Better Health for Everyone

a population health approach for Ireland

Annual Report of the Chief Medical Officer

2001

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contents

	Acknowledgements	4
	Foreword	5
	Introduction	7
Chapter 1	Inequalities in health	15
Chapter 2	Intersectoral approach to health	21
Chapter 3	Health impact assessment	27
Chapter 4	Health promotion	33
Chapter 5	Community participation	39
Chapter 6	Health protection	43
Chapter 7	Health services provision	49
Chapter 8	Population health structure	53
	Appendices	57

ACKNOWLEDGEMENTS

I wish to acknowledge the contribution of the staff of the CMO's office.

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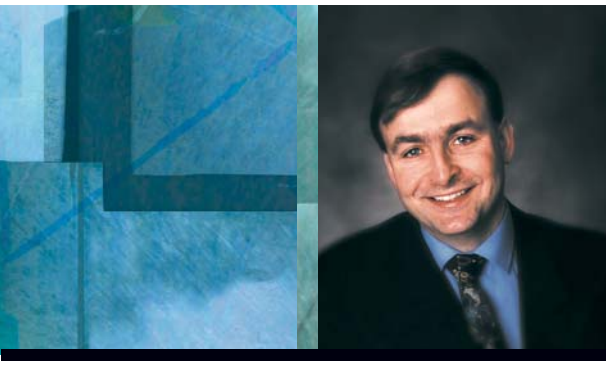
foreword



It is again a great pleasure for me to introduce this latest Annual Report of the Chief Medical Officer of the Department of Health and Children.

Previous reports of the CMO dealt with the health status of the Irish people, children's health, and inequalities in health in Ireland. This report is published in the aftermath of the launch of the Health Strategy *Quality and Fairness: A Health System for You* and deals with the major topic identified in the strategy, that of population health. It sets out how the population health approach, articulated in the Health Strategy, can lead to better health for everyone, the first national goal of the strategy.

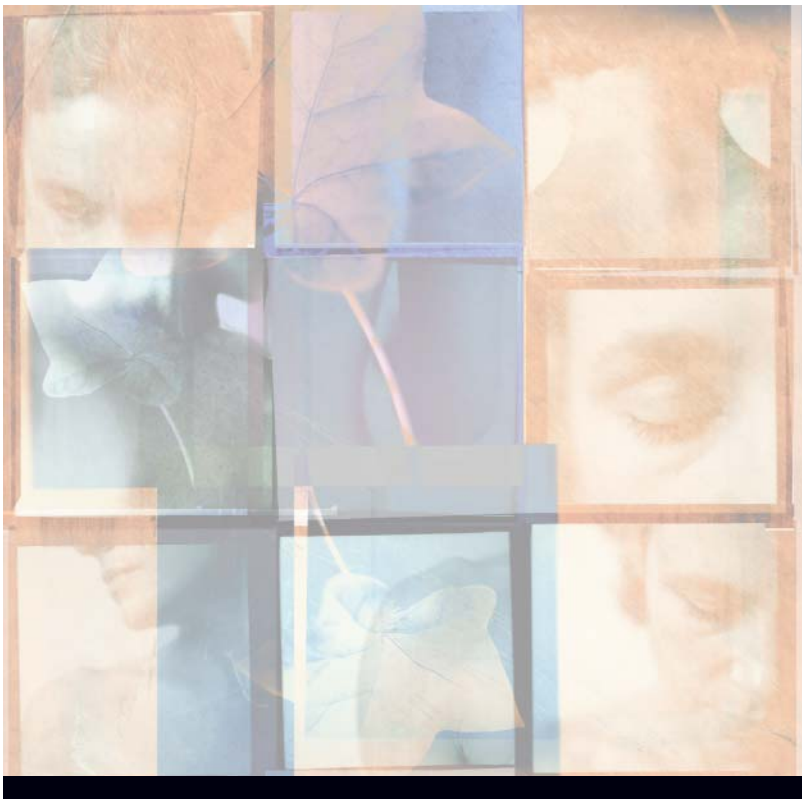
The concept of population health is defined, the various strands are identified and the interaction of these strands in a way which provides a coherent approach to the improvement of our peoples' health is described.

As we move along the implementation phase of the strategy, particularly the restructuring of our system, this report provides a valuable source of insight and direction in relation to a major component of this work. I very warmly welcome its publication.

Micheál Martin

Mr Micheál Martin TD

Minister for Health and Children



Better Health for Everyone

introduction

Annual Report of the Chief Medical Officer 2001

INTRODUCTION

The Chief Medical Officer's report 2001 is being presented in the context of the publication in November 2001 of the Health Strategy *Quality and Fairness: A Health System for You*.

This strategy was developed after the most intensive consultation process ever undertaken by the Department of Health and Children and:

- is underpinned by four basic principles
- sets four national goals
- describes six frameworks for change
- makes 121 recommendations for action
- establishes implementation and evaluation structures to ensure that the strategy is brought forward in accordance with the schedule set out.

The strategy clearly identifies the fact that Ireland has a relatively unhealthy population by comparison with other countries at a similar stage of social, economic and political development. Recent economic improvements have not been matched by equivalent health gains and the gap between life expectancy in Western Europe and Ireland is in fact widening.

The following graphs illustrate some of the more significant divergences in health experience between Ireland and other EU countries. Ireland continues to have a lower life expectancy at birth than the EU average (Figure 1). Although trends in mortality rates for ischaemic heart disease and cancer are improving, they are still substantially higher for the Irish population than the European Union average (Figures 2 and 3).

Figure 1: Life Expectancy at Birth – Ireland and EU, Selected Years: 1970-1998
Source: WHO/Europe, HFA Database, January 2002

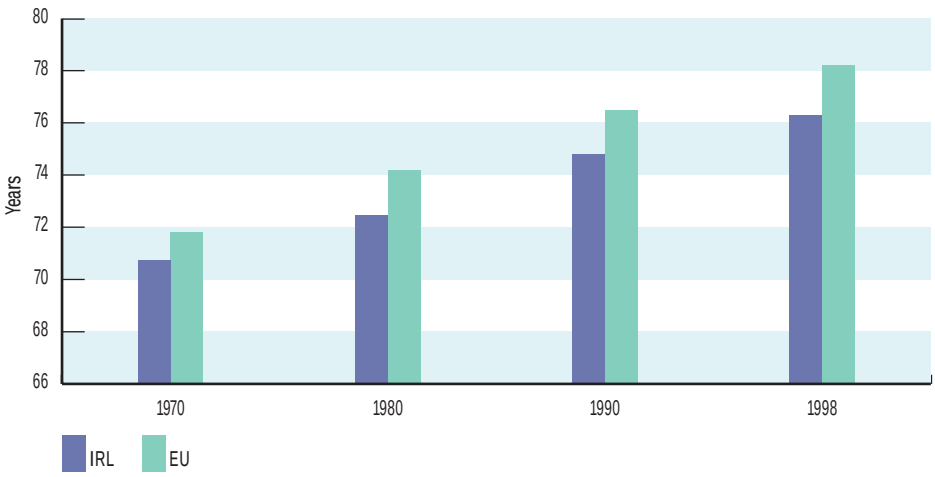


Figure 2: Ischaemic Heart Disease – Trend in Age Standardised Mortality Rates, 1980-1998
Source: WHO/Europe, HFA Database, January 2002

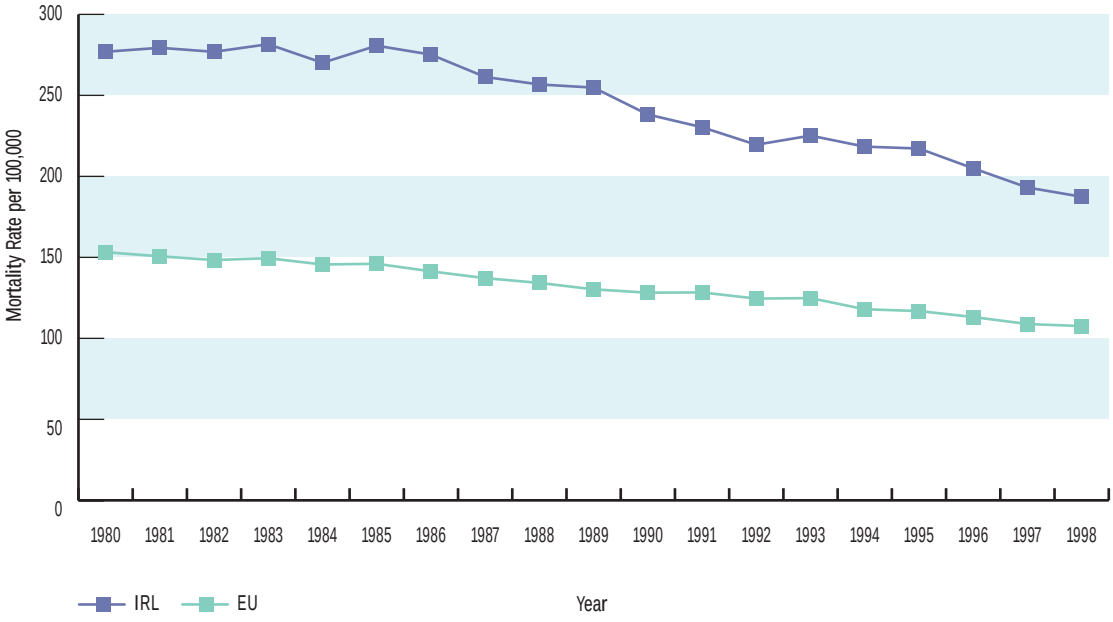
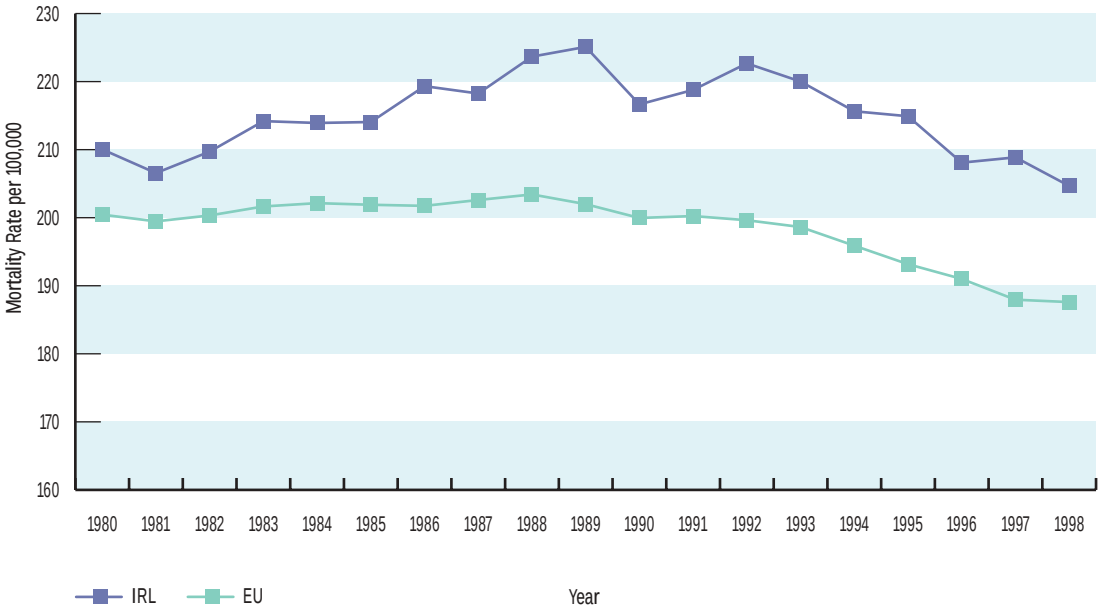


