



All-Ireland Health and Wellbeing Data Set
INIsPHO Data Briefing No 2008: 3

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All-Ireland Health and Wellbeing Dataset

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- Health Protection Surveillance Centre, Republic of Ireland
- Health Research Board, Republic of Ireland
- Health Service Executive, Republic of Ireland
- Irish Social Science Data Archive, University College Dublin, Republic of Ireland
- Local Government Services Management Board, Republic of Ireland
- National Cancer Registry Ireland
- Northern Ireland Cancer Registry
- Northern Ireland Fire and Rescue Service
- Northern Ireland Housing Executive
- Northern Ireland Neighbourhood Information Service
- Northern Ireland Statistics and Research Agency
- Police Service of Northern Ireland
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1. INIsPHO@IPH Data Briefings

Institute of Public Health in Ireland

The Institute of Public Health in Ireland (IPH) is an all-island body which combats health inequalities and influences public policy in favour of health. Its remit is to 'promote cooperation for public health between the Republic of Ireland and Northern Ireland' including the areas of monitoring and surveillance. Further information can be found at www.publichealth.ie.

Ireland and Northern Ireland's Population Health Observatory

In 2005 Ireland and Northern Ireland's Population Health Observatory (INIsPHO) was established within the Institute of Public Health in Ireland. INIsPHO supports those working to improve health and reduce health inequalities by:

- Producing, disseminating and supporting the use of health intelligence on priority health issues
- Strengthening the research and information infrastructure on the island of Ireland.

The Observatory focuses on the practical aspects of the development of health intelligence and its translation into effective policy and practice. Further information can be found at www.inispho.org.

INIsPHO eData website (www.inispho.org/edata)

The INIsPHO eData website (www.inispho.org/edata) brings together health-related data from a variety of sources and includes visualisation tools that allow users to aggregate, chart and map those data.

The information contained in those datasets will be of interest to:

- Public health and health promotion practitioners
- Regional and local planners and policy makers within the health services
- Local government committees engaged in planning and development issues relating to poverty, social exclusion and regeneration
- Regional and local partnerships engaged in tackling social exclusion

- Community and voluntary groups keen to access and utilise information on the needs of the people they represent.

Other public health resources dealing with related issues can be found on the All-Ireland electronic Health Library (AieHL) (www.aiehl.org).

INIsPHO Data Briefings

When a significant new dataset is added to the INIsPHO eData website, an INIsPHO Data Briefing will be produced using INIsPHO eData tools. These Data Briefings have two aims:

- To present highlights from the dataset to allow practitioners and policy makers to decide if the information contained in the dataset is potentially relevant to their work
- To provide a technical description of the dataset, and to illustrate outputs from the visualisation tools, for potential users of the INIsPHO eData website.

Those wanting to access the dataset should go to the INIsPHO eData website (www.inispho.org/edata).

Interpretation of findings

Always interpret data findings cautiously. As a general rule, the INIsPHO eData website does not include confidence limits in its charts and maps. It aims to provide visualization tools that allow you to explore (numerical) datasets. If you find something that you think is important, we strongly urge you to explore it more rigorously - consulting an experienced data analyst if appropriate - before taking any action based on that finding.

Technical descriptions of some of the related issues are given in Appendix 1.

2. Background

2.1 Irish Health Poverty Index (iHPI)

Comprehensive suites of health and wellbeing indicators can contribute to the development of community profiles, local needs assessments and service commissioning, health impact assessments, and help monitor progress in reducing health inequalities. These contributions are possible, in part, because they can contextualise the situation in a local area by facilitating geographical comparisons.

They are critical in tackling health and social inequalities. There is currently no system for monitoring local health and wellbeing across the island of Ireland. Such a system would provide a local picture as well as highlighting health inequalities from an all-Ireland perspective.

A population's 'health poverty' is a combination of its present state of health and its potential for future health. Health Poverty Indices (HPIs) are local area collections of measures of the complex health, social, economic, environmental, and resourcing factors involved in the generation of health and ill-health.

INIsPHO received funding from the Department of Health and Children, the Department of Health, Social Services and Public Safety, and Combat Poverty Agency to adapt the English Health Poverty Index (eHPI) to the Irish context and to develop an Irish Health Poverty Index (iHPI).

The eHPI was developed by a consortium consisting of the Association of Public Health Observatories (APHO), the University of St Andrews and the University of Oxford (www.hpi.org.uk).

2.2 All Ireland Health and Social Care Indicator Set (AIHSC)

The Northern Ireland Health and Social Care Inequalities Monitoring System (NIHSCIMS) was established by the Department of Health, Social Services and Public Safety. It comprises indicators that are monitored over time to assess area differences in mortality, morbidity, utilisation and access to health and social care services.

The All-Ireland Health and Social Care Indicator Set (AIHSC) extends the NIHSCIMS to the island of Ireland.

2.3 All Ireland Health and Wellbeing Data Set (AIHWDS)

In August 2008, Ireland and Northern Ireland's Population Health Observatory (INIsPHO) at the Institute of Public Health in Ireland (IPH) released two new data sets:

- The interim release of the Irish Health Poverty Index (iHPI);
- The All-Ireland Health and Social Care Indicator Set (AIHSC).

These datasets are part of the INIsPHO eData website (www.inispho.org/edata) where the indicators can be charted, mapped or downloaded for later use.

The iHPI has now been completed, and the full iHPI, the AIHSC plus a number of additional demographic and socio-economic indicators, have been incorporated into one combined dataset called the All-Ireland Health and Wellbeing Data Set (AIHWDS). AIHWDS is available to download at www.inispho.org/aihwds. Users will now be able to compare indicators from different indicator sets and get more comprehensive profiles of a particular area.

3. All Ireland Health and Wellbeing Data Set (AIHWDS)

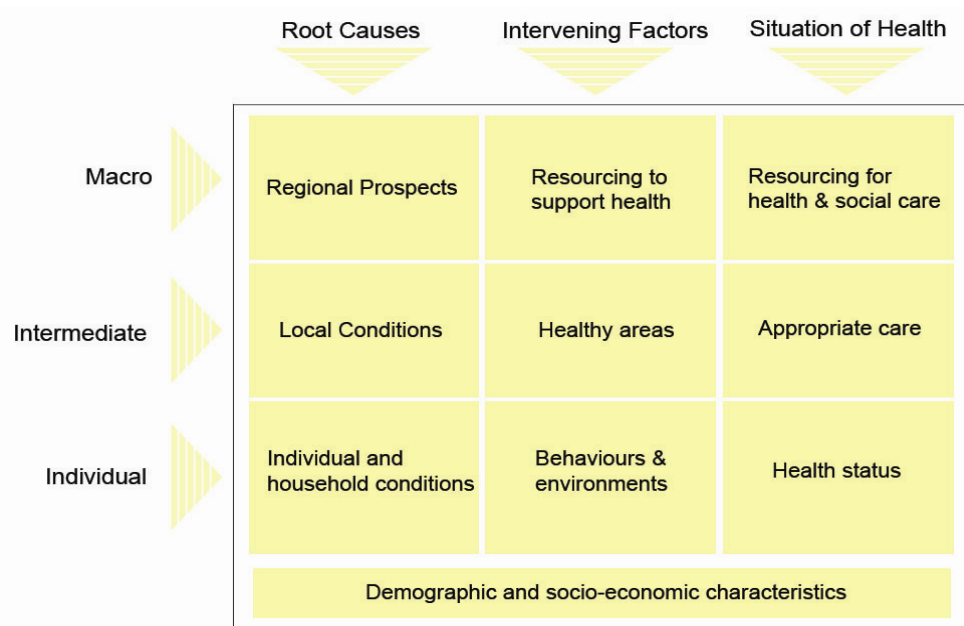
3.1 Conceptual Framework

The conceptual framework underpinning the AIHWDS is presented in Figure 1. The framework views the **situation of health** of a population (often a geographical area) as emerging from **intervening factors** that are themselves based on a set of underlying **root causes**. It recognises that factors influencing health operate at the **individual** level, the **intermediate** (local) level and the wider **macro** (social) level. The framework then groups together measures under nine domains derived from these three stages and three levels. This framework was adapted unchanged from the eHPI.

It should be emphasised that Figure 1 is not intended to be an explanatory 'model'. It simply aims to organise the elements, identified in the literature as important in the construction of health inequalities, into a form that will aid thinking about policies and actions that might tackle these inequalities. The framework, of course, does not exemplify all of the complex ways in which the different elements involved in the production of inequalities interact.

Conceptual Framework for the All Ireland Health and Wellbeing Data Set (AIHWDS)

Fig. 1



3.2 Geographical Scope of Indicators in the AIHWDS

Not all of the indicators are available in both of the jurisdictions on the island of Ireland. Hence it was necessary to classify the indicators according to their geographic scope:

- *All-Ireland indicators*: indicators that are available in both the Republic of Ireland and Northern Ireland and which are sufficiently comparable to be combined into a measure covering the whole island
- *North/South indicators*: indicators that are available in both the Republic of Ireland and Northern Ireland but which are not sufficiently comparable to be combined into a single measure
- *South (only) indicators*: indicators that are available in the Republic of Ireland but not in Northern Ireland
- *North (only) indicators*: indicators that are available in Northern Ireland but not in the Republic of Ireland

In combination, in the AIHWDS there are:

- 27 indicators that cover the island of Ireland;
- 65 indicators that cover every (traditional) county in the Republic of Ireland;
- 81 indicators that cover every Local Government District (LGD) in Northern Ireland.

Where relevant, these components have been compiled for:

- Every (traditional) county in the Republic of Ireland (26 areas)
- Every Local Government District (LGD) in Northern Ireland (26 areas).

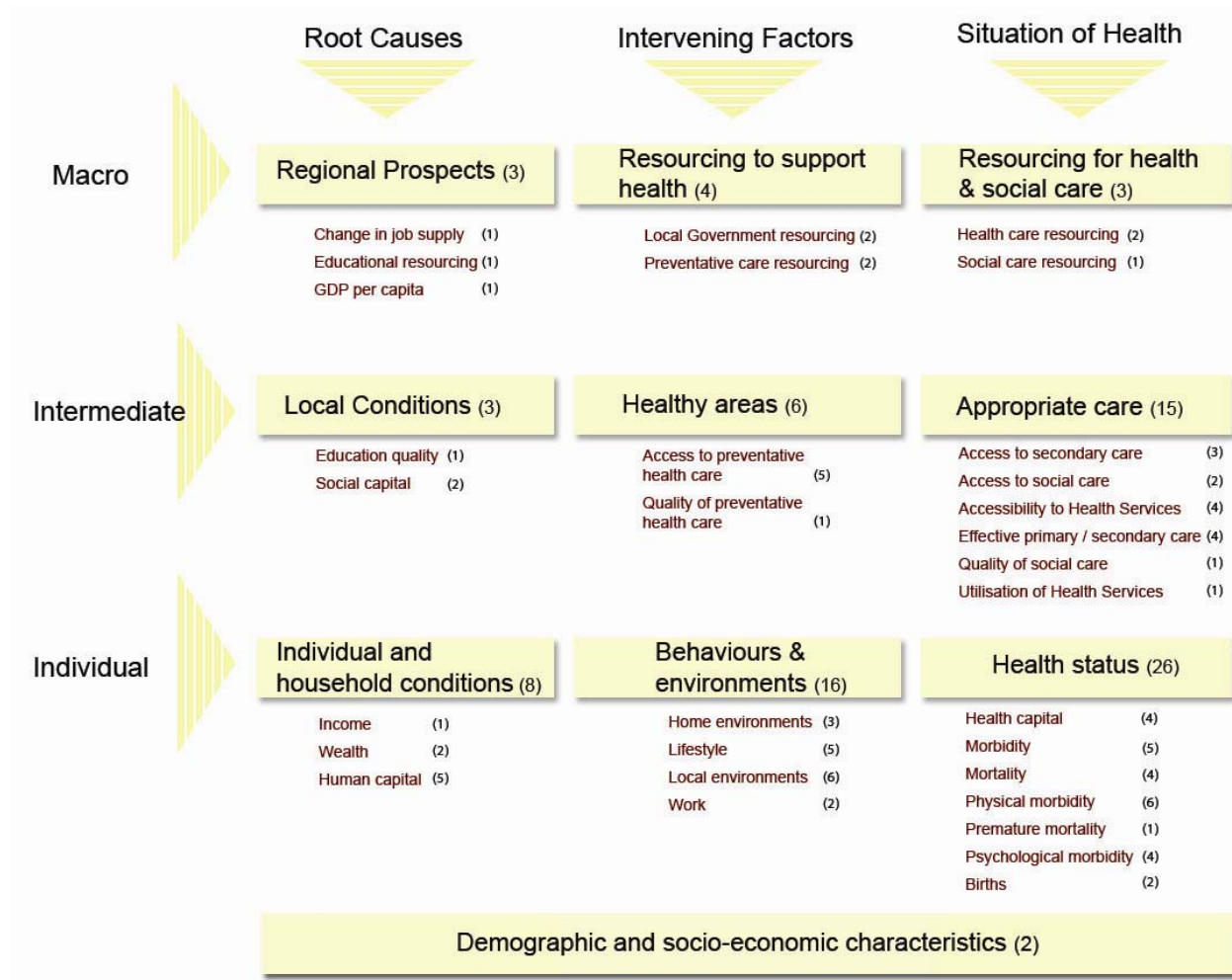
All can be accessed at www.inispheo.org/aihwds.

3.3 Indicators in the AIHWDS

The indicators in the AIHWDS have been mapped to the nine domains made up by combining three stages and the three levels; these domains cover the so-called social determinants of health (SDH). Figure 2 below presents the number of indicators (ignoring their geographical scope) under the various themes in these domains.

Fig.2

Themes and Indicators in the All-Ireland Health and Wellbeing Dataset



3.4 Two separate tables

Two AIHWDS tables are available at www.inishpho.org/aihwds

- The *raw dataset* contains the actual values of each indicator.
- The *ordered dataset* contains the ordered values of each indicator. The raw values are first numerically sorted (see cautionary note below) and then set onto a scale running from 0 to 1 by subtracting the smallest rank value and dividing by the range (largest rank value minus smallest rank value). Zero represents the value most favourable to health and wellbeing as reflected by that indicator and 1 represents the value least favourable to health and wellbeing as reflected by that indicator. An area's position between 0 and 1 reflects its relative position for that indicator.

Cautionary note

For some indicators, larger raw values reflect lesser health and wellbeing (e.g. smoking prevalence). For other indicators (eg GDP per capita), larger raw values reflect greater health and wellbeing. In the latter indicators, orderings have been reversed in the ordered dataset. Irrespective of which type of indicator it is, in the ordered datasets, smaller values reflect "greater" health and wellbeing and large values reflect "lesser" health and wellbeing.

4. Technical details

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<u>GDP per capita</u>	23

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Change in job supply

Stage: Root causes

Level: Regional prospects (Macro)

Theme: Change in job supply

NORTH-SOUTH COMPARABILITY	Separate North and South components
LAY DESCRIPTION	Percentage change in the number of people employed
SOURCE REFERENCE	eHPI: RRP2_1
INDICATOR NAMES	Change in job supply NI, Change in job supply RoI

DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND			
Percentage change in jobs for people aged 16 years or over between 2003 and 2005 by place of work				Percentage change in the labour force aged 15 years or over between 2002 and 2006 by place of residence			
Published?	Yes	Geography	LGD	Published?	Yes	Geography	County
	Northern Ireland Census of Employment				Census		
Frequency	Every two years	Latest Year	2005	Frequency	Every five years	Latest Year	2006
Numerator Definition	Number of employee jobs 2005 less number of employee jobs 2003	Geography	LGD	Numerator Definition	Number in labour force 2006 less number in labour force 2002	Geography	County
Source	Northern Ireland Census of Employment	Year	2003 and 2005	Source	Census	Year	2002 and 2006
Denominator Definition	Number of employee jobs 2003	Geography	LGD	Denominator Definition	Number in labour force 2002	Geography	County
Source	Northern Ireland Census of Employment	Year	2003	Source	Census	Year	2002
DATA ISSUES The components are not directly comparable between Northern Ireland and Republic of Ireland as they refer to different time periods and are assigned to areas using different methods				DATA ISSUES The components are not directly comparable between Northern Ireland and Republic of Ireland as they refer to different time periods and are assigned to areas using different methods			

PUBLIC HEALTH IMPORTANCE

POLICY CONTEXT – NORTHERN IRELAND	POLICY CONTEXT – REPUBLIC OF IRELAND
<p>Under 'A New Deal For Welfare- Empowering people for work' 2006</p> <ul style="list-style-type: none"> Reduce by 1 million the number of people on incapacity benefits; Help 300,000 lone parents into work; and Increase by 1 million the number of older workers. <p>www.dwp.gov.uk/mediacentre/pressreleases/2006/jan/fmc068-240106.asp</p> <p>The 'Economic Vision for Northern Ireland' - closing the productivity gap with the UK in GVA and increasing the percentage of the working age population who are economically active. http://www.detini.gov.uk/cgi-bin/moreutil?utilid=450&site=3&util=2&fold=&parent</p>	<p>National Employment Action Plan Ireland NAPS (2002) NAP/Inclusion (2003) Sustaining Progress Social Partnership Agreement 2003-2005 (2003)</p> <p>National Employment Action Plan targets to be achieved by 2010:</p> <ul style="list-style-type: none"> (i) 70% employment rate for the overall working age population; (ii) 60% employment rate for the female working age population; (iii) 50% employment rate for the 55-64 year age group.

Change in job supply

Stage: Root causes

Level: Regional prospects (Macro)

Theme: Change in job supply

The targets outlined in NAPS (2002) and NAP/Inclusion 2003-2005 in relation to employment are:

- (1) To eliminate long-term unemployment as soon as circumstances permit but in any event not later than 2007;
- (2) To reduce the level of unemployment experienced by vulnerable groups towards the national average by 2007;
- (3) To increase employment participation of women to an average of more than 60% in 2010, as envisaged in the National Employment Action Plan, 2001;
- (4) To achieve the objectives set out in the National Employment Action Plan to increase employment rates.

In Sustaining Progress one of the ten special initiatives is: Supporting the Long Term Unemployed, those who have become Redundant and those in Low-Skilled Employment. A range of specific interventions are outlined with regards to this initiative.

Employment Policy

The most marked development in Ireland over the past decade has been the increase in employment. Ireland's performance has exceeded the EU average with regard to the EU employment indicators (NAP/Inclusion, 2003). For people who are able to work, paid employment offers the best means of combating poverty and social exclusion.

The European Employment Strategy (EES) has been the means since 1997 by which the EU has tried to "define common objectives in relation to employment policy and detailed guidelines for the development of the employment policies of Member States". The EES has continued to evolve. In line with the all important reform agenda agreed at the Lisbon Council of Heads of State and Government in 2000, and based on a streamlined 'second generation' of EES in early 2003, the European Commission currently describes the goals of the strategy as:

- full employment ('more jobs');
- the promotion of quality and productivity at work ('better jobs'); and
- fostering cohesion and an inclusive labour market ('greater social cohesion').

The Commission suggested that "specific priorities, to be supported wherever possible by quantified targets" could include:

- getting women (back) to work;
- helping older workers to stay in work; and
- making work pay.

The implementation of EES relies on what is called the 'open method of co-ordination' whereby there is an agreement by EU member states to co-ordinate employment policies. This is marked by shared priorities and shared goals, supported by a process of plan development (by member states) and review (by the European Commission).

It is not, however, in any way supported or enforced by mandatory directives on member states. (Source: <http://www.moreandbetterjobs.info/ees%20what.htm> accessed 25/5/06)

Under the European Employment Strategy and Guidelines, Member States must produce an annual National Employment Action Plan (NEAP) based on a series of agreed common priorities

Change in job supply

Stage: Root causes

Level: Regional prospects (Macro)

Theme: Change in job supply

for action, setting out national strategy for employment and employability-related human resource development. The Irish NEAP is produced by the Labour Force Development division of the Department of Enterprise, Trade and Employment. FÁS (Foras Áiseanna Saothairthe) is the Irish Training and Employment Authority. The Unit is responsible for policy development on the operation of employment programmes that are administered by FÁS. FÁS, in conjunction with the Department of Family and Social Affairs, has responsibility for the operation of the National Employment Action Plan.

(Source: <http://www.entemp.ie> accessed 25/5/06).

The actions contained in the NEAP cover ten policy areas/guidelines and all actions aim to satisfy the overarching objectives of the EES:

full employment; improving work quality and productivity; and strengthening social cohesion and inclusion. Once submitted by the respective Member States, each NEAP is then examined by the EU Commission who in turn, in the Joint Employment Report, present their analysis and country specific recommendations for improvement.

(Source: *INOUE Bulletin June 2005 Issue*).

The Irish NEAP, adopted by the Government as its response to the European Employment Strategy and Guidelines, includes a commitment to a more systematic engagement of the Employment Services with the unemployed. The core orientation is a preventative strategy, focused on early and systematic intervention with unemployed people, re-integrating them into the labour market as quickly as possible by providing them with the necessary skills.

Implementation of this commitment commenced in September, 1998. From that date, all persons under 25 who had reached six months on the Live Register (LR) were referred by the Department of Social and Family Affairs (DSFA) for interview by FÁS. As the Employment Action Plan progressed, the program was extended to include other groups crossing nominated thresholds of unemployment. (Source: www.esf.ie/en/about_esfinireland.aspx accessed 4/5/06; FÁS Statement of Strategy 2006-2009; <http://www.entemp.ie/publications/labour/2005/eap87.pdf> accessed 25/5/06).

The key objectives of Ireland's Employment Action Plan are:

- To reduce the rates of unemployment and long-term unemployment;
- To increase the labour market participation levels and job progression rates among women and marginalised and excluded groups.

The strategic approach towards achieving these objectives include:

- Having in place a proactive policy of engagement with people of working age on social welfare, to ensure that, where possible, they have the opportunity to avail of employment, education and training options;
- Creating new opportunities for unemployed people and for marginalised groups to access employment and training;
- Eliminating any remaining gaps or disincentives to employment/training in the application of the secondary benefit systems so that, at a minimum, nobody is materially worse off as a result of taking up employment, training or educational opportunities;
- Ensuring that those on low pay have the opportunity to progress to better paid and more highly skilled employment.

Action under the NEAP will be focused on:

- making work pay;
- targeting low-skilled workers and the low-paid for training and further education to support

Change in job supply

Stage: Root causes

Level: Regional prospects (Macro)

Theme: Change in job supply

- | | |
|--|---|
| | <p>their progression to better-quality and better-paid jobs;</p> <ul style="list-style-type: none">• meeting the needs of workers who lose their jobs because of restructuring in the economy;• fostering family-friendly employment practices and supporting women returnees;• further developing child care arrangements including the implementation of the Equal Opportunities Childcare Programme (EOCP);• working to achieve the highest possible levels of employment; and• combating discrimination, accommodating diversity and promoting equal opportunities. |
|--|---|

[Return to Technical Details](#)

Educational resourcing per capita

Stage: Root causes

Level: Regional prospects (Macro)

Theme: Educational resourcing

NORTH-SOUTH COMPARABILITY		North only component	
LAY DESCRIPTION		Educational funding per pupil attending a school in an area	
SOURCE REFERENCE		eHPI: RRP3_1	
INDICATOR NAME		Educational resourcing NI	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Educational resourcing from the Common Funding Formula and Children and Young People Package per pupil attending a school in an area			
Published?	Yes www.deni.gov.uk	Geography	School, Education and Library Board
Frequency	Every year	Latest Year	2008/2009
Numerator Definition	Total resourcing for schools in an area	Geography	LGD
Source	Department of Education	Year	2007/2008
Denominator Definition	Full-time equivalent pupils attending schools in an area	Geography	LGD
Source	Department of Education	Year	2007/2008
DATA ISSUES		DATA ISSUES	
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
‘Schools For the Future - Funding, Strategy, Sharing’ December 2006 – referred to as the Bain Review this dealt with the need for better planning of the schools’ estate in the context of falling enrolments, and with encouraging integration in education, overprovision in that there were too many schools with small pupil numbers (an estimated 15% empty places in 2005/6) and lack of co-ordination. http://www.deni.gov.uk/review_of_education.pdf . It also addressed the issue of Irish medium education.		Education Resourcing Trends	
In addition to this the Education sector has to address:		As a share of GNP, current public expenditure on education in Ireland over the period, 1985-2002, has trended downwards from a high of 5.8 per cent in 1987 to 4.6 per cent in 2002. When the absolute level of spending is distinguished by the level of the educational system where it is incurred, it has more than doubled at primary and secondary levels and tripled at third level.	
<ul style="list-style-type: none">Curriculum reforms including primary and post-primary and new admission arrangements.		There have been markedly different developments in the number of students at each level; it has fallen significantly at primary level, increased marginally at second level and risen rapidly at third level. The net result is that between 1985 and 2002 spending per student has increased by a multiple of 2.8 at primary level from €1,402 to €3,756, by a multiple of 2 at secondary level from €2,699 to €5,528, and a multiple of 1.3 at third level from !6,300 per student to €8,246 (NESC & NESDO, 2005).	

Educational resourcing per capita

Stage: Root causes

Level: Regional prospects (Macro)

Theme: Educational resourcing

- Financing issues around local management of schools and capital funding.
- Restructuring of Education Boards
- Response to reduced pupil numbers

As outlined in 'Strategic Plan for Education – DENI'

http://www.deni.gov.uk/strategic_plan_for_education_2006-08_pdf_-_161_kb-2.pdf

And the presentation by the Permanent Secretary of the Department of Education to the Members of the Legislative Assembly in April 2007. <http://www.deni.gov.uk/index/education-challenges-in-northern-ireland.htm>

and the new Minister's speech to the Primary Heads Conference May 2007 ' Shaping the Future of primary Education'

http://www.deni.gov.uk/index/80-curriculumandassessment_pg/curriculum_and_assessment-newpage-4.htm

The Bain Review Part b specifically deals with education funding

<http://www.deni.gov.uk/strategic-review-of-education-part-b.pdf>

Schools in Northern Ireland are funded on the basis of the Common Funding Scheme

http://www.deni.gov.uk/2007-08_cff_scheme_-_final_version.pdf

Which includes factors such as age weighted pupil numbers, premises size and an adjustment for Targeting Social Need factors expressed as social deprivation factors including proportions eligible for free school meals, and educational needs using Key Stage Assessment Results.

The targets in the Public service Agreement are about achieving by 2008 particular percentages of pass grades in Key Stages, GCSEs (or equivalent) or 'A' Levels or equivalent and reducing the differentials in educational attainment by achieving specified pass levels in disadvantaged schools.

For Key Stage 2 by 2008 80% of Primary pupils will achieve level 4 or above in English and 83% in Maths (compared to 76.6% in English and 79% in Maths in 2004/5)

For Key Stage 2 by 2008 70% of pupils in the most disadvantaged primary schools will achieve level 4 or above in English and in Maths (compared to 64% in English and 67% in Maths in 2004/5)

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GDP per capita

Stage: Root causes

Level: Regional prospects (Macro)

Theme: GDP per capita

NORTH-SOUTH COMPARABILITY		All-island component	
LAY DESCRIPTION		The financial value of goods and services produced in a year per person	
SOURCE REFERENCE		eHPI: RRP1_1	
INDICATOR NAME		GDP per capita	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Gross Value Added (Gross Domestic Product less taxes on products plus subsidies on products) per capita		Gross Value Added (Gross Domestic Product less taxes on products plus subsidies on products) per capita	
Published?	Yes www.statistic.gov.uk	Geography	NUTS 3
Frequency	Yearly	Latest Year	2005
Numerator			
Definition	GVA in Euros	Geography	NUTS 3
Source	ONS	Year	2003
Denominator			
Definition	Mid-year population estimate	Geography	NUTS 3
Source	NISRA	Year	2003
DATA ISSUES		DATA ISSUES	
An LGD's value is assumed to be equal to its NUTS 3 value. This will mask any LGD variation within that NUTS 3 level.		A county's value is assumed to be equal to its NUTS 3 value. This will mask any county variation within that NUTS 3 level.	
Sterling was converted to Euros using the average 2003 Sterling to Euro exchange rate.			
PUBLIC HEALTH IMPORTANCE			
The Gross Domestic Product per capita, or GDP, of a country is a way of measuring the size of its economy . GDP is defined as the total market value of all final goods and services produced within a given country in a given period of time (usually a calendar year), and it is given a money value. It includes the profits of multinationals, which are often repatriated, and is an indicator of a country's degree of economic development, but not synonymous with the income available to people living there (Wikipedia, 2008). "Gross" means depreciation of capital stock is not subtracted. Economists (since Keynes) have preferred to split the general consumption term into two parts; private consumption, and public sector (or government) spending. The former is an indicator for individual financial wealth, which determines human health by influencing lifestyle choices, educational opportunities and reflecting other socio economic factors like employment status, work and living environments. The latter gives an indication of a country's investment in public services including health, education, social development, housing, transport and environmental protection, which serve to improve the health of the population, who can access and benefit from them (Department of Enterprise, Trade and Investment, 2007). Despite this, there is wide inter country variation in the relationship between GDP, investment in health care and health outcomes (Suhrcke et al, 2005).			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
The <i>Economic Vision for Northern Ireland</i> (DETI, 2005) www.detni.gov.uk aims to improve global competitiveness by closing the gap with the remainder of the United kingdom (UK) and increasing Northern Ireland's Gross Value added (GVA) per hour worked and increasing the percentage of the working age population who are		The <i>Ten- Year Framework Social Partnership Agreement 2006-2015 Towards 2016</i> www.taoiseach.gov.ie aims to nurture the complementary relationship between social policy and economic prosperity, develop a vibrant knowledge based economy, reposition Ireland's social policies, integrate an All Ireland economy and achieve higher participation	

GDP per capita

Stage: Root causes

Level: Regional prospects (Macro)

Theme: GDP per capita

economically active. It proposes to increase investment in research and development, encourage enterprise, develop skills and provide a modern infrastructure to support business and consumers.

Based on the *Northern Ireland Draft Regional Economic Strategy* (DFP, 2007) www.dfpni.gov.uk, the *Northern Ireland Department of Enterprise, Trade and Investment Corporate Plan 2008- 2011* (DETI, 2008) www.detni.gov.uk outlines three economic priorities out of twenty three overall Public Service Agreements (PSAs) identified in the *Northern Ireland Programme for Government* (OFMDFM, 2007) www.pfgbudgetni.gov.uk

and proposes to share appropriate objectives with the Northern Ireland Department of Employment and Learning (DEL), given the importance of an increasingly skilled labour force for economic prosperity and development. The specific PSA targets are:

- PSA 1: Productivity growth through improved manufacturing and private services productivity
- PSA 3: Increasing employment by raising employment levels
- PSA 5: Improved tourism through development of the sector

rates and integration of diversity. It places a focus on social justice and sustainable economic development.

The *National Development Plan Transforming Ireland- A Better Quality of Life for All 2007- 2013* <http://www.esri.ie> sets out a roadmap for economic and societal approaches to challenges arising from continuing population increases and less rapid economic growth and development. It integrates strategic development frameworks for regional development, rural communities, all island co- operation, environmental protection and social inclusion with common economic and social goals.

It emphasises the need to remove infrastructural bottlenecks constraining economic development, balanced regional development and environmental sustainability by investing € 184 billion in economic and social infrastructure, enterprise, science and agriculture sectors and in the social fabric of society, creating a vibrant economy and high value employment opportunities:

- To maintain economic expansion at an average annual rate of 4.0- 4.5% per annum
- To increase labour force by 2.0- 2.5% per annum
- To achieve productivity growth of 2.0% per annum.

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http://en.wikipedia.org/wiki/Gross_domestic_product (accessed 07/05/2008)

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Pupil to teacher ratio

Stage: Root causes

Level: Local conditions (Intermediate)

Theme: Education quality

NORTH-SOUTH COMPARABILITY		Separate North and South components	
LAY DESCRIPTION		The number of pupils for each teacher	
SOURCE REFERENCE		eHPI: RLC2_1	
INDICATOR NAMES		Pupil-Teacher ratio NI; Pupil-Teacher ratio RoI	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
The ratio of full-time equivalent pupils to full-time equivalent teachers in nursery, primary, post-primary and special schools		The ratio of pupils to teaching teachers in ordinary schools at primary level. Excludes special needs pupils and special needs teachers in ordinary schools and in special schools	
Published?	Yes www.deni.gov.uk	Geography	School, Education and Library Board
Frequency	Every year	Latest Year	2007/2008
Numerator Definition	Number of full-time equivalent pupils	Geography	LGD
Source	Department of Education	Year	2007/2008
Denominator Definition	Number of full-time equivalent teachers	Geography	LGD
Source	Department of Education	Year	2006/2007
DATA ISSUES		DATA ISSUES	
The components are not directly comparable between Northern Ireland and Republic of Ireland as they include different levels of education.		The components are not directly comparable between Northern Ireland and Republic of Ireland as they include different levels of education.	
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
‘Schools For the Future - Funding, Strategy, Sharing’ December 2006 – referred to as the Bain Review this dealt with the need for better planning of the schools’ estate in the context of falling enrolments, and with encouraging integration in education, overprovision in that there were too many schools with small pupil numbers (an estimated 15% empty places in 2005/6) and lack of co-ordination. http://www.deni.gov.uk/review_of_education.pdf . It also addressed the issue of Irish medium education.		Current Comparative Situation Regarding Pupil-Teacher Ratios The arrangements regarding pupil-teacher ratios are decided by the Department of Education and Science, following consultation with the social partners. Current governmental plans are to bring pupil-teacher ratios into line with commitments entered into at the general election in 2002, which aims to bring Irish standards up to best practice throughout Europe.	
In addition to this the Education sector has to address: <ul style="list-style-type: none">Curriculum reforms including primary and post-primary and new admission arrangements.Financing issues around local management of schools and capital funding.		Pupil-teacher ratios constitute one element of adverse conditions of work for Irish teachers. In general, pupilteacher ratios in Ireland are high by international standards. While improvements in terms of pupil-teacher ratios have been made in recent years, particularly at primary level, Ireland nevertheless continues to have higher ratios in comparison with other OECD countries.	
		For instance, in 2000, the OECD country mean for the ratio of pupils to teaching staff, at primary level, expressed in full time equivalents is 18 pupils per teacher. In Ireland the ratio in the year 2000 was 21.5 pupils per teacher. At post-primary level, the average across OECD	

Pupil to teacher ratio

Stage: Root causes

Level: Local conditions (Intermediate)

Theme: Education quality

- Restructuring of Education Boards
- Response to reduced pupil numbers

As outlined in 'Strategic Plan for Education – DENI'

[http://www.deni.gov.uk/strategic_plan_for_education_2006-08_pdf - 161 kb-2.pdf](http://www.deni.gov.uk/strategic_plan_for_education_2006-08_pdf_-_161_kb-2.pdf)

And the presentation by the Permanent Secretary of the Department of Education to the Members of the Legislative Assembly in April 2007. <http://www.deni.gov.uk/index/education-challenges-in-northern-ireland.htm>

and the new Minister's speech to the Primary Heads Conference May 2007 ' Shaping the Future of primary Education'

http://www.deni.gov.uk/index/80-curriculumandassessment_pg/curriculum_and_assessment-newpage-4.htm

Teacher levels and hence pupil- teacher ratios have been a local matter since the devolution of school budgets. Hence there is not a specific target on pupil teacher ratios in NI.

The targets in the Public service Agreement are about achieving by 2008 particular percentages of pass grades in Key Stages, GCSEs (or equivalent) or 'A' Levels or equivalent and reducing the differentials in educational attainment by achieving specified pass levels in disadvantaged schools.

There is some evidence cited on the effect of pupil/ teacher ratios on achievement

<http://www.niesr.ac.uk/event/vignoles.pdf>

Comparative UK data is available on

<http://www.dfes.gov.uk/rsgateway/DB/SFR/s000725/index.shtml>

countries was 14 pupils per teacher, while in Ireland it was 15.9: 1 (OECD, Education At A Glance, 2002). A rising level of real expenditure in the face of declining primary level numbers or near static secondary level numbers has enabled a higher level of service to be provided in schools, for instance, with the pupil-teacher ratio cut by 32 per cent and 9 per cent respectively between 1985 and 2002. The improved economic conditions from the early nineties allowed for the improvements in pupil-teacher ratios and the social partnership agreements contained provision for such improvements.

Despite these improvements however, the pupil-teacher ratio in primary school is well beyond the OECD mean of 17.9, Ireland ranking 24th out of 27 OECD countries. The ratio at post primary level at 15.9 is also higher than the OECD mean of 14.3, with Ireland ranking 21st highest of 26 OECD countries (OECD, Education At A Glance, 2002). The report of the ministerial committee on The Allocation of Teachers to Second Level Schools (2001) recommended further improvements in pupil-teacher ratios.

(Source: Attracting, Developing and Retaining Effective Teachers – Country Background Report for Ireland Department of Education and Science & OECD, 2003; NESC & NESDO 2005; Department of Education and Science in NESC & NESDO 2005).

