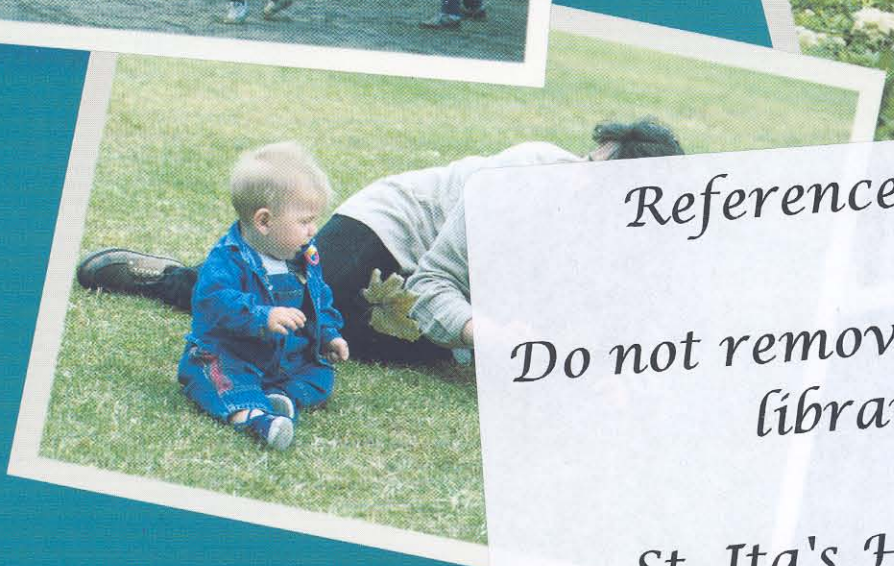
A Health Promotion Strategy



...making the healthier choice the easier choice...

DEPARTMENT OF HEALTH
AN ROINN SLÁINTE

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ISBN: 1 873820 75 5

DEPARTMENT OF HEALTH
AN ROINN SLÁINTE

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Minister for Health

Brian O'Shea T.D., Minister of State at the Department of Health

foreword

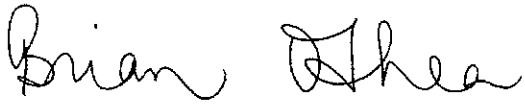
Ireland offers many opportunities for the development and attainment of healthy lifestyles. In this country we are fortunate in having many natural advantages in this respect and in recent years the concept of health promotion as a method of enabling people to make the most of these advantages has been gaining increasing acceptability.

The Government published the Health Strategy *Shaping a Healthier Future* in 1994, the principal theme of which was "the reorientation of our health services so that the primary focus of all our efforts would be improving people's health and quality of life". That Strategy set out explicit goals and targets, particularly in the area of health promotion and disease prevention. However, it promised a separate Health Promotion Strategy which would develop the discussion on health promotion and which would set out more detailed goals and targets and plans for their achievement.

This document delivers on that commitment and presents a detailed strategy for the promotion of health in Ireland. It outlines the rationale for health promotion and relevant developments which have taken place, both internationally and in Ireland, in recent years. The document provides a review of the current health status of the Irish population and sets out a detailed programme containing specific goals and targets and a plan of action for their achievement.

The Health Promotion Unit of the Department of Health will lead this drive towards the achievement of a better health status for the Irish population. The health boards have a vital role to play but everyone – individuals and organisations must play their part in helping to give the people of Ireland a level of health to compare with the best in Europe in the 21st Century. In this regard, I intend to develop a framework of consultation with a broad range of interests including industry, to ensure optimum progress in the achievement of the objectives of this Strategy.

The Minister for Health, Michael Noonan, and I are both confident that the implementation of this Strategy together with the range of service developments and actions provided for in the Health Strategy will effect a significant improvement in the health status of the people of this country.



Brian O'Shea T.D., Minister of State at the Department of Health

contents

Health Promotion Strategy

Health promotion at an individual level involves educational processes enabling people to acquire information and skills that will help them in making good decisions in relation to their health.

At a community, regional and national level it involves the development of appropriate policies, structures and support systems so that the healthier choice becomes the easier one to make.

chapter one

Health Promotion – A Background

Introduction

1.1 The Health Strategy *Shaping a Healthier Future* published in 1994, has provided a major stimulus for adopting an expanded role for health promotion in providing improved standards of health in Ireland. Significant features of the Strategy are:

- *to encourage people to take responsibility for their own health and to provide the environmental support necessary to achieve this;*
- *to provide a high quality health service underpinned by the three principles of equity, quality and accountability.*

1.2 This Health Promotion document proposes a detailed strategy for the promotion of health in Ireland. It reviews progress in the health promotion area to-date. It sets out how health promotion can be effective in improving health and wellbeing and in addressing the causes of ill-health in our community. It also identifies the prerequisites for the implementation of an effective health promotion strategy.

1.3 The Health Promotion Unit consulted with the health boards, the Department of Health Promotion, University College Galway and the major national voluntary organisations in the development of this Strategy.

individuals wishing to adopt a healthy lifestyle may be prevented from doing so by environmental and socio-economic factors which are often beyond their individual control.

1.4 The first Health Promotion target in the Health Strategy's Four Year Action Plan is "to develop health promotion programmes in school, community, workplace and health service settings so as to promote health at local level". Accordingly, the approach adopted in this document emphasises the opportunities offered for successful health promotion in settings such as the workplace, the school, the health facility or the community. This represents a change from the approach which identifies risk factors and categories of ill health and devises a programme for each topic.

Rationale for Health Promotion

1.5 Health promotion acknowledges that the primary causes of premature mortality and preventable morbidity are linked to unhealthy behaviours and lifestyles. It is broader than disease prevention and health education because it recognises that individuals wishing to adopt a healthy lifestyle may be prevented from doing so by environmental and socio-economic factors which are often beyond their individual control.

1.6 Health promotion at an individual level involves educational processes enabling people to acquire information and skills that will help them in making good decisions in relation to their health. At a community, regional and national level it involves the development of appropriate policies, structures and support systems so that the healthier choice becomes the easier one to make. Its purpose has been most succinctly described as endeavouring "to make the healthier choice the easier choice".

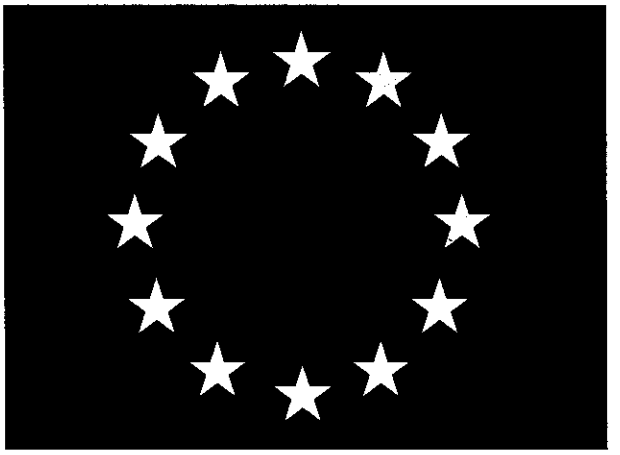
1.7 The key determinants of health are often outside the health care sector. The Health Strategy refers to the need to place health promotion in a wider context. The activities of many other sectors have an impact on health and it is essential therefore that there is a health dimension to policies both in the public and private sector. There is an increasing emphasis, both nationally and internationally, on the multi-sectoral approach to health promotion.

1.8 The rationale for health promotion relies on acceptance of a number of underlying assumptions. These include:

- health is a resource for everyday living, finite but not fixed, and, therefore, susceptible to management for better or worse;
- lifestyles are key determinants of health;
- lifestyles are themselves determined by the individual's social, economic, cultural, physical and ethical environment; and
- lifestyles are also determined by the amount of information and the level of skill that the individual possesses in relation to his/her own health.

1.9 The rationale for health promotion leads to an expectation of benefits in relation to several aspects of health.

In general terms benefits may be expected to accrue in the areas of health gain and social gain. These benefits pertain to quality of life as well as quantity of life and may be characterised as adding life to years and years to life.



During the discussions on the Maastricht Treaty, it was accepted on Ireland's initiative, that health protection should, under Article 129, form an explicit part of the Union's other policies.

In general terms benefits may be expected to accrue in the areas of health gain and social gain. These benefits pertain to quality of life as well as quantity of life and may be characterised as adding life to years and years to life.

