Promoting Health

Through

Public Policy

Health
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Bureau

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REPORT
OF A GROUP
ESTABLISHED BY THE
HEALTH EDUCATION BUREAU

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Between November 1985 and December 1986 the group met on a regular basis. A special workshop was held in June 1986 to review a draft of the report.

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Health and ill health are among the principal concerns of modern society. There is increasing recognition of the effect of the environment in all its aspects on health and wellbeing. Where governments are concerned issues of health have become of greater importance because of their considerable economic and political implications. In general there is a growing realisation that medically orientated services cannot themselves create a healthier society; that progress towards a higher quality of human health lies along a much broader path touching on many aspects of our daily lives.

This report was prepared in the light of these considerations by an advisory group established by the Health Education Bureau following a request from the Minister for Health, Barry Desmond, for advice on the creation of a health promotion policy. The report is intended to deal with the public policy aspects of health promotion. It does not contain detailed proposals for a health promotion policy. It is first necessary to get public understanding and support for the concept. We have attempted to explain it, to point to the compelling arguments for it, and to explain its main implications. We also recommend certain prior initiatives which we regard as desirable. While the report is directed at the public in general it is intended, in particular, to be read by, and to influence, all those who fashion our living environment and the other aspects of our lives that determine the quality of our health and general wellbeing.

Message from Mr Barry Desmond, Minister for Health

I warmly welcome this Report from the Health Education Bureau and I would like to thank the Bureau and those involved in drawing up the document. It sets out the broad context in which health promotion should be considered and indicates the general policy course which must be followed.

The traditional pathway of a concentration on the treatment of illnesses presented particularly through institutionally based services is no longer viable. It must be accepted, therefore, that a future health system must expand the current parameters of health and examine how ill-health can be prevented and especially how good health can be actively and positively promoted.

This Report, in conjunction with the recently issued consultative statement on health policy — "Health — The Wider Dimensions" — puts the issues very clearly before the people. We are being asked to look in a fundamental way on how we perceive health and health care. The options and approaches are suggested as to the future course to be taken.

Health promotion to many people is a new concept and it might be regarded with some suspicion. This Report explains how through such a policy wide-ranging and significant changes in improving the health of the people can be brought about. The active participation of a well informed and motivated population is a prerequisite to its success.

Likewise the Report stresses that the promotion of a healthy life-style in the population at large is not possible overnight. It requires a concentrated effort on a longer term time scale at many levels. The Report gives ample evidence of the lasting benefits of such an undertaking.

I regard this Report as an invaluable contribution to the crucial broader debate on the future of the health of the nation.

Barry Desmond T.D.
Minister for Health
January, 1987

Summary

Chapter One: Health Promotion

Health promotion is a process which aims at improving the quality of life of the whole population no matter what a person's basic level of health. It is based on the understanding that health is more than an absence of disease and therefore is positive in concept.

Health promotion has its origins in the realisation that the modern killer diseases – cardiovascular diseases, cancers and accidents – are linked to unhealthy behaviour and lifestyle. It is broader than disease prevention and health education because it recognises that individuals wishing to adopt a healthy lifestyle may be prevented from doing so by environmental and socio-economic factors which are often beyond their control.

What is required therefore is a co-ordinated approach on two levels to remove barriers to health; at government level, interdepartmental co-operation to develop and facilitate the implementation of a healthy public policy; at community level, co-ordinated action to improve health through self-care, self-help and mutual aid.

Chapter Two: Our Present Patterns of Ill Health

Average life expectancy has increased considerably in Ireland since the beginning of this century. However, our position relative to a number of developed countries suggests that there is still room for improvement. Cardiovascular disease, cancer and accidents are responsible for much of the premature death and disability in Ireland today. These killers are related to lifestyle and the environment. Some of the statistics of death from these causes in Ireland compare unfavourably with those of other countries and underline

the urgency of identifying and tackling the behavioural and environmental features which give rise to them.

Chapter Three: Factors Affecting Health and Wellbeing

Some of the factors which affect health arise from the individual's free choice: s/he may have little or no choice with regard to others. There is evidence, for example that poorer members of society are sick more often and die younger than better off members. Health promotion would be concerned with the availability (in terms of price and distribution) of nutritious food, the curtailment of advertising encouraging people to smoke, the provision of a smoke-free environment in public places and the discouragement of heavy drinking. Health promotion would also be concerned with the following factors: the provision of a healthy environment in terms of air and water quality and safety on the road; minimization of risks from chemicals and radiation; the provision of housing that is physically and socially adequate; the availability of leisure and recreational facilities for all age groups; the pursuit of health-supporting employment policies and practices; the availability of information on health issues and the recognition of the importance of coping skills for psychological wellbeing.

Chapter Four: Economic Considerations

Humanitarian rather than economic reasons should be the underlying motivation in a health promotion policy. It is also useful however to look at the potential cost and benefits.

Expenditure in the health services has risen substantially in Ireland as in other countries and the bulk of the current budget of IR£1.2 billion is spent on curing illness and caring for the sick. However, it is clear that this increased expenditure has not led to the expected improvement in the health of the population.

The cost of ill health and premature death is not only to the individual but to the community and it is clear that prevention of premature death and disability is vital.

Reduction in smoking is a clear health promotion exercise which would substantially cut premature deaths and increase the quality of life for many people which is the aim of health promotion.

Chapter Five: Diet and Nutrition

The area of diet and nutrition is taken as an example of the considerations and issues that need to be addressed in the development of a health promotion policy.

Comparison of the Irish diet with dietary guidelines issued by the Food Advisory Committee of the Department of Health indicates that changes in the national diet are required. These include a reduction in total fat and especially saturated fat, a reduction in salt intake and an increase in fibre consumption.

Such changes will pose considerable challenges for the food and agricultural industries in Ireland. A comprehensive food policy and strategies for modifying dietary habits will require a multisectoral approach which will take health into consideration as well as commercial interests and constraints at national and international levels.

Chapter Six: Conclusions and Recommendations

The present role of the Minister for Health is one of providing services to deal with sickness rather than promoting health. No individual or organization is at present responsible for the promotion of the health of the Irish people. We recommend new statutory provisions expanding the role of the Minister for Health to being responsible for the promotion of the health of the Irish people in addition to providing traditional services. We recommend that a similar responsibility be laid on health boards at local level.

We recommend that the Minister for Health be required to produce an overall plan on a regular basis for promoting the health of the Irish people with an annual report on progress in relation to the targets set in the plan.

We recommend the establishment of a Health Promotion Council which would bring together expertise and experience from the different public and private interests whose activities affect health. This Council would be given the responsibility of identifying issues which would require to be tackled in the interests of the health of the public.

We recommend that the remit and scope of the Health Education Bureau be broadened to take account of a definition of health education that relates not

just to factors of personal lifestyle but also to wider issues about the impact of the physical, economic and social environment on health.

From a financial point of view the adoption of a health promotion policy should not in itself entail additional expenditure but rather the redirection of some existing resources. Spending in all government departments should be sensitive to health promotion issues.

It is necessary to recognise that health and sickness are being influenced by international policies and legislation. Government initiatives are required to ensure that legislative and structural arrangements to promote health at national level are reflected in EEC institutions.

1 Health Promotion

1.1 The Concept of Health Promotion

1.1.1 Health promotion is a process which aims at altering and developing fundamental features of society with a view to promoting good health and removing hazards and obstacles in the way of doing so. It seeks to mobilize resources for health and to pursue healthy public policy. The concept of health promotion is based on an understanding that health is more than an absence of disease. It recognises health as the ability of individuals and groups to adapt to a changing environment, to satisfy needs and to realize aspirations and thus incorporates the physical, social and mental components of health. From this perspective health is a resource for everyday life, an active changing process, not an end product. Health in this sense is a right and health promotion is a way of giving expression to that right and making it accessible to all. A successful health promotion policy will make three important gains:

— it **will add life to years** by enabling as many persons as possible to remain healthy and active throughout the years of their life;

— it **will add health to life** by reducing the occurrence of illness and accidents;

— it **will add years to life** by increasing the average life expectancy of the individual.

1.1.2 Health promotion is not synonomous with prevention in the narrow sense that preventive health services have come to be understood. It is much broader and more dynamic and positive in

concept. It is concerned not only with reducing death and illness but, for example, with making life better for the disabled; adding more activity to the years of old age; facilitating people in general to improve their own quality of life in the physical and psychological sense. Furthermore, health promotion differs in concept from health education although there is not a clear dividing line between them.

Essentially health education is directed at the individual with a view to encouraging a change in lifestyle in the interests of health. There is evidence that many people in Ireland know the importance to the maintenance of health of lifestyle factors such as nutrition, physical fitness, moderation in alcohol use and not smoking tobacco. But there are limitations to what health education and the individual can achieve. No matter how anxious people may be to live a healthier lifestyle they will find that, in some regards, they have little or no choice in the matter. Pollution and other environmental hazards are outside the control of individual citizens. The nature of the food available to them will be determined largely by economic forces uninfluenced by health considerations. An inactive sedentary life may be forced on them by the nature of their employment.

Many who may be anxious to change their style of living may find they cannot afford to do so. Furthermore some persons, because of their low socio-economic status, do not have the same access to the means of good health as the more privileged members of the community.

1.1.3 It is because individual citizens are unable in circumstances such as these to advance their own good health that we need the more fundamental approach of health promotion. It aims to make the healthy choice an easier choice. Health promotion implies two parallel levels of action. At a policy level it means laying responsibility for promoting health on the government (and not just the Department of Health), public authorities and the various other agencies and interests which control, influence and fashion many of the basic features of our society. In other words it implies multisectoral collaboration to promote health. In communities it means enabling individuals and organisations to improve health

through informed self-care, self-help and mutual aid. It means encouraging and supporting spontaneous local initiatives for health.

1.2 Historical Background to Health Promotion

1.2.1 Viewed historically health promotion is a developing process the seeds of which were sown in the last century with the recognition of the role of environmental factors in the causation of infectious disease. For instance the relationship between disease and dirt was clearly established. It has been said that if the last century were responsible for nothing other than the recognition of the benefits of soap and water it would have made a notable contribution to mankind. The discovery of bacteria and the understanding of how infectious diseases were spread came later. These advances led to social changes of a broad nature which transformed aspects of 19th century society.

Safe water and sewage systems were introduced in the towns; insanitary housing was reduced; various threats to public health were eliminated; planning controls were given to local authorities. Doctors, pharmacists and nurses became subject to new and more scientific systems of training and control which shook off the quackery and unprofessionalism of the past. By the end of the 19th century the death toll from infectious disease had been considerably reduced, infant and general mortality rates had fallen dramatically and the individual citizen could look forward to a longer life. There were further remarkable improvements in the early decades of the present century. Public health measures initiated in the last century were further expanded and became more effective.

The identification of the organisms causing infectious diseases, the development of vaccines and the discovery of new and more effective ways of treating complications finally brought many infectious diseases under control. This century has also seen an unparallelled growth in medical technology and therapeutic methods for the investigation and treatment of many non-infectious diseases.

1.2.2 The beneficial outcome of all these measures and discoveries of the last century and a half or so is best summarised by mortality and

life expectancy rates. Since 1900 the maternal mortality rate in Ireland has fallen from 618 to 13 per 100,000 live births and the infant mortality rate from 109 to 10.1 per 1,000 live births. Life expectancy for a man born in 1926 was 57 years and for a woman 58 years. Today the corresponding figures are 70.1 years for men and 75.6 years for women.

1.3 The Health Problems of Today

1.3.1 Though health promotion does not view health as merely the absence of disease, nevertheless, a policy for health promotion, as one of its elements, must recognize and deal with the reality of premature death and disability in our society. The conquering of infectious diseases and the attainment of higher standards of living have left us with a pattern of health problems today that is different from that of former times. Premature death and disability today are mainly due to accidents and to degenerative and chronic diseases such as heart disease and cancer.

Many of these dangers to our health are preventible. In the case of accidents this is obvious. In the case of the degenerative diseases the situation is more complex. Many of these are associated with factors embedded in our lifestyle and in the psycho-social, economic and physical environment that we have developed over time. If we recognize the complexity of the factors involved and take the right measures to deal with them some of the consequences of these diseases could be avoided.

1.3.2 The objective of such measures would not be merely to enable people to live longer. They would also aim to add health and vitality to present life-spans and to ensure that the elderly and the disabled can lead a socially, if not economically, productive life.

1.4 Need for a Broad Plan

1.4.1 The development of an effective health promotion policy will require a multiplicity of actions of a wide-embracing nature. Unlike

in the past the solution to the majority of our present health problems will not be found solely in new discoveries in our medical laboratories but also through changes in the behaviour of the individual and through political action in the social area. Epidemiological studies have shown the links between the modern killer diseases and individual behaviour and lifestyle, such as alcohol consumption, smoking, over-eating or eating the wrong food as well as environmental and social factors such as poverty, pollution and stress. In considering the promotion of health we must therefore view it in its global context as something touching on many aspects of the world around us and the way we live.

1.4.2 In this brief report we draw attention to the main causes of illness and death in Ireland today and outline the social and economic arguments for an active, effective policy of health promotion. We are certain that such a policy would in time lead to a substantial improvement in the health and wellbeing of our citizens. In our view there must be a gradual re-orientation of our approach towards our national health problems. We must, of course, always have health services to provide, in the most appropriate manner, a high standard of care for the sick, the infirm and the disabled. Nothing we say in this report diminishes the importance of continuing to improve these services. But it would not make sense and would not be in the public interest to adopt the somewhat fatalistic approach of continuing to increase the resources of our caring and treatment services without seeking to eradicate the causes which give rise to the demands on them.

Our health services must be supported by a broader national plan for the health of the people which demonstrates an awareness of the main influences on disease and disability in modern society and provides the basis for a reduction in the toll of illness and premature death and a better quality of life for the old and the disabled. Such a plan will require more than the participation of the Minister for Health and those who work in the health services. It will need a much wider acceptance, participation and understanding; it will need to be a fundamental element of public policy. Ultimately its success will depend on intersectoral co-operation, on the extent to which

the policies and programmes of all public and private sectors support the objective of improving and preserving health.

1.5 Health Promotion in the Context of WHO Targets

1.5.1 Ireland is not alone in looking critically at the state of health of its population. The World Health Organization (WHO) has asked all member nations to set social targets over the next few decades. The aim of these targets is "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life". This country, as a member of WHO, supports the ideals of that organization. The WHO has set achievement targets for its various regions. These necessarily vary considerably between one region and another because of the different levels of socio-economic development and health status. The targets set for the European region, one of the most developed areas of the world, are summarised briefly in Appendix 1. They include, for example, the establishment of equity in health by ensuring that all social groups have access to the same quality of health care; the elimination of specific diseases; improvements in mortality rates and life expectancy; and a better life for the disabled.