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Can people be trusted?

Stage: Root causes

Level: Local conditions (Intermediate)

Theme: Social capital

NORTH-SOUTH COMPARABILITY	All-island component
LAY DESCRIPTION	Percentage of people who believe that people in their area can be trusted
SOURCE REFERENCE	eHPI: RLC1_2
INDICATOR NAME	Pct trust neighbours

DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND			
Percentage of people aged 16 years or over who agree or strongly agree that people in their area can be trusted				Percentage of people aged 18 years or over who agree or strongly agree that people in their area can be trusted			
Published?	Yes Continuous Household Survey (CHS)	Geography	Northern Ireland	Published?	No	Geography	N/a
Frequency Numerator Definition	Every two years Number of CHS respondents aged 16 years or over who agree or strongly agree that people in their area trust one another	Latest Year	2005/2006	Frequency Numerator Definition	N/a Number of SLAN respondents aged 18 years or over who agree or strongly agree that people in their area can be trusted	Latest Year	N/a
Source Denominator Definition	CHS Number of CHS respondents aged 16 years or over	Year	2005/2006	Source Denominator Definition	SLAN Number of SLAN respondents aged 18 years or over	Year	2002
Source	CHS	Geography	HSSB	Source	SLAN	Geography	County
DATA ISSUES				DATA ISSUES			
An LGD's value is assumed to be equal to its HSSB value. This will mask any LGD variation within that HSSB.				Small numerator and denominator values at county level may give unreliable estimates.			
CHS surveys people age 16 years or over while SLAN surveys people aged 18 years or over.				CHS surveys people age 16 years or over while SLAN surveys people aged 18 years or over.			

PUBLIC HEALTH IMPORTANCE
Trust in people is a measure of social capital (Balanda & Wilde, 2003), which describes features of social life including networks, norms and trust that support the effective collective functioning of communities (Putnam, 1996). The way we organise our society, the extent to which we encourage interaction among the citizenry and the degree to which we trust and associate with each other in caring communities is considered an important determinant of our health (Lomas 1998). People on the island of Ireland who do not trust their neighbours are significantly less likely to consider themselves to be in good health than those who do (Balanda & Wilde, 2003). The principle of trust as a basis for norms and behaviours implies that individual action in the present will produce a collective result in the future. This includes sharing attitudes related to equality, human rights, acceptance of diversity and social inclusion as well as a common identity and elements of a shared value system, but is not synonymous with an individual's identification with one community (European Foundation for the Improvement of Living and Working Conditions, 2005).
Due to improved transport, communication and social mobility, individuals can belong to many culturally coherent communities, which might be geographically dispersed or cannot be represented geographically at all (McKenzie, Whitley and Weich, 2002). A causal relationship between social capital and health outcomes is difficult to establish and both can be

Can people be trusted?

Stage: Root causes

Level: Local conditions (Intermediate)

Theme: Social capital

regarded as consequences of socioeconomic processes influencing health and wellbeing along the life course (Pearce & Davey Smith, 2003). While the influence of social relations on the health of individuals has long been recognised, the nature of these interactions depends on the developmental state of societies (Rose, 2001). In light of an emerging evidence base, community interventions to increase levels of social capital risk being ineffective and potentially harmful (Pearce & Davey Smith, 2003).

POLICY CONTEXT – NORTHERN IRELAND

The Northern Ireland Public Health Strategy *Investing for Health* (DHSSPS, 2002) www.dhsspsn.gov.uk aims to tackle poverty and social exclusion. Its objectives include the promotion of social inclusion through interagency and cross sectoral collaboration, especially for vulnerable population groups including Travellers and minority ethnic groups, and urban regeneration through, amongst others, community development approaches. It also supports the promotion of mental health and wellbeing at individual and community level, placing a particular emphasis on the need for and benefits of working with communities and through partnership.

Announced in the Northern Ireland public health strategy *Investing for Health* (DHSSPS, 2002), the Northern Ireland Community Safety Strategy *Creating a safer Northern Ireland through partnership* (Community Safety Unit (CSU), 2003) www.communitysafetyni.gov.uk focuses on reducing crime, fear of crime and antisocial behaviour. This Government framework is based on a partnership approach to improving community safety in Northern Ireland.

The *Neighbourhood Renewal Strategy People and Place* (Department for Social Development, 2003) www.dsdni.gov.uk aims to tackle the complex, multidimensional nature of deprivation through community, economic, social and physical renewal of neighbourhoods in the 10% most deprived wards in Northern Ireland.

A Shared Future Policy and Strategic Framework for Good Relations in Northern Ireland (OFMDFM, 2005) www.ofmdfm.gov.uk is based on extensive public consultation and sets out the vision of Government in Northern Ireland for a shared society defined by a culture of tolerance against a historic background of deeply entrenched communal divisions and tensions. Its objectives include the elimination of sectarianism, racism and other prejudice, the reduction of conflict, hostility and mistrust in and between communities and the protection of members of minority groups and mixed marriages from intimidation and violence.

Lifetime Opportunities- Government's Anti- Poverty and Social Inclusion Strategy for Northern Ireland (NIE, 2005) www.ofmdfmni.gov.uk takes a lifecycle cross departmental approach to eliminate poverty and promote social inclusion, based on the concept of social capital. It undertakes to provide opportunities for everyone to participate fully in community social, cultural and economic life, tackling area based and intergenerational cycles of deprivation in recognition of the particular risks the health and wellbeing of those beset by multiple social problems.

The *Northern Ireland Policing Plan 2007- 2010* www.psnipolice.uk is based on consultation with District Policing Partnerships and public surveys. It sets out priorities, targets and actions for effective and efficient policing in Northern Ireland to tackle crime and promote community safety, satisfaction and confidence.

The *Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005- 2025 A Healthier Future* (DHSSPS, 2005) www.dhsspsni.gov.uk acknowledges the importance

POLICY CONTEXT – REPUBLIC OF IRELAND

The National Health Strategy *Quality and Fairness* (DoHC, 2001) www.dohc.ie recognizes that social and community networks and wider socio-economic and cultural factors all mediate the individual's need for health and social services.

A Crime Prevention Strategy for Ireland Tackling the Concerns of Local Communities (National Crime Council, 2003) www.irigov.ie/crimecouncil supports early intervention based on a National Crime Prevention Model to ensure a common approach for cross departmental, interagency and multidisciplinary working. It recommends a partnership approach to develop locally based crime prevention strategies to prevent crime, tackle existing problems, propose solutions to underlying causes and share good practice. In order to achieve this, the strategy proposal considers the necessity:

- To promote social inclusion and reduce the socio-economic, educational, societal and environmental factors that can leave children and young people 'at risk' of engaging in criminal activities

The *An Garda Síochána Corporate Strategy 2005- 2007* (2005) www.garda.ie seeks to contribute to improved quality of life for people living in Ireland without fear of crime or criminal behaviour. It includes a focus on public safety and confidence and the protection of cultural and ethnic diversity.

The National Economic and Social Council (NESC) advises the Irish Government on efficient development of the economy and achievement of social justice as well as social partnership agreements. *The Developmental Welfare State* (NESC, 2005) www.nesc.ie suggests to build consensus across social partners, government and society in a coherent debate that addresses Ireland's social deficits towards integrated policies for employment, social inclusion and economic reform. It challenges the focus on total employment growth and unemployment reduction, calling for an assessment of effectiveness of social inclusion and antipoverty strategies.

The *NESC Strategy 2006: People, Productivity and Purpose* (NESC, 2005) www.nesc.ie emphasises the importance of greater participation, social protection and care, more social mobility and successful handling of diversity. It recommends aiming less for targeted programmes for disadvantaged groups and more for improving participation.

The *Ten- Year Framework Social Partnership Agreement 2006-2015 Towards 2016* (2006) www.taoiseach.gov.ie underpins the NESC vision and aims to take into account factors in the areas of balanced regional and rural development, planning, physical and social infrastructure and environmental sustainability and the development of social capital. A policy for physical recreation will be developed, to complement existing policies in sport for the enhancement and support of participation, and the strengthening of social capital. Future policy will take account of the work of the Task Force on Active Citizenship which will recommend measures to facilitate and encourage a greater degree of engagement by citizens in all aspects of life and the growth and development of voluntary organisations as part of a strong civic culture. Consideration will also be given

Can people be trusted?

Stage: Root causes

Level: Local conditions (Intermediate)

Theme: Social capital

of caring communities for health and wellbeing, both through social support for and participation in health and social care.

The *Programme for Government 2008- 2011* Public Service Agreement Framework (NIE, 2008) www.pfgbudgetni.gov.uk endeavours to promote social inclusion, health and wellbeing by combating rural social exclusion and poverty through regeneration and community development. Under Public Service Agreement 7 “Making Peoples’ Lives Better”, it anticipates by July 2008 agreement on outcomes for co ordinated strategic action to promote social inclusion for lone parents, people with disability, older people and minority groups.

to the development of appropriate measures and indicators of social capital.

The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie (2006) makes reference to the *National Development Plan 2007- 2013* (2006) www.taoiseach.gov.ie and its focus on building viable and sustainable communities to improve the lives of people living in disadvantaged areas and building social capital. It emphasises the role of local authorities in delivering on social inclusion strategies, working with other stakeholders through the County Development Board and RAPID structures in the promotion of social capital, active citizenship and community development.

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Community stability

Stage: Root causes

Level: Local conditions (Intermediate)

Theme: Social capital

NORTH-SOUTH COMPARABILITY		North only component	
LAY DESCRIPTION		The percentage of the population that move away from an area in a year	
SOURCE REFERENCE		eHPI: RLC1_1	
INDICATOR NAME		Community stability NI	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Percentage of the population that migrate out of an area in a year. Migration includes internal migration to another area within Northern Ireland and external migration to a country outside Northern Ireland			
Published?	Yes, as part of NISRA’s mid-year population estimates www.nisra.gov.uk	Geography	LGD, Parliamentary Constituency
Frequency	Every year	Latest Year	2006-2007
Numerator Definition	Number of people who have migrated internally and externally away from an area	Geography	LGD
Source	NISRA	Year	2004-2005
Denominator Definition	Mid-year population estimate	Geography	LGD
Source	NISRA	Year	2004
DATA ISSUES		DATA ISSUES	
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
The Concept of Social capital was promoted in 1990 by University of Chicago sociologist James S. Coleman in his massive treatise (1990), <i>Foundations of Social Theory</i> , and used to very good advantage by Harvard political scientist Robert Putman in his celebrated study of democracy in Italy, <i>Making Democracy Work</i> . Social Capital, Putman (1993: 167) advises: “...refers to features of social organisation, such as trust, norms, and networks that can improve the efficiency of society by facilitating coordinated actions.” It is an idea parallel to the “physical capital” formed by machines and the “human capital” represented by an educated workforce. Social capital is that fund of valued integration that results in a confidence that new problems can be tackled and resolved by groups of neighbours or citizens or fellow workers. The steady depletion of social capital in modern society, Putman asserts, provides a major challenge. His work illustrates that social capital is a public good, one that markets and their private agents alone cannot provide. Third-sector organisations, on the other hand, can play a crucial role facilitating and promoting its growth.		Programme for Prosperity and Fairness White Paper on a Framework for Supporting Voluntary Activity and for Developing the Relationship between the State and the Community and Voluntary sector (2000) The National Children’s Strategy (2000) Quality and Fairness (2001) NAPS (2002) The Concept of Social Capital Putnam defined “social capital” as: “features of social organisation such as networks, norms and trust, that facilitate co-ordination and co-operation for mutual benefit” (Putnam, 1995). These features of social life enable participants to act together more effectively to enhance civic society (National Children’s Strategy, 2000). The individual per se is not the target in this case, for they are subsumed under the integrity of the community’s structure. The European Foundation for the Improvement of Living and Working Conditions published a research study on Regional Social	

Community stability

Stage: Root causes

Level: Local conditions (Intermediate)

Theme: Social capital

Within the objective of developing community cohesion, the Strategy encourages the creation of more balanced local communities characterized by development patterns which contribute to community spirit, neighbourliness and a sense of belonging to a particular place. Diversity and social inclusion are distinguishing marks of well-balanced communities which embrace a mix of social groups, and are able to accommodate people of different backgrounds who wish to live together.

More information is available at <http://www.publichealth.ie/index.asp?docID=451>

High levels of social capital are associated with better health

There are a range of possible measures of social capital applicable to individuals including levels of contact with family or wider society, trust in others and tenure in accommodation. This measure is one which is applicable at an area level reflecting stability of population which is taken to reflect higher levels of social engagement etc.

The concept of social capital and social inclusion runs through 'Lifetime Opportunities' <http://www.ofmdfmi.gov.uk/antipovertynov06.pdf>

And 'A Healthier Future' <http://www.dhsspsni.gov.uk/healthyfuture-main.pdf>

There is no specific target on community stability.

There are broad target on 'Building Caring Communities' In 'A Healthier Future'

<http://www.dhsspsni.gov.uk/healthyfuture-execsummary.pdf>
<http://www.dhsspsni.gov.uk/healthyfuture-main.pdf>

And promoting social inclusion in 'Lifetime Opportunities'

<http://www.ofmdfmi.gov.uk/antipovertynov06.pdf>

Capital in Europe in 2005. Social capital was defined operationally for the purposes of this study as: 'features of social organisation such as networks, norms and trust that can facilitate action and cooperation for mutual benefit'. Three key conditions were identified in the report in terms of making social capital 'work':

1. the interaction of actors;
2. trust and reciprocity;
3. the existence of an institutional structure that facilitates and encourages joint action and that provides instruments and incentives.

It is essential for three distinctive types of social contact to occur in order to enable positive social capital:

- bonding with people similar to oneself;
- bridging with people, or groups of people, dissimilar to oneself;
- linking to people, or groups of people, on a different step on the social ladder, to obtain access to resources and knowledge.

An NESF report on social capital (2003) states that social capital is one resource, among others, which can be used in support of community development and social inclusion. There are a number of inter-related and overlapping key dimensions associated with social capital including: community engagement; community efficacy (a shared sense of empowerment and capacity to effect change at the community level); volunteering; political participation; informal social support networks (e.g. who knows who); informal sociability (speaking, visiting, writing, e-mailing); norms of trust and reciprocity; and trust in various institutions (public, corporate, voluntary).

It notes that properly applied and developed, it can play a role of leverage in linking to public agencies, bridging across to other disadvantaged groups and bonding in terms of developing crucial community level supports and mutual care at local level.

The report notes that the OECD definition of social capital is also compatible with a policy approach which focuses on social inequality and exclusion. Viewing social capital as a group resource, it is possible that certain individuals and groups are excluded from social networks of the advantaged or powerful elites.

The rationale in public support for social capital can be summarised as follows:

- growing awareness of its importance for a wide range of social objectives from inequality to local development;
- recognition of its potential role for achieving more equitable access to local public governance and decisionmaking; and
- limitation on the extent to which any one actor – public, market or voluntary can provide the necessary support for social capital in every case (NESF, 2003).

Social capital and health are intrinsically inter-linked. A report by the Institute of Public Health 'Inequalities in Perceived Health' (2004) explained that understanding social capital as a community characteristic rather than as an individual characteristic leads to the idea that social capital may be particularly useful in that:

Community stability

Stage: Root causes

Level: Local conditions (Intermediate)

Theme: Social capital

- it is linked to individual characteristics which are known to influence health;
- it may have a separate ecological effect on health through the impact of living in a social capital rich or poor community.

The European Foundation for the Improvement of Living and Working Conditions (2005) explains that international research and literature all point to the positive impact of social capital on:

- poverty and social exclusion;
- economic productivity;
- educational achievement;
- personal well-being and health;
- public governance and citizen engagement;
- crime and other forms of social deviance.

Source: European Foundation for the Improvement of Living and Working Conditions 'Regional social capital in Europe' (2005) (Luxembourg: Office for Official Publications of the European Communities)

A case-study by the European Foundation for the Improvement of Living and Working Conditions (2005) found that in the R01/N1 region social capital tends to be more applicable at local level – in community and local development, centred on local governance structures and strategies for regeneration, employment, inclusion, and services development - in contrast to the regional level.

The National Children's Strategy & Social Capital

Supporting 'social capital' is a central theme of the National Children's Strategy (2000). This Strategy adopted a 'whole child' perspective in order to provide a complete understanding of children's lives. This perspective concentrates on interaction between the three core aspects:

- (i) the extent of children's own capacities;
- (ii) the multiple inter-linked dimensions of children's development;
- (iii) the complex mix of informal and formal supports that children rely on.

The latter aspect concerning informal and formal supports and relationships in children's lives is directly connected with the notion of social capital. The Strategy points out that these relationships range from the family, the primary source of care and protection for children, to the State, which acts as the ultimate guarantor of their rights. Essential supports and services are provided for children through the primary, social networks of family, extended family and community, known as the informal supports, and through the formal support services provided by the voluntary sector, commercial sector, the State and its agencies. From these varied and interacting sources children gain the support they need to progress along all the dimensions of their development.

The National Health Strategy Quality and Fairness & Social Capital

The national health strategy, Quality and Fairness (2001) discussed the inter-connected notions of social support and social capital in terms of quality of life and health status. It highlighted the advantages of strong social support in terms of contributing to health by providing people with

Community stability

Stage: Root causes

Level: Local conditions (Intermediate)

Theme: Social capital

emotional and practical resources. It stated that the evolving body of research on social capital suggests that participation in formal and informal networks such as sporting clubs or basic neighbourhood activity can have a major impact on health status. The Strategy pointed out that changes in family structures and community life may mean these supports are less available than in the past. For instance, greater flexible working and the increase in job opportunities have enabled many more women to take up paid employment. Commuter towns, where those living in new developments spend their days travelling to a distant employment, may give rise to a loss of 'community' associated with more traditional neighbourhoods. While the evidence for Ireland is not fully clear, there are indications that these networks are declining in places.

The Health Strategy notes that the loss of such community support also has implications for the care of young children and for support for older people. It highlights the need for the Strategy to take account of the changing role of the family and community and improve supports for community and family participation in voluntary and informal care. It points out that groups such as the elderly, people with disabilities, people with mental illness, and those with chronic illnesses, expect to be able to enjoy a reasonable quality of life, and that in the future, services will be planned to meet these expectations and the 'whole person' perspective.

Volunteering & Social Capital

As provided for in the Programme for Prosperity and Fairness, the National Committee on Volunteering was established in 1999, and it continues with the role of strengthening volunteering and supporting volunteers. In 2000, the government published a White Paper on a Framework for Supporting Voluntary Activity. This forms the basis for a renewed emphasis on the capacity of the voluntary and community sector to develop social capital throughout communities. It asserts that voluntary activity forms the very core of all vibrant and inclusive societies. The Government is particularly keen to encourage new volunteers to come forward, including volunteers from Sectors that are under-represented, and to foster a culture of support for volunteering in schools and third level institutions. The year 2001 was the UN International Year of Volunteers. This provided an opportunity to further raise the profile of volunteering in Ireland and progress the Government's policies with regard to development of social capital and encouragement of voluntarism.

The Agreed Programme for Government (2002), under the heading of "Building an Inclusive Society", states: "We will fund an ambitious programme of data gathering on social indicators, including consistent poverty and social capital, to ensure that policies are developed on the basis of sound information. We will work to promote social capital in all parts of Irish life through a combination of research and ensuring that public activity supports the development of social capital, particularly on a local community level" (NESF, 2003). NESF & Social Capital

In June, 2003 the NESF published a report entitled The Policy Implications of Social Capital which aimed to:

- clarify the concept and use of "social capital" in policy discussions;
- situate the debate on social capital in an Irish context and set of policy concerns;
- identify a limited range of priority socio-economic issues to be addressed; and
- provide a set of policy options or recommendations based on a process of consultation and review of existing evidence.

It explained that interest by the National Economic and Social Forum (NESF) in the concept of social capital is directly related to the mandate given to it by the Government on equality and

Community stability

Stage: Root causes

Level: Local conditions (Intermediate)

Theme: Social capital

social inclusion. In the Third Periodic Report of the NESF the link between social capital and inequality was noted: "Given its remit from Government in relation to equality and social inclusion issues, the findings of the OECD report 'The Well-Being of Nations' (2001) are of particular interest to the Forum as regards the relationship between social capital and inequality, social fragmentation, educational development, increasing productivity in firms, and influencing the organisational culture of firms" (NESF, 2001:88).

In the NESF Strategic Policy Framework for Equality Issues (NESF, 2002), poverty and inequality are viewed from the standpoint of various dimensions and barriers that are embedded in the attitudes, powerful networks, structures and discriminatory practices in our society.

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Low income

Stage: Root causes

Level: Household conditions (Individual)

Theme: Income

NORTH-SOUTH COMPARABILITY		Separate North and South components	
LAY DESCRIPTION		Percentage of people experiencing income deprivation	
SOURCE REFERENCE		eHPI: RH1_1	
INDICATOR NAMES		Pct low income NI; Pct low income Rol	

Low income

Stage: Root causes

Level: Household conditions (Individual)

Theme: Income

population health outcomes (Wilkinson & Pickett, 2007). Social transfers reduce the risk of poverty by 70% in Scandinavia, but only 43% in the Republic of Ireland (Harvey, 2008). Especially for children in developed countries, relative poverty and income inequality are significant barriers, limiting their developmental potential and participation in society (Pickett & Wilkinson, 2007).

Low income is only one aspect of the multi-dimensional nature of child poverty, which impinges on all aspects of children's lives. Poor children tend to do less well in school, suffer more ill health, die younger and are more likely to be homeless or become involved in criminal behaviour (Department of Health and Children, 2000). Policy frameworks that support access to adequately paid work for parents, effective income support and enabling services for families are most effective in preventing child poverty (European Commission, 2008).

POLICY CONTEXT – NORTHERN IRELAND

The Government's public health strategy *Investing for Health* (DHSSPS, 2002) www.dhssps.gov.uk states the need to tackle poverty and social exclusion by addressing poverty, low income and unemployment.

Lifetime Opportunities- Government's Anti- Poverty and Social Inclusion Strategy for Northern Ireland (NIE, 2005) <http://www.ofmdfmi.gov.uk> takes a lifecycle cross departmental approach to eliminate poverty and promote social inclusion. It undertakes to tackle area-based deprivation, rural poverty and inequality in the labour market; address conflict and community division; combat health inequalities and help people to break out of the cycles of deprivation at different stages of the lifecycle from early years to retirement. Amongst its targets is:

- To end child poverty by 2020 (based on the estimate of approximately 130,000 children in Northern Ireland in relative income poverty in 1998/99, this means lifting 65,000 children out of poverty by 2010 on the way to eradication by 2020)

The *Programme for Government 2008- 2011* Public Service Agreement Framework (NIE, 2008) www.pfgbudgetni.gov.uk endeavours to promote social inclusion, health and wellbeing by combating rural social exclusion and poverty and investing in social and affordable housing through regeneration and community development. Under Public Service Agreement (PSA) 7 "Making Peoples' Lives Better", it proposes action to provide for measurable reductions in the levels of poverty and especially child poverty in line with the targets set out in *Lifetime Opportunities- Government's Anti- Poverty and Social Inclusion Strategy for Northern Ireland* (NIE, 2005) <http://www.ofmdfmi.gov.uk>. It also anticipates co-ordinated strategic action to promote social inclusion for lone parents, people with disability, older people and minority groups. It also plans to introduce measures to work towards elimination of the gender pay gap and ensure the central role of the rights of the child.

The *Welfare Reform Bill* (DSD, 2007) www.dsdni.gov.uk introduces reform to the Northern Ireland Social Care System for people on benefits for ill health and aims to contribute to increasing the employment rate for people of working age, increasing social inclusion by creating opportunities for disadvantaged people.

POLICY CONTEXT – REPUBLIC OF IRELAND

The National Health Strategy *Quality and Fairness* (DoHC, 2001) www.dohc.ie recognizes that social and community networks and wider socio-economic and cultural factors all mediate the individual's need for health and social services.

The National Economic and Social Council (NESC) advises the Irish Government on efficient development of the economy and achievement of social justice as well as social partnership agreements. *The Developmental Welfare State* (NESC, 2005) www.nesc.ie suggests to build consensus across social partners, government and society in a coherent debate that addresses Ireland's social deficits towards integrated policies for employment, social inclusion and economic reform. It challenges the focus on total employment growth and unemployment reduction, calling for an assessment of training and lifelong learning practices, creation of equal opportunity in the labour market and effectiveness of social inclusion and antipoverty strategies.

The *NESC Strategy 2006: People, Productivity and Purpose* (NESC, 2005) www.nesc.ie emphasises the importance of greater participation, social protection and care, more social mobility and successful handling of diversity. It recommends to aim less for targeted programmes for disadvantaged groups and more for the responsiveness and flexibility of publicly funded services, securing adequate income and improving participation.

The *Ten- Year Framework Social Partnership Agreement 2006-2015 Towards 2016* www.taoiseach.gov.ie underpins the NESC vision and places a focus on employability, access to employment and income, improved health outcomes and support for caring responsibilities. It especially recognises the needs of young adults for education, training and employment, health and social services. In respect of people with disabilities, it states that the National Disability Strategy (National Disability Authority, 2004) www.nda.ie will be implemented with particular regard to health and education services, income and measures to promote employment. In line with the UN convention on the Rights of the Child and the National Children's Strategy (DoHC, 2000) www.nco.ie it states that:

- Every child should grow up in a family with access to sufficient resources, supports and services, to nurture and care for the child, and foster the child's development and full and equal participation in society;
- Every person of working age, older persons and people with disability would have an income level to sustain an acceptable standard of living and to enable them to provide for an adequate income in retirement.

Low income

Stage: Root causes

Level: Household conditions (Individual)

Theme: Income

The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie proposes to support working age people and people with disabilities , through activation measures and service provision to increase employment and participation. It includes goals

- To reduce the number of those experiencing consistent poverty to between 2% and 4% by 2012, with the aim to eliminate consistent poverty by 2016,
- To maintain the value of child income support measures, social welfare rates and income support and
- To increase employment rates especially among vulnerable groups.

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High value dwelling stock

Stage: Root causes

Level: Household conditions (Individual)

Theme: Wealth

NORTH-SOUTH COMPARABILITY North only component

LAY DESCRIPTION Percentage of domestic houses with a capital value greater than £120,000

SOURCE REFERENCE eHPI: RH2_1

INDICATOR NAME Pct high value dwelling NI

DATA DEFINITION – NORTHERN IRELAND

Percentage of domestic houses with a capital value greater than £120,000 as at 1 January 2005

Published?	No	Geography	N/a
Frequency	N/a	Latest Year	N/a
Numerator			
Definition	Number of domestic houses with a capital value greater than £120,000	Geography	LGD
Source	Land and Property Services domestic housing re-evaluation	Year	2005
Denominator			
Definition	Total number of domestic houses	Geography	LGD
Source	Land and Property Services domestic housing re-evaluation	Year	2005

DATA ISSUES

Land and Property Services undertook a major revaluation of all domestic housing in Northern Ireland between 2005 and 2007 for Domestic Rating purposes. These values are now almost four years old and are not representative of actual house prices today.

DATA DEFINITION – REPUBLIC OF IRELAND

Published?		Geography	
Frequency		Latest Year	
Numerator			
Definition		Geography	
Source		Year	
Denominator			
Definition		Geography	
Source		Year	

DATA ISSUES

PUBLIC HEALTH IMPORTANCE

POLICY CONTEXT – NORTHERN IRELAND

In 2000 the Northern Ireland domestic rating system was reviewed. The new system was introduced in 2007 based on a capital value per dwelling assessed by Value and Lands Agency at 2005 prices. This led to substantial change in the costs of individual rates and transitional arrangements were put in place to bring the changes in over time. Further details can be found on <http://www.ratingreviewni.gov.uk/archive/domestic/domestic-summary.htm>

With the reinstatement of the NI Assembly in May 2007 one of its early actions was to initiate a review of the domestic rating system. This is due to complete by the end of August 2007 with the aim of introducing some changes in the 2008/9 bills.

<http://www.ratingreviewni.gov.uk/tor-2007-executive-review-domestic-rating-reform.pdf>

In 2000 the Northern Ireland Executive launched the 'Housing and Health- Towards A Shared

POLICY CONTEXT – REPUBLIC OF IRELAND

The Planning and Development Act, 2000
NAP/Inclusion 2003-2005
Department of Environment, Heritage and Local Government Statement of Strategy: 2003–2005 (2003)

Sustaining Progress (2003)

The NAP/Inclusion 2003-2005 states that a range of measures are currently in place to achieve the broader housing objectives, whereby key targets are:

- To ensure that housing supply is brought more into line with demand and that the housing requirements set out in the National Development Plan (500,000 new units between 2000-2010) are achieved in a planned and coherent way.

High value dwelling stock

Stage: Root causes

Level: Household conditions (Individual)

Theme: Wealth

Agenda' examined the relationship between Housing and Health including homelessness, fuel poverty and affordability of housing. It made a series of recommendations which formed the basis of the Five Year Housing and Health Action Plan (2001). In 2001 they also launched the 'Homelessness Strategy and Service Review'.

'Housing Health and Wellbeing – Innovation, Practice and Partnerships' reviewed progress on the action plan in 2006 and in July 2007 the Housing Executive launched its' review of Housing and Health. All available via <http://www.nihe.gov.uk/search/index.asp>

Sir John Semple's 'Review of Affordable Housing' was launched in September 2006. The final report recommends a social building programme of 2,000 completions per annum. A review of the DRD Regional Development Strategy housing requirement of 208,000 houses as soon as possible, a target of 9,500 empty homes brought back into stock per annum, reduced VAT on refurbishments. http://www.dsdni.gov.uk/affordable_housing_final.pdf

The Northern Ireland Housing Market Review and Perspectives (2007 and 2010) highlighted falling household size, increased waiting list for social housing and suggested 2,500 new social dwellings and highlighted 24% of households in fuel poverty. It also stressed the vulnerability to fuel poverty from increased energy prices. They identified that affordability has become a significant problem for almost all areas of Northern Ireland' and the reductions in the proportions of first time buyers- down from 60% in 2001 to 33% in 2006. <http://www.nihe.gov.uk/search/index.asp>

There is no specific target about house prices or ratable values.

DRD Regional Development Strategy housing requirement of 208,000 houses

Planning Policy Statement 12 of 60% of development land within the urban footprint.

Proposed by Semple :

2,000 new social housing completions per annum
9,500 empty homes brought back into stock per annum,
Review of the DRD 208,000 house requirement planning figure.
Augment the 60% target by making 30% of it on previously developed brownfield land

- To deliver 41,500 local authority housing unit starts (including acquisitions) between 2000 and 2006.
- To deliver an appropriate mix of social and affordable housing measures which meet the needs of different types of households

Strategic Policy Developments

Since the mid-1990s a number of factors led to a sharp increase in demand for housing. These included strong growth in income and employment, a large increase in the population at household formation stage and a fall in interest rates. The resulting remarkable increase in demand was the most important cause of increased property prices. Given the strength of demand, a rise in house prices was to be expected. The rapidly changing housing market and rising property prices have been independent sources of significant changes in the distribution of wealth and income in Irish society (NESC/NESDO, 2004).

The Government's strategic approach to housing is multi-dimensional reflecting the broad spectrum of housing needs, from those who require some assistance to purchase their own home (affordable housing schemes) to social housing and housing for those with special needs (NAP/Inclusion, 2003-2005). The overall aim of housing policy as expressed by the Department of Environment, Heritage and Local Government is "to enable every household to have available an affordable dwelling of good quality, suited to its needs, in a good environment and as far as possible at the tenure of its choice" (Statement of Strategy: 2003–2005, 2003).

As part of the National Social Partnership Agreement Sustaining Progress 2003-2005, the Government and social partners committed to reviewing the effectiveness of programmes designed to assist low income groups, including those with social housing needs and special housing needs, to ensure that the most effective use is made of the resources available. One of the ten special initiatives outlined in the Agreement concerns the theme of Housing and Accommodation. Under this initiative, the importance of achieving equilibrium between supply and demand in the overall housing market is outlined. A series of programmes and initiatives are discussed with regards to increasing the supply of affordable houses by 10,000 units.

The Agreement undertook to conduct a review of programmes designed to assist low-income groups including those with social housing needs and special housing needs, such as elderly, disabled, homeless, and travellers. It discussed continued support for the role of the voluntary and cooperative housing sector in the provision of social and affordable housing. Sustaining Progress also discussed the further promotion of best practice in the management of the public and social housing sector, in particular through funding the Housing Management Initiatives Grants Scheme, and supporting the work of the Housing Unit. The Agreement refers to the important role of the private rented sector in providing affordable accommodation, and outlined its commitment to the modernisation and development of this sector.

The Affordable Housing Initiative and other arrangements under the Planning and Development Act, 2000, will increase on an ambitious scale the supply of affordable housing for those unable to purchase a house from their own resources in the current housing market. There will also be a priority focus on the implementation of the Local Authority Travellers accommodation programmes (NAP/Inclusion, 2003).

NESC Housing Policy Review and Critique

In preparing its 2003 strategic overview of Irish economic and social policy, An Investment in

High value dwelling stock

Stage: Root causes

Level: Household conditions (Individual)

Theme: Wealth

Quality, the National Economic and Social Council (NESC) agreed to undertake a study of housing policy. A subsequent policy document Housing in Ireland: Performance and Policy was published by the NESC & NESDO in November 2004. This report outlines the economic, social and policy mechanisms at work in the housing system and the key problems that need to be addressed. With regards to three main issues in particular, stability, inequality and sustainability, the Council's view is that the Irish housing system has been dynamic but unbalanced.

Regarding inequality, the analysis confirms anxieties about inequality in the distribution of opportunities and difficulties across income and social groups. Despite its dynamism, the private market for owner occupied housing has not met the housing needs of many of those on low incomes and a number of other social groups. Likewise, despite falling market rents, the market for private rental accommodation is likely to continue to display rent levels that are not affordable for some households. More specifically, the report identifies several, overlapping, categories of household that are likely to have experienced significant housing affordability problems in recent years. These are:

- i) households which have below average earnings and are awaiting accommodation in public, voluntary or cooperative housing;
- ii) households which have below average earnings but are not eligible for publicly assisted housing;
- iii) those with special housing needs, such as people with disabilities, that have not had access to supported housing;
- iv) single earner households, including those on average earnings, especially in the early stages of household formation or seeking to set up house;
- v) many households living in private rented accommodation;
- vi) those seeking entry to owner occupation on modest incomes, but who do not have access to parental gifts or other wealth;
- vii) those in any of the above categories that live in Dublin.

One of the conclusions of the Report is that some of the most important imbalances in the Irish housing system, are likely to continue under current policies. A series of key policy challenges are outlined in terms of addressing a rebalancing of the system:

1. To achieve high quality, sustainable, development in both urban and rural areas;
2. To provide an effective range of supports to those households that fall below the affordability threshold;
3. To assist the market to continue to provide a high level of supply;
4. To ensure a tax and subsidy regime that supports these goals.

[Return to Technical Details](#)

House prices

Stage: Root causes

Level: Household conditions (Individuals)

Theme: Wealth

NORTH-SOUTH COMPARABILITY	Separate North and South components
LAY DESCRIPTION	Average price paid for a house in an area
SOURCE REFERENCE	eHPI: RH2_2
INDICATOR NAMES	House prices NI; House prices RoI

DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND			
Average price paid for a house in an area in pounds Sterling				Average price paid for a house in an area in Euros			
Published?	Yes Northern Ireland House Price Index: University of Ulster, Northern Ireland Housing Executive, Bank of Ireland	Geography	Regional	Published?	Yes www.permanenttsb.ie/house-price-index	Geography	NUTS 3
Frequency	Quarterly	Latest Year	2007	Frequency	Quarterly	Latest Year	2007
Numerator	Sum of the prices paid for houses sold in the sample	Geography	LGD	Numerator	Sum of the prices paid for houses sold in the sample	Geography	County
Definition		Year	2007	Definition		Year	2006
Source	Northern Ireland House Price Index: University of Ulster, Northern Ireland Housing Executive, Bank of Ireland	Year	2007	Source	Permanent TSB House Price Index	Year	2006
Denominator	Number of houses sold in the sample	Geography	LGD	Denominator	Number of houses sold in the sample	Geography	County
Definition		Year	2007	Definition		Year	2006
Source	Northern Ireland House Price Index: University of Ulster, Northern Ireland Housing Executive, Bank of Ireland	Year	2007	Source	Permanent TSB House Price Index	Year	2006
DATA ISSUES				DATA ISSUES			
The routinely published “regional” data does not map directly to LGDs. The LGD data included in the iHPI was obtained by request.				2006 was the most recent year that house prices were reported at county level.			
PUBLIC HEALTH IMPORTANCE							
POLICY CONTEXT – NORTHERN IRELAND				POLICY CONTEXT – REPUBLIC OF IRELAND			
In 2000 the Northern Ireland Executive launched the ‘Housing and Health- Towards A Shared Agenda’ examined the relationship between Housing and Health including homelessness, fuel poverty and affordability of housing. It made a series of recommendations which formed the basis of the Five Year Housing and Health Action Plan (2001). In 2001 they also launched the ‘Homelessness Strategy and Service Review’.				The Planning and Development Act, 2000 NAPS (2002) Department of Environment, Heritage and Local Government Statement of Strategy: 2003–2005 (2003)			
‘Housing Health and Wellbeing – Innovation, Practice and Partnerships’ reviewed progress on the action plan in 2006 and in July 2007 the Housing Executive launched its’ review of Housing and Health. All available via http://www.nihe.gov.uk/search/index.asp				Key Targets under NAPS (2002) regarding the theme of Housing and Accommodation: (i) To ensure that housing supply is brought more into line with demand and that the housing			

House prices

Stage: Root causes

Level: Household conditions (Individuals)

Theme: Wealth

Sir John Semple's 'Review of Affordable Housing' was launched in September 2006. The final report recommends a social building programme of 2,000 completions per annum. A review of the DRD Regional Development Strategy housing requirement of 208,000 houses as soon as possible, a target of 9,500 empty homes brought back into stock per annum, reduced VAT on refurbishments, http://www.dsdni.gov.uk/affordable_housing_final.pdf

The Northern Ireland Housing Market Review and Perspectives (2007 and 2010) highlighted falling household size, increased waiting list for social housing and suggested 2,500 new social dwellings and highlighted 24% of households in fuel poverty. It also stressed the vulnerability to fuel poverty from increased energy prices. They identified that affordability has become a significant problem for almost all areas of Northern Ireland' and the reductions in the proportions of first time buyers- down from 60% in 2001 to 33% in 2006. <http://www.nihe.gov.uk/search/index.asp>

There is no specific target about house prices.

