Community Development & Health Network

Community Development & Health Network (CDHN)

Response to Department of Health Budget 2024 EQIA Consultation

29 August 2024

About CDHN

Community Development Health Network (CDHN) is a regional infrastructure organisation working with local communities and across sectors to take action on the social determinants of health, improve wellbeing and reduce health inequalities. We work with communities to identify their own health & social needs & have a specific focus on those who experience the most disadvantage. With 30 years' experience and a cross sectoral membership of over 2400 individuals and 110 community and voluntary organisations, we have extensive reach across Northern Ireland.

We recognise, value and gather evidence to understand the social determinants of health and people's lived experiences. Together with our members we design, develop, deliver, facilitate and evaluate initiatives that improve health and address health inequalities. We use our learning, knowledge, and experience to create social change and influence policy and practice through learning, capacity building and community investment.

Overall comments

Everyone has a right to good health, but we all don't have the same opportunities to live healthy lives. In Northern Ireland, some people are dying earlier and living more years in poor health than they should. These health inequalities are unfair and unavoidable and are brought about by the conditions in which people are born, grow up, work, live, work and age. We recognise that this equality impact assessment has a specific focus on equality of opportunity for Section 75 categories, however the social and economic impact of inflation, increase in cost of living and more people in NI experiencing hardship and poverty cannot be ignored. Intersectionality[1] must also be considered, people experience different combinations of inequality, and those who experience socio-economic inequality may also have their inequalities widened as part of one or more Section 75 grouping.

We welcome the Health Minister Mike Nesbitt statement that Health Inequalities is one of his main priority areas and the value he places on community and voluntary sector involvement in the new ICS in Northern Ireland. However, our members have told us that the community and voluntary sector is already struggling financially, staff capacity is limited, recruiting and maintaining staff is difficult as they are unable to offer the same pay, benefits and job

[1] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-are-health-inequalities

security as the public and private sector. The cuts to 'core funding grants' and 'payments for support services' will only exacerbate the situation further and will lead to less or no support being given to those most in need and may result charities that provide essential services closing their doors, leaving long lasting effects.

We urge the Department to reconsider the proposed cuts to vital primary care, prevention and early intervention services as they are short sighted and represent false economy in health spending, with substantial opportunity costs[2]. The cuts proposed will cause significant damage to good working relations and the community and voluntary sector health infrastructure, will harm the public and have serious adverse impacts, widening health inequalities for the most vulnerable target groups.

Response to Consultation Questions

A) Are there any adverse impacts in relation to any of the Section 75 equality groups that have not been identified in section 5 of the EQIA Consultation document? If so, what are they?

PROPOSED CUTS

Cease Core Grant Funding completely in 2024/25

Although Core Grant funding represents approximately 0.05% of the Department of Health's 2023/24 Budget[3] it is important to put this relatively small funding allocation into its proper context. It funds organisations with knowledge and expertise in early intervention, prevention, public health and mental health support; and care related work by the community and voluntary sector for disabled people, children, young and older people those with substance abuse issues; people with health conditions; people living in disadvantaged communities; for all genders; education and training; research, policy development, and advocating for diversity and inclusion in the design and delivery of government strategies. All important building blocks for health and our Programme for Government.

Any discontinuation of core grant funding, and wider VCSE funding cuts, **will impact the community and voluntary sector's governance capacity to engage proactively with section 75 groups and support people and communities to contribute effectively to policy initiatives**, such as the Making Life Better review, Valuing Medicines and Medicine Safety Strategies, Children's Social Care Services Reform. It will **undermine the establishment of the new Integrated Care System's (ICS) partnership** structures for population health. It will also have a significant adverse effect on services for marginalised communities who experience poor health outcomes. Consequently, funding cuts to support

[2] Masters R., Anwar E., Collins., *et al.* (2017). Return on investment of public health interventions: a systematic review. *J Epidemiol Community Health*, 71, 827-834.

[3] Department of Health (NI), 22 May 2023, 'Department details 2023/24 Budget measures': https://www.health-ni.gov.uk/news/department-details-202324-budget-measures. This estimate was calculated using the total cost of the scheme, £3.6m, as a percentage of DOH's Resource DEL allocation for 2023/24, £7.3bn.

the development of community orientated health and social care policy and the implementation of integrated primary care initiatives and wider prevention activities will reverberate and **cause a further strain on the demand for more specialist, higher-cost health, and public services.**

CDHN welcomes the Minister's decision to maintain 50% of core grant to allow the Family Policy Unit to instigate a co-design process NICVA for the development and introduction of a new scheme.

