

Making A Start

on Primary care Development

Information for health needs assessment in the Eastern region

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Introduction

The Primary Care Strategy sets out as one of the first steps in the implementation plan the carrying out by the individual health boards of needs assessments for primary care teams. Specifically:

“Health needs assessment is central to effective primary care and will be a continuous process. The coverage, composition and number of primary care teams in each health board area will be established on the basis of needs assessments consistent with a population health approach, to be initiated by the health boards. These assessments will conform with any guidelines or frameworks developed by the National Primary Care Task Force. They will take into account demographic factors, epidemiological factors, geographical considerations and existing health and social service provision. Needs assessments should specifically identify special needs or areas of disadvantage to ensure that primary care teams can be targeted to meet those needs.” (2001 Primary Care Strategy)

Nationally, a Needs Assessment working group was established by the CEOs, under the chairmanship of Dr Kevin Kelleher, to agree the framework for health needs assessment. Regionally, as part of the action plan to implement the Primary Care strategy a needs assessment group added to the process by contributing in particular to the consumer and local factors in this process. A Specialist in Public Health Medicine within the Directorate of Public Health collected most of the information centrally. The General Managers in community care and Primary care managers in each of the three Boards collected information on staffing and GP buildings locally.

The document brings together data from many sources. The aim is to facilitate understanding of health need and supply of health services in the Eastern region i.e. to understand the ‘big picture’. The audience that this document is aimed at is the professionals and managers planning for or delivering primary care services. It is envisaged that this document will be used in conjunction with ‘*Stepping Forward*’, the local needs assessment toolkit the purpose of which is to help primary care teams and networks use needs assessment to produce change at local level.

This document was produced largely in Jan 2003 and inevitably will not satisfy all wishes. In particular, further analysis of Census 2002 will become available and the data on human resources may have altered. Nevertheless, it should be useful document in most environments. Contact details for further information is siobhan.jennings@erha.ie

Report 1 Demography

Section 1 Characteristics of total population, age and gender of Eastern Region

Data Sources

- Central Statistics Office
- Health Information Unit, Dept. of Public Health, ERHA

Key Points

- The population of the ERHA is currently 1.4 million (Census 2002), an increase of 105,375 (8.1%) since 1996 and accounting for 36% of the national population.
- The SWAHB has seen an increase of 60,882 people (11.7%) since 1996 and is now the largest Health Board in the country. Smaller increases are noted in the NAHB 31,406 (6.9%) and ECAHB, 13,087 (4.1%).
- Counties Kildare (21.5%) and Wicklow (11.7%) have experienced most of the population growth between 1996 and 2002 with a smaller increase in Dublin.
- In Dublin, CCA 3, CCA 5 and CCA 6 have seen increases of 11,789 (10%), 15,485 (13.9%) and 17,473 (12.2%).
- In Kildare and CCA 9 there has been an increase of 30,969 (21%) the largest of any single CCA.
- Communities in these areas of population growth have many needs e.g. transport, education as well as health and social needs.
- The ERHA has a higher proportion of people aged 20-34 years and a lower proportion in the over 65 year age group than that seen nationally.
- Males outnumber females across all three Area Health Boards in the 0-19 age group.
- Females outnumber males across all three Area Health Boards in the 20+ age group particularly so after the age of 60 years.

Comment

There have been quite noticeable pockets of population expansion seen in the Eastern region since 1996 particularly so in Kildare and Wicklow affecting the South Western Area Health Board especially. Within Dublin itself the population expansion has been predominantly concentrated in CCA 3, 5 and 6 – the latter two being in the north west and south west parts of the city.

Age and sex breakdown from the 2002 census will not be available until mid 2003. The 1996 results indicate that the most noticeable difference between the ERHA and Ireland is that there are significantly more people in the 20-34 year age group and fewer people aged 60 years and over.

Tables and Figures

- See Table 1 and Table 2

- See Figure 1, Figure 2 and Figure 3

Table 1 Population changes in the ERHA 1996-2002

Geographical Area	Census 2002 Persons	Census 2002 Males	Census 2002 Female	Census 1996 Persons	Change 1996- 2002 Persons	Change 1996-2002 % Change
Northern Area Health Board	486,305	237,356	248,949	454,899	31,406	6.9
South Western Area Health Board	581,551	286,450	295,101	520,669	60,882	11.7
East Coast Area Health Board	333,458	159,496	173,962	320,371	13,087	4.1
Eastern Regional Health Authority	1,401,314	683,302	718,012	1,295,939	105,375	8.1
CCA1	128,443	60,650	67,793	127,146	1,297	1.0
CCA2	105,011	49,529	55,482	103,291	1,720	1.7
CCA3	130,185	62,805	67,380	118,396	11,789	10.0
CCA4	145,793	70,895	74,898	143,154	2,639	1.8
CCA5	126,863	62,521	64,342	111,378	15,485	13.9
CCA6	160,346	78,300	82,046	142,873	17,473	12.2
CCA7	122,154	58,856	63,298	118,550	3,604	3.0
CCA8	203,805	100,200	103,605	193,476	10,329	5.3
CCA9	178,710	90,229	88,481	147,741	30,969	21.0
CCA10	100,004	49,317	50,687	89,934	10,070	11.2

Table 2

Age and Gender of the ERHA Population (1996 Census)

Age Group	ECAHB Females	%	ECAHB Males	%	NAHB Females	%	NAHB Males	%	SWAHB Females	%	SWAHB Males	%	ERHA Total	%	Ireland	%
0 - 4	9,963	11.0	10,857	12.0	15,486	17.1	16,728	18.5	18,215	20.1	19,221	21.2	90,470	7.0%	250,394	6.9%
5 - 9	10,643	11.0	11,463	11.9	16,421	17.0	17,176	17.8	20,074	20.8	20,765	21.5	96,542	7.5%	282,943	7.8%
10 - 14	11,637	10.9	12,239	11.4	17,598	16.4	18,990	17.7	22,653	21.2	23,922	22.3	107,039	8.3%	326,087	9.0%
15 - 19	13,556	11.5	13,645	11.6	20,504	17.4	20,988	17.8	23,957	20.3	25,363	21.5	118,013	9.1%	339,536	9.4%
20 - 24	14,967	12.4	13,737	11.4	22,090	18.3	20,886	17.3	24,715	20.5	24,284	20.1	120,679	9.3%	293,354	8.1%
25 - 29	13,618	12.6	12,095	11.2	19,815	18.3	19,124	17.7	22,496	20.8	21,170	19.5	108,318	8.4%	259,045	7.1%
30 - 34	13,229	12.8	11,726	11.4	18,899	18.3	17,507	17.0	21,662	21.0	20,018	19.4	103,041	8.0%	260,929	7.2%
35 - 39	11,911	12.6	10,986	11.6	16,551	17.5	15,836	16.8	20,277	21.5	18,832	20.0	94,393	7.3%	255,676	7.1%
40 - 44	10,881	12.7	10,203	11.9	14,723	17.2	13,697	16.0	18,812	21.9	17,496	20.4	85,812	6.6%	240,441	6.6%
45 - 49	10,396	13.0	9,715	12.2	13,808	17.3	12,987	16.3	16,533	20.7	16,245	20.4	79,684	6.2%	225,400	6.2%
50 - 54	9,075	13.8	8,349	12.7	12,178	18.6	11,444	17.4	12,168	18.5	12,384	18.9	65,598	5.1%	186,647	5.1%
55 - 59	7,804	14.4	6,863	12.6	10,428	19.2	9,969	18.3	9,819	18.1	9,460	17.4	54,343	4.2%	153,807	4.2%
60 - 64	6,690	14.3	5,991	12.8	9,260	19.8	8,351	17.9	8,578	18.4	7,866	16.8	46,736	3.6%	137,946	3.8%
65 - 69	6,316	15.4	4,887	12.0	8,259	20.2	6,723	16.4	8,068	19.7	6,632	16.2	40,885	3.2%	126,809	3.5%
70 - 74	5,613	16.5	3,905	11.5	7,024	20.6	5,029	14.8	7,257	21.3	5,195	15.3	34,023	2.6%	112,542	3.1%
75 - 79	4,532	18.8	2,601	10.8	5,183	21.5	3,173	13.1	5,316	22.0	3,331	13.8	24,136	1.9%	84,097	2.3%
80 - 84	3,358	21.4	1,578	10.1	3,544	22.6	1,727	11.0	3,684	23.5	1,778	11.3	15,669	1.2%	55,771	1.5%
85+	2,764	26.2	930	8.8	2,557	24.2	865	8.2	2,578	24.4	864	8.2	10,558	0.8%	34,663	1.0%
Total	166,953	12.9	151,770	11.7	234,328	18.1	221,200	17.1	266,862	20.6	254,826	19.7	1,295,939	100.0 %	3,626,087	100.0

Figure 1 Age Profile of the ERHA Population (Census 1996)

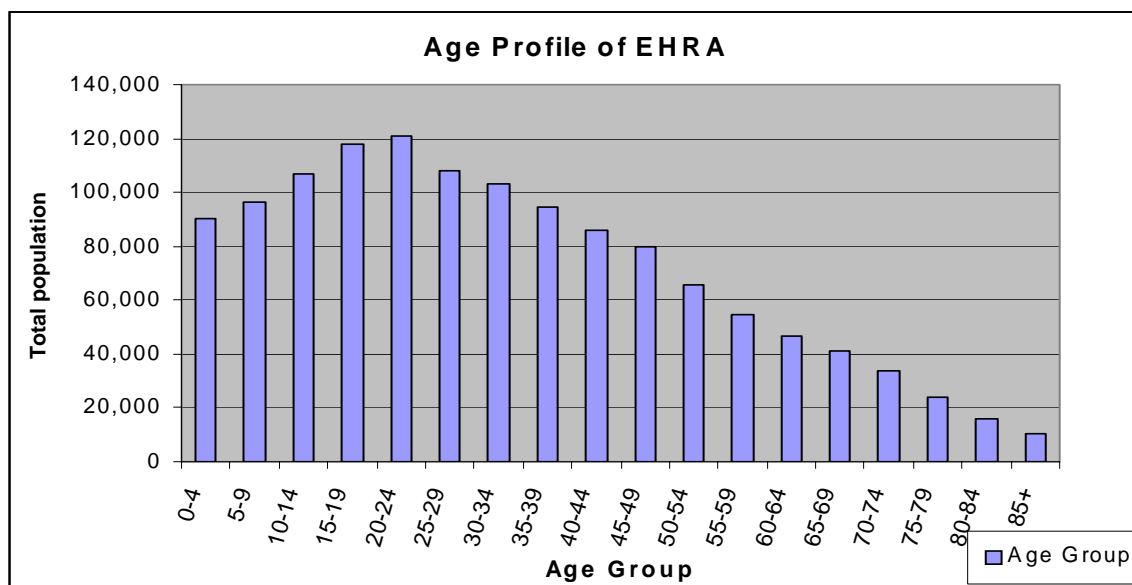


Figure 2 Age Profile of ERHA versus Ireland (Census 1996)

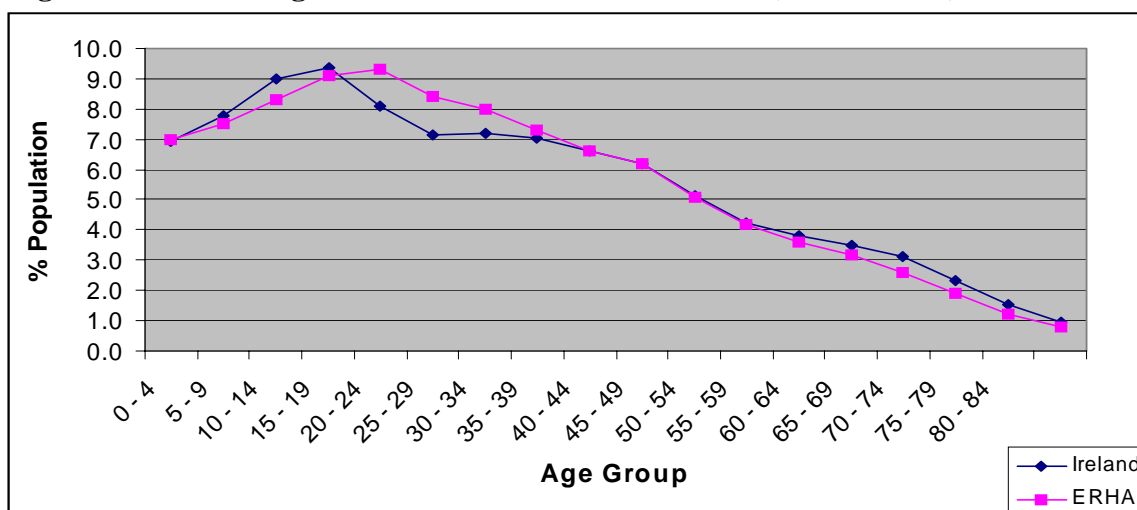
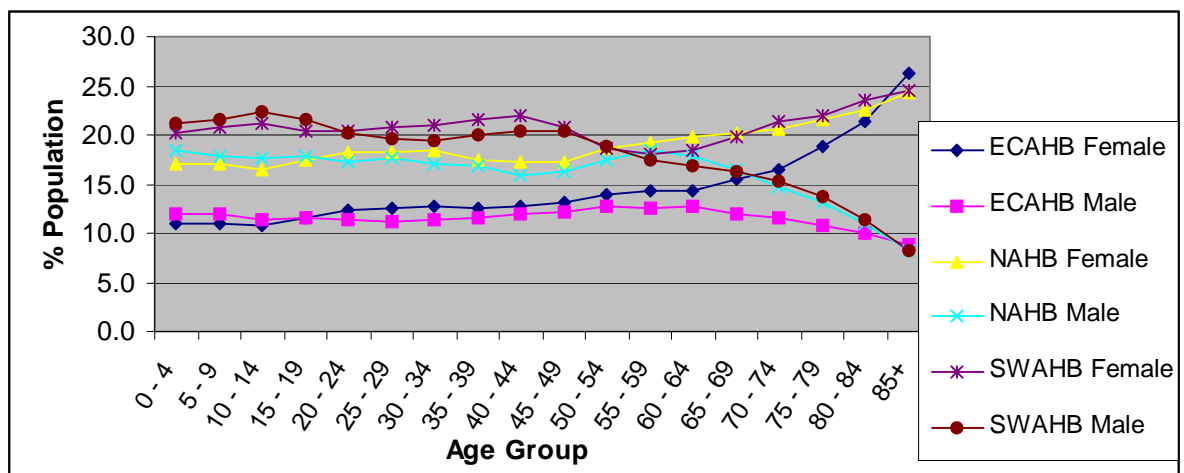


Figure 3 **Age Profile of Area Health Boards (Census, 1996)**



Section 2 Births

Data Sources

- Central Statistics Office
- Health Information Unit, Dept. of Public Health, EHRA

The crude birth rate is the number of births/population x 1,000

Key Points

- Crude birth rate in Dublin is falling slightly
- Actual numbers of births in **Dublin** residents (1996-2000) have risen by **6%**
- Crude birth rate in Kildare is rising
- Actual number of births in **Kildare** residents (1996-2000) have risen by **30%**
- Crude birth rate in Wicklow is stable
- Actual numbers of births in **Wicklow** residents (1996-2000) have risen by **20%**
- Information systems are not sensitive enough to determine the number of births to non-nationals.
- Approximately one third of all live births are to single/unmarried mothers. This is relatively unchanged since 1997.
- Births to teenage mothers (5.5%) have shown only a slight increase since 1997.
- The number and percentage of births to mothers over the age of 35 years has increased by 3% since 1997 to 21.6%.
- The proportion of preterm (5.3%) and low birth weight babies (5.0%) remained constant since 1997.
- Domicillary births represent a very small fraction of the total and have fluctuated around 100 each year.

Comment

The increase in the number of births seen in Dublin (6%) is close to that of national picture (7%). While Kildare (30%) is the only county to have had an increase in crude birth rates all counties have seen sizeable increases in the number of births in the space of five years. This places a considerable pressure on maternity and primary care services in the ERHA.

Regrettably, data on births by Area Health Board is not available.

Tables and figures

- See Table 3

Table 3 Number and Crude Birth Rates in the ERHA and Ireland

Dublin	1996	1997	1998	1999	2000	2001 *
No. births	15,453	16,085	16,529	16,289	16,392	15,598
Rate/1,000 pop	14.6	15.2	15.6	14.5	14.6	13.9
Kildare						
No. births	2,213	2,470	2,571	2,569	2,878	2,821
Rate/1,000 pop	16.4	18.3	19.0	15.7	17.5	17.2
Wicklow						
No. births	1,520	1,601	1,681	1,781	1,820	1,808
Rate/1,000 pop	14.8	15.6	16.4	15.5	15.9	15.8
ERHA						
No. births	19,186	20,156	20,781	20,639	21,090	20,227
Rate/1,000 pop	14.8	15.6	16.0	14.7	15.1	14.4
Ireland	50,655	52,775	53,551	53,354	54,239	57,882
Rate/1,000 pop	14	14.4	14.5	14.2	14.3	15.1

* Provisional numbers from the Central Statistics Office – final total for 2001 estimated at 21,600-21,900

Section 3 Population Projections

Data Sources

- ERHA 1996-2011 population projections - Health Information Unit, Department of Public Health, ERHA: Methodology used included a) natural increase plus the effect of a net inflow of ~ 10,000 into the area per annum 1996-2011, b) Total Fertility Ratio (TFR) of 1.75 (age-specific fertility rates) and c) Population & Labour Force Projections 2001-2031 applied to the age profile of immigrants, Population & Migration Estimates April 2000 (released 12 Sept 2000).

ERHA Data to be reviewed following publication of Regional Population Projections at Area Board Level

Key Points

- Over the 30 year period (1981-2011) the national population is projected to have increased by approximately 22%
- Over the 30 year period (1982-2011) the ERHA population is projected to have increased by 23% through natural increase alone, and between 31%-33% when migration flows from 1996 onwards are included
- Between 1996-2011 the ERHA area is projected to account for 30% of the increase in the national population through natural increase alone, and between 46%-50% when migration flows are included.
- The ERHA area accounted for 34.7% of the national population in 1981, 35.7% in 1996, and is projected to account for 35.0% of the national population by 2011 through natural increase alone, and approximately 37.5 % when migration flows are included.

The key changes in the individual age groups are as follows:

- The under 15 year population, after a period of marked decline between 1981-1996, is projected to increase again in the subsequent 15 year period (1996-2011) both nationally and in the ERHA area (at a much higher rate than nationally).
- The 15-44 year old population between 1996-2011 is projected to increase at a slower rate nationally (10% increase) than in the previous 15 year period (15% increase), whereas in the ERHA area, between 1996-2011 this age group is projected to increase by 3% when the effect of migration is not considered, and by between 13%-15% when migration flows are included, similar to the 15% of the previous 15 years.
- Marked increases have occurred in the 45-64 year age group both nationally and in the ERHA area between 1981-1996 (19% and 29% respectively). However, even greater increases are projected to occur between 1996-2011 both nationally (increasing by 42%) and in the ERHA area (39% through natural increase alone and between 46%-48% when migration flows are included). Over the 30 year period (1981-2011), this age group is projected to have increased by 70% nationally and in the ERHA area by 79% through natural increase, and approximately 90% when migration flows are included, making it the fastest growing age group.
- Between 1981 and 1996, the over 65 year age group increased in the ERHA area at a greater rate than nationally (23% and 12% respectively) with an increase of an

extra 24,000 persons approximately in the ERHA area. A similar increase in population is projected to occur in this age group between 1996-2011 in the ERHA area (between 25%-29%) involving a further 31,000 persons through natural increase alone and approximately 35,000 persons when migration flows are included.

- The over 75 year age group has increased markedly between 1981 and 1996 both nationally and in the ERHA area (32% and 39% respectively), and the age group is projected to increase at a slower rate between 1996-2011 (by 19% in both populations). In the ERHA area between 1981-1996 this age group increased by an extra 14,000 persons approximately, and between 1996 and 2011, it is projected to increase by a further 10,000 persons approximately.

