics of particular population groups, thus optimising health outcomes for all is its main objective.

The Irish Health Care System

The Irish Health Care System is experiencing a time of change, not only in terms of service design and delivery, but, perhaps more fundamentally, in relation to underlying values, core principles and strategic thinking. There is a move from a focus on curative medical intervention towards a healthcare system which incorporates disease prevention and health protection initiatives. The current Health Strategy, *'Quality and Fairness: A Health System for You'* contains many references to Population Health and addressing health inequalities, particularly among certain population groups. Allied to this are its four guiding principles; equity, people-centeredness, quality and accountability, all of which hold resonance with a Population Health agenda. It states; *'Achieving full health potential does not depend solely on the provision of health services. Many other factors and therefore many other individuals, groups, institutions and public and private bodies have a part to play in the effort to improve health status and achieve the health potential of the nation', (p60).*

The National Primary Care Strategy. *'Primary Care – A New Direction'* also defines its remit broadly to include health promotion, screening and assessment, rehabilitation and personal social services along with traditional diagnosis and treatment services. It states; *'Population Health services will be strengthened and expanded to ensure widespread uptake of initiatives such as screening, immunisation and early intervention', (p26).*

The establishment of a designated Population Health Directorate within the Health Service Executive and the primacy of the approach within the Department of Health and Children will further energise and promote the concept at national level. It is envisaged that the approach will be central to the developing structures and subsequent service design at national, regional and local delivery level. Its prominence within the developing policy and delivery mechanisms should influence strategic planning and ultimately service initiatives.

The Disability Sector

The Population Health approach holds particular benefits for the disability sector. People with disabilities are not immune to other health concerns. They are not immune to illness and disease unrelated to their particular disabling condition. People with disabilities experience cancers and cardiovascular disease and all other illnesses that effect the general population. In fact for some people with disabilities co-morbidity (being affected with more than one health condition) is a particular reality resulting in additional pressure for the person concerned.

Having a disability can to a certain degree compromise one's 'health expectancy'. There are particular links between Down's Syndrome and the onset of Alzheimer's, and between Muscular Dystrophy and Diabetes. One review of the research carried out by Carvill in 2001 concluded that people with learning disabilities are between 8.5 and 200 times more likely to have a vision impairment compared to the general population and around 40% are reported to have a hearing impairment, with people with Down's Syndrome at particularly high

risk of developing vision and hearing loss. There is a growing awareness of increased incidences of depression and other mental health issues among those with spinal and head injury and other late onset conditions. Also given our ageing population we should expect to see a corresponding increase in these realities in the decades ahead with subsequent demands on the healthcare system. Developing a Population Health response to these concerns should increase access to health promotion, screening and other public health programmes for people with disabilities. Such services need to be specifically targeted and delivered in partnership with disability organisations if take-up is to increase past its current unacceptably low levels.

DFI Members

A focus on prevention and targeted interventions is well established in the voluntary disability sector. Our members have been active in this area for decades, with many organisations originally set up in response to particular needs among their client/membership base. Voluntary disability organisations provide services such as information, advice, therapeutic interventions, training and employment, advocacy and specialist support, to name a few. In real terms we are about the business of not only keeping people well, but also actively improving health and social gain for people with disabilities and their families. The sector is a major source of information and influence concerning cross-sectoral issues, having developed and maintained successful partnership arrangements over time. Our members consistently respond to new and changing demands from their clients and from funding providers, in a coherent and professional manner. This management of change is something our sector is experienced and skilled in. We also positively acknowledge and welcome change, particularly if it is to the benefit of people with disabilities and their families.

THE DETERMINANTS OF HEALTH FOR THE DISABILITY SECTOR

A range of factors influence people's health. These are known as the determinants of health. Some of these are fixed, including age, sex and genetic make-up. Individual behaviour and lifestyle choices, including smoking, physical activity levels and diet also impact on health. There is also a growing understanding and acceptance that a wide range of social, environmental, economic and cultural factors also have a significant impact. Each of these factors is important in its own right, while also being interrelated. The key determinants, as argued by DFI, for the disability sector are outlined below.

Income and Social Status

'The one thing that all people with disabilities in Ireland have in common is the considerable risk that they will experience a high level of poverty', (DFI 2003).