In specific terms the benefits would include:

- enhancement of levels of perceived health/wellbeing;
- reduction of levels of perceived illness;
- reduction of the incidence of disease;
- reduction of the incidence of accidents;

International Developments

1.10 Throughout the 1980s and 1990s a number of international developments has provoked new thinking in relation to the management of health and stimulated new concepts of health promotion.

1.11 The European Office of the World Health Organisation has been a major catalyst for developments in health promotion. It sponsored the first International Conference on Health Promotion held in Ottawa in November 1986 where a Charter for Health Promotion was adopted.

In the Charter, health promotion in action has five key elements:

- building healthy public policy;
- creating supportive environments;
- strengthening community action;
- developing personal skills;
- re-orienting health services.

The Ottawa Charter has since been widely publicised and employed as a framework for identifying and outlining action areas in health promotion, especially those areas requiring intersectoral effort and co-operation.

1.12 In recent years the European Commission has placed health promotion firmly on its agenda. In 1992, it established a senior expert steering committee for Health Promotion and Education with representation from all Member States. During the discussions on the Maastricht Treaty, it was accepted on Ireland's initiative, that health protection should, under Article 129, form an explicit part of the Union's other policies.

1.13 A proposal for decision is currently before the European Parliament and the Council to adopt a programme of Community action on health promotion, information, education and training within the public health framework for action. The Commission continues to support a health promotion approach as part of its actions in other programmes in the field of public health. It has also been firmly supportive of the settings approach in health promotion as evidenced by its commitment to the establishment of the European Network of Health Promoting Schools.

1.14 In the U.S.A. in the late 1970's a national goal setting approach was adopted which outlined the possibilities for disease prevention and health promotion. In 1987 the US panel, convened to identify the next phase of US objectives for the year 2000, concluded that the process of establishing and tracking measurable national objectives had not only helped to establish a national health agenda and identify explicit health priorities, but had also facilitated organised responses and had supported progress towards enhanced levels of health.

1.15 In 1990, the Health Promotion Authority in Wales published, an ambitious and comprehensive strategy with the overall aim of "giving the people of Wales a level of health to compare with the best in Europe in the 21st century". The scope of the Welsh Health Promotion Strategy demonstrates that bold and ambitious strategies need not be confined to communities with the resources and expertise of the U.S.A., but can also be undertaken by smaller communities, when they give sufficient resources and priority to health promotion within overall health management.

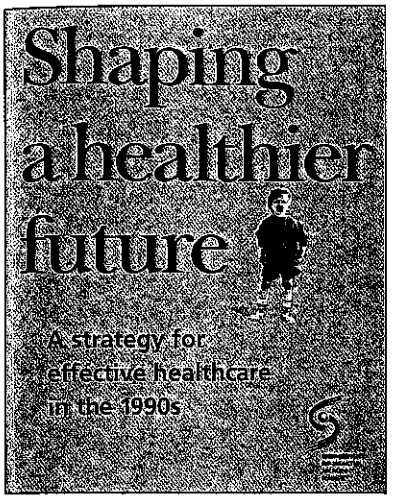
1.16 In Northern Ireland the emphasis on health promotion has been clearly stated in the Regional Strategy for the Health and Social Services in Northern Ireland which is prepared on a five year basis. In the region's Strategy for the period 1992-1997, the major strategic goals for health promotion and disease prevention are to:

- identify and reduce the major preventable causes of disease and disability;
- encourage and support people to adopt a healthier way of life; and
- help people obtain both the information and skills necessary to improve health.

Health Promotion to date in Ireland

1.17 Two key reports produced in 1986: *Health – the Wider Dimensions* (Department of Health) and *Promoting Health through Public Policy* (Health Education Bureau), paved the way for a more integrated approach to health policy and management and the establishment of new health promotion structures. The *Health Strategy* published in 1994 reflects clearly the key role which health promotion must play in achieving the health and social gain targets which are regarded as necessary and attainable.

1.18 The Health Promotion Unit replaced the Health Education Bureau and took on the wider remit of health promotion. The Unit has been assisted in its work by the direction and guidance provided to it by the Cabinet Sub-Committee on Health Promotion, chaired by the Minister for Health, which consisted of the Ministers of Agriculture and Food, Education, Transport, Energy and Communications, Environment and Enterprise and Employment, and by a broadly based Advisory Council on Health Promotion. The increasing emphasis on interdepartmental and inter-sectoral working in many areas of the public service has helped to create an environment in which it becomes easier for the individual to exercise the healthy choice.



The increasing emphasis on interdepartmental and intersectoral working in many areas of the public service has helped to create an environment in which it becomes easier for the individual to exercise the healthy choice.

The Health Promotion Unit has a dual remit:

- a policy-formulation function within the Department of Health concerned with strategic planning, priority setting, research and evaluation and the development of an multi-sectoral approach to health issues at national and local level.
- an executive function concerned with the development and implementation of national and local health promotion programmes independently or in conjunction with statutory and non-statutory agencies.

In developing policy and in the implementation of programmes, the Unit has built up an effective and important liaison with the health boards and with national and local voluntary agencies.

1.19 An academic base for health promotion is recognised as a key element of a national structure. The Health Promotion Unit sponsors a Chair in Health Promotion in University College, Galway. The function of this academic Department is to engage in multi-disciplinary research and teaching programmes in health promotion.

Well-focused, sensitive and sustained health promotion programmes should show a considerable dividend in adding quality to life and reducing premature mortality.

chapter two

Health Status of the Irish Population

Introduction

2.1 In Ireland, as in most other countries, the negative concept of health, i.e. the absence of disease, has dominated the planning, funding and organisation of health services. This disease oriented tradition has meant that Irish health services, in the absence of appropriate indicators of health and well-being, have had to rely on measures such as life expectancy, patterns of mortality/morbidity and limited lifestyle data to assess Irish health status.

2.2 The available morbidity and mortality data do not present an encouraging picture of health in Ireland. The outline of current illness patterns presented beneath shows that the main causes of morbidity and mortality are diseases in which lifestyle and environmental factors play a very important role. It is, therefore, reasonable to assume that well-focused, sensitive and sustained health promotion programmes should show a considerable dividend in adding quality to life and reducing premature mortality.

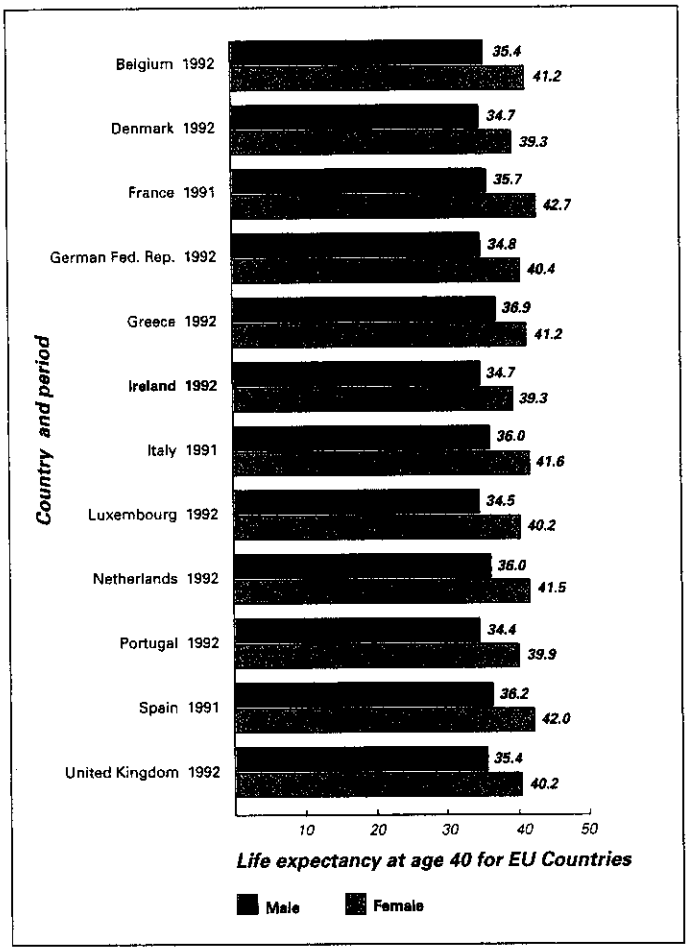


Figure 1 Life expectancy at age 40 for EU Countries.
Source: Demographic Statistics, Eurostat 1994