Comment

Population projections are best estimates based on the balance between births and deaths, inward migration and emigration. This balance is constantly changing and population projections are used to aid planning and service development.

The population of the ERHA will increase. The population structure (males and females combined) of the ERHA area is projected to remain broadly similar to that of Ireland as a whole. A marked demographic “bulge” will continue to be present in the 15-44 age group both nationally and in the ERHA area, and will account for approximately 45% of both populations. The effect of this demographic bulge can be seen to be already moving into the 45-64 age group, and in later decades it is likely to have a dramatic effect on the actual numbers in older age groups with resultant consequences for health and social services.

Table and Figures

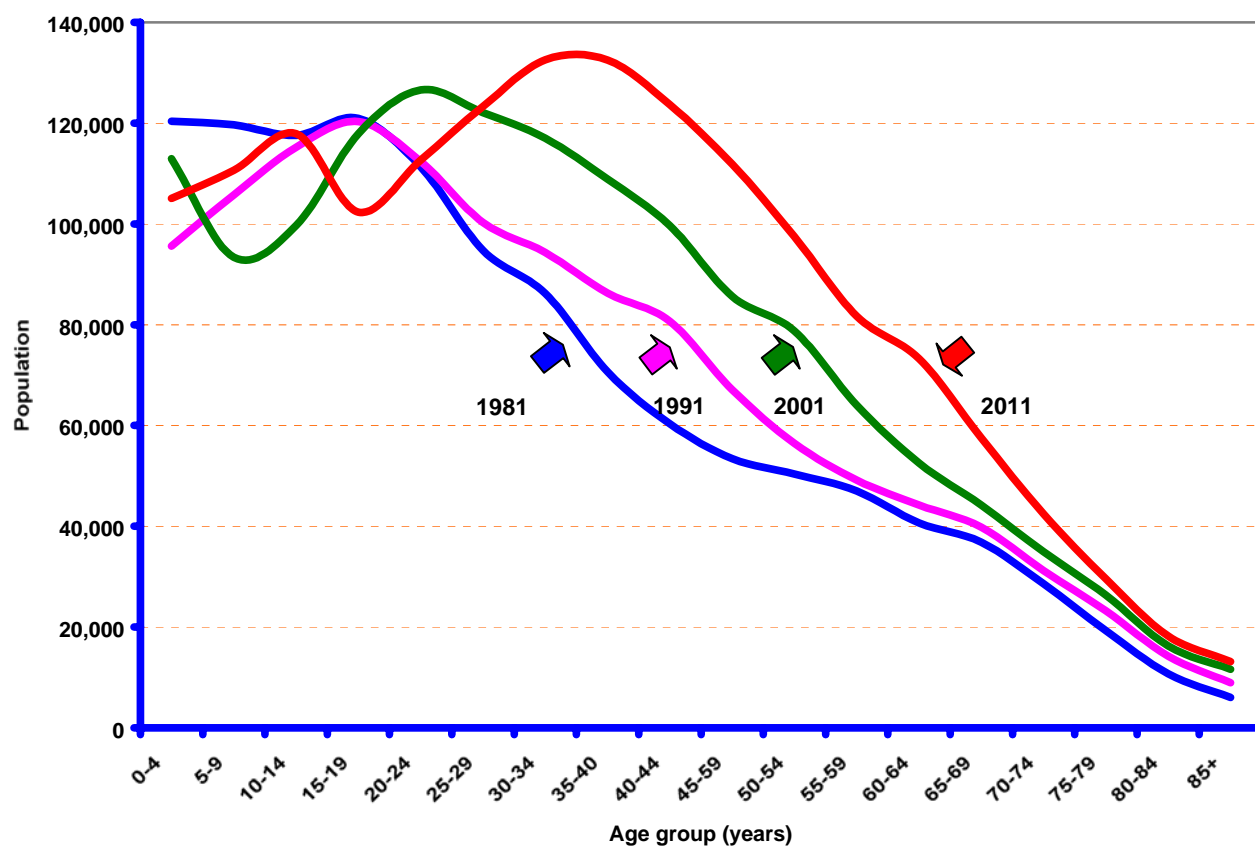
- See Table 4 and Table 5
- See Figure 4

Table 4 Population trends, 1991-2011, ERHA and Ireland (including a net migration inflow of ~ 10,000 per year 1996-2011 into the ERHA area)								
Population			Age group (years)					Total
			0-14	15-44	45-64	65+	75+	
	1991	ERHA	316,548	594,285	216,949	117,443	46,452	1,245,225
		Ireland	940,574	156,0562	621,683	402,900	162,823	3,525,719
	1996	ERHA	294,051	630,256	246,361	125,271	50,363	1,295,939
		Ireland	859,424	1,648,981	703,800	413,882	174,531	3,626,087
	2001	ERHA	306,035	692,099	280,942	133,392	54,243	1,412,468
		Ireland	828,134	1,771,550	806,330	427,697	186,761	3,833,711
	2006	ERHA	320,162	722,919	321,577	144,190	56,863	1,508,848
		Ireland	844,535	1,820,347	914,199	452,354	196,251	4,031,435
	2011	ERHA	333,612	727,171	364,279	160,953	60,991	1,586,015
		Ireland	877,543	1,816,327	1,003,490	503,821	207,440	4,201,181
Percentage	1991	ERHA	25.4	47.7	17.4	9.4	3.7	100.0
		Ireland	26.7	44.3	17.6	11.4	4.6	100.0
	1996	ERHA	22.7	48.6	19.0	9.7	3.9	100.0
		Ireland	23.7	45.5	19.4	11.4	4.8	100.0
	2001	ERHA	21.7	49.0	19.9	9.4	3.8	100.0
		Ireland	21.6	46.2	21.0	11.2	4.9	100.0
	2006	ERHA	21.2	47.9	21.3	9.6	3.8	100.0
		Ireland	20.9	45.2	22.7	11.2	4.9	100.0
	2011	ERHA	21.0	45.8	23.0	10.1	3.8	100.0
		Ireland	20.9	43.2	23.9	12.0	4.9	100.0
% Difference	1996-2011	ERHA	13.5	15.4	47.9	28.5	21.1	22.4
		Ireland	2.1	10.1	42.6	21.7	18.9	15.9

Table 5 Changes in population structure 1981-2011

1981-2011	Ireland	ERHA
Population	3.44 - 4.20m	1.20-1.59 m
% Change in Total Population	22% ↑	33% ↑
0-14 y	16% ↓	7% ↓
15-44 y	26% ↑	34% ↑
45-64 y	70% ↑	90% ↑
65+ y	37% ↑	59% ↑
75+ y	57% ↑	69% ↑

Figure 4. Population Structure ERHA, 1981-2011



Section 4 *Indices of Deprivation – Social class*

Data Sources

- Health Information Unit, Dept. Public Health, ERHA
- Central Statistics Office-Census 1996

Social class and GMS eligibility were the markers of deprivation used in this section. Regarding social class the entire population is divided into one of the following seven social class groups, which are defined on the basis of occupation; 1-Professional Workers, 2-Managerial and Technical, 3-Non-manual, 4-Skilled manual, 5-Semi-skilled, 6-Unskilled and 7-All others gainfully occupied and unknown. Census 1996 was used as 2002 census data will not be available until mid 2003.

Other markers of deprivation include the SAHRU Index, unemployment levels and where available educational attainment.

Key Points

- Levels of social class 1-3 are higher in the Eastern region compared with Ireland overall and those for social class 4-7 are lower making the region more affluent in general than the country as a whole.
- Within the ERHA the ECAHB is noticeably more affluent with a higher proportion of social classes 1 and 2 (42.9%) compared to the NAHB (26.4%), the SWAHB (26%) and Ireland (27.5%).
- While the region is more affluent as a whole, there are noticeable pockets of deprivation (when electoral wards, DEDs, are mapped) in inner city Dublin and those suburbs north of the city towards Finglas, Ballymun and Coolock and to the west of the city to Tallaght, Clondalkin and Ballyfermot.
- In Kildare there is a noticeable east west divide with west Kildare having high levels of deprivation.
- In Wicklow it is southern half of Wicklow that has the highest pockets of deprivation.

Comment

The link between poverty and health is well established. Poor people experience poor health. The data presented here clearly identifies where these people are. The ability to seriously address the area of inequalities in health depends upon the systematic identification of these inequalities and the willingness of the political system and health services to address them. Only then can resources and programmes be used to target the improvement of health and services to people with poorer socio-economic backgrounds and subgroups, which experience poorer health due to marginalisation or deprivation.

Tables and Figures

- See Table 6
- See Figure 5

Table 6 Percentage of Population by Social Class by Area Health Board and in Ireland

Social Class Group	ECAHB	NAHB	SWAHB	ERHA	Ireland
Higher professional/managerial	11.9	4.8	5.1	6.6	5.4
Lower professional/managerial	31.0	21.6	20.9	23.6	22.0
Other non-manual	18.7	20.7	19.7	19.8	18.4
Skilled manual	13.7	19.8	20.9	18.7	20.5
Semi-skilled manual	8.3	12.8	12.7	11.7	12.8
Unskilled manual	5.0	7.0	8.0	7.0	8.5
Unknown	11.6	13.2	12.5	12.5	12.4

Source: Census of Population, 1996

Social Class Distribution in the ERHA



Section 4 Indices of deprivation - General Medical Service coverage

Data Sources

- General Medical Services Payments Board

Persons who are unable, without undue hardship, to arrange general practitioner medical and surgical services for themselves and their dependants and all persons aged 70 years and over receive a free general medical service.

Key Points

- In Ireland, 1,199,033 (30.6%) are eligible for free general medical services
- In the ERHA, 353,710 (25.2%) are eligible for free general medical services
- Over forty two per cent of those eligible in the ERHA are aged 16-64
- Nearly thirty six per cent of those eligible in the ERHA are aged over 65 years
- Almost one third of those eligible in the ERHA are aged over 70 years
- Female eligibility outnumbers male in age groups 16-64, 65-69 and 70+

Comments

Levels of GMS eligibility in the Eastern region are lower than in the country as a whole. This fact concurs with the finding of greater affluence in the region based on social class.

There were discrepancies noted in the over 70s figures between the GMS Payments Board and the Central Statistics Office. In the 1996 census (most recently available age group data) there were 287,073 over 70s in Ireland. The GMS Payment Board figure as of September 2002 is 323,502 a difference of 36,429. Similarly the difference in the ERHA is 22,406 (106,792 versus 84,386). These discrepancies are currently under review.

Regrettably, no data on GMS eligibility are available at Area Health Board level.

Tables and Figures

- See Table 7

Table 7 Age and gender of GMS eligible population in the ERHA and Ireland

Age Group	No. Males	% Males	No. Females	% Females	ERHA Total	% ERHA Total	Ireland Total	% Ireland Total
0-15	41,005	51.2	39,075	48.8	80,080	22.6	255,265	21.3
16-64	60,664	40.8	88,107	59.2	148,771	42.1	553,162	46.1
65-69	7,304	40.7	10,763	59.3	18,067	5.1	67,104	5.6
70+	40,917	38.3	65,875	61.7	106,792	30.2	323,502	26.9
Total	149,890	42.4	203,820	57.6	353,710	100.0	1,199,033	100

Source: GMS Payments Board (September 2002)

Section 5 *Special groups*

(a) Travellers

Data Sources

- Central Statistics Office (Census, 1996)

Key Points

- The number of travellers per thousand population in the ERHA mirrors that seen in Ireland as a whole
- Within the ERHA, Dublin has the highest proportion of travellers with Wicklow and Kildare having similar proportions.
- Within Dublin the county boroughs of Fingal (1,108), South Dublin (1,081) and Dublin County (1,049) had the largest traveller populations in 1996.
- Using national data on age structure in Census 1996, 50% of travellers were aged less than 15 years compared with slightly less than a quarter for the population in general.
- Older travellers (>65yrs) accounted for just 1.3 per cent of the total Traveller population while the corresponding figure for the population in general was 11.4 per cent.
- The distinctive age structure of the Traveller Community results in a median age of 14 in 1996 compared with a national figure of 31.

Comment

The Traveller Community is at significant disadvantage in terms of health status. The Travellers Health Status Study demonstrated that life expectancy at birth for Traveller men was 9.9 years less than for settled men and 11.9 years less for Travellers women than for settled women. Implementation of the Travellers Health Strategy must be a priority.

Tables and Figures

- See Table 8 and table 9

Table 8 Number and Rate of Travellers in the ERHA (Census, 1996)

Area	Males	% Males	Females	% Females	Total	Travellers/1,000 population
Dublin	1,789	49.5	1,824	50.5	3,613	3.4
Kildare	118	47.6	130	52.4	248	1.8
Wicklow	100	52.4	91	47.6	191	1.9
ERHA Total	2,007	49.5	2,045	50.5	4,052	3.1
Ireland	5,511	50.6	5,380	49.4	10,891	3.0

Table 9 Age structure of the Traveller community compared with total population in the country (Census 1996)

	Travellers		Total population	
Age group	Number	(%)	Number	(%)
0 – 14 years	5,454	50.1	859,424	23.7
15 – 64 years	5,290	48.6	2,352,781	64.9
65 years plus	147	1.3	413,882	11.4
	10,891	100	3,626,087	100

Source: Health Statistics, 1999

(b)Physical and Sensory Disability

Data Sources

- Report of the National Physical and Sensory Disability Database Development Committee, 2001

It is important to realise that people with physical and sensory disabilities are a very heterogenous group. The term covers a wide variety of conditions and levels of disability. A person with a visual or hearing impairment has very different needs to a person with a physical disability. A major obstacle to the planning and development of appropriate services for people with physical and sensory disabilities is the continued absence of a national database.

The National Physical and Sensory Disability Database Development Committee was established in 1998. Its remit was to prepare detailed proposals for the development of a National and Physical Sensory Disability Database and to make recommendations for the content of regional datasets on the specialised health and personal social service need of those with a physical or sensory disability.

Key Points

- SWAHB (CCA4) was one of four pilot areas involved in a “dress rehearsal” for the national implementation of the Physical and Sensory Disability Database.
- Eight hundred and ninety one people (891) were identified in the SWAHB-CCA4 that met the registration criteria.

Comment

Regionally and nationally, there is no information as yet from the Physical and Sensory Disability Database.

(c) Intellectual Disability

Data sources

- National Intellectual Disability Database Annual Report, 2000, Health Research Board

The data collection method used by the National Intellectual Disability Database collates data on where a person receives treatment and does not seek information as to place of birth so it is not possible to compare prevalence in different areas for all age groups. However for individuals aged under 25 years the Health board with responsibility for providing services to that person is recorded and as this would generally be the health board in which the person was born the 0-19 age group can be compared with some confidence.

Key Points

- There were 26,760 people registered on the National Intellectual Disability Database in Ireland as of April 2000 of whom 8,420 (31.5%) were receiving services in the Eastern Region.
- Nationally, 34% are aged 0-19years, 30% are aged 20-34 years, 26% are aged between 35-54 years and 10% are 55 years and over. Age breakdown for the Eastern Region is not given.
- The distribution in the ERHA of mild, moderate, severe and profound disability generally mirrors that seen nationally.
- There is a general decrease in current numbers of those aged 0-19 in the moderate, severe and profound categories of intellectual disability both nationally and the ERHA
- Nationally, the total number of those more severely affected has risen from 11256 in 1974 to 14,741 in 2000 (an increase of 31%) and prevalence has risen from 3.80 per thousand to 4.06 per thousand over the same period. Of particular interest, from the point of view of service delivery, is that this increase in both numbers and prevalence is reflected in the adult population only.
- There is an ageing population in the moderate, severe and profound categories of intellectual disability both nationally and the ERHA

Comments

The data for 2000 was compared with the 1974 and 1981 Censuses of Mental Handicap, carried out by the Medico-Social Research Board. The trend that emerges indicates a distinct, changing age profile in the combined moderate, severe and profound category of disability over this period. There is a lower prevalence of and fewer number in childhood with an increased prevalence and increased number of people in the age groups over 20 years of age availing of or in need of intellectual disability services.

There is a population bulge, originating in the 1960's and lasting until the mid-1970's, currently moving through the intellectual disability services. The growth in numbers with intellectual disability during the 1960's and 1970's is attributed to a high birth rate and improved obstetric and paediatric care.

Consequently, with a population bulge moving through and contributing to the changing age structure as well as increased longevity there are significant implications for service provision; there is an increased demand for residential places; there are fewer places becoming free because of increased life expectancy; there is a need for therapeutic support services for people who continue to live with their families; an increased demand for more intensive services and for services designed specifically to meet the needs of older people with intellectual disability.

Tables and Figures

- See Table 10 and Table 11

Table 10 Degree of Intellectual Disability, ERHA and Ireland, 2000 (No. and %)

2000	Mild	Moderate	Severe	Profound	Not Verified	All levels
ERHA	3,038 (36.1%)	3,216 (38.2%)	1,263 (15%)	366 (4.3%)	537 (6.4%)	8,420 (100%)
Ireland	10,826 (40.5%)	9,612 (35.9%)	3,996 (14.9%)	1,133 (4.2%)	1,193 (4.2%)	26,760 (100%)

Table 11 National Intellectual Disability Database, Ireland 2000 (and Eastern Region)
Age breakdown of combined moderate, severe and profound disability.
Prevalence rates per 1,000

	Ireland			Eastern Region
Age Group	1974	1981	2000	2000
0 - 4	1.36	0.97	0.74	0.4
5 - 9	5.2	3.95	3.21	2.7
10 - 14	5.45	4.7	3.62	3.6
15 - 19	5.17	5.88	4.13	3.6
20 - 34	5.48	5.35	5.72	NA
35 - 54	3.46	3.53	5.21	NA
55 & over	1.71	1.51	2.38	NA

(d) Drug Misuse - Data from the Health Research Board

Data Sources

- Trends in Treated Drug Misuse in the Eastern Health Board Area **1996-1999**.
Drug Misuse Research Division, Health Research Board

The National Drug Treatment Reporting System (NDTRS) is based in the Drug Misuse Research Division in the Health Research Board. It is an epidemiological database on treated drug misuse. Data presented here refers to the most recent period for which data is available 1996-1999 and was collected prior to the establishment of the ERHA

Treatment is broadly defined as “any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their drug problems”. Treatment may therefore include non-medical (addiction counselling, group therapy, psychotherapy) as well as medical interventions (detoxification, methadone substitution programmes)

Key Points

- Between 1996 and 1999 the number of all clients presenting for treatment increased from 4,283 in 1996 to 5,380 in 1999
- Almost all those who received treatment in the EHB(98.6%) during 1999 were residents of the EHB
- There is a decreasing trend in the proportion of those treated for the first time (first contacts), 1,648 in 1996 to 1,255 in 1999
- The typical client coming for treatment is male, in his early twenties and living in the family home
- First time clients are younger with a higher proportion of adolescents
- The employment level among drug users is increasing although still very low in comparison to the general population
- Overall and in first time clients opiates are the primary drug of misuse
- There is an increasing trend in injecting heroin use
- Drug users presenting for treatment are likely to be involved in the use of more than one drug.

Comments

The increase in numbers presenting for treatment is partly due to an increase in service provision but also due to an actual increase in drug use. Treatment provision in the EHB is complex and in 1999 was provided by 56 agencies: 50 non-residential, 5 residential and 1 prison. Out of the total number of 5,380, 82% were treated at non-residential centres, 8% by General Practitioners and residential therapeutic communities accounted for 8%.