There is strong and growing evidence that higher social and economic status is associated with better health. Health status improves at each step up the income and social hierarchy. As early as 1980 the evidence of this was overwhelming. The Black Report in the UK detailed the growing class gradient in mortality and morbidity from all the major diseases commenting that; *'There are marked inequalities in health between the social classes in Britain…Mortality tends to rise inversely with falling occupational rank or status, for both sexes and at all ages,' (Jones et al, 2002).*

The healthiest populations are those in societies which are not only prosperous but which also have an equitable distribution of wealth. It is not the poorest societies that experience the greatest health inequalities, but societies in which the gap between rich and poor is widest, (Combat Poverty Agency 2004). In Ireland poorer people in the population experience poorer health and have less access to health services. Research from around the world, including Ireland, has recognised socio-economic and geographic gradients in indicators of disease and health. In general we know that as socio-economic status improves so too does health, (in Burke, S et al 2004).

This is a key determinant for people with disabilities, given the well established fact that poverty and disability are inextricably linked. People with disabilities as a group are poorer than the general population, and people living in poverty are more likely than others to have a disability. People with disabilities have lower education and income levels than the rest of the population. They are more likely to have incomes below poverty level, and less likely to have savings and other assets than other groups in society. A study by Martin and White in 1988 of the financial circumstances of adults with disabilities found that; *'whether measured in terms of income, consumer goods, diet or basic social needs, as a population group they were especially vulnerable to poverty' (Jones et al, 2002).* To further compound this reality, certain groups within the disabled population are more vulnerable to the risk of poverty, including the elderly, those with mental and intellectual disabilities and women, (Elwan, 1999).

On a practical level, income to a large extent determines living conditions and the ability to buy sufficient good food. This is a particular reality and an additional complication for people with disabilities. People with disabilities face extra costs in daily living associated with travel, heating, diet and medication. People with disabilities and their families, are meeting these extra costs. It is clear that people with disabilities and their families are more likely than the rest of the population to live in poverty, and that this is a two-way relationship – disability adds to the risk of poverty, and conditions of poverty increase the risk of disability, (Elwan, 1999).

The Evidence:

- The rate of hospitalisation for mental illness is more than six times higher for people in the lower socio-economic groups as compared with those in higher groups, (Burke, S et al 2004).
- The incidence of chronic physical illness has been found to be two and a half times higher for poor people than for the wealthy, (Burke, S et al 2004).
- Men in unskilled jobs are four times more likely to be admitted to hospital for schizophrenia than higher professional workers, (Burke, S et al 2004).
- Research has shown that poverty directly harms the health of those on low incomes, (in Burke, s et al 2004).
- Low-income Canadians are more likely to die earlier and to suffer more illnesses than Canadians with higher incomes, regardless of age, sex, race and place of birth, (Health Canada 1999).
- A major British study of civil servants found that, for most major categories of disease (cancer, cardiovascular etc.), health increased with job rank, even when other risk factors such as smoking were taken into account, (Canadian Institute of Health Information 2004).
- Two thirds of households headed by an ill/disabled person fall below the 60% median income line, (Combat Poverty Agency 2004).
- Research has consistently shown a strong association between poor health and low income on the one hand and higher income and better health on the other, (Barrington 2004).
- People further down the social ladder usually run twice the risk of serious illness and death as those near the top, (WHO 2003).
- The mortality rate for all causes of death between 1989 and 1998 was almost two and a half times greater for the lowest socio-group than the highest, (Balanda and Wilde, 2001).
- Ireland has the highest level of income inequality in Europe, and the second highest level of income inequality in OECD countries after the U.S., (in Burke, S et al 2004).

Policy Recommendations:

- Social Policy interventions should provide not only safety nets and basic entitlements, but also spring-boards to tackle early and recurrent disadvantage, (eg; housing, income, education etc.)
- Public health policies should remove barriers to health care, social services and social and affordable housing.
- Introduce and pay a Cost of Disability Allowance at a base rate of €40 per week.
- Disability Allowance to be increased by €17 to €165.80 in Budget 2006 in line with the commitment in the NAPS review.