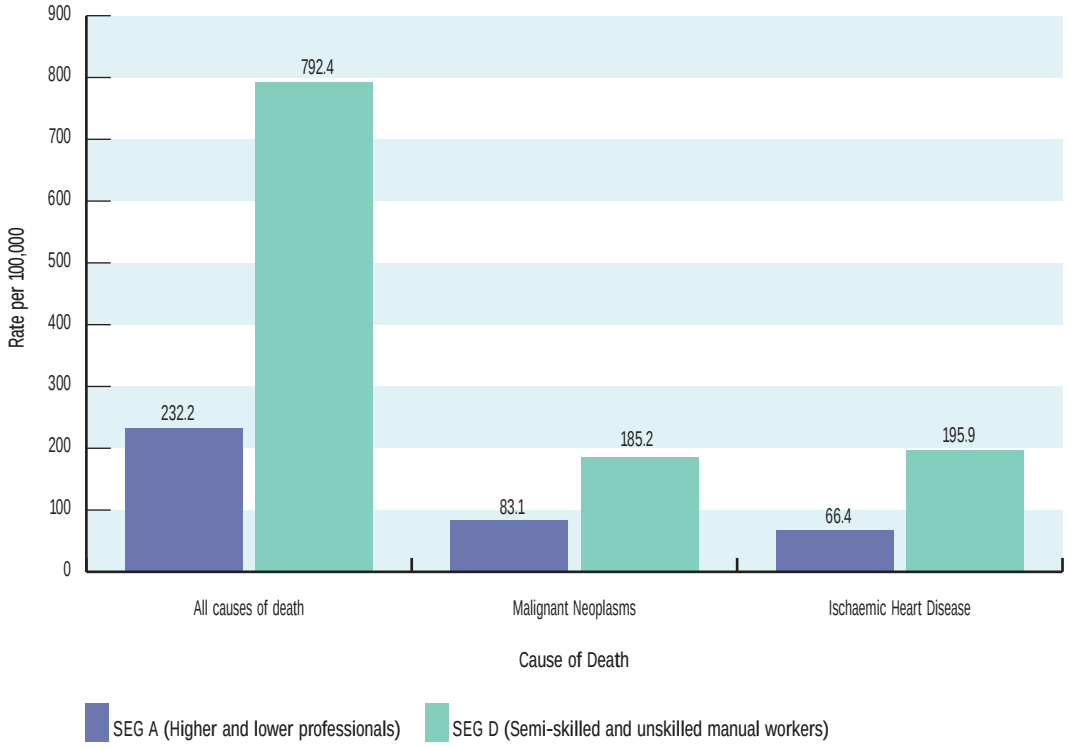
Figure 3: All Cancers – Age Standardised Mortality Rates,1980-1998: Ireland and EU
Source: WHO/Europe, HFA Database, January 2002



As a subset of this relatively poor health status which the country as a whole experiences, it is also clear that the burden of ill-health and premature mortality is unevenly distributed within our population. It is a fact that those whose level of economic prosperity is less than that of the wider community in which they live, suffer

disproportionately in relation to poor health and early death when compared to the community as a whole and, in particular, to those sections of the community who enjoy greater economic prosperity. Figure 4 clearly shows the difference in mortality between the highest and lowest socio-economic groups (SEG) in Ireland.

Figure 4: Annual directly standardised mortality rates for working-age males by occupational class. Source: Inequalities in Mortality: A report on All-Ireland Mortality Data 1989-1998, Institute of Public Health



The identification and understanding of the factors which determine this experience, and the development of strategies and plans to deal with these inequalities, are the most pressing issues facing us in the health field. The multi-dimensional nature of health and the causes of ill-health point inexorably to the fact that the solution to what presents as health problems lies in the wider community and that, while the health services have a part to play in our response to this issue, health service provision must be viewed as only one element within a broader context which recognises the role of multiple influences and participants.

Quality and Fairness: A Health System for You

In light of the recognition that the health of the Irish population has significant scope for improvement, the Health Strategy identifies its first national goal as:

- Better health for everyone.

It describes in broad outline the implications of setting this goal and further defines three other goals:

- Fair access
- Responsive and appropriate care delivery
- High performance.

These goals, while important and relevant in their own right, also constitute the unique contribution of the health system itself to achieving better health for everyone.

The approach to be adopted to progress towards Goal 1, to effect improvement in the overall health of the Irish people, is that of 'population health'.

Aims of Report

The purpose of this report is to:

1 elaborate on the concept of population health described in the Health Strategy

2 identify the strategic, organisational and operational changes which need to be made to give practical effect to the following concepts:

- The health of our population should be a central focus of all public policy initiatives
- The health system can influence the broader public service to serve the interests of better health
- The health system can plan and deliver health services that are safe, effective, of high quality, and are capable of improving the health of the individuals they serve and also of the wider population.

What is population health?

Population health is an approach to health that aims to improve the health of the entire population or sub-groups within the population. It involves the development of policies aimed at reducing health inequalities among population groups. There is a growing body of knowledge as to what determines health and inequalities in health and how these determinants can be influenced so as to improve the health of the population. We know that factors outside the health sector significantly affect health and that the delivery of health care is only a part of what properly constitutes health. The achievement of good health goes beyond the responsibility of the individual or health care providers. It involves many sectors and every stratum of society. The persistence of relatively narrow biologically and individually focused definitions of health and illness will result in the neglect of broader considerations which have a major impact on the health of the population.

In considering health determinants, there are a variety of factors that are important singly and, at the same time, can be inter-related. There is often a complex interaction between determinants that can have a more adverse effect on health. For example, unemployment, leading to social isolation and poverty, in turn influences an individual's psychological and coping skills. Together these factors lead to poor health.

The determinants of health broadly include the following:

- Genetic endowment
- Gender
- Child development/early life experiences
- Personal health practices and coping skills
- Employment/working conditions
- Income and social status
- Social environment and support networks
- Education
- Health services.

The external determinants of health include social cohesion and community networks, education, employment, food production, housing, water and sanitation, transport and the health services. Of the external factors, socio-economic status and, in particular, poverty, are among the most powerful influences affecting good health. There is a clear social class gradient for the major causes of mortality, with those at the lowest socio-economic level suffering most.

This gradient is also maintained for the key lifestyle factors which determine how healthy we become. It is important, therefore, to identify and address the social and economic barriers which deter individuals with the least economic resources from adopting a healthier way of life.

The population health approach acknowledges the varied nature of health determinants and advocates action across different levels and many sectors in society. This involves co-ordinated and integrated, multi-sectoral policy. It calls for the creation of sustained partnership measures so as to engender cross-sectoral support. It includes both the statutory and non-statutory sectors.

The need for reform

The Health Strategy has given the commitment that, in recognition of the importance of the population health approach and the beneficial effect that the implementation of this approach can have on the health of people, a Population Health Division will be established in the Department of Health and Children (DOHC). This innovation will facilitate a more focused and integrated approach to the delivery of strategy objectives, in general, and to current public health problems such as obesity, alcohol consumption and childrens' health.

The Health Strategy identifies a range of strengths and limitations in the current health system. Health remains high on the public agenda and this, together with an increase in the skilled workforce and a range of health initiatives and improved health planning, has contributed to significant improvements in the health of people in Ireland. On the other hand, major health inequalities amongst the population are emerging and there is scope for improvement when our health is compared to that of other countries in Europe.

The current configuration of the Department of Health and Children has worked well for many years. The Department has overseen many new developments and provided leadership in a health care environment that is constantly changing and becoming increasingly complex. However, the current structure is not designed to respond readily to intersectoral issues, especially when more then one division may have responsibility. In addition, the concept that sectors other than health play an important role in determining health has not found full expression in either its structure or activities.

Increasingly, the Department is likely to face population health issues that call for a multidivisional response. Such issues may relate, for example, to crises of communicable disease or the development of new national screening programmes. The Health Strategy acknowledges the need for better linkages and integration within the health care system. The population health approach articulated in the strategy has the potential for reorienting government policy towards health.

The following chapters identify those areas of activity that are comprehended by the term population health and where properly integrated policy making and operations can contribute most to the promotion, protection and restoration of the health of our population.

These are:

- Inequalities in health
- Intersectoral approach to health
- Health impact assessment
- Health promotion
- Health protection
- Community participation
- Health services provision
- Population health structure.

Better Health for Everyone

CHAPTER

1

Inequalities in Health

CHAPTER ONE 1

Inequalities in Health

Introduction

The theme of the first Report of the Chief Medical Officer in 1999 was that of inequalities in health. This refers to a broad range of differences in both health experience and health status between countries, regions and socio-economic groups.

Most inequalities are not biologically inevitable but reflect population differences in circumstances and behaviour that are in the broadest sense socially determined. In industrialised countries the term inequalities in health tends to refer to differences in health status between regions and population subgroups that are regarded as inequitable. Population health, in addition to improving the health of the entire population, through its policies, strives to reduce such inequities in these population subgroups.