Tables and Figures

- See Table 12-17

Table 12 Number of all treatment contacts *by treatment area and area of residence 1996-1999

Year	Total treated in EHB	EHB residents treated in EHB	EHB residents treated elsewhere	Others treated in EHB	Total EHB residents treated
1996	4,283	4,173	36	110	4,209
1997	4,243	4,117	95	126	4,212
1998	5,155	5,050	92	105	5,142
1999	5,380	5,304	86	76	5,390

* Number of all clients receiving treatment during a given year

Table 13 Number of first treatment contacts* by treatment area and area of residence 1996-1999

Year	Total treated in EHB	EHB residents treated in EHB	EHB residents treated elsewhere	Others treated in EHB	Total EHB residents treated
1996	1,648	1,571	24	77	1,595
1997	1,169	1,108	27	61	1,135
1998	1,151	1,107	39	44	1,146
1999	1,255	1,220	38	35	1,258

*Number of people who received treatment for the first time ever during a given year

Table 14 Socio-demographic characteristics of all treatment contacts treated in the EHB 1996-1999

Characteristics	1996	1997	1998	1999
% Males : % Females	71:29	69:31	69:31	67:33
Mean Age (years)	24	24	25	26
Modal Age (years)	20	21	20	21
% Under 18 years of age	13	11	8	4
% Living with parents/family	70	67	67	62
% Early school leavers*	29	28	29	28
% Still at school	4	3	2	2
% Employed	9	13	18	26

* Left school before the age of 15 years

Table 15 Socio-demographic characteristics of first treatment contacts treated in the EHB 1996-1999

Characteristics	1996	1997	1998	1999
% Males : % Females	71:29	70:30	73:27	70:30
Mean Age (years)	21	22	22	24
Modal Age (years)	19	19	20	19
% Under 18 years of age	24	20	20	10
% Living with parents/family	78	75	73	68
% Early school leavers*	24	21	25	23
% Still at school	7	7	7	5
% Employed	12	18	22	30

* Left school before the age of 15 years

Table 16 Main Drug of Misuse of all treatment contacts treated in the EHB, 1996-1999

Main Drug of Misuse	No.	1996 (%)	No.	1997 (%)	No.	1998 (%)	No.	1999 (%)
Opiates	3,774	[88]	3,779	[89]	2,688	[91]	5,045	[94]
Cocaine	20	[0]	30	[1]	61	[1]	39	[1]
Ecstasy	125	[3]	92	[2]	50	[1]	59	[1]
Amphetamines	10	[0]	15	[0]	28	[1]	20	[0]
Benzodiazepines	42	[1]	37	[1]	58	[1]	27	[1]
Volatile Inhalants	14	[0]	14	[0]	17	[0]	8	[0]
Cannabis	275	[6]	245	[6]	225	[4]	169	[3]
Other Substances	16	[0]	18	[0]	15	[0]	13	[0]
Total	4,283		4,243		5,155		5,380	

Table 17 Main Drug of Misuse of first treatment contacts treated in the EHB, 1996-1999

Main Drug of Misuse	No.	1996 (%)	No.	1997 (%)	No.	1998 (%)	No.	1999 (%)
Opiates	1,307	[79]	905	[78]	899	[78]	1,056	[84]
Cocaine	14	[1]	15	[1]	26	[2]	18	[1]
Ecstasy	96	[6]	65	[6]	30	[3]	41	[3]
Amphetamines	6	[0]	10	[1]	16	[1]	15	[1]
Benzodiazepines	6	[0]	13	[1]	11	[1]	4	[0]
Volatile Inhalants	11	[1]	6	[1]	13	[1]	5	[0]
Cannabis	199	[12]	143	[12]	146	[13]	110	[9]
Other substances	7	[0]	9	[1]	7	[1]	6	[0]
Total	1,648		1,169		1,151		1,255	

e) Drug Misuse - Methadone treatment data

Data sources

- Central Methadone Treatment List (held in Trinity Court under the responsibility of the ERHA)

Key points

- 6145 people are currently on the treatment list as at September 2002 – this is close to the target set out in the strategy.
- The Health Boards with the most people on the treatment list are the SWAHB and the NAHB.
- Males outnumber females by over two to one except in the younger age groups especially in the NAHB.
- Methadone treatment is highest in the three age bands from 20 – 34 years.

Comment

The trend in this area is one of increasing numbers of people in treatment in line with the risk reduction approach in the strategy. There has been a parallel decrease in the numbers waiting for treatment.

Tables 18 - 19

Table 18 **Number of people on the methadone treatment list (Trinity Court, Dublin Sept 2002)**

Age Group	SWAHB			NAHB			ECAHB			Regional		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-14	0	0	0	0	0	0	0	0	0	0	0	0
15-19	30	23	53	19	19	38	8	5	13	57	47	104
20-24	421	267	688	299	239	538	92	44	136	812	550	1362
25-29	618	327	945	546	303	849	112	56	168	1276	686	1962
30-34	639	160	799	393	157	550	61	23	84	1093	340	1433
35-39	257	70	327	235	82	317	51	19	70	543	171	714
40-44	123	34	157	119	44	163	33	10	43	275	88	363
45+	86	15	101	61	10	71	30	5	35	177	30	207
	2174	896	3070	1672	854	2526	387	162	549	4233	1912	6145

Table 19 **% of People on the Methadone Treatment list in each Area Health Board**

Age Group	SWAHB	NAHB	ECAHB	Regional
	Total	Total	Total	Total
0-14	0.0%	0.0%	0.0%	0.0%
15-19	1.7%	1.5%	2.4%	1.7%
20-24	22.4%	21.3%	24.8%	22.2%
25-29	30.8%	33.6%	30.6%	31.9%
30-34	26.0%	21.8%	15.3%	23.3%
35-39	10.7%	12.5%	12.8%	11.6%
40-44	5.1%	6.5%	7.8%	5.9%
45+	3.3%	2.8%	6.4%	3.4%
	100%	100%	100%	100%

(f) Asylum Seekers

Data source

- Supplementary Welfare Allowance Payments System (ISTS) , Eastern Region Health Authority. Data correct on 27th Dec 2002.

Key Points

- 1,720 families made claims as asylum seekers for supplementary welfare allowance payments in the Eastern region as at December 27th, 2002.
- 1222 families (accounting for 1852 adults and children) were in receipt of direct provision of accommodation. 498 claimants (accounting for 1272 adults and children) were not in receipt of direct provision.
- Where families were in direct provision of accommodation, males outnumbered females by 1.3 : 1. 45% of claimants were under 20 years. The 1222 families had 490 child dependants.
- Where families were not in direct provision of accommodation, males outnumbered females by 1:7:1 and the claimants under 20 years constituted only 8% of that group. However, these families had 487 child dependants. The distribution across the region was NAHB 254 (51%), SWAHB 184 (37%) and ECAHB 60 (12%).
- Limitations of these data are
 - ◆ Data is collected following a successful claim and so may undercount asylum seekers who have recently arrived or made no claim.
 - ◆ As the purpose of the data collection is financial, use of the data as a demographic record of this group is very limited.
 - ◆ Human error may result in entry and coding problems such as denoting whether a claimant is an asylum seeker or not.
 - ◆ IN the case of direct provision of accommodation it is not possible to be clear on the distribution across area health boards.

(g) Homelessness

Data Sources

- Economic and Social Research Institute on behalf of the Homeless Agency, count carried out in 2002.

The assessment was based in Dublin. Questionnaires were returned on people using homeless services and/or on a local authority list as homeless during the last week in March 2002.

Homelessness is defined as those who are sleeping on the streets or in places not intended for night time accommodation or not providing safe protection from the elements or those whose usual night time residence is a public or private shelter, emergency lodging, B&B or such, providing protection from the elements but lacking the characteristics of a home and/or intended for a short stay.

Main Points

- There were 2,900 homeless adults in Dublin in 1999 and 2,920 in 2002.
- There were 990 homeless children (associated with the adults) in Dublin in 1999. This number rose to 1,140 in 2002, an increase of 15% in the three year period.
- Households with children have increased by 5% since 1999
- Single person households have decreased by 270 (6%) since 1999
- The majority of homeless adults are single men (70%) with an average age of 38 years
- There were 140 rough sleepers identified.

Comments

Homelessness continues to be a major issue in Irish society especially in the eastern region and seems to be concentrated in the Dublin City Council area. The figure of 2,920 represents 0.2% of the population served by the ERHA. After a decade of unprecedented economic growth in Ireland there are still people without shelter, warmth and the most basic of facilities. Particularly worrying is the rise in the number of children documented as homeless.

Tables and Figures

- See Table 20-22

Table 20 No. of homeless people in the 4 Local Authority Areas, Dublin, 2002

Local Authority Area	All Homeless People	% Homeless People
Dublin City Council	2590	89%
Dun Laoghaire/Rathdown County Council	140	5%
South Dublin County Council	130	4%
Fingal County Council	60	2%
Total	2920*	100%

*The total of 2,920 comprise 2,560 family units.

Table 21 Family circumstances of homeless adults in Dublin

Household	1999	2002
Single Person	2050	1780
Two Parent	120	220
Single Parent	420	420
Couple	100	140
Total	2690	2560

Single Person household = single person with no dependents
 Two parent household = couple with dependent child(ren)
 Single parent household = single parent with dependent child(ren)
 Couple = couple with no dependent child(ren)

Table 22 Count of Rough Sleepers – 21st March 2002

Dublin Local Authorities	No of Rough Sleepers Identified
Dublin City Council	79
Dun-Laoghaire/Rathdown	5
Fingal	6
South Dublin	50
Total	140

References

- Trends in Treated Drug Misuse in the Eastern Health Board Area 1996-1999. Occasional Paper No.8/2002. Drug Misuse Research Division. Health Research Board. Available at www.hrb.ie
- Census 2002 Preliminary Report. Department of Public Health, Health InformationUnit, Eastern Regional Health Authority, Dr. Steeven's Hospital, Dublin 8
- Fiona Mulvaney. Annual Report of the National Intellectual Disability Database Committee, 2000. Available at www.hrb.ie
- Pamela Gallagher. Report of the National Physical Sensory Disability Database Development Committee, 2001. Available at www.hrb.ie

Report 2 Density

Section 1 Population Density

Data Sources

- Prof Denis Pringle, Dept of Geography, National University Ireland, Maynooth

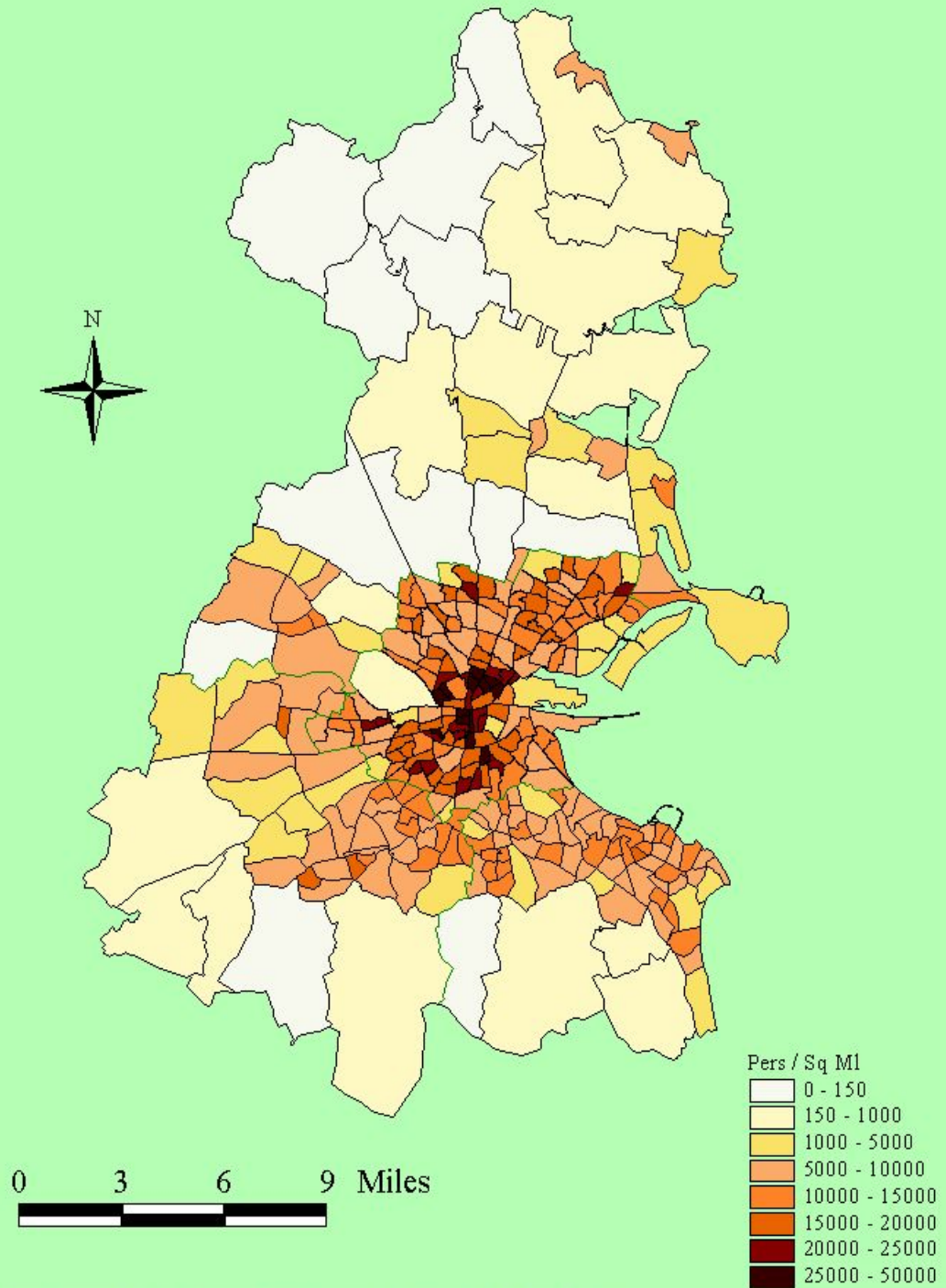
Key Points

- In the ECAHB the highest population density is immediately south of the city extending down the coast from Dun Laoghaire to Bray and Wicklow. Areas of low density are seen to the west of this coastal strip.
- In the NAHB the highest population density is in the north city centre extending to the inner suburbs of Finglas, Ballymun, Coolock. Other pockets of high density include the conurbations on the coast - Howth, Malahide, Skerries and Balbriggan. Notably, there are few areas of low density as seen in the other Boards.
- In the SWAHB the highest population density is that area immediately west and south west of the city. High population density extends further to Leixlip, Celbridge, Naas, Newbridge and Kildare. Areas of low density are to be seen along the coast and at the southern end of the Board's area.

Tables and Figures

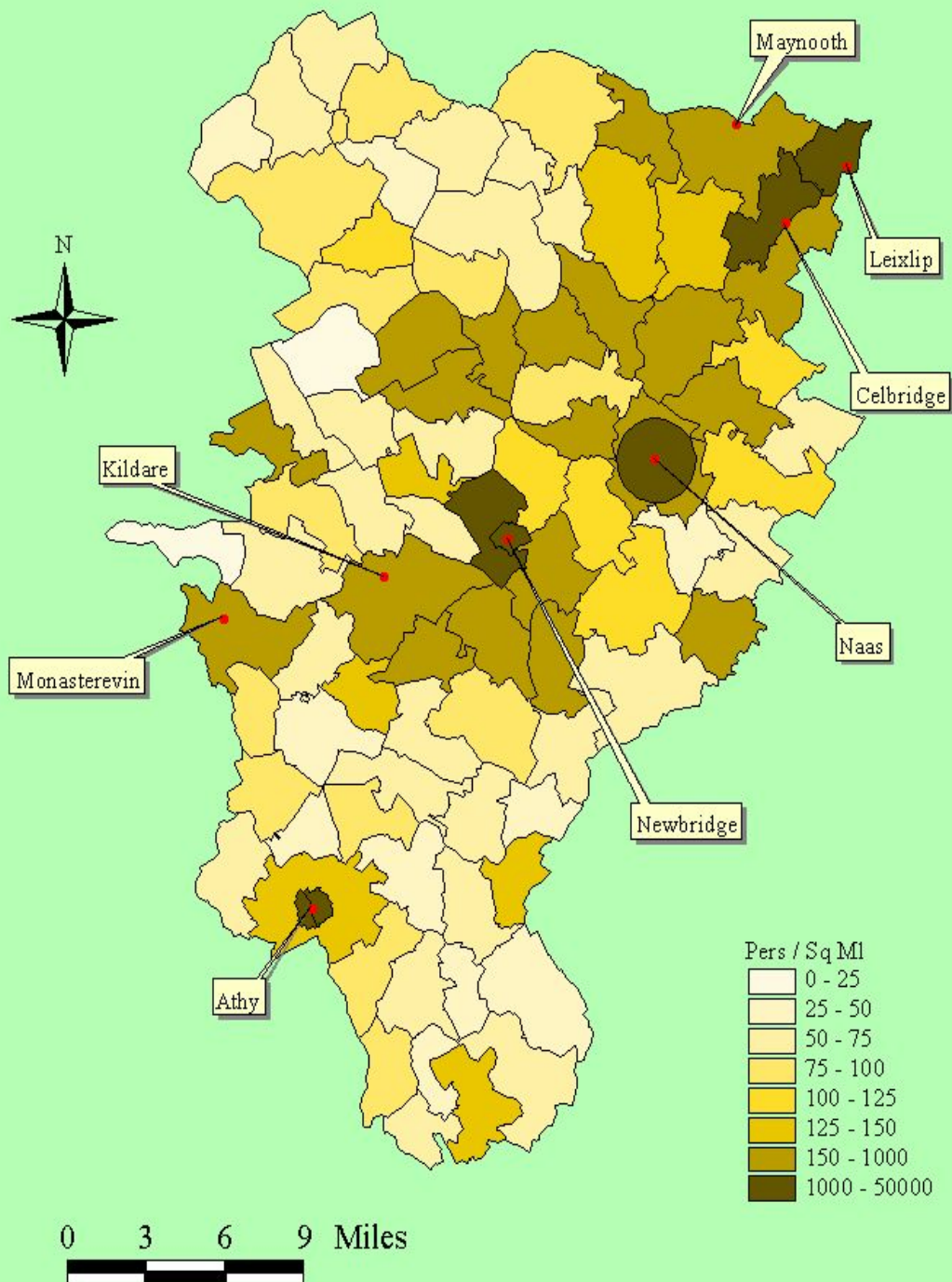
- Maps a) Counties of Dublin, Wicklow and Kildare
b) Area Health Boards - SWAHB, NAHB, ECAHB