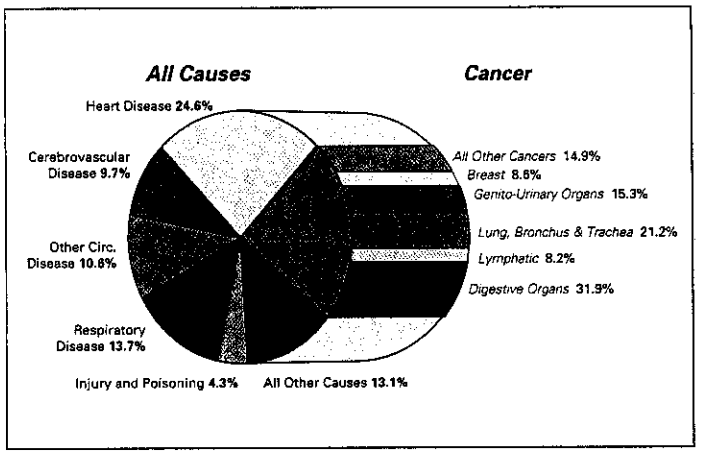


Figure 2 Deaths by principle causes, percentage distribution, Ireland 1993.
Source: Quarterly Report on Vital Statistics, Yearly Summary, 1993

Current Illness Patterns – The Principal Problems

Life expectancy

2.3 Life expectancy refers to the number of additional years a person of a given age can expect to live. Life expectancy at birth has increased by almost 8 years for men and 11 years for women since 1950. However, life expectancy at age 40 has only increased by 3 and 6 years, and at age 65 by 1 and 4 years for males and females respectively since 1950. The higher gain in the younger age group reflects improvements in child health in contrast with the major causes of mortality in adulthood which have remained relatively unchanged.

2.4 Although life expectancy has been increasing in Ireland for those in the youngest age group, life expectancy in middle age does not compare well with that of our EU neighbours.

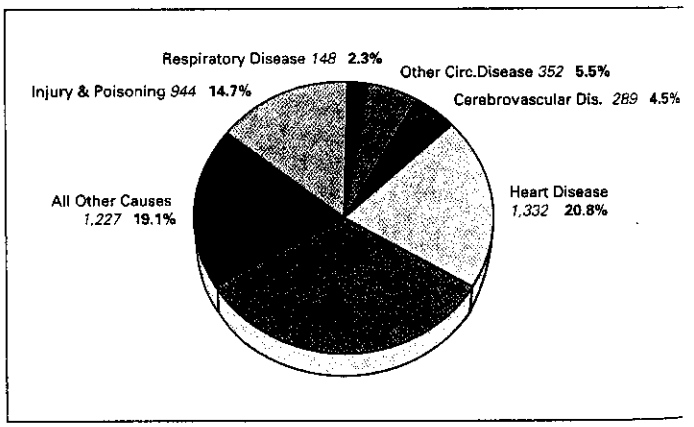


Figure 3 Deaths by Principle Causes, Persons aged 0 - 64 years, Ireland 1993.
Source: Quarterly Report on Vital Statistics, Yearly Summary, 1993

2.5 Irish women rank joint lowest among their EU counterparts in terms of life expectancy at age 40 while Irish men rank third lowest among their counterparts. Irish women have a life expectancy of 39.3 years compared to French women with a life expectancy over 42.7 years. Irish men have a life expectancy of 34.7 years compared to Greek men with a life expectancy of 36.9 years. (Figure 1)

Cardiovascular disease

2.6 Cardiovascular disease is the major cause of death in Ireland (35%) (Figure 2) and the second most frequent cause of death in the under 65 age group (over 25%) (Figure 3). The mortality rate for heart attack per 100,000 of the population (all ages) is much higher than the EU average (238 per 100,000 in Ireland compared to 98 per 100,000 in the EU overall) (Figure 4). However stroke mortality has fallen substantially and is now at the EU level. In the under 65 age group, the mortality rate for cardiovascular disease fell by 42% in women and 29% in men between 1981 and 1991. However, we have the highest death rate from heart disease in this age group in the EU – almost double the EU average (60.7 per 100,000 in Ireland compared to 32.6 per 100,000 on average in the EU) (Figure 5).

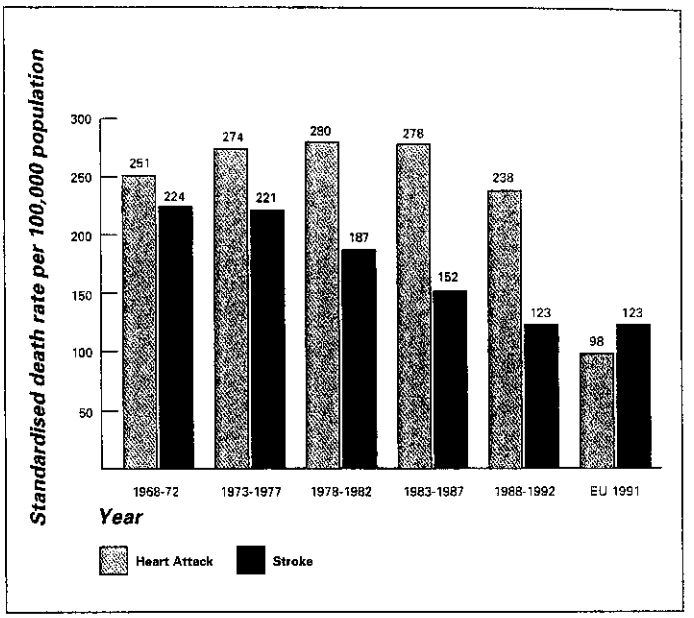


Figure 4 Heart Attack and Stroke Mortality in Ireland.
Source: CSO, Eurostat and WHO

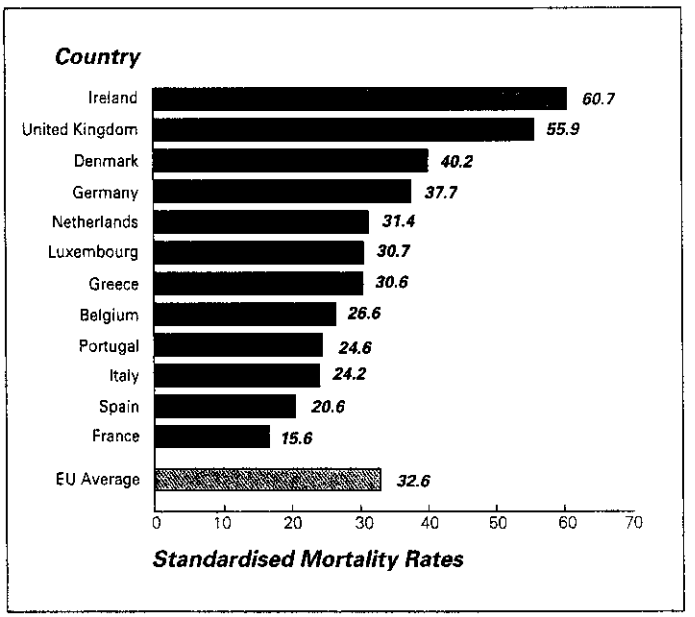


Figure 5 EU Heart Disease Mortality Rates for Persons aged 0 - 64 years.
Rates per 100,000 population for latest available year.
Source: WHO, HFA database.

