

The Economic Benefits of Community Engagement in Health Provision in County Donegal



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

**A Report for the Donegal Community
Participation Advisory Group by**

**Charlie Garratt: Consultancy, Research and Training
Castletown, Dunkineely, County Donegal
074 973 7758
charliegarrett@iol.ie
September 2009**

**Funded by the Combat Poverty Agency which is now
integrated into the Social Inclusion Division in the
Department of Community, Rural and Gaeltacht Affairs.**

Contents

Section 1 - Introduction	1
Section 2 - The Community and Voluntary sector	3
Section 3 - Health and the Contribution of the Community and Voluntary sector	6
Section 4 - Costs of Health Care	10
Section 5 - Findings	12
Section 6 - Survey Methodology	21
Section 7 - Recommendations	24

Section 1 - Introduction

The piece of research associated with this report arose out of an attempt to develop an economic argument for improved engagement with the community and voluntary sector by the HSE. Put very simply, an underlying question might have been ‘if the community and voluntary sector didn’t exist, how much more would the health budget need to be?’.

The research was carried out in mid-2009 and looked at the health-related activities of voluntary and community organisations in two areas of County Donegal. The work was commissioned by the Community Participation Advisory Group as part of a programme of work funded by the HSE Consumer Affairs and the Department of Social and Family Affairs (Combat Poverty Agency) to support community engagement in primary care.

The community and voluntary sector was once described as a “loose and baggy monster”¹ due to the difficulty of describing its form, function and impact. Many organisations in this sector are multifunctional and in this context it is often difficult to see how they contribute specifically to the health and well-being of the population. Very little work has been done to actually quantify the sector’s impact either on health outcomes, on coherent service delivery by public agencies or on public sector financial resource savings. This research was an attempt to contribute to knowledge on that subject.

In 2008 the total HSE revenue spend in Ireland was just under €15 billion, roughly an 8% increase on the previous year. Due to the major economic downturn and the resultant severe financial difficulties in public finances this figure, in 2009 and 2010, is likely to reduce but will still be substantial.

Some initial desk research was carried out to attempt to identify a relatively low cost methodology that might be employed to identify the positive health impacts made by the community and voluntary sector and, from that, to quantify the attendant cost savings. However, what became clear from the desk research was that, firstly, very little work has been done on these issues to date and, secondly, that any work that has been done only seems to have arrived at an assessment of the difficulties of the approach. Each stumbles at the first hurdle, namely, how to attribute a specific health outcome for a specific individual to any one of a number of factors that impinge upon that individual’s life.

There is, however, considerable research evidence quoted by the World Health Organisation (WHO)² that ‘poor social and economic circumstances affect health throughout life’. It can, therefore, be safely assumed that interventions which seek to strengthen those social and economic circumstances are likely to have a positive effect on health. It is clear that many of those interventions are made by the community and voluntary sector using finance and staff that are additional resources to those provided by the HSE/state.

¹ A loose and baggy monster: Boundaries, definitions and typologies. Kendall, J and Knapp, M in *An Introduction to the Voluntary Sector*, Smith, J, Rochester, C and Hedley, R 1995

² *Social Determinants of Health: The Solid Facts* Wilkinson R and Marmot M, WHO 2003

Consequently, there are two possible approaches to looking at the economic benefits of community engagement, namely:

1. by trying to measure health improvements (and their cost benefits) in specific individuals that are attributable to interventions of the community and voluntary sector,
2. by identifying the collective resource that the community and voluntary sector is committing to creating a healthier population.

It is this latter approach that we have adopted in this research.

In order to put the findings into context we felt it important to describe the special nature of the community and voluntary sector (both generally and in County Donegal), the contribution that the sector potentially makes to health and the costs associated with a number of key health problems. These are covered in the following sections.

There is a vast body of literature on community engagement, the community and voluntary sector, and on the social determinants of health. It would be impossible to fully cover all of the material in this short report. References to some of this work are provided where appropriate.

Section 2 - The Community and Voluntary sector

The community and voluntary sector is an incredibly complex entity ranging from very small groups with very few members, minimal funding and little formal structure through to large formal organisations with substantial staff and governance hierarchies, significant budgets and wide geographical areas in which they provide services.

At a functional level the sector includes groups/organisations³ that might be categorised as follows:

- *Service providing*
- *Mutual aid*
- *Campaigning/pressure group*
- *Individual advocacy*
- *Resources, networking and co-ordinating functions*

A further function, *consultative*, has emerged over recent years. Additionally, the majority of groups and organisations in the sector would have *fundraising* as an ongoing function.

Fortunately for society, but perhaps unfortunately for would-be analysts of the sector, a large number of voluntary and community organisations⁴ are multi-functional in terms of the above list. Also, whilst many groups and organisations might primarily focus on a single issue, large numbers do not have a single-issue focus and seek to address multiple objectives to meet the needs and aspirations of their members/users. There is also substantial crossover in many groups, where the addressing of an apparently single issue entails adoption of a range of different functions and interaction with a range of public sector agencies. Table 1 provides two examples.

Table 1 - Objectives and Functions

Group/organisation	Potential objectives	Group functions to achieve objectives
Residents' Association (seemingly multi-issue)	Cleaner environment Improved housing Play facilities Safe neighbourhood Community spirit	Mutual aid, campaigning, consultative, networking, fundraising.
Blindness Support Group (seemingly single issue)	To provide support to people with visual impairment and their carers.	Mutual aid, service providing, individual advocacy, campaigning, consultative, resources, networking, fundraising.

³ The distinction between 'group' and 'organisation' is never clear but a simple starting point would be to view those with a formal structure e.g. constitution, committee and officers as 'organisations' whilst less formal arrangements might be viewed as 'groups'.

⁴ There are no clear definitions of the difference between voluntary and community organisations. The former would tend to refer to larger, more formalised end of the spectrum. See *An Introduction to the Voluntary Sector*, Smith, J, Rochester, C and Hedley, R 1995 for further analysis.