Factors determining inequalities in health

Health inequality has been defined as the 'difference in the prevalence or incidence of health problems between individual people of higher and lower socio-economic status' (World Health Organisation, 1998).

Inequalities in health result from a variety of factors, e.g. gender, age, ethnicity, heredity and geographical location. However, one of the most acknowledged factors affecting health and inequalities is that of socio-economic deprivation. Poverty, unemployment, lack of education, poor housing, and lack of access to health services all affect health.

Inequalities in health were highlighted in the UK in the 1980s with the publication of the Black Report which found large differences in mortality and morbidity between the higher and lower social classes in Britain. '… from birth to old age those at the bottom of the social scale have much poorer health and quality of life than those at the top … gender, area of residence and ethnic origin also have a deep impact.' The recommendations of this report pointed to a wide range of social policy measures to combat inequalities in health. These findings and recommendations have been replicated in a number of countries around the world.

Inequalities in Ireland

Until the early 1990s little work had been published on socio-economic differences in health in Ireland. However, a large number of reports in recent years have addressed the issue and identified a number of concerns.

- The Institute of Public Health in Ireland has highlighted the pervasiveness and magnitude of occupational class mortality. Its report, *Inequalities in Mortality. A report on All-Ireland Mortality Data*, based on data for the ten-year period 1989-1998, has shown that the all-cause mortality rate in the lowest occupational groups was 100-200 per cent higher than the rate in the highest occupational group. These occupational class gradients in mortality were present for all major causes of mortality: cancers, circulatory diseases, respiratory diseases, injuries and poisonings.

- The Institute's report also highlighted the existence of gender differences in mortality. The all-cause mortality rate for men was 54 per cent higher than for females in the ten-year study period. This gender gradient in mortality was present for cancers, circulatory diseases, respiratory diseases, injuries and poisonings.

- Examination of routine health information systems over the past 20 years has demonstrated a higher mortality rate in unskilled manual men compared to higher professional men. Over this time period, unskilled manual men were also eight times more likely to die from accidents than were higher professional men.

- Such occupational class mortality is evident from birth. Perinatal and infant mortality rates are higher in families where the father is an unskilled manual worker or is unemployed.

- Five years (1991-1996) data from the National Psychiatric In-Patient Reporting System provided evidence of an increasing socio-economic gradient in incidence of all psychiatric conditions from professional to unskilled manual groups.

- Travellers have significant disadvantages in health status. Travellers of all ages have much higher mortality rates than people in the general population. Traveller women live on average 12 years less than women in the general population. Traveller men live on average 10 years less than men in the general population. In addition, Travellers experience higher rates of stillbirth, infant mortality and perinatal mortality.

- The health status of the adult homeless population is less than the population average. Homeless adults suffer from a substantially greater burden of ill-health including depression, hypertension, hepatitis, alcoholism and illicit drug use. Also, they experience huge difficulty in accessing the health services they require.

- The incidences of specific conditions, for example coronary heart disease and lung cancer, are higher in geographic areas that experience higher levels of socio-economic deprivation.

- Health behaviours also show a social class gradient. Adults and children in the lower socio-economic groups have significantly less healthy lifestyles (higher levels of smoking, higher body mass index and less healthy eating habits) than those in higher socio-economic groups.

- The prison population suffers from a disproportionately large rate of psychiatric and drug-related problems. All mental health indicators are much worse for prisoners than for the general population and are particularly high for female prisoners. Almost one quarter of this population suffer from a long-standing disability or illness that limits their activity.

Poverty and health

The Health Strategy *Quality and Fairness: A Health System for You* identified the issue of inequalities in health and, in particular, the strong links between socioeconomic factors and health. The association between poverty and ill-health is strong and well established in Ireland. Poorer people experience poor health. Poverty contributes to poor health directly through, for example, inadequate housing or dangerous environments and indirectly, for example, through poor diet. Being poor also makes it more difficult to access or afford health care, and reduces the opportunity for adopting a healthy lifestyle.

Also, people who experience ill-health and disability are more at risk of poverty and social exclusion. Recent evidence shows that people with a disability or illness have a 56.5 per cent risk of falling below the relative 50 per cent income poverty line. While evidence is lacking to demonstrate a direct chain of causation between ill-health and poverty, there is increasing awareness of the negative impact of ill-health and disability on participation in society.

The goal of improving the population's health and reducing health inequalities requires significant political support and commitment. Achieving these objectives is not the sole preserve of the Department of Health and Children and the health services generally. These objectives will only be achieved when population health is an integral part of the policy making, planning and performance management process of all government departments and agencies.

The Health Strategy *Quality and Fairness: A Health System for You* made a commitment to reducing health inequalities by implementing a programme of actions to achieve the National Anti-Poverty Strategy (NAPS) and other health targets. Under NAPS, all government policy is 'poverty proofed' to test if it reduces poverty or has an adverse impact on poorer people. A commitment to review the NAPS and to set new targets in the areas of health and accommodation/housing was given in the Programme for Prosperity and Fairness.

As part of this review, a NAPS and Health Working Group was established by the Department of Health and Children in 2000. This Group developed new targets which, when achieved, will result in reduced inequalities in health status and more equitable access to health services. This target-setting is one of the most important elements of NAPS; in aiming to meet such targets, the Government ensures that the policy framework and the specific policies are adapted accordingly. The role of the NAPS targets is to have a focus for action in some key priority areas which lead to a reduction in poverty and to add value to the poverty proofing process. To be beneficial, these targets need to be limited to a manageable number, based on evidence of effectiveness and linked to resources.

Specific targets have been developed for health status, equity of access, public policy and information. It is envisaged that these targets will be met through the development of a multi-sectoral approach to health and health impact assessment.

The targets and implementation strategy of NAPS and health have been incorporated into the Health Strategy – *Quality and Fairness: A Health System for You.* A key deliverable in relation to NAPS and health will be the putting in place of the indicator and research data needed to monitor and evaluate the NAPS health targets and to review the existing targets.

Quality and Fairness: A Health System for You also identified a range of initiatives to eliminate barriers for disadvantaged groups such as the continued implementation of the *National Health Promotion Strategy 2000-2005*, *The Traveller's Health Strategy* and the ongoing initiatives to improve the health and well-being of homeless people (*Homelessness – An Integrated Strategy*).

Information requirements

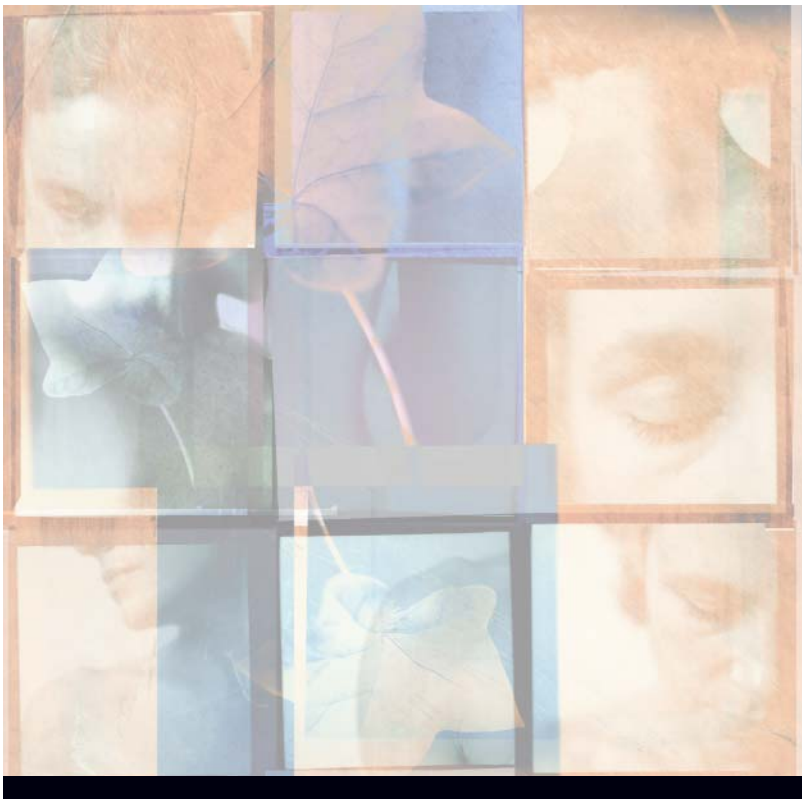
There is increasing interest in the scale and nature of inequalities in health in Ireland. But the discussion is hampered by the lack of quality information. While a substantial amount of data on the Irish health service is collected, drawing inferences on inequalities is not straightforward, primarily because of weaknesses in the data collection systems used.

Current routine data sets do not meet the requirements of quality information. For example, the most recent report by the Perinatal Reporting System was published in 1993 and the Hospital In-Patient Enquiry does not collect any socio-economic data. In order to accurately assess the extent of health inequalities, information must be available at several levels including small area levels.

Routine small area coding of births, deaths and hospital discharges and collection of accurate social class data for vital events on a national basis would greatly enhance our ability to accurately measure the extent of health inequalities in the country. In addition, health status measurements should include social determinants of health, as well as more traditional health service indicators and lifestyle behaviours. These issues were referred to in the 1999 CMO's report and can be addressed in the context of the Health Information Strategy.

Conclusion

The implementation of the Health Strategy *Quality and Fairness: A Health System for You* together with the NAPS and its health targets is a key issue in reducing health inequalities in Ireland. Reducing the health inequalities gap between different socio-economic groups depends on social, economic and environmental action as well as the provision of accessible public services. Action is required across all health targets. However, personal health is the responsibility not only of Government and other providers of health services but also of individuals and communities. Creating a greater impetus for change in this area requires concerted action towards collecting information on the social determinants of health and inequalities, promoting research, strengthening alliances, and developing collaboration with organisations working in allied fields. The development of the proposed Population Health Division within the DOHC and its equivalent within the health boards will give sharp focus within the health system to promoting such cross-cutting intersectoral issues, with the ultimate objective of reducing health inequalities.