DRD Regional Development Strategy housing requirement of 208,000 houses
<http://www.drdni.gov.uk/publications-details.htm?docid=308>

Planning Policy Statement 12 of 60% of development land within the urban footprint.

Proposed by Semple : http://www.dsdni.gov.uk/affordable_housing_final.pdf

2,000 new social housing completions per annum
9,500 empty homes brought back into stock per annum,
Review of the DRD 208,000 house requirement planning figure.
Augment the 60% target by making 30% of it on previously developed brownfield land

requirements set out in the NDP (500,000 new units between 2000-2010) are achieved in a planned and coherent way.

- (ii) To deliver 41,500 local authority housing unit starts (including acquisitions) between 2000 and 2006.
- (iii) To deliver an appropriate mix of social and affordable housing measures which meets the needs of different types of households.
- (iv) To analyse the information gathered in the next statutory assessment of housing needs (to take place in March 2002) and to establish appropriate targets in relation to access to housing.
- (v) By end 2004, sufficient and appropriate emergency accommodation to be available to rough sleepers, in conjunction with appropriate outreach services to enable them to access it. This target is to apply to each local authority and health board area. At end 2003, progress in meeting the target will be reviewed and, if necessary, revised mechanisms put in place to achieve it.

Current House Prices

In real terms new house prices in Ireland doubled between 1996 and 2002. This dramatic increase resulted from a boom in the demand for housing together with a relatively inelastic supply of housing. Exceptionally high economic and employment growth, rapidly rising incomes, an increase in the proportion of the population in the household formation age, and immigration were all factors driving this rapid rise in the demand for housing

(Duffy et al, 2005, The Economic and Social Review, Vol. 36, No. 3, Winter 2005, pp. 251-272).

The average price paid for a house nationally in March 2006 was €287,664, up almost €10,000 on that recorded for December 2005 (€277,852).

The average price paid for a new house in March 2006 was €284,231, while that paid for a second hand house was €291,577.

The average price paid for a house in Dublin in March 2006 was €384,247 while outside Dublin the average house price was €249,168.

(Source: Permanent TSB/ESRI House Price Index www.finfacts.com 2/5/2006)

Strategic Policy Developments

The overall aim of housing policy as expressed by the Department of Environment, Heritage and Local Government is "to enable every household to have available an affordable dwelling of good quality, suited to its needs, in a good environment and as far as possible at the tenure of its choice" (Statement of Strategy: 2003–2005, 2003).

Given the remarkable strength of demand since the mid-1990s driven by unprecedented growth in incomes and employment and a range of demographic factors, a significant increase in Irish house prices was inevitable. Nevertheless, several studies suggest that, at certain times, Irish house prices have risen higher than can be explained by the underlying patterns of incomes, employment, demography and interest rates. The rapidly rising property prices have been independent source of significant change in the distribution of wealth and income in Irish society.

House prices

Stage: Root causes

Level: Household conditions (Individuals)

Theme: Wealth

Concerns in relation to the effect of the large increase in house prices arise from a number of perspectives. They include the following:

- (i) House prices have risen so high that there is a general problem of affordability, except for the very rich;
- (ii) House prices have risen so high that they form a constraint on the overall development of the economy by limiting inward investment and labour mobility;
- (iii) House prices are fuelling wage pressure and thereby damaging competitiveness and undermining national partnership;
- (iv) The arbitrary wealth effects of house price increases have contributed to growing social polarisation.

(Source: NESC/NESDO, 2004).

The overall objective with regards to housing outlined in NAPS (2002) is to enable households experiencing poverty and disadvantage to have available to them housing or accommodation, which is affordable, accessible, of good quality, suitable to their needs, culturally acceptable, located in a sustainable community and, as far as possible, in a secure tenure of their choice. A number of key NAPS targets (2002) with regards to Housing and Accommodation are outlined above. According to NAP/Inclusion (2003-2005) the Affordable Housing Initiative and other arrangements under the Planning and Development Act, 2000, will increase on an ambitious scale the supply of affordable housing for those unable to purchase a house from their own resources in the current housing market.

There will also be a priority focus on the implementation of the Local Authority Travellers accommodation programmes. One of the ten special initiatives outlined in the National Social Partnership Agreement Sustaining Progress 2003 -2005 (2003) concerned Housing and Accommodation. Under this initiative, a series of elements are outlined as an overall approach to achieving equilibrium between supply and demand in the overall housing market. For instance, under the Affordable Housing Initiative, a range of programmes and initiatives are discussed with regards to increasing the supply of affordable houses by 10,000 units. In relation to Social and Affordable Housing Provision, the Partnership Agreement undertook to conduct a review of programmes designed to assist low-income groups including those with social housing needs and special housing needs, such as elderly, disabled, homeless, and travellers.

It discussed continued support for the role of the voluntary and co-operative housing sector in the provision of social and affordable housing. It also discussed the further promotion of best practice in the management of the public and social housing sector (estate management), in particular through funding the Housing Management Initiatives Grants Scheme, and supporting the work of the Housing Unit. The Agreement refers to the important role of the private rented sector in providing affordable accommodation, and outlined its commitment to the modernisation and development of this sector.

NESC Housing Policy Review and Critique

The National Economic and Social Council (NESC) has long considered housing to be a key determinant of economic and social well-being and progress in Ireland. In its strategic overview of Irish economic and social policy, An Investment in Quality (2003) the Council stated that there were a number of inter-related problems which must be addressed to deliver a sustainable

House prices

Stage: Root causes

Level: Household conditions (Individuals)

Theme: Wealth

housing market. These included supply and demand imbalance, affordability, the sustainability of low-density development and the potential costs of one-off rural housing. In its 2003

Strategy, the NESC agreed to undertake a study of housing policy. A subsequent policy document *Housing in Ireland: Performance and Policy* was published by the NESC & NESDO in November 2004. This report outlines the economic, social and policy mechanisms at work in the housing system and the key problems that need to be addressed. With regards to three main issues in particular, stability, inequality and sustainability, the Council's view is that the Irish housing system has been dynamic but unbalanced. The report contends that the unbalanced nature of the housing system is evident in the gap between demand and supply, especially in Dublin in the early years of the housing boom, in the inequality of opportunities and pressures across income groups and in the imbalance between the provision of private and social housing. In terms of inequality specifically, the analysis confirms anxieties about the degree of inequality in the distribution of opportunities and difficulties across income and social groups during the housing boom. Despite its dynamism, the private market for owner occupied housing has not met the housing needs of many of those on low incomes and a number of other social groups.

Likewise, despite falling market rents, the market for private rental accommodation is likely to continue to display rent levels that are not affordable for some households. The report identifies several, overlapping, categories of household that are likely to have experienced significant housing affordability problems in recent years.

These are:

- i) households which have below average earnings and are awaiting accommodation in public, voluntary or cooperative housing;
- ii) households which have below average earnings but are not eligible for publicly assisted housing;
- iii) those with special housing needs, such as people with disabilities, that have not had access to supported housing;
- iv) single earner households, including those on average earnings, especially in the early stages of household formation or seeking to set up house;
- v) many households living in private rented accommodation;
- vi) those seeking entry to owner occupation on modest incomes, but who do not have access to parental gifts or other wealth;
- vii) those in any of the above categories that live in Dublin.

One of the conclusions of the Report is that some of the most important imbalances in the Irish housing system, are likely to continue under current policies. A series of key policy challenges are outlined in terms of addressing a rebalancing of the system:

1. To achieve high quality, sustainable, development in both urban and rural areas;
2. To provide an effective range of supports to those households that fall below the affordability threshold;
3. To assist the market to continue to provide a high level of supply;
4. To ensure a tax and subsidy regime that supports these goals.

In terms of social and affordable housing issue, the NESC recommends:

- 1) an expanded and more flexible stock of housing available at a social rent to ensure an

House prices

Stage: Root causes

Level: Household conditions (Individuals)

Theme: Wealth

- adequate safety net for vulnerable households;
- 2)** a wider range of graduated supports for 'intermediate' households;
- 3)** provision of adequate resources for social and affordable housing.

The Report also points out that from an accounting perspective, land prices are correctly seen as a component part of the price of housing. In times of rising house prices, it is natural to wonder whether they are driven by rising land prices. In discussing future policy on land value, land management and betterment it is common to consider alternative national policy recommendations such as:

- (i)** Zoning more land in order to remove its scarcity;
- (ii)** Betterment-sharing instruments, such as higher Capital Gains Tax, Development Levies and, possibly, a new Planning Gain Levy;
- (iii)** Public land management supported through widespread compulsory purchase;
- (iv)** A general Site Value Tax.

The Council contends that in the context of strong demand, such high land and land value prices are in part the result of public policy decisions, or lack of public policy decisions, on planning, zoning and infra structural investment. It states that an effective policy on land requires a combination of four approaches: 1. a land-use strategy, including zoning and servicing of land; 2. land for enhanced social and affordable housing programmes; 3. sufficient active land management to ensure delivery of housing; 4. betterment-sharing measures, designed in a way that does not damage supply.

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Key stage 2 results English NI

Stage: Root causes

Level: Household conditions (Individual)

Theme: Human capital

NORTH-SOUTH COMPARABILITY		North only component	
LAY DESCRIPTION		Percentage of pupils achieving Level 4 at Key Stage 2 English	
SOURCE REFERENCE		eHPI: RH3_1	
INDICATOR NAME		Key stage 2 English NI	

Key stage 2 results English NI

Stage: Root causes

Level: Household conditions (Individual)

Theme: Human capital

And the presentation by the Permanent Secretary of the Department of Education to the Members of the Legislative Assembly in April 2007. <http://www.deni.gov.uk/index/education-challenges-in-northern-ireland.htm>

and the new Minister's speech to the Primary Heads Conference May 2007 'Shaping the Future of primary Education'
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The targets in the Public service Agreement are about achieving by 2008 particular percentages of pass grades in Key Stages, GCSEs (or equivalent) or 'A' Levels or equivalent and reducing the differentials in educational attainment by achieving specified pass levels in disadvantaged schools.

For Key Stage 2 by 2008 80% of Primary pupils will achieve level 4 or above in English and 83% in Maths (compared to 76.6% in English and 79% in Maths in 2004/5)

For Key Stage 2 by 2008 70% of pupils in the most disadvantaged primary schools will achieve level 4 or above in English and in Maths (compared to 64% in English and 67% in Maths in 2004/5)

and 1.8 per cent by 2006. Related NAPS targets pertaining to Travellers are:

- (i) The transfer rate of Travellers to post-primary schools will be increased to 95% by 2004.
- (ii) Each third-level institution will double the participation by mature disadvantaged students, including Travellers and Refugees by 2006 (within the 15 per cent quota).

The significance of education is reinforced by the following quotation "Educational attainment is a more powerful predictor of differences in mortality than income equality...." (British Medical Journal 2001 cited in Investing for Health, 2002). Current public spending on education in Ireland accounts for a comparatively small share of GNP by EU 15 standards. There are some grounds for satisfaction that this spending is efficient in attaining outcomes, but largely when outcomes for young people from non-disadvantaged backgrounds are considered.

By contrast, educational disadvantage has, so far, not been significantly reduced by higher spending and low levels of spending by international standards are being incurred on behalf of pre-school children and older age groups. In recent years legislation and resources have been targeted at the problem of early school leaving. The enactment of the Education (Welfare) Act, 2000, provides a comprehensive national system for ensuring that children of compulsory school-going age attend school, or, if they do not attend school, that they receive at least a minimum education (National Children's Strategy, 2000).

A range of initiatives focused on school retention and completion will be reviewed under the Agreement to ensure optimum synergy and integration, advised by the Educational Disadvantage Committee. For instance, the Educational Welfare Board will be brought into operation and adult learning opportunities will be particularly targeted at those in disadvantaged communities in rural and urban areas.

Building on the Youth Work Act 2001, the National Youth Work Development Plan will be progressed and implemented on a phased basis, as resources are made available. The extent of compliance with the terms of the Protection of Young Persons (Employment) Act 1995, which provides for proactive information provision, inspection of workplaces, and prosecution where appropriate, will be evaluated. A workplace basic education and literacy /numeracy/Information and Communication Technologies (ICT) programme will be implemented as part of this, building on the recommendations of the National Adult Literacy Agency report on a Workplace Basic Education Strategy and the Report of the Task Force on Lifelong Learning. Pilot initiatives will be implemented in targeted sectors where there are vulnerable workers, in partnership with trade unions.

The objective pertaining to Education in NAPS (2002) is to ensure that all young people leave the educational system with an adequate education and related qualifications to support their full participation in the economy, in employment and in society. In addition all those who have already left school must have the opportunity to address any lack of educational experience and related qualifications that militates against their ability to participate fully in the economy, in employment and in society.

Sustaining Progress (2003) commits to the implementation of initiatives to prevent and address early school leaving, taking account of the framework set out in the NESF Report on Early School Leavers. It identified 'Tackling Educational Disadvantage – Literacy, Numeracy and Early School Leavers' as one of its ten special initiatives. The NESF report states that tackling the issue of educational disadvantage requires a multidimensional and integrated approach. Education plays a fundamental role in providing full access to life chances and in avoiding and breaking the cycle of disadvantage. It notes that a key focus of education policy is to prioritise investment in favour of those most at risk and to optimise access, participation and

Key stage 2 results English NI

Stage: Root causes

Level: Household conditions (Individual)

Theme: Human capital

outcome at every level of the system for disadvantaged groups. Literacy and numeracy skills are identified as a prerequisite for learning and for social and economic participation. Furthermore, under Sustaining Progress, a commitment is given to pay critical attention to literacy and numeracy both in school and for adults of all ages.

The Agreement states that systematic monitoring of literacy attainment levels and assessment and remediation strategies in primary schools will be implemented, supported by targeted initiatives to address the specific needs of disadvantaged schools.

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Key stage 2 results Maths NI

Stage: Root causes

Level: Household conditions (Individual)

Theme: Human capital

NORTH-SOUTH COMPARABILITY		North only component	
LAY DESCRIPTION		Percentage of pupils achieving Level 4 at Key Stage 2 Maths	
SOURCE REFERENCE		eHPI: RH3_1	
INDICATOR NAME		Key stage 2 Maths NI	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Percentage of pupils achieving Level 4 at Key Stage 2 Maths			
Published?	Yes	Geography	LGD
Frequency	Every year	Latest Year	2006/2007
Numerator		Geography	LGD
Definition	Number of pupils achieving Level 4 at Key Stage 2 Maths	Year	2006/2007
Source	Department of Education	Geography	LGD
Denominator		Year	2006/2007
Definition	Number of pupils at Key Stage 2 Maths	Geography	LGD
Source	Department of Education	Year	2006/2007
DATA ISSUES		DATA ISSUES	
LGD refers to the location of the school.			
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
‘Schools For the Future - Funding, Strategy, Sharing’ December 2006 – referred to as the Bain Review this dealt with the need for better planning of the schools’ estate in the context of falling enrolments, and with encouraging integration in education, overprovision in that there were too many schools with small pupil numbers (an estimated 15% empty places in 2005/6) and lack of co-ordination. http://www.deni.gov.uk/review_of_education.pdf . It also addressed the issue of Irish medium education.		Education (Welfare) Act, 2000 NAPS (2002) Northern Ireland ‘Investing in Health’ (2002) Sustaining Progress (2003)	
In addition to this the Education sector has to address: Curriculum reforms including primary and post-primary and new admission arrangements. Financing issues around local management of schools and capital funding. Restructuring of Education Boards Response to reduced pupil numbers		Key Targets under NAPS (2002) regarding Education are as follows: (i) To halve the proportion of pupils with serious literacy difficulties by 2006. (ii) To reduce the proportion of the population aged 16-64 with restricted literacy to below 10 to 20 per cent by 2007 (restricted literacy being defined as falling below 200-225 on the IALS scale or equivalent). (iii) To reduce the number of young people who leave the school system early, so that the percentage of those who complete upper second level or equivalent will reach 85 per cent by 2003 and 90 per cent by 2006	
As outlined in ‘Strategic Plan for Education – DENI’ http://www.deni.gov.uk/strategic_plan_for_education_2006-08_pdf_-_161_kb-2.pdf		A related NAPS target regarding People with Disabilities is: (i) To increase participation by students with disabilities at third-level to 1.35 per cent by 2003	

Key stage 2 results Maths NI

Stage: Root causes

Level: Household conditions (Individual)

Theme: Human capital

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The targets in the Public service Agreement are about achieving by 2008 particular percentages of pass grades in Key Stages, GCSEs (or equivalent) or 'A' Levels or equivalent and reducing the differentials in educational attainment by achieving specified pass levels in disadvantaged schools.

For Key Stage 2 by 2008 80% of Primary pupils will achieve level 4 or above in English and 83% in Maths (compared to 76.6% in English and 79% in Maths in 2004/5)

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Related NAPS targets pertaining to Travellers are:

- (i) The transfer rate of Travellers to post-primary schools will be increased to 95% by 2004.
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The significance of education is reinforced by the following quotation "Educational attainment is a more powerful predictor of differences in mortality than income equality...." (British Medical Journal 2001 cited in Investing for Health, 2002). Current public spending on education in Ireland accounts for a comparatively small share of GNP by EU 15 standards. There are some grounds for satisfaction that this spending is efficient in attaining outcomes, but largely when outcomes for young people from non-disadvantaged backgrounds are considered. By contrast, educational disadvantage has, so far, not been significantly reduced by higher spending and low levels of spending by international standards are being incurred on behalf of pre-school children and older age groups. In recent years legislation and resources have been targeted at the problem of early school leaving.

The enactment of the Education (Welfare) Act, 2000, provides a comprehensive national system for ensuring that children of compulsory school-going age attend school, or, if they do not attend school, that they receive at least a minimum education (National Children's Strategy, 2000). A range of initiatives focused on school retention and completion will be reviewed under the Agreement to ensure optimum synergy and integration, advised by the Educational Disadvantage Committee. For instance, the Educational Welfare Board will be brought into operation and adult learning opportunities will be particularly targeted at those in disadvantaged communities in rural and urban areas.

Building on the Youth Work Act 2001, the National Youth Work Development Plan will be progressed and implemented on a phased basis, as resources are made available. The extent of compliance with the terms of the Protection of Young Persons (Employment) Act 1995, which provides for proactive information provision, inspection of workplaces, and prosecution where appropriate, will be evaluated. A workplace basic education and literacy /numeracy/Information and Communication Technologies (ICT) programme will be implemented as part of this, building on the recommendations of the National Adult Literacy Agency report on a Workplace Basic Education Strategy and the Report of the Task Force on Lifelong Learning. Pilot initiatives will be implemented in targeted sectors where there are vulnerable workers, in partnership with trade unions.

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Sustaining Progress (2003) commits to the implementation of initiatives to prevent and address early school leaving, taking account of the framework set out in the NESF Report on Early School Leavers. It identified 'Tackling Educational Disadvantage – Literacy, Numeracy and Early

Key stage 2 results Maths NI

Stage: Root causes

Level: Household conditions (Individual)

Theme: Human capital

School Leavers' as one of its ten special initiatives.

The NESF report states that tackling the issue of educational disadvantage requires a multidimensional and integrated approach. Education plays a fundamental role in providing full access to life chances and in avoiding and breaking the cycle of disadvantage. It notes that a key focus of education policy is to prioritise investment in favour of those most at risk and to optimise access, participation and outcome at every level of the system for disadvantaged groups. Literacy and numeracy skills are identified as a prerequisite for learning and for social and economic participation. Furthermore, under Sustaining Progress, a commitment is given to pay critical attention to literacy and numeracy both in school and for adults of all ages. The Agreement states that systematic monitoring of literacy attainment levels and assessment and remediation strategies in primary schools will be implemented, supported by targeted initiatives to address the specific needs of disadvantaged schools.

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Key stage 3 result English NI

Stage: Root causes

Level: Household conditions (Individual)

Theme: Human capital

NORTH-SOUTH COMPARABILITY		North only component	
LAY DESCRIPTION		Percentage of pupils achieving Level 5 at Key Stage 3 English	
SOURCE REFERENCE		eHPI: RH3_2	
INDICATOR NAME		Key stage 3 English NI	

Key stage 3 result English NI

Stage: Root causes

Level: Household conditions (Individual)

Theme: Human capital

Restructuring of Education Boards
Response to reduced pupil numbers

As outlined in 'Strategic Plan for Education – DENI'

http://www.deni.gov.uk/strategic_plan_for_education_2006-08_pdf_-_161_kb-2.pdf

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The targets in the Public service Agreement are about achieving by 2008 particular percentages of pass grades in Key Stages, GCSEs (or equivalent) or 'A' Levels or equivalent and reducing the differentials in educational attainment by achieving specified pass levels in disadvantaged schools.

For Key Stage 2 by 2008 80% of Primary pupils will achieve level 4 or above in English and 83% in Maths (compared to 76.6% in English and 79% in Maths in 2004/5)

For Key Stage 2 by 2008 70% of pupils in the most disadvantaged primary schools will achieve level 4 or above in English and in Maths (compared to 64% in English and 67% in Maths in 2004/5)

By 2020, to ensure that all children fulfil their potential to obtain basic numeracy and literacy levels before they leave school and, ensure that every young person can further education, training or employment.

By 2020, to have substantially improved the educational attainment of pupils from disadvantaged background, including looked after children at both primary and post-primary levels.

A related NAPS target regarding People with Disabilities is:

- (i) To increase participation by students with disabilities at third-level to 1.35 per cent by 2003 and 1.8 per cent by 2006.

Related NAPS targets pertaining to Travellers are:

- (i) The transfer rate of Travellers to post-primary schools will be increased to 95% by 2004.
- (ii) Each third-level institution will double the participation by mature disadvantaged students, including Travellers and Refugees by 2006 (within the 15 per cent quota).

The significance of education is reinforced by the following quotation "Educational attainment is a more powerful predictor of differences in mortality than income equality...." (British Medical Journal 2001 cited in Investing for Health, 2002). Current public spending on education in Ireland accounts for a comparatively small share of GNP by EU 15 standards. There are some grounds for satisfaction that this spending is efficient in attaining outcomes, but largely when outcomes for young people from non-disadvantaged backgrounds are considered. By contrast, educational disadvantage has, so far, not been significantly reduced by higher spending and low levels of spending by international standards are being incurred on behalf of pre-school children and older age groups. In recent years legislation and resources have been targeted at the problem of early school leaving. The enactment of the Education (Welfare) Act, 2000, provides a comprehensive national system for ensuring that children of compulsory school-going age attend school, or, if they do not attend school, that they receive at least a minimum education (National Children's Strategy, 2000).

A range of initiatives focused on school retention and completion will be reviewed under the Agreement to ensure optimum synergy and integration, advised by the Educational Disadvantage Committee. For instance, the Educational Welfare Board will be brought into operation and adult learning opportunities will be particularly targeted at those in disadvantaged communities in rural and urban areas.

Building on the Youth Work Act 2001, the National Youth Work Development Plan will be progressed and implemented on a phased basis, as resources are made available. The extent of compliance with the terms of the Protection of Young Persons (Employment) Act 1995, which provides for proactive information provision, inspection of workplaces, and prosecution where appropriate, will be evaluated. A workplace basic education and literacy /numeracy/Information and Communication Technologies (ICT) programme will be implemented as part of this, building on the recommendations of the National Adult Literacy Agency report on a Workplace Basic Education Strategy and the Report of the Task Force on Lifelong Learning. Pilot initiatives will be implemented in targeted sectors where there are vulnerable workers, in partnership with trade unions.

The objective pertaining to Education in NAPS (2002) is to ensure that all young people leave the educational system with an adequate education and related qualifications to support their full participation in the economy, in employment and in society. In addition all those who have already left school must have the opportunity to address any lack of educational experience and related qualifications that militates against their ability to participate fully in the economy, in employment and in society.

Key stage 3 result English NI

Stage: Root causes

Level: Household conditions (Individual)

Theme: Human capital

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Literacy and numeracy skills are identified as a prerequisite for learning and for social and economic participation. Furthermore, under Sustaining Progress, a commitment is given to pay critical attention to literacy and numeracy both in school and for adults of all ages. The Agreement states that systematic monitoring of literacy attainment levels and assessment and remediation strategies in primary schools will be implemented, supported by targeted initiatives to address the specific needs of disadvantaged schools.

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Key stage 3 result Maths NI

Stage: Root causes

Level: Household conditions (Individual)

Theme: Human capital

NORTH-SOUTH COMPARABILITY		North only component	
LAY DESCRIPTION		Percentage of pupils achieving Level 5 at Key Stage 3 Maths	
SOURCE REFERENCE		eHPI: RH3_2	
INDICATOR NAME		Key stage 3 Maths NI	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Percentage of pupils achieving Level 5 at Key Stage 3 Maths			
Published?	Yes Schools for the Future: Funding, Strategy, Sharing. Report of the Independent Strategic Review of Education	Geography	Northern Ireland
Frequency	Not regularly published	Latest Year	2004/2005
Numerator Definition	Number of pupils achieving Level 5 at Key Stage 3 Maths	Geography	LGD
Source	Department of Education	Year	2006/2007
Denominator Definition	Number of pupils at Key Stage 3 Maths	Geography	LGD
Source	Department of Education	Year	2006/2007
DATA ISSUES		DATA ISSUES	
LGD refers to the location of the school.			
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
'Schools For the Future - Funding, Strategy, Sharing' December 2006 – referred to as the Bain Review this dealt with the need for better planning of the schools' estate in the context of falling enrolments, and with encouraging integration in education, overprovision in that there were too many schools with small pupil numbers (an estimated 15% empty places in 2005/6) and lack of co-ordination. http://www.deni.gov.uk/review_of_education.pdf . It also addressed the issue of Irish medium education.		Education (Welfare) Act, 2000 NAPS (2002) Northern Ireland 'Investing in Health' (2002) Sustaining Progress (2003)	
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Key stage 3 result Maths NI

Stage: Root causes

Level: Household conditions (Individual)

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Key stage 3 result Maths NI

Stage: Root causes

Level: Household conditions (Individual)

Theme: Human capital

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Key stage 4 result NI

Stage: Root causes

Level: Household conditions (Individual)

Theme: Human capital

NORTH-SOUTH COMPARABILITY		North only component	
LAY DESCRIPTION		Percentage of pupils achieving 5 or more GCSE grades A* to C	
SOURCE REFERENCE		eHPI: RH3_3	
INDICATOR NAME		Key stage NI 4	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Percentage of pupils achieving 5 or more GCSE grades A* to C			
Published?	Yes www.deni.gov.uk	Geography	School
Frequency	Every year	Latest Year	2006/2007
Numerator Definition	Number of pupils achieving 5 or more GCSE grades A* to C	Geography	LGD
Source	Department of Education	Year	2006/2007
Denominator Definition	Number of pupils taking GCSE examinations	Geography	LGD
Source	Department of Education	Year	2006/2007
DATA ISSUES		DATA ISSUES	
LGD refers to the location of the school.			
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
‘Schools For the Future - Funding, Strategy, Sharing’ December 2006 – referred to as the Bain Review this dealt with the need for better planning of the schools’ estate in the context of falling enrolments, and with encouraging integration in education, overprovision in that there were too many schools with small pupil numbers (an estimated 15% empty places in 2005/6) and lack of co-ordination. http://www.deni.gov.uk/review_of_education.pdf . It also addressed the issue of Irish medium education.		Education (Welfare) Act, 2000 NAPS (2002) Northern Ireland ‘Investing in Health’ (2002) Sustaining Progress (2003) Key Targets under NAPS (2002) regarding Education are as follows: (i) To halve the proportion of pupils with serious literacy difficulties by 2006. (ii) To reduce the proportion of the population aged 16-64 with restricted literacy to below 10 to 20 per cent by 2007 (restricted literacy being defined as falling below 200-225 on the IALS scale or equivalent). (iii) To reduce the number of young people who leave the school system early, so that the percentage of those who complete upper second level or equivalent will reach 85 per cent by 2003 and 90 per cent by 2006 A related NAPS target regarding People with Disabilities is:	
In addition to this the Education sector has to address: Curriculum reforms including primary and post-primary and new admission arrangements.			

Key stage 4 result NI

Stage: Root causes

Level: Household conditions (Individual)

Theme: Human capital

Financing issues around local management of schools and capital funding.
Restructuring of Education Boards
Response to reduced pupil numbers

As outlined in 'Strategic Plan for Education – DENI'

[http://www.deni.gov.uk/strategic_plan_for_education_2006-08_pdf - 161 kb-2.pdf](http://www.deni.gov.uk/strategic_plan_for_education_2006-08_pdf_-_161_kb-2.pdf)

And the presentation by the Permanent Secretary of the Department of Education to the Members of the Legislative Assembly in April 2007. <http://www.deni.gov.uk/index/education-challenges-in-northern-ireland.htm>

and the new Minister's speech to the Primary Heads Conference May 2007 ' Shaping the Future of primary Education'
http://www.deni.gov.uk/index/80-curriculumandassessment_pg/curriculum_and_assessment-newpage-4.htm

The targets in the Public service Agreement are about achieving by 2008 particular percentages of pass grades in Key Stages, GCSEs (or equivalent) or 'A' Levels or equivalent and reducing the differentials in educational attainment by achieving specified pass levels in disadvantaged schools.

For Key Stage 2 by 2008 80% of Primary pupils will achieve level 4 or above in English and 83% in Maths (compared to 76.6% in English and 79% in Maths in 2004/5)

For Key Stage 2 by 2008 70% of pupils in the most disadvantaged primary schools will achieve level 4 or above in English and in Maths (compared to 64% in English and 67% in Maths in 2004/5)

By 2020, to ensure that all children fulfil their potential to obtain basic numeracy and literacy levels before they leave school and, ensure that every young person can further education, training or employment.

By 2020, to have substantially improved the educational attainment of pupils from disadvantaged background, including looked after children at both primary and post-primary levels.

(i) To increase participation by students with disabilities at third-level to 1.35 per cent by 2003 and 1.8 per cent by 2006.

Related NAPS targets pertaining to Travellers are:

- (i) The transfer rate of Travellers to post-primary schools will be increased to 95% by 2004.
- (ii) Each third-level institution will double the participation by mature disadvantaged students, including Travellers and Refugees by 2006 (within the 15 per cent quota).

The significance of education is reinforced by the following quotation "Educational attainment is a more powerful predictor of differences in mortality than income equality...." (British Medical Journal 2001 cited in Investing for Health, 2002). Current public spending on education in Ireland accounts for a comparatively small share of GNP by EU 15 standards. There are some grounds for satisfaction that this spending is efficient in attaining outcomes, but largely when outcomes for young people from non-disadvantaged backgrounds are considered. By contrast, educational disadvantage has, so far, not been significantly reduced by higher spending and low levels of spending by international standards are being incurred on behalf of pre-school children and older age groups.

In recent years legislation and resources have been targeted at the problem of early school leaving. The enactment of the Education (Welfare) Act, 2000, provides a comprehensive national system for ensuring that children of compulsory school-going age attend school, or, if they do not attend school, that they receive at least a minimum education (National Children's Strategy, 2000). A range of initiatives focused on school retention and completion will be reviewed under the Agreement to ensure optimum synergy and integration, advised by the Educational Disadvantage Committee. For instance, the Educational Welfare Board will be brought into operation and adult learning opportunities will be particularly targeted at those in disadvantaged communities in rural and urban areas. Building on the Youth Work Act 2001, the National Youth Work Development Plan will be progressed and implemented on a phased basis, as resources are made available. The extent of compliance with the terms of the Protection of Young Persons (Employment) Act 1995, which provides for proactive information provision, inspection of workplaces, and prosecution where appropriate, will be evaluated. A workplace basic education and literacy /numeracy/Information and Communication Technologies (ICT) programme will be implemented as part of this, building on the recommendations of the National Adult Literacy Agency report on a Workplace Basic Education Strategy and the Report of the Task Force on Lifelong Learning. Pilot initiatives will be implemented in targeted sectors where there are vulnerable workers, in partnership with trade unions.

The objective pertaining to Education in NAPS (2002) is to ensure that all young people leave the educational system with an adequate education and related qualifications to support their full participation in the economy, in employment and in society. In addition all those who have already left school must have the opportunity to address any lack of educational experience and related qualifications that militates against their ability to participate fully in the economy, in employment and in society.

Sustaining Progress (2003) commits to the implementation of initiatives to prevent and address early school leaving, taking account of the framework set out in the NESF Report on Early School Leavers. It identified 'Tackling Educational Disadvantage – Literacy, Numeracy and Early School Leavers' as one of its ten special initiatives. The NESF report states that tackling the issue of educational disadvantage requires a multidimensional and integrated approach.

Education plays a fundamental role in providing full access to life chances and in avoiding

Key stage 4 result NI

Stage: Root causes

Level: Household conditions (Individual)

Theme: Human capital

and breaking the cycle of disadvantage. It notes that a key focus of education policy is to prioritise investment in favour of those most at risk and to optimise access, participation and outcome at every level of the system for disadvantaged groups. Literacy and numeracy skills are identified as a prerequisite for learning and for social and economic participation. Furthermore, under Sustaining Progress, a commitment is given to pay critical attention to literacy and numeracy both in school and for adults of all ages. The Agreement states that systematic monitoring of literacy attainment levels and assessment and remediation strategies in primary schools will be implemented, supported by targeted initiatives to address the specific needs of disadvantaged schools.