Estimates of the size of the sector vary considerably and this is largely due to problems of actually finding the smaller community groups who have no premises, website, staff, etc and who tend to be missed off community directories. An extensive study carried for the Home Office in the UK identified between 4.5 and 19 community and voluntary organisations per 1000 population⁵ whilst an audit carried out in Donegal in 2006 reported 2.5 to 8 per 1000 population.⁶ Within the two areas surveyed there was an average of 9 groups per 1000 population, with Ballyshannon/Bundoran having 12 per 1000 population and Lifford/Castlefinn having 6.5 groups per 1000 population. Across the County, therefore, it could be estimated that there could be between 865 and 1,197 community and voluntary groups in total.

An additional difficulty in examining the sector is that an organisation may be located in one geographical area but provide services and/or activities over a much wider area. Hence, simply counting the groups located within any particular geographical area underestimates the level of community and voluntary sector activity in that area. Taking the survey areas as an example, it was found that whilst 40 (95%) of responding organisations reported that most of their work is done in the local area, almost half (48%) reported that they worked in other areas as well. The breakdown of the focus for work is shown in Table 2.

Table 2 Where do groups carry out some activities?

Some activity in local area	100%
Some activity county-wide	38%
Some activity region-wide	40%
Some activity nationwide	29%
Some activity 'other'	Less than 1%

The Community and Voluntary Sector in County Donegal

Whilst not all of the groups surveyed actually responded, there did appear to be a good enough cross section responding to be able to draw some conclusions about the community and voluntary sector locally.

The one gap which is apparent is those organisations that have a county-wide remit. Only one of the organisations surveyed claimed to operate county-wide for most of its work (although Table 2 shows that a number of groups do work county-wide some of the time). If a similar survey were to be carried out in Letterkenny or Donegal Town the proportion of countywide groups may be considerably higher.

Of the 42 organisations supplying completed questionnaires:

- Annual budgets in 2008 varied from €500 to €620,000. Of those organisations providing figures:
 - roughly half (18) had budgets below €10,000 and roughly half ((17) had budgets above €10,000
 - roughly a quarter (23%) had budgets of €2,500 or below.

⁵ *Local Voluntary Action Surveys (LOVAS)* Marshall, T F., and others Home Office (UK), Research and Statistics Directorate (1997)

⁶ *Donegal Community Audit* Donegal County Council Research and Policy Unit (2006)

- The average income raised by groups through their own non-grant fundraising was 40% of their total budget. This rises to 54% for groups with €10,000 or less annual budget.
- 15 organisations (36%) employed staff
- 29 organisations (69%) deployed volunteers
- Three quarters (77%) of responding organisations said that they did some health related work⁷
- More than half (59%) said that they spent at least half of their time on health related work

Funding of the Sector

As can be seen from the above, the budget range of organisations surveyed is quite substantial. Organisations were asked to provide details of where their funding came from. This was clearly a sensitive area for many organisations so not all respondents provided information on budgets or funding sources.

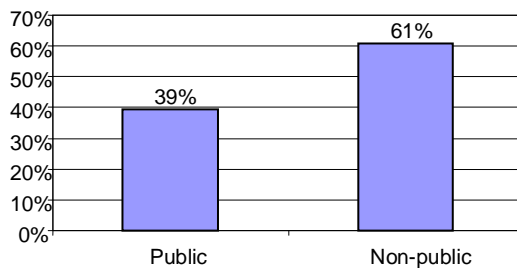
However, 35 organisations did provide figures and it can be seen in Table 3 that the largest source, by far, is the organisations’ own fundraising (i.e. non-grant income).

Table 3 - Funding Sources

Own fundraising	40.4%
HSE	21.1%
Other sources	14.7%
Central Gov't (not HSE)	13.6%
European funding	3.4%
Private sector	3.1%
Charitable trusts	1.9%
Donegal County Council	0.7%
Lottery funding	0.4%
Other Council	0.1%

When public and non-public sources are analysed it can be seen in Figure 1 that, amongst respondents, the majority of funding comes from non-public sources.

Figure 1 Public and Non-public Sources



Further analysis of the deployment of funding on health-related work is provided in Section 5.

⁷ ‘some health related work’ here refers to any response that was recorded as greater than ‘None’ on the survey form.

Section 3 - Health and the Contribution of the Community and voluntary sector

The main determinants of health as described by Dahlgren and Whitehead⁸, indicate a wide range of factors that contribute to positive health outcomes that might be categorised as follows:

- General socio-economic, cultural and environmental conditions;
- Social and community networks
- Individual lifestyle factors
- Age, sex and constitutional factors

It is clear that it would be virtually impossible for any single agency, acting alone, to have a major impact on any one of those factors. It is agencies, public, voluntary/community and private, acting in a mutual and supportive fashion, that will have the most impact.

Within any sizeable community in Ireland it is likely that there will be a range of community and voluntary organisations working on many of the areas in the above model and our research showed this to be the case in the two areas of Donegal that were surveyed.

There are predominantly two streams of activity of community and voluntary organisations that will impact upon the health of the community:

1. Activities that promote, monitor, guide, supplement or complement services delivered by the HSE and health professionals;
2. Activities that promote, monitor, guide, supplement or complement services aimed at addressing the wider range of social determinants of health.