Social Exclusion

Social exclusion, which is linked to poverty and relative deprivation, has a major impact on the health of some population groups, including people with disabilities. This exclusion from the everyday activities of living and contributing to society has repercussions for people's self esteem, mental health and overall general wellbeing. Social exclusion can result from discrimination, stigmatisation and hostility. People with disabilities experience many barriers to participation in education or training, and gaining access to other general activities. This is a particular concern for those living in residential environments. They are excluded from participating in society through low incomes, physical exclusion and lack of access to independent advocacy. This is socially and psychologically damaging, materially costly and harmful to health, (WHO 2003).

The Evidence:

- People who live in, or have left institutions may be particularly susceptible to social exclusion.
- Poverty and social exclusion increase the risk of disability, illness and social isolation and vice-versa, forming vicious circles that deepen the predicament people face, (WHO 2003).
- Some experts have concluded that the health effect of social relationships may be as important as established risk factors such as smoking, physical activity, obesity and high blood pressure, (Canadian Institute of Health Information 2004).

Policy Recommendations:

- Increased support and legal enforcement of existing Equality Legislation can help protect people with disabilities from discrimination and social exclusion.
- There should be a statutory duty on all Government Departments, public bodies and publicly funded bodies and services to 'disability proof' their activities from policy to operational matters. This is to ensure the inclusion of people with disabilities in all public policies and services.
- Government should continue to develop its policy of Mainstreaming of Disability Services as committed to in the 1997 Programme for Government and the National Disability Strategy.
- Improved supports for a Community Development approach within the voluntary disability sector to enhance the social inclusion of people with disabilities in mainstream society.
- Support voluntary disability organisations to further engage in social inclusion initiatives for people with disabilities.

Early Child Development

New evidence on the effects of early experiences on brain development, school readiness and health in later life has sparked a growing consensus about early childhood development as a powerful determinant of health in its own right (Public Health Agency of Canada 2005). Observational research and intervention studies have shown that the foundations for adult health are laid before birth and in early childhood. Poor foetal development and low birth weight is a risk for health in later life. Slow physical growth in infancy is associated with reduced cardiovascular, respiratory, pancreatic and kidney development and function, which increase the risk of illness and disability in adulthood, (WHO 2003). Early identification, diagnosis and treatment of conditions such as in audiology services can result in more positive outcomes in the medium and longer term.

Many of the causes of morbidity and mortality in children relate to preventable causes such as infectious diseases, certain congenital abnormalities (e.g. neural tube defects) and injuries and poisonings. Immunisation uptake is considered to be a good morbidity proxy – yet immunisation uptake in Ireland is well below target rates and a social class gradient is clear, (in Burke, S et al 2004).

In Ireland approximately half of all pregnancies are unplanned, (Kiely 2004). This raises particular challenges in relation to education and other prevention campaigns aimed at women of child bearing age. For example, while there is general awareness of the benefits of folic acid supplementation, the majority of women are not taking it at the time of conception. Providing children with a good start in life means supporting mothers and care givers and the positive health impact of early development and education lasts a lifetime.

The Evidence:

- Experiences from conception to age 6 have the most important influence of any time in the life cycle on the connecting and sculpting of the brain's neurons. Positive stimulation early in life improves learning, behaviour and health into adult life, (Health Canada 1999).
- Investment in the health of mothers and children has a double advantage in improving early life status and influencing life trajectory opportunities, (in Burke, S et al 2004).
- There is a well documented and established relationship between increased folic acid intake and a decreased risk of neural tube defects (NTD) in infancy, (Kiely 2004).
- While we have seen a reduction of the incidence of NTD in Ireland in recent years, compared to other European countries we still have a high incidence of occurrence, (Kiely 2004)
- Tobacco, alcohol and other drug use during pregnancy can lead to poor foetal development and poor birth outcomes, including low birth weight and foetal alcohol syndrome, (Health Canada 1999).
- Smoking during pregnancy can impact on foetal growth and is associated with adverse pregnancy outcomes, including low birth weight, (Kiely 2004).
- The incidence of asthma is higher among children whose parents smoke and research has shown that parental smoking increases the risk of sudden infant death, (Kiely 2004).
- Infants and children who suffer from abuse are at a higher risk for injuries, a number of behavioural social and cognitive problems later in life, and death, (Health Canada 1999).
- Research shows a strong relationship between income level of the mother and the baby's birth weight, (Health Canada 2004).
- Low birth weight has links with problems during childhood and into adulthood, (Health Canada 2004).
- Low birth weight not only increases the risk of ill health or death in the first year of life, but is also associated with the development of heart disease, diabetes and high blood pressure later in life, (Burke, S et al 2004).
- Parental deprivation (characterised by poverty, poor diet, smoking, substance abuse) can lead to poor foetal growth and impaired cardiovascular, respiratory and kidney development.