Department Officials must understand how this small direct investment contributes not only to the core advocacy and inclusion work C&V organisations, but also to the expressed policy priorities and strategic objectives of government to work effectively across-departments and across sectors to address the most complex, cross cutting policy challenges, faced in NI today. It **reduces the capacity of regional C&V support organisations to lead in policy initiatives aimed at supporting the participation of target populations** in accessing the health and public services they need. Their **collective efforts generate a huge return in terms of early intervention, prevention and reducing pressure on statutory health and social care services.** Historically the Department's monitoring and evaluation system for the scheme was underdeveloped and not outcomes based. This situation has impeded efforts to review and develop the funding scheme iteratively and more aligned to evidence and population health objectives.

It is **essential that the new scheme** clearly states the aim and intended outcomes, what the scheme will support (and not support), how the grant can be spent; and the maximum amount of grants that will be awarded. Ideally, funding agreements would be for a minimum of 3 to a maximum of 5 years for successful applicants. To ensure equality of opportunity applications need to be open to organisations that have not previously received core funding and encouraged from those organisations that can co-ordinate collaborative working and improvements within our sector both regionally and locally to support those most in need.

Reduction in payments for support services provided by the Community and Voluntary Sector.

The community and voluntary sector is already under considerable pressure regarding staff capacity, competing with better salaries, terms and conditions and permanent contracts in the private and public sector. The 2.6%[4] unemployment rate in NI makes this even more difficult. There is a lack of sustainable funding to meet increasing demands, and huge competition for the public and philanthropic funding available. The funding and grants received are often **not full cost recovery**, for example, providing programmes costs but not adequately covering administration, management costs or overheads. Future funding

[4] https://www.economy-ni.gov.uk/news/labour-market-statistics-62#:~:text=The%20latest%20NI%20seasonally%20adjusted,Labour%20Force%20Survey%20at%202.6%25.

arrangements should be cognisant of the ongoing work by thew Joint Forums Voluntary & Community Sector Panel on the agreement of a set of **Fair Funding principles**[5]

The community and voluntary sector provide essential programmes and complementary services that enhance and help to join up and improve access to the current statutory health and social system, **helping to address unmet needs, reduce pressure on public services, and more acute treatment programmes**. For example, C&V sector provision of psychological talking therapies, leading to improved health outcomes for people and the population. Reducing the payments for support services will mean less or no support being given to those most in need, in areas where mainstream services are closing or rationed. Also, for some charities it will mean not being able to deliver at all and closing down.

For decades, our sector has bridged the gap in knowledge and understanding between communities and the system; we have shared community infrastructure and networks and leveraged additional funding. We have established positive ways of working with the DoH cross-departmentally to support public strategy and develop and implement policies to improve health and wellbeing. Together we have designed and delivered practical and complementary early intervention and prevention services tailored **to meet the needs of vulnerable groups experiencing poor health who do not usually engage in services**. The Department must continue to value the assets of the VCSE sector and the significant and complementary role the sector plays in the provision of health, social and community care services in NI.

Reduction in funding for Enhanced GP Services and Reduction in staffing of 1,200 provincewide

Both a reduction in funding for Enhanced GP services and a reduction in staffing need to be considered in light of the cost-of-living crisis, increase in poverty and growing hardship. A recent report by Joseph Rowntree Foundation (JRF)[6] has found that **primary and community healthcare services are experiencing rising and changing demand for their services as people are increasingly affected by hardship**, driven by factors including insufficient social security support, insecure work, and unaffordable housing, and struggle to afford the essentials, such as food, heating and appropriate clothing. **Hardship affects demand and resourcing in a way that ripples through the wider service, adding to staff workloads and affecting the quality of services**. The report notes that Section 75 groups such as BAME communities, refugees and asylum seekers, people with English as a second language, elderly patients, and carers as those more likely to experience hardship and the JRF UK Poverty report 2024[7] reports that some **S75 groups face particularly high rates of poverty** – low income women, families with three or more children, many minority ethnic

[5] https://www.nicva.org/event/shaping-the-future-relationship-with-government-update-on-proposals-for-a-new-partnership-0

