New report 28/09/05 9:25 am Page 23

3.

Health - Beyond a Disease Model

Sheila Cronin

The World Health Organisation's definition of health is "complete physical, mental and social well-being and not merely the absence of disease or infirmity" (1967).

There needs to be a fundamental shift from the disease model of health to the social determinant model of health. Our understanding of health will determine how we prioritise the care of health and resource the various activities, agencies and institutions that impact on the care of health. Healthcare is a social right that every citizen should enjoy. The standard of care of any health system depends on the resources made available which in turn is dependant on the expectations of society. In any democratic society this obligation is transferred through taxation and insurance systems to government and other bodies who assume responsibility for this.

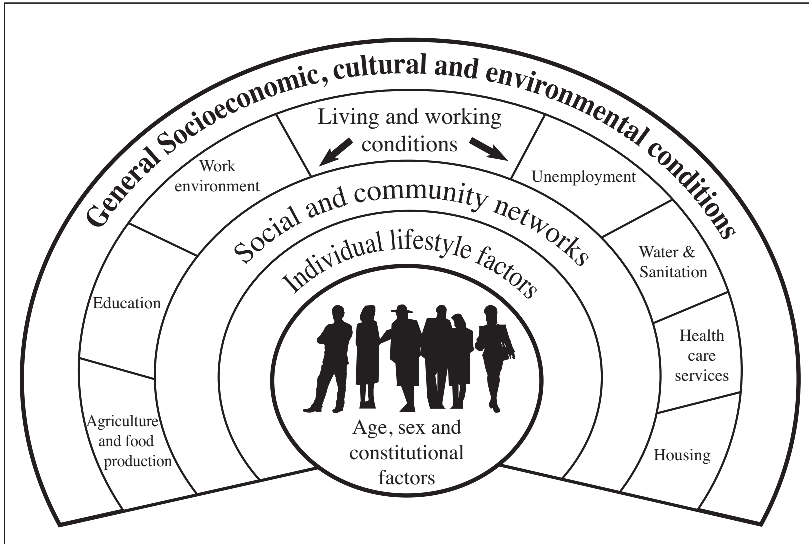
Social determinants of health

There are many factors that influence health. These would include what we now understand as the social determinants of health, i.e. genetic, age, sex, social, cultural, economic, physiological circumstances, early life, quality of work, employment, unemployment and physical environment.

"The weight of scientific evidence supports a socio economic explanation of health inequalities. This traces the roots to such determinants as income, education and employment as well as material environment and lifestyle" (Independent Enquiry into Inequalities in Health Report, Canada, 1998)

New report 28/09/05 9:25 am Page 24

A few years earlier this insight was graphically illustrated as follows:



Dahlgreen and Whitehead in 1991

There are certain factors within this model that are fixed. These would include age, sex and genetic make up but do have an influence on peoples health. Other aspects of this model can be modified to achieve a positive impact on a population's health. These would include lifestyle factors, social and community networks, living conditions, working conditions, nutrition, access to essential services and goods, economic and cultural environment conditions, education and housing.

There are several key tasks to be achieved if the definition of health is to be real. These include:

- Avoiding diseases that are preventable by screening, immunisation, promoting healthier lifestyles and physical activity.
- Treating diseases to the highest possible standards.
- Paying appropriate attention to vulnerable groups especially the chronically ill, old and poor.

New report 28/09/05 9:25 am Page 25

The need for multi-sectoral collaboration to tackle the social determinants of health is highlighted in Health 21, The Health for all Policy Framework for the 21st Century, produced by WHO (European Region). It states that multi-sectoral action should provide a more effective, efficient and sustained way to improve health. This has been recognised in the National Health Strategy Shaping a Healthier Future (2001).

There needs to be active consultation with the public, communities, professionals, the social policy and research community, in the development of policy and cross cutting issues (Boyd 1998 and Burke 2000).

The aim of any health strategy is to ensure the health of all the population. Healthcare today is seen as a key factor in everybody's life and must be seen in the broader context of people's quality of life and not just in terms of service delivery.

Analysis undertaken in the Irish context acknowledges the complex and dynamic processes which are at work with health affecting socio-economic status as well as vice-versa. It concludes that the relationship between economic deprivation and health outcomes appears to be crucial (Nolan 1997).

Health Inequalities

During the year 2000 Public Health Alliance of Ireland (PHA) published a document "*Health in Ireland - An Unequal State*". This report gathered together baseline information in health inequality in Ireland. Many areas were highlighted, e.g.

- Between 1989 and 1998 the death rate for all causes of death were three times higher in the lowest occupational class than the highest.