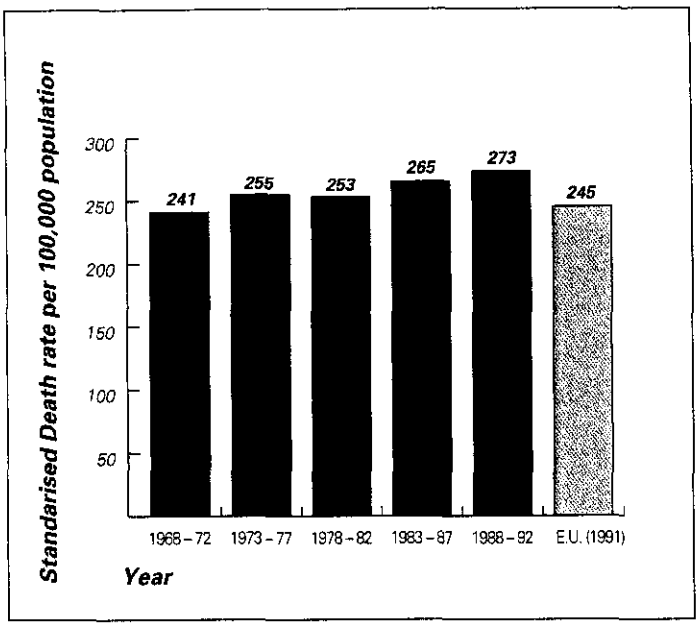


Figure 6 Malignancy Mortality in Ireland.
Source: CSO, Eurostat and WHO

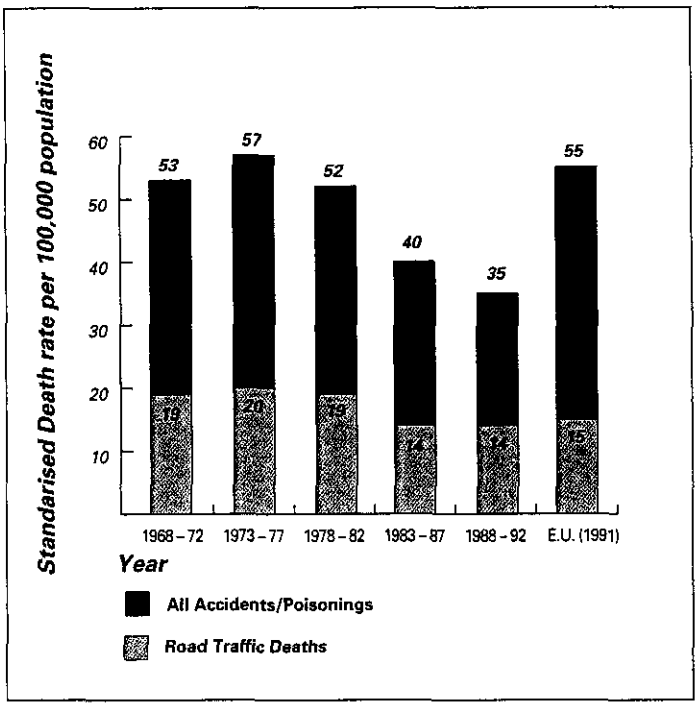


Figure 7 Accident Mortality in Ireland
Source: CSO, Eurostat and WHO

Cancer

2.7 Cancer is the second major cause of death in Ireland (over 23%) (Figure 2) and the major cause in the under 65 age group (33%) (Figure 3). Among men, deaths from cancer of the lung, colon and stomach are the most common, while among women deaths from cancer of the breast, lung and colon are the most common. The death rate from cancer per 100,000 of the population (all ages) in Ireland is increasing and is above the EU average (273 per 100,000 in Ireland compared to 245 per 100,000 in the EU overall) (Figure 6). It is encouraging, however, that cancer mortality has reduced by almost 10% in the under 65 year olds since 1977.

Accidents

2.8 Accidents are the single greatest cause of death in persons under 45 years and are responsible for a third of deaths in this age group. Road traffic accidents are the cause of 56% of deaths attributable to accidents among people under 45 years of age. Mortality rates per 100,000 of the population from accidents/poisoning, showing road accidents separately, are illustrated for Ireland and the EU in (Figure 7). Mortality due to accidents has fallen by a third in the past ten years. This reduction has exceeded the relevant WHO Health for All target.

Sexually transmitted diseases

2.9 Sexually transmitted diseases have harmful social, psychological and physical consequences. Because infection is often unrecognised for lack of apparent symptoms, some people suffer serious permanent complications including sterility. The number of notified cases has continued to increase in the last number of years and has risen from 2,592 in 1989 to 4,663 in 1993.

HIV/AIDS

2.10 With regard to HIV/AIDS, by the end of February 1995 1,553 people had tested positive for HIV. At the end of March 1995 there were 463 cases of AIDS and 231 people had died from the syndrome. Each year the number of cases of AIDS is continuing to grow and the current pattern in relation to new cases is likely to continue for the foreseeable future.

Risk Factors associated with Lifestyle and Environment

2.11 The pattern of illness outlined above demonstrates that the main causes of morbidity and mortality are from illnesses in which lifestyle and/or environmental factors play a role. Such risk factors include smoking, alcohol misuse, overweight, high blood pressure and poverty.

Smoking

2.12 Over 6,000 deaths each year in Ireland are directly attributable to smoking.

- Smoking is one of the main risk factors for heart disease.
- It is a major causative factor in almost 90% of the 1,500 deaths from lung cancer which occur each year. An increasing proportion of cancer deaths among women is due to lung cancer. In 1993, 509 women in Ireland died from this particular type of cancer.
- Smoking is a major cause of bronchitis and emphysema.
- It increases the risk of cerebrovascular disease (stroke) and cancer of the mouth, throat, oesophagus, bladder, kidneys and gastric ulcers. Women who smoke while pregnant put the wellbeing of their unborn babies at risk.
- Recent research shows that smoking by parents is a significant contributory factor in the causation of sudden infant deaths.

2.13 Statistics for the year to the end of June 1994 show that 29% of people aged 15 years and over smoke, 29% of men and 28% of women. This compares with an overall prevalence of 43% in the early 1970s – 49% among men and 37% among women. Preliminary analysis of recent surveys of smoking behaviour among second level school pupils suggests that the prevalence of smoking among young people, including young girls, may have reached a plateau and may even be declining in the younger teenage group. Further analysis is required to confirm this trend.

Alcohol Misuse

2.14 While Ireland has the highest percentage, among EU countries, of the adult population abstaining from alcohol, it experiences considerable problems arising from alcohol misuse. In 1993, approximately 24% (1,742) of first admissions to psychiatric hospitals and units were for alcohol-related disorders. Taking all in-patient admissions to such hospitals in the same year, 21% (5,718) were for alcohol misuse and alcoholic psychosis. Admissions to hospital for alcohol disorders at best provide only a lower limit to the incidence of health problems arising from alcohol misuse. This is particularly so in recent times with the increasing emphasis on out-patient treatment.

2.15 The extent of alcohol misuse among young people in Ireland is a source of increasing concern. In 1993 there were 143 first in-patient admissions under 25 years of age for alcohol-related problems. In the same year all admissions (first and subsequent) for this age group numbered 259.

2.16 While drink driving has been declining in recent years due to a greater awareness of the dangers involved, alcohol is still one of the most important factors that influence traffic safety. Various studies suggest that alcohol is a factor in about 20% of serious and fatal road accidents and the on-going national road safety campaign will continue to feature initiatives to tackle the problem. This campaign, coupled with recent reduction in the maximum blood alcohol level for drivers (from 100 milligrammes to 80 milligrammes of alcohol per 100 millilitres of blood), should contribute to a further reduction in the number of road deaths and injuries in this country.

Overweight

2.17 The National Nutrition Survey, published in 1990, found that 53% of adult men and 33% of adult women were overweight with an additional 10% of males and 15% of females classified as obese. Studies show that mortality from all causes is higher in those who are overweight. Overweight is a recognised risk factor for hypertension, hyperlipidaemia (cholesterol), diabetes and, as a result, cardiovascular disease.

High Blood Pressure

2.18 The Kilkenny Health Project found that almost 24% of both males and females aged 35-64 years in their survey sample had high blood pressure (i.e. had blood pressure above 160/100mm. Hg).

Drug Misuse

2.19 **Drug misuse constitutes a major public health problem and initiatives to combat this problem will be given a high priority.** Its urgency as a health problem has become more acute in recent years because of the association of intravenous drug abuse and needle sharing, with the transmission of HIV. In addition, the experience of those working with drug misusers would indicate that the use of cannabis, ecstasy, opiate and non-opiate drugs generally is increasing among teenagers.

Stress

2.20 Stress, in a positive environment, can be an enhancing aspect to life. However, some stressful conditions can result in psychological or physiological problems such as inertia, illness or violence. In the absence of a national database on drug utilisation, statistics available from the General Medical Service Scheme (G.M.S.) point to a considerable level of mental stress in the population eligible for services under this Scheme. This covers approximately 36% of the population. In 1994, the estimated cost to the G.M.S. of psycholeptic and psychoanaleptic drugs, which include sedatives and anti-depressants, was over £10 million – about 9.5% of overall expenditure on the G.M.S. Scheme. While people covered by medical cards represent the more disadvantaged groups who would be expected to have greater health service needs, these statistics suggest that there are levels of mental stress in the population as a whole which gives cause for concern.

Mental Illness

2.21 There were 27,005 admissions to psychiatric hospitals and units in Ireland in 1993. Of these 7,311 (27%) were first admissions. These figures showed a slight drop on the rates for 1992 but admissions to psychiatric hospitals and units in Ireland have increased in the last 20 years (24,036 in 1973 compared to 27,005 in 1993). Depressive disorders accounted for 29% of all admissions and 33% of first admissions.