Better Health for Everyone

CHAPTER 2

Intersectoral Approach to Health

CHAPTER TWO 2

Intersectoral Approach to Health

The multi-factorial nature of the determinants of health and illness has been recognised for over half a century. However, the control of many of these factors lies outside the areas of activity that can be addressed by traditional health services and, therefore, intersectoral collaboration is important if these factors are to be addressed. The need for and value of this approach is well recognised at both national and international levels but, despite this recognition, the required links have been slow to develop. The Health Strategy *Quality and Fairness: A Health System for You* acknowledges the varied nature of health determinants. One of its stated aims is to ensure that health is given priority across all the sectors with a role to play in improving health status. The strategy also aims to ensure that health becomes embedded as a core value at the strategic planning stage for all relevant departments. This chapter describes the determinants of health and links these with the need for intersectoral actions to support good health for the individual and the population. It also highlights factors that are necessary to sustain the intersectoral approach.

The determinants of health

The foundations of adult health are laid in prenatal life and early childhood. Adverse social and economic circumstances present the greatest threat to a child's growth in terms of social and educational milestones. A person's health and longevity is strongly influenced by lifestyle and the conditions in which he or she lives and works. Good physical and mental health is not only the responsibility of the individual alone but is also influenced by social, economic and environmental factors, together with issues of equality and access.

If we are to achieve our full health potential, it is important to have a broader understanding of these determinants of health as described earlier. Recognition of the health impact of economic and social policies and conditions has far-reaching implications for the way society makes decisions about development. The nature of health determinants points to a compelling need for greater intersectoral and multidisciplinary approaches to address the impact of social, economic and environmental factors on the physical, mental and social well-being of individuals and communities. A systematic practice of *health proofing* public policy which addresses health determinants, particularly those beyond the control of the health sector, has the potential for enhancing the general level of health in Ireland.

The international perspective

The concept that intersectoral action is needed to deal effectively with the determinants of health has been recognised for many years. The World Health Organisation (WHO) has pointed out that policies which are the most

successful in sustaining and improving a population's health are those that deal in an integrated way with economic growth, human development and health. In its current strategic framework, *Health 21 – Health for All in the 21st Century*, WHO proposes multisectoral strategies for creating sustainable health. These are based on an understanding of the nature of health determinants and on the intersectoral actions that are necessary to enhance health. Five separate targets relate to multisectoral strategies dealing with lifestyle and environmental issues and on multisectoral responsibilities for health.

The WHO Health for All policy has been adopted as the policy benchmark for most European countries. There are many good examples of specific multisectoral strategies across Europe, ranging from intersectoral projects based on the Verona initiative, waste recycling in Nordic countries, and the national drugs strategy in Ireland. Within the European Union, the new programme of community action in the field of public health acknowledges the relevance of linking the public health framework with health-related initiatives in other policy areas. Public health has been made a priority in the EU's general policy agenda and the new public health action programme contains proposals on health determinants, health impact assessment and other intersectoral activities.

Intersectoral activities in Ireland

Many intersectoral activities have taken place in Ireland over recent years. These have occurred at national level between government departments, at regional level between the health boards and other agencies, and between the statutory and voluntary sectors. Broad government strategies are by nature intersectoral and recent examples include the National Anti-Poverty Strategy, the National Drugs Strategy, and the National Alcohol Policy. In 1995, the national consultative committee on health promotion was established to foster multisectoral action. This committee, chaired at ministerial level, has contributed to many policy documents including health promotion in the workplace, youth and health, and the prevention of cardiac disease.

At regional level, there are many examples of intersectoral actions, for example between health boards and the Department of Education and Science in relation to health promotion, and between health boards and local authorities regarding environmental issues. The work of the statutory and voluntary sectors in partnership with the recent National Anti-Poverty Strategy is a good example of what can be achieved.

Future challenges

It is important to build on previous successes and in particular to draw on best international practice in this area. It can be difficult to sustain momentum and the following issues must be considered if successful intersectoral activities are to be maintained in the long term.

- ### Establishing the framework

  It is understandable that, over time, the administrative structures which have developed in the public sector tend to underpin lines of accountability and responsibility within individual departments and may not easily accommodate interdepartmental collaboration. Even within departments, the divisional structures tend to favour vertical rather than horizontal communication. The recent Health Strategy gave a commitment to organisational reform within the Department of Health and Children, the health boards and health agencies. This is being pursued through the audit of structures and function and restructuring projects currently underway. In particular, the strategy recommended the establishment of a Cabinet Sub-Committee on the

implementation of the Health Strategy chaired by An Taoiseach. This committee, supported by an interdepartmental group, will focus on high priority, cross-sectoral issues affecting health. Within the Department of Health and Children, the newly established Population Health Division will provide population health leadership and support the intersectoral actions of the interdepartmental group.

The Health Strategy recommended the Cabinet Sub-Committee and its support structures as the most effective way of ensuring intersectoral co-operation so that health considerations are prioritised. It is important that the sustainability of this initiative is maintained. This in turn requires significant political commitment at national level, the support of government departments and the full involvement of the health system, including the voluntary sector. It is important that sectors should recognise and accept responsibility for their role in the determinants of health. Partnerships should be built at a variety of levels, e.g. between government and its agencies including the non-voluntary sector, if this approach is to be successful. Working across sectors/departments is a challenge and barriers do exist. Intersectoral initiatives will require leadership, commitment, resources and accountability mechanisms. These measures will be required at national, regional and local levels. There is a need to strengthen and widen the partnership approach that encompasses the statutory and non-statutory sectors. Sustained partnership-building measures need to be identified and supported.

- ## Achieving accountability

  The health sector is primarily responsible for health as part of the broader political agenda. It is important that effective mechanisms are established including legislation, if necessary, to motivate all sectors in relation to their health responsibilities. The National Health Strategy is government policy and includes health proofing as part of all public policy formulation and the introduction of health into the strategy statements and business plans of all government departments. It is important that these measures are evaluated on a regular basis.

- ## Capacity building

  The development of tools and methodologies such as health impact assessment to support intersectoral working is necessary. This will require particular expertise and the development of new competencies by the sectors concerned.

- ## Action areas

  The Health Strategy identifies a number of high priority, cross-sectoral issues affecting health including accident prevention, tobacco use, alcohol and illicit drug misuse, air pollution, transport and water quality. Many of these relate to providing a healthy and safe physical environment for families. Others relate to lifestyle factors which, through intersectoral action, facilitate healthier choices. The social and economic determinants of health are also prioritised. Policies orientated towards the equitable distribution of income and wealth, the creation of employment and the provision of good social security benefits require sustained intersectoral actions but will yield significant health gains by reducing inequalities in health.

- ## Better information

  The National Health Information Strategy sets the policy framework for future developments in this area. Better information on the determinants of health and on the impact of intersectoral programmes is crucial if the intended health gains are to be realised. It is important to provide a sound evidence basis for these activities.

Conclusions

Health is increasingly viewed as a capacity or resource whether it is at the individual or population level. Responsibility for the achievement and maintenance of good health is a multi-layered concept involving the individual, the health sector, other sectors, and the broader society. It is clear that partnerships must be built across levels of government, the public sector, and regional and local groups including the voluntary sector, if sustainable health gains are to be achieved. There are already many intersectoral actions which have been successful and the Health Strategy has laid out a framework for further developing these activities into the future. This will require sustained levels of commitment and the development of health impact assessment as a practical articulation of this commitment throughout the health system.

Better Health for Everyone

CHAPTER 3

Health Impact Assessment

CHAPTER THREE 3

Health Impact Assessment

Introduction

It is recognised that policies and plans can interact in a complex way and may have important consequences in other areas. In Chapter 1 the wide range of economic, social, psychological and environmental influences on health was considered. There is increasing awareness that systematic assessments of health effects are needed to inform the development of policies that may impact on health. Health impact assessment (HIA) has been developed as a way to systematically evaluate how policy decisions may affect people's health so as to enable decision making that will promote a favourable and equitable health trend. The HIA process is outlined in Appendix 2.

HIA has been defined by the World Health Organisation as 'a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population and the distribution of those effects within the population' (WHO, 1999).

HIA aims to study upstream health determinants in an integrated way rather than concentrating on single risk factors. In this way, HIA plays a key role in the development of intersectoral policies that may impact on health. It is central to the population health approach and contributes to reducing health inequalities amongst the population.

The World Health Organisation has developed a health impact assessment programme which provides advice on the development of HIA policies and strategies. The WHO *Health 21* strategy has set targets for its member states in relation to the development of HIA mechanisms so that all sectors become accountable for the effects of their policies and actions on health. Many European countries, in particular the UK, the Netherlands and Sweden, now have several years experience of HIA which builds on previous developmental work in Canada. In the European Union, legislation under the Amsterdam Treaty makes provision for HIA in policy making. The new public health action programme will facilitate the development of HIA across the EU.

HIA in Ireland

The *Health Impact Assessment Baseline Report* (2001), published by the Institute of Public Health, indicated that there has been little HIA activity in Ireland. Nine initiatives were considered to be completed HIAs. However, none used explicit HIA methodology. There were two related projects on environmental HIA and equality impact assessment. The report showed, however, that there was significant interest in the future development of HIA.

The Institute of Public Health is developing an all-Ireland database of HIA. It participates in the UK HIA network and plans to develop an HIA network on an all-Ireland basis. It is participating in a range of HIA projects including:

- Ballyfermot transport initiatives and air quality
- Regional transportation strategy (Northern Ireland)
- SHSSB (Northern Ireland) – wrap around scheme for children with disabilities
- Farming policy (Northern Ireland).

The Institute is also a partner in the EU project on the development of HIA policies and generic methodologies.

Integrated impact assessments

Many factors can be considered in the assessment of policy, e.g. age, gender, health, poverty. Some factors have more developed approaches. For example, environmental assessment has been in use for many years. Many of the factors that influence the environment are also determinants of health. The stages and procedures (e.g. appraisal, risk management etc.) are similar and it is possible to integrate health and environmental impact assessments without much adjustment to the process. The integration of health and environmental impact assessments can also be generalised to include other important issues. Policy making usually involves trade-offs between competing priorities. The introduction of HIA should not result in health taking primacy over other priorities but should ensure that information about health impact is woven into any such trade-offs. The value in using integrated impact assessment is that it incorporates various impact assessments. This makes the overall policy evaluation more comprehensive and brings a greater transparency to policy making and the priorities that are set by decision makers.

The requirements for HIA

HIA requires a strong commitment if it is to be successful in influencing policy across government and at regional and local levels. This support extends beyond funding and applies to the development of methodologies and ways of promoting the use of HIA as an effective tool in influencing policy. It requires the development of networks in the statutory and voluntary sectors. Community participation in health impact assessment is a requirement if it is to be successful.

