PHA Corporate Plan 2025-30 Equality Screening Additional Information: Supporting all people to experience the positive impacts of improved health and wellbeing

Introduction and Purpose

The Corporate Plan sets out the direction for the next five years. This direction is aimed at having a positive impact on health and wellbeing and on health inequalities. The outworking's of the plan will have a real impact and will therefore be considered individually as they are taken forward to ensure any potential equality impacts are fully thought through and mitigated.

The Public Health Agency (PHA) recognises some additional support or measures may be required for everyone in our population to experience the positive impact intended from the plan. Using a number of sources of information, PHA has considered these as part of the Equality Screening and outlined some examples below. The following information will also be used to help in the development of the annual business plan and in the priorities of the corporate plan to support all people to experience the intended positive impacts on health and wellbeing.

As well as considering the health and wellbeing needs of people identifying within section 75 groups, (based on research and available information), consideration has also been given to themes of the plan and potential examples of where additional support or needs should be considered in the achieving our ambitions.

This paper makes use of a number of documents and briefings as referenced and intends to provide an overview of some of the needs and different supports required to ensure that all people can experience the benefits of improved health and wellbeing. This paper cannot give the full picture but aims to highlight where further consideration may be required in taking forward the outworking's of the corporate plan. Each policy, or programme progressed in line with the corporate plan will require its own screening and/or equality impact assessment and this document aims to provide a starting point.

Themes

The Corporate Plan is based around four outward facing strategic themes encompassing core areas of focus for our organisation as we work towards our vision of a healthier Northern Ireland. This Plan is being developed during a period of reform both for the organisation and for Health and Social Care (HSC) and in a time of significant financial constraint. However, we have embraced the opportunity provided by this time of change and constraint to set out our vision and ambitions for health and wellbeing in Northern Ireland and reiterate our call for a continued focus on improving health and reducing health inequalities across HSC and wider society.

Strategic Themes:

1. *Protecting health* – protect the population from serious health threats; such as infectious disease outbreaks or major incidents.

2. *Starting well* – laying the foundations for a healthy life from pre-birth, infancy, early years, childhood to adolescent years (0-18).

3. *Living well* – ensuring that people have the opportunity to live and work in a healthy way.

4. *Ageing well* – supporting people to age healthily throughout their lives.

The Corporate Plan details the key indicators the PHA will use to monitor public health in relation to the themes and focus of work for the period 2025-2030. It will provide a basis for the Annual Business Plan, mapping the strategic direction the organisation will travel over the next five years ensuring accountability for the Department of Health, (DoH).

The Corporate Plan incorporates how the PHA will work going forward as an organisation, working closely with the Strategic Planning and Performance Group (SPPG) of the Department of Health (DoH), local Health Trusts (HSC Trusts), the Business Services Organisation (BSO), the Patient Client Council (PCC) and the Community and Voluntary (C&V) sector; considering best practice to ensure we work effectively whilst being committed to people, partnerships, processes, digital capacity and be research and evidence driven.

The PHA recognises that the ambitions and priorities of the plan cannot be fully achieved in the lifetime of the plan but are important aspirations to be pursued and progressed towards meaningfully improving the health and wellbeing of all individuals and communities. The following examples outline where additional supports may be required for each theme to help all people experience the positive impact of the improved health and wellbeing intended in the plan. These are not exhaustive but intended to provide an overview of potential areas for support.

Protecting Health

Protecting and improving health is about safeguarding the wellbeing of the entire population, rather than focusing on any one Section 75 group. The PHA are committed to embedding equality considerations into all aspects of our work, ensuring that decisions, policies, and implementations are screened to assess impact on different groups. Screening will help us identify and address potential inequalities, ensuring the corporate plan is inclusive and responsive to the diverse needs of our population.

While our overall aim is to improve health outcomes for everyone, we recognise some Section 75 groups may experience our work differently due to specific health inequalities,

social determinants, or access barriers. Therefore, we are committed to understanding and mitigating any unintended consequences while proactively addressing disparities.

For example;

- People living in the most deprived areas of Northern Ireland experience significantly poorer health outcomes. Life expectancy is lower, and rates of long-term health conditions, including respiratory diseases and mental health issues, are higher in these areas. [1]
- The gap in life expectancy between the most and least deprived areas is approximately 6.8 years for men and 4.5 years for women.[1]
- Older adults are more likely to suffer from chronic illnesses, such as cardiovascular disease, diabetes, and dementia. Social isolation and loneliness are growing concerns among older populations, impacting mental and physical health.[1]
- While the overall population of ethnic minorities in Northern Ireland is small, access to culturally competent healthcare remains a concern. Language barriers and different health beliefs can impact engagement with health services.[1]
- Studies indicate higher rates of mental health issues, including depression and anxiety, among LGBT+ individuals due to experiences of discrimination and stigma. Access to appropriate healthcare services, including mental health support, remains a priority.[1]
- Self-reported general health varies by religious background, with differences in the prevalence of long-term health conditions and disability levels. However, a significant portion of the population does not assign their health experiences to religious identity specifically. [2]
- According to the Northern Ireland Health Survey, older adults report higher incidences of long-term health conditions. Over 40% of people aged 65+ have at least one chronic condition, compared to around 20% in younger age group. The uptake of preventative health measures, such as screening and vaccinations, is generally higher in older populations but may be influenced by socioeconomic factors.[2]
- Research suggests that single individuals and LGBTQ+ populations may experience different health outcomes. LGBTQ+ individuals report higher levels of mental health challenges and may face barriers to accessing culturally competent healthcare. [3]
- Women generally have higher life expectancy than men, but they experience a higher prevalence of long-term health conditions and disabilities. Men are less likely to engage with primary healthcare services, leading to later diagnoses of certain conditions. [3]
- Census 2021 data shows that approximately 24% of the population in Northern Ireland has a long-term health problem or disability that limits daily activities. [7]
- Individuals with disabilities report lower health literacy, affecting their ability to access screening programs and vaccinations. [2]