Some of the proposed targets have already been achieved in Ireland or we are well on the way to reaching them. Others will give us cause for reflection. In general they provide guidelines to help us determine our own national priorities in advancing the health of the people.

The Department of Health, the Health Education Bureau and other Irish health agencies have a close working liaison with the European Regional Office of WHO in Copenhagen. The government has accepted its health targets for the European region. This report has, therefore, been heavily influenced by these targets particularly those related to lifestyle and health promotion. The recommendations that we make herein are intended to be an important element in the overall strategy for the implementation of the WHO aims.

1.6 A Matter of Choice

1.6.1 If we accept that people have a right to health, it follows that a healthy lifestyle should be made accessible to all. At the moment those who seek a healthier lifestyle have the greater obstacles to overcome. Some people argue that individuals should be able to choose the lifestyle that they want, even an unhealthy one. These argue that the imposition of social organization would limit choice and be a curtailment of freedom. While we recognise these fears it remains our aim to facilitate those who wish to remain healthy. Far from imposing a totalitarian concept of health, the aim of health promotion is to make the healthy choice the easier choice.

2 Our Present Patterns of Ill Health

2.1.1 From the perspective of positive health, the health status of a nation would ideally be measured using indicators of health and wellbeing. Traditionally, however, health has been equated with the absence of disease. As a consequence our health services have been directed towards the prevention and cure of disease. This limited concept of health has also influenced the way in which we assess the health status of a nation. Infant mortality, life-expectancy, and incidence and prevalence of disease have been the measures generally used. It is to some of these we now turn in relation to the health of Irish people.

2.2 Life Expectancy

2.2.1 Average life expectancy has been increasing in Ireland for those in the youngest age group though not to the same extent for those in the middle age groups. Life expectancy at birth for men is now 70.1 years and for women 75.6 years.

Comparison with other countries suggests that Ireland still has room for improvement of life expectancy. Irish men rank 3rd lowest and Irish women 2nd lowest among their counterparts in 10 EEC countries (excluding Spain and Portugal) in terms of life expectancy at birth. Irish men rank 2nd lowest and Irish women lowest in terms of life expectancy at age 40. Countries like Iceland and Japan have a still higher life expectancy than the highest of the EEC countries. It should be expected that an effective health promotion policy would bring Irish rates into more favourable comparison with those of other advanced countries.

2.3 Main Causes of Illness and Premature Death

2.3.1 While life expectancy is a common measure of the health status of a nation, health promotion is also concerned with the quality of that life. The achievement of an active old age will depend largely on the extent to which the health and welfare of the population as a whole has been the concern of public policy. It is now clear that cardiovascular disease, cancer and accidents, which are responsible for much of the premature death and disability in Ireland today, are related to lifestyle and the environment.

Furthermore, some of the statistics of death in Ireland compare unfavourably with those of other countries and underline the urgency of identifying and tackling the behavioural and environmental features which give rise to this situation.

2.3.2 In 1982 more than a third of all deaths among males and one fifth of deaths among females between 35 and 64 years were from ischaemic heart disease (constriction or blockage of the blood vessels supplying the heart).

Irish women have more than twice the risk of dying from this disease than women in other EEC countries (see Figure 1). Irish men also have a risk that is about 50% above the average for men generally in EEC countries. Furthermore, as the attached map (Figure 2) shows, Ireland also ranks high for premature deaths from hypertension and stroke. Existing evidence indicates that much of the premature death and disability from these diseases is preventible.

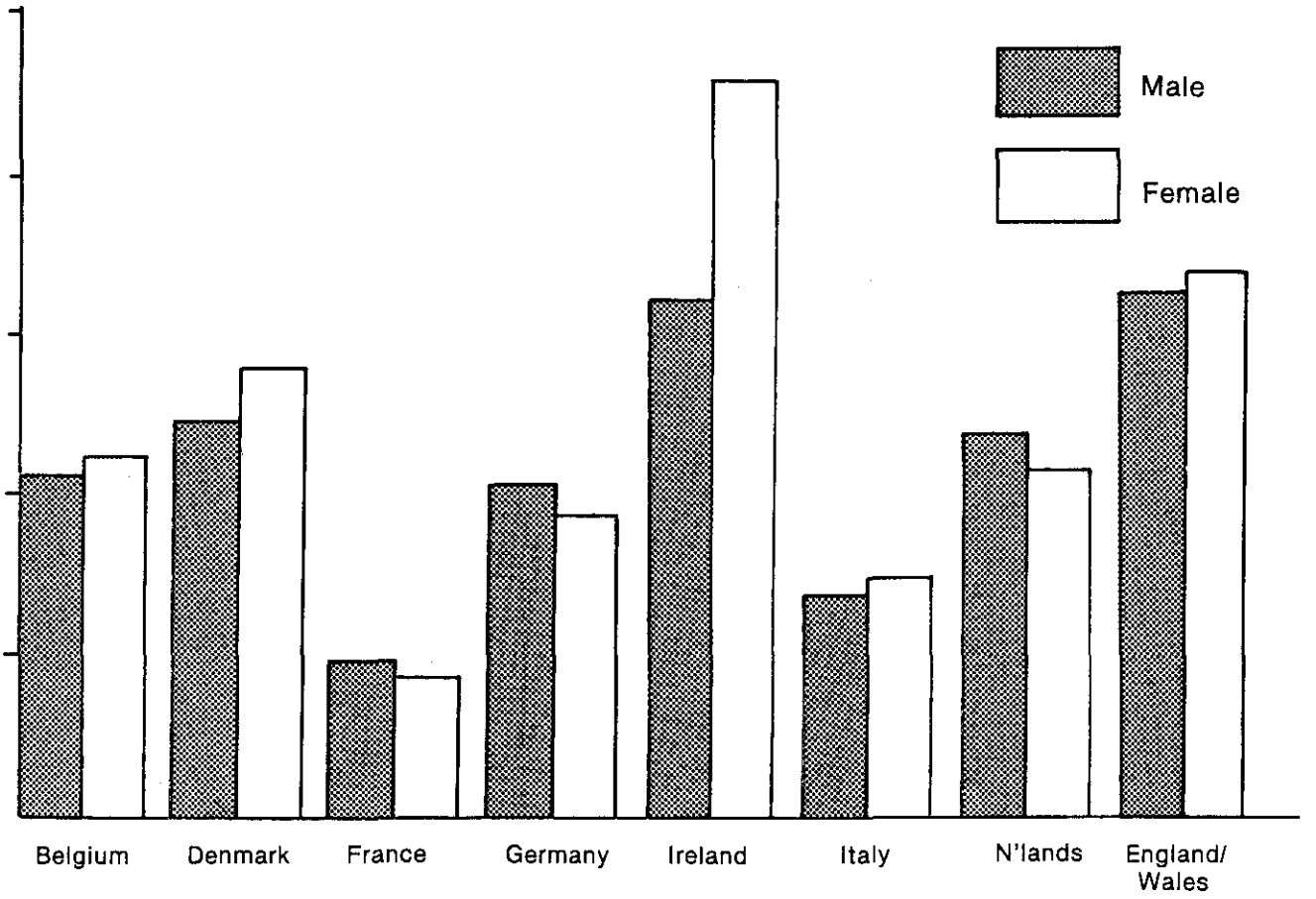
2.3.3 Cancer, the second major cause of death in Ireland, currently accounts for approximately one fifth of all deaths. The trend in regard to lung cancer must give cause for particular concern. Deaths in this category have increased from 13% of all cancer deaths in 1961 to 23% of all such deaths in 1982. This increase is particularly noticeable in the case of women for whom lung cancer accounted for 5% of cancer deaths in 1961 and 13% of cancer deaths in 1982.

One third of all those who died from lung cancer in 1982 were under 65 years of age. Lung cancer is a major avoidable type of cancer

FIGURE 1

Heart Disease (IHD) in EEC Countries

Standardised Mortality Ratio for the period 1969-1978*



*Standardised Mortality Ratio = the number of actual deaths as a percentage of the expected deaths.

Reference population, all EEC, 1969 to 1978 = 100

Source: Dean, Geoffrey, Kelson, Marcia, The Reported Mortality Pattern in the Countries of the EEC for Six Common Cancers and Ischaemic Heart Disease. *Irish Medical Journal,* April 1984, Volume 77, No. 4, pp. 98-100.

since over 90% of those who die from it are smokers and the relationship between smoking and lung cancer has been clearly established.

2.3.4 Colorectal cancer (cancer of the bowel and rectum) is another major type of cancer leading to premature death. Ireland has the highest death rate in the 25-64 year age group from cancer of the colon and the fourth highest death rate from cancer of the rectum in EEC countries (Figure 3).

Current evidence suggests that lifestyle factors play a role in the development of colorectal cancer. Diet is recognised as an important factor in the disease. To date most of the evidence points to low fibre (roughage) and high dietary fat and cholesterol as the most likely dietary factors involved.

2.3.5 We cannot over-stress the fact that the diseases of the heart and circulation together with lung cancer are major smoking-related diseases. When to these are added other smoking-related illnesses*, statistics show that in 1983 there were 16,600 deaths to those aged 15 years and over from smoking-related illnesses. The Department of Health calculates that approximately 5,000 of these deaths are directly attributable to smoking.

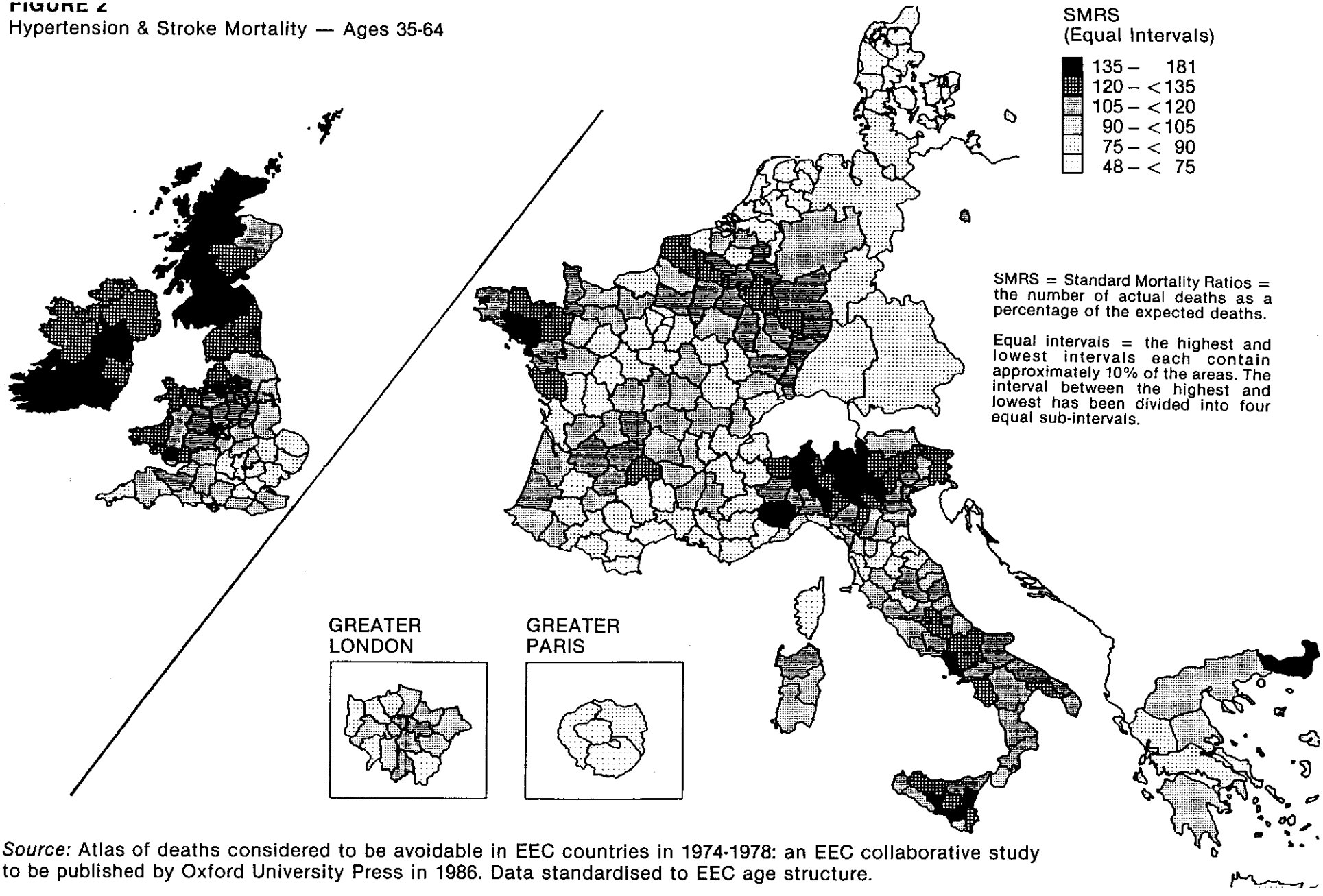
2.4 Accidental Injuries and Deaths

2.4.1 Accidents, rather than disease, contribute significantly to the toll of disability and death in the younger age groups. Measures to reduce them must receive special attention in the development of a health promotion policy. Injuries and accidental poisoning account for over half of all deaths in Ireland to those aged 5-34 years.

Road traffic accidents account for nearly one third of all deaths to persons under 30 years. Comparison with other EEC countries shows Ireland to have a lower rate of road accident deaths. However, this should not give rise to complacency since many background

*Chronic bronchitis and emphysema, cancer of the mouth, larynx, oesophagus, pancreas and bladder and peptic ulcer.