An understanding of the nature of health determinants is also required for the successful implementation of HIA. Up to 100 primary determinants of health can be considered. These can be broadly divided into social and environmental determinants. The development of guidelines or protocols for health impact assessment should incorporate practical examples of how determinants may be affected by development.

The introduction of health impact assessment will impact on the role of the health sector and other sectors, e.g. local authorities, government departments, etc. It involves a more proactive role, with sectors promoting health as part of their policy, and addressing the issue of how HIA fits into their strategic planning cycle.

A further requirement is the development of a public health information system that provides comprehensive information on the health of the population. Allied to this is the provision of a sound evidence base which will determine subsequent public health actions.

International experience demonstrates that despite recent progress in the development of HIA, a number of challenges must be acknowledged. It is important that HIA initiatives are co-ordinated and that there is a systematic means of performing HIA. Usually there is more demand for HIA than capacity to provide it and this has implications for training initiatives. Furthermore, the evidence base may be limited or non-existent. Finally, HIA sometimes leads to unrealistic expectations and then the entire process has to be evaluated. Despite these problems, HIA is viewed as playing an increasingly essential role in the development of policies that impact on health. HIA is an iterative process and its introduction should be on an incremental basis.

Developing capacity

Health impact assessment can operate at local, regional, national and international levels, and it is important that capacity is developed amongst the relevant HIA stakeholders. This includes organisations (e.g. government departments, health boards, voluntary organisations, etc.), professionals (e.g. public health and allied practitioners), representatives of the non-health sector, and the general population. The Institute of Public Health report has demonstrated that a solid basis exists within organisations, with many individuals having the appropriate skills, but that these skills may not have been used formally for the purposes of health impact assessment. It is important to capitalise on the existing skill base and develop training opportunities as the basis for multidisciplinary, intersectoral collaboration.

HIA is an intersectoral initiative. It requires the national, regional and local authorities responsible for health, academic institutions and NGOs to contribute by developing concepts and tools, supplying the evidence base and undertaking the provision of training to support HIA. Comprehensive capacity building will involve substantial change for organisations and reorientation of practice. The following strands provide the basis for successful development of such an initiative:

- ### Co-ordination
  The provision of central direction should include the development of HIA policy.

- ### Information
  Information should cascade from core organisations to the health and other sectors. This will raise awareness and make it easier to establish an inventory of HIA activities. It is important to develop public health information systems and a sound evidence base in support of HIA.

- ### Training
  Training for individuals and organisations is an important part of the capacity building process. This involves both detailed training courses to build knowledge of method and procedure and policy seminars to inform senior management. There are a variety of skills involved in HIA (see table below). Most of these are already available. However, they are not systematically organised in support of HIA.

- ### Developing health impact assessment tools
  The development of tools and skills is key to successful HIA. This involves protocols and methods that can be applied at different levels and between sectors.

It can be seen from the above strands that capacity building would involve multi-strand, multilevel programmes developed on an incremental basis.

Skills involved in HIA

Public Health	Toxicology
Epidemiology	Statistics
Social Sciences	General Management
Environmental Surveillance	Networking

Developing the framework

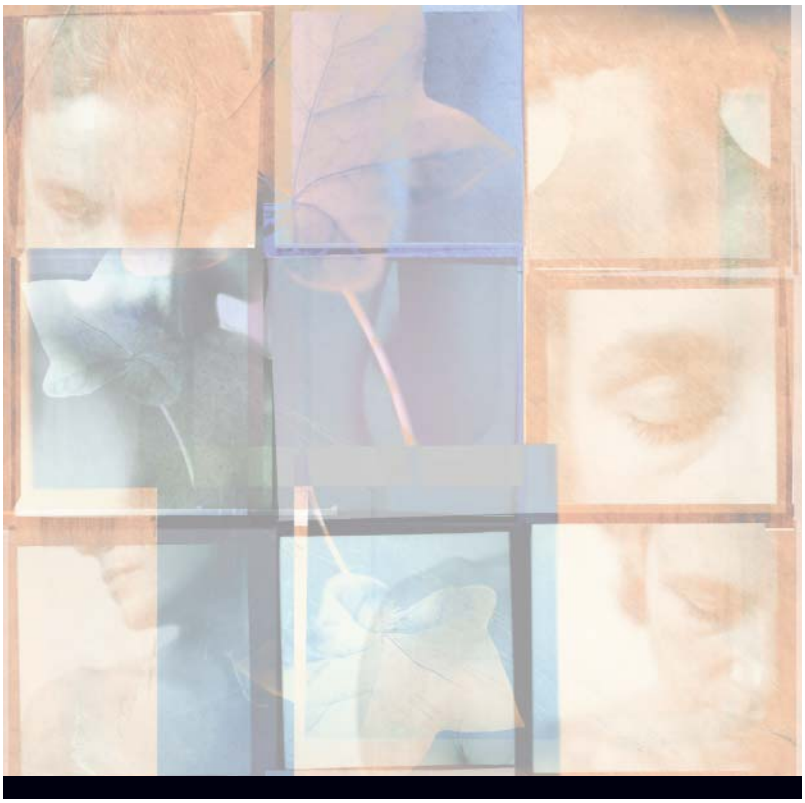
Even in countries with several years experience of health impact assessment, projects are often unco-ordinated and do not reflect national priorities. It is important that the development of HIA is properly co-ordinated and supported by high-level government commitment. This commitment should flow to regional and local levels. The National Health Strategy has set out the structural changes that will give effect to this. In particular the Population Health Division within the Department of Health and Children will have responsibility for implementing health proofing policies.

Given that HIA is at an early stage of development, it is important that the existing centres of expertise and networks within Ireland should be used to support the development of health impact assessment as a policy tool. The Institute of Public Health could support the Department of Health and Children in the development of HIA, in a manner similar to its involvement in the implementation of the National Anti-Poverty Strategy. In partnership with the Institute, a programme should be developed and include:

- policy seminars for senior management
- training courses for HIA practitioners (project management, hazard identification, risk management, health gain interventions, HIA appraisal, intersectoral action)
- review of HIA tools.

The Institute of Public Health already participates in HIA networks (EU, UK). It is also involved in the establishment of an all-Ireland HIA group which is intended to support HIA development and its integration within health policies. There is added value in developing this work on an all-Ireland basis. This all-Ireland HIA group could share experiences relating to the development of HIA and identify areas for cross-border collaboration. Subsequent activities should include the establishment of a world wide web-based inventory of HIA activities, the integration of HIA with other impact assessments, and the development of a research agenda to support HIA.

The National Health Strategy has underlined the significance of HIA as a means of dealing with intersectoral policies which impact on health. The development of sufficient HIA capacity across the health system is a priority. However, the process will take time and should be introduced on an incremental basis. It is important to raise awareness and understanding of the HIA process at central government level. A priority area will be the development of agreed training programmes for government departments and health boards which will cascade to all levels within the health system.



Better Health for Everyone

CHAPTER 4

Health Promotion

CHAPTER FOUR 4

Health Promotion

Components of health promotion

Health promotion can provide a theoretical and organisational umbrella under which several of the strands to achieve population health can be given strategic direction. It is defined as the activities of government, health services and communities that support health and includes, but is broader than, health education, enabling people to increase control over and improve their health. The five action areas for health promotion were set out in the Ottawa Charter in 1986, as follows:

- Building healthy public policy
- Creating environments that support health
- Strengthening community action for health
- Developing personal skills
- Reorienting the health services.

The National Health Strategy *Quality and Fairness* prioritises the health promotion actions necessary to address the social, economic, environmental and cultural factors that influence health, most of which are outside the direct control of either the health service or of the individual. The steps to build and assure healthy public policy are described in the chapters above on intersectoral action (Chapter 2) and health impact assessment (Chapter 3). These actions, as well as community development and participation (Chapter 6), are relevant to tackling health inequalities (Chapter 1).

The National Health Promotion Strategy

The National Health Strategy endorses the National Health Promotion Strategy 2000/2005 which built on previous national strategy documents *Shaping a Healthier Future* (1994) and *A Health Promotion Strategy … Making the Healthier Choice the Easier Choice* (1995). Other relevant national policy documents were also taken into account. The Health Promotion Strategy aimed to build on existing infrastructure and collaboration, and to develop programmes already being implemented.

The Health Promotion Strategy provides a five-year action plan to work with population groups, in specific settings and on priority topics. The three approaches are inter-linked and of equal importance. The population approach (Table 4.1) is used to plan health promotion initiatives to address health issues relevant to specific groups. People are supported to develop skills and to make behaviour changes to improve health and well-being. In the settings approach (Table 4.2) efforts are made to create an environment which supports healthier choices, with complementary education and training programmes. The health topics approach (Table 4.3) can provide a focus to address specific issues and facilitates working with statutory and non-statutory organisations. Priority topics include smoking and injury prevention and it is proposed to develop a plan to protect and promote men's health. The health promotion, cancer and cardiovascular strategies have all recommended that actions should be strengthened to address other major lifestyle factors which impact on health.

Table 4.1: Priority population groups for health promotion strategies

Population group	Strategic aim
Children	To support the development of partnerships with families and relevant bodies in order to promote a holistic approach to the physical and mental well-being of children
Young people	To maintain health and support the development of healthy lifestyle choices for young people
Women	To promote women's physical and mental well-being through the continued development and implementation of relevant policies
Men	To develop a plan for men's health
Older people	To enhance the quality of life and improve longevity for older people
Other groups in the population	To promote the physical, mental and social well-being of individuals from other groups within the population (including those with an intellectual, physical or sensory disability, Travellers and other minority groups in our society)

Table 4.2: Priority settings for health promotion programmes

Setting	Strategic aim
Schools and colleges	To facilitate the implementation of health education and health promotion programmes within the school and college setting
Youth sector	To continue to develop and promote the role of health promotion within the youth sector
Community	To support the development and implementation of community-based approaches
Workplace	To work in partnership with relevant bodies to develop health promotion workplace programmes
Health services	To encourage the health service to become a health-promoting environment

Table 4.3: Priority topics for health promotion

Topic	Strategic aim
Positive mental health	To promote positive mental health and to contribute to a reduction in the percentage of the population experiencing poor mental health
Being smoke free	To increase the percentage of the population who remain non-smokers, with a particular emphasis on narrowing the gap across social classes, and to protect non-smokers from passive smoke
Eating well	To increase the percentage of the population who consume the recommended daily servings of food and maintain a healthy weight
Good oral health	To improve the level of oral health in the general population, with a particular emphasis on people with special needs
Sensible drinking	To promote moderation in alcohol consumption for those who wish to drink and to reduce the level of alcohol-related problems
Avoiding drug misuse	To support models of best practice which promote the non-use of drugs and minimise the harm caused by them
Being more active	To increase participation in regular, moderate physical activity
Safety and injury prevention	To contribute to a reduction in the percentage of the population affected by fatal and non-fatal injuries
Sexual health	To promote sexual health and safer sexual practices amongst the population

Health promotion and the health sector

It is accepted that multisectoral action is a prerequisite to maximise health status at population level. Nevertheless, there is much that the health sector can do to promote health for individuals and families with which it comes in contact.