New report 28/09/05 9:25 am Page 26

- The death rate for all cancers among the lowest occupational class is over twice as high as for the highest class. It is nearly three times higher for strokes, four times higher for lung cancer and six times higher for accidents.
- Perinatal mortality is three times higher in poorer families than richer families.
- Chronic physical illness has been found to be two and a half times higher for the poor than the wealthy.
- The rate of hospitalisation for mental illness is more than six times higher for people in lower socio-economic groups as compared to those in higher socio-economic groups.
- In 2003, 39% of people surveyed identified financial problems as the greatest factor preventing them from improving their health.
- In 2002 Irish people had one of the lowest life expectancies in all EU countries for both males and females. (cf. Table 1)

The figures opposite for Ireland show that males can expect to live 75.2 years while Irish females live 5.1 years longer to 80.3 years.

These findings of the PHA Report indicate that Ireland's poverty problem has serious implications for health in the light of the fact there is clear international evidence between poverty and ill health. Poverty limits access to affordable healthcare and reduces the opportunity for those living in poverty to adopt healthier lifestyles. Therefore those in lower socio-economic groups have a higher percentage of both acute and chronic illnesses.

Inequalities exist in many forms including the access to both acute and primary care. There has been a growing proportion of the population investing in private health insurance. It is estimated that over 45% of the population are now in some form of private health insurance. Of those surveyed the reason given by the majority was the need to access hospital admission when needed.

New report 28/09/05 9:25 am Page 27

Table 1: EU-15 life expectancy at birth by sex in 2001, in years

Country	Males	Females	Sex Difference
Spain	75.8	83.5	7.7
France	75.8	83.0	7.2
Italy	76.8	82.9	6.1
Sweden	77.7	82.1	4.4
Austria	75.8	81.7	5.9
Luxembourg	74.9	81.5	6.6
Finland	74.9	81.5	6.6
Germany	75.4	81.2	5.8
EU-25	*74.8*	*81.1*	*6.3*
Belgium	75.1	81.1	6.0
Cyprus	76.1	81.0	4.9
Malta	75.9	81.0	5.1
Greece	75.4	80.7	5.3
Netherlands	76.0	80.7	4.7
Portugal	73.8	80.5	6.7
Slovenia	72.7	80.5	7.8
United Kingdom	75.9	80.5	4.6
IRELAND	**75.2**	**80.3**	**5.1**
Denmark	74.8	79.5	4.7
Czech Republic	72.1	78.7	6.6
Poland	70.4	78.7	8.3
Slovak Republic	69.9	77.8	7.9
Lithuania	66.3	77.5	11.2
Estonia	65.3	77.1	11.8
Hungary	68.4	76.7	8.3
Latvia	64.8	76.0	11.2

Source: CSO 2005:51

New report 28/09/05 9:25 am Page 28

Inequalities remain a major challenge to health To meet this challenge we need to get a clearer picture of what is happening. To do this there is a need for development of appropriate gathering of health data statistics. Health is a complex mix of many factors and needs to be addressed across all sectors. Therefore public policy development needs to recognise this is not just the responsibility of the Department of Health and Children. Partnership is the key approach to developing health but this needs to be applied to all stages of health policy, from needs assessment to service delivery, to review and evaluation. It needs to be based locally, regionally and nationally and to be firmly grounded in a community development approach so as to enable stakeholders to participate as equal partners. Barriers that need to be addressed include information shortage, understanding and skills to participate as well as practical issues such as transport, resources and childcare.

Data

The importance of health data has been emphasised through all of the health policies and strategies developed over the past number of years. Also in the reports on the health service in most recent times and in the Health Service Reform Programme. The Health Information Strategy (2004) recognised the need to ensure appropriate, accurate and timely information to ensure appropriate policy development and service delivery. This also supported the development of a National Population Health Observatory. This has been established. The function of the Observatory is to support the processes of health surveillance, resource targeting and the narrowing of health inequalities. The National Anti-Poverty Strategy (1997) set out a key target *"to reduce the gap in premature mortality between the lowest and highest socio-economic groups by at least 10% for circulatory diseases, for cancers and for injuries and poisoning by 2007"*. To ensure this happens the databases will need to identify sub-groups and have disaggregated data covering areas such as socio-economic grounds. New cardiovascular and cancer strategies are due in the near future. For these to meet the NAPS target

it is important these strategies would recognise and target high-risk groups. Appropriate data should be collected to enable these strategies to be monitored. The Health Information Strategy supported the establishment of the Health Information and Quality Authority (HIQA) and recognises its central role in data collection. For this to occur there also needs to be long term investment in all IT systems so that they are compatible and user-friendly to all stakeholders, particularly the community.