Policy Recommendations:

- Increased and earlier screening, detection and intervention programmes contribute to prevention of conditions and positive health and financial outcomes for all.
- Develop improved preventative health care (including health education and care facilities) before the first pregnancy.
- Continued promotion of folic acid intake among all women of child-bearing age.
- Examination and development of other methods of folic acid intake promotion, particularly for hard to reach groups, e.g. disadvantaged young women, ethnic minorities and young women with disabilities.
- Provide improved pre and post-natal care for mothers and babies.
- Increase Child Allowance as a direct universal financial intervention for mothers and children.
- Increase the general level of and access to education, to improve the health of mothers and babies in the long run.
- Strategic Task Force on Alcohol to address the issue of alcohol related harm to the foetus and developing child.

Unemployment, Employment and Working Conditions

In general, having a job is better for your health than not having a job. Unemployment puts health at risk, and the risk is higher in areas and among groups where rates of unemployment are high. Even after allowing for other factors, unemployed people and their families suffer a substantially higher risk of illness and premature death. The health effects of unemployment are linked to both its psychological consequences and the financial problems it brings, especially debt. This is of particular relevance to the disability sector. We know that at 70%, people with disabilities endure substantially higher rates of unemployment compared to the general population. Such employment exclusion, combined with experiences of poverty and discrimination, has significant implications for the health and wellbeing of people with disabilities, (Burke, S et al 2004).

The situation is, however, a little more complicated than that. Job insecurity, along with underemployment, low decision making authority, stressful and dangerous working environments are associated with poorer health. Merely having a job will not always protect physical and mental health; job design and quality is also important.

The Institute of Public Health in Ireland published a Review of the Health Impacts of Employment in March 2005 which outlined the varied and intrinsic ways in which employment can affect health. It concluded that; *'The material wellbeing and sense of purpose that a job provides are beneficial to health….however some types of work are healthier than others. Stressful working conditions, bullying, harassment and low pay are all detrimental to health….and the disruption of work/life balance through long or irregular working hours and stressful commuting is also unhealthy', (p16).*

The Evidence:

- High levels of unemployment and economic instability in a society can cause significant mental health problems and adverse effects on unemployed people, their families and their communities, (Canadian Institute of Health Information 2004).
- Lack of control over one's work is particularly related to an increased risk of low back pain, sickness absence and cardiovascular disease, (WHO 2003).
- Between 70% and 80% of people with disabilities are unemployed compared to around 5% of the general population.
- Conditions at work, both physical and psychosocial can have a profound effect on people's health and wellbeing, (Health Canada 1999).
- In Ireland work related accidents and diseases are the main reasons for impairments and disabilities for people aged 45 to 54, (in Doyle et al 2005).
- Having too much work, having responsibility for others at work and the physical working environment are important causes of stress in Ireland, (in Doyle et al 2005).
- Many people have negative preconceptions about the ability of people with disabilities to be productive in the workplace and this can lower advancement opportunities and self-esteem, (Doyle et al 2005).
- The greater the level of control over the work environment, the better someone's health is likely to be, (Doyle et al 2005).

Policy Recommendations:

- Employment Policy should have as its goals:
  (i) to prevent unemployment and job insecurity,
  (ii) to reduce the hardship associated with unemployment and
  (iii) to restore people to secure jobs.
- There is a need to further develop training and employment opportunities in both the public and private sector for people with disabilities.