[6] Schmeuker, K & Bestwick M (2024) The impact of hardship on primary schools and primary and community healthcare JRF https://www.jrf.org.uk/sites/default/files/pdfs/the-impact-of-hardship-on-primary-schools-and-primary-and-community-healthcare-b2e6881e1c318c53b333b894e15f0100.pdf

[7] Joseph Rowntree Foundation (2024) UK Poverty 2024 https://www.jrf.org.uk/uk-poverty-2024-the-essential-guide-to-understanding-poverty-in-the-uk

groups, disabled people and informal carers and it has been reported that Child poverty is on the rise in Northern Ireland[8]

The JRF[3] report states the crucial role for local public services, local authorities and voluntary and community organisations to support people when they face a crisis and to help them get back on their feet. **If the funding is cut to primary care and to the community and voluntary sector, they will be unable to provide this service.**

One of our members Mae Murray foundation[9] have given provided some lived experience of their members experience with GP services. Disabled people who are ill, are reporting having to rise early and redial for 20/30 mins to get a GP appointment, in an attempt to get through, to no avail, carers are reporting the same. Neither group have the option to leave the house, drive to a surgery early morning, to queue outside when ill. This problem is exacerbated for patients who are non-verbal and who previously were able to book appointments for a week in advance. This opportunity to pre-book a non-urgent appointment has been withdrawn for many. People with disabilities are disproportionally affected in the ability to access GP appointments. Any cuts to GP enhanced services or staffing could widen this inequality for people with disabilities.

These proposed cuts also go against the Bengoa (2016)[10] report and the Delivering Together transformation recommendations[11] for the reorientation of the NI health service and the need for a greater proportion of investment in prevention. CDHN shares the Department's disappointment that the bid to increase the number of MDTs was not successful. Moving treatments closer to communities and keeping people out of the more expensive in-patient secondary care. It will not reduce hospital waiting lists that are at a record high.

Regarding the reduction in investment Local Enhanced GP services, treating people with mild to moderate mental health conditions using counselling services. It is recognised that **effective psychological and talking therapies**, for mild to moderate mental ill health, can contribute not only to improving the health and well-being of individuals but also the health of the nation through employability, productivity and social inclusion.[12]

There is a well-established link between social deprivation and mental ill health. NI Research indicates that **patients in deprived areas are less likely to access and receive a course of psychological therapy than those in wealthier areas.**[13] This means that a person's socio-economic status may negatively impact their ability to access counselling in NI. Since 2018

[8] https://niapn.org/child-poverty-on-the-rise/
[9] https://www.maemurrayfoundation.org/
[10] https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-full-report.pdf
[11] https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf
[12] HM Government (2021) COVID-19 mental health and wellbeing recovery action plan. Our plan to prevent, mitigate and respond to the mental health impacts of the pandemic during 2021 to 2022. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973936/covid-19-mental-health-and-wellbeing-recovery-action-plan.pdf
[13] https://www.health.org.uk/blogs/better-access-to-talking-therapies-what-are-the-options

there has been a decline in the number of GP practices providing talking therapies. Deprived areas have a lower percentage of GP practices offering counselling services.

On the other hand, the cost of medicines in Northern Ireland is at an all-time high, exceeding £800m per annum and increasing each year. This represents a 41.5% increase in the last decade and is unsustainable. Research conducted by CDHN (2023)[14] indicates that communities are seeking therapeutic alternatives to the long-term overprescribing of medications for the treatment of depression and pain. These strategically aligned services better meet the needs of the population, reduce overprescribing, waste, and dependency issues to create savings in prescription medication in NI. This cut should be reversed as savings can be redirected into early intervention and contribute to better health and quality of life outcomes for those experiencing health inequalities.

Reductions in Vaccination programmes

There is growing evidence on vaccination uptake in the UK, some of which **impacts section 75 groups**. BAME groups are less likely to get vaccinated than white populations, those who are mentally ill and with learning disabilities are also less likely to uptake vaccinations[15]. Any reduction in vaccination programmes could lead to widening inequalities with these groups.

B) Please state what action you think could be taken to reduce or eliminate any adverse impacts in allocation of the Department's draft budget?

Local evidence-based practice

It is imperative that the Department look at innovative ways of creating collaborative partnerships with the community and voluntary sector and **pay attention to local evidence-based practice** which take action on the social determinants of health and reduce health inequalities and specifically target those most in need. Below are some examples of programmes like this, many more of which exist throughout Northern Ireland.