FIGURE 2
Hypertension & Stroke Mortality — Ages 35-64

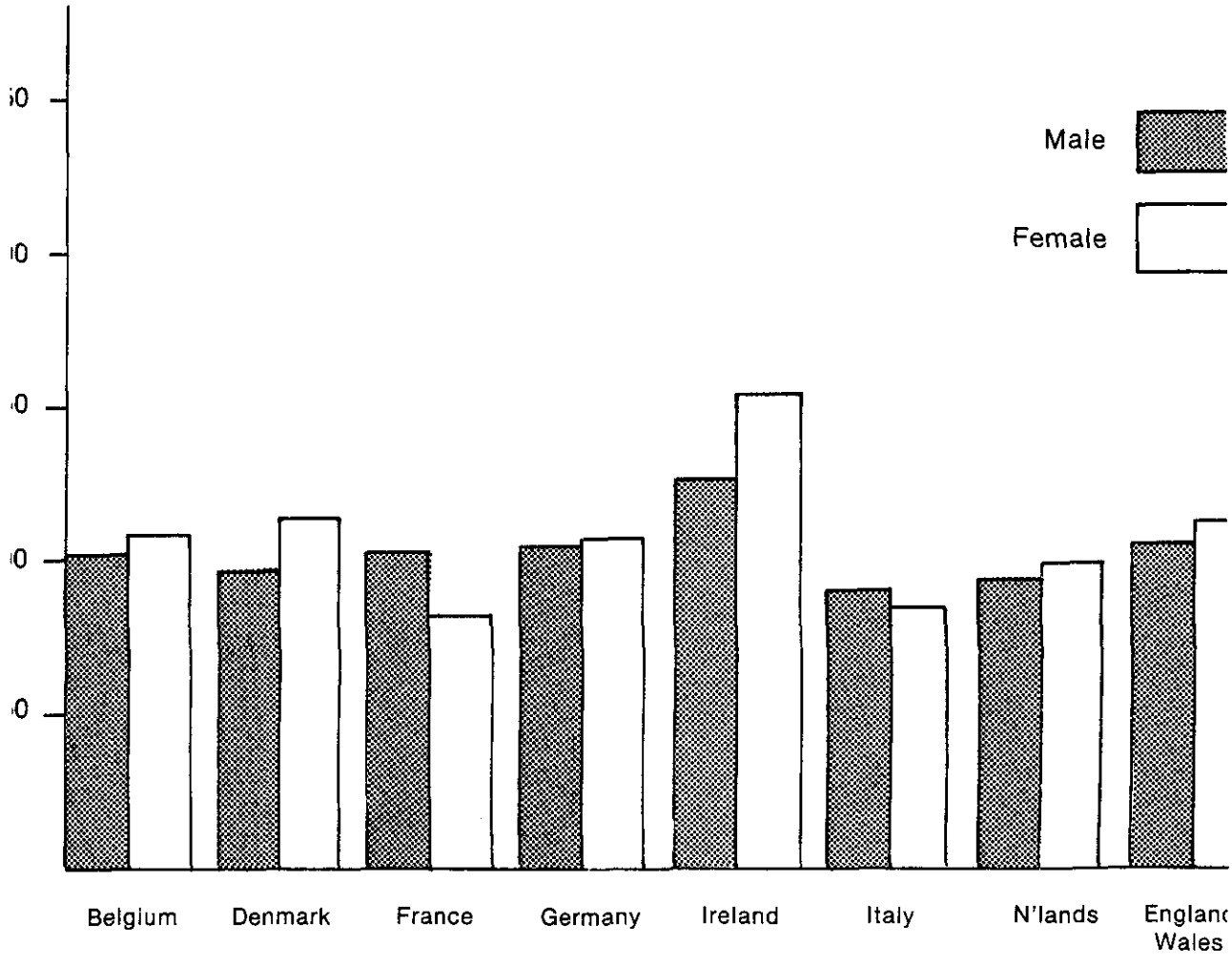


Source: Atlas of deaths considered to be avoidable in EEC countries in 1974-1978: an EEC collaborative study to be published by Oxford University Press in 1986. Data standardised to EEC age structure.

FIGURE 5

Cancer of the Colon

Standardised Mortality Ratio for the period 1969 — 1978 in EEC Countries



Standardised Mortality Ratio = the number of actual deaths as a percentage of the expected deaths.

Reference population, all EEC, 1969 to 1978 = 100

Source: Dean, Geoffrey, Kelson, Marcia, The Reported Mortality Pattern in the Countries of the EEC for Six Common Cancers and Ischaemic Heart Disease. *Irish Medical Journal,* April 1984, Volume 77, No. 4, pp. 98-100.

factors such as population structure, number of miles of roadway and number of motor vehicles affect the level of accidents making meaningful comparison between countries difficult.

2.4.2 In addition to those who died, over 8,000 persons, two thirds of them under 35 years, were reported injured in road traffic accidents in 1984. It is estimated that almost 1,000 of these will have suffered permanent disability. Thousands of others for whom statistics are not available were injured in their homes, at play or at work. Many of the deaths and injuries referred to will have arisen from human error, carelessness or irresponsibility. In other cases the individuals concerned will have been the innocent victims of hazards which should not have been permitted to exist in a more safety conscious society.

2.5 Stress Related Death and Illness

2.5.1 Many instances of illness and death originate in stress; it is a serious hazard not only to the mental but to the physical wellbeing of the individual.

2.5.2 The main indicator of stress in a society will however be found in the statistics of mental illness. At the end of 1983 there were approximately 13,000 patients in residence in psychiatric hospitals and units in Ireland. During the previous year there were almost 29,000 admissions to these services, 9,000 of them being first admissions. Alcohol abuse accounts for 29% and depressive disorders for 27% of first admissions. While the admission rate for female alcoholics has risen since the early 1970's the admission rate for males remains substantially higher at approximately four times that for females. On the other hand the admission rate for women with depressive disorders is considerably greater than that for men.

2.5.3 The striking increase in admissions to psychiatric hospitals is indicated in Figure 4 which shows an increase from about 3,000 in 1930 to close to 30,000 in 1982. However, in interpreting this increase account most be taken of greater use of out-patient facilities, reduced duration of stay by in-patients, and increasing re-admissions.

Out-patient statistics for recent years in particular show the extent to which there is more emphasis on out-patient care. In 1983, for instance, the number of patients attending out-patient clinics was 45,197 compared with 28,054 eight years previously in 1975. The number of actual attendances during the same period rose from 128,000 to over 200,000.

2.5.4 Another indication of emotional stress in Irish society is the large number of tranquillisers consumed. In 1983, there were almost one million perscriptions for tranquillisers under the General Medical Services scheme for which almost 40% of the population is eligible. These accounted for 9% of all the drugs and medicines prescribed to eligible persons. Between 1977 and 1984 the prescribing frequency for tranquillisers increased by 16% while the population covered by the scheme increased by only 5% in the same period.

2.6 Socio-Economic Differences in Illness and Premature Death

2.6.1 No stronger argument is to be found for a re-orientation of our present health policies than that which emerges from a study of the comparative rates of illness and death in the different socio-economic groups. It can be summed up briefly. The poorer members of society are sick more often and die younger.

2.6.2 The Black Report on Inequalities in Health (1980) in the U.K. found that, at any age, people in lower socio-economic groups have a higher rate of death than their better off counterparts. The differences are particularly marked in the first year of life. Within that first year the differences are greatest for accidents and respiratory diseases, the causes of which are largely influenced by environmental factors. The children of people in unskilled jobs are twice as likely to die before they are fourteen as the children of those in professional jobs. Between the ages of one and fourteen, boys in the lowest socio-economic group (i.e. with parents in unskilled manual work) have a ten times greater chance of dying from fire, falls or drowning then those in the highest socio-economic group (i.e. with parents in professions).

2.6.3 These social class differences in health in the U.K. persist into adult life. Thus for both men and women the risk of death before retirement is two and a half times as great in the lowest socio-economic group (i.e. unskilled manual workers and their wives) as it is in the highest socio-economic group (professional men and their wives). It is estimated that on average a professional man born in the U.K. will live seven years longer than a man born into a manual worker background. Furthermore, lung cancer and stomach cancer occur twice as often among men in manual jobs as among men in professional jobs. Four times as many women die of cervical cancer in the lowest socio-economic group as in the highest.

2.6.4 Information is lacking in Ireland on the distribution according to social class of illness and premature death from many diseases. What evidence does exist suggests that the picture does not differ greatly from that found in the U.K. Some data illustrating this is presented below.

2.6.5 Provisional data show that the rate of infant mortality in Ireland is highest in the lower socio-economic groups (Figure 5). A similar trend for perinatal mortality is suggested from preliminary analysis by the Department of Health of data from the Birth Notification Scheme.

Data on the elderly show that those in the higher income groups have substantially better functioning capacity i.e. are physically more active and independent than those on lower incomes. Other notable disparities for the different social classes are apparent from the statistics of mental illness. The rate for first admissions to psychiatric hospitals and units for unskilled manual workers is three times the rate for employers and managers. The rate for all admissions to psychiatric hospitals and units of unskilled manual workers is over five times that of employers and managers (Figure 6) A study of General Practitioner prescribing patterns in 1979, found a much higher level of prescribing of tranquillisers for persons covered by the General Medical Service than for private patients.

2.6.6 There is little data available in Ireland on the socio-economic status of those admitted to general hospitals in Ireland for different diseases.

FIGURE 4

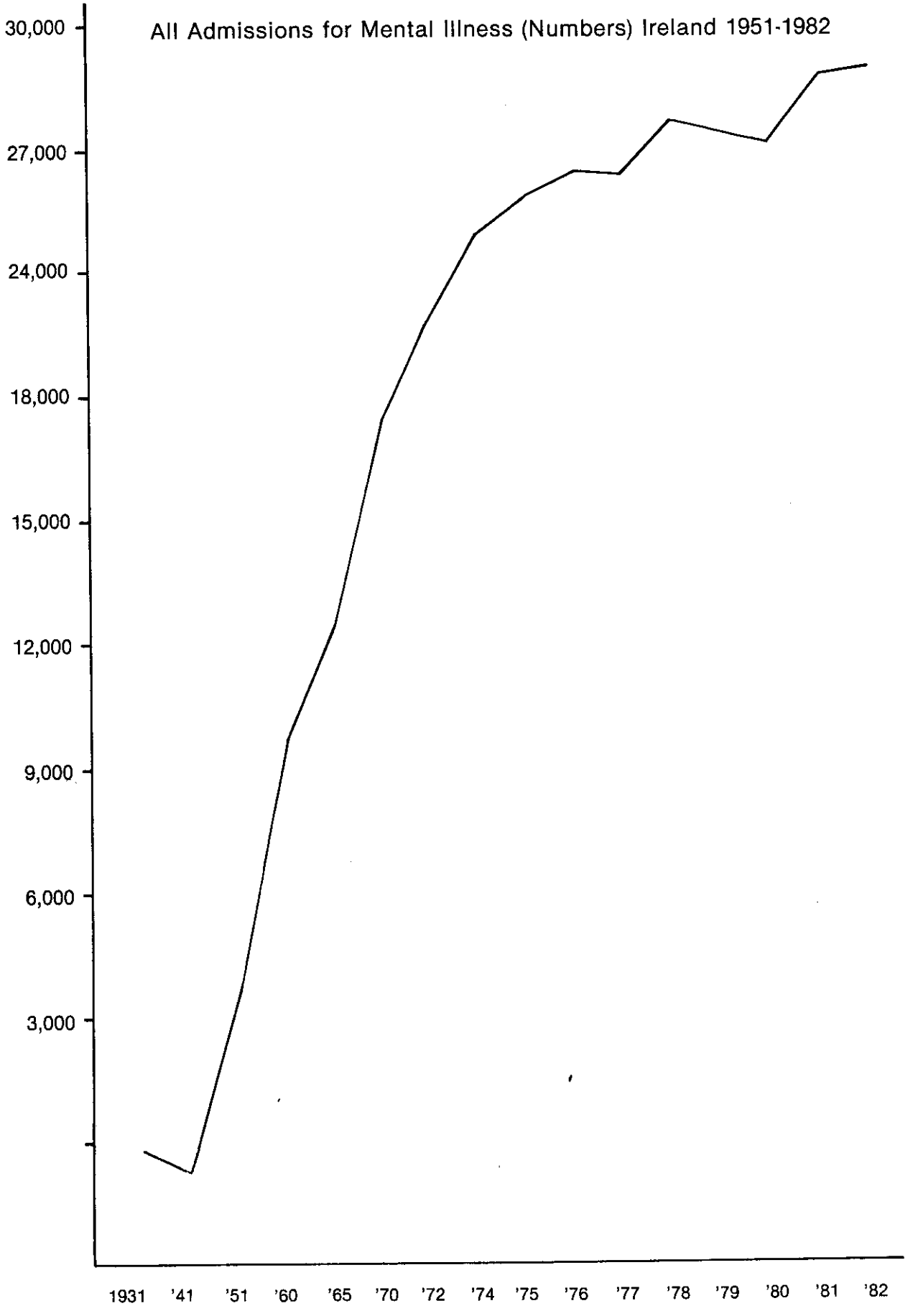
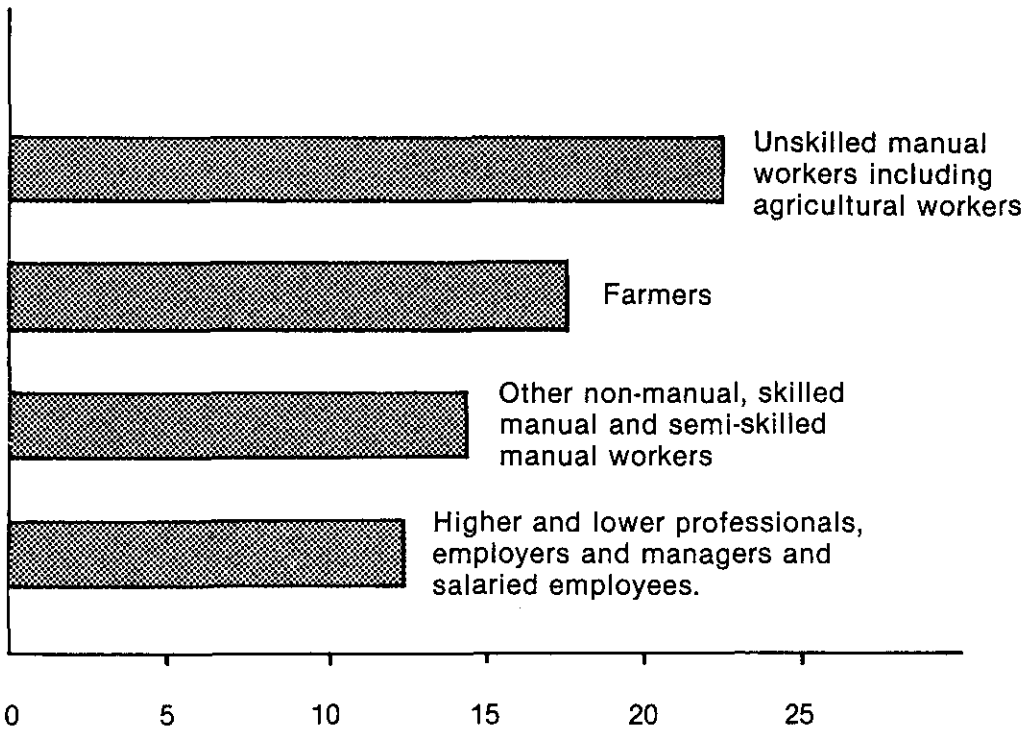

All Admissions for Mental Illness (Numbers) Ireland 1951-1982
30,000
27,000
24,000
18,000
15,000
12,000
9,000
6,000
3,000
1931
'41
'51
'60
'65
'70
'72
'74
'75
'76
'77
'78
'79
'80
'81
'82

FIGURE 5

Infant Mortality Rates per 1,000 Births in 1976 by Socio-Economic Group (Provisional Data)