- Tax relief, employment grants and other financial incentives to be provided to employers to increase the participation of people with a disability in the workforce.
- The 3% target (of employment of people with disabilities) within the public sector needs greater monitoring and adherence.
- All workers should be protected by minimum income guarantees, minimum wages legislation and access to services.
- To reduce musculoskeletal disorders workplaces must be ergonomically designed.
- There is an ongoing need to protect people from exposure to toxic materials at work, by increased adherence and enforcement of Health and Safety and other worker protection legislation, including the workplace smoking ban.
- Workplace health protection should encompass legal aspects, including health and safety legislation and powers of inspection, and workplace health initiatives such as employee assistance programmes and work/life balance programmes.
- Limitations on working hours must be enforced as a matter of priority.
- Appropriate involvement in decision-making benefits employees at all levels in an organisation.
- Good management involves ensuring appropriate rewards – financial, status and self-esteem – with a subsequent positive health impact for all employees.

Stress

The relationship between physical and emotional health is well documented and this link is generally accepted by all exponents of an holistic understanding and definition of health. Positive mental and emotional health contributes to physical health and wellbeing. Stressful circumstances, leading to feelings of worry, anxiousness and inability to cope, are damaging to health and may lead to illness and premature death.

The reality of dealing with a disability, either from birth or acquired, can be a particular cause of stress. This additional stress affects not only the person with the disability but also their partner, parents, wider family members and friends. Carers, in particular family carers, play a vital role in providing essential personal support services to people with disabilities. This is often carried out under extremely time consuming, physically demanding and stressful circumstances. There is the anxiety and worry caused by the financial, social and practical difficulties experienced due to disability. As a result increased stress is a particular outcome and cause of ill health for some people with disabilities and their families.

The Evidence:

- Long-term anxiety, insecurity, low self-esteem, social isolation and lack of control over home and work life, have powerful effects on health. Such psychosocial risks accumulate over the lifetime and increase the chances of poor mental health and premature death.
- Long-term effects of stress contribute to a wide range of conditions including infections, diabetes, high blood pressure, cardiovascular disease, depression and aggression, (WHO 2003).
- People experiencing poverty, including people with disabilities, report higher levels of mental illness and stress, and lower levels of satisfaction with life than the better off, (Combat Poverty Agency, 2004).

Policy Recommendations:

- Social policy needs to address both psychosocial and material needs, as both are major causes of stress.

- In association with the medical response to treating stress, more attention should be focused upstream on reducing the major causes of chronic stress (insecurity, low self-esteem, working environment, poverty etc.).
- Increased financial and other support systems for carers as an acknowledgement of the vital role this group provides in responding to the care needs of people with disabilities.

Health Services

While we know that health services are not the only, or indeed, the main cause of health inequalities, we also know that health services are very important for people who are sick. This often includes children, women of child-bearing age, those with chronic illnesses and disabilities and older people, (Public Health Alliance Ireland 2004).

The underlying principles, design and delivery of health services contribute positively or negatively to people's general health and wellbeing. When centred on disease prevention, the promotion and maintenance of health and the restoration of health functioning, health and social service systems can contribute immensely to health. This concept permeates current international and national health policy. The establishment and development of a Population Health approach underlies the current National Health Strategy and the ongoing Health Service Reform Programme.

The Evidence:

- Disease and injury prevention activities in areas such as immunisation and the use of mammography are showing positive results, (Health Canada 1999).
- There is traditionally no planning for, or inclusion of, people with disabilities in programmes and subsequently very low take up rates of screening and other health protection initiatives.
- Only 19% of women with learning disabilities are likely to undergo cervical smear test compared to 77% of the general population, (Djuretic et al 1999).
- At 33%, women with learning disabilities are much less likely to engage in breast cancer examinations or receive invitations to mammography than the general population, (Davies & Duff 2001).
- Within Ireland poorer people in the population experience poorer health and have less access to health services, (Burke, S et al 2004).

Policy Recommendations:

- The Health Service Executive in partnership with the Department of Health and Children, the voluntary disability sector and other stakeholders should develop as a priority a comprehensive, targeted, National Population Health Strategy.
- A National Assessment of the Health Needs of People with Disabilities should be undertaken to compile baseline data. This data will determine needs, priorities and targets for the planning and development of all health services for people with disabilities.
- All health screening and protection initiatives (e.g. cancer screening programmes) be made available and accessible to people with disabilities including those in all residential settings.
- Population Health programmes and interventions need to be specifically targeted and delivered in partnership with disability organisations if take-up is to increase past its current unacceptably low levels.