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Expenditure on personal social services

Stage: Intervening factors

Level: Resourcing to support health (Macro)

Theme: Local government resourcing

NORTH-SOUTH COMPARABILITY	North only component																																								
LAY DESCRIPTION	Expenditure on personal and social services per person																																								
SOURCE REFERENCE	eHPI: IR1_1																																								
INDICATOR NAME	Personal social services exp NI																																								
DATA DEFINITION – NORTHERN IRELAND	DATA DEFINITION – REPUBLIC OF IRELAND																																								
<p>Expenditure on Family & Child Care, Elderly Care, Mental Health, Learning Disability, and Physical and Sensory Disability Programmes of Care per needs-weighted population</p> <table><tr><td>Published?</td><td>Yes</td><td>Geography</td><td>Local Commissioning Group Areas</td></tr><tr><td></td><td>DHSSPS Strategic Resources Framework 2007-2008 Appendices</td><td></td><td></td></tr><tr><td>Frequency</td><td>Every year</td><td>Latest Year</td><td>2007/2008</td></tr><tr><td>Numerator Definition</td><td>Expenditure on Family & Child Care, Elderly Care, Mental Health, Learning Disability, and Physical and Sensory Disability Programmes of Care</td><td>Geography</td><td>LGD</td></tr><tr><td>Source</td><td>DHSSPS</td><td>Year</td><td>2007/2008</td></tr><tr><td>Denominator Definition</td><td>Needs-weighted population</td><td>Geography</td><td>LGD</td></tr><tr><td>Source</td><td>DHSSPS</td><td>Year</td><td>2006</td></tr></table>	Published?	Yes	Geography	Local Commissioning Group Areas		DHSSPS Strategic Resources Framework 2007-2008 Appendices			Frequency	Every year	Latest Year	2007/2008	Numerator Definition	Expenditure on Family & Child Care, Elderly Care, Mental Health, Learning Disability, and Physical and Sensory Disability Programmes of Care	Geography	LGD	Source	DHSSPS	Year	2007/2008	Denominator Definition	Needs-weighted population	Geography	LGD	Source	DHSSPS	Year	2006	<table><tr><td>Published?</td><td>Geography</td></tr><tr><td>Frequency</td><td>Latest Year</td></tr><tr><td>Numerator Definition</td><td>Geography</td></tr><tr><td>Source</td><td>Year</td></tr><tr><td>Denominator Definition</td><td>Geography</td></tr><tr><td>Source</td><td>Year</td></tr></table>	Published?	Geography	Frequency	Latest Year	Numerator Definition	Geography	Source	Year	Denominator Definition	Geography	Source	Year
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Denominator Definition	Needs-weighted population	Geography	LGD																																						
Source	DHSSPS	Year	2006																																						
Published?	Geography																																								
Frequency	Latest Year																																								
Numerator Definition	Geography																																								
Source	Year																																								
Denominator Definition	Geography																																								
Source	Year																																								
DATA ISSUES <p>An LGD's value is assumed to be equal to its Local Commissioning Group Area value. This will mask any LGD variation within that Local Commissioning Group Area. There are seven Local Commissioning Group Areas.</p>	DATA ISSUES																																								
PUBLIC HEALTH IMPORTANCE																																									
POLICY CONTEXT – NORTHERN IRELAND	POLICY CONTEXT – REPUBLIC OF IRELAND																																								
<p>Personal Social Services expenditure in Northern Ireland is through the Four Health and Social Services Boards rather than the local authority model as in England.</p> <p>As distinct from one personal social services strategy there are a range of strategies and targets covering particular client groups such as children, mental health or elderly.</p> <p>The broad strategies of developing primary care in Caring For Tomorrow (2005) www.dhsspsni.gov.uk/index/hss/primary_care-strategy.htm</p> <p><i>Caring for People Beyond Tomorrow</i> sets out the Department's policy position through a Vision Statement for a future Primary Care Service, and a policy framework designed to steer</p>	<p>Comparative Public Health Spending & Health-Related Outcomes</p> <p>The rise in public health spending in Ireland since 1997 has been dramatic, yet there is a generalised concern that the public health services have not only not improved but deteriorated. Partly as a result, a major reform programme began in 2005 whose impact will need some years before it can be assessed. By 2002, public spending on health as a proportion of GDP/GNP put Ireland in the top third of EU 15 member states, while its per capita spending in constant purchasing power terms was the 6th highest of the 14 countries listed (Denmark, Sweden, Finland, Austria, Netherlands, Germany, France, Belgium, United Kingdom, Ireland, Italy, Greece, Spain, Portugal). Individual traits, lifestyle choices, social and community networks, and wider socio-economic and cultural factors all mediate the individual's need for health services (DoHC, 2001) and, thus, the levels of health service usage that support any given health</p>																																								

Expenditure on personal social services

Stage: Intervening factors

Level: Resourcing to support health (Macro)

Theme: Local government resourcing

the future development of policies and services in primary care.

The broad strategy of 'A healthier Future' (ref) is has key elements which are directly related to the provision or resourcing of Personal Social Services

- Secure an appropriate balance between hospital and community based services within local health economies;
- Continue the expansion and evaluation of intermediate care as a way of working that is designed to prevent unnecessary hospital admission, promote faster recovery from illness, support timely discharge, maximise independent living and improve the quality of assessment of long-term health and social care needs;
- In co-operation with the independent sector, expand the use of supported living, domiciliary care, day care and assistive technologies as alternatives to residential accommodation, focusing on rehabilitation and independent living;
- Develop a range of housing and care options for different levels of support, offering a continuum of care as people's needs change;
- Contribute to the development of a region-wide single assessment process, focused upon the person and designed to streamline and improve decision making about long-term health and social care needs and simplify access to services;
- Expand the range of flexible and responsive respite and support services for carers;
- Increase the take up of Direct Payments; and

None directly on PSS expenditure.

outcome. Major changes in socio-economic conditions and lifestyle over the past two decades have accompanied the large increase in public health spending that has occurred. Falling unemployment, lower levels of deprivation, rising educational attainment, more self-direction in the workplace and less smoking, for example, can be expected to have made major contributions to improving people's health status. On the other hand, the very ability to keep people with severe disabilities alive longer, the growing number of advanced elderly people, the rise in alcohol consumption, rising obesity levels, higher immigration from developing countries, growing relationship instability and the higher incidence of people living alone — are some factors which can be expected to be making even a population more intensive in its use of health services even to maintain its health status.

Current public spending on health in Ireland is broadly comparable to other countries in the share of national resources being devoted to it. That Ireland, nevertheless, has poor relative health outcomes suggests better use can be made of the resources being devoted to health. This is not just a challenge to the management of health organisations and the ethos of health professionals but underlines the need for co-responsibility for health to be exercised right across Irish society (in use of alcohol, diet, etc.)

(Source: NECS & NESDO 2005 The Developmental Welfare State)

Spending on health care, disability and sickness grew particularly strongly in Ireland compared to the rest of the EU during the 1990s. In 1993, expenditure on the function Sickness/Health Care was 34.8 per cent of all social protection expenditure in Ireland as against an EU 15 average of 28 per cent; by 2001, it was 43.4 per cent in Ireland as against an EU 15 average of 28 per cent. In 2001, spending in Ireland on the sickness/health care function as a proportion all social protection expenditure was higher than anywhere else in the EU 15 (European Social Statistics, Social Protection: Expenditure and Receipts Data 1992-2001).

REFERENCES

Expenditure on sports and recreation

Stage: Intervening factors

Level: Resourcing to support health (Macro)

Theme: Local government resourcing

NORTH-SOUTH COMPARABILITY	One South only component
LAY DESCRIPTION	Local Authority expenditure on swimming pools and other recreational amenities per person
SOURCE REFERENCE	eHPI: IR1_2
INDICATOR NAME	Sports expend/capita Rol
DATA DEFINITION – NORTHERN IRELAND	DATA DEFINITION – REPUBLIC OF IRELAND
<p>Local Authority expenditure on swimming pools (Local Government Expenditure Programme Group 6.1) and other recreational amenities (Local Government Expenditure Programme Group 6.4) per person</p> <p>Published? Geography</p> <p>Frequency Latest Year</p> <p>Numerator Geography</p> <p>Definition</p> <p>Source Year</p> <p>Denominator Geography</p> <p>Definition Year</p> <p>Source</p>	<p>Local Authority expenditure on swimming pools (Local Government Expenditure Programme Group 6.1) and other recreational amenities (Local Government Expenditure Programme Group 6.4) per person</p> <p>Published? Yes Department of Environment, Heritage and Local Government: Local Authority Budgets Geography Local Authorities</p> <p>Frequency Every year Latest Year 2005</p> <p>Numerator Expenditure on swimming pools and other recreational Definition Department of Environment, Heritage and Local Government Geography County</p> <p>Source Department of Environment, Heritage and Local Government Year 2005</p> <p>Denominator Mid-year population estimate Definition Public Health Information System Geography County</p> <p>Source Year 2005</p>
DATA ISSUES	DATA ISSUES
	Development or provision of sports facilities is largely funded through the National Lottery and The Department of Arts, Sport and Tourism rather than Department of Environment, Heritage and Local Government: Local Authority Budgets. Therefore, the component doesn't provide comprehensive information on sports and recreation expenditure.
PUBLIC HEALTH IMPORTANCE	
POLICY CONTEXT – NORTHERN IRELAND	POLICY CONTEXT – REPUBLIC OF IRELAND
<p>The Department of Culture, Arts and Leisure is responsible for the central administration and promotion of sport in Northern Ireland.</p> <p>In particular, the Department's role is to determine appropriate policy frameworks through which sport will be developed in Northern Ireland. It is also responsible for ensuring the effective and efficient administration of Sport Northern Ireland which is a statutory body set up under The Recreation and Youth Service (Northern Ireland) Order 1986 and is responsible for the development of sport in Northern Ireland, including the distribution of funding.</p> <p>The Department of Culture, Arts and Leisure (DCAL), in partnership with Sport Northern</p>	<p>The Department of Arts, Sports and Tourism was formed in June 2002 and its mission is: "to contribute to the economic, social and cultural progress of Irish society and the enrichment of its quality of life through promoting sustainable tourism; encouraging excellence in sporting and artistic achievement; facilitating greater access to sport and the arts; and preservation of our cultural inheritance".</p> <p>The Department's role in relation to policy-making pertaining to sports is set out as follows: "formulation, development and evaluation of sport policy (the implementation of which in the main is a matter for the Irish Sports Council); overseeing major sports projects, including the National Aquatic Centre at Abbotstown; developing proposals for the provision of a national stadium; the administration of the Sports Capital and the Local Authority Swimming Pool</p>

Expenditure on sports and recreation

Stage: Intervening factors

Level: Resourcing to support health (Macro)

Theme: Local government resourcing

Ireland, is developing a new Strategy for Sport for Northern Ireland. This will detail the vision and rationale for sport and establish key priorities and actions for the future development of sport in Northern Ireland. The overall aim will be to produce a 10 year Strategy for Sport which reflects Government's policy and priorities for sport and with which key stakeholders can identify. The previous Strategy covered the period 1997-2005.

DCAL established a Steering Group, chaired by the Minister, to oversee the development of the new Strategy. The Department also procured an independent expert to provide advice and support in establishing the rationale for government intervention in sport taking account of the current and future environmental context.

To ensure that the strategy reflects current thinking and views on sports, DCAL and Sport NI also undertook a range of independent consultations with sectoral interests and the wider public.

DCAL has prepared a draft Strategy in partnership with Sport NI. This draft was tested in April 2006 to ensure that it addressed the main issues. The draft was re-considered in light of the outcome of testing and a revised draft has been produced. This revised draft was described as likely to be published for consultation in the early Spring 2007. (Not yet issued July 2007).

Programmes".

(<http://www.irishsportscouncil.ie/about-us-dept-of-arts.aspx> accessed 5/5/06)

The Department of Arts, Sport and Tourism runs two grant programmes:

- (i) the Sports Capital Programme and
- (ii) the Local Authority Swimming Pool Programme.

The Irish Sports Council are responsible for the administration of the Grants Scheme for National Governing Bodies of Sport. The National Lottery-funded Sports Capital Programme is administered by the Department of Arts, Sport and Tourism. It is advertised on an annual basis and allocates funding to projects that are directly related to the provision of sports facilities and are of a capital nature.

This means that the project must involve:

- improving or building an asset; or
- buying sports equipment that is securely stored and will be used for at least five years.

Funding can be allocated to the following organisations under the programme:

- voluntary and community organisations, including sports clubs;
- national governing bodies of sport and third level education institutions, where it is evident that the proposed facility will contribute to the regional and/or national sporting infrastructure; and
- in certain circumstances, schools, colleges and local authorities.

Under the Local Authority Swimming Pool Programme, grant-aid from the Exchequer is made available to local authorities and bodies supported by local authorities, towards the cost of providing new swimming pools or refurbishing existing pools.

(http://www.arts-sport-tourism.gov.ie/grants_funding/default.htm accessed 1/6/06)

Sports Facility Strategy & National Audit of Local Sports Facilities

The programme for Government includes a commitment to complete a national audit of local sports facilities and to put in place a long-term strategic plan to ensure the development of such necessary facilities throughout the country. The first step in the process to meet this commitment was the undertaking of the Sports Capital Programme Expenditure Review. The indications point towards a need for the Sports Capital Programme to operate in the context of a clearly defined strategy for the provision of sports facilities and for such a strategy to be informed by a national audit of sports facilities. An interagency steering group has been established to oversee the development of such a strategy and is commencing its work. The group which held its first meeting in June 2005 is comprised of representatives from this Department along with officials from the Departments of Education and Science, Community, Rural & Gaeltacht Affairs, Environment, Heritage & Local Government and Finance in addition to representatives of the Irish Sports Council, Campus Stadium Ireland Development Limited and the County & City Managers Association. One of the first challenges facing the group is to oversee the commencement of a national audit of sports facilities

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Nurse led care

Stage: Intervening factors

Level: Resourcing to support health (Macro)

Theme: Preventative care resourcing

NORTH-SOUTH COMPARABILITY North only component

LAY DESCRIPTION Expenditure on nurse led care per person

SOURCE REFERENCE eHPI: IR2_1

INDICATOR NAME Nursing expenditure NI

DATA DEFINITION – NORTHERN IRELAND

Expenditure on district nursing, specialist nursing, children/school nursing, and health visiting per person.

Published?	No	Geography	N/a
Frequency	N/a	Latest Year	N/a
Numerator			
Definition	Expenditure on district nursing, specialist nursing, children/school nursing, and health visiting	Geography	Former Health Trusts
Source	DHSSPS	Year	2006/2007
Denominator			
Definition	Mid-year population estimate	Geography	HSCT
Source	NISRA	Year	2007

DATA ISSUES

Data from the 18 former Health Trusts were mapped to the five new HSCTs. An LGD's value is assumed to be equal to its HSCT value. This will mask any LGD variation within that HSCT.

PUBLIC HEALTH IMPORTANCE

POLICY CONTEXT – NORTHERN IRELAND

There has been a series of documents issued by DHSSPS NI on developing the roles and functions of nursing in the Province. These include Poulton et al 'The Contribution of Nurses, Midwives and Health Visitors in the Public health Agenda' (2000) And 'From Vision to Action –Strengthening the nursing contribution to Public health' (2003)

Both available at <http://www.dhsspsni.gov.uk/index/nmag/nmag-projects.htm>

The premise is that community nurses will increasingly have a role in providing first contact and out of hours services and that these will require enhanced training and skills as well as appropriate staffing . As outlined in http://www.dhsspsni.gov.uk/nursing_strategic_direction.pdf

Following approximately two years of development and consultation the Department published its Primary Care Strategic Framework - *Caring for People Beyond Tomorrow* - on 12 October 2005.

Caring for People Beyond Tomorrow sets out the Department's policy position through a

DATA DEFINITION – REPUBLIC OF IRELAND

Published?		Geography	
Frequency		Latest Year	
Numerator			
Definition		Geography	
Source		Year	
Denominator			
Definition		Geography	
Source		Year	

DATA ISSUES

POLICY CONTEXT – REPUBLIC OF IRELAND

There are currently no specific strategic policies relevant to this component measure in the Rol

Nurse led care

Stage: Intervening factors

Level: Resourcing to support health (Macro)

Theme: Preventative care resourcing

Vision Statement for a future Primary Care Service, and a policy framework designed to steer the future development of policies and services in primary care.

Key aspects of the Strategic Framework are:

- A service focused on providing comprehensive person-centered care.
- A first point of contact that is readily accessible and responsive to meet people's needs day or night.
- A coordinated, integrated service employing a team approach with multi-agency linkages.
- An emphasis on engagement with people and communities about their care and the way services are designed and delivered.
- A focus on prevention, health education and effective self-care.

Caring for People Beyond Tomorrow will be a significant driver of reform and modernisation, designed to influence the planning and work of HSS Boards, Trust and other providers of primary and community based care.

Outcomes envisaged will include

- Making primary care services more responsive by encompassing a wider range of services in the community.
- Making primary care services more accessible, by way of time to see practitioners, greater number of locations, enabling people to see appropriate practitioners and greater provision of information.
- Developing more effective partnerships and team working across organisational and professional boundaries, as a means of increasing the effectiveness of the services.
- More proactive engagement with service users about service planning, design and delivery.
- Improved premises and infrastructure, harnessing new technologies and clinical advancements.

Many of these developments will be dependent on appropriate community nursing support and development.

None

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Therapy

Stage: Intervening factors

Level: Resourcing to support health (Macro)

Theme: Preventative care resourcing

NORTH-SOUTH COMPARABILITY		North only component	
LAY DESCRIPTION		Expenditure on therapy per person	
SOURCE REFERENCE		eHPI: IR2_2	
INDICATOR NAME		Therapy expenditure NI	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Expenditure on district nursing , chiropody/podiatry, speech therapy, occupational therapy, physiotherapy, dietetics and community dentistry per person.			
Published?	No	Geography	N/a
Frequency	N/a	Latest Year	N/a
Numerator Definition	Expenditure on district nursing , chiropody/podiatry, speech therapy, occupational therapy, physiotherapy, dietetics and community dentistry	Geography	Former Health Trusts
Source	DHSSPS	Year	2006/2007
Denominator Definition	Mid-year population estimate	Geography	HSCT
Source	NISRA	Year	2007
DATA ISSUES		DATA ISSUES	
Data from the 18 former Health Trusts were mapped to the five new HSCTs. An LGD's value is assumed to be equal to its HSCT value. This will mask any LGD variation within that HSCT.			
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
An Allied Health Professions (AHP) Regional Strategy was developed through a series of 5 workshops from November 2004 to March 2005. The writing up of the Strategy commenced in April 2005 and there was a period of consultation during the summer of 2005. The strategy workshops had the overall theme of AHP Modernisation. One of the key aims of the workshops and ultimately the new Strategy was to share learning across the Allied Health Professions and the HPSS generally. Details and presentations from these is available at http://www.dhsspsni.gov.uk/index/hss/ahp/ahp_strategy.htm		There are currently no specific strategic policies relevant to this component measure in the RoI	
The previous strategy in 1997 is available at http://www.dhsspsni.gov.uk/ahp_pam_strategy.pdf The Strategy identified the key role that AHPs have in delivering services in hospital and community and the importance of this in meeting the then regional strategy targets.			

Therapy

Stage: Intervening factors

Level: Resourcing to support health (Macro)

Theme: Preventative care resourcing

Following approximately two years of development and consultation the Department published its Primary Care Strategic Framework - *Caring for People Beyond Tomorrow* - on 12 October 2005. *Caring for People Beyond Tomorrow* sets out the Department's policy position through a Vision Statement for a future Primary Care Service, and a policy framework designed to steer the future development of policies and services in primary care.

Key aspects of the Strategic Framework are:

- A service focused on providing comprehensive person-centered care.
- A first point of contact that is readily accessible and responsive to meet people's needs day or night.
- A coordinated, integrated service employing a team approach with multi-agency linkages.
- An emphasis on engagement with people and communities about their care and the way services are designed and delivered.
- A focus on prevention, health education and effective self-care.

Caring for People Beyond Tomorrow will be a significant driver of reform and modernisation, designed to influence the planning and work of HSS Boards, Trust and other providers of primary and community based care.

Outcomes envisaged will include

- Making primary care services more responsive by encompassing a wider range of services in the community.
- Making primary care services more accessible, by way of time to see practitioners, greater number of locations, enabling people to see appropriate practitioners and greater provision of information.
- Developing more effective partnerships and team working across organisational and professional boundaries, as a means of increasing the effectiveness of the services.
- More proactive engagement with service users about service planning, design and delivery.
- Improved premises and infrastructure, harnessing new technologies and clinical advancements.

Many of these developments will be dependent on appropriate community nursing support and development.

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Access to health visitor

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Theme: Access to preventative health care

NORTH-SOUTH COMPARABILITY		North only component	
LAY DESCRIPTION		Number of health visitors per 100,000 people	
SOURCE REFERENCE		eHPI: IH2_5	
INDICATOR NAME		Health visitor per capita NI	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Number of whole time equivalent health visitors per 100,000 people. Excludes health visitors with a whole time equivalent of less than or equal to 0.03.			
Published?	Yes	Geography	Northern Ireland
Frequency	DHSSPS Workforce Census	Latest Year	2007
Numerator	Every year		
Definition	Number of whole time equivalent health visitors	Geography	HSCT
Source	DHSSPS Workforce Census	Year	2007
Denominator			
Definition	Mid-year population estimate	Geography	HSCT
Source	NISRA	Year	2007
DATA ISSUES		DATA ISSUES	
An LGD's value is assumed to be equal to its HSCT value. This will mask any LGD variation within that HSCT.			
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
In line a broad strategy of a primary care led service		Health visitors were included in the core primary care team membership in the UK, as identified by the RCGP, while a document entitled Primary care, general practice and the NHS plan (January 2001) states that nurses and health visitors will undertake a wider range of roles determined by patient and community need (DoHC,2001 Primary Care Strategy).	
Following approximately two years of development and consultation the DHSSPS NI published its Primary Care Strategic Framework - <i>Caring for People Beyond Tomorrow</i> - on 12 October 2005.		Whereas the Irish health care system does not have a comparable 'health visitor', the role of the public health nurse would be relevant in terms of core responsibilities and roles with regards to patient and service user care.	
<i>Caring for People Beyond Tomorrow</i> sets out the Department's policy position through a Vision Statement for a future Primary Care Service, and a policy framework designed to steer the future development of policies and services in primary care.			
Key aspects of the Strategic Framework are:		Public Health Nursing	
<ul style="list-style-type: none">A service focused on providing comprehensive person-centered care.		Public Health Nursing was first included on the An Bord Altranais register in 1960 (Commission	

Access to health visitor

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Theme: Access to preventative health care

- A first point of contact that is readily accessible and responsive to meet people's needs day or night.
- A coordinated, integrated service employing a team approach with multi-agency linkages.
- An emphasis on engagement with people and communities about their care and the way services are designed and delivered.
- A focus on prevention, health education and effective self-care.

Outcomes envisaged will include:

- Making primary care services more responsive by encompassing a wider range of services in the community.
- Making primary care services more accessible, by way of time to see practitioners, greater number of locations, enabling people to see appropriate practitioners and greater provision of information.
- Developing more effective partnerships and team working across organisational and professional boundaries, as a means of increasing the effectiveness of the services.
- More proactive engagement with service users about service planning, design and delivery.
- Improved premises and infrastructure, harnessing new technologies and clinical advancements.

http://www.dhsspsni.gov.uk/nursing_midwifery_health_visiting_workforce.pdf published in Sept 05. The review investigates current and future supply and demand factors that will impact on the delivery and development of nursing, midwifery and health visiting services.

Title: Community Health Nursing: Current Practice and Possible Futures

Published: DHSSPSNI July 2003

http://www.dhsspsni.gov.uk/community_health_nursing.pdf

Description: The aim of the project is to develop innovative models of service delivery for community health nursing (CHN) that are consistent with public health principles; workable within the developing primary care structures in Northern Ireland and have the potential to link primary care, public health, community and secondary care and other relevant interest groups. Such models will be inclusive of all community health nursing disciplines, including midwives, and grounded within the context of public health with the aim of vision to create an environment which enables and empowers public health nurses to provide comprehensive health and social care to individuals and populations within the remit of their individual roles (and particular context in collaboration with relevant others to achieve improved, effective public health for all). Its vision was the delivery of health care towards a primary care-led service. It was intended to concentrate resources, planning and support at a primary care level, to create integrated health and social care provision closer to where people live in their communities.

July 2003 - Community health Nursing – Current Practice and Possible Futures - Identified 540 WTE Health Visitors in NI.

'Healthy Futures' has Health Visitor as part of the core primary care team.

www.dhsspsni.gov.uk/healthyfuture-main.pdf. Redesign of community nursing – March 2006 www.dhsspsni.gov.uk/regional_redesign_of_community_nursing_project-4.pdf The overarching aim for the future is to develop a community nursing workforce that is equipped to respond to the increasing demands of first contact care, continuing care and chronic disease management, while always underpinning this with a public health approach.

on Nursing, 1998) and resulted from the amalgamation of the midwifery, voluntary district nursing services, and nurses employed by the local authorities (Leahy-Warren, 1998). There were 1,878 PHNs on the live register of An Bord Altranais in 2001. Population size is the basis for the public health service provision, so each population of 2,500 is served by a PHN. The PHN interfaces with a multitude of client groups in the community. "The Department of Health's Circular (27/66) 1966 is perceived by many as the core strategy statement in relation to the role of public health nursing in the community" (Commission on Nursing, 1998). "The object should be to provide such domiciliary midwifery services as may be necessary, general domiciliary nursing, particularly to the elderly, and least equally important to attend to the healthcare of children (DoHC, 1966). More recently, the PHN job description outlined by the DoHC in 2000 states that the role of the PHN is to focus on "a district or area meeting the curative and preventive nursing needs of the population within the area". The PHN will be expected to provide a broad based, integrated prevention, education, and health promotion services and to act as co-ordinator in the delivery of a range of services in the community (DoHC, 2000).

Source: University of Dublin, Trinity College (April 2004)

A study of the role and workload of the public health nurse in the Galway Community Care Area accessed web site 12/6/06

Access to health visitor

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Theme: Access to preventative health care

The target in the Primary Care Strategy is to provide a comprehensive care out of hours emergency care service providing access, as appropriate, not only to general medical, general dental and community pharmacy services, but also to community nursing, mental health and other social care services.

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Breast screening uptake

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Theme: Access to preventative health care

NORTH-SOUTH COMPARABILITY		North only component	
LAY DESCRIPTION		Percentage of women aged 50-64 years invited for breast cancer screening who have been screened	
SOURCE REFERENCE		eHPI: IH2_3	
INDICATOR NAME		Pct breast screen NI	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Percentage of women aged 50-64 years invited for breast cancer screening who have been screened			
Published?	Yes www.ninis.nisra.gov.uk	Geography	HSSB
Frequency	Every year	Latest Year	2005/2006
Numerator Definition	Number of women aged 50-64 years invited for breast cancer screening who have been screened	Geography	HSSB
Source Denominator Definition	Quality Assurance Reference Centre	Year	2005/2006
	Number of women aged 50-64 years invited for breast cancer screening	Geography	HSSB
Source	Quality Assurance Reference Centre	Year	2005/2006
DATA ISSUES		DATA ISSUES	
An LGD's value is assumed to be equal to its HSSB value. This will mask any LGD variation within that HSSB.			
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
Breast cancer is the most common form of cancer among women in Northern Ireland – with 1 in 12 developing it before the age of 75. It can develop at any time but is more common in women over 50. If detected at any early stage there is a good chance of successful recovery.		Cancer Services in Ireland: A National Strategy (DoHC, 1996) BreastCheck (2000) Quality and Fairness (DoHC, 2001) A Strategy for Cancer Control in Ireland National Cancer Forum (DoHC, 2006)	
UP to 300 cancers are identified through breast screening every year. Breast cancer is the most common form of cancer in women. One woman in twelve will develop it by the age of 75. Every year approximately 900 women in Northern Ireland are diagnosed with breast cancer. In 2005, 304 women died from it. Seventy eight of these women were aged between 50 and 64, the age group who are currently offered screening in Northern Ireland.		Under the National Health Strategy Quality and Fairness (2001), the goal of the National Breast Screening Programme, Breastcheck, is to reduce breast cancer mortality by 20 per cent in the cohort of women screened between 2000-2010.	
Breast Screening can detect breast cancer at an early stage before it has caused any symptoms or signs, and when it is easier to treat and cure. At breast screening an x-ray (mammogram) is taken of each breast. Some people find it a bit uncomfortable but the x-ray only takes a few seconds.		BreastCheck's best performance against Women's Charter parameters: The acceptance rates for the programme are in excess of the target of 70%. The standardised detection ratio, a measure of overall programme performance, remains well in excess of the standard of 0.75. The percentage of women with small cancers (less than 15 mm) is just short of the target of 40%. All other standards are met or exceeded.	

Breast screening uptake

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Theme: Access to preventative health care

The Screening Programme

In Northern Ireland the aim is to invite all women who are aged between 50 and 64 for screening every three years. This amounts to about 50,000 women per year. However, only three out of four women attend. This figure masks considerable variations across Northern Ireland. In general attendance is poorer by women who live in the more deprived areas.

At present, women aged 65 and over are not automatically invited for screening, but they can continue to attend for screening by making an appointment through their local screening centre. We plan to extend the screening programme up to age 70 as soon as the additional staff needed to run the programme can be recruited.

Routine breast screening is not offered to women under 50 because their risk of breast cancer is much lower. Also, younger women have denser breast tissue which makes the mammogram more difficult to interpret.

There is a specific website dedicated to the NI screening programmes

<http://www.cancerscreening.ni.nhs.uk/>

'Priorities For Action' DHSS PANI http://www.dhsspsni.gov.uk/pfa_final.doc

'High uptake rates for breast and cervical cancer screening to be maintained'

A much greater proportion of women receiving an invitation for repeat screening within the target of 21-27 months were seen since the previous screen. Although the BreastCheck programme fell short of the target, a further 4% of women were invited before 21 months, while 90% of women were invited within 28 months of the previous round. The figure of 91.2% of women offered hospital admission for treatment represents a major increase compared to previous years and now exceeds the target for the first time.

The 1996 National Cancer Strategy set a target to reduce the death rate from cancer in the under-65 age group by 15% in the ten-year period from 1994.

An evaluation commissioned by the Department of Health and Children on behalf of the National Cancer Forum found that the target of the 1996 National Cancer Strategy to reduce the death rate from cancer in the under-65 age group by 15% in the ten-year period from 1994 was achieved by 2001.

Breast Cancer Prevalence

More than 7,500 deaths each year are due to cancer, accounting for about a quarter of all deaths. Breast cancer remains the commonest cause of cancer death for women (18%). There are approximately 1,600 new invasive breast cancer cases annually (DoHC, 2006).

General Strategic Policy Developments regarding Cancer

The National Cancer Strategy was published in 1996 and was followed by a three year action plan in 1997. The main elements of the Strategy involved:

- reorganisation of cancer treatment services based on principles of best practice, patient-centredness and equity of access throughout the country. This involved organising services around three supra-regional centres and regional centres based in other health board areas;
- establishing screening and early detection programmes of proven value;
- using health promotion activities to emphasise the importance of healthy lifestyles;
- further developing specialist palliative care services;
- facilitating greater co-ordination of cancer research.

A second cancer strategy, A Strategy for Cancer Control in Ireland by the National Cancer Forum was launched by the Department of Health and Children in June, 2006. Its stated aims are to build on the major successes in cancer that have been delivered under the 1996 National Cancer Strategy and further progress implementation of this Strategy. In order to address the rapidly rising burden of cancer, it advocates a comprehensive cancer control policy programme. Cancer control is a whole population, integrated and cohesive approach to cancer that involves prevention, screening, diagnosis, treatment, and supportive and palliative care. It places a major emphasis on measurement of need and on addressing inequalities and implies that we must focus on ensuring that all elements of measurement of need and on addressing inequalities and implies that we must focus on ensuring that all elements of cancer policy and service are delivered to the maximum possible extent. The Strategy also focuses substantially on reform and reorganisation of the way we deliver cancer services.

The Cancer Control Strategy (2006) identified the ongoing need for policy guidance to be provided on many aspects of cancer control, particularly on screening, management of cancer patients, genetics, quality assurance, and research. The National Cancer Forum was established by the Minister on foot of a recommendation in the 1996 National Cancer Strategy. Its primary

Breast screening uptake

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Theme: Access to preventative health care

role is to provide ongoing and independent policy advice on cancer to the Minister and the Department of Health and Children. The evaluation of the first National Cancer Strategy concluded that the Forum played a pivotal role in the development and improvement of cancer services. It has also played an important role in the creation of national consensus around many aspects of cancer policy.

The Cancer Control Strategy (2006) recommends that A third National Cancer Forum should be appointed by the Minister with terms of reference and composition reflecting the changed health system. In particular, it proposes that the Forum should now focus more on policy and its impact. According to the Strategy, cancer care is changing more rapidly now than at any time in the past and this generates a particular need to have a consistent high-quality source of credible leadership capable of creating a policy consensus in respect of priorities, necessary developments and deficiencies in service performance.

The Cancer Control Strategy also proposes that the HSE should present a report on policy indicators each year to the National Cancer Forum on a national basis and from each of the four Managed Cancer Control Networks. It stresses the importance for the Third National Cancer Forum to establish clear targets that are consistent with the vision of the 2006 Strategy . It explains that the first report on policy indicators from the HSE will allow targets to be set for each policy indicator. These targets should then be reviewed annually by the National Cancer Forum. Source: http://www.dohc.ie/publications/pdf/cancer_control_2006.pdf?direct=1 accessed 15/6/06

Cancer and Health Inequalities

The Strategy for Cancer Control in Ireland (DoHC, 2006) explains that the occurrence of cancer and the experience that people have of services for cancer demonstrate health inequalities. It identifies a number of reasons for these inequalities in cancer, including genetic factors and different exposure to risk factors such as smoking, alcohol and diet. Other factors include differences in the awareness of, and response to, cancer symptoms, lower uptake of screening and variations in access to high-quality services. The Strategy asserts the need for a consistent focus on risk factors for cancer, incidence of cancer, access to services, and outcome from services to help to reduce health inequalities between various groups. It proposes that the HSE should put in place arrangements to monitor inequalities in cancer risks, cancer occurrence, cancer services and cancer outcomes. It contends that a series of policy indicators within this Strategy will provide an important means of maintaining a policy focus on cancer inequalities. Source: http://www.dohc.ie/publications/pdf/cancer_control_2006.pdf?direct=1 accessed 15/6/06

Strategic Policy Developments regarding Breast Cancer

In terms of preventive actions, breast screening is where an x-ray of the breast (a mammogram) is taken to look for signs of early breast cancer. It also includes follow-up and surgical management of women who are screened positive within the programme. In Ireland, the BreastCheck Programme is a population based screening programme that aims to reduce mortality from breast cancer. Phase 1 of this National Breast Screening Programme, commenced in February 2000 and covers the Eastern half of the country (i.e. the former Eastern Regional Health Authority, Midland Health Board and North-Eastern Health Board areas). Screening in these areas is available to all women aged between 50-64 years every two years.

This service also delivered in two central units with outreach to the community by means of three mobile units. The Department of Health and Children outlined a commitment in its national health strategy (2001) to provide national coverage as soon as possible, having regard to the experience gained in implementing the first phase of the programme. The extension of the service nationally began from 2004, with Wexford included in the programme in 2004, followed by Carlow in 2005. The service is currently being developed in Kilkenny, while plans are

Breast screening uptake

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Theme: Access to preventative health care

underway to extend the service to women in the South and West of the country as soon as possible.

The recently published Cancer Control Strategy (June, 2006) stated that it is imperative that the programme is rolled-out nationally as quickly as possible in line with current plans. It also recommended that, in line with European Council recommendations, the upper age limit for breast screening should be extended to 69.

The most recently published data in BreastCheck's Annual Report 2004-2005 reveals that during 2004 BreastCheck maintained a high volume of screening activity with 68,046 women invited for screening and 50,540 women attending. An increased proportion of women attending for screening were being invited for subsequent screening (as opposed to initial screening) which resulted, as expected, in a lower number of cancers detected. A total of 309 cancers were diagnosed resulting in a cancer detection rate of 6.1 cancers per 1,000 women screened, as compared to 7.2 in 2003.

BreastCheck's performance is measured against the Women's Charter parameters. The overall uptake rate for 2004 of 73.1% continues to exceed the target of 70%. While the overall rate was marginally lower than in 2003, this results from a much higher number of Previous Non-Attendees (PNAs) being invited for screening in 2004 (9,225) as compared to 2003 (4,834) – and this group is the least likely to attend screening. Therefore, the importance of communications and health promotion efforts to target this group in information campaigns is highlighted. The uptake rate among the other categories of invitees remained impressive. The uptake rate for eligible initial women (women invited to BreastCheck for the first time) increased from 74.5% in 2003 to 78% in 2004. The uptake rate for eligible subsequent women remained high at 89.8%, as compared to 91.1% in 2003.

In early 2004, BreastCheck commissioned Public Communications Centre and Lansdowne Market Research to implement a research programme which would provide them with a better understanding of the women in BreastCheck's target age group and of their relationship with BreastCheck. The report entitled Evaluating Women's Awareness, Understanding & Experiences of BreastCheck was published in November 2004. The research involved both quantitative and qualitative methodologies. The main findings of the research indicated a high level of awareness of BreastCheck amongst its target audience and very positive feedback amongst those who have experienced the service. In terms of attendance, the research found that nationally, 31% of the women claim to have attended BreastCheck for screening. This rises to 67% of those living in Dublin. The main reasons cited for non-attendance were ineligibility. Of the other reasons for non-attendance having had a recent mammogram elsewhere was the most common reason (15%). Smaller number of women cited fear (5%), inconvenience (2%) and lack of confidence in the service (3%). The GP is regarded as the most likely encouragement to attend for screening, followed by more information about the procedure and encouragement from family and friends. Fear of attending involves fear of the end result, fear of the mammogram and fear of coping, fear of dying and fear of misdiagnosis. Those who attend view the screening as a precautionary measure and have an optimism that cancer will not be detected. Having had a previous mammogram or having experience of breast cancer among family or friends have a positive influence on the decision to attend. Findings from the qualitative group discussions revealed that attendees tend to be: younger; better educated; have an active social life; either have had experience of illhealth or are very healthy. Whereas, non-attendees tend to be: older; less well educated; a less active social life; have less experience of ill-health or a very strong negative experience of breast cancer.