Suicide

2.22 There has also been an increase in suicide in Ireland in recent years, particularly suicide among males. In 1983 there were 282 cases of suicide recorded in Ireland of which 202 were male. By 1993 these figures had increased to 357 and 291 respectively. Although not all people who take their own lives suffer from a mental illness, the mental health services have a particular responsibility to assist in the prevention of suicide.

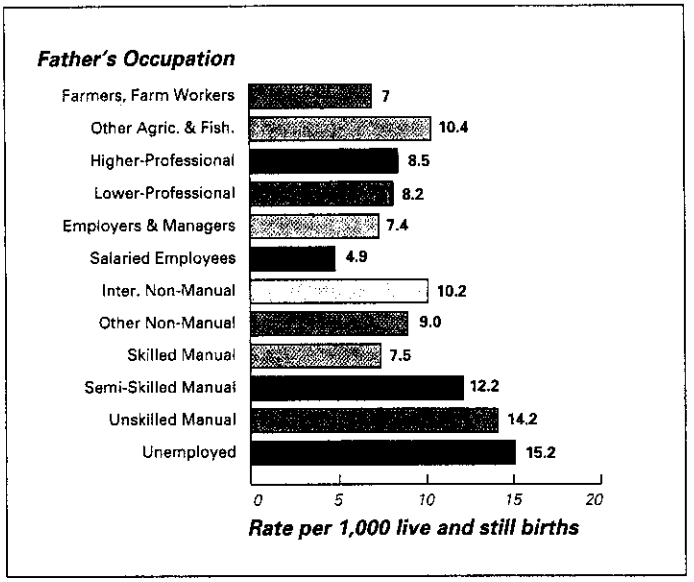


Figure 8
Perinatal Mortality Rates by Father's Occupation, Ireland 1991.
Singleton births, rate per 1,000 live and still births.
Source: Perinatal Statistics, Department of Health, 1991.

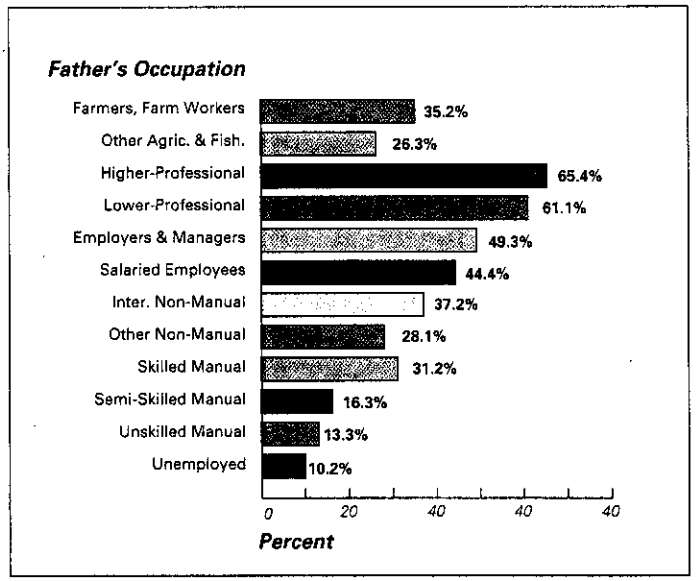


Figure 9
Percentage of Mothers Breastfeeding by Father's Occupation, Ireland 1991. Singleton births.
Source: Perinatal Statistics, Department of Health, 1991.

Economic Status and Health

2.23 Though data are scarce on how health status in Ireland varies according to socio-economic group there are indications that income is an important variable affecting health, with lower socio-economic status and unemployment being associated with higher rates of mortality, morbidity and psychological stress.

Perinatal mortality is highest among children of unemployed men, (over 15 per 100,000. Figure 8). The percentage of children breastfed (the desirable method from a health perspective) varied in 1991 from 65.4% among those whose fathers were in the higher professional group to 13.3% and 10.2% respectively among those whose fathers were in the unskilled manual and the unemployed group (Figure 9). Similarly, rates of in-patient admission to psychiatric hospitals are considerably higher in the unskilled manual group than in the other socio-economic groups (1420.4 per 100,000 in the unskilled manual group compared to 200.9 per 100,000 in the employers and managers group. Figure 10).

2.24 In 1990, a community-based cross-sectional survey of behavioural risk factors for premature mortality was carried out on a group of adults aged 25-44 years from previously identified high mortality "black spots" in Dublin. These were compared with others from low-mortality areas. In the "black-spot" areas, 50.9% of respondents were current smokers versus 28.5% in low-mortality areas and 14.6% took "sufficient" exercise versus 31.4% in low-mortality areas. People living in "black spots" were also less likely to make "healthy" dietary choices than those in low-mortality areas.

2.25 The link between lower socio-economic status and low health status is also clearly demonstrated in the case of the travelling community. The Travellers' Health Status Study in 1987 found that life expectancy at birth for male travellers is 9.9 years less than that for settled males and is 11.9 years less for women travellers than for settled women. The study also found that from before birth to old age, travellers have high mortality rates, particularly from accidents, metabolic and congenital problems and also from the other major causes of death. Those members of the travelling community who do not live in houses, approximately 50%, have even higher mortality rates than housed travellers.

Conclusions

2.26 The morbidity and mortality data demonstrate the influence which lifestyle and environmental factors have on the health and wellbeing of the community. Making the healthier choice easier therefore involves greater knowledge and commitment on the part of the individual and the creation of an environment which supports those who want to pursue a healthy lifestyle. The remainder of this document is concerned with setting out a strategy to bring about both of these conditions.

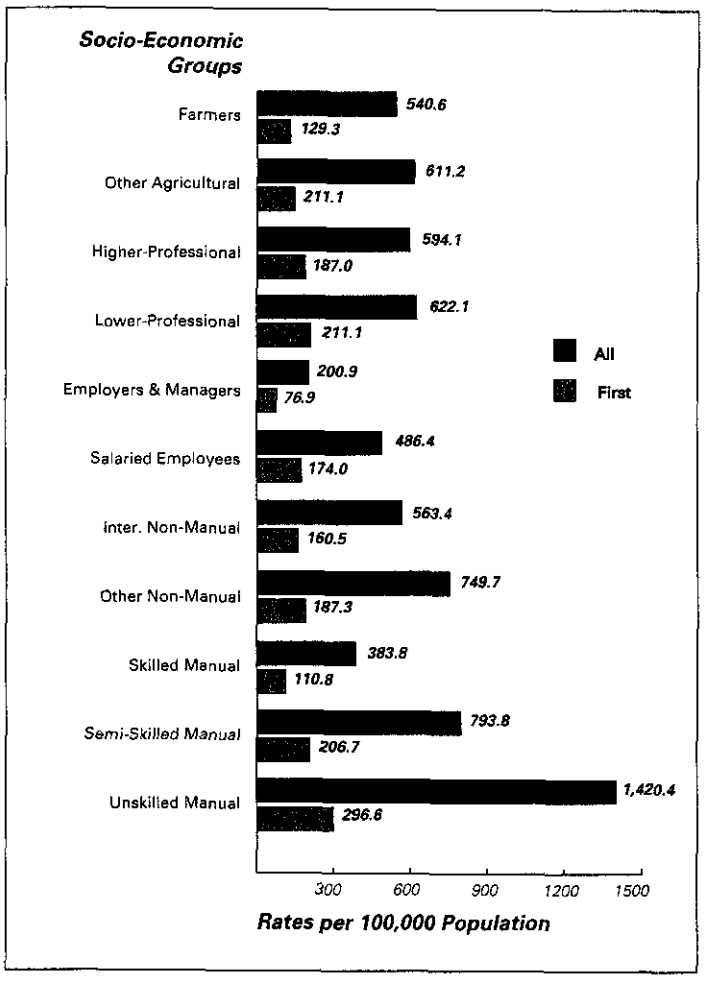


Figure 10
All and first admissions to psychiatric hospitals and units by socio-economic group, Ireland.
Source: Activities of Irish Psychiatric Hospitals and Units, Health Research Board, 1993.

If goals and targets are to become significant, they must be supported by all the groups with a stake in their pursuit and be seen by the population at large as desirable and attainable.

chapter three

National Goals and Target Setting

Introduction

3.1 An essential aspect of the process of developing a national strategy for health promotion is gaining widespread support for national goals and targets for health. If goals and targets are to become significant, they must be supported by all the groups with a stake in their pursuit and be seen by the population at large as desirable and attainable.