County Dublin



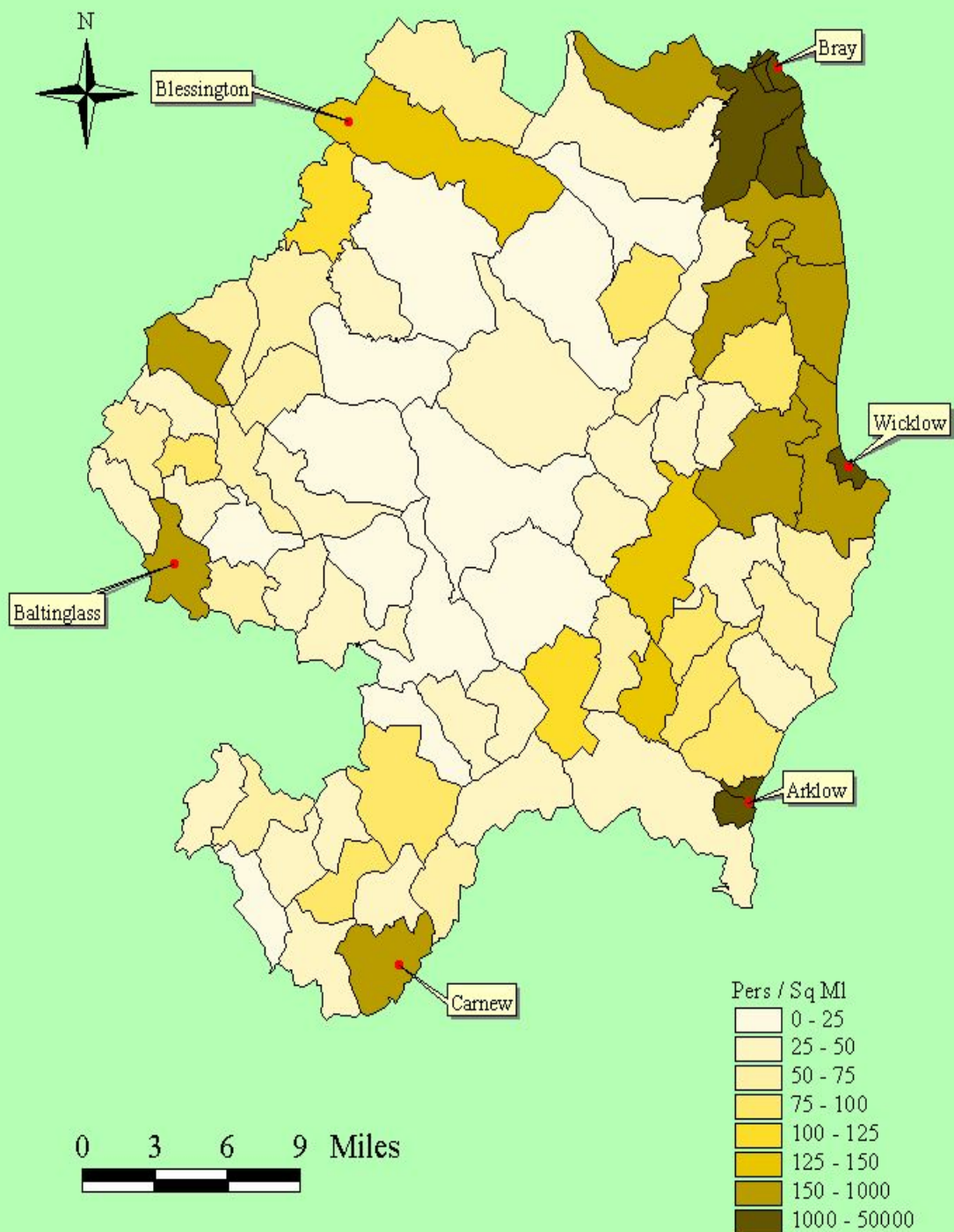
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County Kildare



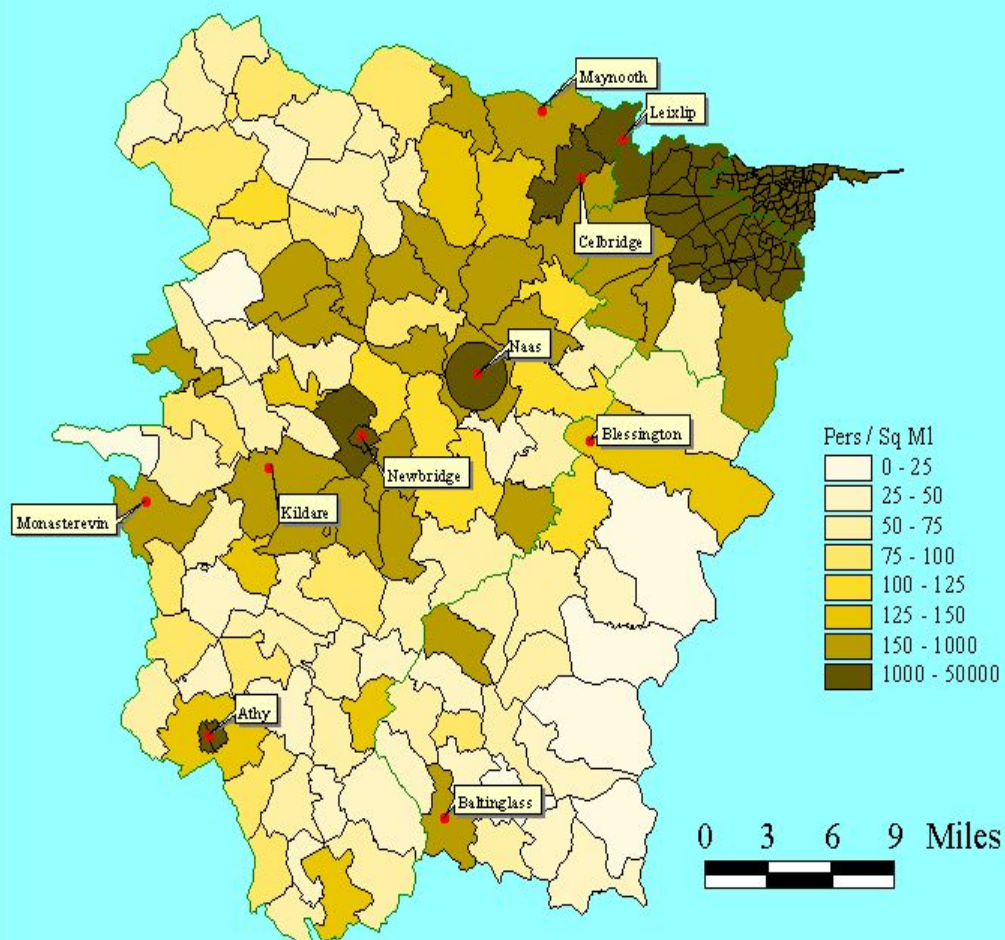
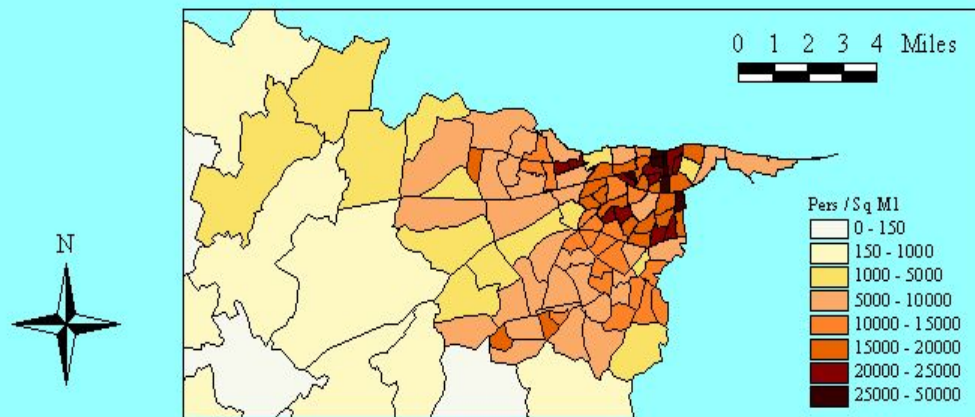
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County Wicklow



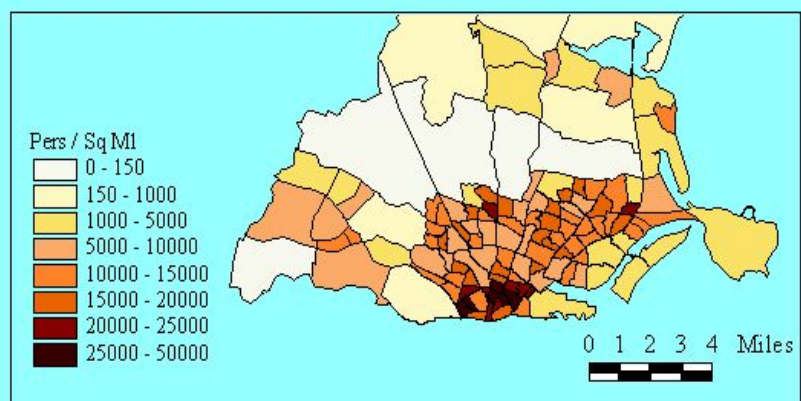
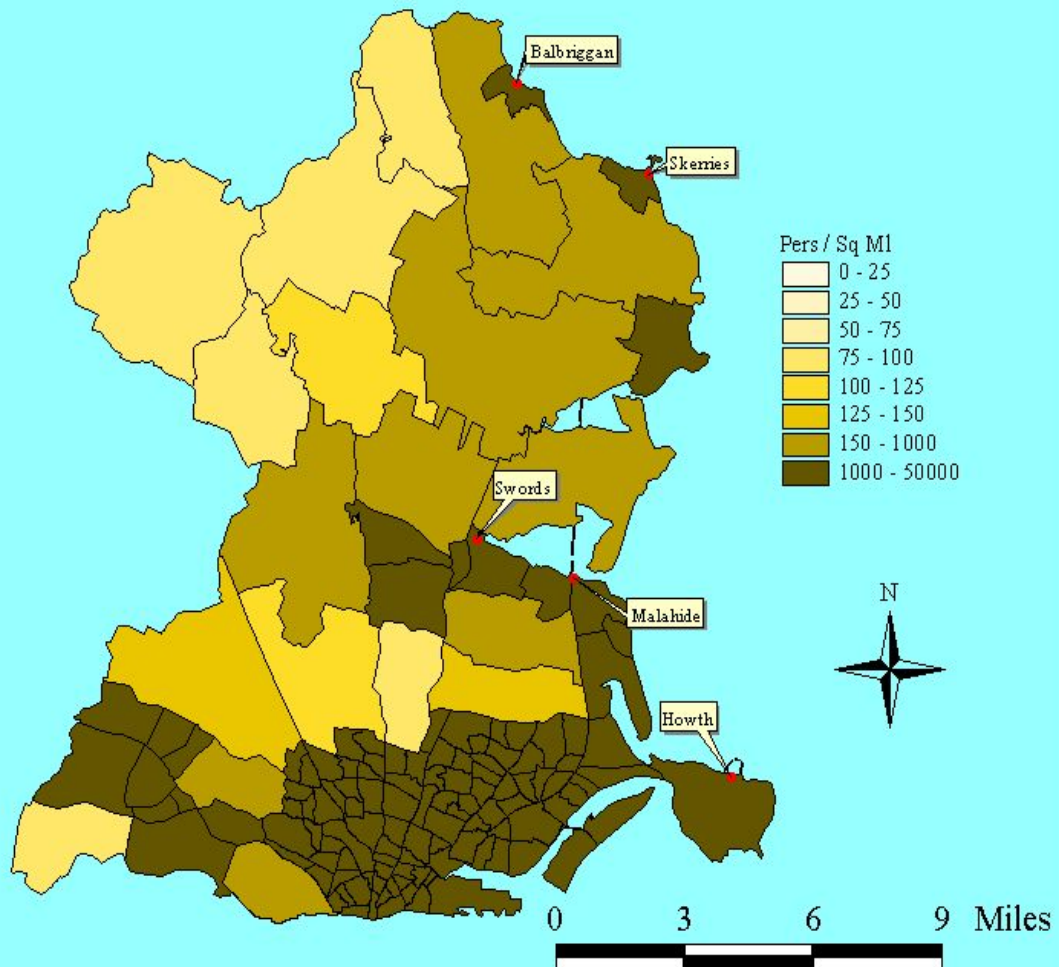
Data Sources: Ordnance Survey Ireland, Central Statistics Office

South West Area



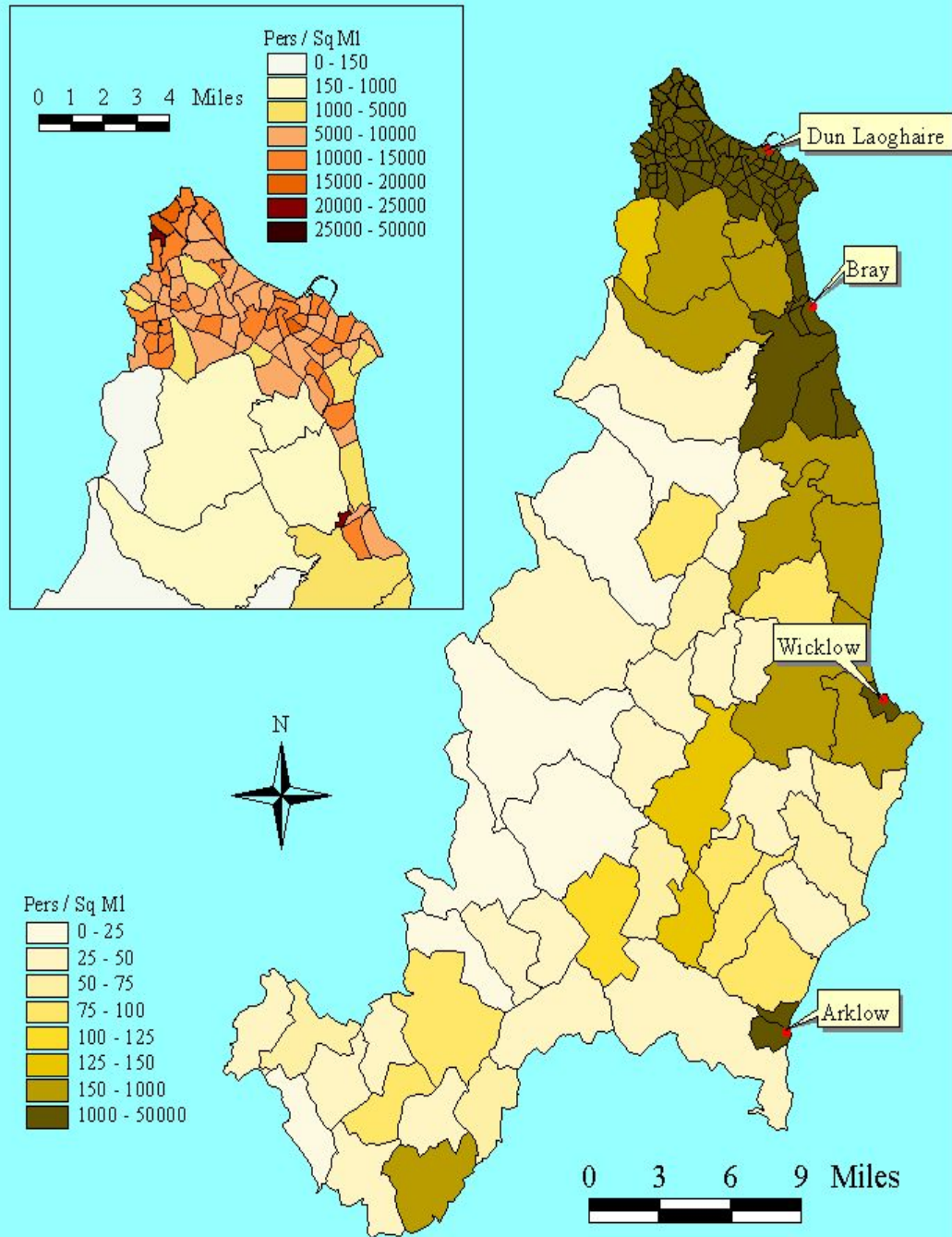
Data Sources: Ordnance Survey Ireland, Central Statistics Office

Northern Area



Data Sources: Ordnance Survey Ireland, Central Statistics Office

East Coast Area



Data Sources: Ordnance Survey Ireland, Central Statistics Office

Technical Notes

Data Sources

Locational Data

DED boundaries are based on data supplied by OSI.

Attribute Data

Data containing preliminary estimates of total population in each DED in 2002 were downloaded from the CSO web pages. These data also contained population counts for 1996. This was merged with data from the 1996 census, which in addition to containing population counts also contains estimates of the area of each DED.

Community Care Areas

Community Care Area boundaries were constructed using information provided on the DEDs within each Area.

Methodology

Locational Data

The OSI data were supplied in a non-topological format (DXF) so, although they could be used to locate the location of the DED boundaries, they had to be further processed to build the topology (i.e. create polygons to which attribute data could be joined). Having created the polygons, it was then necessary to identify which polygon corresponds to each DED. Given that the number of polygons does not match the number of DEDs for which attribute data are available from the CSO, this is more problematic than it might appear. A number of topological inaccuracies in the OSI data were also corrected.

A unique identifier was created for each DED in the country based on the county number code (1st two digits) and DED number code (last 3 digits) used by the CSO to identify counties and DEDs. This enables the attribute data to be joined to the polygons.

Attribute Data

The number of DEDs recognised by the CSO does not correspond with the number of DEDs as mapped by OSI. It also varies from one census to the next, mainly due to the division by the CSO of some rural DEDs on the edge of towns into separate rural and suburban areas, and the merger of adjacent DEDs with low populations to form a larger unit to preserve confidentiality of individual respondents. It was therefore necessary to identify a set of common DEDs which could be used for mapping purposes. It was decided to standardise, as far as possible, on the 'official' set of DEDs mapped by OSI as the location of the boundaries 'revised' by the CSO is unknown.

Given that the 1996 census data contains an estimate of the area of each DED, it is desirable to use these areas to calculate accurate estimates of the population density in 2002. Given that the 2002 census contains population estimates for some towns plus their 'environs', where the 'environs' in question form part of an adjoining DED, it was desirable where possible to reassign the population in environs to the adjoining DED to facilitate accurate population densities to be estimated for both 'urban' and 'rural' DEDs. The 'rural' DEDs in such instances will tend to have relatively high population densities because they include a suburban population.

Unfortunately, it was not possible to do this in all instances because the area estimates provided in the 1996 census refer in some instances to the town and environs combined, and therefore it was not possible to reassign the suburban populations to

their correct DED. In such instances, the population density for 2002 was estimated for the town plus its environs on the assumption that the area had remained unchanged since 1996. Given that the spatial location of the ‘environs’ is unknown, the boundaries of the official DED were used as an approximation for mapping purposes. The net effect in such instances is that the spatial extent of the high density area is likely to be underestimated on the map, and the differences in density between the urban area and the surrounding rural areas is likely to be sharper than they would be if the suburban population had been reassigned to the adjoining rural areas. Appendix A lists the towns affected..

Joining Locational And Attribute Data

The second step was to compare the 1996 CSO DEDs with those for which locational data were available from OSI, to produce a set of common areas. This required editing of some boundaries between DEDs.

Details of both steps are listed in Appendix A.

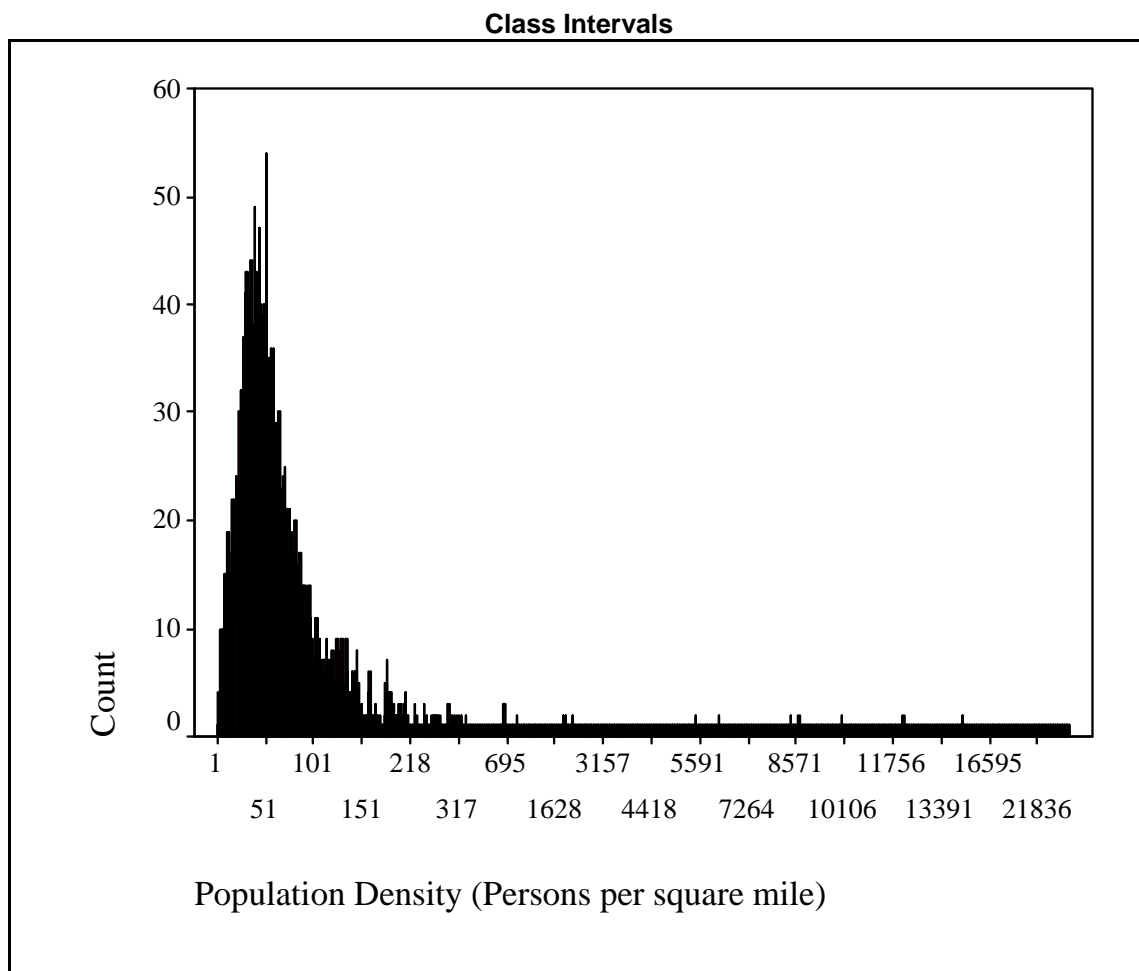


Figure 1. Frequency Distribution of Population Densities By DED

It was decided that it use a standard set of class intervals, with a standard set of colours, for all maps. This facilitates easy comparisons between maps. The alternative – to use a different set of class intervals for each map – could result in an areas having a comparatively high population density within a map depicting a CCA with a low overall population density appearing to have a higher population density than middle-ranked areas within a CCA with a high overall population density on a different map, even though the latter may actually have a higher population density.