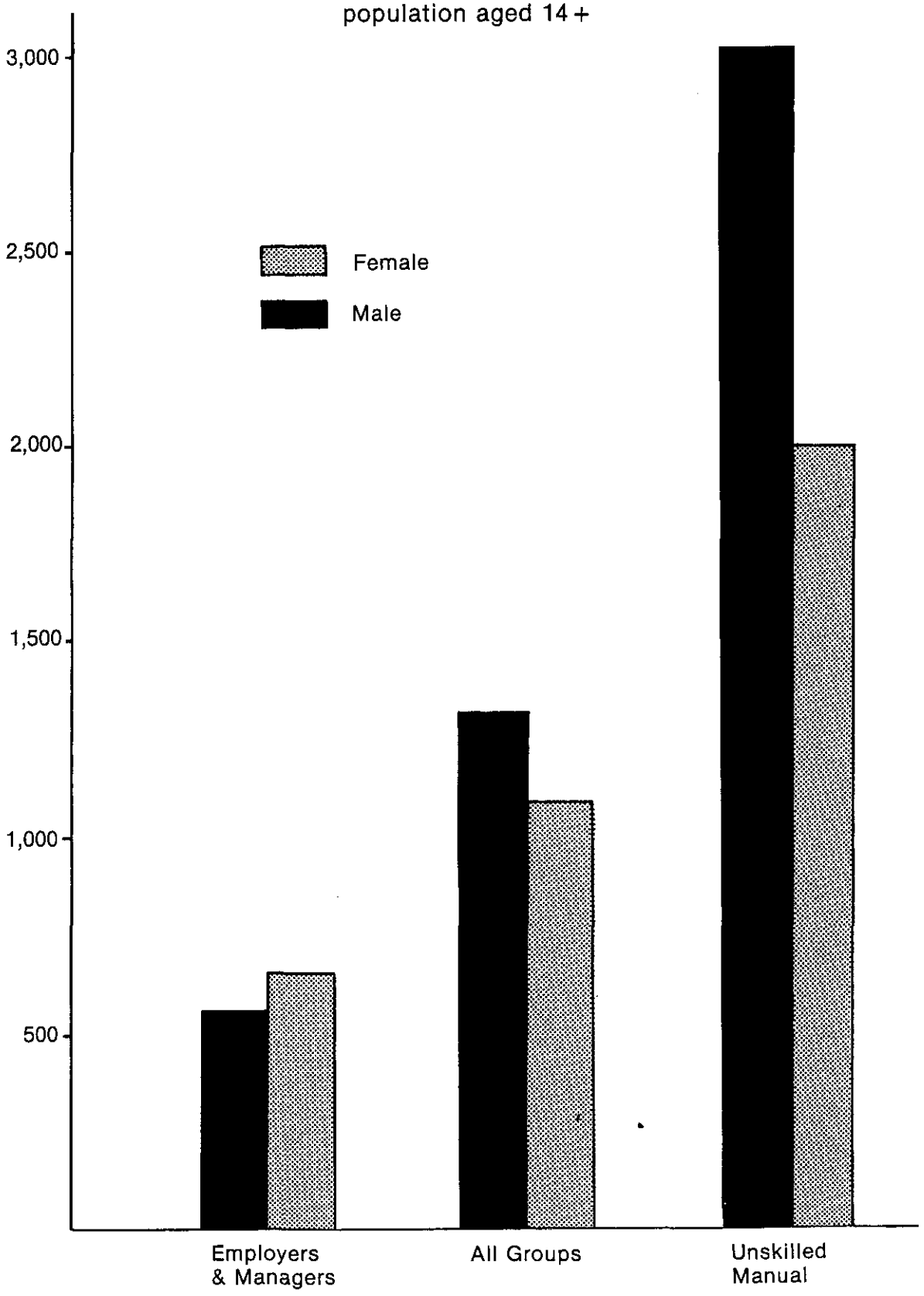


Kirke, Peader, Sources on Child Health Reappraised, *Irish Medical Times*, Nov. 20, 1981, p. 33.

Neither is there data on those attending a doctor for illnesses which do not require hospitalisation. This is a serious gap in the information needed for an effective health promotion programme as risk factors for some social classes and occupations will probably differ from those for the population as a whole.

All Admissions to Psychiatric Hospital, Ireland 1982.

Socio-Economic Group and Sex. Highest, Lowest and all group rates per 100,000 population aged 14 +



Source: O'Hare, Aileen and Walsh, Dermot. Activities of Psychiatric Hospitals & Units, Medico-Social Research Board, 1982.

3 Factors Affecting Health and Wellbeing

3.1.1 As we have already pointed out health is influenced to an important degree by lifestyle, by behaviour, by nutrition as well as by various environmental and social factors. Some of these influences arise entirely from the individual's free choice; s/he may have little or no choice in regard to others. In the following paragraphs we outline in a general way the more important of the factors which will influence the quality of health of the individual. The multiplicity and disparate nature of these factors will be noted. The picture presented serves to emphasise the many elements required to constitute a comprehensive health promotion policy.

3.2 Food

3.2.1 In recent years the importance of nutrition to health status has been increasingly recognised. The scientific evidence has been reviewed and evaluated by a number of expert committees. A consensus is emerging on how the diet of western countries such as Ireland should be modified in order to reduce the risks to health.

The common threads in recommendations include a reduction in consumption of dietary fat, particularly saturated fat, a reduction in the consumption of salt, an increase in the consumption of dietary fibre and a moderation in alcohol intake. Studies on a variety of diseases including coronary heart disease, certain cancers, diabetes and gallstones suggest the need for the modification of diet along these lines. In an Irish context, the Report of the Nutrition

Surveillance Committee to which further reference will be made indicates the gap between the actual diet and the recommended diet for the population as a whole and for specific subgroups within it.

3.2.2 The type of food available in a society is heavily influenced by agricultural policies and also by industrial policies in the food manufacturing and processing sectors. In most instances these policies are seen in terms of economic factors. A health promotion policy would require that health factors were also taken into consideration. Such a policy would not only have regard to the quality and nature of the food produced but would necessarily also entail strict monitoring and control of the use of additives, pesticides and hormones. Because of the importance of diet and nutrition in any consideration of the measures necessary to advance the quality of health we return to this subject in more detail in the next chapter.

3.3 Alcohol

3.3.1 The health effects of alcohol are well documented. Alcohol in large amounts damages the stomach, liver, heart, skin, brain and nervous system. Many of those who abuse alcohol are admitted to psychiatric hospitals. Approximately one quarter of admissions to psychiatric hospitals in Ireland are for alcoholism. The abuse of alcohol also accounts for many admissions to general hospitals. There is a well established relationship between per capita consumption of alcohol and alcohol problems in a society. Between 1958 and 1979 the gross national consumption of spirits increased fourfold, consumption of beer more than doubled and consumption of wine increased fivefold.

3.3.2 Alcohol consumption declined in the early 1980s during a period of economic depression, lower disposable incomes and significant increases in the retail price of alcohol. Decreases in spirit sales were particularly sharp. In late 1984 the duty on spirits was reduced and provisional figures since then show that spirit sales are increasing once more. Ireland in 1984, ranked eighth among 10 EEC countries in terms of consumption of alcohol per person aged 15 years and over. In interpreting this figure, however, account must be taken of the fact that there is a greater percentage of abstainers in Ireland

than in many EEC countries so that total alcohol consumed is spread over fewer people. Comparison between Ireland and the United Kingdom shows that although proportionately more men in the U.K. drink, 11% of all male drinkers in Ireland are heavy drinkers compared to 6% in the U.K..

3.3.3 The cost of alcohol abuse is high. In human terms it includes not only the high number of admissions to hospital for alcoholism or alcohol-related diseases, but also untreated alcohol-related disabilities, stress to families, loss of work time and alcohol-related accidents. Though precise figures are difficult to calculate the Department of Health estimates that loss of output in the Irish economy due to absenteeism related to alcohol abuse was IR£250 million in 1985. Health promotion would seek to take these factors into account in all public policies affecting use of alcohol.

3.4 Smoking

3.4.1 The evidence as to the health risks of tobacco use is overwhelming. Smoking is clearly the most important identifiable cause of premature death. In Ireland, approximately 5,000 deaths a year, principally from coronary heart disease, stroke, lung cancer, and chronic bronchitis and emphysema, are directly attributable to smoking. Since the early 1970s there has been a steady decrease in the percentage of the population which smokes. Thirty two per cent (32%) of the population aged 15+ now smoke. Approximately 20,000 fewer people are smoking each year and the cigarette market in Ireland contracted by 3% in both 1984 and 1985. Nevertheless, despite the drop in the overall percentage of smokers there is evidence of some increase in the percentage of those smoking in their early teens. This is particularly true in the case of girls.

3.4.2 Passive smoking — non-smokers breathing air which contains smoke produced by smokers in the immediate vicinity — has become a subject of increasing concern in recent years. Passive smoking aggravates existing heart and respiratory disease as well as irritating

the eyes, nose and throat of non-smokers. There is some evidence that it increases the risk of cancer in non-smokers exposed over prolonged periods. There is also increased risk to the foetus of a mother who smokes during pregnancy. Young children of smoking parents have a higher than normal frequency of respiratory complaints.

3.4.3 We are conscious of the fact that the Minister for Health has taken various measures in recent months to strengthen the legislative controls over the sale and advertising of tobacco products. But the essential facts are that cigarettes are still readily available; that many persons, particularly young persons, will continue to smoke; and that tobacco will continue to wreak havoc on those who consume it. We are particularly concerned about the cynical disregard by the tobacco industry for the social damage done by its products and particularly by the manner in which it continues, through sponsorship, to promote smoking in the context of healthy outdoor activities.

A serious health promotion policy would seek to have far stricter controls on the destructive and anti-social influences of the industry and particularly on its exploitation of the young and the vulnerable. Success in eliminating the use of tobacco would, in itself, be a major step in the advancement of human health, and in terms of the saving of lives, would be comparable to the virtual elimination of tuberculosis a few decades ago.

3.5 The Environment

3.5.1 The environment — the air we breathe, the water we drink, where we live, our place of work — affects our health. This environment is constantly changing as a result of social, political, industrial and ecological processes. One of the biggest changes in recent times is the way in which urbanisation has brought about an imbalance in population density and structure. This has had implications for health and social services and informal social supports such as extended families and neighbours. Few of us are in a position to choose our working and living environment in its totality. It is

imposed on us. If it contains factors harmful to our health there is little we can do about it. We point to some of these factors in the following paragraphs; they illustrate the extent to which the removal of hazards to our health lies outside the influence of the individual citizen and depends on a multi-sectoral approach involving many public and private agencies.

3.5.2 **Transport:** Transport is an integral part of the environment and road traffic plays a large part in many of the environmental hazards. Noise and air pollution are two potentially injurious side effects of motor vehicles. However, in terms of actual deaths and disablement, road accidents are a most obvious environmental hazard. Research has shown that many factors amenable to change affect the level of road traffic fatalities — alcohol use, speed, seat belt usage, enforcement of road safety regulations and design of built-up areas and roads.

3.5.3 **Air Quality:** Air pollution occurs when the concentration of materials in the atmosphere reaches a level that is harmful to health and the environment. Several factors contribute in a synergistic way to air pollution — motor vehicles, domestic, commercial and industrial chimneys, some types of power generating stations and individual smoking habits. Air pollution can exacerbate respiratory problems. At high levels of air pollution the effects are clearly shown in terms of increased death and illness especially to those with pre-existing respiratory illness, the very young and the elderly. The results of research on the effects of long term exposure to lower levels of pollution are not yet conclusive.

3.5.4 **Water Quality:** Due to increased population, increased urbanisation, industrial development and intensive agriculture, water pollution — largely unknown in Ireland up to the first half of the 20th century — has increased. The main sources of man-made water pollution are domestic activities, industrial and agricultural processes. Radioactive waste in the Irish sea and the constant threat that it may increase as a result of accidents is a cause of national concern. There is no single means of determining water quality because water quality is defined with respect to its suitability for a particular use.

The main uses of water are domestic activities, manufacturing processes, transport, fishing and recreation.

3.5.5 **Chemical Risks:** Developments in technology and chemistry in recent years have given rise to a rapid increase in the numbers and variety of chemicals used in industry. The adverse health effects of occupational exposure to certain toxic metals, chemical compounds and gases have been well documented and are referred to later in paragraph 3.6.2. However, new ways of using these chemicals and the increasing industrial and commercial use of less well known elements are giving rise to different types and levels of exposure. The organic and inorganic derivatives of some of these materials are known to be highly toxic and the health problems which may arise from the processing of these and other chemicals through waste emissions and effluents must be carefully assessed. The co-ordination and the monitoring of the transportation of these substances would also be the concern of a health promotion policy.

3.5.6 **Radiation:** Radiation in the environment comes from both natural and artificial sources. Natural radiation from radio activity in the ground, cosmic radiation, the food chain and internally in the body accounts for 80% of the radiation burden received in a year. Man-made contribution is chiefly from medical and industrial uses of X-rays and radiation, the development and testing of nuclear weapons and the nuclear power industry generally in its processes, waste disposal and accidents.

The acute radiation syndrome, resulting from whole body doses of radiation over a short period, is fortunately a rare occurrence. However, as radioactive elements find a wider application in industry and hospital practice the number of radioactive sources is increasing and thus the possible danger from long term exposure to lower doses. Chronic effects from such exposure of which cancers, leukaemias and genetic disturbance are the most important, are potentially a hazard and point to the need for on-going monitoring and epidemiological studies.

3.5.7 In recent years the level of radon in domestic dwellings is giving rise to some concern. Radon is the product of radioactive decomposition of the naturally occurring uranium series in the soil. The demand for heat conservation which led to greater insulation of houses without adequate ventilation has resulted in a rise in radon levels in certain areas. Studies carried out in Scandinavian countries have shown a correlation between high levels of radon and cancer of the lung. These findings suggest the need for monitoring radon levels and their implications in this country.

3.5.8 **Noise:** Noise is an environmental factor affecting the quality of people's lives and posing a health threat by impairing hearing and interfering with sleep. High levels of urbanisation, industrialisation and mobility — factors already identified in changing the environment — are among the reasons for the increase in noise. In Ireland noise pollution has not been identified as a major problem but it is increasingly being seen as an interference with human comfort and there is a growing awareness of the need for measures to reduce noise levels.

3.5.9 **Where we live:** Health can be affected by the type of housing in which we live and also by the wider community environment in which our housing is situated. Damp, overcrowded living conditions make hygiene difficult, increase the spread of infection and create stress through noise, interpersonal conflict and lack of privacy and safe places for children to play indoors. Where attempts have been made to alleviate bad physical conditions, it has often been done by moving families to newly built estates in the outer suburbs. Here lack of an infrastructure of shops, community centres, recreational facilities and public transport as well as isolation from the extended family, have brought their own hazards to health. The accumulation of such stress increases the pressure to seek temporary relief in alcohol, tobacco and tranquillizers.