Goals

3.2 Goals represent broad aspirations concerning desirable improvements in health. They do not usually specify timeframes or degrees of change and do not address the question of implementation. Broad health goals are usually uncontroversial, but their generality is their main limitation.

Targets

3.3 Targets, in contrast, are specific. Where a health goal might aspire to reduce road traffic injuries, a target would aim to increase seatbelt wearing by a specific amount or make the wearing of safety helmets compulsory for all cyclists. Targets assume the availability of reliable basic data, effective strategies to achieve change and means of measuring that change. Setting targets makes it possible to identify and quantify progress towards the achievement of goals. Targets need not be numerous or elaborate to begin with but need to reflect key national priorities for a stated time period whose attainment is as measurable as available indicators permit.

Maximising young people's health potential with particular reference to physical exercise, anti-*smoking and other substance misuse*, healthy nutrition and healthy relationships.

3.4 In the Health Strategy and in this document, the goals and targets have been concentrated on the following:

- the changes in lifestyle/risk factors contributing to health which can be achieved to protect health, promote wellbeing and prevent illness in the future;
- the changes in the organisation and delivery of health services which should contribute to the protection of health, the promotion of wellbeing and the prevention of illness in the future;
- the changes in the environment which can be achieved to *"make the healthier choice the easier choice"* in the future;
- the changes which can be achieved in the environment and in lifestyle to enhance and protect health and so prevent illness/disease in the future.

Progress made in achieving these goals and targets will result in a reduction in overall mortality.

3.5 In setting goals and targets for health promotion, it is useful to bear in mind that, while the ultimate goals are the enhancement of health status and the reduction in rates of avoidable illness, premature disease and death, these are often only achievable in the medium to long term. Shorter term goals and targets can, therefore, be usefully set alongside these longer term ones. These shorter term goals can be set in terms of key settings and priority population groups. In the interest of achieving equity in health status, it makes sense to give priority to those who are often at a disadvantage e.g. those in lower socio-economic groups. Goals and targets can also be set in terms of risk factors and lifestyle, and within these to knowledge, attitudes and behaviour in relation to the risk factors. The assumptions underlying the rationale for health promotion imply that reducing the risk factors for preventable illnesses will make an important contribution to enhancing health status and ultimately to reducing rates of illness, premature disease and death.

3.6 Goals and targets are addressed under the following major categories, between which there is a significant degree of interdependence:

- **Key Settings**
- **Priority Population Groups**
- **Risk Factors and Lifestyle**
- **Death, Disease and Illness Rates**

It is stressed that the actions proposed in the following paragraphs are merely illustrative of the range of activities that will be initiated in pursuit of the various goals and targets.

Key Settings

3.7 **Multi-sectoral co-operation, either within individual settings, or across a number of them, adds significantly to the opportunities for progress towards the national goals and targets. Opportunities to work towards the achievement of the goals and targets and indeed of other health and social gains, will be similarly enhanced if action, above all joint action, is pursued in various discrete "settings" in the places where people live and work.**

Goals & targets

The development of health promotion programmes in the settings of the family, the community, the school, the health services and the workplace and the optimum use of the potential of these settings for the promotion of health at local level.

Actions planned in this area include:

- support for the implementation of the Health Promoting Schools Project;
- exploration of the potential of a health promotion approach in the environments of health service facilities and third level educational institutions. An example would be the proposed development of a national network of health promoting hospitals;
- development of partnerships with key organisations with an interest in health promotion in different settings e.g. youth action projects;
- support for employer and trade union health promotion initiatives in the workplace;
- continuing support for the Irish Heart Foundation's Happy Heart Programme, and in particular, its Happy Heart at Work component.

Priority Population Groups

3.8 **Focusing on specific sub-groups of the population will help address particular vulnerabilities within those sub-groups.**

Goals & targets

Examples of goals and targets with priority population groups include:

Children

- Maximising young people's health potential with particular reference to physical exercise, anti-smoking and other substance misuse, healthy nutrition and healthy relationships.
- Achieving an uptake of 95% for the National Immunisation Schedule.

Actions planned in this area include:

- continuing co-operation with the Department of Education particularly within the Health Promoting Schools concept to develop health education components for the curriculum;
- develop training programmes for teachers and parents;
- continue support for school-based health education programmes such as Bí Folláin, the Lifeskills Programme, the Nutrition Education at Primary School Programme and the Child Abuse Prevention Programme;
- support for Health Education/ Promotion Programmes in youth clubs and youth organisations;
- implementing mass media campaigns aimed at young people on particular topics e.g. smoking;
- effective screening and health protection services through primary health care;
- promoting the benefits of immunisation to the public and to health professionals.

Sexually active people

- Promoting safer sexual practices.
- Achieving a reduction in the risk of disability by providing a range of information on topics such as the influence of age on pregnancy; family planning; and genetic counselling.

Actions planned in this area include:

- provision of education and training programmes for those who wish to avoid pregnancy;
- education programmes to minimise the risk of sexually transmitted diseases including HIV/AIDS;
- encouraging avoidance of alcohol and drug misuse which may lead to greater risk taking;
- targeted programmes for people engaging in high risk behaviours.
- development, with health boards, of appropriate programmes to reduce teenage pregnancies;
- development, with health boards, of appropriate responses to the needs of teenagers who become pregnant.

...women's health needs are identified and, where appropriate, health promotion programmes are put in place to address these needs.

Women

- Ensuring that women's health needs are identified and,where appropriate, health promotion programmes put in place to address these needs.

Actions planned in this area include:

- preparation of a national plan for women's health, following consultation with all those interested in improving the health and welfare of Irish women, based on the recently published Women's Health Discussion Document.

Maternal Health

- encouraging the avoidance of smoking and alcohol and drug misuse before and during pregnancy;
- promoting breastfeeding;
- promoting healthy nutrition before and during pregnancy;
- encouraging improvements in parenting skills;
- increasing the numbers who understand the value of immunisation and accident prevention and first aid.

Disadvantaged

- Reducing inequality in health status by giving priority in health promotion activities to vulnerable groups e.g. those of lower socio-economic status.

Actions planned in this area include:

- developing health education programmes for those with low literacy levels;
- providing targeted educational materials for travellers and others in lower socio-economic groups on nutrition, smoking, alcohol and substance misuse;
- developing training programmes for those working with travellers.

Increasing the proportion of the elderly who enjoy an active, independent and healthy old age

Elderly

- Increasing the proportion of the elderly who enjoy an active, independent and healthy old age.

Actions planned in this area include:

- the development, in conjunction with the National Council for the Elderly, of a national programme to promote 'healthy ageing' in Ireland: this programme will seek to promote the health and autonomy of older people;
- promoting self-respect, dignity and a positive role for older people in society;
- developing programmes that encourage pre-retirement age groups to remain fit, active and independent for as long as possible;
- developing programmes for the carers of the elderly.

Risk Factors and Lifestyles

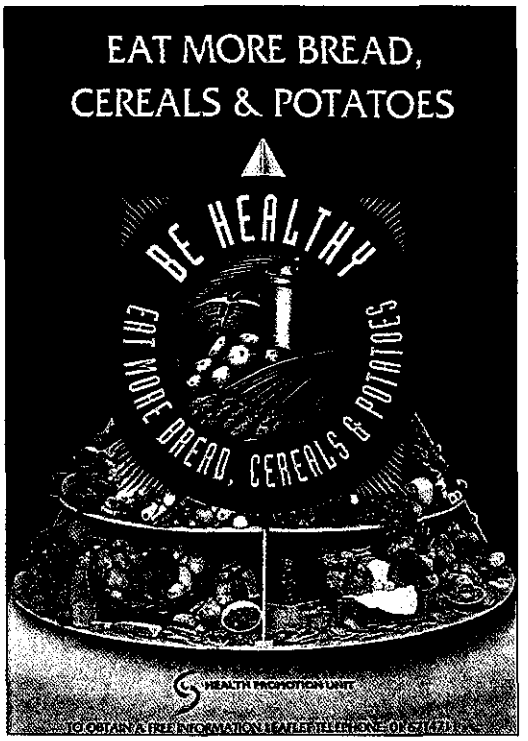
3.9 **Much of the current toll of disease and illness of the Irish population is strongly associated with environmental determinants and lifestyles. Many of the lifestyle-related risk factors for Ireland's major causes of death overlap.**