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Cervical screening uptake

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Theme: Access to preventative health care

NORTH-SOUTH COMPARABILITY		North only component	
LAY DESCRIPTION		Percentage of women aged 25-64 years invited for cervical cancer screening who have been screened	
SOURCE REFERENCE		eHPI: IH2_4	
INDICATOR NAME		Pct cervical screen NI	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Percentage of women aged 25-64 years invited for cervical cancer screening who have been screened. Coverage refers to the five-year period ending 31 March 2006			
Published?	Yes www.ninis.nisra.gov.uk	Geography	HSSB
Frequency	Every year	Latest Year	2006
Numerator Definition	Number of women aged 25-64 years invited for cervical cancer screening who have been screened	Geography	HSSB
Source	Quality Assurance Reference Centre	Year	2001-2006
Denominator Definition	Number of women aged 25-64 years invited for cervical cancer screening	Geography	HSSB
Source	Quality Assurance Reference Centre	Year	2001-2006
DATA ISSUES		DATA ISSUES	
Cervical screening in Northern Ireland is calculated as "Coverage over 5 years" where the number of smears taken over the last 5 years is expressed as a percentage of the eligible female population aged 25-64.			
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
Cervical screening is not a test for cancer. It is a method of preventing cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer in a woman's cervix (the neck of the womb). Early detection and treatment can prevent 75 per cent of cancers developing.		Cancer Services in Ireland: A National Strategy (DoHC, 1996) National Health Strategy - Quality and Fairness: A Health System for You (2001) A Strategy for Cancer Control in Ireland National Cancer Forum (DoHC, 2006)	
All women between the age of 25 and 64 are eligible for a free cervical smear test every three to five years. In the light of new evidence the NHS Cervical Screening Programme will now be implementing screening at different intervals depending on age. The change is recommended to take place after a woman's next smear which will already have been scheduled.		The Department of Health and Children's target regarding cervical cancer screening outlined in the national health strategy 'Quality and Fairness' (2001) is to achieve a greater than 80 per cent participation rate by women aged 25-60.	
The national target for Cervical Screening Uptake is 80%		Cervical Cancer Prevalence More than 7,500 deaths each year are due to cancer, accounting for about a quarter of all deaths (DoHC, 2006). Cancer of the cervix is the second most common cancer among women world-wide and the latest data in Ireland show that there were 1090 new cases of cervical pre-	

Cervical screening uptake

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Theme: Access to preventative health care

Source: <http://www.cancerscreening.nhs.uk/cervial>

Many cases of cervical cancer can be prevented. Around 30 to 40 women in Northern Ireland die from this disease each year and many of them never had a cervical smear. A cervical smear screening programme has been operational in Northern Ireland since the late 1980s. Women aged 20-64 are invited for a smear test every five years and coverage rates are about 72%

There is a specific website dedicated to the Ni screening programmes

<http://www.cancerscreening.n-i.nhs.uk/>

'Priorities For Action' DHSSPANI http://www.dhsspsni.gov.uk/pfa_final.doc

High uptake rates for breast and cervical cancer screening to be maintained.

By March 2004 increase the coverage rate for cervical screening from 70% (in 2001) to 75%, especially in those areas where uptake is noticeably low.

cancer, 193 cases of cervical cancer and 65 deaths from cervical cancer in 2000, which is one of the highest rates in Western Europe
(Source: <http://www.cancer.ie/news/news.php?newsID=82> accessed 15/6/06).

Strategic Policy Developments

The National Cancer Strategy was published in 1996 and was followed by a three year action plan in 1997. The main elements of the Strategy involved:

- reorganisation of cancer treatment services based on principles of best practice, patient-centredness and equity of access throughout the country. This involved organising services around three supra-regional centres and regional centres based in other health board areas;
- establishing screening and early detection programmes of proven value;
- using health promotion activities to emphasise the importance of healthy lifestyles;
- further developing specialist palliative care services;
- facilitating greater co-ordination of cancer research.

A new Cancer Strategy for Cancer Control in Ireland by the National Cancer Forum was launched by the Department of Health and Children in June, 2006. It explains that the occurrence of cancer and the experience that people have of services for cancer demonstrate health inequalities. It identifies a number of reasons for these inequalities in cancer, including genetic factors and different exposure to risk factors such as smoking, alcohol and diet. Other factors include differences in the awareness of, and response to, cancer symptoms, lower uptake of screening and variations in access to high-quality services.

The Strategy asserts the need for a consistent focus on risk factors for cancer, incidence of cancer, access to services, and outcome from services to help to reduce health inequalities between various groups. It proposes that the HSE should put in place arrangements to monitor inequalities in cancer risks, cancer occurrence, cancer services and cancer outcomes. It contends that a series of policy indicators within this Strategy will provide an important means of maintaining a policy focus on cancer inequalities.

Source: http://www.dohc.ie/publications/pdf/cancer_control_2006.pdf?direct=1 accessed 15/6/06

Cervical Screening

Cervical screening identifies abnormalities that may, if left untreated, develop into cervical cancer. Arising from commitments in the Cancer Strategy (1996), and a recommendation in the Report of the Department of Health Cervical Screening Committee for National Cervical Screening Programme, the first ever-organised approach to cervical screening in Ireland was launched in October 2000. Phase 1 of the Irish Cervical Screening Programme (ICSP) commenced in the former Mid-Western Health Board region (this region is now part of the HSE West).

Participation in the screening programme is on a voluntary basis, and all women in the health board area aged between 25 and 60 years (72,000 approx.) have been encouraged to register with the programme. Those registered are invited to have a cervical smear taken free of charge at five-yearly intervals.

Campaign to Extend Cervical Cancer Screening Programme Nationally

Despite the commitment outlined in the National Health Strategy (2001) to extend this screening service nationally, this has not occurred to date. However, some indications of a move in this

Cervical screening uptake

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Theme: Access to preventative health care

regard are evident. For instance, in 2003 the former Health Board Executive (now known as the Health Service Executive) commissioned an international expert in cervical screening to examine the feasibility and implications of a national roll out of the programme.

Subsequently, a Report on the Irish Cervical Cancer Screening Programme was published in December, 2004. Following the publication of the Report the Department of Health and Children undertook a consultation with the relevant professional and advocacy stakeholders. Discussions are currently underway with the HSE to extend the programme nationally.

(www.oasis.gov.ie/health/womens_health/cervical_screening_programme.html)

In order to progress a national roll out of the service, the national cancer care charity, the Irish Cancer Society (ICS), launched a national campaign for a free nation-wide cervical cancer screening programme in early 2006. It contends that a national screening programme will achieve an 80% reduction in cervical cancer.

The ICS in conjunction with the health and trade union lobby is calling on the Department of Health and Children to:

- o To roll out a national cervical screening programme as soon as possible and recommends that this screening programme be developed as a systematic (call/recall) programme organised around four regional screening centres, which would serve a defined population through a network of professionals working in primary care, laboratories and colposcopy services
- o To offer cervical screening free of charge to all women aged 25-60 years. Women aged 25-35 years should be screened every 3 years and thereafter at 5 year screening intervals if their smear is negative, until the age of 60 years.
- o To establish a complete register of all women in Ireland aged 25-60 years and to establish a formal register of smear takers.

Source: <http://www.cancer.ie/news/news.php?newsID=82> accessed 15/6/06

One of the recommendations of the new Cancer Strategy for Cancer Control in Ireland (DoHC, 2006) is the national rollout of the Irish Cervical Screening Programme to be completed as quickly as possible.

Source: http://www.dohc.ie/publications/pdf/cancer_control_2006.pdf?direct=1 accessed 15/6/06

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Effective vaccination service

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Theme: Access to preventative health care

NORTH-SOUTH COMPARABILITY		All-island component	
LAY DESCRIPTION		Percentage of children who have been vaccinated aged 24 months	
SOURCE REFERENCE		eHPI: IH2_2	
INDICATOR NAME		Pct child vaccination	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
The average percentage uptake of the vaccines against diphtheria (D3), pertussis (P3), tetanus (T3), Haemophilus influenzae type b (Hib3), meningococcal group C (MenC3), measles, mumps and rubella (MMR1) at age 24 months. The component is calculated as the average of the six vaccines' uptake percentages.		The average percentage uptake of the vaccines against diphtheria (D3), pertussis (P3), tetanus (T3), Haemophilus influenzae type b (Hib3), meningococcal group C (MenC3), measles, mumps and rubella (MMR1) at age 24 months. The component is calculated as the average of the six vaccines' uptake percentages.	
Published?	Yes www.cdscni.org.uk	Geography	Northern Ireland
Frequency	Quarterly	Latest Year	2007
Numerator Definition	Number of children vaccinated at age 24 months	Geography	LGD
Source	Child Health System	Year	2005/2006
Denominator Definition	Number of children aged 24 months	Geography	LGD
Source	Child Health System	Year	2005/2006
DATA ISSUES		DATA ISSUES	
		Where necessary, Local Health Offices (LHO) were combined to form counties using the LHO percent weighted by the number of children born in the LHO during the relevant time period. This method will mask any sub-county variation in immunisation rates.	
		LHOs consisting of more than one county were split by assigning the LHO percent equally to each county. This method will mask any county variation within that LHO.	
PUBLIC HEALTH IMPORTANCE			
Vaccine preventable infectious diseases were a major cause of morbidity and mortality in children prior to the introduction of routine universally available immunisation programmes. Tuberculosis, measles, mumps, rubella, pertussis, poliomyelitis, tetanus, diphtheria, hepatitis B, influenza and bacterial pneumonia and meningitis continue to blight and take the lives of many children in developing countries, threatening achievement of the millennium goal on reducing child mortality by 4.4% annually (Edejer et al, 2005). Immunisation programmes are highly cost effective and safe health care interventions (Health Protection Agency, 2005), but inequalities in immunisation uptake are persistent and result in lower coverage in poorer and socially excluded people even in developed countries. Those who remain unimmunised are more likely to live in disadvantaged areas and less likely to use primary care services (Social Exclusion Unit, 2005).			

Effective vaccination service

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Theme: Access to preventative health care

POLICY CONTEXT – NORTHERN IRELAND	POLICY CONTEXT – REPUBLIC OF IRELAND
<p>The Department of Health (DH) in England through its Immunisation Unit on behalf of Wales, Scotland and Northern Ireland develops and implements immunisation policy. The National Health Service (NHS) facilitates this unified process. There is no legal compulsion for immunisation, nor a school entry requirement. The DH is advised by the independent expert Joint Committee on Vaccination and Immunisation (JCVI), which develops recommendations for new and alterations to existing immunisation programmes. The non governmental UK wide Health Protection Agency (HPA) provides scientific advice both to DH and JCVI. Funding for immunisation programmes and procurement is provided centrally. DH publishes a book, <i>Immunisation against Infectious Diseases</i> (2006) www.dh.gov.uk, which contains guidance on current policy and vaccine information. Vaccines are free at the point of delivery and uptake is monitored. Recent changes to the national immunisation programme include Haemophilus influenza type B (Hib) vaccination for preschool children, pneumococcal vaccination (PVC) for all children and phased introduction of a vaccine against human papilloma virus (HPV) to prevent cervical cancer (Salisbury, 2005).</p> <p>The Northern Ireland Health Promotion Agency www.hpa.org.uk supports vaccination programme delivery through public awareness campaigns and information materials.</p> <p>Following controversy in 1998, uptake rates for MMR vaccine of 91% at two years remain below the target of 95% and outbreaks of mumps and measles continue to occur. Uptake of all other childhood immunisations at one year of age exceeds targets at 96%. www.dhsspsni.gov.uk</p>	<p>The National Children's Strategy: Our Children - Their Lives (2000) www.omc.gov.ie mentioned the need for continued progress towards the national target of 95% uptake in the Primary Childhood Immunisation Programme.</p> <p>The schedule of immunisation programme is guided by the recommendations of the National Immunisation Advisory Committee of the Royal College of Physicians of Ireland (RCPI), which published a Report on Childhood Immunisation in 2001, recommending the achievement of a 95% uptake in the Primary Childhood Immunisation Programme (PCIP). It issued an updated document on National Immunisation Guidelines in 2002 http://www.dohc.ie.</p> <p>The National Health Strategy 'Quality and Fairness: A Health System for You' (2001) stated that national minimum standards and targets for immunisation uptake, surveillance and screening would be drawn up as a means of improving children's health. http://www.dohc.ie</p> <p>The National Immunisation Office established in 2006 is government funded by the Health Service Executive (HSE) and co ordinates the delivery of the national immunisation programme in Ireland, which is available free at the point of delivery through the HSE. www.immunisations.ie</p> <p>Recent changes to the national immunisation programme include Haemophilus influenza type B (Hib) vaccination for preschool children (2005), pneumococcal vaccination (PVC) and Hepatitis B (HepB) for all children born on or after the 1st July 2008. An introduction of a vaccine against human papilloma virus (HPV) to prevent cervical cancer is currently under consideration. Influenza and pneumococcal vaccines are routinely recommended for all adults over 65 yrs of age.</p> <p>Uptake rates for the PCIP at one year of age and for MMR at two years of age were 86%, well below the target of 95%, which is achieved in some regions, but not nationally. Outbreaks of mumps and measles continue to occur. http://hpsc.ie</p>
<p>REFERENCES</p> <p>Edejer, T.T.-T., Aikins, M., Black, R., Wolfson, L., Hutubessy, R., Evans, D.B. (2005) "Achieving the millennium development goals for health. Cost effectiveness analysis of strategies for child health in developing countries" in <i>British Medical Journal</i>, Vol 331, No 7526, pp1177</p> <p>Health Protection Agency (2005) "Vaccine preventable diseases modelling and economics". www.hpa.org.uk accessed 21 May 2005</p> <p>Salisbury, D.M. (2005) "Development of Immunisation Policy and its Implementation in the United Kingdom" in <i>Health Affairs</i>, Vol 24, No 3</p> <p>Social Exclusion Unit (2005) "Improving Services, Improving Lives: Evidence and Key Themes: A Social Exclusion Unit Interim Report". www.socialexclusion.gov.uk accessed 21 May 2005</p>	

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Flu vaccine uptake

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Indicator: Access to preventative health care

NORTH-SOUTH COMPARABILITY		Separate North and South components	
LAY DESCRIPTION		Percentage of people aged 65 years or over who have been vaccinated against influenza	
SOURCE REFERENCE		eHPI: IH2_1	
INDICATOR NAMES		Pct flu vaccine 65+ NI; Pct flu vaccine 65+ RoI	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Percentage of GP registrations aged 65 years or over who have been vaccinated against influenza		Percentage of General Medical Services card holders aged 65 years or over who have been vaccinated against influenza	
Published?	No	Published?	No
Frequency	N/a	Frequency	N/a
Numerator		Numerator	
Definition	Number of GP registrations aged 65 years or over who have been vaccinated against influenza	Definition	Number of General Medical Services card holders aged 65 years or over who have been vaccinated against influenza
Source	HSSB	Source	HSE
Denominator		Denominator	
Definition	Number of GP registrations aged 65 years or over	Definition	Number of General Medical Services card holders aged 65 years or over
Source	HSSB	Source	HSE
Geography	N/a	Geography	N/a
Latest Year	N/a	Latest Year	N/a
Geography	LGD	Geography	County
Year	2005	Year	2005
Geography	LGD	Geography	County
Year	2005	Year	2005
DATA ISSUES		DATA ISSUES	
The components are not directly comparable between Northern Ireland and Republic of Ireland as they reflect different data collection systems.		The components are not directly comparable between Northern Ireland and Republic of Ireland as they reflect different data collection systems.	
		General Medical Services card holders aged 65 years or over doesn't include all people aged 65 years or over.	
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
'Influenza vaccinations for older people are a cost effective way of saving lives...if older people get influenza, they are more likely than the young to suffer complications such as pneumonia. Thousands of emergency admissions and deaths among older people can be traced back to a bout of influenza. Influenza vaccinations for older people are a cost effective way of saving lives, preventing serious illness and hospitalisation. If all older people were immunized against influenza, nearly 5,000 lives could be saved each year in England.'		Considerable resources are devoted each year to treating patients in hospital who contract influenza and develop complications. Influenza can affect all ages, however it has more severe consequences in the elderly or people defined as being high risk, such as those with chronic heart conditions, chronic respiratory disease, diabetes mellitus and those who are immunosuppressed. The elderly contribute between 80 - 90% of reported deaths from influenza.	
HealthCare Commission England 2004			
In line national UK policy as part of the Winter planning each year General Practitioners are encourage to vaccinate at risk and elderly patients for influenza. Detail is contained in the		In addition, to targeting high-risk groups vaccination is also recommended for health care workers both for their own protection, as these are a group likely to come into contact with influenza during outbreaks, and for the protection of their patients. Influenza vaccine provides up to 90% protection against the disease and it is highly effective against the complications of	

Flu vaccine uptake

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Indicator: Access to preventative health care

annual Chief Medical Officer letter <http://www.dhsspsni.gov.uk/hssmd16-2007.pdf>

The Influenza Immunisation Programme is now one of the biggest public health programmes in the United Kingdom and Northern Ireland has consistently achieved very high uptake rates in the target groups. During the 2006/07 season. In early 2007 there was a separate initiative to implement a seasonal flu immunisation programme to poultry workers in 2006-07. As a precautionary public health measure, I have taken the decision, in the line with my colleagues elsewhere in the UK, to offer poultry workers the seasonal flu vaccination to minimize the theoretical risk of avian influenza mixing with seasonal influenza and possibly mutating into a strain with pandemic potential.

In October 2000, the HPA was commissioned by the Department of Health, Social Services and Public Safety to develop a public information campaign on flu as part of a regional influenza immunisation programme.

This programme was set up to protect people most at risk from flu and to ease the pressures normally associated with the winter months, among Northern Ireland's GP surgeries and hospital services.

In the first year of the campaign 'Catch the vaccine not the flu!' a target of 65% uptake was set by the Department. This was exceeded, with 68% of people aged 65 or over availing of the vaccine. At the beginning of the 2001 campaign this target was raised to 70%. And it has been met since then.

In 2005 the highest ever uptakes to date was recorded – 76.8% of people aged 65 years and over and 80.9% of those aged less than 65 in an 'at risk' category.

Separately there has been substantial cross agency planning for a potential pandemic http://www.dhsspsni.gov.uk/index/phealth/php/infectious_diseases/pandemicflu.htm

Public Service Agreement Target

'By March 2004 maintain a 70% uptake of 'flu immunisation for people aged over 65 years, and 60% uptake for people aged under 65 years with specific medical indications.'

'Priorities For Action' DHSSPSNI 2006/7 http://www.dhsspsni.gov.uk/pfa_final.doc

'Maintenance of the current high level of uptake rates for flu immunisation.

influenza. Its impact in reducing mortality from influenza in older people is well documented. Protection lasts about one year therefore it is important that at risk people are vaccinated annually against the most recent strains. Influenza vaccine is available free of charge from general practitioners to medical card holders at risk of contracting the disease.

Strategic Policy Developments

In Ireland, the National Influenza Vaccination Campaign is normally launched at the end of September each year. The influenza vaccination programme has been greatly enhanced in recent years, with the quantity of vaccine available increasing from 300,000 doses in 1999/2000 to 530,000 doses for the year ended 2004. The average uptake of Influenza vaccination in patients >65 years of age is 62 per cent. (Source: www.dohc.ie/press/speeches 2004 and 2006 accessed 2/5/06).

An Influenza Pandemic Expert Group was established by the Minister for Health and Children in 2000 to draw plans to address any future influenza pandemic in the event of a dramatic increase in the incidence of influenza world-wide. The Expert Group is chaired by Professor William Hall, Director of the National Virus Reference Laboratory (NVRL). Ireland's first influenza pandemic preparedness plan was finalised in 2002 "A Model Plan for Influenza Pandemic Preparedness". The 2002 plan was based on the World Health Organisation (WHO) blueprint for an Influenza Pandemic Plan published in 1999. It addresses a range of issues including prevention strategies, scientific and medical issues, and communications. This Group was reconvened in early 2005 in order to review and update Ireland's influenza pandemic preparedness plan. Vaccination is the principal measure for preventing influenza and reducing the impact of epidemics. However, since influenza pandemics occur when a new flu virus emerges to which people have no immunity, the vaccine can only be manufactured once the new strain emerges. Pending the availability of virus specific vaccines, antiviral drugs will be the only influenza specific medical intervention available for use in a pandemic. Antivirals can be used for prophylaxis (prevention) and for treatment.

The Government has agreed in principle that antiviral drugs should be stockpiled. Recommendations for the stockpiling of antivirals are kept under constant review by the Influenza Pandemic Expert Group. (Source: www.dohc.ie/press/releases 2005 accessed 2/5/2006)

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Use of statins

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Theme: Quality of preventative health care

NORTH-SOUTH COMPARABILITY		Separate North and South components	
LAY DESCRIPTION		The prevalence of the prescribing of statins	
SOURCE REFERENCE		eHPI: IH3_1	
INDICATOR NAMES		DDD statins per capita NI; Pct statins RoI	

Use of statins

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Theme: Quality of preventative health care

of acute myocardial infarction, angina, peripheral artery disease or stroke.

The utilization of Statins has continued to increase year on year since their introduction in 1989. The treatment and prevention of coronary heart disease and diabetes are likely to continue to be important drivers of growth in this area. Coronary Heart Disease (CHD) is still receiving particular attention as an area where more can be done to improve patient care as highlighted in the Quality and Outcomes section of the new GMS contract.

The growth and increased volume of prescribing is beneficial to the general health of the population because of the proven benefits of Statin therapy in reducing and preventing cardiovascular events.

In Northern Ireland the number of items of Statins dispensed has increased 24% on the 2002 figures. The equivalent figure for England is 30%, Scotland 22% and Wales 31%.

The use of Statins has NICE approval – January 06

National Institute for Health and Clinical Excellence (NICE) Technology Appraisal for Implementation in the HPSS - Cardiovascular Disease - Statins

http://www.nice.org.uk/pdf/2006_002_Launch_of_statins.pdf

<http://www.nice.org.uk/TA094>

The Health care commission 'State of Healthcare Report 2004' estimated that 6,000 to 7,000 lives would be saved each year by cholesterol lowering drugs (Statins).

Target to reduce deaths from Coronary heart disease in NI per 100,000 people under 80 years of age from 130 for males in 2002 and 66 for females to compare with the European country with the lowest death rates.

By 2008 seven major service wide Chronic Condition Management (CCM) programmes will have been established across the HPSS. These programmes will focus on the enhanced management of: Diabetes, CHD, Stroke Recovery, Arthritis and Musculo-Skeletal problems, Chronic Obstructive Pulmonary Disease and Asthma, Depression and Stress management. The Cancer Network which has already been established is effectively a CCM Programme.

'A Healthier Future' www.dhsspsni.gov.uk/healthyfuture-main.pdf

disease by 30% over ten years. It stated that the medium term objective should be to bring our levels of premature death from cardiovascular disease in line with the European average at a minimum. The Group's longer term goal is to reduce our rates to those of the best performers in the European Union.

Cardiovascular Death Prevalence

Cardiovascular disease including heart disease, stroke and related diseases is one the single largest causes of death in Ireland and a significant cause of morbidity. However, the trends points towards a fall in death rates from cardiovascular disease, in line with the national targets set in the national health strategy and in the national health promotion strategy for older people 'Adding Years to Life and Life to Years' (1998) (DoHC, 1999).

Strategic Policy Developments

The national health strategy, 'Shaping a Healthier Future' (1994) provided direction for the development of a strategy for cardiovascular health. In March 1998 the Minister for Health and Children established the Cardiovascular Health Strategy Group with the following terms of reference: '..... to develop a strategic approach to reduce avoidable death and illness caused by cardiovascular disease'.

The role of the Group included responsibility for engaging in a wide-ranging consultation process and making recommendations on the development and implementation of an integrated strategy to improve cardiovascular health.

In particular, it was given responsibility for advising on:

- (i) Initiatives which can be taken to improve cardiovascular health;
- (ii) steps necessary to develop further cardiac care and rehabilitation services at primary, secondary and tertiary levels, having regard to considerations of equity, quality, effectiveness and efficiency;
- (iii) the future organisation and co-ordination of services to patients throughout the country;
- (iv) any additional measures which may be necessary to assess the impact of the overall strategy and its main constituent elements.'

The report of the Cardiovascular Health Strategy Group, Building Healthier Hearts, was launched in July 1999. The Cardiovascular Health Strategy addressed the common aspects of prevention of cardiovascular diseases, as well as the treatment and rehabilitation of patients with CHD. It stated that it is possible to make a real impact on the heart health of Irish people by the year 2010. The following were overall aims of the Strategy (1999):

- to reduce the risk factor profile in the general population,
- to detect those at high risk,
- to deal effectively with those who have clinical disease, and
- ensure the best survival and quality of life outcome for those who recover from an acute attack.

The Cardiovascular Health Strategy Group made 211 recommendations in the areas of:

- Health promotion
- Primary Care
- Pre-hospital Care
- Hospital Services

Use of statins

Stage: Intervening factors

Level: Healthy areas (Intermediate)

Theme: Quality of preventative health care

- Cardiac Rehabilitation
- Surveillance, Audit and Evaluation

It recommended that because heart disease is so common there is a need to standardise approaches to the care of patients throughout the health care system with the nation-wide application of :

- Clinical protocols
- Clinical audit and evaluation
- Shared care between hospital and general practice
- Structures for the identification of those at high risk in general practice
- Structures for the care of patients with chronic disease in general practice

Source: Building Healthier Hearts Introduction to the Report of the Cardiovascular Health Strategy Group (DoHC, 1999)

<http://www.dohc.ie/publications/pdf/heart.pdf?direct=1> accessed 15/6/06

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Living alone

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Home environments

NORTH-SOUTH COMPARABILITY	All-island component
LAY DESCRIPTION	Percentage of households that consist of one person
SOURCE REFERENCE	eHPI: IB2_1
INDICATOR NAME	Pct live alone

DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND			
The percentage of households that consist of one person				The percentage of households that consist of one person			
Published?	Yes www.nisranew.nisra.gov.uk/census	Geography	Ward, LGD, HSSB	Published?	Yes www.cso.ie	Geography	County
Frequency	Every ten years	Latest Year	2001	Frequency	Every five years	Latest Year	2006
Numerator Definition	Number of households that consist of one person	Geography	LGD	Numerator Definition	Number of households that consist of one person	Geography	County
Source	Census 2001	Year	2001	Source	Census 2006	Year	2006
Denominator Definition	Total number of households	Geography	LGD	Denominator Definition	Total number of households	Geography	County
Source	Census 2001	Year	2001	Source	Census 2006	Year	2006
DATA ISSUES				DATA ISSUES			

PUBLIC HEALTH IMPORTANCE

Living alone is increasing and considered a psychosocial risk factor. It results from changing demographic profiles, societal trends and lifestyles with different causes, associations and health effects in the heterogeneous population groups affected by it (Kandler et al, 2007). Children leaving care, lone parents, those affected by marital separation, divorce, death of a spouse and the elderly are especially predisposed to poverty, social isolation, living in poor housing and disadvantaged communities (OFMDFM, 2005). Living alone is associated with adverse health behaviours including tobacco smoking and alcohol consumption. It is a predictor of mortality in middle aged men (Kandler et al, 2007) and a risk factor for suicide (Agerbo, 2005).

POLICY CONTEXT – NORTHERN IRELAND

Lifetime Opportunities- Government's Anti- Poverty and Social Inclusion Strategy for Northern Ireland (NIE, 2005) <http://www.ofmdfmni.gov.uk> takes a lifecycle cross departmental approach to eliminate poverty and promote social inclusion. It envisages that by 2020, every pensioner will live in a community with reduced levels of isolation and loneliness.

Ageing in an Inclusive Society (NIE, 2005) <http://www.ofmdfmni.gov.uk> aims to promote the social inclusion of older people and support independent living. It is part of the Government's overall anti-poverty strategy to develop an integrated approach for tackling financial, economic and social exclusion in Northern Ireland. It sets out vision, objectives and key recommendations to improve the lives of older people by

POLICY CONTEXT – REPUBLIC OF IRELAND

Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People (DoHC, 1998) www.dohc.ie marked the launch of the National Council on Ageing and Older People (NCAOP) Healthy Ageing programme. The strategy addresses health promotion for older people, acknowledging the impact of environmental and social factors such as housing, security, transport, attitudes and income on the quality of life of older people.

The *National Council on Ageing and Older People* (NCAOP, 2004) <http://www.ncaop.ie> is an advisory body to the Minister for Health on ageing and the welfare of older people. It works to promote the health and social inclusion of older people; advises on ways to

Living alone

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Home environments

addressing rural isolation, transport and housing.

The *Programme for Government 2008- 2011* Public Service Agreement Framework (NIE, 2008) www.pfgbudgetni.gov.uk endeavours to promote social inclusion, health and wellbeing by combating rural social exclusion and poverty and investing in social and affordable housing through regeneration and community development. Under Public Service Agreement 7 "Making Peoples' Lives Better", it anticipates by July 2008 agreement on outcomes for co ordinated strategic action to promote social inclusion for lone parents, people with disability, older people and minority groups.

meet the needs of the most vulnerable among the older population; and encourages positive attitudes to life after the age of 65. The Council also works to enhance greater co-ordination between public bodies at national and local levels in the planning and provision of services for older people.

Population Ageing in Ireland: Projections 2002-2021 (Connell and Pringle, 2004) commissioned by the NCAOP sets out projections at national and county levels for the period 2002-2021 with reference to the elderly.

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Agerbo, E. (2005). "Midlife suicide risk, partner's psychiatric illness, spouse and child bereavement by suicide or other modes of death: a gender specific study" in *Journal of Epidemiology and Community Health*, Vol 59, pp407-412.

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Poor quality housing

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Home environments

NORTH-SOUTH COMPARABILITY	Separate North and South components
LAY DESCRIPTION	The percentage of houses that are of poor quality
SOURCE REFERENCE	eHPI: IB2_4
INDICATOR NAMES	Pct poor housing NI; Pct poor housing RoI

DATA DEFINITION – NORTHERN IRELAND			
Percentage of dwellings that are “unfit” for human habitation as set out in schedule 5 of the Housing (Northern Ireland) Order 1992 or “defective”. A dwelling is deemed “defective” if, in the opinion of a surveyor, it has a defect that could lead to unfitness.			
Published?	Yes Northern Ireland Housing Condition Survey Statistical Annex	Geography	NUTS 3
Frequency	Every five years	Latest Year	2006
Numerator Definition	Number of houses surveyed that are unfit or defective	Geography	NUTS 3
Source	Northern Ireland Interim Housing Condition Survey Statistical Annex	Year	2004
Denominator Definition	Total number of houses surveyed	Geography	NUTS 3
Source	Northern Ireland Interim Housing Condition Survey Statistical Annex	Year	2004
DATA ISSUES			
The components are not directly comparable between Northern Ireland and Republic of Ireland as housing quality is measured differently.			
An LGD's value is assumed to be equal to its NUTS 3 value. This will mask any LGD variation within that NUTS 3 level. Lisburn and Derry were reported separately from the NUTS 3 classification.			
PUBLIC HEALTH IMPORTANCE			
Shelter is a basic human need and essential for survival and therefore health and wellbeing. In the 19 th century slum clearances and provision of public water supply and waste management addressed crowding, poor sanitation and inadequate ventilation to reduce communicable diseases and fire hazards. Poor housing conditions remain a major determinant of public health and are amongst others associated with respiratory illness, lead poisoning, injuries and mental health problems (Krieger & Higgins, 2002), compounding poverty and inequalities in health and wellbeing.			
Affordable and good quality housing is in limited supply, which is of concern both to the public and policy makers, who need to address the challenges for interagency working to achieve health improvements through social interventions and sustainability. Housing improvement interventions including rehousing, refurbishment and energy efficiency measures have shown health gains, but pragmatic difficulties in evaluation remain due to the complex and multifactorial nature of the relationship between housing, community regeneration and			

Poor quality housing

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Home environments

deprivation, which calls for political support of a holistic approach. Improved housing might result in positive social effects such as perceptions of safety, increased social support and community participation as well as children's school readiness and educational progress (Thomson, Pettigrew & Morrison, 2001).

POLICY CONTEXT – NORTHERN IRELAND

The Northern Ireland Housing Executive's (NIHE) strategic document *Housing and Health- A Shared Future* (2000) <http://www.nihe.gov.uk> highlights the importance of both health and housing for Northern Ireland's future development. Its recommendations focus on interagency and partnership working, the importance of research in planning and commissioning, integrated service delivery and initiatives to support people in need due to multiple deprivation, homelessness, domestic violence, teenage pregnancy, rural deprivation, fuel poverty or ethnic minority status.

Through a five year *Housing and Health Action Plan* (2001), *The Homelessness Strategy* (2002) and it's *Supporting People in Northern Ireland 2004- 2009 strategy* (2003), NIHE has subsequently developed action plans and programmes to develop housing support services, also reflecting new arrangements under *Investing for Health* (DHSSPS, 2002) partnerships and neighbourhood renewal strategies.

The Department of Regional Development's (DRD) *Shaping Our Future- the Regional Development Strategy for Northern Ireland* (2001) <http://www.drndi.gov.uk> sets out a strategic planning framework and guides physical development within the region up to 2025. Its first five year review in 2006 states that by 2010 all social housing in Northern Ireland is to meet the 'decent homes standard'.

The *Draft Housing Bill NI* (2002) <http://www.odpm.gov.uk> introduces a number of measures to provide decent housing for all, including a new rating system to replace the current housing fitness standard, licensing schemes for parts of the private rented sector, reforms to the home buying and selling process with a Home Information Pack, reforms to the Right to Buy and revised definitions of homelessness.

The Department for Social Development (DSD) *Neighbourhood Renewal Strategy People and Place* (2003) <http://www.dsdni.gov.uk> seeks to target those communities throughout Northern Ireland who are suffering the highest levels of deprivation. It aims to bring together the work of all Government Departments in partnership with local people to tackle disadvantage and deprivation in all aspects of everyday life. Its strategic objectives are community renewal, economic renewal, social and physical renewal. *Housing Health and Wellbeing – Innovation, Practice and Partnerships* (2006) reviews progress on its action plan, while the *Neighbourhood Renewal Housing Prospectus* (2007) provides a strategic framework and detailed plans for neighbourhood renewal areas outlined.

DSD in its *Fuel Poverty Strategy for Northern Ireland* (2004) <http://www.dsdni.gov.uk> aims to reduce the number of households living in fuel poverty. Its *Review into Affordable Housing* (2007) considers government interventions in the housing market via planning and housing systems to increase supply of social housing and support homeownership.

The Department of Culture, Arts and Leisure have developed a policy on *Architecture and the Built Environment* (2007) <http://www.dcalni.gov.uk> to promote the creation of

POLICY CONTEXT – REPUBLIC OF IRELAND

Part V of the *Planning and Development Act* (2000) enables local authorities to require that up to 20 per cent of new residential developments are employed for social or affordable housing for sale at less than market value to low and moderate income households and is expected to result in more mixed-tenure estates. www.irishstatutebook.ie

The *National Spatial Strategy (NSS) 2002- 2020 People, Places and Potential* (2002) <http://www.irishspatialstrategy.ie> is a national planning framework for Ireland. It aims to achieve a better balance of social, economic and physical development across Ireland, supported by more effective planning. In addressing spatial issues for the island of Ireland as a whole and strengthening cross-border co-operation, the NSS acknowledges the importance of *Shaping Our Future*, the Regional Development Strategy for Northern Ireland. A framework of collaboration on spatial policy between North and South is being progressed in order to create enhanced, globally competitive and dynamic economic conditions on the island of Ireland by providing strategic, forward-looking planning frameworks which will assist in targeting appropriate investment in infrastructure and lead to better co-ordination of public services improving the quality of life on both sides of the border.

The Department of the Environment, Heritage and Local Government *Housing Policy Framework – Building Sustainable Communities* (2005) <http://www.environ.ie> provides a vision of high quality, integrated sustainable communities that are worth building. It also aims to take into account other factors in balanced regional and rural development, planning, physical and social infrastructure, environmental sustainability and the development of social capital.

The *Ten-Year Framework Social partnership Agreement 2006-2015 Towards 2016* (2006) www.taoiseach.gov.ie is designed to support economic development and prosperity in Ireland, through investment in physical and social infrastructure. Taking a lifecycle approach, it aims to address housing needs of people of working age, older people and people with disability.

The *National Action Plan on Social Inclusion 2007- 2016* (2007) <http://www.taoiseach.ie> as part of its commitment to building an inclusive society in Ireland and reducing consistent poverty aims to build viable and sustainable communities, improving the lives of people in disadvantaged areas and building social capital by delivering increased housing output to meet the accommodation needs of 60,000 new households, the homeless, travellers, older people and people with disability.

The Irish Government's *National Development Plan 2007-2013 Transforming Ireland A Better Quality of Live for All* (2007) <http://www.ndp.ie> includes under the Social Infrastructure Priority 4 a commitment to investing €21 billion in housing development through social, affordable and voluntary housing schemes to over 140,000 households, including 100,000 new social and affordable units and delivering support under the rent supplement scheme to other households.

Poor quality housing

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Home environments

an attractive, healthy, safe and sustainable built environment, which is affordable, functions efficiently and enriches the experience of living for everyone in Northern Ireland. It aims to promote the value of good design to those who commission, design, construct, use and care for buildings, public open spaces and the general infrastructure. It emphasises the importance of architecture to the value of amenities for communities, crime prevention, education, healthcare, housing, public service buildings and offices.