Physical Environment

The physical environment is an important determinant of health. At certain levels of exposure contaminants in our air, water, food and soil can cause a variety of adverse health effects, including cancer, birth defects, respiratory

and gastrointestinal ailments. In the built environment housing, air quality and design of communities and transport systems can significantly influence our health and wellbeing, (Public Health Agency of Canada, 2005).

The physical environment includes where people live and are accommodated. While housing for people with disabilities is not the focus of this Paper, as a determinant in its own right it requires mentioning. There is clear evidence that poor housing and accommodation, such as cold, damp or poorly designed homes has adverse effects on the health of people living in them. Cold ambient temperature, with inadequate heating and insulation, dampness with condensation, and mould all contribute to illness and deaths from hypothermia, respiratory illness and ischaemic heart disease, (in Burke, S et al 2004). These living conditions are a reality for some people with disabilities in Ireland. For further discussion and particular recommendations see DFI's Programme for Local Government 2004 entitled; 'Housing – The Vital Element'.

The physical environment is also of particular relevance to people with disabilities, especially in the areas of accessibility and safety. Physical access remains a major obstacle to the ability of people with physical and sensory disabilities to live in, and contribute, to their own communities. Lack of accessible public transport continues to be a major impediment to both the social and economic advancement, and subsequently the health of people with disabilities. It is therefore vital to ensure that everyone can make full use of the buildings and environments they live in, work in and visit. Availability and accessibility of communication and information systems for people with disabilities is vital, particularly given the non-stop technical advances in this field. It holds boundless opportunities for people with disabilities, if harnessed and developed, for the further inclusion not exclusion of this population group.

In terms of the prevention of disabling conditions the physical environment, socio-cultural influences and individual behaviour choices combine to result in increased incidences of accidents and injuries. Nowhere is this more evident than in the annual toll of road traffic accidents in Ireland and the subsequent acquired brain and spinal injuries experienced by many of the survivors. This holds particular resonance for those aged under twenty-five years of age. Cardiovascular disease and cancer are by far the most important causes of morbidity and mortality in the population as a whole. However, for those aged under twenty-five years, accidents and unintentional injuries are the commonest cause of death and illness in this group, (Kiely 2004). Much of this is preventable. According to the National Safety Council, the main causes of death and injury on Irish roads remain excessive or inappropriate speed, drink driving, non wearing of seat belts, driver fatigue or a combination of these factors. Given that deaths are only part of the problem, since acute and chronic injuries leave a legacy of disability and personal and family disruption, accident prevention has the potential to significantly impact on public health, (Kiely 2004). It is obvious from this analysis that many acquired disabilities, especially those caused by road traffic accidents, are preventable.

The Evidence:

- The prevalence of childhood asthma (which is highly sensitive to airborne contaminants) has increased sharply over the last 20 years among the 0 to 5 year age group, (Health Canada 1999).
- Exposure to Environmental Tobacco Smoke (ETS) has a well accepted negative impact on health, most notably cardiovascular and cancer rates.
- Research indicates that lung cancer risks from ETS are greater than the risks from the hazardous air pollutants from all regulated industrial emissions combined, (Canadian Institute of Health Information 2004).
- In Ireland approximately 12,000 people are injured in road crashes annually, 1,500 of whom are seriously injured, (National Safety Council 2004).

- Of 55 drivers, pedestrians and passengers killed in the North East between 2001 and 2002, 22 or 40% had alcohol detected in blood samples, (Bedford 2004).
- It is estimated that alcohol is associated with at least 30% of all Irish road accidents, (Kiely 2004).
- In the built environment, factors associated with housing, indoor air quality and the design of communities and transportation can significantly influence our physical and psychological wellbeing, (Public Health Agency of Canada 2005).