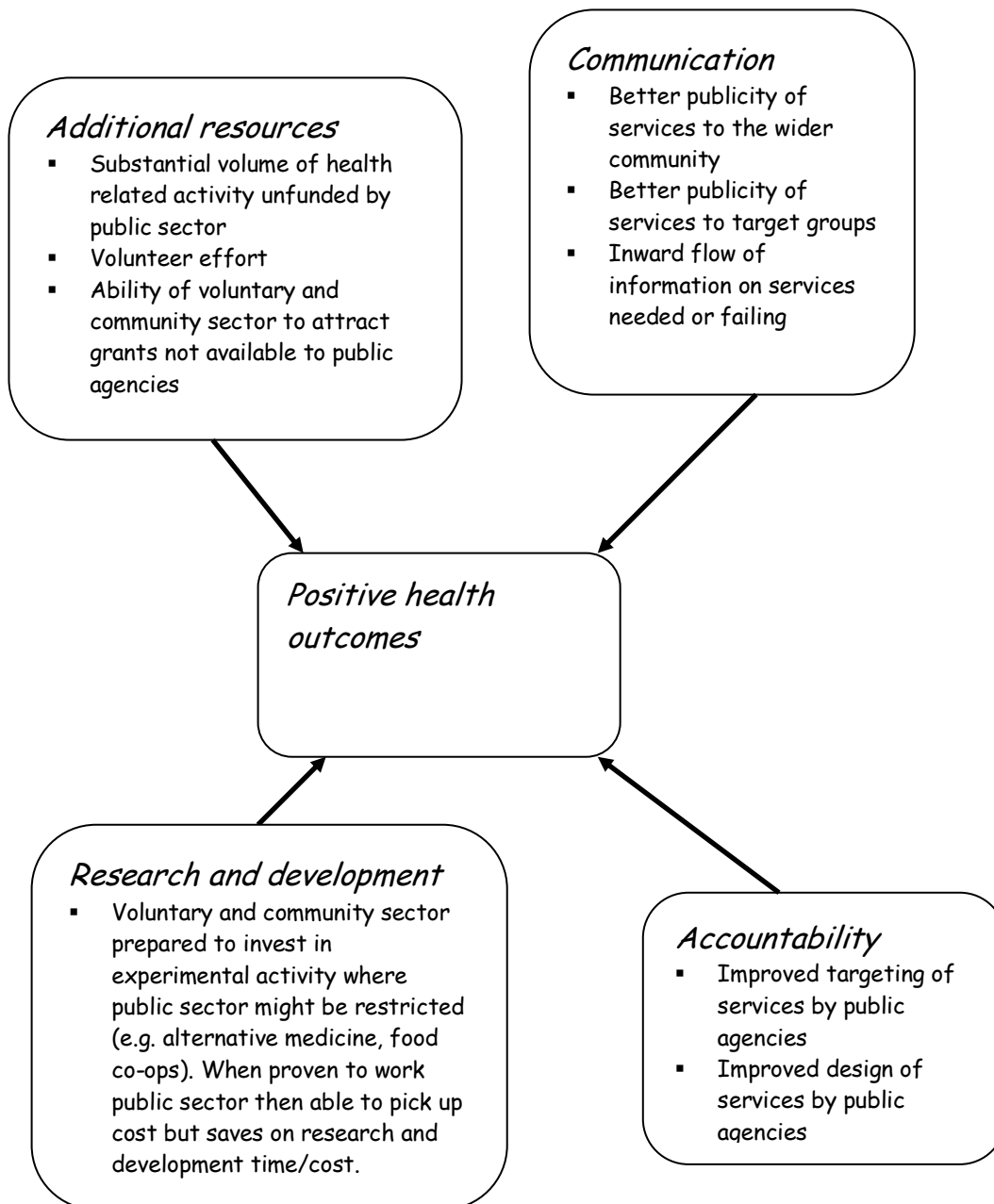
In both of these streams the activity might be funded by the HSE or another public body:

- under a service level agreement to deliver specific services;
- through a grant not directly linked to the delivery of specific services;

In many cases, however, voluntary and community organisations will carry out their activities with no public funding whatsoever. For example, about a third (32%) of organisations surveyed reported that they received no funding from public sources.

There are a number of ways in which engagement with community and voluntary organisations might be seen to be improving healthcare. The graphic below shows the four most important:

⁸ European Strategies for Tackling Inequalities in Health, Dahlgren G., Whitehead M., WHO, 2007



If we take examples of two cases that might present themselves at a GP surgery:

1. Someone with an infected cut. There will be a fairly straightforward prescribed treatment e.g. cleaning the wound, applying antiseptic cream, possibly tetanus shot and possibly more intensive medication depending on the severity of the infection.
2. Middle aged man has routine tests showing high cholesterol, marginally high blood pressure and minor obesity. May also occasionally smoke and drinks more than recommended limits. All risk factors for CHD, stroke and diabetes.

Recommendations might be:

- Change diet
- Take more exercise
- Stop smoking
- Reduce alcohol intake

In the first of these examples a basically clinical response is required, probably only involving the GP and a Practice Nurse. In the second example a lifestyle response is required, potentially utilising a number of community and voluntary groups (e.g. golf club, smoking support group, slimmers' club, etc). It is the resources of these groups that often goes unrecognised and are additional to those of the health professionals.

A further issue that arises in identifying the resources deployed is that many community and voluntary organisations do not have health improvement as a clearly stated objective.

The WHO report⁹, presents evidence that:

- High levels of social cohesion are associated with low rates of coronary heart disease;
- Social support can improve patient recovery rates and improve pregnancy outcomes in vulnerable groups of women;
- Improved social environment in schools, workplace and wider community will contribute to health, especially mental health.

However, in many community and voluntary organisations, the fact that they are providing opportunities for social interaction, improving social cohesion and providing social support is not necessarily seen, in itself, as a primary objective. In the survey, the inclusion of an option of listing 'social activities and networking' as an activity inevitably acted as a prompt but still only a little over a half (56%) of organisations responded that it was, even though it is clear from their other responses that this activity is an integral part of what they do. Consequently, even to the groups and organisations themselves, health improvement is seen as at least one step removed from their primary objectives i.e. health improvements are simply a result of some of their activities and approaches rather than the group's main purpose.

The WHO report also indicates that unemployment puts health at risk with a substantially increased risk of premature death, negative effects on mental health, and increased heart disease. There were 10 organisations responding to the survey who reported that they were focusing on work, employment or unemployment, with 30% of their budget coming from HSE and the remainder from other sources. There were six of these 10 organisations receiving no funding from HSE.

It has already been stated that community and voluntary organisations often have multiple objectives and functions that impact upon health in a number of complex ways. The following table provides an example of how one organisation, a residents' group, may have a number of stated objectives, none of them specifically health related, but nonetheless having a wide range of potential impacts on the health of the community that the residents' association serves.