Population densities range from little more than 1 person per square mile (Sheskin DED, Co. Mayo) to 44,207 persons per square mile (Rotunda A Ward, in Dublin's North Inner City). A bar chart (Figure 1) shows that the distribution is highly skewed, and that most DEDs have population densities in the 1-150 range, with a mode of about 50. However, a histogram of the logarithm of the population densities (Figure 2) reveals a bimodal distribution. One peak corresponds to the predominantly rural DEDs with a population density of less than 150 persons per square mile, whilst the other corresponds to predominantly urban DEDs with a population density of more than 1,000 persons per square (i.e. log value of 3). Given that rural DEDs tend to dominate the visual impression created by the maps, because they are more numerous and are normally larger in area than urban DEDs, it was decided after some experimentation to divide the rural 'clump' into six equal sized classes (i.e. 0-25, 25-50, 50-70, 75-100, 100-125 and 125-150). Values greater than 150 were originally grouped within a single 'urban' category, but this failed to distinguish between high density 'rural' areas in the commuter zones and true urban areas. The residual category was therefore split into two: a 'semi-urban' category (150-1,000) and a true 'urban' category (>1,000).

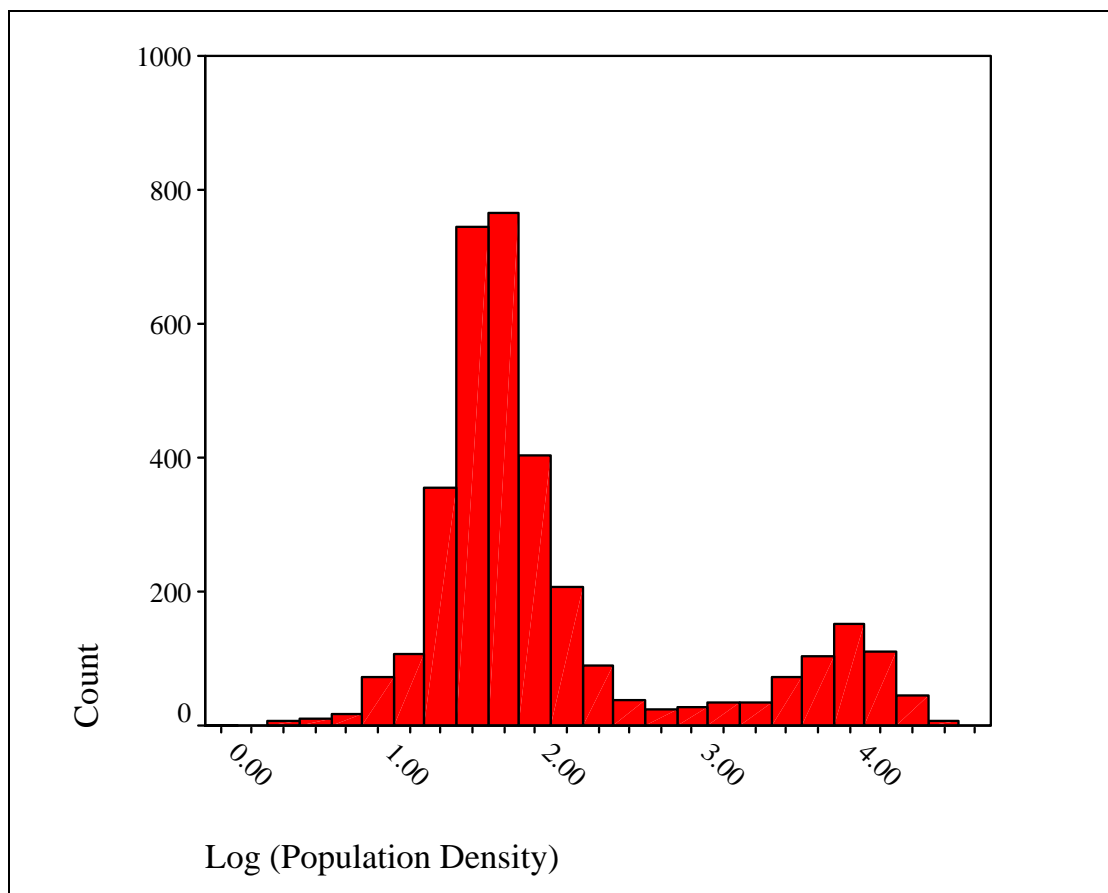


Figure 2. Frequency Distribution of Log Population Density BY DED.

These categories would appear to work fairly well for most CCAs. However, they fail to differentiate between high and low density wards within the major urban areas. It was therefore decided to create a second standard set of class intervals which could be used to display more detail within the major urban areas in inset maps. This retained a 150-1000 category for 'semi-urban' areas, after which the class boundaries were set at equal intervals of 5,000 up to 25,000. Areas with a density of more than 25,000 per square were grouped into a single category.

Colour Schemes Etc.

Two sets of tones were defined for the two sets of class intervals. Layout templates were defined for landscape and portrait page shapes. Labels must be applied manually. All fonts were standardised as Time New Roman. Town names were set to 10 point. The dots for towns are red tone 3, 8 point. DED boundaries were set to 01, counties to 0.5 and area outline to 1.0.

Output Formats

The printed maps were created using ArcView. Digital copies of the maps were saved as jpeg (.jpg) files. These should display within any graphics application or any web browser, but may appear slightly 'chunky' at high magnification. The maps were also saved as encapsulated postscript (.eps) files. If a colour postscript printer is available then these may produce better quality hard copy.

Report 3

Health Status

Section 1 Summary

- The purpose of this chapter is to summarise currently available data on the health status of the population of the region. These data are crucial in determining need and are invaluable in informing the commissioning of services required for health and social gain.
- This report is not an exhaustive account. Further information with regard to health status is contained in Public Health in the Eastern Region, Report of the Department of Public Health 2001 along with previous reports from the department and other relevant reports.
- Where possible data is presented at Area Health Board level (or occasionally at community care/service area)
- Relevant comparisons are made between parts of the region and with the national situation or the European Union averages where possible.
- A key issue highlighted in the Health Strategy (Quality and Fairness) is that of health inequality and this is noted in the last section.
- The Eastern region has poor health as evidenced by mortality rates compared with EU averages. This is especially true for premature mortality from cardiovascular disease, cancers, suicide and road traffic accidents.
- Life expectancy at birth has increased for Irish men and women but is still considerably less than our EU partners. Life expectancy at older ages has not increased significantly.
- Mortality patterns differ across the region
- Hospital usage is increasing due to a variety of factors such as the ageing population, increase in chronic diseases, medical technology and increasing patient expectations.
- Birth numbers have increased in recent years though the birth rate is falling slightly. In addition there has been a huge increase in the number of births to non-nationals with different cultural norms and health care requirements to the Irish population.

- Inequalities in health status have been identified within the Eastern Region. Large parts of the north and south inner city, which have high level of deprivation also have high levels of heart disease. Similarly eastern and western inner city deprived areas show some of the highest levels of lung cancer.
- Drug abuse continues to be a significant concern.
- Mental health needs are of concern. This section gives only an introductory, broad overview.
- Infectious diseases have not gone away. Of major concern is a syphilis outbreak among men who have sex with men.
- Immunisation rates have dropped to a worryingly low level and the consequent emergence of vaccine preventable diseases mainly measles.

Section 2 Overview of mortality in the region

Data sources

- Public Health information System (PHIS version 4), Department of Health & Children
- Mortality in the Eastern Region, 1994-1998, Department of Public Health, ERHA
- Inequalities in Mortality, 1989-1998, A report on All-Ireland mortality data

Key Points

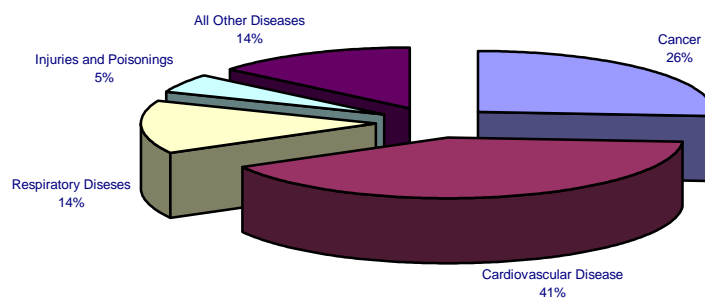
- Mortality rates in the Eastern Region are lower than Ireland overall but compared poorly with the EU average
- The principal causes of death in the Eastern Region are similar to the national picture and are circulatory diseases (notably Ischaemic Heart Disease), cancer and injury.
- One-quarter (25 %) of all deaths are premature, i.e. deaths under 65 years of age with almost 20% of heart disease deaths being premature, as are 31% of cancer deaths and 73% of deaths from injury.
- There are over 600 lung cancer deaths per year in the region. At least 500 of these could be prevented if people did not smoke. Smoking prevention is a major priority in the region.
- The rate of deaths and injury from road traffic accidents continue at an unacceptably high rate. A total of 448 deaths occurred in the region between 1997 and 2000 and 83.5% of these were aged less than 65 years. The main causative factors are speeding, alcohol and drugs, non-compliance with the wearing of seat belts. The recent introduction of a penalty points system should result in a reduction in road accidents. However, attention is now urgently needed to address the high prevalence of drink driving in Ireland.
- Nationally 413 suicides were reported in 2000 and 132 (32%) of these were in the Eastern Region. Although the region has lower suicide rates than other parts of the country, suicide is a major concern and a significant and avoidable cause of premature mortality.

- Death rates are not equal across the region.
 - For all cause mortality, the Northern Area and the South Western area differ from the region as a whole by having significantly higher mortality. Conversely, the East Coast area has significantly lower mortality.
 - In terms of specific causes of death, the East Coast area has significantly lower mortality than the region as a whole for all categories of disease with the exception of cerebrovascular disease mortality which is lower but not significantly so.
 - In terms of specific causes of death, the Northern Area differs from the region as a whole in the following ways: (a) the all cancer category shows significantly higher mortality and this is mainly due to lung cancer in females (b) while circulatory disease mortality as a whole is not significantly higher, ischaemic heart disease mortality in males is significantly higher and cerebrovascular disease mortality in females is significantly lower.
 - In terms of specific causes of death, the South Western area has significantly higher mortality than the region as a whole for all major disease categories except injuries and poisonings. With regard to gender, the following points are noted: (a) cancer is significantly higher only in males and this is largely due to lung cancer (b) while ischaemic heart disease, cerebrovascular disease and respiratory disease are each significantly higher overall, the difference is not significantly higher in either males or females.
- People in the lower socio-economic groups have higher premature mortality rates.

Table 1

Age standardised mortality rates in the Eastern Region, Ireland and EU, 1996			
Age standardised mortality rate/100,000 population	Eastern Region	Ireland	EU average
	832	853	719

Fig. 1 Principal Causes of Death, 1995-1999, ERHA, All Ages

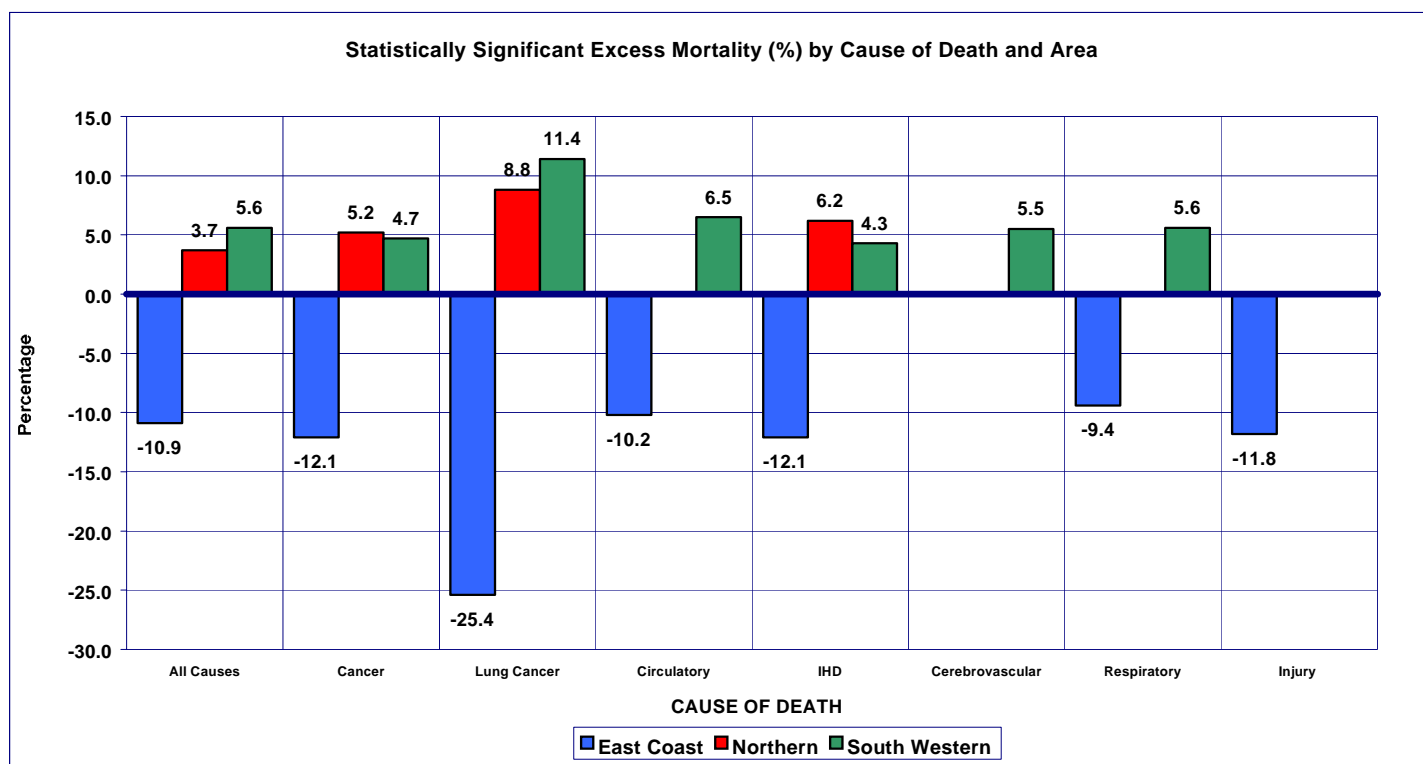


Source: PHIS version 4

Table 2: Premature Deaths in the Eastern Region from major causes, 1997-2000

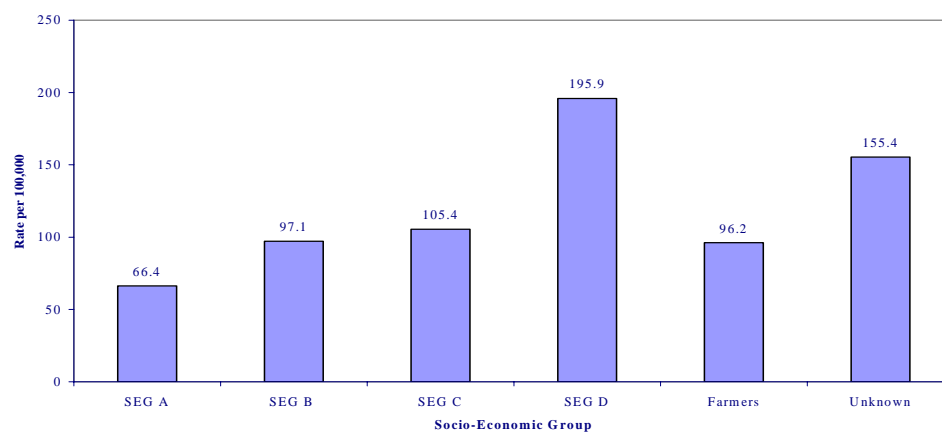
1997-2000	Total Deaths Number	Premature Deaths Number	Premature Deaths % Total
All causes	38,759	9,624	24.8
All circulatory disease	15,428	2,453	15.9
Ischaemic Heart Disease	7,973	1,491	18.7
Cancer	10,156	3,199	31.5
Injury & Poisoning	1,835	1,338	72.9

Fig. 2 Mortality by Area Health Board



**Fig. 3 Annual Directly Standardised Mortality Rates (per 100,000)
for IHD in Working Age Males, by Occupational Class, Republic of
Ireland**

Source: Inequalities in mortality report.



Section 3 Mortality in infancy

Data sources

- Health Statistics, Department of Health and Children. 1999

Key points

- The Infant Mortality Rate (IMR) is an important indicator of health status.
- Considerable improvements have been achieved in the IMR in Ireland and in the Eastern Region over the last 20 years. None the less, the latest data show that Ireland and the Eastern Region lag behind the EU average for IMR with little difference between the two Irish statistics.
- Perinatal mortality rates have also improved over the last two decades. However, the latest international data show that perinatal mortality in Ireland (10.6 per 1000 live and still births) lags behind the EU average (7.7 per 1000 live and still births). The perinatal mortality rate for 1998 in the Eastern Region was 9.7 deaths per 1000 live and still births and is amongst the lowest in the country.

Table 3 Infant Mortality Rate (IMR) for selected years – Eastern Region, Ireland and EU average

<i>Year</i>	<i>Eastern Region</i>	<i>Ireland</i>	<i>EU average</i>
1980	11.87	11.09	NA
1985	8.8	8.85	NA
1990	7.74	8.18	NA
1995	6.56	6.37	5.6
1999	5.42	5.49	NA

Source: Health Statistics, Department of Health and Children. 1999

Section 4 Life Expectancy

Data sources

- Central Statistics Office, Sept 2001

Key points

- In Ireland, life expectancy at birth has increased by 6.9% for men and by 7.5% for women since 1970 (Table 5). This is mainly due to a reduction in death from infectious diseases and accidents in childhood. However life expectancy in older age groups has not improved significantly reflecting the high death rates from cancer and cardiovascular disease. Further improvements can be made in this area.
- Certain disadvantaged groups within this country have lower life expectancy than the average, for example, the life expectancy of Irish travelling women is twelve years shorter than Irish women generally. Such inequities need to be addressed.