3.5.10 **Leisure and Recreational Activities:** How people spend their leisure time has an effect on their mental, social and physical wellbeing. From a health promotion perspective the provision of recreational and leisure facilities for all ages is an integral part of — and not just

an optional extra in — community planning. In a situation where more people are not working either because of retirement or unemployment the availability of leisure and recreational facilities becomes of greater importance to the maintenance of physical and mental wellbeing. Lifestyle, particularly in the areas of work and transport, has become increasingly sedentary so there is particular need for facilities for sport and exercise suitable for all stages of life.

3.6 Employment Policies and Practices

3.6.1 **Occupational Risks Including Accidents:** Gainful employment or the lack of it is a major factor affecting people's lives. In health terms, employment can affect health positively by providing opportunities for fulfilment of potential, giving people a sense of contributing to the society in which they live, providing opportunities for social interaction, structuring time and providing the financial resources to enable them to enjoy an acceptable standard of living. Conversely, employment can also have adverse effects on health, some specific and obvious, and some much more general, subtle and potentially more difficult to ameliorate. The most obvious area is that of accidents at work. The Department of Social Welfare puts the accident total for those at work (excluding the self-employed) at between 11,000 and 12,000 a year.* The Barrington Report gave a tentative estimate of 4,000 to 36,000 accidents involving slight (1-3 day absence) injuries. Between 30 and 35 persons are killed annually in factories, construction sites, mines and quarries. An estimated further 30 are killed each year in agriculture. Each year between 500 and 600 persons become entitled to new pensions in respect of loss (20% or more) of physical or mental faculty because of injury at work. Roughly the same number receive gratuities in respect of a lesser loss of faculty.

3.6.2 In addition to the actual known accidents that have occurred the potential hazard from many substances and processes in the workplace gives cause for concern. The past twenty years has seen a steady increase in the numbers employed in the chemical and

*Accidents involving less than three days absence from work and those involving only damage to property are excluded.

pharmaceutical industries. In addition to this there has been an increase in the use of chemicals in Irish industry. This includes the use of pesticides and herbicides in agriculture. The Dangerous Substances Acts 1972 and 1979 administered by the Department of Labour provide a basis for protecting persons and property against risk of injury caused by any dangerous substances. This is supplemented by a number of regulations made under EEC directives and by other regulations in existing occupational safety and health acts.

The Barrington Report states that the potential for accidents and for a major disaster in Ireland has increased dramatically in line with the increase in transport, storage and use of chemicals. The report also states that there is a lack of specific knowledge about the long-range and short term hazards of toxic chemicals, their environmental impact and occupational health consequences. Many potentially dangerous substances and compounds are at present unregulated. A health promotion policy would seek to monitor more effectively potentially dangerous materials and processes, to provide information to those concerned on them and ideally, in the words of The Barrington Report, "would pursue a policy of containment commencing with the substitution of less hazardous materials and processes."

3.6.3 In addition to dangers arising from materials and processes, there are other more general and less easily quantifiable sources of danger particularly in terms of the stress they can cause. Among such potential stressors would be excessive workload, either mental or physical, monotony and repetitiveness, uncertainty relating to change and reorganisation in work methods and technology. There can be difficulty in disentangling the stress caused by these factors from stress arising from non-work factors.

A study by the European Foundation for the Improvement of Living and Working Conditions (1982) entitled Physical and Psychological Stress at Work, concluded that "the general level of physical and psychological strain in the working population is high" and that "there appears to have been an increase in strain during the 1970s."

The report acknowledges that issues and problems of stress in the workplace are difficult to disentangle from issues and problems of improving the quality of working life or humanizing the work-place: it also suggested that the only approach that commended itself was holistic and one that would involve getting the subjective views and feelings of workers themselves as well as the more objective types of data.

3.6.4 **Occupational Hazards Specific to Women:** Traditionally occupational health and safety regulations have been concerned with predominantly male areas of work — those involving use of heavy machinery, quarrying, mining, etc. Attention has been drawn to a number of predominantly female occupations where protection against potential health hazards is inadequate or non-existent, for example, hairdressing, laundry work, hospital/laboratory work, office work and chemical industries.

3.6.5 One area that has given concern in recent years is the potential effect of workplace hazards on reproductive health. This started with a concern for the pregnant woman and her foetus but has now rightly broadened to concern with the reproductive health of both sexes. The implementation of health and safety procedures in these areas without discrimination in terms of job opportunities is a complex and challenging one. While the balance of evidence to date suggests that radiation from VDUs is well below known biological standards for safety and health there is need for more research and continuous monitoring in this area.

Women in home duties, particularly those in low income groups face their own health hazards. These would include poor housing conditions, social isolation and exclusion (except during pregnancy) from the optical and dental benefits to which their insured husbands are entitled. Women in the agricultural and forestry sector (as well as their families) are exposed to health hazards from brucellosis and farmer's lung as well as from the increased use of pesticides and fertilizers.

3.6.6 **Retirement Policies:** Another aspect of employment with potential consequences for health is retirement policy and practices. Since

in our society employment fills so many functions, giving opportunities for achievement, status, financial reward, social contact and structuring of time, retirement can mean an abrupt loss of all of these benefits. It is now recognised that phased retirement, with a gradual easing out from the routine of work by perhaps working three days a week rather than five, for a lead-up period, would make the transition easier. Similarly there is a need for greater flexibility in relation to age of retirement, to provide for those who will happily retire in their early fifties and those who are capable of, and wish to continue, working into their late sixties and early seventies. In fact there is every reason to think that the life cycle in general is not as inflexible as was thought and that there should be greater facility to enter and exit from work and education right through the lifespan.

3.6.7 **Unemployment:** With 232,448 people (74,012 under 25 years) currently unemployed in Ireland (October, 1986), the effects of unemployment on health is an area of increasing concern. Research in Ireland has shown the considerable psychological distress suffered by the young unemployed — two to three times higher than among comparable samples of employed young people. Several studies from other countries also indicate the adverse effects of unemployment on mental health. The data on the effects of unemployment on physical health are less clear. A recent British Medical Journal series on Occupationless Health, summarized the position as follows: "We cannot be certain, though we can be fairly confident that unemployment caused extra and premature deaths. Similarly we cannot be certain that unemployment causes extra physical illness, although the best evidence suggests that it does."

3.6.8 When looking at the health effects of unemployment it is important to bear in mind the cumulative stress to persons and families over time. Long term unemployment usually results in poverty which in turn is associated with higher levels of ill health which then itself lessens the chance of re-employment. The wider social consequences of unemployment in a society which in turn affect health, must also be borne in mind. Paid employment in our society is at present the main legal distributor of income and the method of integration into the social structure beyond the family. A health promotion

policy would examine how realistic this is as a model for society in the future.

3.7 Usage of Information on Health Issues

3.7.1 People need and have a right to information and education on the factors affecting health to help them to make the most appropriate choices in order to increase their chances of a long and healthy life. Information on a wide variety of topics including nutrition, exercise, substance abuse and preventive services has been made available to the public in recent years. Though such information may be available to all, experience has shown that it is more difficult for some groups to act on it and this further increases inequalities in health. Poor transport facilities and lack of social support in terms of extended family or child-minding facilities for lower income groups can act as barriers to the uptake of preventive health services even where people are aware of them. The accumulation of stresses for some low income groups may make it difficult for people to forgo temporary relief from substances dangerous to health. An example of this is the use of tobacco against which there have been media campaigns accessible to all over the past number of years. Despite decreases in tobacco consumption in all socio-economic groups in Ireland in recent times, its use remains highest in the lowest socio-economic group, a phenomenon also found in many other countries.

3.8 Personal Relationships, Stress and Coping Skills

3.8.1 In recent years the volume of research on stress and coping has alerted us to the need to take a holistic view in understanding health and disease. Traditional divisions between physical and psychological wellbeing are being reexamined since the relationship between them is so intimate and complex. The pursuit of psychological wellbeing is a worthy health aim in itself, but increasingly it is being recognised that emotional and psychological factors can precipitate, exacerbate and prolong most physical illnesses. There is reasonably strong evidence now that stressful life events play a significant role in provoking the onset of many emotional disorders which in turn may precipitate and maintain physical illness.

3.8.2 A description of the many stressors to which children are exposed is beyond the scope of this chapter. A central element in the stressors of childhood is the psychological threat posed by loss of, or separation from, a parent or significant caregiver. This can come about as a result of parental death, illness, marital breakdown, repeated hospitalisations, or as a result of psychological deprivation due to parental neglect, rejection or abuse, severe marital discord or other chronic stresses in the home. Such stressors can have long lasting consequences for an individual's development not just in childhood but throughout adult life. This is particularly likely when the stress is severe, prolonged, repeated and cumulative.

3.8.3 In adult life, stressful life events, particularly those with long term consequences can provoke emotional disorders which in turn can affect physical wellbeing. As in childhood, many such stressful events involve loss or the threat of loss, such as is experienced in the break-up of significant emotional relationships, marital discord, divorce, the threat of a serious illness or unemployment. In a more general way disturbed interpersonal relationships can result in lowered self-esteem, reduced coping capacity and vulnerability to many emotional and physical illnesses. However, the links between stressful life events and long term physical and emotional wellbeing are complex, uncertain and indirect. There are no obvious or simple formulae for the prevention of many stressors. However there is now a growing body of psychological data on such issues as parent-child relations, stress management, conflict resolution and interpersonal effectiveness. This data could be used in the development of appropriate social and economic policies in relation to families, children and marriage; in the development of health education programmes and in the provision of preventive, therapeutic and remedial services. An effective health promotion strategy will crucially depend on accepting that psychological wellbeing is an important issue for society.

3.9 Poverty

3.9.1 There is evidence that income is one of the most important variables influencing health. Data on illness and premature death as presented

in chapter two support this point. While the disparity in health between the upper and lower income group persists throughout life the greatest differences are found among children. There are many ways in which poverty can affect health. Most obviously it can affect it through insufficient resources to provide for basic physical necessities such as food, clothing and housing. The hazards to health of poor housing and an impoverished community environment have already been referred to in paragraph 3.5.9.

On a cultural level, poverty may breed apathy and make it difficult to develop good health habits in the areas of nutrition and exercise. As mentioned in paragraph 3.7.1, people living in areas with a poor infrastructure of transport and social services, such as child-minding, may find it difficult to avail of preventive services such as immunization and screening. Indeed poverty can be seen to be of underlying importance in many of the factors which have an adverse effect on health. Any serious attempt at promoting the health of the community would seek to have health factors taken into account in the formulation of policies on income distribution.

4 Economic Considerations

4.1.1 In chapter two we have suggested that the statistical facts of illness, ageing and death in Ireland today indicate a need for a broad public policy of health promotion. The aim of such a policy would be entirely humanitarian namely, the creation of higher standards of physical and mental wellbeing for citizens of all ages. We are not, we would emphasise, putting forward the case for such a policy on the basis of economic arguments such as suggesting it as a strategy to check the growing costs of our present health services. There are, nonetheless, important economic considerations to which we would like to draw attention. An effective health promotion policy should lead to decreasing demands on medical care services and facilitate the gradual shifting of emphasis on public social spending from the treatment of illness to measures likely to maintain health. This would clearly be a more positive and productive approach towards the expenditure of limited public funds. In this regard we would point out that during 1986 expenditure on our health services is likely to be in excess of £1.2 billion, about one fifth of all public expenditure. The great bulk of this spending is required to cope with sickness; only an insignificant proportion is used to maintain health.

4.2 Trends in Health Expenditure

4.2.1 There has been a very substantial increase in health expenditure in Western countries generally over the past two decades. In the 1960s and 1970s expenditure on health in the OECD countries grew nearly twice as fast as national income, a trend which has moderated

in the last decade. Ireland also showed this pattern of rapid growth of expenditure on health care. Contributing to this pattern was the complex of factors which has operated internationally including the growing demand for health care; increased longevity; the greater costs of provision, in part due to the advent of new technologies and procedures; and the increased role of the State in meeting the costs of health care. As a result, Irish public expenditure on health services rose from 5.5% to 7.2% of GNP between 1975 and 1980.

The increased demands on the services are exemplified by the fact that there were 282,000 discharges from general (including sub-acute) hospitals in 1962 and this rose to 550,000 in 1983. Mental hospital admissions increased from 12,555 in 1960 to 28,778 in 1982. For persons covered by medical cards, the average number of family doctor consultations per year increased from 5 in 1974 to 6.4 in 1985. Despite the significant increase in consumption of services, the demand continues to increase at a steady rate. In general this demand reflects the experience in other developed countries including those with a significantly higher level of income per head than we have in Ireland.

4.3 Relationship of Expenditure to Levels of Health

4.3.1 The level of expenditure on health services in this country, though substantial, is notably lower than that of some other countries. It is not clear, however, that increased levels of expenditure on health services would necessarily produce significant increases in levels of health. Clearly, additional health care could reduce some aspects of the effects of ill-health and provide for certain needs in a more satisfactory manner. But there would be no assurance that these benefits would be commensurate with the additional resources required. Indeed much of the concern expressed in recent years at the rate of increase in expenditure on health services in Western countries has stemmed from the belief that the impact of additional resources has not resulted in a proportionate increase in levels of health. This belief has been strengthened by examination of the historical picture concerning improvements in life expectancy and standards of wellbeing. For example, the decline of mortality and

sickness due to infectious disease since the middle of the last century can be attributed as much to the development of better living standards as to individualised health care, whether of a preventive or curative nature. The decline of the water-borne diseases, such as cholera and typhoid, which had been mass killers in urban areas, followed the introduction of improved sanitary services in the last century. These benefits were reinforced by the effects of improved nutrition and living conditions associated with higher levels of income.

The benefits of mass immunisation programmes came later and had a relatively lower impact on levels of illness in the community. Indeed, it has been suggested that increased levels of health care over the decades have had little impact on mortality, except perhaps in the first year of life. Many commentators have concluded that more fundamental social responses are necessary to tackle current health problems rather than the care or treatment of individuals for specific conditions.

4.3.2 The argument that increased expenditure on health services does not necessarily create a healthier society is supported by indicators of health for those countries where spending on health services is high. This is seen in Figure 1 where expenditure per head on health care for OECD countries is compared with life expectancy. These present only a partial impression of the effects of differing levels of expenditure, but the pattern is such as to indicate that the pursuit of a higher quality of health for the whole population, which should be the goal of health policy, is not likely to be effective through reliance on ever increasing volumes of health services.