- Carers experience significantly higher stress and poorer mental health than the general population. The provision of unpaid care has a direct impact on the health of carers, particularly those providing 50+ hours of care per week. [2]
- Individuals without dependents may experience different health service usage patterns, often accessing mental health and social care services at different rates than those with dependents.[3]
- The Equality Commission for Northern Ireland (ECNI) highlights that access to healthcare can be unequal due to barriers related to age, disability, gender, and other factors. For example, individuals with disabilities report dissatisfaction with health services, with 40% citing negative attitudes from medical professionals. Additionally, the Bamford Review found that mental ill-health affects one in four people in Northern Ireland, yet investment in mental health services has been historically lower compared to other UK regions. [4,5]
- Certain Section 75 groups face disparities in vaccination and screening. For instance, older adults and disabled individuals may encounter logistical barriers, while women may have more difficulty accessing reproductive health services compared to the rest of the UK. Ethnic minorities, such as the Traveller community, experience significantly poorer health outcomes, including much higher child mortality rates. [4]
- Research commissioned by the Equality Commission for NI notes men and women have different healthcare access patterns. Women are more likely to face challenges due to caring responsibilities, whereas men may avoid seeking healthcare due to stigma. Carers, who are predominantly women, also report higher levels of ill health, with 19% of those providing 50+ hours of care per week describing their health as poor .[5]
- The Department of Health (NI) emphasizes that emergency preparedness planning must consider vulnerable groups, such as older adults, disabled individuals, and those with pre-existing health conditions. Climate-related risks, such as heatwaves or flooding, disproportionately affect these populations due to mobility and access issues. [2]
- According to The Health Foundation [51] There has been a failure to act on education gaps due to lost learning time in the pandemic. These are between children from richer and poorer backgrounds and compared with previous cohorts. A cohort of ‘left-behind’ children face significant risks to their long-term health and living standards, as well as causing a long-term economic cost to the country. [51]
- People living in the most deprived areas, some ethnic minority groups and people without English as a first language are more likely to not be fully vaccinated.[52]
- People from minority groups may have problems accessing or understanding information about screening and in some cases methods of screening may create obstacles for some individuals. For example there is anecdotal evidence that uptake of cancer screening is lower amongst some section 75 groupings.[5]

Starting Well

What happens during pre-conception, pregnancy, the early years, the school years and adolescence is key to what happens in later life. This includes having an adequate standard of living, a secure family environment, good physical and mental health and wellbeing and being protected from harm.[6] The PHA will work in partnership with key organisations to support and empower families to create and provide a safe and nurturing home environment such as making better decisions about physical and mental health and wellbeing. We recognise that adolescence is a unique stage of development and an important time for laying the foundations of good health. Health inequalities can have a profound impact on a child's start in life. All children and young people, including those who have additional needs, should have the opportunity for better health and wellbeing.

The PHA recognises some children and young people throughout Northern Ireland will require additional support to experience the positive impacts on health and the best start in life as intended within the plan.

For example:

- A child who does not experience economic well-being and lives in poverty will be more likely to have poor health, will face barriers to play and can feel isolated. [6]
- Health outcomes can be affected at a very early age and even before children are born. Low birth weight can be a determinant of infant mortality or disability, and affect health outcomes into adulthood. [6]
- For disabled and chronically ill young people both the planning process and the actual move to adult services can be difficult frightening and stressful.[7]
- Anecdotal research suggests that there are between 40 and 50 young transgender people accessing support services in NI due to gender identity issues and referrals appear to be rapidly increasing. This figure however is likely to be a gross underestimate of the actual number of young people who experience gender distress in Northern Ireland. Extreme social pressures including the high levels of prejudice, discrimination and harassment trans people face combined with a general lack of awareness, understanding and knowledge of trans issues means many young people who experience gender distress do not or unable to seek the professional support they require.[8]
- In a project '*Achieving Equality for Transgender and Gender Diverse Youth in Schools*' transgender and gender diverse youth school experiences were characterised by rejection, harassment and bullying that prevented them from participating in learning [9]
- There are roughly 30,000 LGBT children in NI schools. Children and young people who are LGBT+ can experience bullying in schools and there is evidence of disproportionate levels of depression, anxiety, self-harm and suicide ideation among young LGB and transgender people. 'Outing' or fear of 'outing' has resulted in homelessness and social isolation. Concern about accessing public services and the need for inclusion and participation are often issues for young LGBT+ people [9]