Table 4 Life Expectancy at Birth – Ireland and the EU

Life Expectancy in years (trends at birth)	Ireland	EU
<i>Females</i>		
1970-72	73.5	-
1980-82	75.6	77.1
1990-92	77.9	79.4
1995-97*	78.8	80.5
<i>Males</i>		
1970-72	68.8	-
1980-82	70.1	70.5
1990-92	72.3	72.8
1995-7*	73.2	74.0

*Latest data from CSO September 2001

Section 5 Heart Health

Data Sources

- Public Health information System (PHIS version 4), Department of Health & Children
- Mortality in the Eastern Region, 1994-1998, Department of Public Health, ERHA
- Heart Health Action Plan, ERHA

Key Points

- Ireland has the highest premature mortality rate per 100,000 population from heart disease in the EU. While the region has a significantly lower mortality rate than the national average, it lags considerably behind the EU average.
- While deaths from heart disease are declining in the region, one-quarter of all deaths are caused by heart disease.
- Inequality in mortality from heart disease exists in the region:
 - a) Males are twice as likely to die from heart disease than females,
 - b) The Northern Area Health Board and the South Western Area Health Board have significantly higher levels of mortality from ischaemic heart disease whereas the East Coast Area Health Board has the lowest levels of IHD mortality. Within these areas, Kildare and some parts of Dublin have higher mortality rates than the region as a whole,
 - c) A national study shows that males in the lowest socio economic group have significantly higher death rates from heart disease than males in the highest socio economic group. (*Inequalities in Health in Ireland: Hard Facts, Department of Community Health and General Practice, Trinity College, 2001*) This is likely to be similar in the Eastern region.
- While death rates from heart disease are declining, hospital discharges are slightly increasing. This is, undoubtedly, due to the changing nature of the disease to that of a chronic one and to the effect of an ageing population. Residents of

the region are more likely to receive certain interventions (e.g. Angioplasty) but have a similar chance of receiving surgery (Coronary Artery By-pass Grafting) compared with the national population.

- Targeting effective interventions at areas of lower social class is an important factor in reducing inequity in the incidence of heart disease. A multisectoral approach is essential.
- The Cardiovascular Health Steering Group has recently agreed a five year *Heart Health Action Plan* for structuring the implementation of *Building Healthier Hearts*.

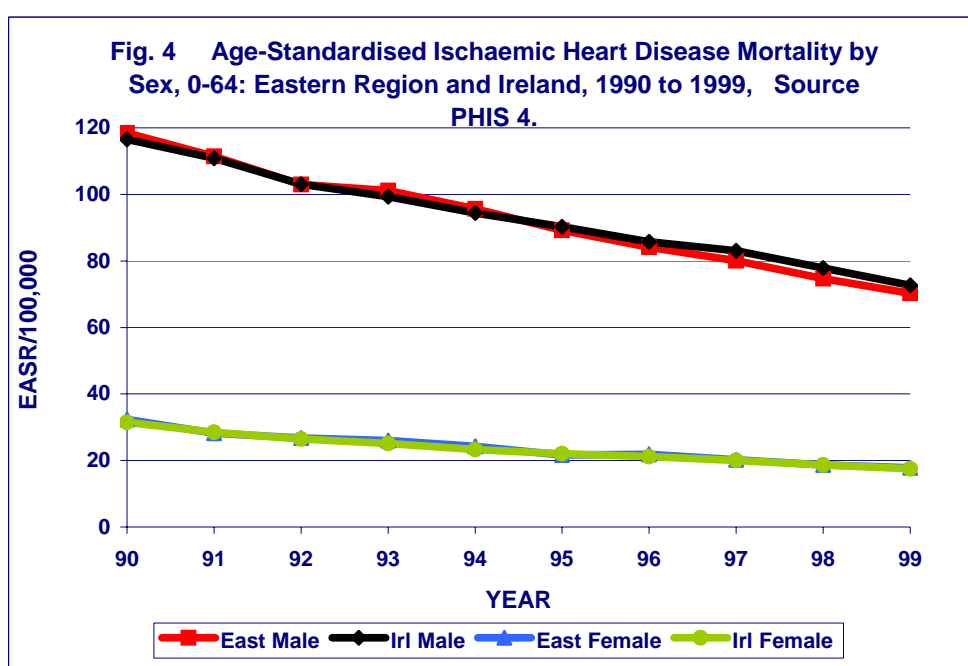
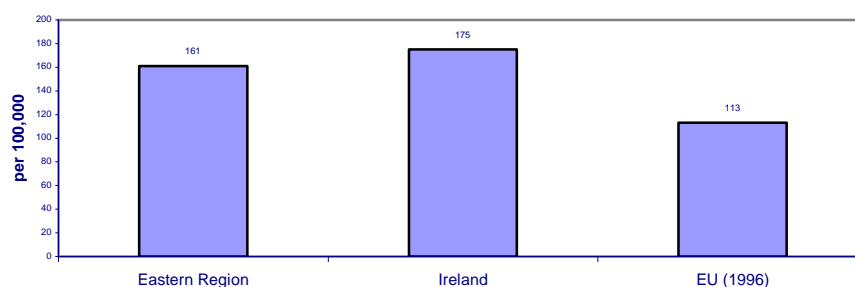
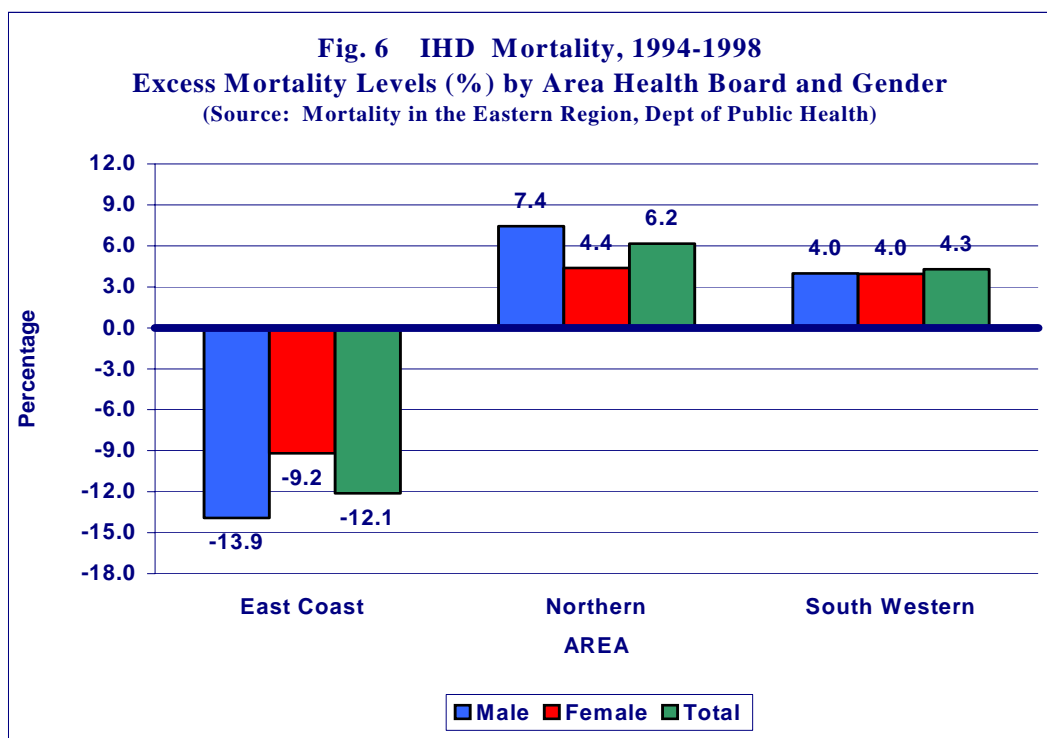


Fig. 5 Standardised Death Rates/100,000 due to Ischaemic Heart Disease, Eastern Region, Ireland and EU : All Ages, 1999





Section 6 Cancer

Data sources

- PHIS version 4, Department of Health and Children
- Regional analysis in the Department of Public Health, ERHA with Cancer
- Mortality in the Eastern Region 1994-1998, Department of Public Health, ERHA

Key Points

- **Cancer is the second most common cause of death, in all ages. It is the most common cause of death in people under 65-years of age.**
- **Cancer of the lung, gastrointestinal tract and prostate are the most common causes of cancer death in males (under 65 years for all ages). In women, cancer of the breast, lung and bowel are the most common causes of cancer deaths with breast cancer particularly high in the under 65 year age group.**
- **Cancer incidence, for males and females, is significantly higher in the Eastern Region than the national average. This is mainly due to lung cancer.**
- **Skin, lung, colorectal, breast, prostate and lymphoma are the main cancers affecting the region's population.**
- **Excluding skin cancer, lung cancer is the most common cancer overall with approximately one in every five male cancers and one in every ten female cancers situated in the lung. Over two-fifths (42%) of all lung cancers in the country occur in the region.**
 - **For males, excluding skin cancer:**
 - Lung cancer is the most common cancer (27.8%).
 - Prostate cancer (25.2%) is the second most common cancer. The risk of developing prostate cancer is 1% before the age of 65 years, increasing to 5% during the next ten years.
 - Between 45-74 years lung cancer dominates and prostate cancer gradually increases its ranking from third in the 45-64 age group to first in the oldest age group.

- For females, excluding skin cancer:
 - **Breast cancer is the most common (28%), followed by colorectal (12%) and lung cancer (11%). For women under 65 years, breast cancer accounts for almost two in every five cancers diagnosed (38%). The chance of developing breast cancer before the age of 65 years is 1 in 18.**
 - **Cancer of the Breast, ovary, cervix and corpus uteri has the majority of cases diagnosed in the under 65 age group.**
- **Significant geographic variations in incidence exist within the region for males**
in relation to lung and prostate cancers:
 - The age-standardised lung cancer rate in the South Western Area Health Board is 21% higher than the regional average whereas the rate in the East Coast Area Health Board is 34% lower than the regional average.
 - The highest age standardised rate for prostate cancer was recorded in the East Coast Area Health Board, (28% higher than the regional average), while the lowest rate was in the Northern Area Health Board, (19% lower than the regional average).
- The medium term target for cancer mortality as set out in the *National Cancer Strategy* is to reduce deaths in the under 65 age-group by 15% in the ten year period from 1994. In this context, lung cancer is of particular concern:
 - The survival rate for lung cancer is poor (10% at 5 years) so the focus must be on prevention. As over 90% of lung cancers are attributable to smoking, a reduction in smoking prevalence will have the greatest impact on reducing incidence and mortality.
 - Breast cancer has been shown to be associated with high socio-economic status in other countries. It is notable therefore that a

higher than average prevalence was found in the East Coast Area Health Board which has the largest proportion of its population in the higher socio-economic groups (SEGs). Conversely, lung cancer, which is commonly associated with lower SEGs (primarily because smoking is more common in these groups), is lower than average for the same area. Use of the deprivation index should help with further analysis of these and other SEG associations.

- In meeting our targets to reduce incidence and improve survival, the provision of effective, evidence-based preventive programmes and treatment services are essential. These objectives are all the more important as an increase in the order of 40% by 2015 in the number of people who will get cancer is forecasted due to the ageing of the population.

Table 6 All Cancers
Mortality in the Eastern Region, 1994 to 1998
Numbers of Deaths, SMRs with 95% Confidence Limits,
and Excess Mortality Levels, by Gender and Area

GENDER: AREA	NUMBER	SMR	95% CONFIDENCE LIMITS		EXCESS MORTALITY (%)
			LOWER	UPPER	
TOTAL (M+F):					
East Coast	3,036	84.6	81.6	87.6	-12.1
Northern	4,422	101.2	98.2	104.2	5.2
South Western	4,502	100.7	97.8	103.7	4.7
EASTERN REGION	11,960	96.2			
MALES:					
East Coast	1,501	83.4	79.1	87.6	-13.1
Northern	2,255	99.4	95.3	103.5	3.5
South Western	2,380	102.5	98.4	106.6	6.8
EASTERN REGION	6,136	96.0			
FEMALES:					
East Coast	1,535	86.4	82.1	90.7	-10.4
Northern	2,167	102.8	98.5	107.1	6.6
South Western	2,122	98.5	94.3	102.7	2.2
EASTERN REGION	5,824	96.4			

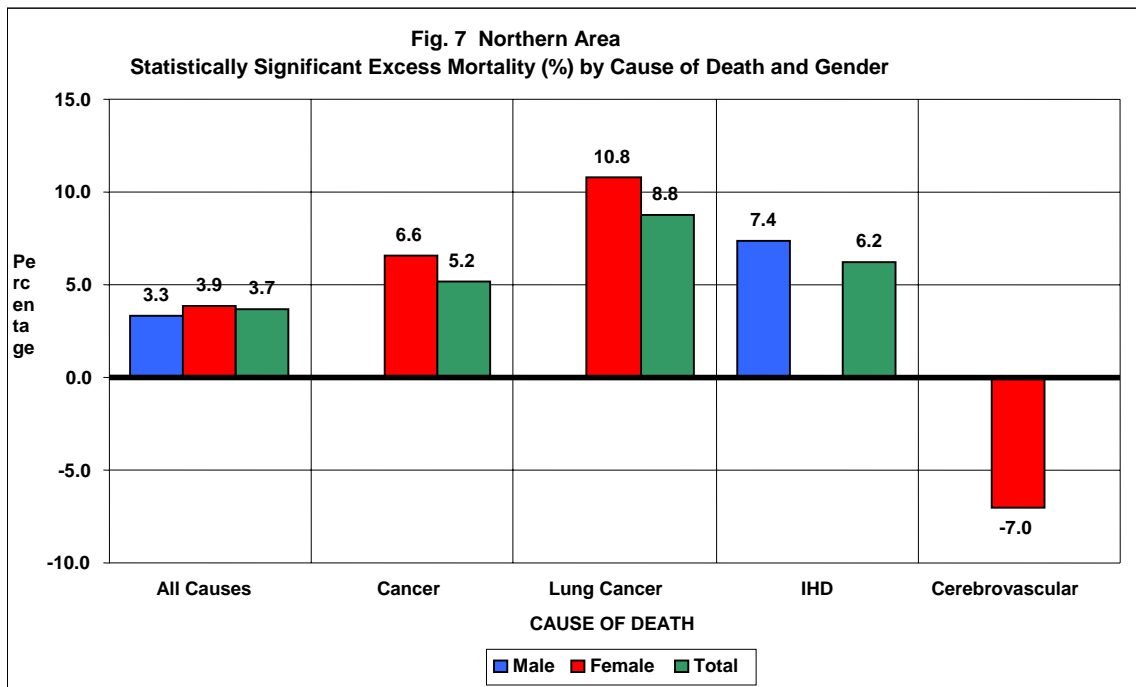


Table7

**Cancer Incidence in the Eastern Region,
Numbers, Percentages, EASRs, DSRRs and
by Gender, Age and Area**

ALL		EAS COAS	NORTHE	SOUT WESTE	EASTE REGIO
Numbe	Mal	2,14	2,84	3,12	8,13
	Femal	2,40	2,90	3,10	8,43
	Tota	4,55	5,74	6,22	16,56
Europe Age-Standardised Per 100,000 Population	Mal	426.	442.	472.	449.
	Femal	348.	337.	346.	343.
	Tota	371	373	391	380
Rate Ratio	Mal	94.	98.	105.	100.
	Femal	101.	98.	100.	100.
	Tota	97	98	103	100
Cumulative Risk 0-	Mal	28.	29.	30.	29.
	Femal	24.	23.	24.	24.
	Tota	26	26	27	26
LESS THAN 65		EAS COAS	NORTHE	SOUT WESTE	EASTE REGION
Numbe	Mal	77	1,13	1,23	3,15
	Femal	1,10	1,40	1,51	4,02
	Tota	1,87	2,53	2,74	7,17
Percentage of All	Mal	35.	40.	39.	38.
	Femal	45.	48.	48.	47.
	Tota	41	44	44	43
Europe Age-Standardised Per 100,000 Population	Mal	172.	181.	190.	183.
	Femal	219.	206.	210.	212.
	Tota	196	194	200	197
Rate Ratio	Mal	94.	99.	104.	100.
	Femal	103.	97.	99.	100.
	Tota	99	98	101	100
Cumulative Risk 0-	Mal	12.	12.	13.	12.
	Femal	14.	13.	14.	14.
	Tota	13	13	13	13

* Includes 38 cases where the area health board of

** Includes 23 cases where the area health board of

Data sources

- **The Public Health Information System (PHIS) Version 4 which is an information system produced by the Dept of Health and Children from CSO deaths data and HIPE data from hospitals.**
- **Inequalities in mortality 1989-1998, A report on All-Ireland mortality. The Institute of Public Health in Ireland.**

Key points

- **Annually, circa 120 deaths in the eastern region are attributable to diabetes mellitus. Most (85%) of these deaths occur in the older age group (65 years and over). Diabetes deaths account for 1% of the deaths overall in the Eastern region.**
 - **The All Ireland annual directly standardised mortality rate for diabetes mellitus for the period 1989-1998 was 8.6 per 100,000 and that this rate was lower than the rate in the (combined) EU-15 countries. Similarly WHO data shows Ireland to have lower standardised death rates compared with EU average though higher than UK.**
 - **The standardised mortality rate in the lowest occupational class was significantly higher than the rate in the highest occupational class (over 230%) in the All Ireland study.**
- **The Eastern Region has a lower mortality rate for diabetes than each of the other Health Boards, significantly so for four Boards (SEHB, SHB, MWHB and MidHB). These lower rates are seen both in the under 65 year age group and in the older group (aged 65 years and over).**
- **Within the Eastern Region, there is a difference between the three counties with Dublin having significantly lower mortality rates and Kildare and Wicklow demonstrating higher rates compared with the region overall.**
- **In the Eastern Region annually there are some 1,000 discharges of residents from hospitals. The age standardised discharge rate, including the rate for**

discharges under 65 years, was lower in the Eastern Region than Ireland overall and lower than each of the Health Boards.

- Other measures of outcome of care and compliance are needed but unavailable at present such as complication rates, annual review rates etc.

Table 8 Mortality (SDR) from diabetes per 100,000

(Source: WHO, Health for All database, June 2000)

Country	Year of data	SDR per 100,000
Ireland	1996	11.5
Denmark	1996	8.65
Germany	1998	16.2
UK	1997	7.62
EU average	1996	14.2
Sweden	1996	10.8
Norway	1995	8.13
Spain	1996	15.7
Netherlands	1997	16.0
France	1997	7.38

Section 9 Hospital admission

Data sources

- HIPE data, analysed in the Dept of Public Health, ERHA.

Key points

- The following tables show the top ten causes (i.e. diagnoses) of admission to hospital of residents of the Eastern region whether it be for inpatient care or day case care. The major reasons for admission as an inpatient are not the same as for day case care.
- The third table illustrates the top three diagnoses in terms of numbers of patients, bed days used (BDU) and length of stay.
- This data is very broad but highlights the conditions which largely affect middle aged and older people, cause a lot of morbidity and result in demands on the health sector and often on family carers. Also it is important to put this data in context with the fact that the Eastern region will experience an increasingly elderly population. Consequently, the pressure on this sector as well as the primary care sector in regard to care prior to admission and follow on care after admission is important to understand.