The Anti- Poverty and Social Inclusion Strategy for Northern Ireland *Lifetime Opportunities* (2007) www.ofmdfm.gov.uk aims to ensure that every child and young person will live in decent, warm homes and a safe environment with access to cultural and recreational activities by 2020, while every pensioner enjoys housing of a comparable standard in a community with reduced levels of isolation and loneliness.

The *Programme for Government 2008- 2011* Public Service Agreement (PSA) Framework (NIE, 2008) www.pfgbudgetni.gov.uk under PSA 12 (Housing, Urban Regeneration and Community Development) aims to promote decent, energy efficient, affordable housing and regenerate disadvantaged areas and towns and city centres and support community development to create environments, which enhance quality of life and contribute to wellbeing. It foresees an investment of £500m in regeneration projects by 2012, £925m in social and affordable housing by 2011 and at least £1.8bn by 2018. Under PSA 7 (Making People's Lives Better) it aims to alleviate fuel poverty in 9,000 households annually.

The aim of the *Centre for Housing Research* is to improve the management of the social and affordable housing sectors through research, training and policy advice. The Department of the Environment, Heritage and Local Government and local authorities fund its work. The Centre consults with the Housing Forum, established under the Social Partnership Agreements, and supports strategic developments for vulnerable and socially excluded groups like travellers, homeless people and ethnic minorities.

<http://www.centreforhousingresearch.ie>

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Thomson, H., Pettigrew, M., Morrison, D. (2001) "Health effects of housing improvement: systematic review of intervention studies" in *British Medical Journal*, Vol 323, No 7306, pp187-190

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Social support scale

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Home environments

NORTH-SOUTH COMPARABILITY	Separate North and South components		
LAY DESCRIPTION	Percentage of people who are experiencing a severe lack of social support		
SOURCE REFERENCE	eHPI: IB2_2		
INDICATOR NAMES	Pct lack social supp NI; Pct lack social supp RoI		
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Percentage of people aged 16 years or over who are experiencing a severe lack of social support as per HSWB definition: score of less than 18 on questions 25-32, HSWB 2005/2006		Percentage of people aged 18 years or over who are experiencing an average of little social support or less: question H1, SLÁN 2002	
Published?	Yes Health and Social Wellbeing Survey (HSWB)	Published?	Yes, but with different definition. Survey of Lifestyles, Attitudes and Nutrition (SLÁN)
Frequency	Every 4/5 years	Frequency	Every four years
Numerator Definition	Number of HSWB respondents aged 16 years or over who are experiencing a severe lack of social support	Latest Year	2007
Geography	HSSB	Definition	Number of SLÁN respondents aged 18 years or over who are experiencing an average of little social support or less
Source	HSWB	Geography	County
Denominator Definition	Number of HSWB respondents aged 16 years or over	Year	2002
Geography	HSSB	Definition	Number of SLÁN respondents aged 18 years or over
Year	2005/2006	Geography	County
Source	HSWB	Year	2002
DATA ISSUES		DATA ISSUES	
The components are not directly comparable between Northern Ireland and Republic of Ireland as social support is measured differently by HSWB and SLÁN.		The components are not directly comparable between Northern Ireland and Republic of Ireland as social support is measured differently by HSWB and SLÁN.	
An LGD's value is assumed to be equal to its HSSB value. This will mask any LGD variation within that HSSB.		Small numerator and denominator values at county level may give unreliable estimates.	
HSWB surveys people age 16 years or over while SLÁN surveys people aged 18 years or over.		HSWB surveys people age 16 years or over while SLÁN surveys people aged 18 years or over.	
PUBLIC HEALTH IMPORTANCE			
Friendship, good social relations and supportive networks contributes to health improvement by making people feel cared for and valued. Individual social isolation and exclusion are associated with premature death, impaired physical and mental health. Societal inequalities impair social relationships and cohesion, potentially leading to increased crime rates, antisocial behaviour and violence. Improved social environments in schools, at work and in communities encourages participation and contributes to improved self esteem (Wilkinson and Marmot, 2002).			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
The Northern Ireland Public Health Strategy <i>Investing for Health</i> (DHSSPS, 2002) www.dhsspsn.gov.uk aims to tackle poverty and social exclusion. Its objectives include the promotion of social inclusion through interagency and cross sectoral collaboration, especially for vulnerable population groups including Travellers and minority ethnic groups, and urban		The National Health Strategy <i>Quality and Fairness</i> (DoHC, 2001) www.dohc.ie recognizes that social and community networks and wider socio-economic and cultural factors all mediate the individual's need for health and social services.	

Social support scale

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Home environments

regeneration through, amongst others, community development approaches. It also supports the promotion of mental health and wellbeing at individual and community level, placing a particular emphasis on the need for and benefits of working with communities and through partnership.

Announced in the Northern Ireland public health strategy *Investing for Health* (DHSSPS, 2002), the Northern Ireland Community Safety Strategy *Creating a safer Northern Ireland through partnership* (Community Safety Unit (CSU), 2003) www.communitysafetyni.gov.uk focuses on reducing crime, fear of crime and antisocial behaviour. This Government framework is based on a partnership approach to improving community safety in Northern Ireland.

Investing for Health's *Promoting Mental Health Strategy and Action Plan 2003- 2008* (DHSSPS, 2003) www.dhsspsni.gov.uk in acknowledging the importance of social inclusion and support for mental health highlights the needs of children, carers, older people and other vulnerable groups.

The *Neighbourhood Renewal Strategy People and Place* (Department for Social Development, 2003) www.dsdni.gov.uk aims to tackle the complex, multidimensional nature of deprivation through community, economic, social and physical renewal of neighbourhoods in the 10% most deprived wards in Northern Ireland.

A *Shared Future Policy and Strategic Framework for Good Relations in Northern Ireland* (OFMDFM, 2005) www.ofmdfm.gov.uk is based on extensive public consultation and sets out the vision of Government in Northern Ireland for a shared society defined by a culture of tolerance against a historic background of deeply entrenched communal divisions and tensions. Its objectives include the elimination of sectarianism, racism and other prejudice, the reduction of conflict, hostility and mistrust in and between communities and the protection of members of minority groups and mixed marriages from intimidation and violence.

Lifetime Opportunities- Government's Anti- Poverty and Social Inclusion Strategy for Northern Ireland (NIE, 2005) <http://www.ofmdfmni.gov.uk> takes a lifecycle cross departmental approach to eliminate poverty and promote social inclusion. It envisages that all children, working age adults and older people are supported to achieve their full potential and participate fully in societal life.

Ageing in an Inclusive Society (NIE, 2005) <http://www.ofmdfmni.gov.uk> aims to promote the social inclusion of older people and support independent living. It is part of the Government's overall anti-poverty strategy to develop an integrated approach for tackling financial, economic and social exclusion in Northern Ireland. It sets out vision, objectives and recommendations to improve the lives of older people by addressing rural isolation, transport and housing.

The *Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005- 2025 A Healthier Future* (DHSSPS, 2005) www.dhsspsni.gov.uk acknowledges the importance of caring communities for health and wellbeing, both through social support for and participation in health and social care. It identifies carers, older people and people with disability as being particularly at risk of social isolation and the associated ill mental health effects.

The *Programme for Government 2008- 2011 Public Service Agreement Framework* (NIE, 2008) www.pfgbudgetni.gov.uk endeavours to promote social inclusion, health and wellbeing by combating rural social exclusion and poverty and investing in social and affordable housing

A *Crime Prevention Strategy for Ireland Tackling the Concerns of Local Communities* (National Crime Council, 2003) www.irlgov.ie/crimecouncil supports early intervention based on a National Crime Prevention Model to ensure a common approach for cross departmental, interagency and multidisciplinary working. It recommends a partnership approach to develop locally based crime prevention strategies to prevent crime, tackle existing problems, propose solutions to underlying causes and share good practice. In order to achieve this, the strategy proposal considers the necessity:

- To promote social inclusion and reduce the socio-economic, educational, societal and environmental factors that can leave children and young people 'at risk' of engaging in criminal activities

The *An Garda Síochána Corporate Strategy 2005- 2007* (2005) www.garda.ie seeks to contribute to improved quality of life for people living in Ireland without fear of crime or criminal behaviour. It includes a focus on public safety and confidence and the protection of cultural and ethnic diversity.

The National Economic and Social Council (NESC) advises the Irish Government on efficient development of the economy and achievement of social justice as well as social partnership agreements. *The Developmental Welfare State* (NESC, 2005) www.nesc.ie suggests to build consensus across social partners, government and society in a coherent debate that addresses Ireland's social deficits towards integrated policies for employment, social inclusion and economic reform. It challenges the focus on total employment growth and unemployment reduction, calling for an assessment of effectiveness of social inclusion and antipoverty strategies.

The *NESC Strategy 2006: People, Productivity and Purpose* (NESC, 2005) www.nesc.ie emphasises the importance of greater participation, social protection and care, more social mobility and successful handling of diversity. It recommends aiming less for targeted programmes for disadvantaged groups and more for improving participation.

The *Ten- Year Framework Social Partnership Agreement 2006-2015 Towards 2016* (2006) www.taoiseach.gov.ie underpins the NESC vision and aims to take into account factors in the areas of balanced regional and rural development, planning, physical and social infrastructure and environmental sustainability and the development of social capital. Future policy will take account of the work of the Task Force on Active Citizenship which will recommend measures to facilitate and encourage a greater degree of engagement by citizens in all aspects of life and the growth and development of voluntary organisations as part of a strong civic culture. Consideration will also be given to the development of appropriate measures and indicators of social capital.

The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie (2006) makes reference to the *National Development Plan 2007- 2013* (2006) www.taoiseach.gov.ie and its focus on building viable and sustainable communities to improve the lives of people living in disadvantaged areas and building social capital. It emphasises the role of local authorities in delivering on social inclusion strategies, working with other stakeholders through the County Development Board and RAPID structures in the promotion of social capital, active citizenship and community development.

Social support scale

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Home environments

through regeneration and community development. Under Public Service Agreement 7 "Making Peoples' Lives Better", it anticipates by July 2008 agreement on outcomes for co-ordinated strategic action to promote social inclusion for lone parents, people with disability, older people and minority groups.

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Alcohol abuse

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Lifestyle

NORTH-SOUTH COMPARABILITY		All-island component	
LAY DESCRIPTION		The rate of admissions to hospital for alcohol abuse per 100,000 European standard population	
SOURCE REFERENCE		eHPI: IB1_3	
INDICATOR NAME		DSR adm alcohol	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Directly age and gender standardised rate of admissions to hospital for alcohol abuse		Directly age and gender standardised rate of admissions to hospital for alcohol abuse	
(ICD 10 codes E52, F10, G31.2, G62.1, G72.1, I42.6, K29.2, K70, K86.0, O35.4, P04.3, Q86.0, R78.0, T50.6, T51.0, T51.9, X65, Y15, Y57.3, Y90, Y91, Z13.3, Z50.2, Z63.7, Z71.4, Z72.1, Z81.1, Z86.4)		(ICD 10 codes (E52, F10, G31.2, G62.1, G72.1, I42.6, K29.2, K70, K86.0, O35.4, P04.3, Q86.0, R78.0, T50.6, T51.0, T51.9, X65, Y15, Y57.3, Y90, Y91, Z13.3, Z50.2, Z63.7, Z71.4, Z72.1, Z81.1 Z86.4)	
per 100,000 European standard population		per 100,000 European standard population	
Published?	No	Published?	No
Frequency	N/a	Frequency	N/a
Numerator Definition	Number of admissions to hospital for alcohol abuse	Definition	Number of admissions to hospital for alcohol abuse
Source	Hospital Inpatients System, DHSSPS	Source	Hospital Inpatient Enquiry (HIPE)
Denominator Definition	Mid-year population estimate	Definition Source	Mid-year population estimate
Source	NISRA	Source	Public Health Information System
Geography	N/a	Geography	N/a
Latest Year	N/a	Latest Year	N/a
Geography	LGD	Geography	County
Year	2006/2007	Year	2005
Geography	LGD	Geography	County
Year	2005	Year	2005
DATA ISSUES		DATA ISSUES	
Includes primary and secondary diagnoses.		Includes primary and secondary diagnoses.	
The crude rate was directly age and gender standardised to the European standard population.		The crude rate was directly age and gender standardised to the European standard population.	
		Values for five or less cases in a particular combination of age, sex, and area were not disclosed. The value was assumed to be three.	
		Excludes admissions to private hospitals.	
PUBLIC HEALTH IMPORTANCE			
Alcohol is considered a main risk factor for premature death, physical and mental ill health, affecting nearly every organ in the human body. Alcohol related problems are not confined to the consequences experienced by the drinker, but cause harm to others through health and social problems. These include injury, reduced road and public safety, crime, violence, child neglect, domestic abuse, impaired social functioning and relationships, unsafe sex, lost productivity and health care costs. While men still account for the largest number of people suffering from alcohol related ill health, the increases in the proportion of women and young people have been largest in recent years (Hope, 2008). Both overall level of alcohol consumption and predominant patterns of drinking are predictors of alcohol problems in a society. Therefore effective alcohol policy must address the total population and also target high risk groups and individuals (WHO, 1995)			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	

Alcohol abuse

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Lifestyle

Building on the *Strategy for Reducing Alcohol Related Harm* (DHSSPS, 2000) www.dhssps.gov.uk, the national public health strategy *Investing for Health* (DHSSPS, 2002) aims to address a broad range of economic, social and environmental issues, which are recognised as determinants of health and wellbeing. It outlines the commitment of the Northern Ireland Executive to ensuring equality of opportunity and tackling social disadvantage. It proposes to promote awareness of safe alcohol consumption and to ensure that resources are available to support people in changing harmful drinking behaviour.

The health strategy *A Healthier Future- A twenty year vision for health and wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2005) www.dhssps.gov.uk recognises the importance of healthy nutrition for the improvement of population health and wellbeing. It recognises the complex interplay of environmental and individual factors contributing to the burden of chronic diseases and health inequalities. It considers the role of health and social care services in addressing these. It aims:

- To reduce the proportion of male drinkers aged 18- 75 years who engage in at least one binge drinking session a week from 4% in 2002 to 20% in 2025,
- To reduce the proportion of women drinkers who engage in at least one binge drinking session from 35% in 2002 to 10% in 2025,
- To reduce the number of men and women drinking above the recommended limits from 33% and 11% respectively in 2002/3 to 10% and 5% in 2025.

The *New Strategic Direction for Drugs and Alcohol* (DHSSPS, 2006) www.dhsspsni.gov.uk reflects the views of the health and education sectors, the criminal justice system, the police, the prison service and the voluntary and community sector and aims to reduce the level of alcohol and drug-related harm in Northern Ireland. It is structured around the five pillars of prevention and early intervention; treatment and support; law and criminal justice; harm reduction and monitoring, evaluation and research, proposing key indicators to measure the effects of alcohol use. It aims to integrate those policies which contribute to the reduction of alcohol and drug related harm into all Government Department strategies and to promote opportunities for those under the age of 18 years to develop appropriate skills, attitudes and behaviours to enable them to resist societal pressures to drink alcohol and/or use illicit drugs, with a particular emphasis on those identified as potentially vulnerable. Its focus is on children, young people and their families as well as adults and the general public. It aims:

- To reduce by 5% the proportion of binge drinkers by 2010, from the 1999 baseline.

Reflecting *Priorities for Action* (DHSSPS, 2007) www.dhsspsni.gov.uk

- To reducing the percentage of adult drinkers who binge drink to 30% in the Northern, 30% in the Southern, 40% in the Eastern and 41% in the Western Health and Social Services Board areas,

the Northern Ireland Executive *Programme for Government 2008- 2011* (NIE, 2007) www.ofmdfm.gov.uk under Public Service Agreement (PSA) 8 includes targets:

- To ensure a 5% reduction in the proportion of adults who binge drink by 2010
- To ensure a 10% reduction in the proportion of young people who drink and who report getting drunk
- To ensure a 10% reduction in the number of children at risk from parental alcohol and/ or drug dependency

The national health strategy *Quality and Fairness* (DoHC, 2001) www.dohc.ie referred to the achievement of the alcohol targets set out in the *National Health Promotion Strategy 2000-2005* (DOHC, 2000) www.dohc.ie through:

- Introducing further actions to promote sensible alcohol consumption on the basis of a review of the National Alcohol Policy
- Examining further restrictions on the advertising of alcohol.

It also endorsed one key element of the *National Drugs Strategy* (DoHC, 2001), which was to develop formal links at local, regional and national levels with the *National Alcohol Policy Ireland* (DoHC, 1996) and to ensure co-ordination between the different measures being undertaken. It stated that the continued promotion of moderation in alcohol intake as outlined in the National Alcohol Strategy is intended to help reduce crime, lawlessness and violence, while early interventions in schools through Social, Personal and Health Education (SPHE) programmes should help to encourage civil and nonviolent behaviour in adolescents.

The Minister for Health and Children established the Strategic Task Force on Alcohol (STFA) in January 2002 to recommend specific, evidence based measures to Government to prevent and reduce alcohol related harm in Ireland based on a public health approach endorsed by the World Health Organisation (WHO, 1995). The two reports published by the STFA in 2002 and 2004 outline over 100 recommendations in 16 key areas. These include taxation increases, enforcement of licensing laws, regulating industry, reducing drink driving, effective treatment services, professional training, community mobilization, protection of children, young people and the family from alcohol effects, education and research.

The *Ten- Year Framework Social Partnership Agreement 2006- 2015 Towards 2016* (Department of the Taoiseach, 2006) www.taoiseach.gov.uk and the *National Action Plan for Social Inclusion 2007- 2016* (Government of Ireland, 2007) www.taoiseach.gov.uk support the recommendations from the above policies, including introduction of mandatory alcohol testing to deter drink driving and monitoring prevalence trends of smoking and substance use through the National Health and Lifestyle Surveys and the European School Survey Project on alcohol and other Drugs (ESPAD). They call for the development of health promotion strategies with a focus on healthy living environments for children, young people and families.

The *Strategy for Cancer Control in Ireland* (DoHC, 2006) highlights the increased risk of cancers of the oral cavity, pharynx, larynx, oesophagus, liver and breast associated with a high consumption of alcohol and recommends full implementation of the Report of the Strategic Task Force on Alcohol.

Alcohol abuse

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Lifestyle

The Northern Ireland Government's *Anti- Poverty and Social Inclusion Strategy for Northern Ireland* (OFMDFM, 2007) www.ofmdfmni.gov.uk acknowledges the need to help people avoid problem debt and better manage their finances as well as providing early health interventions in relation to alcohol and drugs.

Proposed in the *New Strategic Direction for Drugs and Alcohol* (DHSSPS, 2006) and based on the UK strategy *Hidden Harm: responding to the needs of children of problem drug users* (Advisory Council on the Misuse of Drugs (ACMD), 2003) and a subsequent progress report published in early 2007, DHSSPS in Northern Ireland commenced work on developing an action plan to address the needs of an estimated 40,000 children living here in families with alcohol and drug misuse.

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Drug misuse

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Lifestyle

NORTH-SOUTH COMPARABILITY	All-island component
LAY DESCRIPTION	The rate of admissions to hospital for drug misuse per 100,000 European standard population
SOURCE REFERENCE	eHPI: IB1_4
INDICATOR NAME	DSR adm drug
DATA DEFINITION – NORTHERN IRELAND	DATA DEFINITION – REPUBLIC OF IRELAND
Directly age and gender standardised rate of admissions to hospital for drug misuse (ICD 10 codes F11-F19) per 100,000 European standard population	Directly age and gender standardised rate of admissions to hospital for drug misuse (ICD 10 Australian Modification codes F11-F19) per 100,000 European standard population
Published? No Frequency N/a Geography N/a Latest Year N/a	Published? No Frequency N/a Geography N/a Latest Year N/a
Numerator Definition Number of admissions to hospital for drug misuse Source Hospital Inpatients System, DHSSPS Geography LGD Year 2006/2007	Numerator Definition Number of admissions to hospital for drug misuse Source Hospital Inpatient Enquiry (HIPE) Geography County Year 2005
Denominator Definition Mid-year population estimate Source NISRA Geography LGD Year 2005	Denominator Definition Mid-year population estimate Source Public Health Information System Geography County Year 2005
DATA ISSUES Includes primary and secondary diagnoses. The crude rate was directly age and gender standardised to the European standard population.	DATA ISSUES Includes primary and secondary diagnoses. The crude rate was directly age and gender standardised to the European standard population. Values for five or less cases in a particular combination of age, sex, and area were not disclosed. The value was assumed to be three. Excludes admissions to private hospitals.
PUBLIC HEALTH IMPORTANCE	
Drug use both occurs in response to and also contributes to disadvantage and social breakdown, worsening health inequalities. Addiction develops in individuals, but is associated with societal markers of deprivation and fostered by aggressive marketing as well as organised crime. Effective strategies to deal with drug use need to offer support and treatment to people at risk of or with addictions, but also have to address social patterns of deprivation, regulation of industry and health promotional education and support (WHO, 2003).	
POLICY CONTEXT – NORTHERN IRELAND	POLICY CONTEXT – REPUBLIC OF IRELAND
Building on the <i>Drugs Strategy</i> (Northern Ireland Office and DHSSPS, 1999), the national public health strategy <i>Investing for Health</i> (DHSSPS, 2002) www.dhssps.gov.uk aims to address a broad range of economic, social and	The national health strategy <i>Quality and Fairness</i> (DoHC, 2001) www.dohc.ie endorsed one key element of the <i>National Drugs Strategy</i> (DoHC, 2001), which was to develop formal links at local, regional and national levels with the <i>National Alcohol Policy Ireland</i>

Drug misuse

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Lifestyle

environmental issues, which are recognised as determinants of health and wellbeing. It outlines the commitment of the Northern Ireland Executive to ensuring equality of opportunity and tackling social disadvantage. It undertakes to combat the misuse of illicit drugs by building resilience in children and young people, protecting communities from drug related anti social and criminal behaviour, to reduce availability of drugs and facilitate recovery of individuals from drug use, recognising the close links between alcohol and drug use.

The health strategy *A Healthier Future- A twenty year vision for health and wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2005) www.dhssps.gov.uk recognises the importance of healthy nutrition for the improvement of population health and wellbeing. It acknowledges the complex interplay of environmental and individual factors contributing to the burden of chronic diseases and health inequalities. It considers the role of health and social care services in addressing these. It aims:

- To reduce the number of people who have taken illegal drugs during the previous year from 10% for men and 3% for women in 2002/3 to 5% and 1% respectively.

The *New Strategic Direction for Drugs and Alcohol* (DHSSPS, 2006) www.dhsspsni.gov.uk reflects the views of the health and education sectors, the criminal justice system, the police, the prison service and the voluntary and community sector and aims to reduce the level of alcohol and drug-related harm in Northern Ireland. It is structured around the five pillars of prevention and early intervention; treatment and support; law and criminal justice; harm reduction and monitoring, evaluation and research, proposing key indicators to measure the effects of drug use. It aims to integrate those policies which contribute to the reduction of alcohol and drug related harm into all Government Department strategies and to promote opportunities for those under the age of 18 years to develop appropriate skills, attitudes and behaviours to enable them to resist societal pressures to drink alcohol and/or use illicit drugs, with a particular emphasis on those identified as potentially vulnerable. Its focus is on children, young people and their families as well as adults and the general public.

Reflecting *Priorities for Action* (DHSSPS, 2007) www.dhsspsni.gov.uk

- By March 2008, to reducing the incidence of illicit drug taking among 15-64 year-olds to 5.9% in the Northern, 4.8% in the Southern, 6.9% in the Eastern and 5.5% in the Western Health and Social Services Board areas,

the Northern Ireland Executive *Programme for Government 2008- 2011* (NIE, 2007) www.ofmdfm.gov.uk under Public Service Agreement (PSA) 8 includes targets:

- To ensure a 5% reduction in the proportion of young adults who take illicit drugs by 2010
- To ensure a 10% reduction in the number of children at risk from parental alcohol and/ or drug dependency

The Northern Ireland Government's *Anti- Poverty and Social Inclusion Strategy for Northern Ireland* (OFMDFM, 2007) www.ofmdfmni.gov.uk acknowledges the need to help people avoid problem debt and better manage their finances as well as providing early health interventions in relation to alcohol and drugs.

Proposed in the *New Strategic Direction for Drugs and Alcohol* (DHSSPS, 2006) www.dhsspsni.gov.uk and based on the UK strategy *Hidden Harm: responding to the*

(DoHC, 1996) and to ensure co-ordination between the different measures being undertaken. It stated that early interventions in schools through Social, Personal and Health Education (SPHE) programmes should help to encourage civil and nonviolent behaviour in adolescents.

The overall strategic objective for the *National Drugs Strategy 2001 – 2008* (DoHC, 2001) www.dohc.ie is to significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and research.

The *Ten- Year Framework Social Partnership Agreement 2006- 2015 Towards 2016* (Department of the Taoiseach, 2006) www.taoiseach.gov.uk and the *National Action Plan for Social Inclusion 2007- 2016* (Government of Ireland, 2007) www.taoiseach.gov.uk support monitoring prevalence trends of smoking and substance use through the National Health and Lifestyle Surveys and the European School Survey Project on alcohol and other Drugs (ESPAD). They call for the development of health promotion strategies with a focus on healthy living environments for children, young people and families.

Drug misuse

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Lifestyle

needs of children of problem drug users (Advisory Council on the Misuse of Drugs (ACMD), 2003) and a subsequent progress report published in early 2007, DHSSPS in Northern Ireland commenced work on developing an action plan to address the needs of an estimated 40,000 children living here in families with alcohol and drug misuse.

REFERENCES

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Fresh fruit intake

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Lifestyle

NORTH-SOUTH COMPARABILITY	Separate North and South components
LAY DESCRIPTION	Percentage of people who consume less than five portions of fruit or vegetables per day
SOURCE REFERENCE	eHPI: IB1_2
INDICATOR NAMES	Pct eat < 5 fruit & veg NI; Pct eat < 5 fruit & veg RoI;

DATA DEFINITION – NORTHERN IRELAND

Percentage of people aged 16 years or over who consume less than five portions of fruit or vegetables per day

Published?	Yes Health and Social Wellbeing Survey (HSWB)	Geography	Northern Ireland
Frequency	Every 4/5 years	Latest Year	2005/2006
Numerator Definition	Number of HSWB respondents aged 16 years or over who eat less than five portions of fruit or vegetables per day	Geography	HSSB
Source	HSWB	Year	2005/2006
Denominator Definition	Number of HSWB respondents aged 16 years or over	Geography	HSSB
Source	HSWB	Year	2005/2006

DATA ISSUES

HSWB respondents provided the number of portions of fruit and vegetables consumed on an average day.

An LGD's value is assumed to be equal to its HSSB value. This will mask any LGD variation within that HSSB.

HSWB surveys people age 16 years or over while SLAN surveys people aged 18 years or over.

DATA DEFINITION – REPUBLIC OF IRELAND

Percentage of people aged 18 years or over who consume less than five portions of fruit or vegetables per day

Published?	Yes Survey of Lifestyles, Attitudes and Nutrition (SLÁN)	Geography	Ireland
Frequency	Every four years	Latest Year	2007
Numerator Definition	Number of SLAN respondents aged 18 years or over who consume less than five portions of fruit or vegetables per day	Geography	County
Source	SLÁN	Year	2002
Denominator Definition	Number of SLÁN respondents aged 18 years or over	Geography	County
Source	SLÁN	Year	2002

DATA ISSUES

Number of portions of fruit and vegetables consumed per day was derived from a food frequency question.

Small numerator and denominator values at county level may give unreliable estimates.

HSWB surveys people age 16 years or over while SLAN surveys people aged 18 years or over.

PUBLIC HEALTH IMPORTANCE

Availability of healthy food is a political issue, because global markets control supply. Economic growth has not only resulted in an epidemiological transition from infectious to chronic illness, but also in a nutritional transition, leading to overconsumption of energy dense fat and carbohydrate and resulting in obesity especially among the poor, resulting in a social gradient in food quality and contributing to health inequalities (WHO, 2003). Fresh fruit and vegetable consumption can lower the risk of chronic illness and death from cardiovascular diseases and cancer. It might delay the development of visual impairment due to cataracts and macular degeneration, reduce the symptoms of asthma, improve bowel function and health, help to manage diabetes and obesity and protect unborn babies from malformations of the nervous system. These effects are due to the fact that fruit and vegetables contain many vitamins, trace elements and minerals essential for healthy human live as well as complex plant components, which act as antioxidants, preventing cell damage and ageing. Eating fruit and vegetable increases fibre intake, reduces fat and refined sugar intake, helps to maintain a healthy weight and contributes to a balanced diet (Department of Health, 2007), as well as promoting oral health (Health Promotion Agency, 2008). The European Common Agricultural

Fresh fruit intake

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Lifestyle

Policy (CAP) subsidises the production of meat and dairy products and needs to be changed to stimulate the production of fruit and vegetable. Only a minority of European countries currently meets the population requirements for the availability of fresh fruit and vegetable in line with healthy eating guidelines (European Public Health Alliance, 2003). Variety is as important as quantity (Harvard School of Public Health, 2008), but people living in disadvantage are at risk of food poverty with reduced access to healthy food and the consequent ill effects on health and wellbeing (Institute of Public Health, 2008). An estimated 2.7 million deaths globally per annum can be attributed to low fruit and vegetable intake (WHO, 2008).

POLICY CONTEXT – NORTHERN IRELAND

The UK wide Food Standards Agency was launched in 2000 and has a role in regulating industry, promoting healthy eating and researching nutrition www.foodstandards.gov.uk.

The Northern Ireland public health strategy *Investing For Health* (DHSSPS, 2002) www.investingforhealthni.gov.uk is a cross-departmental, multi-sectoral framework for action to improve health and wellbeing of people living in Northern Ireland. The strategy aims to address a broad range of economic, social and environmental issues recognised as major determinants of health and wellbeing and outlines the commitment of the Northern Ireland Executive to ensuring equality of opportunity and tackling social disadvantage within communities. It recognises the importance of nutrition for health, especially in early life, and acknowledges that consumption of fruit and vegetable is low among disadvantaged population groups due to lack of availability, affordability, access and knowledge of the importance and usage of healthy foodstuffs. It aims to improve the health of people and increase the years they spend free from disease and illness and enable them to make healthier choices. It proposes to support community and school based programmes, which improve access to healthy eating choices.

The cross departmental investing for Health task force report *Fit Futures: Focus on Food, Activity and Young People* (DHSSPS, 2005) www.investingforhealthni.gov.uk examines options for preventing the rise in levels of overweight and obesity in children and young people. It envisions that all children and young people “will be motivated and supported to access a range of readily available, quality, enjoyable opportunities to be active and eat healthily”. Its recommendations focus on developing coherent and healthy public policy, providing accessible and acceptable choices, supporting healthy early childhood development, creating healthy school and community environments as well as supporting research. It summarises the broad range of synergistic socioeconomic policies that need to support healthy nutrition to It stipulates the inclusion of home economics in the secondary school key stage 3 curriculum and endorses the Public Service Agreement (PSA) target:

- To halt the rise of obesity in children by 2010.

The health strategy *A Healthier Future- A twenty year vision for health and wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2005) recognises the importance of healthy nutrition for the improvement of population health and wellbeing. It recognises the complex interplay of environmental and individual factors contributing to the burden of chronic diseases and considers the role of health and social care services in addressing these. It seeks:

- To reverse current trends of adult obesity by 2025,
- To reduce the levels of childhood obesity by 50% by 2025,
- To increase the level of 5 year olds without dental decay to 75% and reduce the gap in oral health between socioeconomic groups

POLICY CONTEXT – REPUBLIC OF IRELAND

One of the strategic aims of the *National Health Promotion Strategy 2000-2005* (DoHC, 2000) www.dohc.ie was to increase the percentage of the population who consume the recommended daily servings of food and maintain a healthy weight. It recognised the need for an inter-sectoral and multi-disciplinary approach in the implementation of the aims and objectives of the strategy and identified the importance of facilitating the implementation of various related recommendations on nutrition and eating well as outlined in other policies including the *National Food and Nutrition Policy* (Nutrition Advisory Group, 1995), *Cancer Services in Ireland: A National Strategy* (DoHC, 1996), the cardiovascular health strategy *Building Healthier Hearts* (DoHC, 1999) and the *National Food and Nutrition Policy for Older People* (Food Safety Authority of Ireland, 2000).

The *Report of the National Task Force on Obesity – The Policy Challenges* (DoHC, 2005) www.dohc.ie makes recommendations relating to government, education, social and community, health, industry and the physical environment sectors. It calls on all state agencies and government departments to develop health impact assessment based healthy eating and physical activity strategies. It also recommended that access to a healthy diet (for example fruit and vegetables) should be included as an indicator to measure food poverty as part of the National Anti-Poverty Strategy and Social Inclusion process.

The *Strategy for Cancer Control in Ireland* (DoHC, 2006) calls for the full implementation of the recommendations of the *Report of the National Task Force on Obesity* should be implemented in full. It points to a need for measures that raise awareness of the links between diet and cancer. It highlights the importance of both health promotion and knowledge initiatives with regards to nutrition and the need for affordable and accessible foods Including fresh fruit and vegetables to overcome key barriers to healthy eating.

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Fresh fruit intake

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Lifestyle

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Less than 5 hours physical activity per week

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Lifestyle

NORTH-SOUTH COMPARABILITY	Separate North and South components
LAY DESCRIPTION	Percentage of people who are physically inactive
SOURCE REFERENCE	eHPI: IB1_5
INDICATOR NAMES	Pct inactive NI; Pct inactive RoI;

DATA DEFINITION – NORTHERN IRELAND			
Percentage of people aged 16 years or over who are sedentary as per HSWB survey definition: have not performed any activity of at least a moderate level, lasting 20 minutes on at least one occasion in the last seven days			
Published?	Yes Health and Social Wellbeing Survey (HSWB)	Geography	Northern Ireland
Frequency	Every 4/5 years	Latest Year	2005/2006
Numerator Definition	Number of HSWB respondents aged 16 years or over who are sedentary	Geography	HSSB
Source Denominator	HSWB	Year	2005/2006
Definition	Number of HSWB respondents aged 16 years or over	Geography	HSSB
Source	HSWB	Year	2005/2006
DATA ISSUES			
The components are not directly comparable between Northern Ireland and Republic of Ireland as physical activity is measured differently by HSWB and SLAN.			
An LGD's value is assumed to be equal to its HSSB value. This will mask any LGD variation within that HSSB.			
HSWB surveys people age 16 years or over while SLAN surveys people aged 18 years or over.			
PUBLIC HEALTH IMPORTANCE			
“Physical inactivity [is one] of the main modifiable risk factors for most of the main chronic diseases. Overall, 1.9 million death [worldwide annually] are attributable to physical inactivity (WHO, 2008). Physical activity has been shown to protect against cardiovascular disease, diabetes, osteoporosis, obesity, some cancers and mental ill health. While there are indications of some promising trends towards reducing physical inactivity, most adults (American Heart Association, 2007) and children (Riddoch, Mattocks, Deere <i>et al</i> , 2007) in resource rich countries do not undertake the recommended amount of moderately intense exercise of 30 and 60 minutes respectively five times per week. Modern technology reduces the energy needed for daily living and there are economic disincentives rewarding sedentary over active work, limiting opportunities for physical activity.			

DATA DEFINITION – REPUBLIC OF IRELAND			
Percentage of people aged 18 years or over who <ul style="list-style-type: none">do not engage in strenuous physical exercise andattend a gym once a week or less andwhose job is not very physically active or not physically active at all			
Published?	Yes, but with different definition. Survey of Lifestyles, Attitudes and Nutrition (SLÁN)	Geography	Ireland
Frequency	Every four years	Latest Year	2007
Definition	Number of SLAN respondents aged 18 years or over who are not physically active	Geography	County
Source	SLÁN	Year	2002
Definition	Number of SLÁN respondents aged 18 years or over	Geography	County
Source	SLÁN	Year	2002
DATA ISSUES			
The components are not directly comparable between Northern Ireland and Republic of Ireland as physical activity is measured differently by HSWB and SLAN.			
Small numerator and denominator values at county level may give unreliable estimates.			
HSWB surveys people age 16 years or over while SLAN surveys people aged 18 years or over.			
POLICY CONTEXT – REPUBLIC OF IRELAND			

Less than 5 hours physical activity per week

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Lifestyle

The Northern Ireland Public Health Strategy *Investing For Health* (DHSSPS, 2002) www.investingforhealthni.gov.uk aims to address a broad range of economic, social and environmental issues recognised as major determinants of health and wellbeing. It outlines the commitment of the Northern Ireland Executive to ensuring equality of opportunity and tackling social disadvantage within the community. It estimates that in 2002 the health and economic costs of lack of physical activity in terms of deaths, life years and working days lost as well as financial economic losses. It endorses existing and planned strategies and their aims for physical activity, cycling, walking, transport and sport. It emphasises the importance of physical activity in childhood, endorses school based programmes to increase physical activity and plans to provide facilities for physically active recreation.