- Research from the Dept of Education indicates 67% of LGBT young people find their schools unsupportive and unwelcoming. From the same research 48% of respondents had experienced bullying as a result of their sexual orientation or gender identity. The main forms of bullying experienced by LGB&T young people included name calling, lies or false rumours, being isolated by other pupils or hit/kicked/pushed/shoved around.[10]
- Census 2021 figures reflect there are 2,600 carers aged 15 or younger in Northern Ireland.[12]
- The Young Persons Behaviour & Attitudes Survey 2022: Substance Use (Smoking, Alcohol & Drugs) found that Boys (9%) were more likely to report ever having smoked than girls (6%) and young people living in the most deprived quintile were more likely to report ever having smoked (11%) than those in the least deprived quintile (5%). A proportion of boys and girls indicated they use e-cigarettes now (9%) and within this group 6% were classed as regular e-cigarette user. Around a third (31%) of young people reported ever having drank alcohol; Boys were more likely to report having taken an alcoholic drink (33%) than girls (29%). Boys (5%) were more likely to report having used drugs than girls (3%). [13]
- At 31 March 2024, there were 1,990 total waits for a Child and Adolescent Mental Health Service (CAMHS) assessment in Northern Ireland, of which 1,026 were waiting for more than nine weeks (52%). [14]
- A quarter (23%) of young people surveyed, and three quarters (75%) of young people interviewed with alcohol and/or drug problems, had experience of using A&E during a mental health crisis as specialist crisis services were not available or easily accessible to young people.[14]
- 390 children and young people in Northern Ireland were admitted to hospitals with a self-harm diagnosis, with four of the five Trust Areas registering an increase. Under 18's account for 10% of all self-harm presentation at emergency departments, with two thirds of these female. [6]
- Children known to social services represent 49.5% of all children in NI that experienced mental ill-health in 2015. Young adults known to social services in childhood represent 40.9% of those who presented to ED with self-harm or ideation, 38.0% of those who experienced a psychiatric admission, and 39.7% of suicide deaths in NI during follow-up.[15]
- Twice as many children are now growing up in poverty in a working family as a decade ago. Children of single parents, children with two or more siblings, and children who live in a family where someone experiences a disability, all face a much higher risk of poverty. [17]
- Associations between poor mental health outcomes and Adverse Childhood Experiences (ACE) highlight 47.5% of young people aged 11-19 years experienced at least one ACE. Young people in the least deprived areas more likely to have experienced no ACEs compared to those in the most deprived (59.9% vs 36.0%).[16]
- Neonatal mortality accounts for 70-80% of infant deaths in the UK, largely due to perinatal causes, such as maternal health, congenital malformations and preterm

birth. In 2018, the infant mortality rate was 4.2 per 1,000 live births in Northern Ireland, compared to 3.9 per 1,000 in England, 3.5 per 1,000 in Wales and 3.2 per 1,000 in Scotland. In 2018, the neonatal mortality rate was 3.2 per 1,000 live births in Northern Ireland, compared to 2.8 per 1,000 in England, 2.5 per 1,000 in Wales and 2 per 1,000 in Scotland. [16]

Living Well

Adults now generally enjoy better health and wellbeing and can expect to live longer than previous generations. However, in recent years life expectancy rates have been stalling and there are still many challenges and significant health needs within our population that impact the ability of people to experience good physical and mental health and wellbeing. There are many factors that impact our health and wellbeing during our adult lives. These include where we live, our environment, access to education and employment, health services and the effects of poor diet, smoking, drug and alcohol misuse, low levels of physical activity, homelessness and food, fuel and financial poverty. Health inequalities continue to compound challenges to health and prevent many from experiencing good health and wellbeing. We must ensure that we provide targeted approaches where needed for those more vulnerable in our society. Equipping individuals and communities to live long healthy lives is a key outcome of the plan and addresses health and wellbeing throughout life but mainly in adulthood.

The PHA recognises that there are people throughout Northern Ireland who will require additional support to experience the positive impacts on health and well-being as intended within the plan and through the pursuit of this outcome.

For example:

- The long-term trend of improving life expectancy has stalled in all four UK nations, from a reduction of 0.05 in Northern Ireland. Northern Ireland has shown a decrease of 1.4 healthy life expectancy years from 2018–20 onwards.[18]
- Life expectancy for females living in the 20% most deprived areas in NI was 79.3 years. This was 5.0 years less than those in the 20% least deprived areas (84.3 years).[18]
- Women live longer than men but spend more years in poor health.[18]
- In a Lancet Public Health issue, a global review of three decades of health data has revealed huge health differences in men and women that begin in adolescence and grow throughout life. Globally, females have a higher burden of morbidity-driven conditions with the largest differences in disability adjusted life years (DALYs) for low back pain, depressive disorders and headache disorders, whereas males have higher DALY rates for mortality-driven conditions with the largest differences in DALYs for COVID-19, road injuries and ischaemic heart disease. [18]
- A review of the existing evidence shows that people of all ages from ethnic minority groups are more likely to have poor physical and mental health in later life.[19]