Table 9

INPATIENT ACTIVITY IN ACUTE PUBLICLY FUNDED HOSPITALS, 2001. NUMBERS AND PERCENTAGES OF INPATIENT CASES DISCHARGES FOR RESIDENTS OF THE REGION BY CATEGORY OF PRINCIPAL DIAGNOSIS IN DESCENDING ORDER OF FREQUENCY		
	Frequency	Percent
Injuries and Poisonings	17327	14.6
Circulatory System Diseases	15794	13.31
Respiratory system Diseases	14996	12.64
Digestive system Diseases	12692	10.69
Ill defined Diseases	11869	10.00
Neoplasms	9148	7.71
Genito urinary Diseases	8411	7.09
Nervous System/Sensory Organs diseases	5441	4.58
Diseases of the Musculoskeletal System and Connective Tissue	4807	4.05
Infectious and Parasitic Diseases	4302	3.62

Table 10

DAY CASE ACTIVITY IN ACUTE PUBLICLY FUNDED HOSPITALS, 2001. NUMBERS AND PERCENTAGES OF DAY CASES FOR RESIDENTS OF THE REGION BY CATEGORY OF PRINCIPAL DIAGNOSIS IN DESCENDING ORDER OF FREQUENCY		
	Frequency	Percent
Factors influencing Health Status	20656	19.93
Neoplasms	17263	16.65
Digestive system Diseases	15190	14.65
Genito urinary diseases	9113	8.79
Diseases of the skin and subcutaneous tissue	8068	7.78
Nervous system/sensory organs diseases	7593	7.32
Ill dedined diseases	6201	5.98
Circulatory system diseases	4789	4.62
Diseases of the musculoskeletal system and connective tissue	4722	4.56
Endocrine/metabolic/immunity disorders	2634	2.54

Table 11

DAY CASE ACTIVITY IN ACUTE PUBLICLY FUNDED HOSPITALS, 2001. NUMBERS AND PERCENTAGES OF PROCEDURES PERFORMED ON RESIDENTS OF THE REGION IN DESCENDING ORDER OF FREQUENCY		
	Frequency	Percent
Endoscopy –Gastro –Intestinal	19890	24.45
Chemotherapy	12836	15.78
Skin procedures	12437	15.29
Other procedures	3482	4.28
Bladder & urethral procedures	3453	4.24
External eye procedures	2367	2.91
Endoscopy & gynaecological procedures	1772	2.18
Minor anal procedures	1728	2.12
Cardiac catheterisation	1722	2.12
Esternal ear procedures	1530	1.88

**INPATIENT ANALYSIS FOR RESIDENTS TREATED IN ACUTE HOSPITALS IN THE REGION,
2001. NUMBERS AND PERCENTAGES OF CASES AND BDU AND AVERAGE LENGTHS OF STAY
IN DAYS BY CATEGORY OF PRINCIPAL DIAGNOSIS**

	Cases N	Cases %	BDU N	BDU %	Mean LOS	Median LOS
Injuries and Poisonings	17327	14.6	203101	20.6	17.8	8
Circulatory System Diseases	15794	13.3	124472	12.6	12.9	7
Respiratory System Diseases	14996	12.6	115012	11.6	12.6	

Section 8 Mental Health

Data Source

- Health statistics, 1999, Department of Health and children
- Suicide in Ireland, a national study, 2001, Department of Public Health on behalf of CEOs of the Health Boards.
- Mental disorders in older Irish people – incidence, prevalence and treatment. National Council for the Elderly report No 45. Authors: Fiona Keogh and Anne Roche. (With thanks to Geraldine Kenny, Psychologist)

Key points

- In terms of deaths there were 141 deaths due to suicide in 1997 in the Eastern Region. The rates of suicide in the region are similar to the national picture.
- Males outnumber females by five to one. Young males are predominant.
- Regarding hospital admissions in 1996, 1,827 people were inpatients in psychiatric hospitals in the Eastern Region.
- The main cause of admission to psychiatric hospitals in Ireland are
a) depressive disorders, b) alcoholic disorders, c) schizophrenia, d) mania. Highest admission rates are in the 35-44 year and 45-54 year age group, in males and in those widowed.
- In estimating prevalence of mental disorders in the community a framework is quoted in the National Council report (see above) which predicts that in the adult population in any one year there will be approximately 26-31 per cent of people living in the community with a mental disorder, mostly with mild problems. Of those that attend primary care services, approximately 23 per cent will have a mental disorder. General practitioners will identify approximately 10 per cent as having a mental disorder and will refer about two per cent of these to the psychiatric services. Less than one in 100 will be admitted to a psychiatric hospital.

Looking specifically at depression, 6 to 10 per cent of all patients visiting general practitioners for any reason have a major depressive syndrome though

it is estimated that GPs fail to diagnose major depression in their patients up to 50 per cent of the time.

The Irish prevalence rate of dementia in the community of 5.5 per cent (table) is comparable to international estimates.

**Fig. 8 Percentage Admissions to Psychiatric Hospitals
By diagnosis for Females and Males, 1996**

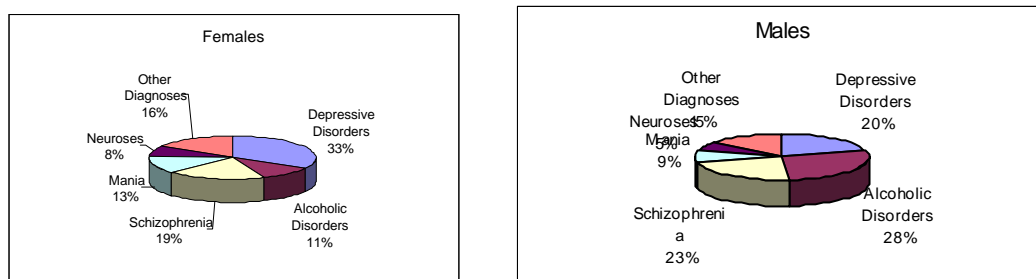


Table 12 The number of suicides identified in each Health Board Region

	1997	1998	Total
<i>Eastern Health Board</i>	<i>141</i>	<i>NA</i>	<i>141</i>
Midland Health Board	22	32	54
Mid-Western Health Board	33	49	82
North Eastern Health Board	42	40	82
North Western health Board	24	32	56
South Eastern Health Board	56	49	105
Southern Health Board	95	92	187
Western Health Board	54	46	100
Total	467	340	807

Table 13 Eastern Health Board Region, Age Group by Sex

Age Group	Females		Males		Total	
	No	%	No	%	No	%
< 15	0	0.0	1	0.8	1	0.7
15-24	3	13.0	35	29.7	38	27.0
25-34	1	4.3	30	25.5	31	22.0
35-44	5	21.7	21	17.8	26	18.5
45-54	5	21.7	14	11.8	19	13.5
55-64	6	26.0	11	9.3	17	12.1
65-74	2	8.7	2	1.7	4	2.8
75-84	0	0.0	3	2.5	3	2.1
85+	1	4.3	0	0.0	1	0.7
Not Stated	0	0.0	1	0.8	1	0.7
Total	23	100.0	118	100.0	141	100.0

Table 14 Estimates of the prevalence of depression in those over 65 from Irish Data. 1994.

Level	Irish Data	Extrapolated to total Population over 65
<i>Level 1: The Community</i>	1,310 per 10,000	52,793
<i>Level 2&3: General Practitioners Attenders</i>	900 per 10,000	36,270
<i>Level 4: Psychiatric Services</i>	79 per 10,000	3,184
<i>Level 5: Psychiatric hospitals</i>	45 per 10,000	1,814

Table 15 Irish data on the prevalence of dementia in those aged over 65

Level	Irish Data	Extrapolated to total Population over 65
<i>Level 1: The Community</i>	550 per 10,000	22,165
<i>Level 2&3: General Practitioners Attenders</i>	1,600 per 10,000	64,480
<i>Level 4: Psychiatric Services</i>	21 per 10,000	846
<i>Level 5: Psychiatric hospitals</i>	14 per 10,000	564

Section 10 Problem Drug Use

Data sources

- Building on experience – National drug strategy 2001-2008 (2001) Department of Sports, Tourism and Recreation.
- Annual report (2001) Eastern Regional Health Authority
- Also many other sources. With thanks to Niamh Randle, Merchants Quay Ireland and the Dept of Public Health, ERHA.

Note: Data on drug use is also presented in the Report 1 the Demography Section

Key points

- Data on drug use in Ireland is outlined in the table. The source is the SLAN survey in 1998. Some aspects of drug use may have changed since 1998.
- The most commonly used illegal drug in Ireland is cannabis followed by amphetamines and ecstasy.
- In 1999 the percentage of Irish students who reported experimenting with drugs was higher than the EU average.
- Heroin is the drug associated with the greatest harm to individuals, communities and families.
- Problem heroin use remains almost exclusively a Dublin phenomenon.
- Problematic use of cocaine is on the increase. This is a trend seen across the whole of the EU (EMCDDA).
- Links are firmly established between poverty, deprivation, social exclusion and problem drug use.
- There are three main categories of drug user
 1. Experimental users
 2. Problem drug users in treatment
 3. Problem drug users outside of drug treatment
- Prevalence of heroin use : It is estimated between 12,000 and 15,000 people use heroin in Ireland and another study estimated that there are 13,460 opiate users in the greater Dublin area, a prevalence of over 21 per 1,000.
- 6145 people are currently on the central methadone treatment list as of September 2002 – this is close to the target set out in the National Drug strategy.
- Of particular concern are those users outside of treatment. These are often referred to as “hard to reach” groups and include
 - Out of home drug users
 - Female drug users
 - Young drug users
 - Sex workers
- *Profile of problem drug users*
 - The majority of those presenting for treatment are male, under 30 years of age and unemployed. The majority are male aged between 20 and

24 years of age, more than three quarters left school before the age of 16 years and over 70 per cent were unemployed.

- There is very clear evidence of significant levels of drug use in Irish prisons.
- There is a serious problem of poly drug use – prescription and non prescription.
- Drug related deaths have stabilised and in some cases decreased across the EU yet Ireland is still experiencing increases rising from 7 in 1990 to 90 in 1999.
- The prevalence of drug use amongst the homeless population is of particular concern . 63% (n120) of clients presenting at a contact centre reported being currently homeless.
- Injecting drug users are known to be at high risk of acquiring blood borne viruses. Prevalence rates have been reported of between 60% to 80% for HCV (hepatitis C virus), 10 % to 20% for HIV and 5% to 20% for HBV (hepatitis B virus).
- Abuse of prescription medicine particularly benzodiazepines is of concern and is referred to in the report of Benzodiazepine Committee in Aug 2002.
- Lastly, abuse of alcohol on its own or in combination is also of concern and would need to be covered more fully.

Table 15 SLAN survey, Ireland 1998. Last 12 months prevalence. Type of drug by age groups. Percentages

Type of drug	Age group		
	18-64	18-34	18-24
Cannabis	9.4	17.7	26.0
Amphetamines	2.6	5.4	8.8
Ecstasy	2.4	4.9	8.1
LSD	1.4	2.9	5.1
Cocaine	1.3	2.6	3.4
Hypnotics and Sedatives*	1.2	1.4	2.1
Solvents	0.3	0.8	1.4
Heroin	0.3	0.7	0.8

Source: SLAN, Centre for Health Promotion Studies, NUI, Galway

* Includes benzodiazepines

Section 11 Congenital anomalies

Data Source

- The birth prevalence of congenital anomalies in the Eastern Region is carried out by the EUROCAT Registry, based in Dept. of Public Health, Eastern Regional Health Authority.

Key points

- On average, there are approximately 400 children born each year with a birth defect.
- The most significant changes during the past two decades are:
 - ◆ A substantial decline in the birth prevalence of Neural Tube Defects (Spina Bifida/Anencephaly), which may be attributable to better nutrition in the population and widespread and all-year-round availability of foods containing folic acid.
 - ◆ A rising trend in the birth prevalence of Down syndrome in the past ten years, largely due to advancing maternal age with more mothers choosing to have children at a later age. It may nevertheless have implications for health care services.
 - ◆ A rising trend in the birth prevalence of the anterior abdominal wall defect - Gastroschisis. The reason for this trend is unknown. It is occurring among younger mothers and a proportion may be associated with nutrition, smoking or illicit drug use.

Fig. 9 NTD: birth prevalence rate per 10,000 births in ERHA region from 1980-99

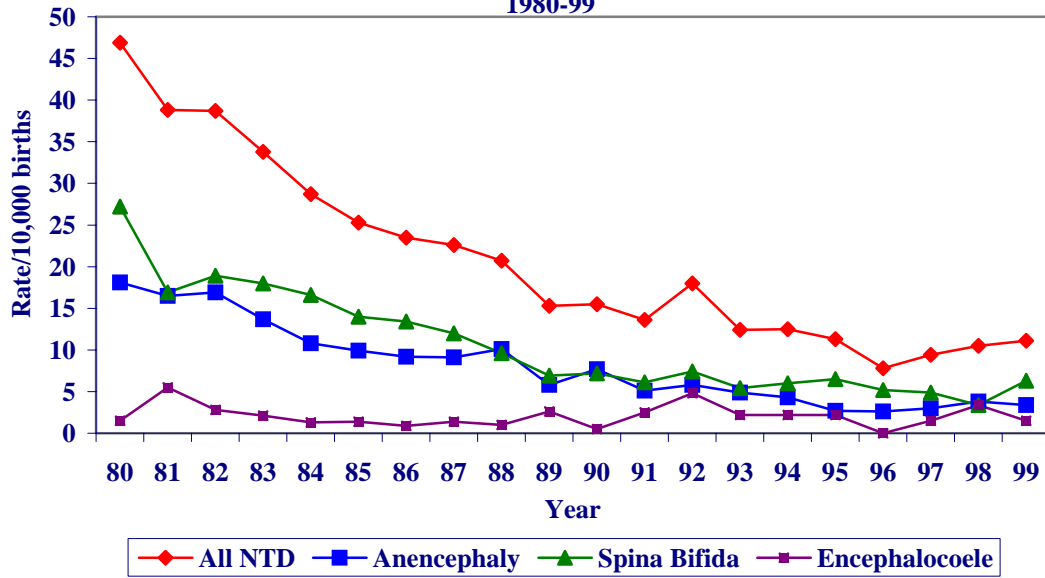
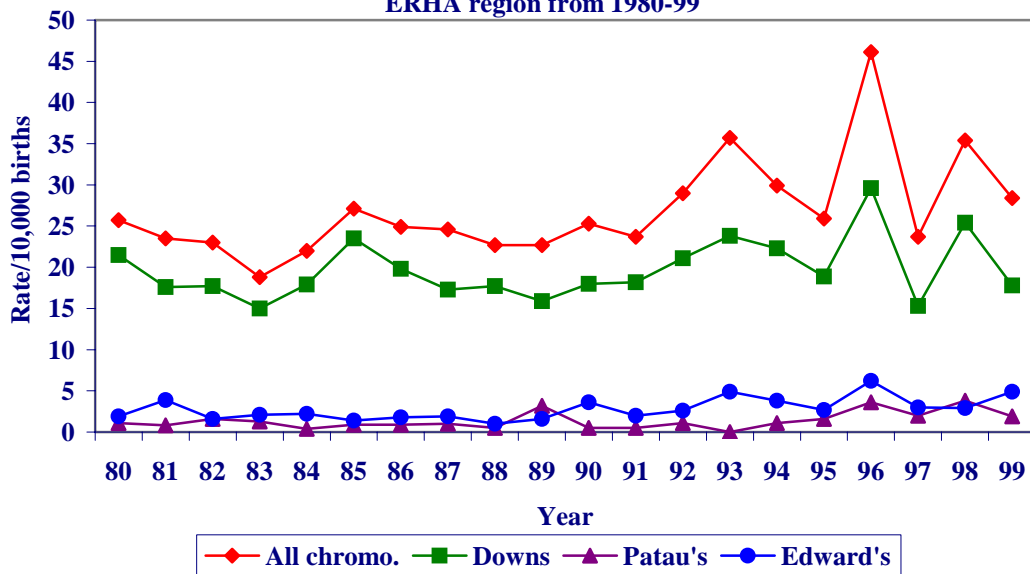


Fig. 10 Chromosomal anomalies: birth prevalence rates per 10,000 births in ERHA region from 1980-99



Section 9 Immunisation uptake rates in the Eastern Region

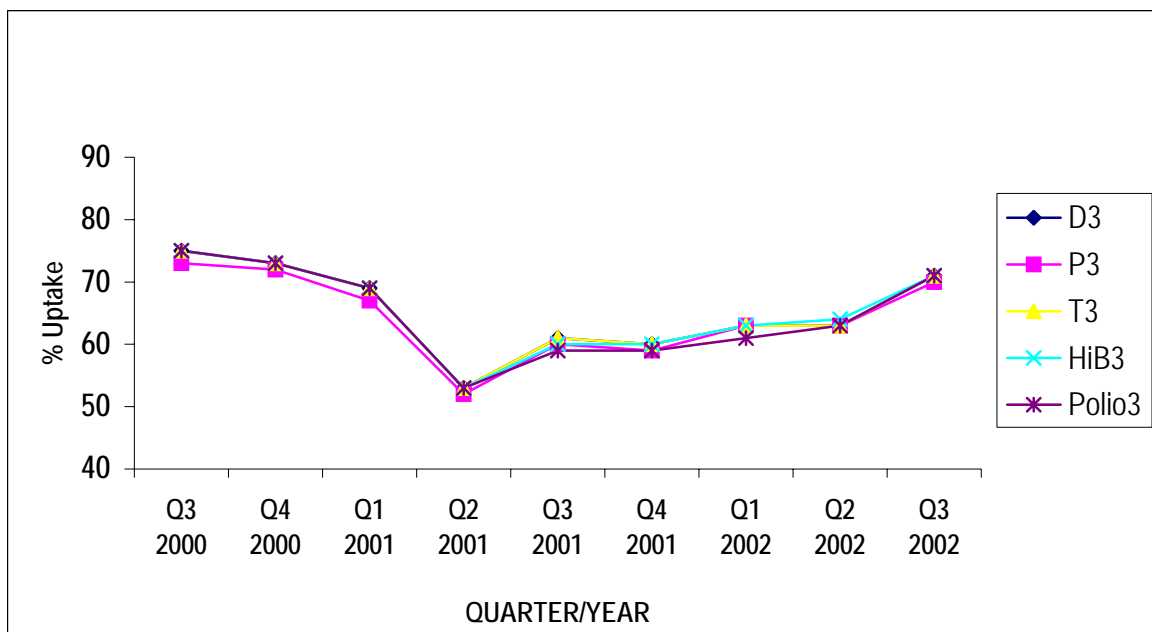
Data source

- Department of Public Health, ERHA

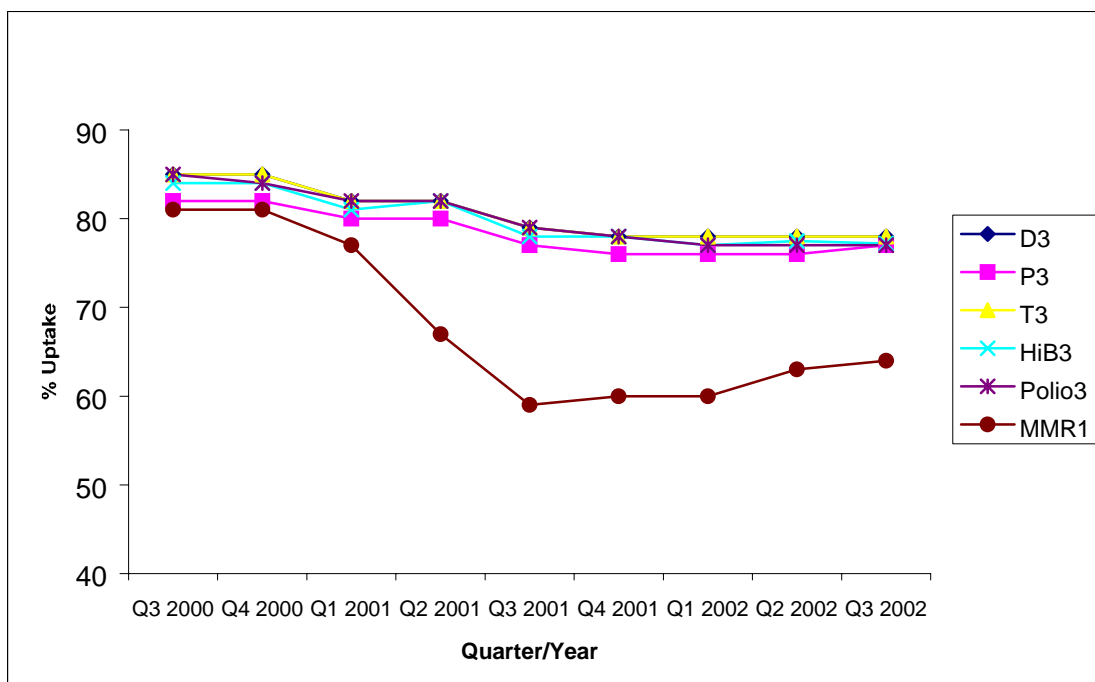
Key points

- By late 2001 MMR uptake in children at 24 months of age decreased by almost 20% from 77% to 59.7%. In some areas, MMR uptake fell to under 50% (CSA 3 and 7). By the end of 2002 the uptake rate was 63%. In order to eliminate measles and protect against the mumps and rubella it is imperative to achieve MMR uptakes in excess of 90%. The current low uptake rates greatly increase the risk of an outbreak of measles or mumps.
- The uptake of primary immunisation (DTaP/Polio/Hib) at 12 months also dropped but by a smaller margin. Uptake at the end of 2002 was 73%. Again to ensure health protection uptake rates should be in excess of 90%.
- Inner city areas (especially CSA 3 and 7) have the lowest uptake rates for all vaccines.
- The Eastern region has the lowest uptake at 12 and 24 months for all childhood immunisations and in particular MMR. compared to the rest of the country. Consequently, improving and the maintaining high uptake rates must be a priority.
- Meningococcal C vaccine, launched in 2000 with everyone up to the age of 23 years offered the vaccine has been very well received especially in schools with uptakes reaching almost 90%. Now, this vaccine becomes part of the primary vaccination programme.