⁹ *Social Determinants of Health: The Solid Facts* Wilkinson R and Marmot M, WHO 2003

Group	Potential objectives	Health impacts¹⁰
Residents' association	Cleaner environment	Fewer children's accidents Less stress - heart, mental health
	Improved housing conditions	Better child development Less anxiety and depression Reduced complications from circulatory illness Reduced respiratory illness Fewer accidents by elderly
	Play facilities	Reduced childhood obesity - diabetes
	Safe neighbourhood	Less anxiety and depression Reduced smoking
	Improved social cohesion	Lower coronary heart disease Improved patient recovery rates Better pregnancy outcomes Better mental health Better health generally

¹⁰ *Social Determinants of Health: The Solid Facts* Wilkinson R and Marmot M, WHO 2003 and *Health Risks and Inequalities in Housing – A Self-Assessment Tool* Blackman T, DoH (UK) 2005

Section 4 - Costs of Health Care

In 2008 the total HSE revenue spend in Ireland was just under €15 billion, roughly an 8% increase on the previous year. The total spend on healthcare, once private health care and individual contributions are taken into account is far in excess of this figure.

As has been seen elsewhere in this report, it is not claimed that engagement with the community and voluntary sector has an impact on health in all situations. The primary impact is on prevention of acute conditions through a number of interlinked and complex processes including:

- Physical and mental activity;
- Social inclusion and reduced isolation;
- Improvement in physical, economic and social environment;
- Health promotion.

These processes have an impact on the incidence or management of health in areas such as:

- Coronary Heart Disease
- Diabetes
- Strokes
- Mental health

The 'Get Ireland Active' website¹¹ quotes a Canadian study showing that physical inactivity results in about 6% of total health care costs. European studies are also cited as showing physical inactivity possibly costing about €150–300 per citizen per year. In Ireland the average of this (€225) would result in almost €954M a year, approximately 6.4% of the total health budget in 2008. As an example of the preventative work being carried out in the community and voluntary sector, there were a number of organisations responding to the survey who were clearly targeted at providing physical activity. Between them they reported almost 2,500 users/participants in an average month (a potential cost saving to the health system of around half a million euros a year, in the surveyed areas alone).

Heart Disease

In 2003 it was estimated that cardiovascular diseases cost Ireland €866M a year, or €108 for every person in the country, with health care making up 62% (€537M) of the total cost.¹² Using these figures, the estimated healthcare cost for Donegal would be roughly €12.5M (at 2008 rates).

Diabetes

Type 2 diabetes mostly appears in adults (though is increasingly diagnosed in children) and is linked to rising obesity rates in young and old alike, as well as in life styles during childhood.

¹¹ <http://www.getirelandactive.ie> HSE/DHC

¹² Economic Burden of Cardiovascular Diseases in the Enlarged EU, Leal J., Luengo-Fernández R., Gray A., Petersen S. and Rayner M. European Heart Journal 2006

A study in Ireland in 2007¹³ suggested that the life-threatening complications of diabetes such as heart disease and stroke are costing the taxpayer almost €600 million per annum. The study found that diabetes costs €2,468 for every patient in Ireland every year. Two thirds of the cost is spent on dealing with complications of the disease.

In 2006, the Institute of Public Health¹⁴ estimated that at least 141,063 adults in the Republic of Ireland (4.7%) had diabetes (diagnosed or undiagnosed) and predicted this would rise to at least 193,944 or 5.6% of the population by 2015 - a 37% increase. Their report points out that it is estimated that over 10% of governmental healthcare spending is diabetes related. Nine out of 10 cases of diabetes are Type 2.

The American Diabetes Association estimates that people with diagnosed diabetes have medical expenditures that are 2.3 times higher than what expenditures would be in the absence of diabetes.

Stroke

The average cost of a hospital admission for the treatment of an episode of acute ischaemic stroke in 2000 was €6,722.¹⁵ The projected cost for the treatment of stroke using the consumer price index for December 2008 would be €8,530.

In contrast to CHD and cancer, the burden of stroke lies with long term disability as opposed to death and it is the most common cause of neurological disability in the western world. Consequently such patients frequently require longer acute hospital stays followed by lengthy periods of rehabilitation where such services are available, long term nursing care or indefinite dependency on community care. Inevitably stroke is a major economic burden on healthcare systems. It has been estimated that approximately 6% of total healthcare resources are consumed in the management of this condition, a figure which is expected to grow with an increasing elderly population.¹⁶

Mental Health

It was estimated that, in 2002, the direct costs of health and social care due to mental health problems in Ireland cost €717M, €569M being public expenditure and €148M being private expenditure.¹⁷ A major cost factor associated with mental health problems, however, is on the economy, due to time lost from work and premature mortality. The same study identified these losses as a little over €2 billion a year.

¹³ The cost of treating type 2 diabetes (CODEIRE), J. J. Nolan, D. O'Halloran, T. J. McKenna, R. Firth, S. Redmond *Irish Medical Journal*, Vol. 99, No. 10, 2007

¹⁴ Making Diabetes Count, Institute of Public Health in Ireland, 2006

¹⁵ Cost of Treating Stroke in an Irish Teaching Hospital, McGowan B., Heerey A., Tilson L., Ryan M., Barry M., *Irish Medical Journal*, 2003

¹⁶ *Ibid*

¹⁷ The Economic Costs of Mental Health Care in Ireland, O'Shea E., Kennelly B., Mental Health Commission, 2008

Section 5 - Findings

Comparing Survey Area and County

The figures gathered only relate to two areas of the county and to those organisations that responded to the survey. An extrapolation of the figures to cover the whole of County Donegal is inherently difficult due to the diverse nature of the sector and the likely concentration of larger voluntary organisations in Letterkenny. However, on a very basic level, the population of the area surveyed is around one tenth of the total of County Donegal and with a survey response rate of 38% it would be reasonable to assume that multiplying the figures by a factor of 10 is likely to be a significant under-estimation rather than on over-estimation.

The multiplying factor of 10 is therefore used in the remainder of this section.

Additional Resources - Funding

Many voluntary and community organisations operate with a mix of funding from different sources and hence there are a number of issues to be considered when assessing the additional resources that the sector brings to bear on the health agenda.