In CDHN, we have two regional programmes, Building the Community Pharmacy Partnership (BCPP)[16] and Elevate[17] that are delivered in communities using a bottom-up approach, guided by lived experiences and local needs and priorities without imposing a top-down agenda. Both these programmes specifically target Section 75 groups and show how a community development approach can be used to take action on the social determinants of health, and result in healthier and stronger communities and improve lives, health and wellbeing.

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[14] McNamee, Shields & Vance (2023) Our Lives, Our Meds, Our Health: Exploring Medication Safety Through a social lens https://www.cdhn.org/sites/default/files/downloads/OLOMOH%20Final%20full%20report.pdf

[15] https://www.local.gov.uk/our-support/coronavirus-information-councils/covid-19-service-information/covid-19-vaccinations/behavioural-insights/resources/research

[16] https://www.cdhn.org/sites/default/files/downloads/FINAL%20BCPP%20Full%20Report%202024_1.pdf

[17] https://www.cdhn.org/sites/default/files/downloads/A4%20Elevate%20Impact%20Report%20202223%20%2019Jan24.pdf

The IMPACTAgewell[18]® programme **improves health and wellbeing outcomes for older people** whilst also demonstrating providing a reduction in unscheduled costs to the health service. e.g. FROI £1: £2.38 Sharing Our Learning Reports - Agewell[19]. Evidence based models of care such as this have great potential to become embedded in health and social care regionally. IMPACTAgewell was recently involved with the IMPACT UK Centre for Improving Adult Care as demonstrator site. This report made recommendations on how learnings from the model of care can be embedded in practice in Northern Ireland. It found that this model worked well and should be replicated across Northern Ireland. It also found that the voluntary and community sector is integral to the delivery of social care and requires funding certainty and strategic influence.[20]

SEMM[21] is a South East wide Health and Wellbeing Hub linking the 4 Healthy Living Centre in the South East Area. The Hub provides support to individuals (children, young people and adults), families and carers who are experiencing mental health issues or living with a mental health condition. SEMM was highly valued by people, communities and services, the approach could be scaled up and replicated. The programme, which was developed through the DOH Mental Health Support Fund, ceased operations in March 2024.

Pharmacy education

We welcome the additional funding that is needed in 2024/25 to meet new regulatory standards for pharmacy education. This should also **include health literacy training**; it is recognised a social determinant of health, by improving health literacy you can address health inequalities. **Many S75 groups have been identified as experiencing disproportionately low or inadequate health literacy**, these are migrants and people from ethnic minorities, older people and disabled people[22]. The recent impact report on the Building the Community Pharmacy (BCPP) programme[23] shows that the programme supports the reduction of inequalities by improving the health literacy of disadvantaged communities and those most in need.

Cross-sectoral working

There is a need for more effective cross-departmental working to mitigate the potentially catastrophic impacts of the proposed cuts on Section 75 groups. **Currently, departments are working in silos, failing to collaborate and coordinate their efforts**. Departments must work closely together to mitigate the negative consequences of these cuts and ensure the continuity of essential services. Without a holistic view of the situation, departments may unintentionally exacerbate the inequality and hardships faced by Section 75 groups. The

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[18] https://impact.bham.ac.uk/our-projects/demonstrators/asset-based-approaches/
[19] https://dunhillmedical.org.uk/award-holder-stories/impactagewell-revolutionising-the-way-that-older-people-access-healthcare/
[20] https://impact.bham.ac.uk/our-projects/demonstrators/asset-based-approaches/
[21] https://resurgamtrust.co.uk/projects/healthy-living-centre/
[22] Public Health England (2015) Local action on health inequalities Improving health literacy to reduce health inequalities https://assets.publishing.service.gov.uk/media/5a80b62d40f0b62302695133/4b_Health_Literacy-Briefing.pdf
[23]CDHN (2024) BCPP Impact Report https://www.cdhn.org/impact

Executive Office (TEO) and DoH could bring departmental leads together to refocus on the whole government approach to societal wellbeing outcomes across the life cycle.

At this critical time for the DoH, we feel it is necessary to highlight the steady improvements to the current community health infrastructure built up with existing community resources through leveraging a cocktail of short and long-term public cross-departmental funding, charitable foundations and community and voluntary assets.

We strongly recommend that you pause the cuts to the VCSE, Public health and GP enhanced services and conduct a cross-departmental rapid review to assess the cumulative impact and knock-on effects of cuts to community health infrastructure and the Section 75 groups. Following the review, develop a mitigation strategy outlining targeted actions, alternative funding sources and measures to address the adverse impacts identified.