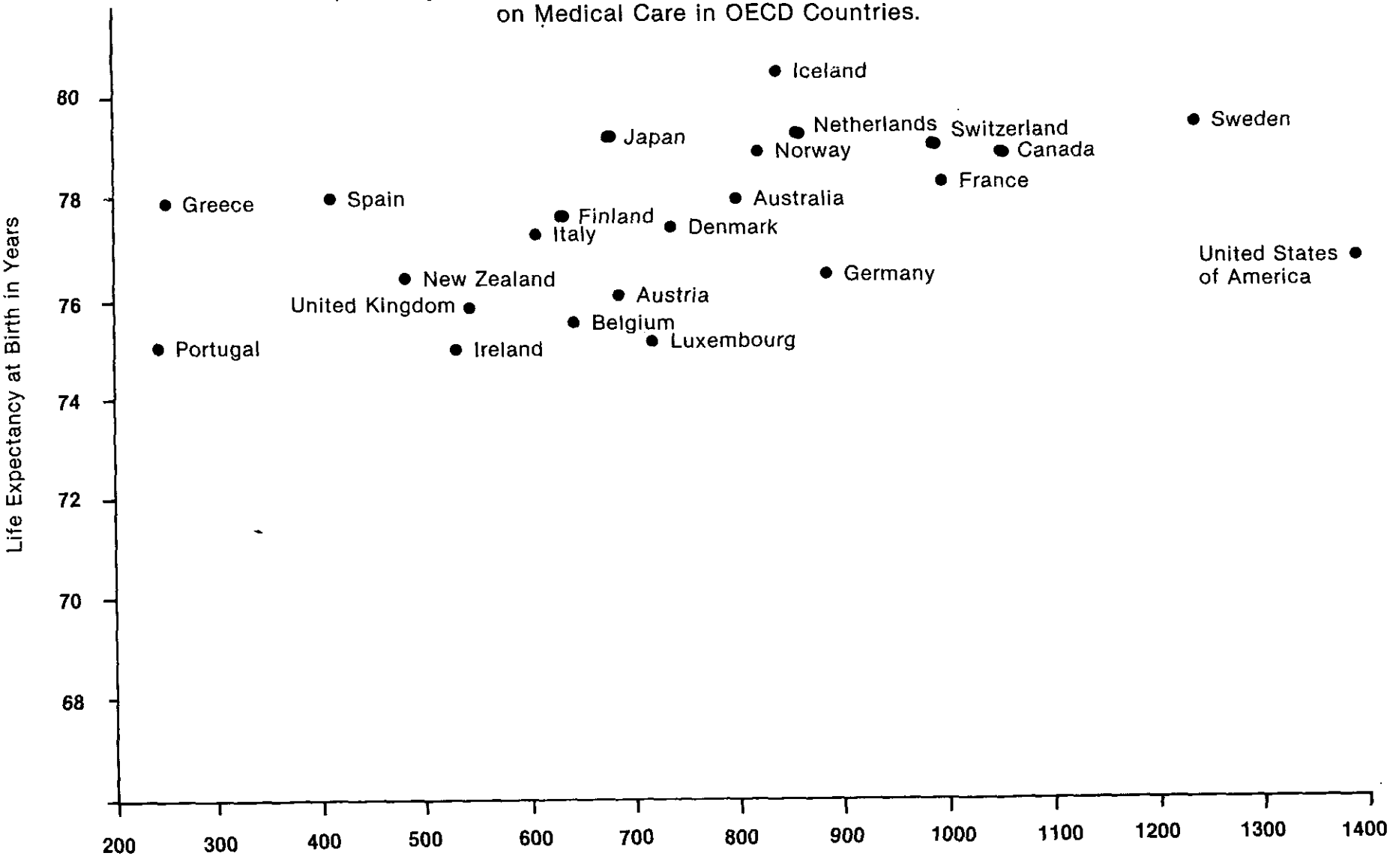
Further evidence in support of this contention comes from analysis of health levels and health spending within the United Kingdom. A recent analysis showed that while expenditure per head was 25% higher in Scotland there than in England, there was no greater achievement of strategic health care objectives than in England.

4.4 Indirect Costs of Illness

4.4.1 The pursuit of health through the provision of mainly curative services has resource implications other than the direct cost of

FIGURE 1(a)

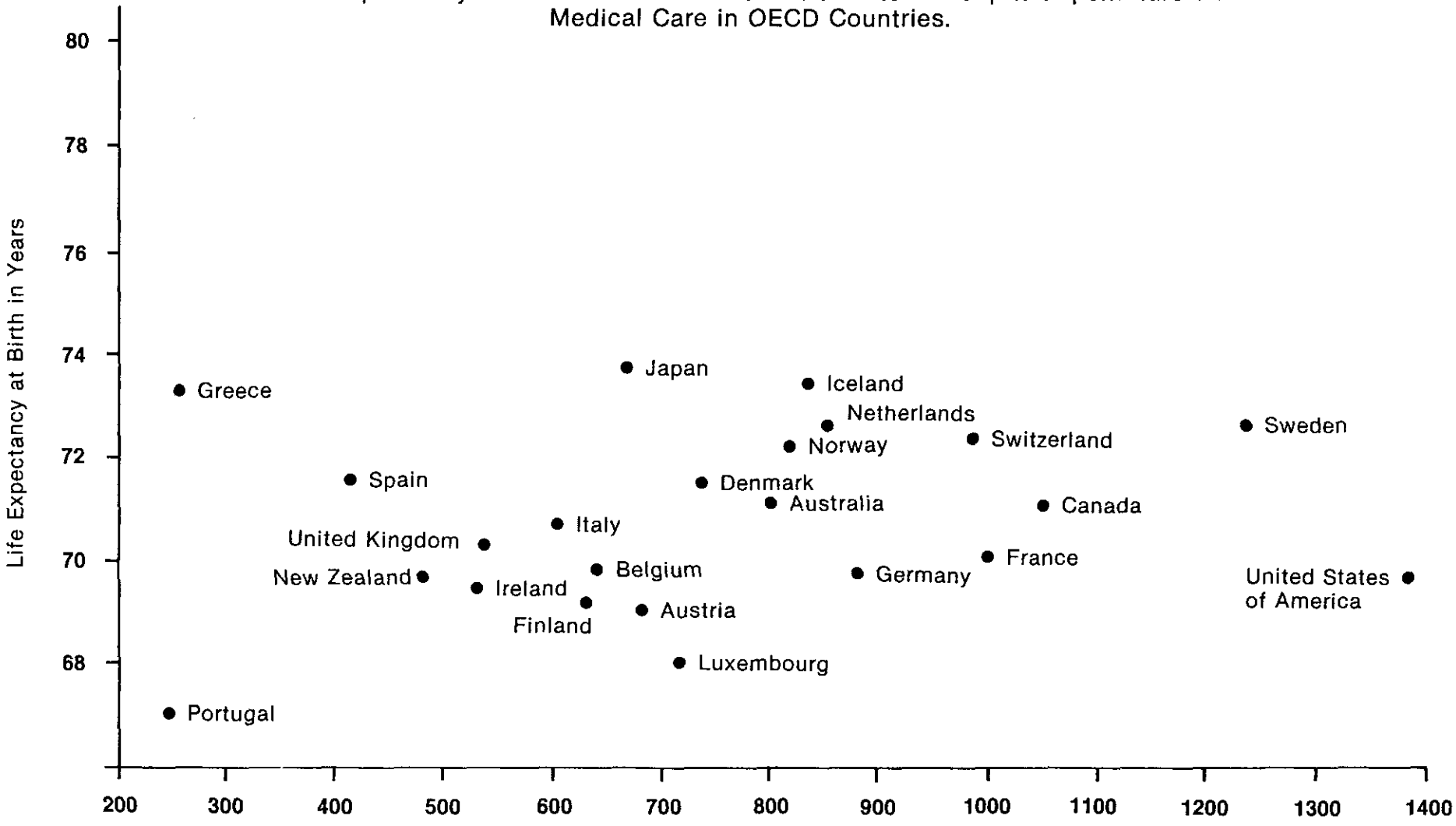
Life Expectancy of Females at Birth in Years related to Per Capita Expenditure on Medical Care in OECD Countries.



Source: Measuring Health Care 1960-1983: Expenditure, Costs and Performance, OECD. Social Policy Studies, No. 2

FIGURE 1(b)

Life Expectancy of Males at Birth in Years related to Per Capita Expenditure on Medical Care in OECD Countries.



Source: Measuring Health Care 1960-1983: Expenditure, Costs and Performance, OECD, Social Policy Studies, No. 2

providing health care. For every episode of illness there are other real costs which have to be borne. These include:

— lost output if the patient or the caring relatives would be otherwise gainfully employed, which reduces the level of income of the community as a whole;

— travel and time costs for patients and family members arising from the provision of health care;

— pain and anxiety for the patient and others which may not carry a cash price but are costly in human terms.

The financial losses can be very substantial. For example, lost output due to absenteeism has been estimated at nearly 5% of GNP. Much of this is due to sickness and is equivalent to over 60% of the cost of the health services.

4.5 Costs of a Health Promotion Policy

4.5.1 It is clear that a very substantial burden is imposed on the community, directly and indirectly, as a result of the toll of illness and death associated with contemporary lifestyles. It is also clear that much of this cost could be reduced and the great tragedy of premature death and disability lessened through policies which removed the causes of these conditions. Policies to alter behaviour in such areas as smoking, diet and exercise as well as environmental change would be capable of substantially altering the profile of death and sickness outlined in previous chapters, in a way which would not be possible through the provision of curative services alone.

4.5.2 Objections could be made that such policies, if implemented, would merely postpone death from, in some cases, middle age to old age and that the cost to the community arising from such a change would be prohibitive. Such costs, it might be argued, would include the cost of treating sicknesses which may arise as more people live to an older age. These costs would be increased by the cost of providing pensions and other support services of a non-health nature to an increasing proportion of elderly people.

4.5.3 Such a perspective is totally alien to health policy, to the human values which underpin it and to social policy in general. Very expensive treatment procedures are employed at the moment to intervene in life-threatening conditions whenever they arise and whatever the economic or productive capacity of the individual patient. The capacity to benefit from treatment in a physical sense is the only criterion for access to available health care and this is entirely in keeping with the wishes of the population. In the light of that value stance it is unthinkable that an alternative strategy for achieving the same result, that is, extending useful life and improving its quality for as long as possible, should be resisted. This is not to deny that successful health promotion will pose challenges to society, not least in the devising of income maintenance policies for those who live longer. But such challenges are at least as capable of solution as the prospect of ever-increasing demand for high-cost health services for a population which is going to age in any event. The present level of expenditure on health care represents an implicitly high valuation of human life, irrespective of age or economic circumstance. Consistency in public policy requires that this high valuation be reflected in the pursuit of feasible health promotion policies.

4.6 An Illustration of the Consequences of Health Promotion

4.6.1 It may be useful to illustrate some of the consequences of a policy of health promotion and in particular to identify some of the economic consequences. Far and away the most important public health problem in Ireland is that arising from smoking. It is a clearly identifiable problem; its consequences can justifiably be termed catastrophic. The elimination of smoking must therefore have a high claim for priority in any strategy for health promotion. If such a policy were successful it is possible to anticipate the consequences as follows:

— there would be a reduction of 5,000 in the number of premature deaths directly attributable to smoking;

— there would be a reduction of over 120,000 bed days in acute hospitals due to smoking-related illness;

— there would be a quarter of a million fewer family doctor consultations for smoking-related illness each year with a comparable reduction in prescribing costs;

— there would be 12,000 fewer claims for disability benefit each year as a direct result of smoking.

4.6.2 The benefits of the elimination of smoking would include the reduced cost of providing health care for smoking-related illness. In order to estimate the extent of the saving it would be necessary to quantify the difference between health care costs for each segment of the population as between smokers and non-smokers. Such evidence is not currently available. It is likely, however, that the costs for smokers are significantly higher in each age group. For example, infants born to smoking mothers have a higher incidence, (and consequently higher health care costs), of respiratory disease than those born to non-smokers. Among the elderly, smokers are more likely to be institutionalised and to be in receipt of acute treatment than non-smokers.

4.6.3 Thus, the savings which would derive from the elimination of smoking are not the total cost of present treatment of smoking-related illness but rather the difference between that cost and the cost of treating non-smokers in each age group. However, the cost of treating smoking-related illness may be used as a reasonable proxy for the somewhat lower saving which would be likely to arise from the elimination of smoking.

Another economic benefit of the elimination of smoking would be higher output through lower absenteeism in the workforce on the part of smokers. Reduced sickness rather than lower death rate would contribute to the lowering of absenteeism since the sickness levels are likely to be higher in the middle and younger age groups than in the older workforce which is more susceptible to smoking-related death. There would also be a minor benefit through reduced fire damage, cleaning costs and ventilation costs.

4.6.4 As against these benefits it would have to be recognised that there would be economic costs associated with the reduction in

employment and output in the tobacco and related sectors. There are currently over 1,500 people directly employed in the tobacco industry and the sale of cigarettes and their advertising is a significant support to the distributive and media sectors. It might also be argued that the elimination of smoking would represent a signficant loss to the Exchequer. In 1985 nearly 6% of government revenue came from excise duties and VAT on tobacco sales, amounting to IR£389,000,000.

In addition, significant sums were received in corporation and income tax from the industry and its employees. However, these are not economic benefits over and above the output of the industry as a whole. They are transfers from one sector to another. If smoking were to be eliminated, the present level of expenditure on tobacco products would be diverted to other uses, at least a signficant part of which would include the purchase of products and services produced in the State. It is unlikely that the diversion of expenditure by consumers of IR£525,000,000 per annum would fail to support employment at least equal to present levels of employment attributable to the tobacco industry. That employment would thus support present levels of contribution of corporation and income tax. Equally, the alternative uses to which consumers' income is transferred from tobacco could be made liable to VAT to replace existing income from VAT on tobacco. It is undoubtedly true that the raising of excise duty on tobacco is a relatively attractive method for governments to raise necessary revenue. It would be possible, however, to devise alternative methods of raising income from the community whose total level of output should not be reduced in aggregate by the elimination of the tobacco industry.

4.6.5 It is difficult to provide firm evidence as to the net cost or benefit to the community of the elimination of smoking. It is likely that the net cost, if any, would be small. It would represent the cost to be paid for the immense benefit in human terms which would flow from the elimination of smoking, that is the reduction in the toll of premature death, chronic sickness and human suffering.

A successful policy for the elimination of smoking would be gradual in its effect and would thus provide ample time for the diversification

of industry and the emergence of alternative patterns of consumer spending which would enable levels of output to be maintained despite the disappearance of the tobacco industry.

5 Diet and Nutrition

5.1.1 Our main aim in this report is to explain the concept of health promotion and to emphasise the importance of its development as one of the basic elements of health policy. It is not our aim to spell out the detailed issues which will arise in each of the sectors affecting the quality of our health. Nevertheless we consider that it would be helpful in illustrating the implications of a policy aimed at creating healthier living if we set out in more detail some of the considerations and issues which will arise in one of the most important of these sectors, namely, the diet and nutrition area.