- Indicative evidence suggests that minoritised ethnic groups have higher risk of developing multiple long-term conditions (MLTCs)(e.g. chronic kidney disease, hypertension and depression) and do so earlier than the majority white population. [19]
- Prevalence of depression is significantly higher in older residents (unspecific ethnicity) living in care homes, compared with older people living in community settings [20]
- People in the most deprived areas of NI (30%) are more likely to have a probable mental illness compared to those in least deprived areas (20%); and poverty, particularly child poverty is key contributor, with one in 4 (24%) children in Northern Ireland living in poverty. Stable housing is also a key driver of wellbeing with almost 70% of people experiencing homelessness having a diagnosed mental health condition.[16]
- A considerable body of evidence points to a knock-on relationship between income or social inequalities with wider inequalities in areas such as health and social inclusion and the evidence in this report suggests that inequalities are increasing in some aspects among our ageing population.[24]
- Current statistics report that Lesbian, Gay, Bisexual and Transgender (LGB&T) people make up between 6 and 10% of the Northern Ireland population. For those over the age of 55, growing old is a real concern.[23]
- Northern Ireland has the fastest-growing older population in the United Kingdom and this number will continue to increase every year. Older people who identify as Lesbian, Gay, Bisexual and/or Transgender (LGB&/T) are generally likely to have a greater need for health and social care services compared with their heterosexual peers. Overall, they are two and half times more likely to live alone, twice as likely to be single and four and half times more likely to have no children to call on in times of need.[23]
- There are 80 to 100 transgender people known to, or who are accessing support services in Northern Ireland. However, it is widely acknowledged that transgender people remain invisible and the numbers are estimated to be much higher. There may be a prevalence of 600 per 100,000 people.[23]
- People living in poverty are more likely to have bad health in childhood and this is likely to persist right through the life cycle and to cause earlier death than for people who are ‘well-off’.[24]
- Studies suggest that the prevalence of smoking, alcohol and drug use is higher among LGB&T people. For example, a 2012 study of substance use among LGB&T people in Northern Ireland reported that 44% of respondents smoked, 91% of respondents reported that they drink alcohol and that 37% reported using an illegal drug in the last year. (p7-8)[25]
- Men have lower life expectancy 78.3 years for men, 82.3 years for women), and higher suicide rates (77% men, 23% women) and health risks in relation to alcohol, drug and substance abuse than women [2]

- The 2021 Census tells us 34.7% of people in Northern Ireland have one or more long-term health condition (659,800 people). The most prevalent conditions (whether

solely or in combination with others) were ‘Long-term pain or discomfort’ (11.6% of people), ‘Mobility or dexterity difficulty that limits basic physical activities’ (10.9% of people), and ‘Shortness of breath or difficulty breathing’ (10.3% of people).

- LGB&T people may experience barriers to accessing healthcare services. For example, a survey to explore the emotional health and wellbeing of LGB&T people in Northern Ireland (2013) found that around two fifths (42.6%) of LGB&T people reported being ‘out’ to their doctor, 35.8% reported that their doctor is not aware and 21.6% said they were unsure.[23]
- Women have also been reported to experience barriers to accessing health and social care services, including access to reproductive health services[28].
- There is a general lack of awareness amongst Black and Minority Ethnic people as to what health care services are available.[27]
- A research update in 2013 indicated that 10% of 16year olds felt that, at some point over the previous 12 months, they had needed professional medical support but had chosen not to access it. [7]
- People with Learning Difficulties have problems in accessing primary health care. Access is made more difficult because of communication difficulties and barriers in encounters between health professionals and PLD and practical issues such as long waiting times and lack of consultation time. [27]
- 1 in 4 carers in Northern Ireland are suffering mental ill-health [29]
- 50% of carers feel lonely at least some of the time [29]
- More than 1 in 3 have put off health treatment for themselves because of the demands of caring. [29]

Ageing Well

As a population, we are living longer and many older adults enjoy good health and make significant contributions to their communities. For others, however, older age brings a risk of poor physical and mental health, social isolation and complex health problems. Poor health and frailty should not be inevitable outcomes as we age. As well as living longer, we also want to live healthier for longer so that we can continue to participate in activities we enjoy and live fulfilled, independent lives.

Older people make up an extremely heterogenous group, and their diversity is increasing. While the broad trend in longer lives can be celebrated, the way people experience older age varies hugely, influenced by a range of factors including income, geography, housing, gender, marital status, and health and disability. The PHA recognises some older people will require additional support to experience the positive impacts on health and living longer into old age as intended within the plan.

- More than one in six of the population of Northern Ireland is aged 65 or over.[30]
- The NI population aged 85 and over increased by 25.8% in the decade since mid-2013, a rate over five times higher than the population as a whole. An aging population presents a range of societal and economic challenges, as older people tend to require more health and social care.[30]

- The number of people aged 65 and older will grow from 17.8% in 2023 (342,482 total individuals) to 25.8% in 2050 (499,337 total individuals)[49]
- The number of people aged 65 and over will, on average, grow annually by 7,409 individuals until 2040, and in the period 2024 to 2034, it will grow by 8,517 individuals on average every year.[50] This will have a tremendous effect on the health and social care system, older people are more likely to experience health issues and disability.
- Findings from the NICOLA study (the largest public health study in Northern Ireland of older people) show a quarter of participants live alone and over half of those aged over 75 live alone, which could have serious health implications for this population. Living alone is twice as common in the most deprived areas compared to the least deprived areas and three times as common in larger urban areas than in most rural areas. Loneliness is a major public health (and welfare) issue and its effects on the health of older people are as large as the effects of many biological risk factors such as high blood pressure or cholesterol.[30]
- Women live longer than men but spend more years in poor health [18]
- Evidence shows that people of all ages from ethnic minority groups are more likely to have poor physical and mental health in later life.[20]
- Prevalence of depression is significantly higher in older residents (unspecific ethnicity) living in care homes, compared with older people living in community settings [20]
- Statistics report that Lesbian, Gay, Bisexual and Transgender (LGB&T) people make up between 6 and 10% of the Northern Ireland population. For those over the age of 55, growing old is a real concern.[23]
- Older LGB&/T people are likely to have a greater need for health and social care services. Research indicates that when compared to their heterosexual peers, they are 2.5 times more likely to live alone, twice as likely to be single and 4.5 times more likely to have no children to call on in time of need [23]
- Research in Northern Ireland in 2010 by Age NI found that 45% of people agreed they were aware of instances where older people had been treated with less dignity and respect when accessing services because of their age[31]
- The RNIB estimates that by 2030 there will be a 24 per cent increase in the number of people with sight loss in Northern Ireland and with sight loss comes increased risks for falls and accidents.