Alcohol/substance misuse

- *The development of a national policy* to promote moderation in alcohol consumption and reduce risks to physical, mental and family health associated with alcohol misuse – such policy to be adopted and launched during 1995.
- Ensure that 75% of the population aged 15 years and over knows and understands the recommended sensible limits for alcohol consumption (14 units a week for a woman and 21 for a man) within the next 4 years. (These limits are subject to ongoing review, based on research findings).
- Reduce substantially over the next 10 years the proportion of those who exceed the recommended sensible limits of alcohol consumption.
- A reduction in the percentage of cigarette smokers in the population by at least 1% per annum so that more than 80% of the population aged 15 years and over are non-smokers by the year 2000.
- **All pupils leaving school will have received information and education programmes on the dangers of substance misuse in the context of a comprehensive health education programme.**

Actions planned in this area include:

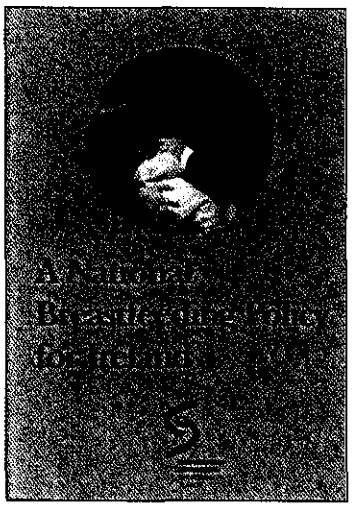
- education and training programmes and mass-media initiatives that promote the avoidance of substance misuse, including alcohol and tobacco;
- continuing support for the dissemination of specific programmes such as the **Substance Abuse Prevention Programme**, the **Drink Awareness for Youth Programme**, the **Drugs Questions – Local Answers Programme** and the **Family Communication and Self-Esteem Programme**.



Nutrition

The on-going implementation, within the next five years, of the Department of Health's Healthy Eating Guidelines including:

- educating and motivating Irish people to eat a wide variety of foods in line with current recommendations as illustrated in the Food Pyramid;
- the encouragement of the achievement and maintenance of a healthy weight through healthy eating and regular exercise;
- the encouragement of a reduction in total fat intake (to no more than 35% of energy as fat) by the year 2005 and to attain an appropriate balance of fats;
- the achievement of a moderate reduction of 10% in the percentage of people who are overweight and a reduction of 10% in the percentage of people who are obese by the year 2005; (This target has been set understanding the difficulties associated with reducing overweight and maintaining a healthy weight).



Breastfeeding

- An overall breastfeeding initiation rate of 35% by 1996 and 50% by the year 2000.
- An overall breastfeeding rate of 30% at 4 months by the year 2000.
- Among lower socio-economic groups, a breastfeeding initiation rate of 20% by 1996 and 30% by the year 2000.

Actions planned in these areas include:

- implementing the Five Year Framework for Action on Nutrition;
- establishing a community nutrition service in each health board;
- continuing to promote healthy eating through initiatives like National Healthy Eating Week;
- continuing nutrition education for health professionals;
- expanding community based healthy eating initiatives for lower socio-economic groups;
- implementing the recommendations in the National Breastfeeding Policy.

Exercise

- A 30% increase in the proportion of the population aged 15 years and over who engage in an accumulated thirty minutes of light physical exercise most days of the week, by the year 2000;
- a 20% increase in the proportion of the population aged 15 years and over who engage in moderate exercise for at least twenty minutes, three times a week, by the year 2000.

Actions planned in this area include:

- educational and mass media initiatives in the context of a community based National Exercise Programme, to be launched in 1995;
- reinforcing, by means of educational initiatives in relevant settings, the benefits to be derived from regular participation in exercise;
- encouraging participation in physical exercise and, where appropriate, co-operating with the Department of Education, the Department of the Environment and other agencies to achieve this.

A 30% increase in the proportion of the population aged 15 years and over who engage in an accumulated thirty minutes of light physical exercise most days of the week, by the year 2000

Cholesterol and blood pressure

- To achieve a situation where 75% of the population in the 35-64 age group will have a blood pressure of less than 140/90mm Hg by the year 2005.
- To achieve a reduction in mean serum cholesterol in the 35-64 year age group from a present level of 5.6mmol/L to 5.2 mmol/L by the year 2005.

Actions planned in this area include:

- these two conditions will be very positively influenced by the achievement of the various goals and targets in relation to alcohol consumption, smoking, nutrition and exercise.

Diabetes Mellitus

- Diabetes is an important public health problem which causes prolonged ill-health, increases the risk of heart attack and stroke and leads to premature death.
- General goals include improving life expectancy in terms of quality and quantity and the prevention and cure of diabetes and its complications.

Actions planned in this area include:

- raising awareness in the population and among health care professionals of the opportunities for the prevention of the complications of diabetes and of diabetes itself;
- promoting independence, equity and self-sufficiency for all people with diabetes;
- reduction in morbidity and mortality from coronary heart disease in the diabetic by rigorous programmes of risk factor reduction.

HIV/AIDS

- A decrease in the percentage of the population which engages in behaviour which risks HIV transmission and the transmission of other sexually transmitted diseases.

Actions planned in this area include:

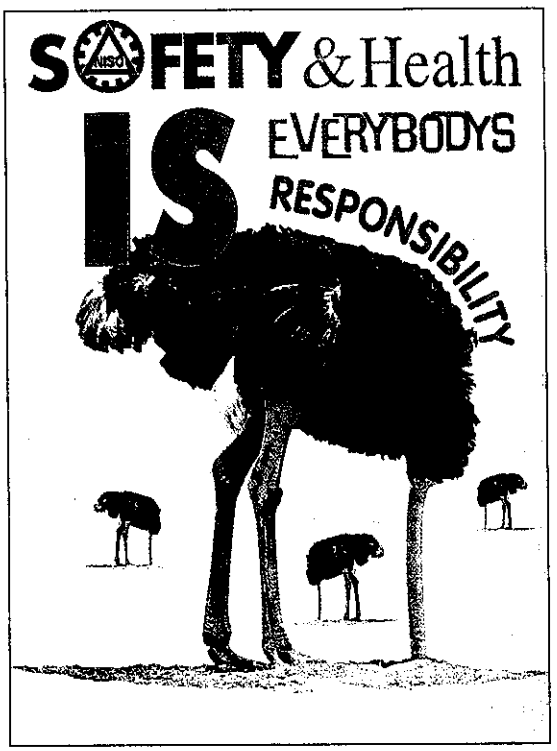
- providing education programmes in the area of human sexuality, relationships, reproduction and contraception.

Mental health

- Promote mental health in co-operation with the voluntary mental health bodies and the health boards.

Actions planned in this area include:

- Providing programmes that develop mental and emotional health, self-esteem, personal relationships and coping skills;
- Strengthening the individual's basic capacity to make healthy choices and to cope with stressful situations without recourse to behaviours which may damage health;
- Continuing support for an intervention study aimed at reducing the prevalence and cost of para-suicide.



Oral Health

- Improving the level of oral health in the population overall. The ability to chew one's food, communicate orally, have a positive self-image and develop productive social interaction are adversely affected when the mouth or orofacial complex are afflicted with disease or disorder.

Actions planned in this area include:

- Providing oral health education programmes aimed at the family, at priority population groups and at individuals, through the media and in health care and education settings.

Safety

- A reduction of 10% in mortality due to accidents within the next ten years and a significant reduction in morbidity particularly among children.

Actions planned in this area include:

- Promoting educational programmes to improve knowledge and safety skills in the home and in other environments;
- Working with other appropriate Government departments and agencies to introduce measures which facilitate a safer environment.

Death, Disease and Illness Rates – Goals and Targets

3.10 These are indicators traditionally used to measure health status. They are readily available and are useful for international comparisons.

Longer term goals, whose achievement would in many cases depend on the achievement of those shorter term goals already outlined, include;

- the improvement of life expectancy for Irish men and women from one of the lowest in the EU to the EU average within the next fifteen years;
- the reduction in mortality due to cardiovascular disease in the under-65 age group by 30% within the next ten years;
- a reduction in premature mortality due to cancer in the under-65 age group by 15 per cent in the next ten years.

These longer-term goals should be positively influenced by many of the actions proposed under the previous headings.