A similar approach could be applied to other aspects of the environment that affect health, for example, tobacco, air pollution, road traffic accidents, radiation and hazards in the workplace. In all of these areas it is increasingly apparent that while health education can provide information, there is need for basic policy changes and for greater structural support to make a healthy lifestyle more easily available to the community generally and to remove the obstacles in the way of pursuing such a lifestyle. Such an approach requires the co-operation of many sectors other than the traditional health sector.

5.2 The Desirable Diet

5.2.1 The food we eat has long been recognized as important to our health and wellbeing. A recent study has shown that a majority of Irish people recognize this with 65% mentioning good or healthy food as being among the principal factors contributing to good health.

The Food Advisory Committee of the Department of Health has recommended that "in order to ensure an adequate and balanced intake of all essential nutrients, to avoid an excessive intake of individual nutrients and to prevent the build-up of additives and contaminants, the normal diet should be based on a wide and varied range of foodstuffs."

5.2.2 The Food Advisory Committee of the Minister for Health has issued a report (FAC, 1984) which set out quantitative dietary guidelines, for the community as a whole. A comparison between these guidelines and the present Irish diet as outlined in the Nutritional Surveillance Report (1985) is given below.

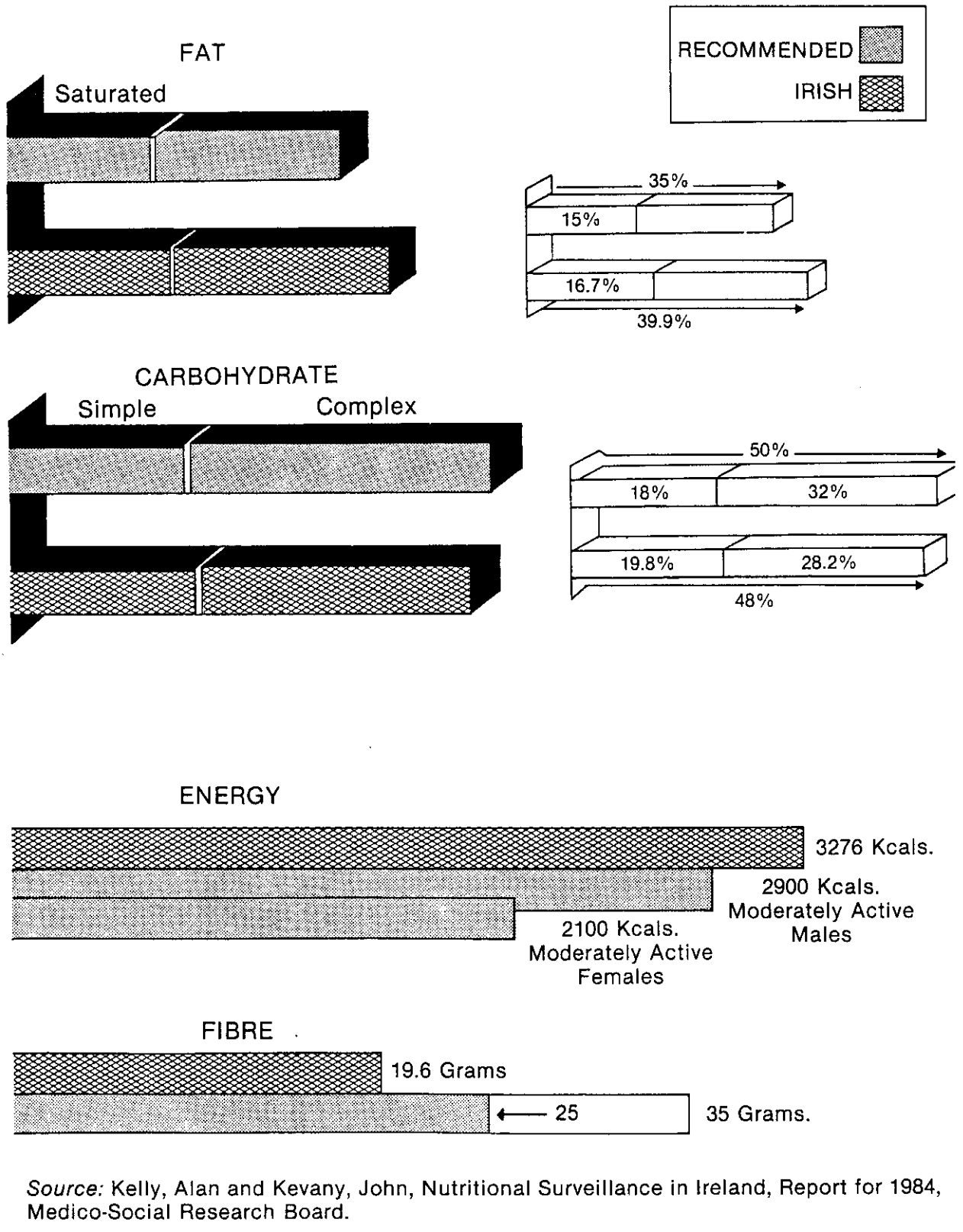
5.3 The Present Irish Diet

5.3.1 As Figure 1 shows the guidelines recommended that on average no more than 35% of dietary energy should come from fat. At present approximately 40% of energy in the Irish diet comes from this source, the other sources being protein and carbohydrates. There is particular need for a reduction in saturated fat i.e. fat derived from animal sources. A recent study in Kilkenny suggests that about one third of the population there are already keeping within the recommended intake of fat.

5.3.2 Figure 1 also suggests that we need to increase our fibre intake. Fibre (roughage) is obtained from bread and other cereal products preferably in wholemeal and whole grain form. It is also obtained from fresh fruit and vegetables eaten raw or lightly cooked. At present we eat on average 20 grams of fibre per day. The recommended diet would include a minimum of 25 grams per day. (It should be borne in mind that the picture given here of the present Irish diet is based on the average for the population as a whole. Particular sub-groups within the population may have an even less favourable diet). The Food Advisory Committee also recommends a reduction in salt intake to 9 grams per day. In practice this means that salt should not be added to food in cooking or at the table, as salt is already present in most foods.

FIGURE 1

Comparison of Irish National Diet with Recent Guidelines



Source: Kelly, Alan and Kevany, John, Nutritional Surveillance in Ireland, Report for 1984, Medico-Social Research Board.

FIGURE 2

Decile Ranking of Ireland with Selected European Countries for per capital Consumption of Major Foodstuffs.*

FRUIT	FISH	MARG.	VEG.	VEG. OIL	EGG	MEAT	CEREALS	ANIMAL OIL	MILK	POTATOES	SUGARS
SPA HOL	NOR SPA		SPA POR	SPA ITA	SPA FGR	FGR FRA	YUG POR	AUS BL	FIN SWE	UK IRE	UK IRE
SWE	DEN		ITA	ITA	UK	BL	ITA	FIN	NOR	SPA	SWE
FGR ITA	POR SWE		YUG SWZ	POR SWZ	FRA SWE	AUS SWZ	SPA SWE	FRA IRE	SWE IRE	BL NOR	DEN FIN
AUS	FIN		FRA	SWE	BL	DEN	FIN	FGR	HOL	FIN	SWZ
NOR SWE	HOL FRA	NOR HOL	HOL AUS	FRA YUG	DEN AUS	HOL IRE	IRE NOR	HOL YUG	DEN UK	SWE HOL	AUS FGR
FRA FIN	UK ITA	DEN UK	UK BL	UK DEN	NOR IRE	UK SPA	UK FRA	POR SWZ	FRA FGR	FRA POR	HOL NOR
BL	FGR	BL	FGR	IRE	ITA	SWE	BL	DEN	AUS	DEN	BL
UK YUG	SWZ AUS	FGR POR	NOR IRE	FIN FGR	HOL FIN	FIN ITA	FGR SWZ	SWE UK	BL ITA	FGR AUS	FRA YUG
POR	BL	IRE	DEN	BL	SWZ	YUG	AUS	ITA	SPA	SWZ	SPA
DEN IRE	IRE YUG	FRA ITA	SWE FIN	HOL NOR	YUG POR	NOR POR	DEN HOL	NOR SPA	YUG POR	YUG ITA	POR ITA

Source: Kelly, Alan, Nutrition Surveillance in Ireland. Report for 1985, Medico-Social Research Board, p. 28.

*Each box corresponds to a level of consumption per head of population. The boxes are ranked from 1 to 10 with the highest levels of consumption at the top of the diagram.

5.4 Comparison With Other Countries

5.4.1 It is of interest to rank countries in terms of their per capita consumption of major foodstuffs. Such a comparison for 16 European countries is given in Figure 2. The ranking shows that for fruit and fish — two desirable dietary components — Ireland is bottom of the table i.e. our average consumption of these foods is the lowest of the 16 selected countries. For intake of vegetables, vegetable oils and eggs we remain in the bottom half of the table. For consumption of meat, cereals, animal oils, milk, potatoes and sugars we are in the top half of the table, exceeding most of our neighbours in the consumption of the last four of these foods.

5.5 Trends in Regard to Irish Diet

5.5.1 The Nutrition Surveillance Reports provide regular data on trends in food consumption and nutrient intake. Thus between 1954 and 1974, there was a steady decline (30%) in cereal consumption which levelled off in 1974 and now remains stable. Potato consumption, which fell gradually from the mid-fifties to the early seventies, appears to have increased by the mid-eighties. Vegetable consumption and fruit consumption have both increased (by 50% and 225% respectively) since the mid-fifties. Therefore, whilst there have been dramatic shifts in the pattern of consumption of fibre-rich foods, the average daily intake of dietary fibre has changed little since the late fifties. Meat consumption has shown a dramatic and steady increase since 1954 tending to level out in the last decade. In contrast, milk consumption has declined by 20% since the late fifties. The consumption of oils and fats has risen sharply since the early seventies. Again, although these major foods which provide most dietary fats have shown vastly different trends in consumption, fat intake as a percentage of energy intake has changed relatively little since the mid-sixties and has remained in the last decade at about 40% of dietary energy.

5.6 Bringing About Change

5.6.1 These data simply indicate the capacity for change in the Irish diet although it should be emphasised that most of the trends arise from

social, economic and cultural factors rather than the impact of health education or a public awareness of what constitutes good food. Nonetheless, they do indicate that the capacity for change exists. However, the individual, no matter how health conscious, will not always be in a position to adopt healthier eating habits. The choices of food available, or affordable, will not necessarily be what one would like to have. Economic forces, cultural traditions and popular foods are likely to be the main determinants of what is produced and offered to the consumer.

5.6.2 A strategy for modifying dietary habits must recognise that not all foods are regarded equally by consumers. Foods can be categorised into core-foods, secondary foods and peripheral foods. The core foods will form the mainstay of the diet and resistance to dietary modification will be greatest in this category. For Ireland, the core foods are — bread, milk, potatoes and meat. Together these foods account for about two thirds of our energy intake, three quarters of our protein and fat intake, 40% of fibre intake as well as being the main sources of sodium, calcium, iron and many vitamins.

Secondary foods play an important, but by definition a subsidiary, role in nutrient supply. This category includes foods such as fruits, vegetables, sugar, tinned foods, processed meat, breakfast cereals and so forth. Peripheral foods are consumed irregularly, e.g., fish, pasta, legumes, sugar, cheese, etc. The emphasis for dietary change must therefore centre on core foods which form the mainstay of the diet and the consumption of which is most conservative. We would suggest, therefore, that it would be unwise to advocate that the consumption of core foods be radically altered. Rather it is better to examine how the presentation of these foods may be altered.

5.6.3 In the case of dairy products there has been a commendable response to the growing awareness of healthy eating by the industry concerned. Thus, consumers may choose full, low fat or skimmed milk and yogurt as well as low fat cheeses. Butter, by law has a maximum acceptable water content and therefore butter with more water and less fat, while technologically feasible, cannot legally be sold as butter. Legislative problems also surround the addition of

vitamins to fat-reduced milk to restore the level of vitamins that are normally found in full milk. It is therefore desirable that the respective legislative groups within the public service reconsider existing legislation so that active encouragement be given to the dairy industry. In so doing, this industry will have fulfilled its role of providing a range of products which allow individuals to maintain their consumption of core foods while also achieving dietary goals. There is a need to invest money in research and development to find ways in which surplus milk fat can be utilised for economic gain.

5.6.4 From our enquiries it would appear that the meat industry lags well behind the dairy industry in its response to the provision of a range of products with varying fat contents. Several steps could be taken to redress this situation. The first area is in production itself. In Ireland, beef cattle are slaughtered at about 36 months of age. We are advised that the rate of change of body composition in beef cattle is such that if cattle were slaughtered at 24 months of age, the level of carcass fat could be considerably reduced. Equally, more extensive use of bull beef production would further reduce carcass fat.

It should, however, be noted that cattle husbandry is as prone to conservatism and tradition as eating habits so that advocating change in husbandry practices alone is not enough to induce changes. The system of payment for beef should be such that premiums would be paid for leaner carcasses which of course means that consumers would have to be willing to pay more for leaner meat. Finally, methods of butchering meat could be looked at to reduce fat content of retail cuts perhaps by introducing the continental practice of purchasing a lean joint with the option of taking home the trimmed fat.

5.7 International Considerations

5.7.1 For Ireland there also exists the unique problem in that the major portion of meat and dairy products are exported. Therefore, unless the recipient countries require lower-fat products, there is relatively less economic incentive for these industries to invest money in modifying production or processing towards this end of the market. Obviously, the Department of Agriculture and the agencies

concerned with the marketing of Irish agricultural products abroad could usefully evaluate the trends in consumer preferences in recipient countries if this is not already being done. In our view changes in the dietary patterns of all developed countries are inevitable with the growing awareness of the relationship between good health and diet. It would make sound economic sense for the Irish agricultural sector to anticipate these changes and to be in a position to take advantage of the new market demands that will arise both at home and abroad.

5.7.2 The Common Agricultural Policy of the European Economic Community appears at present to be founded largely on the continuance of traditional patterns of agricultural production. This no doubt reflects the conservatism of agricultural producers generally in the Community countries. The experience in recent years of the overproduction of some products, the consequent "mountains" and "lakes" of unwanted food, the growing burden of Community subsidies all point towards the need for more emphasis at both the primary and secondary levels of production on more marketable, and potentially more profitable, types of products. Because of the particular importance to the Irish economy of its agricultural sector, Ireland might well take the lead not only in gearing its own agricultural policy to meet the increasing demand for healthier foods but in attempting to influence the Community approach. We would, in this regard, share the view expressed some time ago by Professor Frank Convery of the Resource and Environmental Policy Centre of University College, Dublin:

"Food that is perceived by consumers to be "natural", i.e., relatively unscathed by residues of pesticides, herbicides, growth stimulants, etc. can, if properly marketed, commend a substantial price premium...Ireland is an island of "naturalness" with an agricultural sector which is not yet in the mainstream of "modernism"...Ireland could be "sold" as a brandname for wholesome food, as a country which took extrordinary pains to ensure that its produce in all areas was up to the highest standard."