Our organisation works effectively

The capacity and efficacy of our organisation and our staff will underpin and enable progress towards the realisation of the first four themes. We must ensure our staff are supported, equipped and empowered to take forward this work over the next five years, in line with our values and cross-cutting principles.

The PHA recognises that some staff members may require additional measures to experience the positive impact intended by the plan and by this outcome of supporting, equipping and empowering staff.

For example, a recent breakdown of available information on known staff composition by Section 75 group shows that:

- Approximately 76% of PHA staff are female and approximately 23% are male
- Approximately 46% of staff are aged 30-54 years; over 39% of staff are over 55 years and around 13% are 16-29 years
- Approximately 35% of staff are or are perceived to be either Protestant or Roman Catholic

Other sources of information on HSC [32,33] workforce note that:

- At 31st March 2024, the HSC employed 74,039 (65,984.2 WTE) staff in post on either a full-time or part-time basis
- The HSC workforce grew by 22% (11,898.5 WTE) between 2015 and 2024
- Over three quarters (78%) of staff (57,780 headcount) were female and 22% were male (16,259 headcount)
- Over two fifths (42%) of HSC staff were under the age of 40; 38% were between 40 and 54, and 20% were aged 55 and over

Section 75 Groups and Health and Wellbeing

The following examples outline where additional supports may be required for Section 75 groups to help all people experience the positive impact of the improved health and wellbeing intended in the plan. These are not exhaustive examples nor intended to be but are intended to provide an overview of potential areas for where additional measures may be required.

Category	***Potential areas for where additional measures may be required.***
Gender	Men have lower life expectancy (78.3 years for men, 82.3 years for women), and higher suicide rates (77% men, 23% women) and health risks in relation to alcohol, drug and substance abuse than women. Women also experience barriers to accessing health and social care services, including access to reproductive health services.[1] Transgender people experience disadvantage both in terms of access to specialist healthcare and the lack of transgender awareness in the general health care service. [23] Additional health issues exist aligned to multiple identities. For example, there are high rates of suicide amongst young males, high levels of gay men bullied at school have considered suicide and the suicide rate amongst Travellers is higher than that of men in the general population. See Carafriend, Rainbow (2011) Left out of the Equation,UCD (2010) All Ireland Traveller Health Study and ECNI (2014) UNCRPD Parallel jurisdictional report.[37] Reports indicate that there may be some challenges faced by LGBT+ people during the COVID-19 pandemic. The Stonewall LGBT in Britain - Health Report states that LGBT+ people are at greater risk of marginalisation during crises, and that those with multiple marginalised identities can struggle even more. A report produced by the Lesbian Advocacy Services Initiative (LASI) found that lesbian and bisexual women experienced significant barriers to accessing health [38] Women who had children before the age of 20 and who were unmarried when they had their first child are also at greater risk of being in poor health in later life[35] Poor general health is closely associated with being financially poor in later life and is also associated with social isolation in later life, especially for men.[39] These include high levels of mental ill-health

Category	Potential areas for where additional measures may be required.
	among gay men, high suicide rates amongst Traveller men and barriers for disabled women in accessing sexual health and maternity services See Carafriend, Rainbow (2011) Left out of the Equation,UCD (2010) All Ireland Traveller Health Study and ECNI (2014) UNCRPD Parallel jurisdictional report. – [37] There is evidence to suggest that low income women forgo hospital appointments because of the cost and inconvenience and highlight that this can have serious consequences for both women and their children. Higher mortality from circulatory disease (1.4 years) and cancer (1.3 years) combined, contributed more than a third of the male life expectancy deprivation gap. Cancer was the largest contributor to the female life expectancy deprivation gap. Women live longer than men but spend more years in poor health.[18] In 2020-22, females in NI could expect to live 3.8 years longer than males. Males living in the 20% most deprived areas of NI could expect to live 74.0 years, 7.2 years less than those living in the 20% least deprived areas (81.2 years). Female life expectancy in the 20% most deprived areas was 79.3 years, 4.8 years fewer than females in the 20% least deprived areas (84.1 years). For both males and females, mortality across the majority of causes of death was higher in the most deprived areas than in the least deprived.[53]
Age	In 2021-23, life expectancy at age 65 in NI was 18.5 years for males and 20.7 years for females, with no significant change over the last five years. [53] When asked which specific group was treated most unfairly, people aged over 70 were considered to be treated most unfairly in Northern Ireland (15% of respondents), [29] There is a clear link between homophobia and poor mental health in Northern Ireland. For example, research into the mental and emotional health of 16year olds has confirmed that a group which is particularly vulnerable in terms of their mental health are same-sex attracted males and females.[29] Evidence suggests that breastfeeding initiation rates and duration of breastfeeding remain low amongst teenage mothers [41]