**Fig.11 ERHA Quarterly Immunisation Update Rates at 12 Months:
Q3 2000-Q3 2002**



**Fig. 12 ERHA Quarterly Immunisation Update Rates at 24 Months:
Q3 2000-Q3 2002**



Section 13 Communicable diseases

Data sources

- Department of Public Health , ERHA

Key points

- Infectious diseases which are a source of concern are
 - *measles* with an increase in notifications in line with the significant drop off in immunisation uptake,
 - *SRSV or winter vomiting disease* has affected many institutions as well as in the community. Outbreaks in hospitals has resulted in debilitation of patients and significant bed problems.
 - *Sexually transmitted diseases* The prevalence of sexually transmitted infections, including HIV infection, has increased substantially in the Region since the early 1990's reflecting national and international trends. There is currently a serious outbreak of syphilis in the Dublin area among men who have sex with men.
 - *Hepatitis B* notifications have shown an increase in 2002 (138 cases in 2002 compared with 102 in 2001) yet underreporting has also been identified. With the drug abuse problem in Dublin and the influx of people from endemic countries enhanced surveillance as proposed is important.
- Infectious diseases on the decline are
 - meningococcal C infection is on the decline in line with good uptake of the vaccine in 2000 and 2001. Furthermore, there has been no concomitant increase in meningococcal B infection.
- Other infectious diseases
 - *Tuberculosis (TB)* The Eastern region has similar rates of TB to Ireland overall. The highest rates are seen in the NAHB though CCA3 (within the SWAHB) also has high rates.

Fig. 13 Measles notifications, Eastern region, 1998-2002

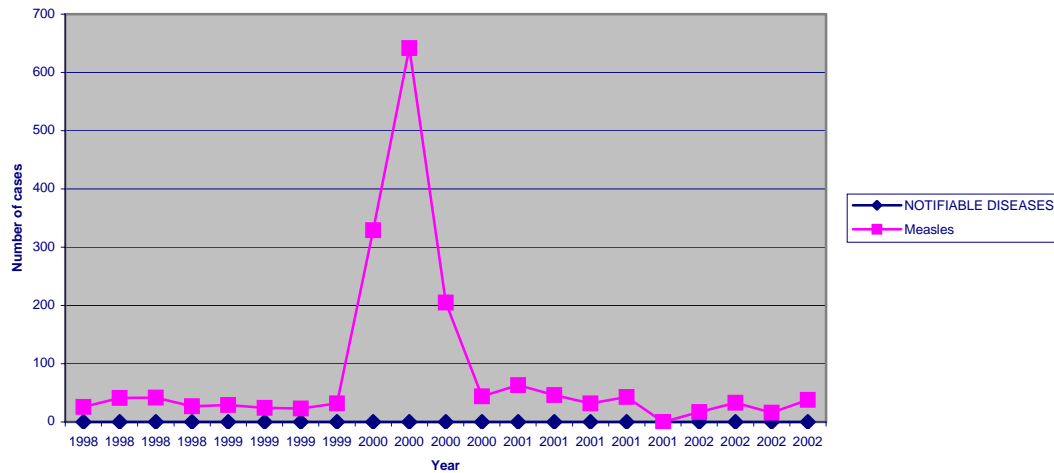
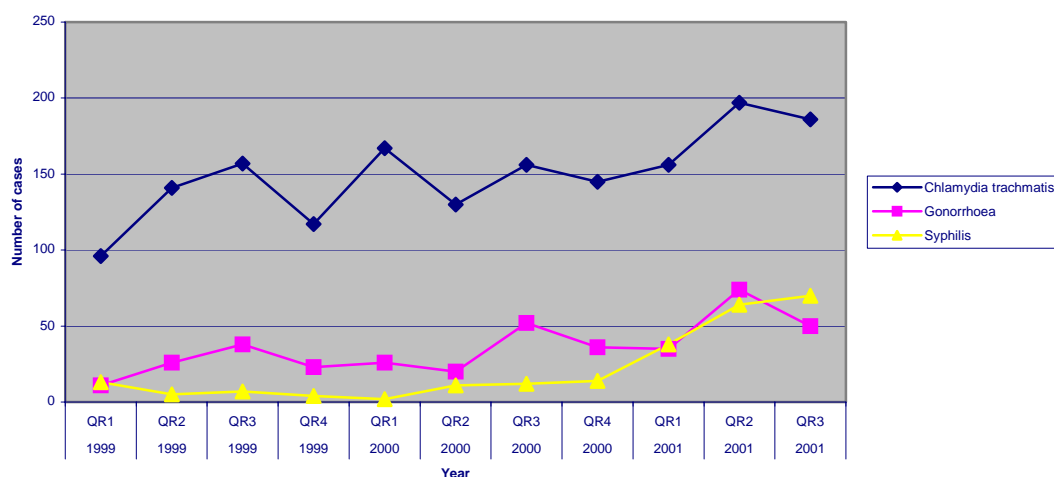


Table 16 Notifications of tuberculosis, Eastern Region, 2001

Area Health Board	Number of cases	Crude rate per 100,000
ECAHB (CCA 1,2, 10)	17	5.1
NAHB (CCA 6,7,8)	87	17.89
SWAHB (CCA 3,4,5, 9)	67	11.52
Total	171	12.18

Note: Highest numbers seen in CCA 3,6,7,8,

Fig. 14 Notifications of Sexually transmitted diseases, Eastern Region, 1999-2001



Section 14 Breast screening uptake in Eastern region

Data sources

- BreastCheck of 'first round' women (Feb 2000 to Dec 2002).

Key points

- The BreastCheck target uptake is 70% in order to achieve the desired effect on breast cancer mortality.
- Uptake rates are good in each AHB.

Table 17 Breast Screening Uptake in the Eastern Regional Health Authority for eligible women invited between February 2000 and December 31 2002*

Area	No. Eligible women invited	No. women screened	% uptake
East Coast Area Health Board	23,293	17,735	76
Northern Area Health Board	32,874	24,392	74
South Western Area Health Board	18,823	13,466	72
Total	74,990	55,593	74

*Number includes only women invited for first round of screening. Second round of screening commenced in Aug 2002 in some areas but numbers are not yet significant.

Section 15 Health Inequalities

Data sources

Key points

- The demography report outlined social class variation across the area health boards and mapped the variation at small area level (DED) across the region.
- The main indicators show that:
 - While the unemployment rate and the rate of those in Social Class 5 & 6 are slightly below the national average, the actual numbers are considerable.
 - The unemployment rate showed a steady decline in 1999 and 2000 both in the Eastern Region and Ireland.
 - The rate of GMS eligibility is lower in the Eastern Region compared with the rest of the country.
 - Homelessness continues to be a problem. In a survey undertaken by the Economic and Research Institute in 1999, it was estimated that there were 2900 homeless adults in the region. Of these 1850 (64%) were male and 1050 (35%) were female.
 - The link between poverty and health is well established. Poor people experience poor health including mental health . Inequalities in the health of different socio-economic groups have been highlighted in various sections of this report.
 - The report of the working group on the National Anti-Poverty Strategy (NAPS) has set four health status targets to address inequalities in health by 2007

- Target 1: The gap in premature mortality between the lowest and the highest socio economic groups should be reduced by at least 10% for cardiovascular disease.
- Target 2: The gap in life expectancy between the travelling community and the whole population should be reduced by at least 10% by 2007.
- Target 3: The life expectancy and health status of travellers, asylum seekers and refugees should be monitored so the targets for asylum seekers and refugees can be reviewed and revised for travellers by 2003.

Target 4: The gap in low birth weight rates between children from lowest and highest social group should be reduced 10% from the current level by 2007

Targets 5-11 are mainly directed towards equity of access to health and personal social services and developing new ways of working to address factors which link poverty and ill-health. The Health Strategy is committed to ensuring that health inequalities are reduced. [Action 18] The Health Strategy approaches health inequalities from both a population and individual risk factor perspective. The targets include:

- Implementation of a programme of actions to achieve National Anti-Poverty Strategy and Health targets. [Action 18]
- Elimination of barriers for disadvantaged groups to achieve healthier lifestyles will be developed and expanded. [Action 19]
- Health of travellers will be improved. [Action 20]
- Health and well-being of homeless people will be advanced. [Action 21]
- Health and well-being of drug misusers will be advanced. [Action 22]
- Health needs of asylum seekers/refugees will be addressed. [Action 23]
- Initiatives will be taken to improve the health of prisoners.

Table 18 Data on Disadvantage – Eastern Region and Ireland

Source: CSO, 1996; GMS (Payments) Board, 2001

Indicator	Eastern (%)		Ireland (%)	
	Region			
Unemployed population aged 15+ including first job seekers (unemployment rate, June to August 2001, CSO)		(3.3%)		(4.3%)
Population in social Class 5 & 6 (census 1996)	240,841	(18.6%)	774,007	(21.3%)
Eligible persons under GMS (Payments) Board (Dec 2000)	333,390	(25.7%)	1,148,055	(30.3%)
Number of adult people who Are homeless (ESRI survey 1999)	2900		NA	

Section 16 **Areas for further attention**

As stated earlier this report is a global overview of indices of health status. Fuller reports are to be found in previous reports from the Department of Public Health. Areas not presented here but which would be useful if sought after are:

- Data on lifestyle indicators in the Region
- Analysis of perinatal mortality
- Further data on mental health
- Indices of maternal health
- Further analysis on mortality (premature and mortality at small area level)
- Analysis on GMS data
- Further data on child health, elderly health
- More information on other care groups

Report 4

Human resources

East Coast Area Health Board

Summary of staff by discipline

DISCIPLINE	TOTAL WTEs	COMMENTS
General Practitioner	225	GMS Contractors + private practitioners
Health Care Assistant	24.29	
Home help	N/A	
Nurse / midwife	116.38	excluding Dir & Ass Dir of PHN
Occupational therapist	23.25	
Physiotherapist	15.65	
Social worker	70.97	
Receptionist / Administrators	147.25	included in Administration grades HB grades only
Chiropodist	6 sessions	Based in Area 10
Community pharmacist	110	
Community Welfare Officer		
Dentist Health Board	11	Salaried officers
Dentist Private contractors	N/A	DTSS Contractors + private practitioners
Dietician	N/A	
Psychologist		
Speech & Language therapist	20.5	

Human resources assessment using Primary care strategy

PCT DISCIPLINE	No. per team as per strategy	Currently in post	Multiplier for team of 5,000	NAHB Projected under PCS
General Practitioner	4	225	66.69	267
Health Care Assistant	3	24.29	66.69	200
Home help	3	N/A	66.69	200
Nurse / midwife	5	123.6	66.69	333
Occupational therapist	0.5-1.0	23.25	66.69	33-67
Physiotherapist	0.5-1.0	15.56	66.69	33-67
Social worker	0.5-1.0	70.97	66.69	33-67

Northern Area Health Board

Summary of Staff by Discipline

DISCIPLINE	TOTAL WTEs	COMMENTARY
General Practitioner	257	Includes GMS GPs and Private GPs
Health Care Assistant	35.4	
Home help	160	calculation based on hours divided by 39 =1 WTE
Nurse / midwife	186.49	not including psychiatric nurses
Occupational therapist	27.6	
Physiotherapist	15.36	Working in the Community Setting, may not be available to PCT
Social worker	143.11	Working in the Community Setting, may not be available to PCT
Receptionist / Administrators	168.2	Working in the Community Setting, may not be available to PCT
Chiropodist	not available	not possible to provide this figure
Community pharmacist	129	
Community Welfare Officer	109	Working in the Community Setting, may not be available to PCT
Dentist Health Board	33.9	
Dentist Private contractors	104	Includes GMS GDPs and Private GDPs
Dietician	7	Working in the Community Setting, may not be available to PCT
Psychologist	59.1	Working in the Community Setting, may not be available to PCT
Speech & Language therapist	26.72	Working in the Community Setting, may not be available to PCT

Human Resources assessment using Primary care strategy

<i>PCT DISCIPLINE</i>	<i>No. per team as per strategy</i>	<i>Currently in post</i>	<i>Multiplier for team of 5,000</i>	<i>NAHB Projected under PCStrategy</i>
General Practitioner	4	257	97.26	389
Health Care Assistant	3	35.4	97.26	292
Home help	3	160	97.26	292
Nurse / midwife	5	186.49	97.26	486
Occupational therapist	0.5-1.0	27.6	97.26	49-97
Physiotherapist	0.5-1.0	15.36	97.26	49-97
Social worker	0.5-1.0	143.11	97.26	49-97

South Western Area Health Board

Summary of Staff by Discipline

DISCIPLINE	TOTAL WTEs	COMMENTARY
General Practitioner	264	Includes GMS GPs and Private GPs
Health Care Assistant	54.6	Working in the Community Setting, may not be available to PCT
Home help	1341.4	Working in the Community Setting, may not be available to PCT
Nurse / midwife	273	Working in the Community Setting, may not be available to PCT
Occupational therapist	35.5	Working in the Community Setting, may not be available to PCT
Physiotherapist	24.2	Working in the Community Setting, may not be available to PCT
Social worker	154	Working in the Community Setting, may not be available to PCT
Receptionist / Administrators	222	Working in the Community Setting, may not be available to PCT
Chiropodist	not known	data required
Community pharmacist	162	
Community Welfare Officer	67	
Dentist Health Board	51.6	Working in the Community Setting, may not be available to PCT
Dietician	6.2	Working in the Community Setting, may not be available to PCT
Psychologist	not known	data required
Speech & Language therapist	38.4	Working in the Community Setting, may not be available to PCT

Human Resources assessment using Primary care strategy

<i>PCT Discipline</i>	<i>No. per team as per strategy</i>	<i>Current Posts</i>	<i>Multiplier for team of 5,000</i>	<i>SWAHB Projected under PCStrategy</i>
General Practitioner	4	264	116.3	465
Health Care Assistant	3	54.6	116.3	349
Home help	3	1341	116.3	349
Nurse / midwife	5	273	116.3	582
Occupational therapist	0.5-1.0	35.5	116.3	58-116
Physiotherapist	0.5-1.0	24.2	116.3	58-116
Social worker	0.5-1.0	154	116.3	58-116

Report 5 Buildings

East Coast Area Health Board

Buildings

1. Number of GPs operating from their own premises 223
2. Number of GPs operating from Health Board premises 2
3. Total number of GPs in Board's area 225
4. Number of GP practice premises 125

5. Number of centres of practice per GP

116 1 9 2 0 3

6. Number of GPs involved in partnerships with GPs

2 GPs 11 3 GPs 4 4 GPs 2 5 GPs 2

7. Pharmacies

	Total:
No. of Privately owned Pharmacies	N/A
No. of Urban Pharmacies	102
No. of Rural Pharmacies	8
No. of Pharmacies operating from Health Board facilities	0
No. of Community Pharmacy Contracts issued by Health Board	110

Northern Area Health Board

Buildings

1. Number of GPs operating from their own premises
2. Number of GPs operating from Health Board premises
3. Total number of GPs in Board's area
4. Number of GP practice premises
5. Number of centres of practice per GP (*GMS only*)

248
9
257
170

162 1
 25 2
 0 3

6. Number of GPs involved in partnerships with GPs (*GMS only*)

1 GPs 162
 2 GPs 25
 3 GPs 0

7. Pharmacies

	Total:
No. of Privately owned Pharmacies	126
No. of Urban Pharmacies	Not known
No. of Rural Pharmacies	Not known
No. of Pharmacies operating from Health Board facilities	Not known
No. of Community Pharmacy Contracts issued by Health Board	Not known

Comment

There is a comprehensive network of privately owned GP practice premises and pharmacies throughout the region. However, a major difficulty for the Authority/Boards is the large number of general practitioners continuing to operate in single handed practices.

South Western Area Health Board

Buildings

1. Number of GPs operating from their own premises 216
2. Number of GPs operating from Health Board premises 48
3. Total number of GPs in Board's area 264
4. Number of GP practice premises 248
5. Number of centres of practice per GP (*GMS only*)

172

 1

41

 2

9

 3
6. Number of GPs involved in partnerships with GPs (*GMS only*)

2 GPs

68

3 GPs

18

4 GPs

0

5 GPs

5

7. Pharmacies

	Total:
No. of Privately owned Pharmacies	162
No. of Urban Pharmacies	149
No. of Rural Pharmacies	13
No. of Pharmacies operating from Health Board facilities	0
No. of Community Pharmacy Contracts issued by Health Board	162

Comment

There is a comprehensive network of privately owned GP practice premises and pharmacies throughout the region. However, a major difficulty for the Authority/Boards is the large number of general practitioners continuing to operate in single handed practices.

Primary Care Team								
Percentage of staff utilising computers for the following:	PHN	RGN	Health Care Assistant	Home Help	Physio	OT	Social Worker	Administrative Personnel
Word Processing	7%	3%	0	?	<10	<10	>25	?
E-mail	5%	0	0	?	<10	<10	>40	?
Service User Data / records	0	0	0	?	100	100	>40	?
Appointments	2-3%	?	0	?	<10	<10	<10	?
Health Information / Advice	?	?	0	?	<10	<10	<10	?
Other Please specify	?	?	0	?	?	?	?	?
Is the computer system/s used linked to a computer system in any other service					No	No	No	
Are records shared with other professionals?					No	No	No	
Percentage staff that have undertaken Computer Training ?	15-20%							
Primary Care Network								
Percentage of staff utilising computers for the following:	Chiropodist	Community Welfare Officer	Community Pharmacists (405 pharmacies)	Health Board Dentist	Dietician n=8 (NAHB), n=7 (SWAHB), n=5.4WTE (ECAHB)	Psychologist	Speech and Language Therapist	
Word Processing		<10	?	<50%	100%	100	<10	
E-mail		100	33%	<50%	100%	100	<10	
Service User Data / records		<10	99%	<30%	50%-NAHB 33% SWAHB and will be increased in ECAHB as service develops	<10	<10	
APPOINTMENTS		<10	?	<30%	50% NAHB 33% SWAHB	0	<10	
Health Information / Advice		<10	?	?	Internet access	90	<10	
Other Please specify			?	?	MS publisher, PSS, Access			
Is the computer system/s used linked to a computer system in any other service		Yes	Yes	No	Yes	No	No	
Are records shared with other professionals?		Yes	No	No	No	No	No	
Percentage staff that have undertaken Computer Training ?					50%	100%		