A major challenge recognised by the Health Promotion Strategy is to achieve a balance between the treatment of illness on the one hand and the prevention of disease and the promotion of health on the other hand. The optimum treatment of many patients includes health education and intervention to reduce the risk of disease in the future. For example, it is recommended that patients with coronary heart disease be offered lifestyle advice and medication (secondary prevention) and structured cardiac rehabilitation, which aim to improve quality of life and reduce the risk of recurrence of symptoms in the future. Implementation of the Cardiovascular Health Strategy has substantially increased resources for hospital-based cardiac rehabilitation and a secondary prevention programme in general practice is now under way. Both the National Cancer Strategy and the Cardiovascular Strategy emphasise the importance of reducing the prevalence of smoking. Health services resources to support smoking cessation have been substantially increased in recent years. Community nutrition services have also expanded in recent years, with input to health promotion in the community as well as providing a clinical nutrition service.

The health sector can play an important role in health promotion for older people. In line with the Health Promotion Strategy for Older People, the health services have supported the development of health promotion initiatives for older people in the community, particularly in promoting physical activity. In addition, there are many examples of programmes in different health service settings that aim to reduce risk of disease and promote health in older people.

Health promotion with other sectors

Healthy public policy

In order to maintain and promote the health status of the population it is important to adopt a holistic approach and to consider all determinants of health, particularly those beyond the remit of the health services. The Heart Health Task Force and other consultative committees facilitate the exchange of information on policies that impact on health between the Department of Health and Children and a number of other government departments, as well as relevant statutory and voluntary organisations. However, the Health Strategy proposes a more pro-active approach. Statements of strategy and business plans of all relevant government departments will be required to incorporate an explicit commitment to sustaining and improving health.

To provide an evidence base that will retain the commitment of other departments and agencies to support health, the Health Strategy proposes that relevant policies, strategies and legislation will be subject to health impact assessment. The potential impact on the physical, mental and social health and well-being of the population will be estimated and set in the context of the broader benefits and risks for society or for sub-groups of the population. The Institute of Public Health has taken a lead in developing the technical expertise and training that will be needed to undertake HIA. It will also be important to integrate the management and surveillance of identified benefits and risks into relevant health information systems for the monitoring and surveillance of diseases and injuries.

The creation of an environment which supports health

This refers not just to the physical environment but includes the economic, cultural and social factors that impact on health. The creation of such an environment most often involves action on a voluntary basis by relevant stakeholders. However, occasionally the creation of a safe, health promoting environment needs to be supported by legislation, for example legislation to control access to and use of tobacco products.

It will not be sufficient to have the impact on health taken into account when policies or legislation are being drawn up in other government departments. In many instances sustained action is required to give effect to the required health benefit. In relation to tobacco control, the explicit deployment of environmental health officers is important to ensure that retail and food outlets abide by the legislation.

The implementation of some policies will require substantial investment. For example, reducing traffic injuries and promoting safe physical activity will require investment by local authorities, e.g. to build cycle and foot paths. As well as identified sources of funding for these developments, it will be necessary to raise awareness of those with responsibility for their implementation as to the importance of actions to sustain health and its relevance to their own work arena.

Just as structures will be necessary at national level to support the development and implementation of policies and plans which support health, it will also be important to have parallel structures at local level. Population health structures in health boards will need to be linked to local partnerships with a health agenda. There are precedents for such local coalitions in other arenas, e.g. job creation. Partnership arrangements are also relevant to health protection, particularly in relation to environmental health action plans.

Developing personal skills and settings for health promotion

Social, personal and health education (SPHE) is now a core component of the curriculum for all schools. In-service training for teachers is provided when SHPE is being introduced or developed in schools. The expansion of SPHE to all schools is supported by structures and personnel nationally and regionally. This facilitates liaison and networking with health board health promotion personnel.

It is important that health education programmes are provided in the context of a physical and social environment that 'makes the healthier choice the easier choice'. Developments in SPHE have been complemented by the work of the Irish Network of Health Promoting Schools. Progress has been made in the development of health promoting environments in a number of other settings, including workplaces, as well as within the health services.

A multisectoral approach will be essential to promoting health in the workplace. *Healthy bodies – healthy work* identified the Department of Health and Children as having a prominent role in formulating policy, liaising with health boards and making information available on workplace health promotion. Other key partners include the Health and Safety Authority, trade unions, employer organisations, occupational health personnel and voluntary organisations.

The health sector as an employer can provide a role model for the creation of health promoting workplaces. Health boards and other agencies have involved staff in local events in the context of national initiatives. The Health Promoting Hospitals network supports sustained development towards health promoting working environments for those working in the hospital setting.

Infrastructure

In line with other divisions in the Department of Health and Children, the remit of the Health Promotion Unit in the Department has evolved in recent years. The Unit's executive function is being further devolved to the health boards, allowing its policy function to be strengthened. This devolution of function is complemented by the provision of the Health (Amendment)(no. 3) Act 1996 which now confers a statutory obligation on health boards to develop health promotion programmes, having regard to national policy and to meet the needs of the population as appropriate.

There have been substantial developments in health promotion at health board level in recent years. A health promotion department led by a senior manager and with a dedicated budget has been established in each health board. In addition, the development of other services, such as cardiac rehabilitation and the appointment of suicide resource officers, has enhanced liaison between health promotion services and other health service locations. Community-based health services play an important role in health promotion at local level. It is envisaged that this will be substantially enhanced with the implementation of the Primary Care component of the National Health Strategy.

The development of health service structures at national and regional level dedicated to improving population health will increase the effectiveness of health promotion initiatives within the health services. It will be important that there is effective and efficient co-ordination between those in the health services with a population health remit and other agencies whose policies and actions will be required in order to maintain our most valuable resource – the health of the population.

CHAPTER

5

Community Participation

CHAPTER FIVE 5

Community Participation

Introduction

The Health Strategy *Quality and Fairness: A Health System for You* includes people-centredness as one of its four key principles. As well as addressing the manner in which health and social services are delivered in the system, this principle sets out a commitment to increased involvement of consumers as partners in planning and evaluation as an important component of achieving full health potential, addressing health inequalities and promoting openness and accountability.

Community participation

Community participation may be defined as a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change.

The term community participation is often used interchangeably with or alongside a number of other terms such as:

- ***Consultation*** – This involves people being referred to for information and asked their opinions. Although this implies that communities' views may be taken into consideration, it has not generally meant that people are actively engaged in the decision-making process

- ***Involvement*** – This is a term often used synonymously with participation. It implies being included as a necessary part of something

- ***Empowerment*** – This is a process whereby individuals or communities gain confidence, self-esteem and power to articulate their concerns and ensure that action is taken to address them.

Community participation in health has been promoted by the World Health Organisation for many decades. The 1976 Alma Ata declaration made participation a central feature of primary health care. It stated that people have the right and duty to participate individually and collectively in the planning and implementation of their health care. The Harare declaration of 1987 outlined community involvement in health as a process of direct public involvement in health systems, not only strengthening people's organisation and skills, but also reorienting political and health systems to support such participation. The Ottawa Charter for Health Promotion, 1986, highlighted the importance of strengthening community action and empowering communities. Health promotion works through concrete and

effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, and their ownership and control of their own endeavours and destinies.

Community participation takes place at a number of different levels and can be viewed from a range of perspectives. There is no one correct approach to community participation; a number of models have been developed to help organisations think through their approaches and guide them in considering and developing community participation practice.

The way forward

Community participation is an essential component of a more responsive and appropriate system of care which is truly people-centred. A number of measures were set out in the Health Strategy *Quality and Fairness: A Health System for You* to ensure that community participation in health is established and continues in Ireland. The Strategy recognises that, while there are some community participation initiatives already operating in discrete areas of activity at national and regional level, a more structured approach to community participation is required. Such participation has a number of important advantages. It sets out the following actions:

- Initiatives will be taken to inform and educate the public
- Regional Advisory Panels/Co-ordinating Committees (including service providers and consumers) will be established
- Randomly selected consumer panels will be convened at regular intervals in each health board area
- A National Consultative Forum will be established.

These measures will ensure that community participation occurs at a number of different levels such as the development and evaluation of health policy, the identification and addressing of local health issues, the implementation of changes and the evaluation of health services. It will be important to ensure that these are in place as soon as possible. Relative to many other developments within the system, their cost will be modest yet their potential impact in ensuring the development of a person-centred health system will be significant.

Primary Care: A New Direction provides for community involvement in the assessment of need and the planning and evaluation of services under the Primary Care Strategy. The early stages of implementation of the Primary Care Strategy have reflected this considerable emphasis on involvement of the community.

The development of community involvement will require that human resource policy within the health system fully enables the health system to realise its potential involvement. Appropriate skills development and training will be needed by staff to facilitate community involvement in an integrated fashion within the health services. In addition to this, change management processes at all levels within the health system will have to facilitate and enable the realisation of the objectives of community involvement

However, just as with any other new development within the health system, the direction of community participation and involvement should be based on best available evidence derived both from on-going evaluation of these initiatives within the health system and also from international experience and best practice to ensure that we can maximise their potential for the good of individuals, communities and the health system as a whole.

CHAPTER 6

Health Protection

CHAPTER SIX 6

Health Protection

Introduction

As already described, the population health approach recognises the varied nature of health determinants and advocates actions across different levels and many sectors in society. The foregoing chapters outline the key policy areas and actions required across different sectors to improve the health of the population.

Within the health sector itself, there are significant opportunities for achieving improved population health through a reorientation to a population health approach. The primary aim of the health sector is to enhance the health and quality of life of the population.