Population Health

Population health is an approach to health that aims to improve the health of the entire population and reduce health inequalities among population groups. In order to reach these objectives it looks and acts upon a broad range of factors and conditions that have a strong influence on our health. This requires a shift in our thinking of how health is defined. The contribution of health to social wellbeing and quality of life should be seen as reciprocal and mutually reinforcing. Health is a capacity or resource rather than just a state. This corresponds with the notion of being able to pursue ones goals to acquire skills and education and to grow. This broader definition of health recognises the range of social, economic and physical environmental factors that contribute to health. This concept of health has been defined as “the capacity of people to adapt to, respond to or control life’s challenges and changes” (Frankish et al 1996[1]).

A population health approach plans programs and policies and interventions along the entire spectrum of health action. These would include health promotion and prevention, disease prevention, risk management, medical treatment, rehabilitation and palliative care. A

[1] Health Impact Assessment as a Tool for Population Health Promotion and Public Policy by C.J. Frankish et al., Institute of Health Promotion Research, University of British Columbia, Vancouver: 1996

population health approach can be the unifying force for the entire spectrum of a health system's interventions from prevention, promotion, protection, diagnosis, treatment and care. A population health approach calls for an increased focus on health outcomes and on determining the degree of change that can be attributed to this approach. This would have an impact on planning and goal setting processes as well as choice of interventions and strategies developed. Outcome evaluation is essential in any population health approach. This requires a monitoring of the long term changes in both health and the determinants of health. To do this there must be an understanding of behaviour changes, shifts in social, economic and environmental conditions as well as changes to public policy and health systems. It must also seek to measure reduction in health status inequalities between population sub-groups. As evaluation is a long term process, this must be done on a continuous basis to ensure change is ongoing.

There are several groups that are recognised to have poorer health than the general population due to many factors. Some of these groups could be identified as ethnic communities, rural and remote communities, socially and economically disadvantaged, prisoners and those with mental health issues, children and older people.

Health Expenditure

If health is seen as a social right for all people, then health must be viewed as an investment and not a cost. For this to be upheld the Government needs to provide adequate funding.

In table 2 we see that Ireland spent 7.3% of GDP on health. This is less than most of the other EU countries. Ireland has the seventh lowest expenditure on health, according to OECD data (as a percentage of GDP). This funding must be questioned in the light of waiting lists, bed closures, staff shortages and long term care requirements which are all issues in the health service today.

New report 28/09/05 9:25 am Page 31

Table 2: Health expenditure as a percentage of GDP, 2002.

Country	% of GDP	Country	% of GDP
United States	14.6	New Zealand	8.5
Switzerland	11.2	Japan*	7.8
Germany	10.9	Hungary	7.8
Iceland	9.9	Austria	7.7
France	9.7	United Kingdom	7.7
Canada	9.6	Spain	7.6
Greece	9.5	Czech Republic	7.4
Portugal	9.3	Finland	7.3
Sweden	9.2	**IRELAND**	**7.3**
Belgium	9.1	Luxembourg	6.2
Australia*	9.1	Mexico	6.1
Netherlands	9.1	Poland	6.1
Denmark	8.8	Korea*	5.9
Norway	8.7	Slovak Republic	5.7
Italy	8.5		

Source: OECD, 2004
Note: * these figures are for 2001

Needs Assessment

How the health budget is spent is a key factor in the development of an appropriate health system in the light of population today. To best achieve this there needs to be both a macro and a micro needs assessment carried out. This would ensure that the services can respond to the needs of the population. An adequate needs assessment would identify changes which would lead to improvements in the health of the population. It also helps to prioritise changes that can improve the services and how best to target new resources including those often outside the health service. By starting with needs assessment it helps take a wider view of the problems and the availability of resources. The involvement of the local community is key if there is to be a commitment to change and to achieve the agreed

New report 28/09/05 9:25 am Page 32

health outcomes. The needs assessment also gives a better understanding of local health issues and how they are perceived by the local community and other agencies.

Community Involvement

"Community participation in primary care will be strengthened by encouraging and facilitating the involvement of local and voluntary groups in the planning and delivery of primary care services" (Primary Care Strategy 2001). There is a need to achieve a systematic approach to ensure that the service users and the local community are involved in the planning, commissioning, monitoring and evaluation of services. For this to occur there needs to be:

- clarity of roles,
- clear vision and understanding of the function,
- capacity building of both staff, service users and community,
- a common language and culture that is inclusive.
- all members need to be seen as equal partners,
- have identified clear methods of decision making and procedures,
- transparency of protocols need to invest both time and resources in team building.
- Flexibility in the methods which facilitate community involvement is necessary, e.g. focus groups, consultation fora, user advisory panels, public meetings, etc.