5.8 Other Considerations

5.8.1 Cereals, including bread and flour are showing a changing pattern of production with most retail outlets providing a wide range of breads from white bread to wholemeal bread. If the bread and cereal industry together with the fruit and vegetable industries engaged in greater promotion of their foods on "health" grounds, the poor image which bread and potatoes suffer (fattening and not nutritious) would decline.

5.8.2 On the other hand cakes, sweets, chocolates, biscuits, etc., are major sources of hidden fats and sugar and therefore education on the nutrient content of these foods and their overall contribution to nutrition would enhance the likelihood that people would select a balanced intake of nutrients.

5.8.3 As prosperity grows the proportion of individuals eating meals outside the home rises. The catering sector may well have to examine its present attitudes to menu planning. Many large companies and organisations such as health boards have had the nutritional value of the meals served by them examined by nutrition consultants. The end product is often an improvement in nutritional value and greater consumer satisfaction. Changes in institutional diets may not initially result in money saved. However, in the long term such a move may indeed prove to be cost effective.

5.8.4 Advertising in relation to health foods requires review. In general the advertiser cannot claim that a particular food has any health quality. It is important that the public is made aware that healthy food is available in local shops e.g. at greengrocers and bakeries and not just in "health food" shops.

5.9 Responsibility for Food Policy

5.9.1 The development of a policy on food and health cannot be achieved by the Department of Health alone. At present responsibility for food legislation and controls is shared by three government departments namely, health, agriculture, and industry, trade, commerce and tourism. A comprehensive food policy will require

a multisectoral approach which will take health into consideration as well as commercial interests and constraints at national and international level.

We are considerably indebted to Dr. M.J. Gibney, Department of Clinical Medicine and Nutrition, Trinity College Dublin, for his assistance in drafting this Chapter.

6 Conclusions and Recommendations

6.1.1 In this concluding chapter of our report we would like to summarise briefly our conclusion and put forward recommendations for the initiation and development of a health promotion policy. We have attempted to take a critical look at the state of our health. We have concluded that it can be improved in the long term only by certain fundamental changes which will encourage and facilitate healthier living. We have stressed that we must always have health services to provide in the most appropriate manner a high standard of care for the sick, the infirm and the disabled. However, the evidence suggests that improvements in health standards have not always been commensurate with the increasing cost of the health services. Such services must be supported by a broader national plan for promoting the health of Irish people — a plan which shows an awareness of the main origins of disease and disability in modern society and provides a basis for a reduction in the toll of illness and premature death and a better quality of health for people of all ages.

6.1.2 Such an approach, with a redirection of resources, is likely to be more beneficial to the health of the community than sole reliance on continuous increases in expenditure on curative services. It would provide people with more information on factors affecting health. It would seek to ensure that the environment was supportive of healthy choices, for example, in terms of food and recreational activity. It would also aim at ensuring that aspects of the wider environment, for example, air and water quality, industrial policy, housing and income distribution would be health supporting.

Such an approach should lead to a decrease in illness and premature death, reduce the incidence of infirmity and ensure a more active life for the elderly. In a broader and a more positive way it should lead to a greater sense of wellbeing among Irish people by equipping them with more knowledge about health and increasing their involvement in, and responsibility for, their own health.

6.1.3 It is obvious that the measures and policies necessary for a comprehensive approach to health promotion will be a gradual development which will involve most sectors of our society. It is not the remit of this group to attempt to make detailed recommendations. We would like, however, to recommend the structural arrangements which, in our view, are essential elements in the initiation of such a comprehensive approach.

6.2 Role of the Minister for Health

6.2.1 The present role of the Minister for Health is primarily one of providing services to deal with sickness rather than promoting health. Present health legislation and the health budget (currently IR£1.2 billion) are devoted almost exclusively to curing and caring for the sick. No individual or organisation is at present responsible for the promotion of the health of the Irish people. We recommend new statutory provisions expanding the role of the Minister for Health to being responsible for the promotion of the health of the Irish people in addition to providing traditional health services.

6.2.2 We recommend that the Minister for Health make such structural changes as are necessary in the Department of Health to take into account the redefined role of the Minister. The Minister would, of course, as part of his responsibility for promoting health, continue to be responsible for the provision of treatment and care for the sick, the infirm and the disabled.

6.2.3 We recommend that the Minister for Health be statutorily required to produce an overall plan on a regular basis, (e.g. every five years), with long term and short term objectives and strategies for promoting the health of the Irish people. Such a plan would spell

out the factors constraining the health of the population. It would specify indicators for measuring health which could be used for both planning and evaluation purposes.

6.2.4 We recommend that the Minister for Health be required to produce an annual report on the health of the community. Such a report would include a progress report in relation to the objectives set in the 5-year plan.

6.3 Health Promotion Council

6.3.1 Since the creation of a healthier living environment must involve many sectors, there must be acceptance by the government and other public agencies that the Minister for Health's role in promoting the health of the community should be that of giving leadership. As well as having the support and understanding of other government and non-government agencies the Minister will require to have available the structures and resources necessary for securing advice on the wide range of issues likely to arise. For that reason we recommend that the Minister for Health establish by statute a Health Promotion Council which would bring together expertise and experience from the different public and private interests whose activities affect health.

6.3.2 The Council would be given the responsibility of identifying issues which would need to be tackled in the interests of the health of the community. It should become the main public lobby for seeking action of this sort. Its important role in national affairs should be reflected in the selection of its members who should be persons of standing and influence in their respective professions and occupations.

6.3.3 We recommend that the Health Promotion Council be serviced from within the Department of Health.

6.4 Health Boards and other Health Agencies

6.4.1 We recommend that the statutory responsibilities of the health boards be amended in a similar way to that of the role of the Minister

for Health, i.e., the health boards would be made clearly responsible for the promotion of the health of people in their areas in accordance with the national plan prepared by the Minister.

6.4.2 We recommend that the composition of health boards and other health agencies be altered and strengthened to reflect a broader remit of health promotion. Health boards should be required to produce policies, plans and reports on health promotion.

6.4.3 We recommend that each health board administration should have a unit at senior level to deal with health promotion/education including co-operation with, and co-ordination of, the actions of other agencies in their area.

6.5 Health Education Bureau

6.5.1 We recommend that the concept of health education be broadened to include not only personal factors affecting health but also the impact of broader factors such as the economic, social and physical environment.

6.5.2 We recommend that the remit and scope of the Health Education Bureau be broadened to deal with this more comprehensive definition of health education.

6.6 Research

6.6.1 In order that the Minister and other agencies concerned with health promotion are adequately informed it is vital that facilities for research and evaluation should be available. We recommend that the Health Research Board which is being established as a result of the amalgamation of the functions of the Medical Research Council and the Medico-Social Research Board should see itself as having the major input into this area.

However, in view of the multi-faceted nature of health promotion it is obvious that the skills and resources of other existing research bodies should also be drawn upon. We have in mind such bodies

as An Foras Forbatha, the Economic and Social Research Institute, the Health Education Bureau, the Institute of Industrial Research and Standards, the Agricultural Institute and the research sections of the various third level educational centres.

6.7 Finance

6.7.1 The adoption of a health promotion policy should not in itself entail additional expenditure but rather the redirection of some existing resources. Essentially what is involved is the formulation or reformulation of public policies with their health implications in mind. There should be a gradual redirection of expenditure within the Department of Health to reflect greater awareness of the social factors identified in this report as affecting health. Spending in all government departments should be sensitive to health promotion. Many initiatives will also involve voluntary decisions in the private sector.

6.7.2 We recommend that government policy would discriminate in favour of healthy as against non-healthy aspects of commercial and social life so as, for example, to encourage healthier patterns of consumer behaviour and healthier lifestyles.

6.8 International Arena

The European Economic Community

6.8.1 We recommend government initiatives at international level to promote health. The health of Irish people is at present being influenced by EEC legislation, for example, in the agricultural industry. Our national policy of health promotion should be reflected in decisions at EEC level. The legislative and structural integration and co-ordination recommended by us at national level is also necessary at EEC level. This would aim to have agricultural, industrial, environmental and social policies within the EEC supportive of health.

6.8.2 While there are limitations to the actions that can be taken by the EEC on health matters, Irish members of the European Parliament

and the Economic and Social Committee could, with representatives of other countries, help to focus attention on the community-wide dimensions of a health policy. Therefore every advantage should be taken of our membership of these institutions to ensure that the health impact of developments in other sectors are known and reflected in policy at a European level. The Council of Europe and the OECD provide a framework for joint action which is less constrained in matters of health policy than the EEC may be at present.

The World Health Organization

6.8.3 We recommend that the Department of Health continue to draw on the support and expertise of the World Health Organization in the development and implementation of a health promotion policy.

APPENDIX 1

World Health Organisation — Targets for Health for All

Brief Summary of Targets
in Support of the European Regional
Strategy for Health for All by the Year 2000

World Health Organisation
Regional Office for Europe
Copenhagen
1985

1. Reducing the Differences
By the year 2000, the actual differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups.

2. Adding Life to Years
By the year 2000, people should have the basic opportunity to develop and use their health potential to live socially and economically fulfilling lives.

3. Better Opportunities for the Disabled
By the year 2000, disabled persons should have the physical, social and economic opportunities that allow at least for a socially and economically fulfilling and mentally creative life.

4. Reducing Disease and Disability
By the year 2000, the average number of years that people live free from major disease and disability should be increased by at least 10%.

5. Elimination of Specific Diseases
By the year 2000, there should be no indigenous measles, polio-myelitis, neonatal tetanus, congenital rubella, diphtheria, congenital syphilis or indigenous malaria in the Region.

6. Life Expectancy at Birth
By the year 2000, life expectancy at birth in the Region should be at least 75 years.

7. Infant Mortality
By the year 2000, infant mortality in the Region should be less than 20 per 1000 live births.

8. Maternal Mortality
By the year 2000, maternal mortality in the Region should be less than 15 per 100,000 live births.

9. Diseases of the Circulation
By the year 2000, mortality in the Region from diseases of the circulatory system in people under 65 should be reduced by at least 15%.

10. Cancer
By the year 2000, mortality in the Region from cancer in people under 65 should be reduced by at least 15%.

11. Accidents
By the year 2000, deaths from accidents in the Region should be reduced by at least 25% through an intensified effort to reduce traffic, home and occupational accidents.

12. Suicide

By the year 2000, the current rising trends in suicides and attempted suicides in the Region should be reversed.

13. Healthy Public Policy

By 1990, national policies in all Member States should ensure that legislative, administrative and economic mechanisms provide broad intersectoral support and resources for the promotion of healthy lifestyles and ensure effective participation of the people at all levels of such policy-making.

14. Social Support Systems

By 1990, all Member States should have specific programmes which enhance the major roles of the family and other social groups in developing and supporting healthy lifestyles.

15. Knowledge and Motivation for Health Behaviour

By 1990, educational programmes in all Member States should enhance the knowledge, motivation and skills of people to acquire and maintain health.

16. Positive Health Behaviour

By 1995, in all Member States, there should be significant increases in positive health behaviour, such as balanced nutrition, non-smoking, appropriate physical activity and good stress management.

17. Health-Damaging Behaviour

By 1995, in all Member States, there should be significant decreases in health-damaging behaviour, such as overuse of alcohol and pharmaceutical products; and dangerous driving and violent social behaviour.

18. Multisectoral Policies

By 1990, Member States should have multisectoral policies that effectively protect the environment from health hazards, ensure community awareness and involvement, and support international efforts to curb such hazards affecting more than one country.

19. Monitoring and Control Mechanisms

By 1990, all Member States should have adequate machinery for the monitoring, assessment and control of environmental hazards which pose a threat to human health, including potentially toxic chemicals, radiation, harmful consumer goods and biological agents.

20. Control of Water Pollution

By 1990, all people of the Region should have adequate supplies of safe drinking-water, and by the year 1995 pollution of rivers, lakes and seas should no longer pose a threat to human health.

21. Control of Air Pollution
By 1995, all people in the Region should be effectively protected against recognised health risks from air pollution.

22. Food Safety
By 1990, all Member States should have significantly reduced health risks from food contamination and implemented measures to protect consumers from harmful additives.

23. Control of Hazardous Wastes
By 1995, all Member States, should have eliminated major known health risks associated with the disposal of hazardous wastes.

24. Human Settlements and Housing
By the year 2000, all people of the Region should have a better opportunity of living in houses and settlements which provide a healthy and safe environment.

25. Working Environment
By 1995, people of the Region should be effectively protected against work-related health risks.

26. A System Based on Primary Health Care
By 1990, all Member States, through effective community representation, should have developed health care systems that are based on primary health care and supported by secondary and tertiary care as outlined at the Alma-Ata Conference.

27. Rational and Preferential Distribution of Resources
By 1990, in all Member States, the infrastructures of the delivery systems should be organised so that resources are distributed according to need, and that services ensure physical and economic accessibility to the population.

28. Content of Primary Health Care
By 1990, the primary health care system of all Member States should provide a wide range of health-promotive, curative, rehabilitative and supportive services to meet the basic health needs of the population and give special attention to high-risk, vulnerable and underserved individuals and groups.

29. Providers of Primary Health Care
By 1990, in all Member States, primary health care systems should be based on co-operation and teamwork between health care personnel, individuals, families and community groups.

30. Co-ordination of Community Resources
By 1990, all Member States should have mechanisms by which the services provided

by all sectors relating to health are co-ordinated at the community level in a primary health care system.

31. Ensuring Quality of Care
By 1990, all Member States should have built effective mechanisms for ensuring quality of patient care within their health care systems.

32. Research Strategies
Before 1990, all Member States should have formulated research strategies to stimulate investigations which improve the application and expansion of knowledge needed to support their health for all developments.

33. Policies for Health for All
Before 1990, all Member States should ensure that their health policies and strategies are in line with health for all principles and that their legislation and regulations make their implementation effective in all sectors of society.

34. Planning and Resource Allocation
Before 1990, Member States should have managerial processes for health development geared to the attainment of health for all, actively involving communities and all sectors relevant to health and, accordingly, ensuring preferential allocation of resources to health development priorities.

35. Health Information Systems
Before 1990, Member States should have health information systems capable of supporting their national strategies for health for all.

36. Planning, Education and Use of Health Personnel
Before 1990, in all Member States, the planning, training and use of health personnel should be in accordance with health for all policies, with emphasis on the primary health care approach.

37. Education of Personnel in Other Sectors
Before 1990, in all Member States, education should provide personnel in sectors related to health with adequate information on the country's health for all policies and programmes and their practical application in their own sectors.

38. Appropriate Health Technology
Before 1990, all Member States should have established a formal mechanism for the systematic assessment of the appropriate use of health technologies and of their effectiveness, efficiency, safety and acceptability, as well as reflecting national health policies and economic restraints.

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