Category	Potential areas for where additional measures may be required.
	A child who does not experience economic well-being and lives in poverty will be more likely to have poor health, will face barriers to play and can feel isolated.[16] There has been an increase in the number of children referred to children's services, children in care and children on the child protection register in NI. DOH indicates that there were 4317 children in care as of September 2024 which represented a 27.6% increase from March 2020. Poor people are more likely to have bad health in childhood and this is likely to persist right through the life cycle and to cause earlier death than for people who are well-off.[17] Health outcomes can be affected at a very early age and even before children are born. Low birth weight can be a determinant of infant mortality or disability, and affect health outcomes into adulthood In 2014, a total of 390 children and young people in Northern Ireland were admitted to hospitals with a self-harm diagnosis, with four of the five Trust Areas registering an increase. Under 18's account for 10% of all self-harm presentation at emergency departments, with two thirds of these female.[6] A considerable body of evidence points to a knock on relationship between income or social inequalities with wider inequalities in areas such as health and social inclusion and the evidence in this report suggests that inequalities are increasing in some aspects among our ageing population.[9] A research update in 2013 indicated that 10% of 16 year olds felt that, at some point over the previous 12 months, they had needed professional medical support but had chosen not to access it. [15] Research in Northern Ireland in 2010 by Age NI found that 45% of people agreed they were aware of instances where older people had been treated with less dignity and respect when accessing services because of their age [30] People over 60 make up 19% of the population, according to Census 2021. This represents a near 25% increase from 2011 and demonstrates the scale of population change due to ageing. People aged 65 and over account for 326,500 people or 17.2% of the Northern Ireland population. [02]

Category	Potential areas for where additional measures may be required.
	The Young Persons' Behaviour Attitude Survey (YPBAS) 2013 found that 13% of 11-16 yrs had smoked tobacco and 38% had drunk alcohol. Alcohol and drug related admissions to hospital and alcohol and drug related deaths are 3-4 times higher in areas of deprivation.[13] In 2022/23 the percentage of primary 1 pupils in the most deprived areas affected by obesity was more than double the proportion in the least deprived areas. The inequality gap in year 8 pupils affected by obesity was slightly lower, with the proportion in the most deprived areas 94% higher than in the least deprived areas.(Health Inequalities Annual Report 2024, DOH)
Religion	Jamison et al (2004:34) concluded that when both need and supply factors are considered, there appears to be no significant effect of religion on inpatient hospital use in Northern Ireland. [41]
Political Opinion	McEvoy et al (1999), in a study of Loyalist and Republican prisoners and their families, highlight that political ideology can often act as a barrier to accessing and using services provided by statutory and voluntary agencies. They also note that politically motivated ex-prisoners and their families have a tendency not to use professional and voluntary organisations who do not take into account their status and political ideology. Evidence continues to suggest that many ex-prisoners and their families are suspicious of institutions which are supported or influenced by Government agencies (Shirlow, 2001). 42 Within a NI context, the 2022 NI Life and Times survey welcomed 1,405 respondents and included people who were generally uninterested in politics or feel unrepresented by mainstream political party positions. Six out of ten respondents did not think of themselves as supporters of any particular party, although one in two said they felt a little closer to one party than others. The breakdown of self-described community identities is unionist (31%), nationalist (26%) and 'neither' (38%) 55 In a previous study, by NILT in 2019, the same survey revealed over a quarter (26%) replied that they considered themselves to be unionists, while just over a fifth (21%) described themselves as nationalists. The results suggest women were more likely than men to describe themselves as neutral re political opinion - 55% of women said they were neither unionist nor nationalist, compared with 45% of men. A quarter of 18 to 24-year-old respondents describing themselves as unionist, and just 14% who said they were nationalists. Just under a fifth

Category	*Potential areas for where additional measures may be required.*
	(19%) of pensioners described themselves as nationalist while more than twice that number (41%) replied that they were unionist.
Marital Status	Women who had children before the age of 20 and who were unmarried when they had their first child are also at greater risk of being in poor health in later life [43] What evidence that is available (mainly GB studies) suggest that poverty and associated factors such as lone mother's lack access to affordable transport and child care can be barriers to accessing health and social care.[43] Evidence suggests that women living on low incomes, especially lone mothers, struggle to provide a balanced healthy diet for both themselves and their children. Research carried out by the Food Commission on behalf of the NCH highlights that lack of money often made it impossible for parents to buy nutritional foods for their children and that in Northern Ireland healthier versions of food cost on average 14% more than unhealthier versions (NCH, 2004:5). [43] Burchett & Seelie (2003:5) in an examination of the diet of pregnant teenagers found that the risk of a seriously inadequate diet during pregnancy was higher for pregnant teenage women who lived alone and had no support from parents, partners or friends. [28] Men who become lone fathers through the death of their partner and men who become lone fathers through, for example, the inadequate parenting of the mother may have different needs and experiences in accessing health and social care. Similarly lone fathers with younger children may have different needs and experience different access barriers in comparison to lone fathers with older children. Non-custodial fathers may have different needs and experience different access barriers than custodial fathers. Older lone fathers, younger lone fathers and lone fathers with children with disabilities may also have different experiences. There is clearly a need for a greater research focus exploring the variations in experiences between lone fathers. [43] Married people have better mental and physical health compared with unmarried people. Those who have been married longer also tend to live longer. [7]