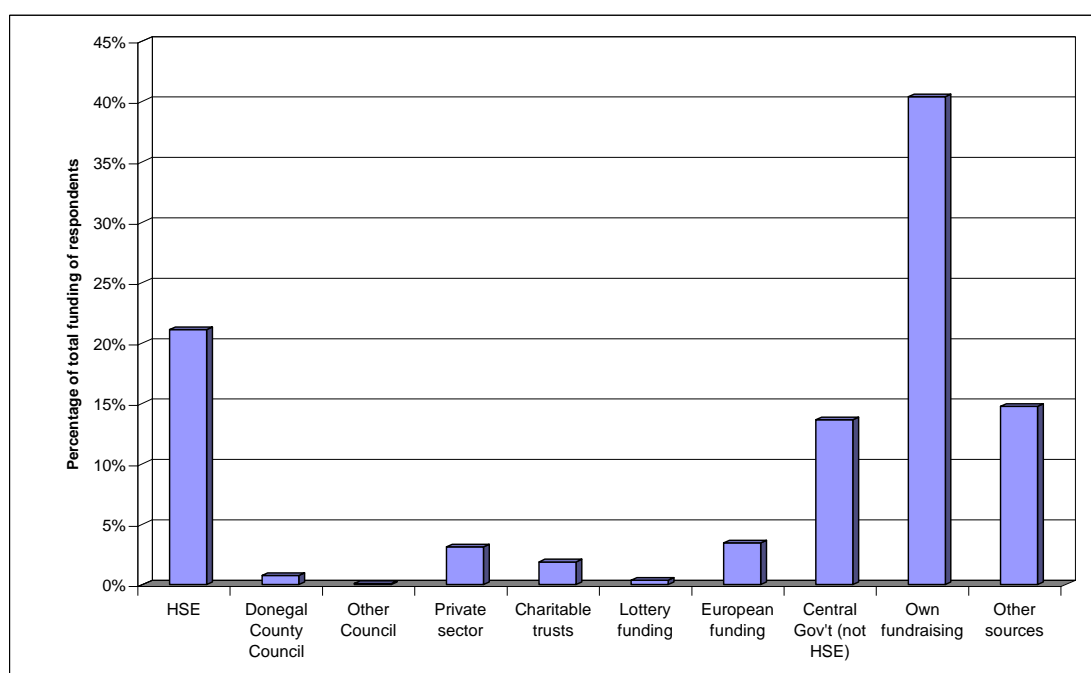
A total of 37 organisations provided a breakdown of their funding sources, though the actual budget was only provided by 35. Those organisations not providing any financial information on their returned survey forms were followed up by telephone but a significant number were unwilling to provide this information. The general reason given was the sensitivity of the current financial climate.

The total budget in 2008 of the 35 organisations providing budget information was €2,737,223. For those organisations reporting that they did some health related work¹⁸ the total budget was €2,610,923. Of this, €2,024,009 came from non-HSE sources.

The breakdown of funding sources for all organisations providing details (37) is shown in Figure 2.

¹⁸ 'some health related work' here refers to any response that was recorded as greater than 'None' on the survey form.

Figure 2 - Funding Sources 2008



Twelve organisations reported receiving some funding from the HSE although 93% of HSE funding went to three organisations. It is clear in those organisations in receipt of HSE funding that additional funding is levered in to assist in the delivery of their functions. Each €1 of HSE funding is matched by an average of €1.34 from other sources in those organisations receiving some funding from the HSE. This leverage ranges from virtually zero (as a small number of organisations are fully funded by HSE) through to €49 for each €1 of HSE funding.

Across the sector as a whole this leverage is €3.74 for each €1 of HSE money invested in the sector. Research carried out by Donegal County Council¹⁹ showed that those projects that received external funding were also the most successful at raising finance through their own (non-grant) fundraising.

The survey indicated that €1.1M was raised by respondent organisations in the two survey areas in 2008 through their own (non-grant) fundraising efforts.

Using the extrapolation calculation devised at the start of this section, it might be estimated that over €27M per year is expended by the community and voluntary sector in County Donegal, €20M of which comes from non-HSE sources.

If those organisations reporting that they spend no time on health related work are extracted, and the budget of those that spend some time is apportioned in relation to the amount of time they spend on health related work, the annual spend by them in the two survey areas is just over €1.6M on health related work. Once again, extrapolating the figure for the county it can be estimated that the community and voluntary sector spends at least €16M a year on health related work.

¹⁹ The Donegal Community Audit - A Strategic Needs Assessment. Research and Policy Unit, Donegal County Council 2006

This level of spending, alongside other resources committed that are reported later in this section, confirms that the community and voluntary sector is not simply a minor player that is a drain on public funds but, in fact, a major resource contributor and a crucial partner in the delivery of an effective health service in the County.

Additional Resources – Volunteers

The community and voluntary sector deploys significant numbers of volunteers in its operations. These volunteers tend to have three main functions:

1. People delivering services,
2. People involved in the management and/or governance of the organisations,
3. People raising funds.

Often these functions will be combined in individuals i.e. one person might carry out two or three of these functions at different times, but also, in many situations, the functions are carried out by different people. There are also organisations where the volunteers are both service users and service providers (e.g. self-help group).

In the 36 organisations responding to the question on volunteers, 31 reported using some volunteers. The total number of volunteers deployed was 347 with an average commitment of 3.25 hours per week for each volunteer. The total reported volunteer hours per week was 1,388. This equates to 72,176 hours a year or around 36 whole time equivalent posts. At current national minimum wage rates (€8.65) this is a cash equivalent of €624,322 free time committed into the work of the sector in just the two areas surveyed.

Applying the extrapolation factor referred to earlier in this section results in an estimated 360 whole time equivalent posts in the County being provided by volunteer effort. Taking only those that report that half, or more than half, of their activity is health related results in an estimated 280 whole time equivalent health-related posts in the County being provided by volunteer effort. This is only those who are reported as being involved in community and voluntary organisations and any volunteers associated directly with health services (e.g. hospitals) will be additional. The economic value of the 280 posts at minimum wage levels is €4.4M a year (360 posts equates to €5.7M a year) across the County.

Additional Resources – Staff

Although the community and voluntary sector deploys volunteers it also employs a significant number of staff. The survey found that there were 43 full time and 67 part time staff employed in the organisations responding. The hours of part time staff varied but there were total of 66.8 whole time equivalent (WTE) posts of full- and part-time staff employed. In organisations where at least half the time was spent on health related work there were 45 WTEs.