Policy Recommendations:

- The Departments of Health and Children and Environment, Heritage and Local Government to develop a joint national accommodation and support strategy for people with disabilities.
- The principle of Universal Design is the target in relation to the built environment.
- Local Authorities should encourage and require, by legal means if necessary, that all building developments, as a minimum, comply with Part M of the Building Regulations.
- Local Authorities should employ an Access Officer to inspect planning applications and building developments.
- All Local Authorities to implement and deliver on the commitments of the Barcelona Declaration.
- The Department of the Environment, Heritage and Local Government should 'design in' the issues and needs of people with disabilities in line with the Government's commitments in the National Disability Strategy and to Mainstreaming, particularly with regard to the housing and accommodation needs of people with disabilities.
- The six Government Departments mandated to implement the National Disability Strategy through the development of Sectoral Plans to develop a partnership approach to the development, implementation and monitoring of these initiatives.
- Government agencies and partner groups to continue the promotion and enforcement of the Workplace Tobacco Ban.
- There should be continued improvement and development of an accessible public transport network, to include rural and other hard to reach communities.
- Increased implementation and enforcement of the penalty points system as a proven road safety measure.
- Reduction of the blood alcohol concentration level to zero in line with that of most other EU countries.
- Continued promotion of designated driver schemes such as free soft drinks, through licensed premises.

CONCLUSION

Some of the factors which influence health are fixed and are outside our direct control, such as age and genetics. However, it is now widely accepted that many other factors, including socio-economic and environmental conditions are also key in determining levels of health and wellbeing. These determinants have a direct impact of the health and social gain of people with disabilities, who as a population group are not immune, but indeed more susceptible to conditions such as poverty and social exclusion, resulting in negative impacts on their health and wellbeing.

As social beings, we need not only good material conditions, but from early childhood onwards we need to feel valued and appreciated. We need friends, we need more sociable societies, we need to feel useful and we need to exercise a significant degree of control over meaningful work. Without these we become more prone to depression, drug use, anxiety, hostility and feelings of hopelessness, which all rebound on health. However important individual genetic susceptibilities to disease may be, the common causes of the ill health that affect populations are environmental, (WHO, 2004).

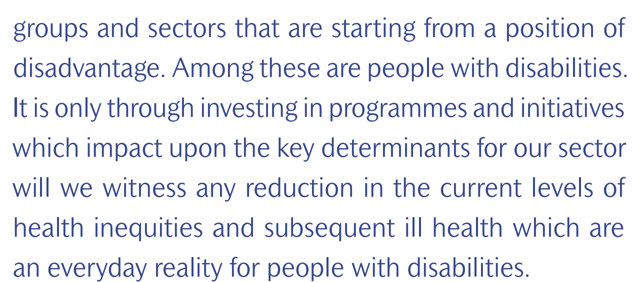
This Paper has set out DFI's current position in relation to the Population Health concept, with particular reference to its importance to people with disabilities. It makes very specific recommendations for action, which if adopted would not only improve the lives of people with disabilities, but should also have positive outcomes in relation to many preventable conditions. The concept represents a shift in thinking from the purely curative, medical approach to health policy and practice to a more holistic, preventative view encompassing the many varying factors which influence why some people experience good health and others do not.

As a result the challenge is set. Planning and working towards good health for all is not merely the responsibility of the health sector, rather it falls within the remit of all offices of State and Government. It demands mainstreaming in action and cross-departmental working partnerships. It requires that all public policy is health and disability proofed to ensure a positive impact on health and social inclusion is experienced by the whole population, and not merely the advantaged few.

We know that good societal planning, design and practice is of benefit to all members of that society. In this regard we note the recent commitment of the Taoiseach* to the amendment of cabinet procedures to ensure that all policy and legislation coming to cabinet is disability proofed in the future. This positive action measure will target a well recognised disadvantaged group, people with disabilities. The current National Health Strategy, *'Quality and Fairness – A Health System for You'*, has as its vision, *'A health system that supports and empowers you, your family and your community to achieve your full health potential.'* It also goes on to include as an action, *'Initiatives to eliminate barriers for disadvantaged groups to achieve healthier lifestyles will be developed and expanded,' (Action 19).* These assertions depend upon the development of a more strategic approach to health service design and delivery, an approach strong on tackling the current inequalities, which exist not only in the health care system but also within society as a whole.

Policy makers need to plan and work towards systems whereby housing, employment, social cohesion, child development and the physical environment are conducive to the health of the whole population. To achieve these demands, there is a need for a particular focus on certain

*Commitment made by the Taoiseach to the Disability Legislation Consultation Group at a meeting held on 25th May, 2005.



groups and sectors that are starting from a position of disadvantage. Among these are people with disabilities. It is only through investing in programmes and initiatives which impact upon the key determinants for our sector will we witness any reduction in the current levels of health inequities and subsequent ill health which are an everyday reality for people with disabilities.