The cross departmental Investing for Health task force report *Fit Futures: Focus on Food, Activity and Young People* (DHSSPS, 2005) www.investingforhealthni.gov.uk examines options for preventing the rise in levels of overweight and obesity in children and young people. It envisions that all children and young people "will be motivated and supported to access a range of readily available, quality, enjoyable opportunities to be active and eat healthily". Its recommendations focus on developing coherent and healthy public policy, providing accessible and acceptable choices, supporting healthy early childhood development, creating healthy school and community environments as well as supporting research. It summarises the broad range of synergistic socioeconomic policies that need to support healthy nutrition to It stipulates the inclusion of home economics in the secondary school key stage 3 curriculum and endorses the Public Service Agreement (PSA) target:

- To halt the rise of obesity in children by 2010.

The health strategy *A Healthier Future- A twenty year vision for health and wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2005) recognises the importance of physical exercise for the improvement of population health and wellbeing. It acknowledges the complex interplay of environmental and individual factors contributing to the burden of chronic diseases and considers the role of health and social care services in addressing these. It seeks:

- To reverse current trends of adult obesity by 2025,
- To reduce the levels of childhood obesity by 50% by 2025.

The draft *Northern Ireland Strategy for Sport and Physical Recreation 2007- 2017* (DHSSPS, 2007) www.dcalni.gov.uk supports the aspirations for lifelong involvement in sport and physical recreation for all people and for a sustainable recreational culture as part of Government objectives. Under the headings of participation, performance and places, it acknowledges the importance of research to monitor participation in sports and physical recreation and sets targets:

- To stop the decline in adult participation in sport and physical recreation by 2011,
- To provide every child in Northern Ireland aged over 8 years with at least two hours extracurricular opportunities for sport and physical recreation by 214,
- To increase adult participation in sport and physical recreation by 3% and

One of the strategic aims of the *National Health Promotion Strategy 2000-2005* (DoHC, 2000) www.dohc.ie was to increase participation in regular, moderate physical activity. The objectives linked to this strategic aim were to identify models of good practice which encourage young people (especially young girls) and older people to participate in regular, moderate physical activity, to work in partnership with relevant bodies to facilitate access and participation in regular, moderate physical activity and to support the implementation of the recommendations in *Promoting Physical Activity: A Strategy for Health Boards in Ireland* (DoHC, 1997) and *Building Healthier Hearts* (DoHC, 1999).

The national health strategy *Quality and Fairness* (DoHC, 2001) www.dohc.ie identified the need for continuing actions on major lifestyle factors to promote physical exercise.

Ireland is a signatory to the *Global Strategy on Diet, Physical Activity and Health* (WHO, 2004), which has made recommendations in relation to the responsibility of WHO, Ireland and the public and private sector in the area of diet, physical activity and health.

The *Report of the National Task Force on Obesity – The Policy Challenges* (DoHC, 2005) www.dohc.ie makes recommendations relating to government, education, social and community, health, industry and the physical environment sectors. It calls on all state agencies and government departments to develop health impact assessment based healthy eating and physical activity strategies. It points to poor facilities, insufficient amenities, a reduction in physical labour, increased mechanisation and personal issues surrounding self-efficacy and self-esteem as factors which contribute to this complex issue. It states that current evidence shows that a large proportion of children and adolescents do not meet the physical activity recommendations, and despite the relationship between physical education and long-term physical activity, Ireland does not have mandatory physical education classes.

The *Strategy for Cancer Control in Ireland* (DoHC, 2006) calls for the full implementation of the recommendations of the *Report of the National Task Force on Obesity* should be implemented in full and highlights the evidence linking regular physical activity to a reduced risk of cancer.

The Irish Sports Council Strategy *Building Sport for Life 2006- 2008* (Irish Sports Council, 2006) www.irishsportsCouncil.ie aims to have more people more active in sport and by achieving that goal assist in the building of a healthier society. The target is:

- To increase adult participation rates by 1.5% by 2008, by achieving a reduction of 1.5% in the number of totally inactive adults and increasing by 1.5% in the number of adults meeting the recommended minimum level of health-enhancing physical activity,
- To increase 3% the numbers of children taking part in some level of extra curricular sport and extra school sport combined.
-

The research collaboration between the Irish Sports Council and the Economic and Social Research Institute provides the data against for measuring participation rates over time.

The *Ten- Year Framework Social Partnership Agreement 2006-2015 Towards 2016* (2006) www.taoiseach.gov.ie underpins the NESC vision and aims to take into account

Less than 5 hours physical activity per week

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Lifestyle

- women's participation by 6% in 2017,
- To deliver an increase of 6% in the number of people in disadvantaged areas and with disability who regularly participate in sport and physical recreation by 2017.

The *Programme for Government 2008- 2011* Public Service Agreement Framework (NIE, 2008) www.pfgbudgetni.gov.uk endeavours:

- To have 125,000 children participating in sport and physical recreation by 2011,
- To halt the rise in obesity and decline in adult sports and physical recreation by 2011.

factors in the areas of balanced regional and rural development, planning, physical and social infrastructure and environmental sustainability and the development of social capital. A policy for physical recreation will be developed, to complement existing policies in sport for the enhancement and support of participation, and the strengthening of social capital.

Reflecting the priorities in the *National Development Plan 2007-2013* and in *Towards 2016 – the Social Partnership Agreement 2006–2015* and taking into account the commitment to enhanced North-South co-operation under the Good Friday Agreement, the Department of Arts, Sports and Tourism www.arts-sport-tourism.gov.ie goals are to increase participation and interest in sport, to improve standards of performance and to develop sports facilities, thereby contributing to healthier lifestyles and an improved overall quality of life.

REFERENCES

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Haskell, W.L., Lee, I., Pate, R.R., Powell, K.E., Blair, S.N., Franklin, B.A. *et al* (2007) "Physical Activity and Public Health. Updated Recommendations for Adults from the American College of Sports Medicine and the American Heart Association" in *Circulation*, Vol. 116, pp 1081- 1093.

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Smoking prevalence

Stage: Intervening factors

Level: Behaviours and environments (individual)

Theme: Lifestyle

NORTH-SOUTH COMPARABILITY	All-island component																																																								
LAY DESCRIPTION	The percentage of people who currently smoke cigarettes																																																								
SOURCE REFERENCE	eHPI: IB1_1																																																								
INDICATOR NAME	Pct smoke																																																								
DATA DEFINITION – NORTHERN IRELAND	DATA DEFINITION – REPUBLIC OF IRELAND																																																								
Percentage of people aged 16 years or over who currently smoke “at all”	Percentage of people aged 18 years or over who currently smoke “regularly” or “occasionally”																																																								
<table><tr><td>Published?</td><td>Yes</td><td>Geography</td><td>HSSB</td></tr><tr><td></td><td>Continuous Household Survey (CHS)</td><td></td><td></td></tr><tr><td>Frequency</td><td>Every two years</td><td>Latest Year</td><td>2004/2005</td></tr><tr><td>Numerator Definition</td><td>Number of CHS respondents aged 16 years or over who currently smoke “at all”</td><td>Geography</td><td>HSSB</td></tr><tr><td>Source</td><td>CHS</td><td>Year</td><td>2004/2005</td></tr><tr><td>Denominator Definition</td><td>Number of CHS respondents aged 16 years or over</td><td>Geography</td><td>HSSB</td></tr><tr><td>Source</td><td>CHS</td><td>Year</td><td>2004/2005</td></tr></table>	Published?	Yes	Geography	HSSB		Continuous Household Survey (CHS)			Frequency	Every two years	Latest Year	2004/2005	Numerator Definition	Number of CHS respondents aged 16 years or over who currently smoke “at all”	Geography	HSSB	Source	CHS	Year	2004/2005	Denominator Definition	Number of CHS respondents aged 16 years or over	Geography	HSSB	Source	CHS	Year	2004/2005	<table><tr><td>Published?</td><td>Yes</td><td>Geography</td><td>Ireland</td></tr><tr><td></td><td>Survey of Lifestyles, Attitudes and Nutrition (SLÁN)</td><td></td><td></td></tr><tr><td>Frequency</td><td>Every four years</td><td>Latest Year</td><td>2007</td></tr><tr><td>Numerator Definition</td><td>Number of SLÁN respondents aged 18 years or over who currently smoke “regularly” or “occasionally”</td><td>Geography</td><td>County</td></tr><tr><td>Source</td><td>SLÁN</td><td>Year</td><td>2002</td></tr><tr><td>Denominator Definition</td><td>Number of SLÁN respondents aged 18 years or over</td><td>Geography</td><td>County</td></tr><tr><td>Source</td><td>SLÁN</td><td>Year</td><td>2002</td></tr></table>	Published?	Yes	Geography	Ireland		Survey of Lifestyles, Attitudes and Nutrition (SLÁN)			Frequency	Every four years	Latest Year	2007	Numerator Definition	Number of SLÁN respondents aged 18 years or over who currently smoke “regularly” or “occasionally”	Geography	County	Source	SLÁN	Year	2002	Denominator Definition	Number of SLÁN respondents aged 18 years or over	Geography	County	Source	SLÁN	Year	2002
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Tobacco smoking remains the single greatest cause of preventable illness and premature death in the United Kingdom (Secretaries of State, 1998). Tobacco is the single largest cause of cancer, accounting for 30% of all cancer deaths in developed countries. Environmental tobacco smoke is also carcinogenic (DoHC, 2006). Tobacco smoke also causes lung and cardiovascular disease. It worsens asthma and osteoporosis. It affects the growth of unborn babies and the health of children. Smoking is addictive and most smokers take up the habit as children and teenagers. Those from disadvantaged groups of the population are most at risk (Acheson, 1998). Tobacco is the principal cause of the gap in life expectancy between rich and poor (Secretaries of State, 1998). Among 1000 20 year old smokers, one is likely to be murdered, six will die in accidents, but 250 will die in middle age from smoking and a further 250 in old age (Peto et al, 1994). The costs to individuals and societies in terms of ill health, impaired quality and loss of life, financial burden on health services and lost productivity are immense.																																																									
POLICY CONTEXT – NORTHERN IRELAND	POLICY CONTEXT – REPUBLIC OF IRELAND																																																								
Investing For Health (DHSSPSNI, 2002) www.dhsspsni.gov.uk proposes actions to reduce smoking levels in the population.	One of the nine topics in the <i>National Health Promotion Strategy 2000- 2005</i> (DoHC, 2000) http://www.dohc.ie is ‘being smoke free’. It recommended:																																																								

Smoking prevalence

Stage: Intervening factors

Level: Behaviours and environments (individual)

Theme: Lifestyle

A Five Year Tobacco Action Plan 2003-2008 (DHSSPSNI, 2003) www.dhsspsni.gov.uk identifies twenty four multi agency action points to change public perception of tobacco use, prevention, helping smokers to quit and protecting the public from tobacco smoke, especially in disadvantaged adults, young people and pregnant women as key target groups.

The commitment to preventing people starting to smoke, helping people to quit and protecting non-smokers from the harmful effects of environmental tobacco smoke is re-emphasized in *A Healthier Future – A Twenty year Vision for Health and Wellbeing in Northern Ireland 2005-2025* (DHSSPS, 2004) <http://www.dhsspsni.gov.uk>. It includes specific primary prevention targets

- To increase the proportion of 11-16 year old children who do not smoke from 86.9% in 2003 to 95% in 2025
- To increase the proportion of adults who do not smoke from 74% in 2002/03 to 95% in 2025

The *Strategic Framework for Respiratory Conditions* (DHSSPS, 2006) <http://www.dhsspsni.gov.uk> recommended recording of smoking status, professional advice to quit and access to smoking cessation services.

The Regional Cancer Framework- A Cancer Control Plan for Northern Ireland (DHSSPS, 2006) <http://www.dhsspsni.gov.uk> proposes to reduce smoking levels in younger people, improve smoking cessation services and public education, utilise community and primary care services.

The *Programme for Government 2008- 2011* Public Service Agreement Framework (NIE, 2008) www.pfgbudgetni.gov.uk endeavours:

- To reduce to 21% and 25% respectively the proportion of adults and manual worker subsets who smoke by 2011.

- To increase the percentage of the population who remain non- smokers with a particular emphasis on narrowing the gap across social classes and to protect non- smokers from passive smoking.

Towards a Tobacco Free Society (DoHC, 2001) <http://www.dohc.ie> proposes an integrated strategy for tackling tobacco consumption and promoting a tobacco-free society.

The national *Health Strategy Quality and Fairness* (DoHC, 2001) <http://www.dohc.ie> describes current and future policy and legislative developments with regards to smoking in Ireland to tackle cancer and cardiovascular disease and to promote healthier lifestyles. In continuing to implement the National Cancer, Cardiovascular and Health Promotion Strategies it calls for enhanced health promotion initiatives aimed at addressing the risk factors associated with cancers and cardiovascular disease such as smoking and targeting a reduction in smoking for young women, supported by appropriate fiscal policies.

The *Office of Tobacco Control* (OTC) was established as a statutory structure in May 2002 to increase the capacity of government and the health services to tackle the problem of smoking.

The *Public Health (Tobacco) Act (2002)* and the *Public Health (Tobacco) Amendment Act (2004)* legislation www.irishstatutebook.ie place restrictions and conditions on the advertising, sale and consumption of tobacco. It includes the ban on smoking in indoor work and public places implemented in Ireland in 2004.

In 2005, Ireland became the 101st country to ratify the World Health Organisation (WHO) Framework Convention on Tobacco www.who.int.

The *Strategy for Cancer Control in Ireland* (DoHC, 2006) <http://www.dohc.ie> describes the ban on smoking in indoor public places, which was implemented in Ireland in 2004, as a very significant success and an example of how Ireland can play a leadership role in cancer control internationally. It makes a number of recommendations with regards to tobacco:

- Compliance with all provisions of the Public Health (Tobacco) Acts 2002 and 2004 should be monitored.
- Excise duty on cigarettes should be substantially increased each year above the rate of inflation.
- Nicotine replacement therapy should be made available free of charge to all medical card holders.

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 National Cancer Forum (2006). A Strategy for Cancer Control in Ireland. Dublin, Department of Health and Children.
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 Secretary of State for Health and the Secretaries of State for Scotland, Wales and Northern Ireland. (1998) Smoking kills – A White Paper on Tobacco. The Stationary Office.

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Burglary

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Local environments

NORTH-SOUTH COMPARABILITY		All-island component	
LAY DESCRIPTION		The number of recorded burglaries per 100,000 people	
SOURCE REFERENCE		eHPI: IB3_4	
INDICATOR NAME		Rate burglary	
DATA DEFINITION – NORTHERN IRELAND			
The number of recorded burglaries (Class 3) in an area per 100,000 people.			
Published?	Yes www.ninis.nisra.gov.uk	Geography	Ward, LGD, Parliamentary Constituency, HSSB, PSNI Areas
Frequency	Yearly	Latest Year	2007/2008
Numerator Definition	Number of recorded burglaries	Geography	LGD
Source	PSNI	Year	2004/2005
Denominator Definition	Mid-year population estimate	Geography	LGD
Source	NISRA	Year	2005
DATA ISSUES			
Although burglary consists of different specific offences in Northern Ireland and Republic of Ireland, the offences are broadly comparable.			
PUBLIC HEALTH IMPORTANCE			
Crime affects the health of victims, perpetrators and those living in fear of it. While the impact of property crimes tends to be less severe than that of murder, rape, assault or robbery, it nevertheless leads to victimisation and anxiety or fear of crime. This can result in health symptoms like stress, sleeping difficulties, loss of appetite, depression, loss of confidence and health harming coping mechanisms e.g. smoking or alcohol drinking. Crime has a negative impact on the behaviour of victims and non victims, resulting in avoidance behaviour e.g. staying in after dark or avoiding certain areas. It affects quality of live by causing mental distress and social exclusion. It can result in financial hardship through loss of and damage to property. Crime prevention contributes to improved health and wellbeing of individuals, as well as community cohesion (Hirschfield, 2004).			
POLICY CONTEXT – NORTHERN IRELAND			
Announced in the Northern Ireland public health strategy <i>Investing for Health</i> (DHSSPS, 2002), the Northern Ireland Community Safety Strategy <i>Creating a safer Northern Ireland</i>			
DATA DEFINITION – REPUBLIC OF IRELAND			
The number of recorded burglaries (Group 7) in an area per 100,000 people.			
Published?	Yes www.cso.ie	Geography	Garda Division
Frequency	Quarterly	Latest Year	2007
Definition	Number of recorded burglaries	Geography	Garda Division
Source	An Garda Síochana	Year	2005
Definition	Mid-year population estimate	Geography	Garda Division
Source	Public Health Information System	Year	2005
DATA ISSUES			
Although burglary consists of different specific offences in Northern Ireland and Republic of Ireland, the offences are broadly comparable.			
Where a Garda Division consists of two counties, each county's value is assumed to be equal to its Garda Division's value. This will mask any county variation within that Garda Division.			
CSO now have responsibility for reporting crime data and have developed a new classification system for offences.			

Burglary

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Local environments

through partnership (Community Safety Unit (CSU), 2003)

www.communitysafetyni.gov.uk focuses on reducing crime, fear of crime and antisocial behaviour. This Government framework is based on a partnership approach to improving community safety in Northern Ireland through the development and implementation of local community safety plans. In relation to burglary, it aims:

- To work in partnership with others to reduce the rate of domestic burglary in Northern Ireland by 15% by 2007, using 2001/02 as the base.

The Neighbourhood Renewal Strategy People and Place (Department for Social Development, 2003) www.dsdni.gov.uk aims to tackle the complex, multidimensional nature of deprivation through community, economic, social and physical renewal of neighbourhoods in the 10% most deprived wards in Northern Ireland. It aims:

- To reduce the overall crime rates,
- To halve residents' reported perceptions of levels of crime and antisocial behaviour in their area and
- To increase residents' reported level of security.

The Northern Ireland Policing Plan 2007- 2010 www.psni.police.uk is based on consultation with District Policing Partnerships and public surveys. It sets out priorities, targets and actions for effective and efficient policing in Northern Ireland to tackle crime and promote community safety, satisfaction and confidence. It endeavours to address areas of public concern including anti social behaviour, violent and hate crime, domestic burglary and roads policing. It includes the following targets:

- To reduce total number of crimes by 2% and
- To reduce the number of domestic burglaries by 3%.
- To establish a baseline of the percentage of people who say they feel safe in their community.

criminal behaviour. Its focus is on national and international security, crime incidence, road safety and traffic management, public safety and confidence and the protection of cultural and ethnic diversity.

It aims:

- To reduce the incidence of organised, drug related and serious crime, and criminal behaviour

A Crime Prevention Strategy for Ireland Tackling the Concerns of Local Communities (National Crime Council, 2003) www.irlgov.ie/crimecouncil supports early intervention based on a National Crime Prevention Model to ensure a common approach for cross departmental, interagency and multidisciplinary working and highlights the difficulties to record crime, monitor trends and evaluate interventions in the absence of agreed definitions. It recommends a partnership approach to develop locally based crime prevention strategies to prevent crime, tackle existing problems, propose solutions to underlying causes and share good practice. In order to achieve this, the strategy proposal considers the necessity:

- To reduce opportunities to commit crime
- To promote social inclusion and reduce the socio-economic, educational, societal and environmental factors that can leave children and young people 'at risk' of engaging in criminal activities
- To reduce recidivism through integration of young and adult offenders into the community in a planned and supportive way, involving training and education, skills development and personal support
- To provide appropriate interventions through an interagency partnership approach where knowledge, expertise and best practice are shared to the maximum

The Criminal Justice Act 2006 (Department of Justice, Equality and Law Reform, 2006) www.oireachtas.ie contains a comprehensive package of anti crime measures, enhances the powers of the Gardai and aims to improve the operation of the criminal justice system. It introduces the concept of restorative justice to the juvenile justice system and provides for the establishment of the *Criminal Law Codification Advisory Committee*.

In response to the National Crime Council's recommendations, the Central Statistics Office, An Garda Síochána and the Advisory Group on Crime Statistics have developed a new integrated *Irish Crime Classification System* (CSO, 2008) www.cso.ie capable of also handling offences not normally dealt with by the police.

REFERENCES

Hirschfield, A. (2004). "The Health Impact Assessment of Crime Prevention" in Kemm, J., Parry, J., and Palmer, S. (eds.) *Health Impact Assessment: Concepts, theory, techniques and applications*. Oxford, Oxford University Press.

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Criminal damage

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Local environments

NORTH-SOUTH COMPARABILITY	Separate North and South components		
LAY DESCRIPTION	The number of recorded criminal damage offences per 100,000 people		
SOURCE REFERENCE	eHPI: IB3_6		
INDICATOR NAMES	Rate criminal damage NI; Rate criminal damage RoI		
DATA DEFINITION – NORTHERN IRELAND			
The number of recorded criminal damage offences (Class 7) per 100,000 people			
Published?	Yes www.ninis.nisra.gov.uk	Geography	Ward, LGD, Parliamentary Constituency, HSSB, PSNI Areas
Frequency	Yearly	Latest Year	2007/2008
Numerator Definition	Number of recorded criminal damage offences	Geography	LGD
Source	PSNI	Year	2004/2005
Denominator Definition	Mid-year population estimate	Geography	LGD
Source	NISRA	Year	2005
DATA ISSUES			
The components are not directly comparable between Northern Ireland and Republic of Ireland as criminal damage consists of different offences in Northern Ireland and Republic of Ireland.			
DATA ISSUES			
The components are not directly comparable between Northern Ireland and Republic of Ireland as criminal damage consists of different offences in Northern Ireland and Republic of Ireland.			
Where a Garda Division consists of two counties, each county's value is assumed to be equal to its Garda Division's value. This will mask any county variation within that Garda Division.			
CSO now have responsibility for reporting crime data and have developed a new classification system for offences.			
PUBLIC HEALTH IMPORTANCE			
Crime affects the health of victims, perpetrators and those living in fear of it. While the impact of property crimes tends to be less severe than that of murder, rape, assault or robbery, it nevertheless leads to victimisation and anxiety or fear of crime. This can result in health symptoms like stress, sleeping difficulties, loss of appetite, depression, loss of confidence and health harming coping mechanisms e.g. smoking or alcohol drinking. Crime has a negative impact on the behaviour of victims and non victims, resulting in avoidance behaviour e.g. staying in after dark or avoiding certain areas. It affects quality of live by causing mental distress and social exclusion. It can result in financial hardship through loss of and damage to property. Crime prevention contributes to improved health and wellbeing of individuals, as well as community cohesion (Hirschfield, 2004).			

Criminal damage

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Local environments

POLICY CONTEXT – NORTHERN IRELAND	POLICY CONTEXT – REPUBLIC OF IRELAND
<p>Announced in the Northern Ireland public health strategy <i>Investing for Health</i> (DHSSPS, 2002), the Northern Ireland Community Safety Strategy <i>Creating a safer Northern Ireland through partnership</i> (Community Safety Unit (CSU), 2003) www.communitysafetyni.gov.uk focuses on reducing crime, fear of crime and antisocial behaviour. This Government framework is based on a partnership approach to improving community safety in Northern Ireland through the development and implementation of local community safety plans. In relation to criminal damage, it does not have any specific objectives, but aims:</p> <ul style="list-style-type: none"> • To reduce the rate of increases in business crime by 2005, • To reduce the level of crime and criminality specifically attributable to young people, • To work with community relations and other organisations to reduce the levels of crime with a sectarian motivation and • To promote and enhance the safety of minority ethnic residents. <p>The <i>Neighbourhood Renewal Strategy People and Place</i> (Department for Social Development, 2003) www.dsdni.gov.uk aims to tackle the complex, multidimensional nature of deprivation through community, economic, social and physical renewal of neighbourhoods in the 10% most deprived wards in Northern Ireland. It aims:</p> <ul style="list-style-type: none"> • To reduce the overall crime rates, • To halve residents' reported perceptions of levels of crime and antisocial behaviour in their area and • To increase residents' reported level of security. <p>A <i>Shared Future Policy and Strategic Framework for Good Relations in Northern Ireland</i> (OFMDFM, 2005) www.ofmdfm.gov.uk is based on extensive public consultation and sets out the vision of Government in Northern Ireland for a shared society defined by a culture of tolerance against a historic background of deeply entrenched communal divisions and tensions. Its objectives include the elimination of sectarianism, racism and other prejudice, the reduction of conflict and tension in and between communities and the protection of members of minority groups and mixed marriages from intimidation and violence. It indicates the need to develop meaningful, measurable and relevant indicators. These are contained in <i>A Shared Future and Racial Equality Strategy Good Relations Indicators Baseline Report</i> (NISRA & OFMDFM, 2007)</p> <p>The <i>Northern Ireland Policing Plan 2007- 2010</i> www.psni.police.uk is based on consultation with District Policing Partnerships and public surveys. It sets out priorities, targets and actions for effective and efficient policing in Northern Ireland to tackle crime and promote community safety, satisfaction and confidence. It endeavours to address areas of public concern including anti social behaviour, violent and hate crime, domestic burglary and roads policing. It includes the following targets:</p> <ul style="list-style-type: none"> • To reduce total number of crimes by 2% and • To reduce the total number of recorded crimes of criminal damage by 2% and • To establish a baseline of the percentage of people who say they feel safe in their community. 	<p>The <i>An Garda Síochána Corporate Strategy 2005- 2007</i> www.garda.ie seeks to contribute to improved quality of life for people living in Ireland without fear of crime or criminal behaviour. Its focus is on national and international security, crime incidence, road safety and traffic management, public safety and confidence and the protection of cultural and ethnic diversity. It aims:</p> <ul style="list-style-type: none"> • To reduce the incidence of organised, drug related and serious crime, and criminal behaviour <p>A <i>Crime Prevention Strategy for Ireland Tackling the Concerns of Local Communities</i> (National Crime Council, 2003) www.irlgov.ie/crimecouncil supports early intervention based on a National Crime Prevention Model to ensure a common approach for cross departmental, interagency and multidisciplinary working and highlights the difficulties to record crime, monitor trends and evaluate interventions in the absence of agreed definitions. It recommends a partnership approach to develop locally based crime prevention strategies to prevent crime, tackle existing problems, propose solutions to underlying causes and share good practice. In order to achieve this, the strategy proposal considers the necessity:</p> <ul style="list-style-type: none"> • To reduce opportunities to commit crime • To promote social inclusion and reduce the socio-economic, educational, societal and environmental factors that can leave children and young people 'at risk' of engaging in criminal activities • To reduce recidivism through integration of young and adult offenders into the community in a planned and supportive way, involving training and education, skills development and personal support • To provide appropriate interventions through an interagency partnership approach where knowledge, expertise and best practice are shared to the maximum <p>The <i>Criminal Justice Act 2006</i> (Department of Justice, Equality and Law Reform, 2006) www.oireachtas.ie contains a comprehensive package of anti crime measures, enhances the powers of the Gardai and aims to improve the operation of the criminal justice system. It introduces the concept of restorative justice to the juvenile justice system and provides for the establishment of the <i>Criminal Law Codification Advisory Committee</i>.</p> <p>In response to the National Crime Council's recommendations, the Central Statistics Office, An Garda Síochána and the Advisory Group on Crime Statistics have developed a new integrated <i>Irish Crime Classification System</i> (CSO, 2008) www.cso.ie capable of also handling offences not normally dealt with by the police.</p>

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Household waste

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Local environments

NORTH-SOUTH COMPARABILITY	One South only component
LAY DESCRIPTION	Household waste per person
SOURCE REFERENCE	Other Indicators
INDICATOR NAME	Household waste kg/capita RoI
DATA DEFINITION – NORTHERN IRELAND	DATA DEFINITION – REPUBLIC OF IRELAND
<p>Published? Geography</p> <p>Frequency Latest Year</p> <p>Numerator Geography</p> <p>Definition Year</p> <p>Source Geography</p> <p>Denominator Year</p> <p>Definition Year</p> <p>Source Year</p>	<p>Total weight (Kg) of household waste per person. Household waste consists of:</p> <ul style="list-style-type: none"> Mixed residual collection (Black Bins) Separate kerbside collection of mixed dry recyclables (Green Bins) Separate kerbside collection of food and garden waste (Brown Bins) Household waste brought to bring banks Household waste brought to CA sites Household waste delivered directly to landfill face by householders Estimate of home composting "Uncollected" household waste <p>Published? Yes Environmental Protection Agency National Waste Report 2006 Appendix B www.epa.ie</p> <p>Frequency Every year</p> <p>Numerator Kgs of household waste</p> <p>Definition Year</p> <p>Source County 2006</p> <p>Denominator Population</p> <p>Definition Year</p> <p>Source Census</p> <p>Geography County 2006</p> <p>Local Authority</p>
DATA ISSUES	DATA ISSUES
PUBLIC HEALTH IMPORTANCE	PUBLIC HEALTH IMPORTANCE
POLICY CONTEXT – NORTHERN IRELAND	POLICY CONTEXT – REPUBLIC OF IRELAND

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Quality of drinking water

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Local environments

NORTH-SOUTH COMPARABILITY		One South only component
LAY DESCRIPTION		Quality of drinking water
SOURCE REFERENCE		Other Indicators
INDICATOR NAME		Drinking water % compliance RoI
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND
		Percentage overall compliance with microbiological, chemical, and indicator standards of drinking water supplies
Published?	No/Publication name	Geography
Frequency		Latest Year
Numerator		Geography
Definition		Year
Source		Geography
Denominator		Year
Definition		
Source		
DATA ISSUES		DATA ISSUES
PUBLIC HEALTH IMPORTANCE		
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND

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Theft

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Local environments

NORTH-SOUTH COMPARABILITY	All-island component
LAY DESCRIPTION	The number of recorded thefts per 100,000 people
SOURCE REFERENCE	eHPI: IB3_5
INDICATOR NAME	Rate theft

DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND			
The number of recorded thefts (Class 5) per 100,000 people.				The number of recorded thefts (Group 6) per 100,000 people.			
Published?	Yes www.ninis.nisra.gov.uk	Geography	Ward, LGD, Parliamentary Constituency, HSSB, PSNI Areas	Published?	Yes www.cso.ie	Geography	Garda Division
Frequency	Yearly	Latest Year	2007/2008	Frequency	Quarterly	Latest Year	2007
Numerator Definition	Number of recorded thefts	Geography	LGD	Definition	Number of recorded thefts	Geography	Garda Division
Source	PSNI	Year	2004/2005	Source	An Garda Síochána	Year	2005
Denominator Definition	Mid-year population estimate	Geography	LGD	Definition	Mid-year population estimate	Geography	Garda Division
Source	NISRA	Year	2005	Source	Public Health Information System	Year	2005
DATA ISSUES				DATA ISSUES			
Although theft consists of different specific offences in Northern Ireland and Republic of Ireland, the offences are broadly comparable.				Although theft consists of different specific offences in Northern Ireland and Republic of Ireland, the offences are broadly comparable.			
				Where a Garda Division consists of two counties, each county's value is assumed to be equal to its Garda Division's value. This will mask any county variation within that Garda Division.			
				CSO now have responsibility for reporting crime data and have developed a new classification system for offences.			
PUBLIC HEALTH IMPORTANCE				PUBLIC HEALTH IMPORTANCE			
Crime affects the health of victims, perpetrators and those living in fear of it. While the impact of property crimes tends to be less severe than that of murder, rape, assault or robbery, it nevertheless leads to victimisation and anxiety or fear of crime. This can result in health symptoms like stress, sleeping difficulties, loss of appetite, depression, loss of confidence and health harming coping mechanisms e.g. smoking or alcohol drinking. Crime has a negative impact on the behaviour of victims and non victims, resulting in avoidance behaviour e.g. staying in after dark or avoiding certain areas. It affects quality of life by causing mental distress and social exclusion. It can result in financial hardship through loss of and damage to property. Crime prevention contributes to improved health and wellbeing of individuals, as well as community cohesion (Hirschfield, 2004).				The An Garda Síochána Corporate Strategy 2005- 2007 www.garda.ie seeks to contribute to improved quality of life for people living in Ireland without fear of crime or			
POLICY CONTEXT – NORTHERN IRELAND				POLICY CONTEXT – REPUBLIC OF IRELAND			
Announced in the Northern Ireland public health strategy <i>Investing for Health</i> (DHSSPS, 2002), the Northern Ireland Community Safety Strategy <i>Creating a safer Northern Ireland</i>				The An Garda Síochána Corporate Strategy 2005- 2007 www.garda.ie seeks to contribute to improved quality of life for people living in Ireland without fear of crime or			

Theft

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Local environments

through partnership (Community Safety Unit (CSU), 2003)

www.communitysafetytni.gov.uk focuses on reducing crime, fear of crime and antisocial behaviour. This Government framework is based on a partnership approach to improving community safety in Northern Ireland through the development and implementation of local community safety plans. In relation to theft, it aims:

- To reduce the theft of and theft from motor vehicles by 10% by 2007, using 2001/02 as the base.
- To reduce the rate of increases in business crime by 2005.

The *Neighbourhood Renewal Strategy People and Place* (Department for Social Development, 2003) www.dsdni.gov.uk aims to tackle the complex, multidimensional nature of deprivation through community, economic, social and physical renewal of neighbourhoods in the 10% most deprived wards in Northern Ireland. It aims:

- To reduce the overall crime rates,
- To halve residents' reported perceptions of levels of crime and antisocial behaviour in their area and
- To increase residents' reported level of security.

The *Northern Ireland Policing Plan 2007- 2010* www.psni.police.uk is based on consultation with District Policing Partnerships and public surveys. It sets out priorities, targets and actions for effective and efficient policing in Northern Ireland to tackle crime and promote community safety, satisfaction and confidence. It endeavours to address areas of public concern including anti social behaviour, violent and hate crime, domestic burglary and roads policing. It includes the following targets:

- To reduce total number of crimes by 2% and
- To establish a baseline of the percentage of people who say they feel safe in their community.

criminal behaviour. Its focus is on national and international security, crime incidence, road safety and traffic management, public safety and confidence and the protection of cultural and ethnic diversity.

It aims:

- To reduce the incidence of organised, drug related and serious crime, and criminal behaviour

A *Crime Prevention Strategy for Ireland Tackling the Concerns of Local Communities* (National Crime Council, 2003) www.irlgov.ie/crimecouncil supports early intervention based on a National Crime Prevention Model to ensure a common approach for cross departmental, interagency and multidisciplinary working and highlights the difficulties to record crime, monitor trends and evaluate interventions in the absence of agreed definitions. It recommends a partnership approach to develop locally based crime prevention strategies to prevent crime, tackle existing problems, propose solutions to underlying causes and share good practice. In order to achieve this, the strategy proposal considers the necessity:

- To reduce opportunities to commit crime
- To promote social inclusion and reduce the socio-economic, educational, societal and environmental factors that can leave children and young people 'at risk' of engaging in criminal activities
- To reduce recidivism through integration of young and adult offenders into the community in a planned and supportive way, involving training and education, skills development and personal support
- To provide appropriate interventions through an interagency partnership approach where knowledge, expertise and best practice are shared to the maximum

The *Criminal Justice Act 2006* (Department of Justice, Equality and Law Reform, 2006) www.oireachtas.ie contains a comprehensive package of anti crime measures, enhances the powers of the Gardai and aims to improve the operation of the criminal justice system. It introduces the concept of restorative justice to the juvenile justice system and provides for the establishment of the *Criminal Law Codification Advisory Committee*.

In response to the National Crime Council's recommendations, the Central Statistics Office, An Garda Síochána and the Advisory Group on Crime Statistics have developed a new integrated *Irish Crime Classification System* (CSO, 2008) www.cso.ie capable of also handling offences not normally dealt with by the police.

REFERENCES

Hirschfield, A. (2004). "The Health Impact Assessment of Crime Prevention" in Kemm, J., Parry,J., nd Palmer, S. (eds.) *Health Impact Assessment: Concepts, theory, techniques and applications*. Oxford, Oxford University Press.

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Violent crime

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Local environments

NORTH-SOUTH COMPARABILITY	Separate North and South components
LAY DESCRIPTION	The number of recorded violent crimes per 100,000 people
SOURCE REFERENCE	eHPI: IB3_3
INDICATOR NAMES	Rate violent crime NI; Rate violent crime RoI;

DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND			
The number of recorded violent crimes per 100,000 people. Violent crimes consist of offences against the person (Class 1), sexual offences (Class 2), and robbery (Class 4)				The number of recorded violent crimes per 100,000 people. Violent crimes consist of homicides (Group 1), assault (Group 2) and robberies (Group 8)			
Published?	Yes www.ninis.nisra.gov.uk	Geography	Ward, LGD, Parliamentary Constituency, HSSB, PSNI Areas	Published?	Yes www.cso.ie	Geography	Garda Division
Frequency	Yearly	Latest Year	2007/2008	Frequency	Quarterly	Latest Year	2007
Numerator Definition	Number of recorded violent crimes	Geography	LGD	Numerator Definition	Number of recorded violent crimes	Geography	Garda Division
Source	PSNI	Year	2004/2005	Source	An Garda Síochána	Year	2005
Denominator Definition	Mid-year population estimate	Geography	LGD	Denominator Definition	Mid-year population estimate	Geography	Garda Division
Source	NISRA	Year	2005	Source	Public Health Information System	Year	2005
DATA ISSUES				DATA ISSUES			
The components are not directly comparable between Northern Ireland and Republic of Ireland as violent crime consists of different offences in Northern Ireland and Republic of Ireland.				The components are not directly comparable between Northern Ireland and Republic of Ireland as violent crime consists of different offences in Northern Ireland and Republic of Ireland.			
				Where a Garda Division consists of two counties, each county's value is assumed to be equal to its Garda Division's value. This will mask any county variation within that Garda Division.			
				CSO now have responsibility for reporting crime data and have developed a new classification system for offences.			