C) Are there any other comments you would like to make in regard to this EQIA or the consultation process generally?

Gathering evidence

On assessing the impact of the budget on Section 75 groups, the DOH relies only on the data collected by the 2021 Census to reach its conclusion concerning each component of Section 75. The EQIA states that there is no evidence to indicate that the Department's Budget allocation would negatively impact any part of this Section 75 category more than the general population. We would suggest that there **is a lack of available data to provide evidence** to determine the impact of cuts on Section 75 groups compared to the general population.

Statistics are vital to support policy decisions and a central component of any investment and development of this service in NI. The Department should invest in **systematically collecting and recording robust standardised data** on both the availability and the outcomes of services for individuals at a population level. We would hope that DoH would publish its **own equality monitoring data on the nine Section 75 categories and geographical areas for rural assessment** in order to assess accurately the impact of the budget decisions on services and population groups.

We would also urge DoH to put out a **call for evidence** to people and communities that will be impacted by a consultation **before the formal consultation process** takes place. This means that evidence can be considered before the consultation and there is less pressure for consultees to both gather evidence and respond in a limited time period. We understand part of the ICS planning will be to gather regional, area and local level data, we hope this can be used in future consultations. Our members have made us aware of some evidence by organisations who work with Section 75 groups that may be useful:

- Devine (2023)[24] Men's Health in Northern Ireland: Why do we need a men's health policy?
- Mens Health Forum (2024)[25] Men's Health in Numbers
- LGBT Foundation (2020) Hidden Figures LGBT Health Inequalities in the UK[26]
- Glasgow Centre for Population Health (2024) Examining the social determinants of LGBT+ health and wellbeing A scoping review of evidence, unmet health needs, and policy recommendations[27]

Consultation process

This consultation process in itself is an inequality issue. Unfortunately, CDHN like many other community and voluntary organisations are prioritising paid work and do not have the capacity within our small team to fully engage with our members on the consultation, the **timing during the summer means capacity** is stretched even further as staff and volunteers take their holidays. To truly engage with the Section 75 groups who may be affected by the cuts, efforts must be made **by DoH to reach out directly** to the organisations that work with the groups and **listen to the lived experience** of people in the community. They also need to reach out directly with all stakeholders that may be affected by the proposals, for example, those services named in the reduction in funding for enhanced GP services - diabetes, psychology, carers health and palliative care. As mentioned earlier, this could be alleviated by a call for evidence in advance of the consultation.

Rural Needs Impact Assessment (RNIA)

It states in the RNIA that *"Our initial assessment is that the cost reductions which need to be applied will not impact differently on people in rural areas from people in urban areas"*.

We have received feedback from our members that it will impact differently on people from rural areas. This evidence is provided by ARC Healthy Living Centre[28]

A combination of factors created a perfect storm in health and social care for the community in the South West of Northern Ireland. Historically the area was served by a combined Health and Social Care Trust (Sperrin Lakeland) that Trust struggled to sustain two acute hospitals (in Enniskillen and Omagh). That financial liability, coupled with a statutory obligation to reach breakeven created a sustained under investment in community services. The shoring up of acute at the expense of community endured over decades, resulting in entrenched rural health inequalities. Conversely the Northern Part of the Western Trust area had separate

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[24] https://onlinelibrary.wiley.com/doi/10.1111/1467-9566.13697?utm_campaign=4b4f93fe6e-EMAIL_CAMPAIGN_2023_09_25_COPY_01&utm_medium=email&utm_source=CES&utm_term=0_-f7edd07c1f-%5BLIST_EMAIL_ID%5D

[25] https://mhfi.org/MensHealthInNumbers3.pdf

[26] https://lgbt.foundation/wp-content/uploads/2023/12/Hidden-figures-LGBT-health-inequalities-in-the-UK.pdf

[27] https://www.gcph.co.uk/assets/000/003/485/Examining_the_social_determinants_of_LGBT__health_and_wellbeing_FINAL_original.pdf?1716892499

[28] https://www.archlc.com/

acute and community Trusts (Altnagelvin and Foyle), creating a legacy of community investment that was subsequently sustained.