Based on our growing body of knowledge of the determinants of health and of the epidemiology of diseases and conditions within the population, it is possible to protect the health of the population through the identification of possible threats and through putting in place measures to prevent or reduce their impact on health.

Scope of health protection

A number of areas of activity may be identified under the heading of health protection. These include health protection measures against specific external threats to human health such as biological hazards including communicable diseases, acute and chronic environmental radiation and chemical threats, and measures to ensure food safety. The threats to human health under these headings are many and varied and it is recognised that new threats continue to emerge.

There is also scope for protecting the health of the population through the development of services in response to identified areas of need. At the population level, groups can be identified where health protection initiatives can be targeted towards specific health issues or problems. Children can be screened for childhood disorders or immunised against a variety of communicable diseases, thus preventing considerable morbidity and mortality. Screening for specific diseases such as cervical cancer or breast cancer has the potential to significantly reduce the impact of these conditions. Major threats to the health of older people include dementia, mental illness, cancer, cardiovascular disease, osteoporosis, incontinence and injuries. It is possible to prevent many of these diseases in the first instance or to limit the extent of their complications.

Communicable disease, food safety and environmental threats have a number of common elements in terms of their identification, surveillance, and management, which for the purpose of this discussion allow them to be considered together. Population-based preventive services and disease specific preventive activities will be referred to in Chapter 7.

International perspective

European Union

At international level, there is an emphasis on the importance of fostering and maintaining links between national and international organisations in order to anticipate, manage and protect against risks emerging from changes in the physical environment. Within the European Union, the entry into force of Article 152 of the Amsterdam Treaty on public health affirms that a high level of human health protection must be ensured in the definition and implementation of all Community policies and activities. Co-operation between member states is extended to 'all sources of danger to human health' and Community measures in various areas such as cancer, drug addiction, doping, communicable diseases and more general measures in the field of health protection, including measures laying down standards for the safety and quality of organs and substances of human origin.

The Health Strategy of the European Union (June 2000) consists of two main elements:

- A public health framework, including an Action Programme in the field of public health (2001-2006) and in public health policy and legislation

- Development of an integrated health strategy: as a result of the Treaty provision which stipulates that a high level of health protection must be ensured in the definition and implementation of Community policies, health protection concerns all key areas of Community activity. This new strategy contains specific measures to address the obligation to incorporate health protection into all Community policies.

A new action programme is part of this framework for which three main strands of intervention are identified:

- Improve health information

- Create a mechanism for responding rapidly to major health threats

- Address health determinants, notably harmful factors linked to lifestyle.

World Health Organisation (WHO)

In 1998, the WHO adopted the policy *Health for All in the 21st Century* (HFA), which sets out global priorities and targets that will create the conditions to enable people worldwide to reach and maintain the highest attainable level of health. The European Region of WHO in 1999 published its responding policy document *Health 21*, which sets out 21 targets for the region to enable it to meet the global HFA objectives. The targets include health protection through the reduction of communicable diseases (Target 7) and the achievement of a healthy and safe physical environment (Target 10).

The *Health 21* target is that by the year 2020 the adverse effects of communicable diseases should be substantially diminished in the European region through systematically applied eradication, elimination and control programmes. A historic milestone was reached in June 2002 when the European region of WHO was certified as polio-free. The WHO has also targeted the elimination of diseases such as neonatal tetanus and indigenous measles and the control of diphtheria, hepatitis B, mumps, pertussis, Haemophilus Influenza, syphilis, rubella, malaria, HIV and AIDS.

Management of specific threats to human health

Communicable diseases

Communicable diseases have long been recognised as a threat to public health. Improved socio-economic conditions and advances in medical technology, including vaccines and antibiotics, have greatly reduced this threat to the point where many such diseases have either been eliminated or greatly reduced in the developed world, smallpox, poliomyelitis, and meningococcal C disease being important examples.

However, despite these advances, communicable diseases constitute a major ongoing public health threat in a number of areas:

- In the global context there is an increasing burden and risk of spread of communicable disease, arising from ever-increasing global travel and trade.
- Recent decades have seen the emergence of new, previously unrecognised threats such as Acquired Immune Deficiency Syndrome (AIDS), Transmissible Spongiform Encephalopathies (TSEs) and Variant Creutzfeldt Jacob Disease (vCJD), Ebola virus and the ongoing risk of pandemic Influenza.
- Anti-microbial resistance in infectious organisms is a growing problem arising from the greatly increased use of anti-microbial agents in humans and animals.
- Advances in medical technology have been accompanied by such problems as rising numbers of hospital acquired infections, particularly by anti-microbial resistant organisms and an increasing number of immuno compromised patients who are susceptible to a wide range of communicable diseases.
- Events in the past year have thrown the global risk of infectious disease arising from bioterrorist attacks into sharper focus.

Food safety

Trends in the area of food production, many brought forward by commercial pressures to intensify production, raise questions about food safety and the transference of disease from animals to humans. The Food Safety Authority of Ireland (FSAI) was established to take all reasonable steps to ensure that food produced, distributed or marketed in the State meets the highest standards of food safety and hygiene and to ensure that food complies with legal requirements, or where appropriate with recognised codes of good practice.

Similarly, the Food Safety Protection Board (FSPB), set up under the terms of the Good Friday Agreement in December 1999, aims to create an environment where consumers can have confidence in the food they eat. It draws on expert scientific support to provide advice and guidance to the food industry and to consumers. The body conducts its work throughout the island and reports to the North/South Ministerial Council (NSMC).

Other external environmental threats

Global warming, a reduction in air quality and availability of housing are all identified in the Strategy as areas of growing public concern. The continuing pressures on the environment affecting water and food quality are concerns that are shared globally.

Other areas of growing public concern include the management of waste disposal and the risk of chemical incidents and radiation arising from industrial and other processes/sources. Recent international events have also identified the threat to human health from bioterrorism.

Public health protection measures

Recent experience, globally and nationally, in the management of external threats to human health emphasises the necessity for the following:

- Enhancement and harmonisation of surveillance for biological, chemical and radiation hazards
- Strengthened interfaces with international surveillance mechanisms
- Early warning and response systems to public health threats
- Risk management
- Multi-agency plans to deal with acute incidents
- Information and communication
- Education and training
- Horizon scanning
- Research and development.

The policy and operational responsibility of protecting public health lies with a number of specialist organisations at national level and the health boards at regional level. The National Disease Surveillance Centre (NDSC), the Radiation Protection Institute of Ireland (RPII), the Environmental Protection Agency (EPA), the Food Safety Authority of Ireland (FSAI) and the National Poisons Centre are all agencies with specialist remits in their appropriate areas. While each organisation carries out its responsibilities in a professional and effective manner, there is an inherent risk of such institutional boundaries leading to isolation and fragmentation of expertise in different agencies and poor connections between national expertise and local service needs. There are also identified gaps in operational aspects of service provision, particularly in dealing with chemical incidents and non-ionising radiation issues.

A major initiative that has been proposed for dealing with environmental health issues is the National Environmental Health Action Plan (NEHAP). This is nearing completion and will address the need for an increase in health input into public health policy in other sectors, with the recommendation that the Department of Health and Children establish a partnership platform to be called the Public Health Network.

A draft plan, setting out the proposed parameters for the final NEHAP, was published in 1999. One of its recommendations was the establishment of local environmental health committees to evaluate health board and authority plans from an environmental health perspective and a recommendation that each health board develop a five-year local environmental health action plan, in partnership with other environmental health partners in its area, to be reflected in the service plans of health boards and local authorities.

Role of population health divisions at national and regional levels

From the point of view of the health system, the major requirement is to ensure that the protection of public health is central to the considerations of all agencies dealing with these cross-cutting issues. This role will fall to the new Population Health Division of the DOHC which will liaise with these agencies, co-ordinate the health dimension to their activities and ensure that the policy considerations of their parent Departments, including the DOHC itself, are consistent with the achievement of better health for everyone.

Serious consideration needs to be given to the mechanisms through which the effective and integrated management of services for the surveillance and management of potential and actual environmental and communicable disease threats can be achieved. Specifically to address this issue, the United Kingdom in January 2002 announced a new national agency to act as a source of national expertise and to provide key services at national, regional and local level in a range of specified areas of health protection (National Infection Control and Health Protection Agency).

While an exactly similar configuration may not be feasible (or desirable) from an organisational point of view in this country, nevertheless an overarching, co-ordinating intersectoral mechanism is needed to deal with potential and actual health threats to our population. This should relate to all levels whilst maintaining the integrity of local and regional autonomy and statutory responsibilities. This need should be identified and addressed in the context of both the development of the NEHAP and the development of the population health function at national and local levels.

Better Health for Everyone

CHAPTER

7

Health Services Provision

CHAPTER SEVEN 7

Health Services Provision

The final element of the proposal to implement the population health concept is to ensure that the activities of the health system itself are directed towards the goal of planning and delivering health services that are safe, based on sound evidence, effective, of high quality and, therefore, capable of measurably improving the health of the individuals they serve and also the health of the wider population.

The capacity of a well-planned, effective and high quality service to deliver longer, better lives is well documented.

There is a range of activities within the health care system which can generally be assessed as population based and would include the following:

- Health promotion (implementation of health promotion strategy, tobacco legislation and development of men's health policy). See chapter 4
- Communicable diseases (immunisation, implementation of antimicrobial resistance policy, and implementation of national AIDS strategy). See chapter 6
- Environmental health (implementation of NEHAP). See chapter 6
- General health protection, e.g. screening policies

> *A screening programme for breast cancer has been in place in some areas of the country for several years and a screening programme for cervical cancer is being launched shortly. These are based on the widely accepted evidence that early detection and treatment of these conditions will result in significant reductions in mortality. For children, a very successful screening programme for the detection of inborn errors of metabolism has been in operation for many years*
>
> *Research continues to develop valid and reliable screening tools for a variety of conditions such as prostate and colorectal cancers, and cystic fibrosis in children. The imperative here is to devise and implement population-screening programmes for both children and adults which are based on sound evidence and ethics and which truly provide scope for disease prevention in large, identifiable segments of the population.*

The provision of effective diagnostic, curative and rehabilitation services has significant capacity to achieve long-term population health gain.