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Dependent Status	Women who had children before the age of 20 and who were unmarried when they had their first child are also at greater risk of being in poor health in later life[25] The State of Caring 2024 survey found that unpaid carers are finding it increasingly difficult to afford day-to-day living costs, with the worry and anxiety of this affecting their mental health and wellbeing. The pressures of caring can take a significant toll on carers' physical and mental health. In the 2021 State of Caring Survey, 25% of carers say their physical health is bad or very bad and 30% of carers say their mental health is either bad or very bad. The 2011 Census found that carers providing round the clock care are more than twice as likely to be in bad health than non-carers.1 6 out of 10 carers (61%) said their physical health has worsened as a result of caring, while 7 out of 10 (72%) said they have experienced mental ill health.2 These findings are reinforced in the 2021 GP Patient Survey, which found that carers are more likely to be in poor health than the general population, with 6 in 10 (60%) of carers having a long-term condition, disability or illness compared to 50% of those who weren't caring. Many carers continue to feel marginalised and often believe that their own particular health and social care needs are overlooked (Arksey et al, 2003:1). [34] *These include:* 1. Professional Characteristics Barriers 2. Barriers relating to service issues 3. Barriers relating to language or cultural issues 4. Barriers relating to carer or care recipient characteristics 5. Barriers relating to information and knowledge issues: Research[12] suggests that the caring role has both negative and positive affects on young people. It is notable that the vast majority of young people actually want to provide care. Other positive impacts of caring include, maturing earlier, developing life skills and learning to take responsibility (Thomas et al, 2003:37). However, as Thomas et al (2003:36-37) suggests, caring can also have a range of negative impacts including: • Physical Impact • Social Impact • Educational Impact • Emotional Impact

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	There are over 220,000 people providing unpaid care for a sick or disabled family member or friend in Northern Ireland. Despite the multi-billion-pound savings they deliver here each year, too many local carers are being driven to breaking point by unrelenting caring duties, few opportunities for a break, poverty and patchy support from Health and Social Care services. (A New Deal for unpaid carers in Northern Ireland | Carers UK 2023) CarersNI State of Caring 2023 Annual survey (UK wide, including NI) This report examines the impact of unpaid caring on health and wellbeing in Northern Ireland, based on data from Carers NI's State of Caring 2023 survey. It shows: • 1 in 4 carers in Northern Ireland are suffering mental ill-health • 50% feel lonely at least some of the time • 43% identify more breaks as among their main needs as a carer • More than 1 in 3 have put off health treatment for themselves because of the demands of caring. *(Available at State of Caring 2023: The impact of caring on health in Northern Ireland | Carers UK)* People with learning disabilities now have a greater life expectancy than ever before and as a result there is an expanding population of older parents who are continuing to care for a son or daughter well into old age.[34] There are also specific barrier to service access for BME Carers: (Barriers to Service Access :Welsh Assembly Government Report, 2003)[35] • Self-identification: often BME carers do not define themselves as such. • Lack of culturally sensitive services: BME carers are unlikely to access health and social services which are not culturally sensitive • Language barriers: insufficient language specific information and lack of translation and interpretation services are perceived to be major barriers to accessing services. • Stereotyping: some health and social care professionals continue to stereotype BME carers often having perceptions that they “look

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	after their own" and assume that BME carers do not wish to access carers' support services. • Lack of knowledge: the health and social care system is • Complex and often many BME carers are confused about where to go to for assistance. Prevalence of depression is significantly higher in older residents (unspecific ethnicity) living in care homes, compared with older people living in community settings. [8]
Disability	Findings suggest that most women with learning disabilities did not make their own decisions and some of those who did, found their choices constrained by various factors, such as their young age, fears of losing their service, and previous traumatic experiences. [45] People with Learning Difficulties47 have problems in accessing primary health care. Access is made more difficult because of communication difficulties and barriers in encounters between health professionals and PLD and practical issues such as long waiting times and lack of consultation time. This can result in a failure to access primary health services such as men's and women's health screening, cervical screening, genetic screening, dental checks and treatment and health promotion. Basic health problems may be unidentified or regarded merely as part of the learning disability rather than a medical problem. There can be issues around a lack of understandable information and addressing carers instead of users. [47] For disabled and chronically ill young people both the planning process and the actual move to adult services can be difficult, frightening and stressful. During adolescence, they will experience change in a number of areas: from paediatric to adult health services, school to higher education or work and childhood dependence to adult autonomy. Associated problems can occur such as social isolation, a lack of daily-living skills, difficulties in finding work and additional problems in family relationships such as over-protectiveness by parents and low parental expectations. Transition can also cause considerable stress for families and carers.[7] Public health emergencies will always disproportionately affect disabled citizens, it is vital that they are included in all stages of planning, to mitigate the effects of emergencies. By 2030 there will be a 24 per cent increase in the number of people with sight loss in Northern Ireland –