Evaluation and Monitoring

3.11 On-going evaluation is an essential part of monitoring the effectiveness of the implementation of this Strategy. There is need to develop comprehensive data bases which monitor the health status of the Irish population. These should address general health indicators as well as behavioural and lifestyle information on smoking, alcohol and other drug use, nutrition, oral health, exercise, obesity, cardiovascular fitness, stress and sex education. Such data bases would serve to identify high risk groups enabling more precise targeting of interventions and would also facilitate the ongoing monitoring of progress in relation to the goals and targets contained in the Health Strategy and in this Strategy. The new Departments of Public Health Medicine will have a major contribution to make in terms of expert epidemiological input, the development of health information systems and the preparation of an annual report on the health of the population of each region. With regard to nutrition, the National Nutrition Surveillance Centre at the Health Promotion Studies Centre, UCG will continue to provide on-going baseline up-to-date nutrition information on which to structure food and nutrition policy and better targetted nutrition information campaigns.

The practice of health promotion requires integration of existing knowledge from areas such as community development, adult education, health education, public health, social psychology, medicine, community mental health, political science and social marketing.

chapter four

Prerequisites for the Success of a National Strategy for Health Promotion

Role of Department of Health

4.1 The Department of Health must discharge a key leadership role in maintaining and developing a health promotion orientation in the health services. The accountability of the Department and indeed of health boards has been clearly placed in the arena of health gain and health status. The Department also has a key role in stimulating multisectoral co-operation at national level among those other Government departments and agencies whose policies and activities impact on the health of the community. This is particularly relevant as health promotion policies and their implementation extend beyond the remit of a single department.

National Health Promotion Structures

4.2 The Department has sought to give effect to multi-sectoral co-operation in recent years through various mechanisms such as those outlined in paragraph 1.18. Experience would suggest, however, that there are certain shortcomings – largely of a practical nature – associated with those arrangements. It is now proposed to establish a *National Consultative Committee* on Health Promotion chaired by the Minister of State at the Department of Health and comprising high-level inter-sectoral and expert representation. Relevant Government departments and other interests whose activities impact on the health of the community will be represented on this Committee. Such interests will include the health boards, youth and sport, communications, the voluntary sector, women's groups and health professionals. This Committee will submit periodic reports on health promotion to the Cabinet Sub-Committee.

4.3 Consideration will also be given to the most appropriate location for the health promotion function at national level. This is being addressed as part of a general review of the role and structure of the Department of Health currently taking place in the context of the Strategic Management Initiative in Government departments.

Health Boards

4.4 The successful implementation of a national strategy for health promotion which is sensitive to local issues and priorities will require a deliberate and explicit commitment by health boards to achieving the agreed objectives. Each health board should have in place a regional inter-sectoral consultative committee on health promotion. This will be representative of the various local interests whose activities impact on the health of the community. In addition, health boards' responsibilities in relation to health promotion will be reflected in forthcoming legislation to amend the Health Act 1970. The discharge of these responsibilities will require, inter alia, the establishment of a dedicated health promotion function at a senior level (preferably functional officer) under each health board. An important aspect of the work of this function will be to maximise the health promotion potential of all other health board staff. Health promotion cannot be the sole preserve of health promotion practitioners. Key contributions to health promotion can be made by staff in all disciplines and at all levels.

4.5 The establishment of new Departments of Public Health Medicine in the health boards provides a further opportunity for the enhancement of health promotion in the boards. It will greatly strengthen the boards epidemiological data bases, facili-

tate the identification of "black spots" and at-risk groups, and provide a better basis on which to evaluate the impact of programmes. The relationship between the health promotion function within the health boards and the public health medicine function will be close and mutually supportive.

Role of Health Professionals

4.6 To succeed in implementing an effective health promotion strategy a range of professional groups in the health services will need to be actively involved. Professionals such as nurses, pharmacists and dietitians, who are in direct contact with the public, will make a significant contribution. The other health professionals with a key role in health promotion in terms of expertise, numbers and level of contact with the public are General Practitioners. With the establishment of a National General Practice Unit within the Department of Health and of regional General Practice Units within each of the health boards, a structure now exists for general practice through which experimental innovations that merit wider application within primary medical care can be identified and their diffusion promoted. The General Practice Units provide a concrete model of a specialist-based structure, spanning both national and regional levels, which has been put in place to support a longterm programme of action for the enhancement of quality and effectiveness of GP services and which could be used to complement other structures for health promotion at national and regional level.

Role of the Voluntary Sector

4.7 The voluntary sector already plays a key role in promoting health at both national and local level. The health promotion activities of voluntary groups range from national programmes addressing various health topics through different settings to the development of information materials by a local group on one particular health topic. Such activities of voluntary agencies can, in certain instances, be more effective than if provided by statutory bodies as the voluntary agencies can operate in a more flexible manner and are often in closer contact with, and indeed, integrated into, local communities. Support will be provided to the various national and local voluntary/community groups to enable them to develop their potential in this area.

Funding

4.8 In 1994 the Government increased the national health promotion budget by 32% over the 1993 figure. The budget has been increased by a further 14% for the 1995 programme of activities. The Government will aim to continue to provide the resources for the various developments outlined in this Strategy, within the limits of overall budgetary policy each year. Consideration will be given to earmarking funding for health promotion under each health board with effect from 1996. Consideration will also be given to alternative ways of raising specific revenue for health promotion. Useful and acceptable initiatives along these lines have been taken in other countries.

Technical Support

4.9 The technical support required for health promotion activity includes a variety of epidemiological and behavioural information, health information, educational materials, teaching, communication, research, evaluation and planning skills. It draws on a system and style of professional preparation, training and education which is multidisciplinary, multisectoral and diverse in strategies, approaches and methods. The practice of health promotion requires integration of existing

knowledge from areas such as community development, adult education, health education, public health, social psychology, medicine, community mental health, political science and social marketing.

4.10 The task of providing adequate technical resources to support a health promotion strategy will be difficult and demanding. Health promotion practitioners will require a reliable source of high level technical support which the public also perceives as a competent and credible source of practical expertise. The Department of Health now proposes to facilitate an expansion of the skills-mix available to the Health Promotion Unit. This support will be available to health boards, education agencies, voluntary agencies, professional groups and other bodies involved in implementing national and local health promotion policies, strategies and plans.

Professional Training

4.11 The Health Strategy has already acknowledged that the reorientation of the health delivery system will necessitate a detailed examination of its implications for the way in which the professional groups who deliver the services are trained and educated. All professional bodies in the health sector should review the extent to which undergraduate curricula embrace health promotion principles and make relevant revisions as appropriate.There is also need for the organisation of a system of professional preparation and training to assist health workers engage in promoting health in the health service setting of their normal occupation. This system could also help prepare health workers in industry to better employ workplace settings to promote health in the workplace. The course programme in the Health Promotion Centre in U.C.G. offers an appropriate model for such a system.

4.12 In summary, the following prerequisites are required to establish and support a National Strategy for Health Promotion:

- the building of health focused public policies;
- the development of a national programme, setting goals and targets;
- leadership from the Minister and Department of Health to orient the health service towards health promotion;
- the creation of supportive environments;
- the strengthening of community action;
- the development of personal health-related skills;
- revised structures for health promotion at national level;
- statutory assignment to health boards of responsibility for health promotion and a complementary development of the functions of health promotion and public health medicine under health boards;
- increased financing, with ear-marked funding for health promotion at health board level;
- the involvement of voluntary and professional organisations and self-help/mutual aid groups in health promotion;
- provision of technical support to health promotion programmes;
- a system of professional preparation and training; and
- evaluating, on an on-going basis the effectiveness and impact of a national health promotion strategy.

Conclusion

4.13 The overall objective of this Strategy is to effect a significant improvement in the health status of the people of Ireland. While many of the issues addressed in this Strategy are already receiving detailed attention this is usually taking place through separate one-dimensional programmes. The implementation of the recommendations set out in this Strategy would mean that the various health problems and challenges would be addressed for the first time as part of an integrated, structured, clearly defined strategy.

The concept of health promotion is based on providing opportunities for individuals to develop health skills and healthy behaviours and on a recognition that a supportive environment is necessary to assist people in making healthy lifestyle choices. The creation of such an environment can only take place with the support of many sectors outside the health sector. Intersectoral co-operation therefore will be essential to the successful implementation of this Strategy.

This Strategy sets goals and targets as a means of mobilising support among all relevant individuals and groups and for the purpose of measuring progress. Implementation will be continually monitored and, where it can be accelerated, targets will be revised accordingly.

The Department of Health sees this Strategy as an opportunity for the Department itself to act as a catalyst in shifting, in a planned and integrated way, the orientation of the Irish health sector from one where treatment services and illness are emphasised to one which also places an emphasis on health promotion, prevention of illness and individual empowerment.

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Design - Language