- Cardiovascular diseases are a major health burden and cause over 40 per cent of mortality in Ireland each year. Although death rates have declined in recent years, much more needs to be done. Other countries such as USA and Finland, which had higher rates in the 1960s, now have lower rates. In the USA it is estimated that up to 50 per cent of the decline can be attributed to cardiological and surgical interventions to treat acute events. Treatments such as thrombolysis and other drug therapies, coronary angioplasty and cardiac surgery are of proven efficacy and can reduce complications, increase survival and reduce the risk of a further event.

- Cancer is the second most common cause of death in Ireland. There has been significant development in the infrastructure of cancer services in recent years and much has been done in tackling issues such as regional variations in service provision. However, much more needs to be done to further develop the services and to consider what people can expect in terms of the quality of care and health outcomes which are achievable from the range of treatment modalities available to modern cancer care practitioners.

- Mental health has been highlighted in the Health Strategy *Quality and Fairness: A Health System for You* as an area requiring particular attention. The integration of mental health care services, together with the development of a holistic approach which is evidence based and targeted at specific groups, has the potential to significantly reduce the burden of mental health disease in Ireland.

- The ageing of our population will mean a significant increase in the prevalence within our community of chronic degenerative diseases such as cardiovascular disease, cancers, locomotor disease and dementia. The presentation of many more patients with multisystem disease is inevitable. There is a large volume of evidence available to show that in chronic, multi-system diseases such as Diabetes Mellitus, properly integrated, multidisciplinary, protocol-driven care can postpone and minimise complications such as coronary heart disease, blindness, renal failure and limb amputations. The provision of such care to an identifiable cohort of people, which currently constitutes over 3 per cent of our population, and is set to rise, has obvious benefits in terms of population health improvement and mortality reduction.

- Finally, there is compelling evidence that the application of modern, effective modalities of continuing care and rehabilitation has significant capacity to improve the quality and duration of life.

The development and delivery of the services outlined above is, therefore, an integral part of the overall effort to achieve better health for everyone within the concept of population health. But to achieve this objective such services must be delivered on the basis of:

- objective needs assessment

- evidence-based prioritisation of services and resource allocation

- performance management.

This approach has to be underpinned by a linkage between service planning and delivery and the other major cross-cutting issues identified in the strategy, i.e. quality and health information.

What is required then is to align the broader strategic, intersectoral activities described in earlier chapters with those

of service delivery described in this chapter, in the interest of better population health. This is best achieved through the service planning process.

Such an alignment will require that both policy makers and providers deliver the following:

- Make the objectives of the system as a whole, and of its constituent parts, more explicit
- Co-ordinate policies and objectives across all divisions in the Department, and all programmes in the health boards and the ERHA
- Establish and monitor meaningful performance indictors
- Evaluate the performance of the system in improving health.

The corollary of this change in orientation and emphasis is to ensure that the appropriate skill mix is available within the system in relation to policy analysis, health economics, statistics, knowledge, management and research and development.

The following chapter gives a broad outline as to how a Population Health Division might be structured and how it might operate to give practical effect to the ideas outlined.

CHAPTER 8

Population Health Structure

CHAPTER EIGHT 8

Population Health Structure

The unique feature of the proposal in the Health Strategy to incorporate population health into the structure of the DOHC is that, for the first time, it explicitly commits the DOHC to achieving better health for all through a combination of its own efforts and its responsibility for co-ordinating those intersectoral areas of public policy where decisions and the consequences flowing from those decisions have direct or indirect impact on the health of the population.

In carrying out this function, the division would have a broad strategic focus and its activities would include:

1 *supporting and servicing the Interdepartmental Committee charged with responsibility for monitoring the strategy*

2 *ensuring that the population health perspective is central to business plans and legislation in all Departments and public bodies*

3 *developing, disseminating and ensuring utilisation of robust HIA instruments*

4 *co-ordinating specific intersectoral activities, e.g. prisoners' health, heart health*

5 *providing leadership in population health within the DOHC*

6 *developing a population health strategy within the DOHC*

7 *implementing NAPS health targets*

8 *developing an R&D function for population health.*

In addition, to align the activities of the health services with these intersectoral actions, the Population Health Division would require a significant role in the service planning process.

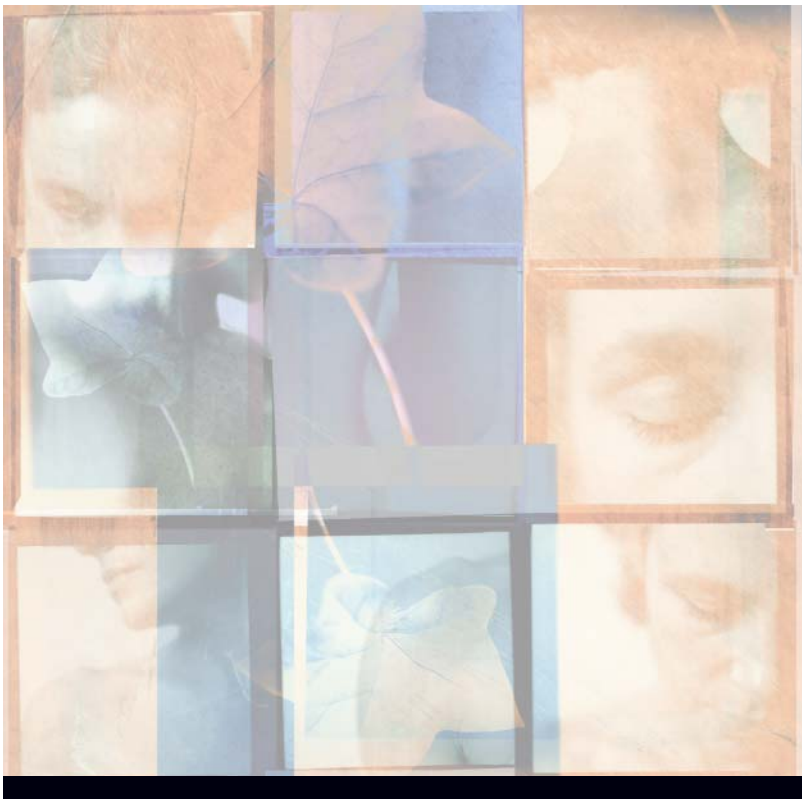
This would revolve around the requirement for service plans to reflect health agency actions to achieve better health for all through service provision. The achievement of these objectives would of course relate closely to the level and type of activity undertaken by agencies and the resources allocated to them for this purpose.

Taken together, these three elements of service planning and evaluation would form the basis for monitoring the contribution of the health system towards the achievement of better health for all.

The advantages that would accrue for this structure would be to:

- provide maximum potential for achievement of population health goals and objectives
- integrate broader strategic intersectoral activities with those of service delivery
- make system/organisational objectives more explicit
- co-ordinate policies and objectives across all divisions
- deliver value for money objectives
- provide a good working model for health boards
- avoid duplication and increase efficiency
- facilitate the pursuit of other cross-cutting agendas, e.g. quality and health information.

Continuing discussions within the Department of Health and Children on the overall restructuring of the Department and a parallel audit on structures being conducted in the wider system, will determine the final shape and function of the population health structures within the Irish health service. We are hopeful that the identification of the scope and purpose of the population health approach and the outline recommendations on structures contained in this report will be of assistance in these deliberations.



Better Health for Everyone

appendices

Annual Report of the Chief Medical Officer 2001

Appendix 1: Targets developed by the NAPS and Health group to help reduce inequalities in health

Health status	Reduce the gap between the lowest and highest socio-economic group by at least 10 per cent for circulatory diseases, cancers, injuries and poisonings by 2007. Reduce the gap in life expectancy between the Traveller Community and the whole population by at least 10 per cent by 2007. Monitor the life expectancy and health status of asylum seekers and refugees so that targets can be set for these groups. Monitor the life expectancy and health status of Travellers so that targets can be reviewed and revised. Reduce the gap in low birth weights between children from the lowest and highest socio-economic groups by 10 per cent from the current level by 2007.
Equity of access	There should be equity of access to effective primary care services by 2007. There should be equity of access to public acute hospitals by 2007. There should be equitable access to available effective interventions for cardiovascular disease and cancer by 2007. There should be increased equity of access to community supports for continuing care by 2007. A comprehensive injury prevention strategy to reduce higher injury rates in people at risk should be developed by 2007.
Public policy	It should be government policy for all relevant sectors to recognise and accept their responsibility for health by developing multisectoral working and the adoption of health impact assessment by 2007.
Monitoring and revision	Systems to monitor NAPS health targets and indicators should be included within the National Health Information Strategy. A programme of research should be set up to support the development of further NAPS health targets and indicators. An adequately resourced and supported system should be put in place to ensure that NAPS health targets and implementation strategies are reviewed and revised.

Appendix 2: The HIA Process

HIA has been developed as a process to enable all sectors to determine the effects of their policies and actions on health. At present, there is no agreed single method of applying HIA. However, it is accepted that its application should be interdisciplinary and employ both qualitative and quantitative approaches to data collection. Ideally, HIA is prospective so that modifications to a policy can be considered and implemented. It can also be applied retrospectively to assess the consequences for health of a development or policy already implemented. Finally, it can be applied concurrently with implementation so as to identify and counter any negative effects associated with the implementation of a particular proposal.

HIA can be adapted in accordance with time and resource constraints. The HIA process involves five main stages:

- *Screening* – This is intended to act as a filter during which policies, programmes and projects are quickly assessed for their potential to affect the health of the population. It should answer whether a project is likely to pose significant health problems, whether a full HIA is required and what depth of HIA is necessary.

- *Scoping* – This identifies the issues related to health in the appraisal and sets the boundaries for the evaluation. At this point, a steering group is often established to manage the HIA.

- *Appraisal of potential health impact* – This is the core of HIA involving an analysis of the policy or project, profiling the affected population, identifying and characterising the potential health impacts, reporting on the impacts, and recommendations for management of those impacts. This appraisal uses available evidence and the knowledge, experience and opinions of stakeholders. The appraisal can be rapid, intermediate or comprehensive, with many organisations using rapid appraisal as the entry point to HIA.

- *Reporting and decision making* – This records the impacts on health and recommendations on how the policy programme or other development can be modified to minimise negative and maximise positive health impacts. These are subsequently communicated to those responsible for the development process. The decision makers may be part of the steering group for the HIA and must act on the recommendations of the steering group.

- *Monitoring and evaluation* – This follows the actual impacts of implementation on health over a predetermined time period. It should involve all of the relevant stakeholders.