This extrapolates to 450 staff in the County employed in the community and voluntary sector on health related work. This figure is actually likely to be higher as there are probably a greater proportion of larger voluntary groups, with paid staff, in Letterkenny than in the two areas surveyed. Even at minimum wage levels this staffing equates to over €7M a year across the County.

User/Participant Numbers

There were 40 organisations that provided information on their user/participant numbers. Due to the nature of the sector the term ‘user’ will mean different things to different groups with, for example, a community resource centre having a different interpretation to a mutual aid residents’ group, hence the term ‘participant’ was included. It is often useful to be able to discern between the number of individual users/participants and the number of user/participant contacts²⁰ but it was felt that this degree of analysis was probably not widely available across the sector. Consequently a basic figure of users/participants per average month was requested but it is assumed that it is a figure for user/participant contacts that has mainly been provided.

There were 10,089 users/participants per month reported by those organisations providing figures. For those spending at least half their time on health related work the figure was 8,266 users/participants per average month.

Extrapolating these figures for the County would suggest over 100,000 user/participant contacts per month for the sector as a whole, with over 82,000 contacts for organisations spending at least half their time on health related work.

Health-related Activity

Time Spent

Organisations were asked how much time they spent on health-related activity, using a definition associated with the social determinants model as follows:

Work which not only involves dealing with illness but also the promotion of good health. For example: health promotion and work which contributes to the reduction of health inequalities caused by poverty and deprivation.

It was clear from some of the responses that, even using the broad definition above, organisations still see health in terms of illness, rather than general well-being. Consequently there is probably some under-reporting of health-related activity.

There were 39 organisations providing information on this and the results are shown in Table 4.

Table 4 Time Spent on Health-related Work

Organisations spending:	Organisations
No time on health related work	9
Less than a quarter of time on health related work	4
A quarter of time on health related work	3
Half of time on health related work	3
Three-quarters of time on health related work	6
All of time on health related work	14
Totals	39

²⁰ For example, a group may see 10 people on 20 occasions a month, giving 10 users/participants but 200 user/participant contacts.

From this it can be seen that 23 organisations (59%) spend at least half their time on health-related work, whilst 30 organisations (77%) spend at least some of their time on health-related work.

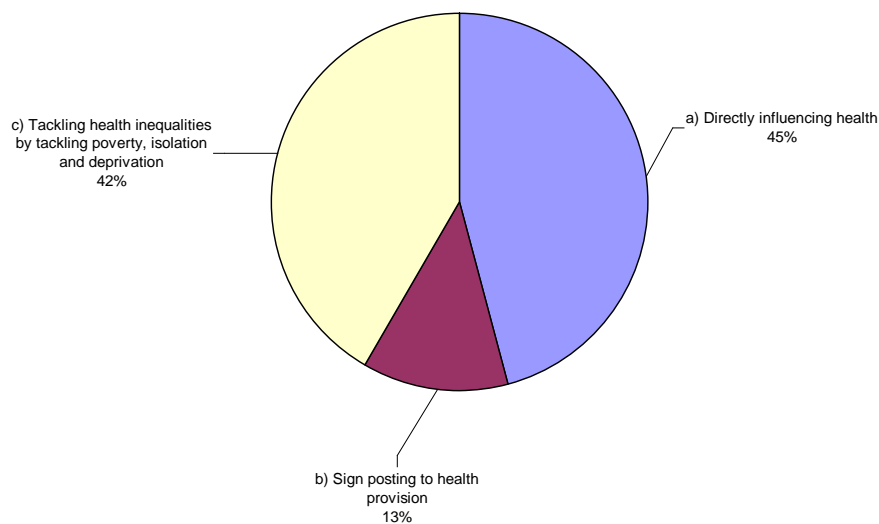
Types of Activity

Three types of activity were explored in the survey:

- a) *Activities which directly influence people's health*
- b) *Signposting users/members to suitable health provision.*
- c) *Tackling health inequalities, through addressing poverty and inequality.*

Twenty four organisations reported that their main activity was in one of the above categories and the breakdown is shown in Figure 3.

Figure 3 - Main Activity Health Related



Analysis of the financial resources committed to each of these areas shows, as might be expected, that almost two-thirds is spent on activity which is addressing the wider determinants of health. Table 5, however, shows that substantial sums are also spent on the other two areas of activity.²¹

²¹ The difference in percentages between Figure 4 and Table 5 is due to the former being the basic count of organisations and the latter being an analysis of their financial resources committed to each area of activity.

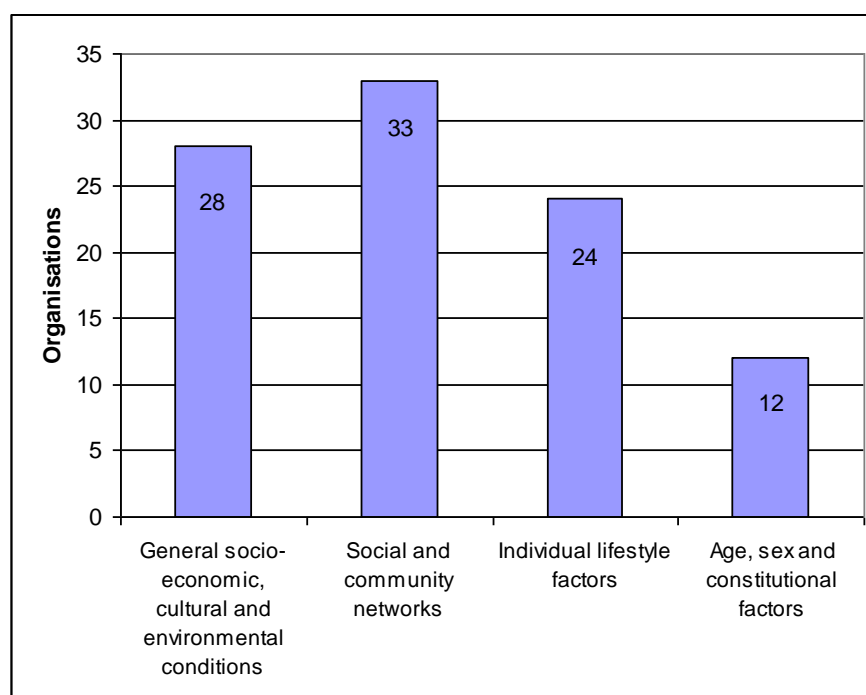
Table 5 - Analysis of Surveyed Sector Spend on Health-related Activity

Health-Related Activity	Sector Spend	Percentage of Total Sector Budget	Estimated Sector Spend in County
Activities which directly influence people’s health	€ 288,000	16%	€2.88M
Signposting users/members to suitable health provision	€ 355,416	20%	€3.55M
Tackling health inequalities, through addressing poverty and inequality	€ 1,111,592	63%	€11.12M

Health Determinants Activity

One of the main points being addressed in the survey was the extent to which community and voluntary organisations carry out activities that impact upon the determinants of health (see Section 3). Twenty two categories were used in the survey and these have been grouped, in Figure 4, into the four areas in the health determinants model to show the number of organisations addressing each area.