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Action for Mobility
AHEAD
Alzheimer Society of Ireland
Anne Sullivan Centre*
APT
Arklow Disability Action Group*
Arthritis Ireland
ASPIRE
Asthma Society of Ireland
AWARE
BIH Housing Association
Bodywhys*
Brainwave
BRÍ
Caring and Sharing Association
Center for Independent Living
Central Remedial Clinic
Centre for Independent Living Blanchardstown*
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Centre for Independent Living Dublin 7*
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Centre for Independent Living Offaly*
Centre for Independent Living Sligo*
Centre for Independent Living Tipperary
Centre for Independent Living Waterford*
Centre for Independent Living Wexford*
Cheeverstown House
Cheshire Ireland*
Children in Hospital Ireland*
COPE Foundation
Co. Roscommon Support Group of People with Disabilities
Cystic Fibrosis Association of Ireland
DEBRA Ireland
Diabetes Federation of Ireland Southern Regional Office*
Disabled Drivers Association
Disabled People of Clare
Doorway to Life
Down Syndrome Ireland
Dyslexia Association of Ireland
Dyspraxia Association of Ireland*
Enable Ireland
Féach*
Fibromyalgia Support Group (Midlands)*
Fighting Blindness
Focus Ireland
Freidreich's Ataxia Society of Ireland
Galway County Association for Mentally Handicapped Children*
Genetic & Inherited Disorders Organisation
HAIL Housing
Headway Ireland
Heart Children Ireland*
Huntington's Disease Association of Ireland
Irish Association for Spina Bifida and Hydrocephalus
Irish Deaf Society
Irish Guide Dogs for the Blind
Irish Haemophilia Society
Irish Kidney Association
Irish Motor Neurone Disease Association
Irish Raynaud's & Scleroderma Society
Irish Society for Autism
Irish Wheelchair Association
Jack and Jill Children's Foundation
KARE
Leitrim Association of People with Disabilities
Lucan Disability Action Group*
Migraine Association of Ireland*
Multiple Sclerosis Society of Ireland
Muscular Dystrophy Ireland
National Association for Deaf People
National Council for the Blind of Ireland
National Federation of Arch Clubs
Neurofibromatosis Association of Ireland
Noinin Support for Autism*
North West MS Therapy Centre
Out and About Association*
Parkinsons Association of Ireland
Peacehaven Trust*
Peter Bradley Foundation*
Post Polio Support Group
Reach Ireland
Rehab Group
Royal Hospital Donnybrook
Schizophrenia Ireland
Shannon Community Workshops
Sophia Housing Association
Special Olympics Ireland
Spinal Injuries Ireland
St. Catherine's Association
St. Gabriel's School and Centre
St. Mary's Hospital & Residential School
St. Michael's House
Vantastic
Vergemount Housing Fellowship
Walkinstown Association
West Limerick Community Workshop
Western Care Association

* Associate Members.

Supporting Organisations to Enable People with Disabilities
An Advocate for the Voluntary Disability Sector

Disability Federation of Ireland (DFI) is the national support organisation and advocate for voluntary disability organisations in Ireland who provide services to people with disabilities and disabling conditions.

- Hidden
- Mental Health
- Sensory
- Intellectual
- Physical
- Emotional

Disability Federation of Ireland (DFI) works to ensure that Irish society is fully inclusive of people with disabilities and disabling conditions so that they can exercise fully their civil, social and human rights. In pursuit of this vision:

- DFI acts as an advocate for the voluntary disability sector
- Supports organistions to further enable people with disabilities

DFI represents and supports over 150 voluntary disability organisations and groups of which 72 comprise its National Council, and 25 of which are Associate Members. Allied to this, it works with and supports over 200 organisations and groups around the country that have a significant and growing disability interest, mainly coming from the statutory and voluntary sectors. DFI provides:

- Information
- Organisation and Management Development
- Advocacy and Representation
- Training and Support
- Research and Policy Development
- Networking

DFI also supports the broader voluntary and disability sector through its representation of the disability strand within the Community and Voluntary Pillar of the Social Partnership process, as a social partner at the National Economic and Social Forum, Health Board Co-ordinating Committees and other fora at regional, national and European level.

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