The crisis was brought to a head with the loss of emergency general surgery from the South West Area Hospital (SWAH) in December 2022. This - coupled with the unfolding and deepening crisis in primary care and the long-standing problems in social care have variously and adversely impacted groups and neighbourhoods within the population. Furthermore, these challenges to service access for the local population are happening in a subregion where topography, internal travel distances, and distances to other centres, create their own realities for service users and services providers. The cost of living is higher in rural areas and rural households are twice as likely as urban households to be in fuel poverty - almost a third (32%) of rural households' experience fuel poverty compared to 16% of those in urban areas. Private transport is also a necessity in many rural areas in terms of access to employment and basic services – 92% of rural households had access to at least one car or van in 2019/20. As a result, vehicle ownership and running costs may consume a greater share of available household income.

Not surprisingly, the current crisis in health and social care in the SouthWest has become and remains a matter of serious and growing concern amongst local people. **There is a growing appreciation that the fabric of the network of service provision is rapidly unravelling.** Increasingly the community is relying on private provision and those without financial means are turning to community voluntary sector provision. At ARC whilst we are established and exist to serve the population, we do not have the resources to meet expectation and **rural service inequality is increasing.** As a charity, we are haemorrhaging staff to statutory and private sectors, the reality is with a lack of long-term assurances and real cost of inflation uplifts our jobs can't offer terms and conditions the match other sectors. Consequently, without people we cannot deliver programmes, **infrastructure enables operational activity, without sustainable core support there is reduced mechanism to actively reduce health inequality.**

Evidence

- Primary care is represented by the South West (SW) GP Federation. This is made up of 20 GP Practices with 128,500 patient population.
- The geography within this area is spans 2836 Km^2 and serves a population of 116,812. The population density of the area is 0.4 and is the lowest of all other areas Northern Ireland. **The rurality of the area means patients face poorer roads, longer travel distances to specialist services and less public transport provision. This results in increased reliance on primary care services**. (2021 Census Data (nisra.gov.uk))
- There has been a **30% decline in the number of GPs in Fermanagh & Omagh from 2014 to 2021** - the largest decline across the whole of Northern Ireland. With the current number sitting at 82 this represents the smallest number of GPs across the region. (Ref:- GMS for NI annual Statistics report published June 22 by BSO)

- The Northern Ireland Average is 70.2 GPs per 100,000 registered patients (1 GP for every 1,425 patients). Fermanagh and Omagh LGD has a ratio of 1GP for every 1567 patients. (Ref:- GMS for NI annual Statistics report published June 22 by BSO)
- The SW Federation has the highest proportion of GPs aged 55 and over, which accounts for 35% of the overall GPs in the area. Subsequently several retirements have led to closures and practice amalgamations **resulting in increased patient list sizes for remaining practices**. (Ref:- GMS for NI annual Statistics report published June 22 by BSO)
- The **funding is critical in providing additional services to bolster General Practice in the SW region**. It would be a significant step forward to get the "Skill Mix" funding stream moved across to "Recurring funding" Status. Skill Mix funding is significantly less than the patient funding attributed to an MDT, creating widening health inequalities across a small geography i.e. patients can access an MDT in Ederney but 7 miles away in Irvinestown they have no MDT in place.
- GP wellbeing – GPs report being overwhelmed by the increasing challenges of primary care and the workload they carry, combined with difficulties recruiting and retaining staff.
- "It is also noteworthy that there is no palliative care inpatient unit in the Fermanagh area. And there is no acute-care or Hospital at home provision in the Omagh area at present"

Conclusion

We are concerned that the cumulative effect of separate, siloed departmental cuts will re-enforce poverty and inequality in Northern Ireland. They do nothing to reduce health inequalities; rather they will worsen the health outcomes of our population and significantly set back the progress made. The proposed budget cuts will have catastrophic consequences for our most vulnerable groups and organisations that support them. These services are not a 'nice to have'. They provide vital and holistic support and are a lifeline to Section 75 groups. Consequently, these cuts will push the health burden to different parts of the system, including primary and emergency care, which are already at the point of collapse. The Department must reconsider these cuts and the cumulative impact, collaborate with the VCSE on the evidence-based strategies that we have in place to prioritise the wellbeing, and equity of all; supporting and empowering marginalised communities to reduce health inequalities.

Thank you for considering our response. We will continue to work with the Department and addressing these budgetary and equity challenges constructively. We are happy to engage with this process further at any stage.

Contact:

Helen McNamee
Research and Policy Manager
helenmcnamee@cdhn.org
Community Development and Health Network