This is a long term investment but can have positive outcomes if resources, both financial and personnel, are allocated to its development. Communities can and will take responsibility for local health issues once information is shared, time is dedicated to building local skills and they are treated as equal partners in development (Models of Good Practice for Community Involvement in Health, *Dean, December 2004*).

New report 28/09/05 9:25 am Page 33

Primary Care

The Government has recognised that Primary Care is a cornerstone of the health system (National Health Strategy 2001). Between 90-95% of the population are treated by the primary care system yet this is not reflected in the allocation to primary care in the budget. The model of primary care as indicated in the Primary Care Strategy is a welcome development but must be interpreted in a very flexible way if it is to respond to local needs assessment. It should be underpinned, as is the National Health Strategy, by the principles of the social model of health. This needs an immediate commitment of resources but also a commitment over the long term to ensure the appropriate recognition that primary care should get.

The General Medical Services (GMS) system was first introduced in 1972 and gave a commitment that 40% of the population would be covered by this system. By 2003 this figure had decreased to approximately 27% of the population. This has implications for many lower income families. As both the cost of a visit to a GP plus prescription costs could amount to 25% of their total weekly income. In the last budget the Government introduced the concept of doctor-only cards. This has not been delivered due to lack of agreement between the Government and GPs. This failure needs to be seen in the light of the Government's own commitment in Quality and Fairness - A Health System for You (2001), in which Action 38 states "income guidelines for medical cards will be increased ". What is required is universal access to primary care for all people in Ireland if the change is to occur from a disease model to a social determined model of health.

Mental Health

The World Health Report 2001 "Mental Health: New Understanding, New Hope" estimated in 1990 that mental and neurological disorders accounted for 10% disability adjusted life years (DALYs) loss due to

New report 28/09/05 9:25 am Page 34

all diseases and injuries. This was 12% in 2000 and by 2020 it is projected that this will have increased to 15%. This has serious implications both for services in the coming years and also how we as a society address and support those with mental illness. The development of a community service approach with the required resources is urgently needed and this would be in keeping with the Government's own belief that primary care is the cornerstone of any health service. Within this category there are many vulnerable groups including those with an intellectual disability, homeless, prisoners, asylum seekers and refugees. When the social determinants of health are not met the connection between those who are disadvantaged and have ill-health is well documented. This will also be true of those with mental health issues. There are also inequalities within the present system which include vast regional variations, in relation to nursing, medical and support staff, as well as bed availability. Furthermore there appears to be no relationship between improvements in clinical resources and socio-economic need.[2]

Older People

Over the next 10 years there will be a significant increase in the number of older people in Ireland. Older people have much to offer to society and should be supported to live independent and fulfilled lives. While ageing is not a disease it has implications for any society and its health system. The focus should be to enable people to develop a healthier lifestyle, with the built in supports that are needed when diseases or other vicissitudes need to be addressed. There are many reports on the issue of older people and their needs in the coming years (National Council on Ageing and Older People Reports 74, 63, 24). There is a strong commitment in all these reports to supporting the

[2] cf. Veronica O'Kane, Dermot Walsh and Siobhan Barry, 2005, *The Black Hole: The funding allocated to adult mental health services: where is it actually going?* Irish Psychiatric Association.

New report 28/09/05 9:25 am Page 35

concept of older people in their own community as long as possible, if that is their choice, but this is far from the reality. In fact many policies work against this, e.g. subventions for nursing care but none for home care. It is recognised that services play an important role in enabling older people to remain independent longer. However, many of our services have been developed on an ad-hoc basis. There is often lack of coordination both in terms of coverage and access. A lack of clear commitment or service entitlement to older people means that equity or quality in the service is not facilitated.

What is needed at this point from the Government is a commitment to an inter-sectoral approach to address these issues. This would be in keeping with the social determinants model of health.

Reform Process

The Government has committed itself to reform of the health system (Health Act 2004). It has given the day-to-day function of managing the health service to the Health Service Executive. This has the potential to change the focus but only if the allocation of resources are also changed, particularly to the development of primary care as a key factor in this service. This concept has been supported by Professor Drumm (September 2005) in his statement noting that unless the primary care system is addressed the crisis in the acute sector will not change. In the reform process it is important that there is community participation and involvement both nationally, regionally and locally.

The health of any nation is its best asset both economically and socially. If it is to be achieved and maintained there must be a move towards supporting the social determinants of health model. While this is not a short-term goal political and financial commitment must be made provided now if this is to be achieved over the next 10 years.