Figure 4 - Activity on Health Determinants



Note: Organisations could select a number of choices hence the overall total will be higher than the actual number of organisations responding.

This is a fairly basic analysis and, in reality, the picture is much more complex as the social determinants categories are fairly wide and not mutually exclusive. For example, virtually all of the organisations surveyed will have some degree of provision of social and community networking, regardless of whether they report this as one of the issues they work on. In fact, only 23 organisations listed ‘social activities and networking’ as an area of activity even though further examination reveals that all except 2 or 3 clearly have some degree of social networking. The

reason for this under-reporting is probably because a group may see its main activity as one thing and not see that in order to achieve its objectives it performs other functions as well.

Relevance to Key Health Priorities

Examination of a range of strategies and policy documents indicated a list of 13 current health priorities in Ireland. A total of 38 respondents provided information and the number of organisations working on issue is shown in Table 6.

Table 6 Health Issues Being Addressed

Health Issue	No. of organisations
Coronary Heart Disease	4
Strokes	3
Cancers	2
Mental Health	14
Substance misuse	6
Learning disabilities	2
Accidents	1
Older people	13
Sexual health (including HIV/AIDS)	3
Maternal and infant health (including low birth weight and breastfeeding)	2
Environmental Issues	9
Obesity	6
Diabetes	3

Once again it was clear from further examination of the responses that there was some under-reporting due, possibly, to the organisation not making the link between its activity and the potential health benefits. The above figures also need to be seen in the context that only 16% of organisations said that their main activity directly influenced health. For most organisations the health benefits are a bi-product of their main activity. A soccer club, for example, primarily exists to provide sporting activities. The fact that training and healthy eating as part of a fitness regime will also tend to reduce risk factors such as obesity, smoking and substance misuse which, in turn, have an impact on incidence of heart disease, diabetes and strokes may, or may not, be identified as an objective by that organisation.

Delivery Mechanisms

Organisations provide their health-related services in a wide variety of ways as shown in Table 7

Table 7 Health-related Services Provided

Service	Orgs	Service	Orgs
Keep fit/Sport	18	Counselling	4
Health promotion	15	Luncheon clubs	4
Health advice	12	Advocacy	4
Befriending	9	Pregnancy advice	3
Childcare advice	7	Slimming/diet support	2
Drop-in centre	6	Crisis intervention	2
Self help	6	Carer support	2
Day care	5	Money advice	1
Home safety and repairs	5	Campaigning	1
Other	4	Supported accommodation	1

Again, it should be noted that organisations were able to provide multiple responses to this question so a single organisation might be providing several different services in the above table. However, it can be derived that there were 1,432 users per month of health promotion and health advice services provided by community and voluntary sector organisations. A little over half (52%) of the total funding for these organisations came from the HSE, the other half coming from other sources. The HSE funding, however, isn't evenly spread across the sector. For example, of the 13 organisations providing these services only five received HSE funding in 2008.

Work with Target Communities

Analysis of HSE policy and service plan documents indicates a number of at-risk target communities and hence organisations were asked to provide information about their work with these specific target communities.

Table 8 - Target Communities Worked With

Target Community	Orgs
Older people	18
Lone parents	17
Children	16
Teenagers	15
Lower socio-economic groups	12
People with disabilities	12
Women (as a specific target)	9
Ethnic minorities	7
Isolated rural men	7
Traveller community	6
People with mental health problems	6
Men (as a specific target)	4
Asylum seekers and refugees	2
Homeless people	1
Drug misusers	1
Prisoners	1
Other target groups	4

Table 8 shows that a significant number of groups in the areas surveyed are working with (or supporting, or made up of) people from key HSE target groups.

Support Required

Groups surveyed were asked how effective they thought they were being at their health-related work. The overwhelming majority (81%) of those that responded claimed to be more than 50% effective in their health-related work, although only one claimed to be 100% effective.

When asked what, apart from funding, might help them to be more effective, a number of issues emerged and these have been grouped in Table 9.

Table 9 What would improve effectiveness in health-related work?²²

	Organisations
Better engagement with HSE and other public agencies	4
Free access to health professionals to provide training, information etc	8
Improved resources e.g funding, premises, members etc	10
Assistance with publicising service/activity	2

The three categories other than ‘improved resources’ are linked, in that they are all related to receiving a degree of support from the health profession. Underlying them is a sense of partnership in which the community and voluntary groups believe that they carry out their functions effectively but could be even more effective if they had a small amount of extra input from health professionals and health agencies.

²² Even though requested to exclude ‘funding’ from their responses a small number did include this issue.

Section 6 - Survey Methodology

Choice of Sample

There were four Primary Care Teams in County Donegal in early 2009, each of these with an associated Community Health Forum. Work had recently been carried out in one of these, Ballyshannon and Bundoran Community Health Forum, to improve the list of community and voluntary sector contacts and it was hence decided by the Community Participation Advisory Group to use this as one of the sample areas. The Lifford/Castlefinn Community Health Forum was the first established and it was agreed that this should be the other area to be included. The resources available for the survey meant that it would be limited to these two areas.

It was agreed that the list of contacts in each area would be expanded as much as was feasible and would include all organisations that could be identified as part of the community and voluntary sector. The list would attempt to include small community groups as well as the more visible larger voluntary organisations.