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	predicting an increased risk of number of falls and accidents. Sight loss also has profound emotional and practical impacts: there is a significant association between depression and sight loss [i], which can be compounded by a lack of awareness of available support. (RNIB 2025) Persons with disabilities must be considered when preventing and responding to health emergencies because they are more likely to be affected, both directly and indirectly. For example, during the COVID-19 pandemic, persons with disabilities living in institutions have been "cut off from the rest of society" with reports of residents being overmedicated, sedated, or locked up, and examples of self-harm also occurring (Brennan, C.S 2020) In the COVID-19 pandemic, there are higher mortality rates among persons with intellectual disabilities (Williamson, E.J., et al), who are also less likely to receive intensive care services (Baksh, R.A., et al 2021) An estimated 1.3 billion people – or 16% of the global population – experience a significant disability today. This number is growing because of an increase in noncommunicable diseases and people living longer. (WHO 2023) Persons with disabilities find inaccessible and unaffordable transportation 15 times more difficult than for those without disabilities. Health inequities arise from unfair conditions faced by persons with disabilities, including stigma, discrimination, poverty, exclusion from education and employment, and barriers faced in the health system itself. Persons with disabilities die earlier, have poorer health, and experience more limitations in everyday functioning than others.
Ethnicity	Poor life expectancy and high levels of suicide persist for the Irish Traveller community. Maternal and infant mortality is also an issue for some BME groups. There are also concerns about poor health outcomes for the Roma community. 38 Most people felt their opportunities to access services were about the same as everyone else. For instance 72.3% in ROI and 73.5% in NI thought their access to the Accident and Emergency Department (A & E) was the same, with 14.9% in ROI and 17.9% in NI rating their access as worse, and 12.8% in ROI and 8.6% in NI as better, than everyone else.

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	Respondents were asked to rate various difficulties in accessing health services. The barriers identified included the waiting list (cited by 62.7% of respondents in ROI and 46.8% in NI), embarrassment (47.8% in ROI and 50.0% in NI) and lack of information (37.3% in ROI and 28.6% in NI).39 Connolly (2002:7)48 identifies a number of difficulties experienced by Black and Minority Ethnic people which he suggests are consistent across a wide range of public services (including health and social services). These include: • Difficulties accessing existing services by those who speak little or no English (that is, language barriers). • A general lack of awareness amongst Black and Minority Ethnic people as to what services are available. • Low take-up of GP registration amongst some Black and Minority Ethnic groups (for example, Irish Travellers find it difficult registering with a GP because of no permanent address). • the need for more staff training and cultural awareness in issues relevant to Black and Minority Ethnic people. • a failure to meet even the most basic cultural needs of Black and Minority Ethnic people (such as dietary requirements or religious observance).48 For disabled and chronically ill young people both the planning process and the actual move to adult services can be difficult frightening and stressful.7 A review of the existing evidence shows that people of all ages from ethnic minority groups are more likely to have poor physical and mental health in later life.7 People of all ages from ethnic minority groups are more likely to have poor physical and mental health.7 For migrants, having little or no English is considered to be one of the most significant barriers to accessing health and social care and other key services. 1 There is a general lack of awareness amongst Black and Minority Ethnic people as to what services are available. 48 It is recognised that some Black and Minority Ethnic persons can face barriers to accessing support services, and that there may be cultural differences in knowledge and understanding of self harm and suicidal

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	ideation and that at times additional support is needed. For example, individuals for which English is not their main language. The Department of Health (England) assessment of impacts on equalities for the Preventing suicide in England noted that, 'Black and minority ethnic groups have high rates of severe mental illness, which may put them at high risk of suicide. The rates of mental health problems in particular migrant groups, and subsequent generations, are also sometimes higher. More recent arrivals, such as some asylum seekers and refugees, may also require mental health support following their experiences in their home countries. *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/267020/Preventing_suicide_equalities_impact-1.pdf*
Sexual Orientation	LGB&T people may experience barriers to accessing healthcare services. For example, a survey to explore the emotional health and wellbeing of LGB&T people in Northern Ireland (2013) found that around two fifths (42.6%) of LGB&T people reported being 'out' to their doctor, 35.8% reported that their doctor is not aware and 21.6% said they were unsure.[13] A report produced by the Lesbian Advocacy Services Initiative (LASI) found that lesbian and bisexual women experienced significant barriers to accessing health[48] There is, for example, a clear link between homophobia and poor mental health in Northern Ireland. For example, research into the mental and emotional health of 16 year olds has confirmed that a group which is particularly vulnerable in terms of their mental health are same-sex attracted males and females.[10] Research has indicated that people from the LGB&/T community generally have poorer health. This is manifested, for example, in higher rates of cervical, breast and anal cancer. [10] Anecdotal evidence suggests there are between 40-50 young trans people accessing support services due to gender identity issues and referrals are increasing[4] Trans young people face lengthy waiting lists when seeking specialist gender services and problems with the referral process. In order to cope and thrive, online resources and spaces have become increasingly

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	important for trans young people. Finding good-quality resources and information can be difficult for young people and families. Current statistics report that t 2.1% (31,600) of our population aged 16 and over identified as 'lesbian, gay, bisexual or other (LGB+)' and 90.0% (1,363,900) identified as 'straight or heterosexual' Older LGB&/T people are likely to have a greater need for health and social care services. Research indicates that when compared to their heterosexual peers, they are: ○ 2.5 times more likely to live alone ○ Twice as likely to be single ○ 4.5 times more likely to have no children to call on in time of need[11] There are 80 to 100 transgender people known to, or who are accessing support services in Northern Ireland. However, it is widely acknowledged that transgender people remain invisible and the numbers are estimated to be much higher. There may be a prevalence of 600 per 100,000 people.[12] Studies suggest that the prevalence of smoking, alcohol and drug use is higher among LGB&T people. For example, a 2012 study of substance use among LGB&T people in Northern Ireland reported that 44% of respondents smoked, 91% of respondents reported that they drink alcohol and that 37% reported using an illegal drug in the last year. (p7-8)[13]

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