An important issue in identifying the organisations to be surveyed was the inclusion only of those groups and organisations that were actually located in the two chosen areas. The nature of the community and voluntary sector and of community support systems generally, is that there will be a significant number of organisations that might be located in one place but provide support and services across a much wider area. It was considered that the inclusion of county-wide, regional and national organisations not located in the chosen areas would not be possible with the resources available. It was acknowledged, however, that this would result in a significant underestimate of the resources committed by the community and voluntary sector to health provision in the County.

A range of local directories and online resources were used, as well as the existing contact lists of the Community Health Forums, to build up the mailing list. There were 130 organisations initially identified although contact details could not be found for six of them, leaving a final mailing list of 124 organisations.

It was apparent that some of the contacts may not actually be groups, but rather individuals associated with groups located outside the area (e.g. local fundraisers), also that there may be some multiple contacts for the same group (e.g. where the group might have slightly different names and contacts in different lists/directories). The final list was checked back with local contacts and these anomalies excluded as far as possible.

The Survey

The questionnaire was largely based on one that had been used for a similar investigation in Coventry in 1999. Questions were added to reflect some local interests (e.g. effectiveness of health related work) and the format simplified to enable multiple choice options as much as possible. The questionnaire was piloted with two organisations, one from each area, and modified in the light of comments received.

Each questionnaire was personally addressed where the name of the contact was known and basic contact details were included on the form so that the respondent merely needed to amend if that was required. Each questionnaire was coded to facilitate ease of identification on its return.

A prize draw was included to act as an incentive for an early response. This seems to have largely worked as virtually all of the responses were received by the deadline. Stamped and addressed envelopes were also included with the mailed questionnaires to encourage a response.

Where telephone numbers were available, non-respondents were telephoned two weeks after the mail-out to encourage them to return the forms in advance of the deadline. There was also some 'chasing up' after this deadline.

Choice of Question Categories

There appears to be no single document available that lists current health priorities or targets in relation to health outcomes either in the County or in the State. The National Service Plan 2009 issued by the HSE, for example, has an extensive range of targets but they are primarily service delivery targets rather than health outcomes. Consequently, the categories for the questions on health concerns, social determinants and target groups were drawn from a number of sources, primarily:

- An analysis of Government policy documents carried out by Helen McEvoy, Institute of Public Health in Ireland, March 2009.
- *Social Determinants of Health – The Solid Facts* Wilkinson and Marmot, WHO 2003
- *Tackling health inequalities. An All-Ireland approach to social determinants* Farrell, McEvoy and Wilde, Institute of Public Health in Ireland/Combat Poverty Agency, 2008

Responses Received

There were 48 responses received (38.7%). Of these:

- 3 provided no data due to current circumstances in the organisation;
- 1 was not an organisation but a local volunteer in a group located elsewhere;
- 2 were 'sub-groups' of another organisation that did return a form.

Consequently, there were 42 valid questionnaires returned.

Issues With Completion

It was clear from the returned questionnaires and the follow-up telephone calls that there were some issues that limited the completeness of the responses and the overall response rate.

Funding – Respondents and some non-respondents to whom we spoke were clearly unhappy about divulging financial information and were concerned about the possible end-use of the information. Several respondents refused to provide the material, though were happy to complete the remainder of the questionnaire. It is known that this issue of trust resulted in a number of non-returns.

Interpretation of questions – It became clear in the responses that in some cases similar organisations were interpreting questions, especially in relation to health activities, differently. It is likely that this was echoed in organisations that were not so similar but the differences were less easy to identify. It would seem that organisations were likely to under-report their health-related activity due to them not drawing a link between, say, sport and heart problems, or community support and mental health.

Relevance – Some organisations clearly had difficulties with seeing the relevance of some questions to their specific activities. For example, it was reported to us that the use of the phrase ‘services provided’ caused confusion for self-help and mutual aid groups who didn’t actually provide services. Most respondents appeared to interpret the phrase appropriately for their own circumstances but it may have produced some non-responses. A further, more complex issue, became apparent in respect of the relevance of some questions to those organisations that might be viewed as ‘second-tier’, that is, providing resources and facilities to other organisations. In one case an organisation that provides space to a clinic and to a pharmacy, as well as a number of community groups, responded that it carried out no health-related activity. This, once again, results in under-reporting of the extent of health related activity in the sector.

Recommendations

The research indicates that the community and voluntary sector is a significant contributor to the maintenance of a healthy community in terms of the services it provides, the impact it has on the social determinants of health and the substantial financial savings to the statutory health budget.

Consequently, there are a fairly obvious series of recommendations that suggest themselves for the maintenance and development of the sector.

These would include:

- Maintaining the current funding streams to the sector as far as is possible, in the knowledge that public sector funding is enhanced by funds levered in from other sources or through volunteer labour.
- Maintaining and supporting a system of engagement with the sector through the various structures including Community Health Fora and community representation on the Primary Care Teams (PCTs) and the Local Implementation Groups (LIGs).
- Accepting that engagement requires the commitment of time and some financial resources and building this into the process. This includes ensuring that community representatives have the resources to carry out the functions required of them and that health professionals also have support to maximise their involvement in the process.

Additionally, the following recommendations emerge:

1. It is vital that the community and voluntary sector, and the wider community, is fully involved in the needs assessment in each area. This will create the conditions whereby all sectors can work together to address the needs identified, building on the resources, skills and experience that each sector can bring to the table.
2. Joint working should be strengthened through identifying key health issues/themes which have come up in each PCT to date. These could then be presented to each PCT for discussion and analysis. Each team might be asked to select one or two themes to focus on and to bring all the resources of the team together to address them. The question could be “How do we keep people well?” It is important to ensure that the social determinants are considered in this process.
Examples of such themes might be –
 - The health and social needs of isolated older people
 - The health needs of young people – particularly sexual health and mental health
 - Mental health and access to mental health services
 - Transport to services and facilities
 - Long term conditions such as Asthma, Diabetes or Heart conditions – from the perspective of integrated care, self-care, prevention and promotion
3. Examples of existing good partnership work on PCTs should be showcased at LIG meetings on a regular basis.
4. In order to ensure that issues raised by community representatives and others at PCT meetings are fed into service enhancement discussions, there needs to be a clear and structured communication link in place between the PCTs and the LIG.