PUBLIC HEALTH IMPORTANCE	
Crime affects the health of victims, perpetrators and those living in fear of it. While the impact of property crimes tends to be less severe than that of murder, rape, assault or robbery, it nevertheless leads to victimisation and anxiety or fear of crime. This can result in health symptoms like stress, sleeping difficulties, loss of appetite, depression, loss of confidence and	

Violent crime

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Local environments

health harming coping mechanisms e.g. smoking or alcohol drinking. Crime has a negative impact on the behaviour of victims and non victims, resulting in avoidance behaviour e.g. staying in after dark or avoiding certain areas. It affects quality of life by causing mental distress and social exclusion. It can result in financial hardship through loss of and damage to property. Crime prevention contributes to improved health and wellbeing of individuals, as well as community cohesion (Hirschfield, 2004).

POLICY CONTEXT – NORTHERN IRELAND

Announced in the Northern Ireland public health strategy *Investing for Health* (DHSSPS, 2002), the Northern Ireland Community Safety Strategy *Creating a safer Northern Ireland through partnership* (Community Safety Unit (CSU), 2003)

www.communitysafetyni.gov.uk focuses on reducing crime, fear of crime and antisocial behaviour. This Government framework is based on a partnership approach to improving community safety in Northern Ireland through the development and implementation of local community safety plans. In relation to violent crime, it aims:

- To work in partnership with others to reduce the rate of increase in violent crime in Northern Ireland,
- To publish a draft strategy and action plan to address violence against women, including domestic violence, by May 2003
- To work with others to reduce levels of sexual assault and sexual abuse.

The *Neighbourhood Renewal Strategy People and Place* (Department for Social Development, 2003) www.dsdni.gov.uk aims to tackle the complex, multidimensional nature of deprivation through community, economic, social and physical renewal of neighbourhoods in the 10% most deprived wards in Northern Ireland. It aims:

- To reduce the overall crime rates,
- To halve residents' reported perceptions of levels of crime and antisocial behaviour in their area and
- To increase residents' reported level of security.

The Strategy for addressing domestic violence and abuse in Northern Ireland *Tackling Violence at Home* (NIO & DHSSPS, 2005) www.nio.gov.uk sets out to work towards elimination of all domestic violence through prevention, protection and justice and support. It is accompanied by action plans and proposes the development of performance indicators to measure the impact of its five year live span.

A Shared Future Policy and Strategic Framework for Good Relations in Northern Ireland (OFMDFM, 2005) www.ofmdfm.gov.uk is based on extensive public consultation and sets out the vision of Government in Northern Ireland for a shared society defined by a culture of tolerance against a historic background of deeply entrenched communal divisions and tensions. Its objectives include the elimination of sectarianism, racism and other prejudice, the reduction of conflict and tension in and between communities and the protection of members of minority groups and mixed marriages from intimidation and violence. It indicates the need to develop meaningful, measurable and relevant indicators. These are contained in *A Shared Future and Racial Equality Strategy Good Relations Indicators Baseline Report* (NISRA & OFMDFM, 2007)

The *Northern Ireland Policing Plan 2007- 2010* www.psni.police.uk is based on consultation with District Policing Partnerships and public surveys. It sets out priorities, targets and actions for effective and efficient policing in Northern Ireland to tackle crime and promote community safety, satisfaction and confidence. It endeavours to address areas of public concern including anti social behaviour, violent and hate crime, domestic burglary and roads policing. It includes the following targets:

POLICY CONTEXT – REPUBLIC OF IRELAND

The *An Garda Síochána Corporate Strategy 2005- 2007* www.garda.ie seeks to contribute to improved quality of life for people living in Ireland without fear of crime or criminal behaviour. Its focus is on national and international security, crime incidence, road safety and traffic management, public safety and confidence and the protection of cultural and ethnic diversity. It aims:

- To reduce the incidence of organised, drug related and serious crime, and criminal behaviour

A Crime Prevention Strategy for Ireland Tackling the Concerns of Local Communities (National Crime Council, 2003) www.irlgov.ie/crimecouncil supports early intervention based on a National Crime Prevention Model to ensure a common approach for cross departmental, interagency and multidisciplinary working and highlights the difficulties to record crime, monitor trends and evaluate interventions in the absence of agreed definitions. It recommends a partnership approach to develop locally based crime prevention strategies to prevent crime, tackle existing problems, propose solutions to underlying causes and share good practice. In order to achieve this, the strategy proposal considers the necessity:

- To reduce opportunities to commit crime
- To promote social inclusion and reduce the socio-economic, educational, societal and environmental factors that can leave children and young people 'at risk' of engaging in criminal activities
- To reduce recidivism through integration of young and adult offenders into the community in a planned and supportive way, involving training and education, skills development and personal support
- To provide appropriate interventions through an interagency partnership approach where knowledge, expertise and best practice are shared to the maximum

The *Criminal Justice Act 2006* (Department of Justice, Equality and Law Reform, 2006) www.oireachtas.ie contains a comprehensive package of anti crime measures, enhances the powers of the Gardai and aims to improve the operation of the criminal justice system. It introduces the concept of restorative justice to the juvenile justice system and provides for the establishment of the *Criminal Law Codification Advisory Committee*.

The *National Women's Strategy 2007- 2016* (Department of Justice, Equality and Law Reform, 2007) www.justice.ie states the Irish Government's priorities in advancing the role of women in society. Under three themes of equalising socioeconomic opportunity for, ensuring wellbeing of and engaging women as equal and active citizens, it sets out objectives and actions, including:

- To combat violence against women through improved services for victims together with effective prevention and prosecution,
- To address the issue of trafficking of women and children and
- To enhance the capacity of Irish Aid and Development partners to respond effectively to Gender based Violence in conflict, post- conflict and developing

Violent crime

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Local environments

- To reduce total number of crimes by 2%,
- To reduce the number of domestic burglaries by 3% and
- To reduce the number of violent crimes by 2%.
- To establish a baseline of the percentage of people who say they feel safe in their community.

The *Violent Crime Reduction Act 2006* (Home Office, 2007) www.opsi.gov.uk provides the legal framework for dealing with violent crime offences.

The Regional Strategy 2008- 2013 *Tackling Sexual Violence and Abuse* (NIO & DHSSPS, 2008) highlights the high incidence of sexual violence and abuse against low levels of reporting and disclosure with many victims not seeking help or getting support. It aims to increase awareness, improve responses and support for victims and work with perpetrators to reduce the risk of recurrence by providing leadership and direction, prevention, protection, justice and support. Like *Tackling Violence at Home* (NIO & DHSSPS, 2005), it is accompanied by action plans for its five year life span and proposes mechanisms for performance monitoring across agencies.

environments.

In response to the National Crime Council's recommendations, the Central Statistics Office, An Garda Síochána and the Advisory Group on Crime Statistics have developed a new integrated *Irish Crime Classification System* (CSO, 2008) www.cso.ie capable of also handling offences not normally dealt with by the police.

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Hirschfield, A. (2004). "The Health Impact Assessment of Crime Prevention" in Kemm, J., Parry, J., and Palmer, S. (eds.) *Health Impact Assessment: Concepts, theory, techniques and applications*. Oxford, Oxford University Press.

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Low control work environments

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Work

NORTH-SOUTH COMPARABILITY

Separate North and South components

LAY DESCRIPTION

Percentage of people in an area who work in routine/unskilled or semi-routine/semi-skilled employment

SOURCE REFERENCE

eHPI: IB3_1

INDICATOR NAMES

Pct low control work NI; Pct low control work RoI

DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND			
Percentage of the people aged 16-74 years who work in routine or semi-routine employment				Percentage of people aged 15 year or over in the workforce who work in unskilled or semi-skilled employment			
Published?	Yes Census	Geography	LGD	Published?	Yes Census	Geography	County
Frequency	Every ten years	Latest Year	2001	Frequency	Every five years	Latest Year	2006
Numerator Definition	Number of people aged 16-74 years who work in routine or semi-routine employment	Geography	LGD	Numerator Definition	Number of people aged 15 year or over in the workforce who work in unskilled or semi-skilled employment	Geography	County
Source	Census	Year	2001	Source	Census	Year	2006
Denominator Definition	Number of people aged 16-74 years	Geography	LGD	Denominator Definition	Number of people aged 15 year or over in the workforce	Geography	County
Source	Census	Year	2001	Source	Census	Year	County
DATA ISSUES				DATA ISSUES			
The components are not directly comparable between Northern Ireland and Republic of Ireland as different occupational classifications are used.				The components are not directly comparable between Northern Ireland and Republic of Ireland as different occupational classifications are used.			
PUBLIC HEALTH IMPORTANCE							
POLICY CONTEXT – NORTHERN IRELAND				POLICY CONTEXT – REPUBLIC OF IRELAND			
The NI 2001 Regional Development Strategy http://www.drndi.gov.uk/publications-details.htm?docid=308				National Social Partnership Agreement Sustaining Progress 2003-2005 The Equal Opportunities Childcare Programme 2000-2006 (EOCP)			
A strategic objective is to support a sustainable economic drive which will provide jobs and wealth across the region and help reduce socioeconomic differentials. This is a major challenge in an economy where firms face intense competition and there is a fast growing workforce.				A core aspect of the National Social Partnership Agreement Sustaining Progress 2003-2005 is Workplace Relations and Environment, in which, building on the work carried out under previous agreements, the social partners agreed the following package of legislation, codes and programmes aimed at:			
'A New Deal For Welfare- Empowering people for work' 2006 is a national strategy aiming at higher employment www.dwp.gov.uk/mediacentre/pressreleases/2006/jan/fmc068-				<ul style="list-style-type: none">protecting employees' rights;ensuring greater equality;			

Low control work environments

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Work

[240106.asp](#)

Our economy will benefit from higher employment rates among lone parents, older people with a health condition or disability.

The 'Skills Strategy for Northern Ireland 2004'

http://www.delni.gov.uk/skills_strategy_for_northern_ireland-2.pdf identified reducing high levels of economic inactivity and a need to increase the skill base in a competitive economic situation.

The 'Economic Vision for Northern Ireland ' published 2005 identified a low but long term in nature level of unemployment, A high dependence on the public sector (a third compared to 20% in the UK) or traditional industries prone to threat from low cost competition (29% versus 18% in manufacturing) <http://www.detini.gov.uk/cgi-bin/moreutil?utilid=450&site=3&util=2&fold=&parent=> It highlights the need to improve competitiveness, and move to relying less on low costs and more on higher value added products and services. This would be achieved through investment in training and R&D, promoting entrepreneurship, developing Tourism and infrastructure. These improvements would be measured by changes in GVA, increased percentage economic activity rates and reductions in incapacity benefits claimants.

Under 'A New Deal For Welfare- Empowering people for work' 2006

- Reduce by 1 million the number of people on incapacity benefits;
- Help 300,000 lone parents into work; and
- Increase by 1 million the number of older workers.

www.dwp.gov.uk/mediacentre/pressreleases/2006/jan/fmc068-240106.asp

The 'Economic Vision for Northern Ireland ' - closing the productivity gap with the UK in GVA and increasing the percentage of the working age population who are economically active.

<http://www.detini.gov.uk/cgi-bin/moreutil?utilid=450&site=3&util=2&fold=&parent=>

- improving skills;
- promoting health and safety; bringing about a better work-life balance (aspects of which include: maternity review, adoptive leave, parental leave, national framework committee for work/life policies, workplace childcare, and a fully inclusive social insurance model); and developing integrated policies for migrant workers.

The Equal Opportunities Childcare Programme 2000-2006 (EOCP) This programme funds applications for childcare service provision throughout the country. The funding is provided under the NDP, with the assistance of the ERDF and ESF (NAP/Inclusion 2003-2005).

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Unemployment

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Work

NORTH-SOUTH COMPARABILITY

Separate North and South components

LAY DESCRIPTION

Percentage of working age people aged 15-64 years involuntarily excluded from work

SOURCE REFERENCE

eHPI: IB3_2

INDICATOR NAMES

Pct unemployment NI; Pct unemployment RoI

DATA DEFINITION – NORTHERN IRELAND

Percentage of people aged 15-64 years who are in receipt of Incapacity Benefit, Severe Disability Allowance, or included in the unemployment claimant count

Published?	Yes www.ninis.nisra.gov.uk	Geography	Ward LGD HSSB
Frequency	Every year	Latest Year	2007
Numerator Definition	Number of people who are in receipt of Incapacity Benefit, Severe Disability Allowance, or included in the unemployment claimant count	Geography	LGD
Source Denominator		Year	2007
Definition Source	Number of people aged 15-64 years NISRA	Geography Year	LGD 2007

DATA ISSUES

The components are not directly comparable between Northern Ireland and Republic of Ireland as they refer to different social welfare systems.

DATA DEFINITION – REPUBLIC OF IRELAND

Percentage of people aged 15-64 years who are in receipt of Disability Benefit

Published?	Yes Statistical Information on Social Welfare Services	Geography	County
Frequency	Every year	Latest Year	2007
Numerator Definition	Number of people aged 15-64 who are in receipt of Disability Benefit	Geography	County
Source Denominator	Department of Social and Family Affairs	Year	2006
Definition Source	Number of people aged 15-64 years Census	Geography Year	County 2006

DATA ISSUES

The components are not directly comparable between Northern Ireland and Republic of Ireland as they refer to different social welfare systems.

PUBLIC HEALTH IMPORTANCE

Unemployment puts health at risk, and the risk is higher in deprived regions where unemployment is widespread. The effects on health of unemployment result from psychological consequences and financial problems for individuals, but are also related to the impact of reduced productivity on economic prosperity, which can lessen society's ability to address socio economic disadvantage and reduce health inequalities (WHO, 2003). Health on the other hand affects employment, and a healthy workforce is necessary for economic success (Surckhe *et al*, 2005). Unemployment threatens the benefits to mental health from employment through structured time, social contact and satisfaction arising from involvement with a collective effort, all of which impact on aspects of life that are important to health, including family and social life (Institute of Public Health, 2005). Job insecurity can lead to sickness absence, which predicts the risks of illness and dying. Long working hours on the other hand are linked to cardiovascular disease, diabetes and a sense of poor health and fatigue (WHO, 2003). While the psychosocial environment at work is an important determinant of health and contributor to the social gradient in ill health, the loss of income from paid employment can place people at risk of poverty and the adverse effects of living with less opportunity than wealthier people to enjoy good health, live in decent housing, eat wholesome food, access appropriate education, participate in community life and have supportive social relationships. Living in or at risk of poverty can be stressful, difficult and harmful, but the distribution of low income can be different from that of worklessness and deprivation, depending on levels of pay and redistributive social welfare policies. Wealthy countries with high levels of income redistribution through taxation and welfare policies reduce the number of people at risk of or living in poverty and achieve greater financial equality, which is associated with better population health outcomes (Wilkinson & Pickett, 2007).

POLICY CONTEXT – NORTHERN IRELAND

POLICY CONTEXT – REPUBLIC OF IRELAND

Unemployment

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Work

The public health strategy for Northern Ireland, *Investing for Health* (DHSSPS, 2002) www.dhsspsni.gov.uk identifies the workplace as a priority setting for improving population health and aims to reduce work related ill health, create health promoting working environments and support people to return to work. It emphasises the link between poverty, low income and unemployment, leading to multiple deprivation on known health determinants of disadvantaged communities, families with children and other vulnerable people. It undertakes to address adult literacy problems and other barriers to employment.

The Workplace Health Strategy for Northern Ireland *Working for Health* (HSENI, 2003) www.hseni.gov.uk has been developed by the Occupational Health Forum for Northern Ireland as a long-term strategy, not only to reduce the incidence of work related ill health, but also to fully exploit the workplace as a priority setting for the health of our people generally. The Northern Ireland Workplace Health Network was established to support the *Working for Health* strategy and improve workplace health management. The Department of Enterprise, Trade and Investment (DETI) in cooperation with the Department of Employment and Learning (DEL) and Investing for Health (IfH) aims at improving the health of employees, especially those with existing health problems and disability.

The *Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2004) www.dhsspsni.gov.uk emphasises the need for cross departmental and interagency partnerships to ensure that those least able to access the labour market are provided with meaningful employment opportunities by supporting the unemployed, improving skills and promoting the health and wellbeing of those seeking employment.

The *Shared Future Policy and Strategic Framework for Good Relations in Northern Ireland and the Racial Equality Strategy for Northern Ireland* (OFMDFM, 2005) www.ofmdfm.gov.uk undertake to establish a society with equal opportunity for all.

The *Economic Vision for Northern Ireland* (DETI, 2005) www.detni.gov.uk aims to improve global competitiveness by closing the gap with the remainder of the United Kingdom (UK) and increasing Northern Ireland's percentage of the working age population who are economically active. It proposes to increase investment in research and development, encourage enterprise, develop skills and provide a modern infrastructure to support business and consumers.

Social security in Northern Ireland is governed by the principle of parity with Great Britain. Policy change is therefore UK wide. The Green Paper *A new deal for welfare: Empowering people to work* (Department for Work and Pensions (DWP, 2006) www.dwp.gov.uk states the Government's responsibility to ensure that citizens have the right and are supported to enter the world of work. It undertakes to break down barriers that prevent many from fulfilling their potential, impede social mobility and through economic inactivity put people at risk of or into poverty and disadvantage. It aims (UK wide):

- To reduce by one million the number of people on incapacity benefits,
- To help 300,000 lone parents into work, and
- To increase by one million the number of older workers.

The *Success through Skills: The Skills Strategy for Northern Ireland* (DEL, 2006) www.delni.gov.uk is the Government's interagency approach to improving skills, productivity and competitiveness of the workforce, thereby increasing people's chances for employment.

Pathways to Work (Department for Employment and Learning (DEL), Department for Social

The National Economic and Social Council (NESC) advises the Irish Government on efficient development of the economy and achievement of social justice as well as social partnership agreements. *The Developmental Welfare State* (NESC, 2005) www.nesc.ie suggests to build consensus across social partners, government and society in a coherent debate that addresses Ireland's social deficits towards integrated policies for employment, social inclusion and economic reform. It challenges the focus on total employment growth and unemployment reduction, calling for an assessment of training and lifelong learning practices, creation of equal opportunity in the labour market and effectiveness of social inclusion and antipoverty strategies.

The *NESC Strategy 2006: People, Productivity and Purpose* (NESC, 2005) www.nesc.ie emphasises the importance of greater participation, social protection and care, more social mobility and successful handling of diversity. It criticises the benefit traps created by erosion of income eligibility thresholds and the contingency basis of benefits, which can encourage people to cling to a status which secures income at such low levels that many recipients are vulnerable to poverty, debt and low self-esteem. It recommends that benefit recipients, like the unemployed, should be regularly reassessed to identify opportunities and reassess options for improvements to their situation.

The *Ten- Year Framework Social Partnership Agreement 2006-2015 Towards 2016* www.taoiseach.gov.ie underpins the NESC vision and places a focus on employability, access to employment and income, improved health outcomes and support for caring responsibilities. It especially recognises the needs of young adults for education, training and employment, health and social services, in respect of people with disabilities, it states that the National Disability Strategy (National Disability Authority, 2004) www.nda.ie will be implemented with particular regard to health and education services, income and measures to promote employment. It aims:

- To implement policies to increase employment levels with the goal of exceeding the EU Lisbon employment rate targets for 2010 of 70% overall, 60% for females and 50% for older workers.

The *National Development Plan Transforming Ireland- A Better Quality of Life for All 2007- 2013* <http://www.esri.ie> sets out a roadmap for economic and societal approaches to challenges arising from continuing population increases and less rapid economic growth and development. It integrates strategic development frameworks for regional development, rural communities, all island co-operation, environmental protection and social inclusion with common economic and social goals. It emphasises the need to remove infrastructural bottlenecks constraining economic development, balanced regional development and environmental sustainability by investing € 184 billion in economic and social infrastructure, enterprise, science and agriculture sectors and in the social fabric of society, creating a vibrant economy and high value employment opportunities:

- To increase the labour force by 2.0- 2.5% per annum

The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie proposes to support working age people and people with disabilities, through activation measures and service provision to increase employment and participation. It commits:

- To increasing the employment and participation of people with disabilities by bringing an additional 7,000 into employment by 2010, raise the employment rate of people with disabilities from 37% to 45% and the overall participation rate in education, training and employment to 50% by 2016 and
- To reduce by 20% the number of those whose total income is derived from long term social welfare payments by 2016.

Unemployment

Stage: Intervening factors

Level: Behaviours and environments (Individual)

Theme: Work

Development (DSD) and Department of Health, Social Services and Public Safety (DHSSPS, 2007) www.delni.gov.uk is an interdepartmental initiative to support lone parents and people with health conditions towards meaningful employment decisions.

The *Government's Anti- Poverty and Social inclusion Strategy for Northern Ireland* (OFMDFM, 2007) www.ofmdfm.gov.uk aims to eliminate poverty, area based deprivation and inequalities in the labour market, ultimately addressing health inequalities and intergenerational cycles of deprivation. Economic development, skills and employment support programmes are to improve people's chances of gainful employment. It aims:

- To contribute to an UK employment rate aspiration of 80% by 2050 and ab overall UK lone parent employment target rate of 70% by 2010,
- To double by 2020 the percentage of young people who have left care and are in employment, higher or further education or training at age 19,
- To provide flexibility of choice over retirement age by 2020.

The *Welfare Reform Bill* (DSD, 2007) www.dsdni.gov.uk introduces reform to the Northern Ireland Social Care System for people on benefits for ill health and aims to contribute to increasing the employment rate for people of working age, increasing social inclusion by creating opportunities for disadvantaged people. It replaces incapacity benefits with a new Employment and Support allowance in line with the remainder of the United Kingdom.

This recommendation is included in the Northern Ireland's Programme for Government 2008-2011 (OFMDFM, 2007) www.pfgbudgetni.gov.uk under Public Service Agreement (PSA) 3, which aims to increase employment levels subject to economic conditions and reduce economic inactivity by addressing the barriers to employment and providing effective careers advice. The target is:

- To assist 70,000 working age benefit clients to move into employment by March 2011.

Further targets under PSA 3 are based on the *Northern Ireland Draft Regional Economic Strategy* (DFP, 2007) www.dfpni.gov.uk and the *Northern Ireland Department of Enterprise, Trade and Investment Corporate Plan 2008- 2011* (DETI, 2008) www.detni.gov.uk, which outlines economic priorities identified in the *Northern Ireland Programme for Government* (OFMDFM, 2007) www.pfgbudgetni.gov.uk and proposes to share appropriate objectives with the Northern Ireland Department of Employment and Learning (DEL), given the importance of an increasingly skilled labour force for economic prosperity and development.

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Spend on medical and surgical specialties

Stage: Situation of health

Level: Resourcing for health and social care

Theme: Health care resourcing

NORTH-SOUTH COMPARABILITY	North only component		
LAY DESCRIPTION	Expenditure on medical and surgical Programmes of Care per person. Expenditure on mental health is excluded.		
SOURCE REFERENCE	eHPI: SR1_1; SR1_2		
INDICATOR NAME	Medical/surgical exp NI		
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Expenditure on Acute Services, Maternity & Child Health, Family & Child Care, Elderly Care, Learning Disability, Physical and Sensory Disability, Health Promotion & Disease Prevention, and Primary Health & Adult Community Programmes of Care per needs-weighted population			
Published?	Yes DHSSPS Strategic Resources Framework 2007-2008 Appendices	Geography	Local Commissioning Group Areas
Frequency	Every year	Latest Year	2007/2008
Numerator Definition	Expenditure Acute Services, Maternity & Child Health, Family & Child Care, Elderly Care, Learning Disability, Physical and Sensory Disability, Health Promotion & Disease Prevention, and Primary Health & Adult Community Programmes of Care	Geography	LGD
Source	DHSSPS	Year	2007/2008
Denominator Definition	Needs-weighted population	Geography	LGD
Source	DHSSPS	Year	2006
DATA ISSUES		DATA ISSUES	
An LGD's value is assumed to be equal to its Local Commissioning Group Area value. This will mask any LGD variation within that Local Commissioning Group Area. There are seven Local Commissioning Group Areas.			
The English HPI reports expenditure on medical and surgical specialties separately. Expenditure on medical and surgical specialties are not separate in Northern Ireland's Programmes of Care.			
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	

Spend on medical and surgical specialties

Stage: Situation of health

Level: Resourcing for health and social care

Theme: Health care resourcing

The Appleby Report www.bmc.n-i.nhs.uk/viewpagelist.asp?id=55 identified that NI spends 7% more per head of population than the UK average (2004/5).

The SRF is designed to identify spend across Programme of Care by local area to identify inequity.

Health Care Resourcing

Overall, the two major influences on health spending are ageing and the expectation of and demand for higher standards. The factors behind a generally rising demand for health services can be summarised as (DHC, 2002):! Previously unmet need. Medical conditions that lower social groups, in particularly their older members, and other people discouraged by lengthy waiting times and the expense of treatment 'put up with' is translated into demand for health services accordingly as the services improve;

- The availability of new services (technological advances in diagnosis and treatment; the development of new services [e.g., magnetic resonance imaging, non-invasive surgery, etc.]; the availability of new drugs and medicines);
- Increasingly accessible health information through public bodies, the media and the internet;
- The increasing demand for the active treatment of chronic conditions;
- Higher per capita income. As people become wealthier, they place more priority on avoiding discomfort as well as alleviating pain, on preventative health measures as well as on curative, on personally tailored and immediate health services rather than on standardised treatments for which they may have to wait; and
- A larger, more educated, more self-confident and assertive population. This is largely a positive development as increased awareness and vigilance by patients contributes to driving up standards. However, it also entails a more litigious health system and rising medical insurance premiums.

Current public spending on health in Ireland is broadly comparable to other countries in the share of national resources being devoted to it. That Ireland, nevertheless, has poor relative health outcomes suggests better use can be made of the resources being devoted to health. This is not just a challenge to the management of health organisations and the ethos of health professionals but underlines the need for co-responsibility for health to be exercised right across Irish society (in use of alcohol, diet, etc.)

(Source: NESC & NESDO 2005 The Developmental Welfare State)

Comparative Public Health Spending & Health-Related Outcomes

The rise in public health spending in Ireland since 1997 has been dramatic, yet there is a generalised concern that the public health services have not only not improved but deteriorated. Partly as a result, a major reform programme began in 2005 whose impact will need some years before it can be assessed. By 2002, public spending on health as a proportion of GDP/GNP put Ireland in the top third of EU 15 member states, while its per capita spending in constant purchasing power terms was the 6th highest of the 14 countries listed (Denmark, Sweden, Finland, Austria, Netherlands, Germany, France, Belgium, United Kingdom, Ireland, Italy, Greece, Spain, Portugal). Individual traits, lifestyle choices, social and community networks, and wider socio-economic and cultural factors all mediate the individual's need for health services (DoHC, 2001) and, thus, the levels of health service usage that support any given health outcome. Major changes in socio-economic conditions and lifestyle over the past two decades have accompanied the large increase in public health spending that has occurred. Falling unemployment, lower levels of deprivation, rising educational attainment, more self-direction in the workplace and less smoking, for example, can be expected to have made major contributions to improving people's health status.

Spend on medical and surgical specialties

Stage: Situation of health

Level: Resourcing for health and social care

Theme: Health care resourcing

On the other hand, the very ability to keep people with severe disabilities alive longer, the growing number of advanced elderly people, the rise in alcohol consumption, rising obesity levels, higher immigration from developing countries, growing relationship instability and the higher incidence of people living alone — are some factors which can be expected to be making even a population more intensive in its use of health services even to maintain its health status.

Current public spending on health in Ireland is broadly comparable to other countries in the share of national resources being devoted to it. That Ireland, nevertheless, has poor relative health outcomes suggests better use can be made of the resources being devoted to health. This is not just a challenge to the management of health organisations and the ethos of health professionals but underlines the need for co-responsibility for health to be exercised right across Irish society (in use of alcohol, diet, etc.)

(Source: NECS & NESDO 2005 The Developmental Welfare State)

Spending on health care, disability and sickness grew particularly strongly in Ireland compared to the rest of the EU during the 1990s. In 1993, expenditure on the function Sickness/Health Care was 34.8 per cent of all social protection expenditure in Ireland as against an EU 15 average of 28 per cent; by 2001, it was 43.4 per cent in Ireland as against an EU 15 average of 28 per cent. In 2001, spending in Ireland on the sickness/health care function as a proportion all social protection expenditure was higher than anywhere else in the EU 15 (*European Social Statistics, Social Protection: Expenditure and Receipts Data 1992-2001*).

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Spend on psychiatric specialties

Stage: Situation of health

Level: Resourcing for health and social care

Theme: Health care resourcing

NORTH-SOUTH COMPARABILITY	North only component
LAY DESCRIPTION	Expenditure on Mental Health Programme of Care per person
SOURCE REFERENCE	eHPI: SR1_3
INDICATOR NAME	Psychiatric expenditure NI

DATA DEFINITION – NORTHERN IRELAND			
Expenditure on Mental Health Programme of Care per needs-weighted population			
Published?	Yes	Geography	Local
	DHSSPS Strategic Resources		Commissioning
	Framework 2007-2008 Appendices		Group Areas
Frequency	Every year	Latest Year	2007/2008
Numerator			
Definition	Expenditure on Mental Health Programme of Care	Geography	LGD
Source	DHSSPS	Year	2007/2008
Denominator			
Definition	Needs-weighted population	Geography	LGD
Source	DHSSPS	Year	2006
DATA ISSUES			
An LGD's value is assumed to be equal to its Local Commissioning Group Area value. This will mask any LGD variation within that Local Commissioning Group Area. There are seven Local Commissioning Group Areas.			
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND			
The Appleby Report www.bmc.n-i.nhs.uk/viewpagelist.asp?id=55 identified that NI spends 7% more per head of population than the UK average (2004/5). Bring in Barnet etc.			
The SRF is designed to identify spend across Programme of Care by local area to identify inequity.			

DATA DEFINITION – REPUBLIC OF IRELAND	
Published?	Geography
Frequency	Latest Year
Definition	Geography
Source	Year
Definition	Geography
Source	Year
DATA ISSUES	
POLICY CONTEXT – REPUBLIC OF IRELAND	
Comparative Public Health Spending & Health-Related Outcomes	
The rise in public health spending in Ireland since 1997 has been dramatic, yet there is a generalised concern that the public health services have not only not improved but deteriorated. Partly as a result, a major reform programme began in 2005 whose impact will need some years before it can be assessed. By 2002, public spending on health as a proportion of GDP/GNP put Ireland in the top third of EU 15 member states, while its per capita spending in constant purchasing power terms was the 6th highest of the 14 countries listed (Denmark, Sweden, Finland, Austria, Netherlands, Germany, France, Belgium, United Kingdom, Ireland, Italy, Greece, Spain, Portugal). Individual traits, lifestyle choices, social and community networks, and wider socio-economic and cultural factors all mediate the individual's need for health services (DoHC, 2001) and, thus, the levels of health service usage that support any given health outcome. Major changes in socio-economic conditions and lifestyle over the past two decades have accompanied the large increase in public health spending that has occurred.	

Spend on psychiatric specialties

Stage: Situation of health

Level: Resourcing for health and social care

Theme: Health care resourcing

Falling unemployment, lower levels of deprivation, rising educational attainment, more self-direction in the workplace and less smoking, for example, can be expected to have made major contributions to improving people's health status. On the other hand, the very ability to keep people with severe disabilities alive longer, the growing number of advanced elderly people, the rise in alcohol consumption, rising obesity levels, higher immigration from developing countries, growing relationship instability and the higher incidence of people living alone — are some factors which can be expected to be making even a population more intensive in its use of health services even to maintain its health status.

Current public spending on health in Ireland is broadly comparable to other countries in the share of national resources being devoted to it. That Ireland, nevertheless, has poor relative health outcomes suggests better use can be made of the resources being devoted to health.

This is not just a challenge to the management of health organisations and the ethos of health professionals but underlines the need for co-responsibility for health to be exercised right across Irish society (in use of alcohol, diet, etc.)

(Source: NECS & NESDO 2005 The Developmental Welfare State)

Spending on health care, disability and sickness grew particularly strongly in Ireland compared to the rest of the EU during the 1990s. In 1993, expenditure on the function Sickness/Health Care was 34.8 per cent of all social protection expenditure in Ireland as against an EU 15 average of 28 per cent; by 2001, it was 43.4 per cent in Ireland as against an EU 15 average of 28 per cent. In 2001, spending in Ireland on the sickness/health care function as a proportion all social protection expenditure was higher than anywhere else in the EU 15 (European Social Statistics, Social Protection: Expenditure and Receipts Data 1992-2001).

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Spend on personal social services

Stage: Situation of health

Level: Resourcing for health and social care

Theme: Social care resourcing

NORTH-SOUTH COMPARABILITY	North only component		
LAY DESCRIPTION	Expenditure on personal and social services per person		
SOURCE REFERENCE	eHPI: SR2_1		
INDICATOR NAME	Personal social services exp NI		
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Expenditure on Family & Child Care, Elderly Care, Mental Health, Learning Disability, and Physical and Sensory Disability Programmes of Care per needs-weighted population			
Published?	Yes DHSSPS Strategic Resources Framework 2007-2008 Appendices	Geography	Local Commissioning Group Areas
Frequency	Every year	Latest Year	2007/2008
Numerator Definition	Expenditure on Family & Child Care, Elderly Care, Mental Health, Learning Disability, and Physical and Sensory Disability Programmes of Care	Geography	LGD
Source	DHSSPS	Year	2007/2008
Denominator Definition	Needs-weighted population	Geography	LGD
Source	DHSSPS	Year	2006
DATA ISSUES		DATA ISSUES	
An LGD's value is assumed to be equal to its Local Commissioning Group Area value. This will mask any LGD variation within that Local Commissioning Group Area. There are seven Local Commissioning Group Areas.			
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
Personal Social Services expenditure in Northern Ireland is through the Four Health and Social Services Boards rather than the local authority model as in England.		Comparative Public Health Spending & Health-Related Outcomes	
As distinct from one personal social services strategy there are a range of strategies and targets covering particular client groups such as children, mental health or elderly.		The rise in public health spending in Ireland since 1997 has been dramatic, yet there is a generalised concern that the public health services have not only not improved but deteriorated. Partly as a result, a major reform programme began in 2005 whose impact will need some years before it can be assessed. By 2002, public spending on health as a proportion of GDP/GNP put	
The broad strategies of developing primary care in Caring For Tomorrow (2005)			

Spend on personal social services

Stage: Situation of health

Level: Resourcing for health and social care

Theme: Social care resourcing

www.dhsspsni.gov.uk/index/hss/primary_care-strategy.htm

Caring for People Beyond Tomorrow sets out the Department's policy position through a Vision Statement for a future Primary Care Service, and a policy framework designed to steer the future development of policies and services in primary care.

The broad strategy of 'A healthier Future' (ref) is has key elements which are directly related to the provision or resourcing of Personal Social Services

- Secure an appropriate balance between hospital and community based services within local health economies;
- Continue the expansion and evaluation of intermediate care as a way of working that is designed to prevent unnecessary hospital admission, promote faster recovery from illness, support timely discharge, maximise independent living and improve the quality of assessment of long-term health and social care needs;
- In co-operation with the independent sector, expand the use of supported living, domiciliary care, day care and assistive technologies as alternatives to residential accommodation, focusing on rehabilitation and independent living;
- Develop a range of housing and care options for different levels of support, offering a continuum of care as people's needs change;
- Contribute to the development of a region-wide single assessment process, focused upon the person and designed to streamline and improve decision making about long-term health and social care needs and simplify access to services;
- Expand the range of flexible and responsive respite and support services for carers;
- Increase the take up of Direct Payments; and

None directly on PSS expenditure.

Ireland in the top third of EU 15 member states, while its per capita spending in constant purchasing power terms was the 6th highest of the 14 countries listed (Denmark, Sweden, Finland, Austria, Netherlands, Germany, France, Belgium, United Kingdom, Ireland, Italy, Greece, Spain, Portugal).

Individual traits, lifestyle choices, social and community networks, and wider socio-economic and cultural factors all mediate the individual's need for health services (DoHC, 2001) and, thus, the levels of health service usage that support any given health outcome. Major changes in socio-economic conditions and lifestyle over the past two decades have accompanied the large increase in public health spending that has occurred. Falling unemployment, lower levels of deprivation, rising educational attainment, more self-direction in the workplace and less smoking, for example, can be expected to have made major contributions to improving people's health status. On the other hand, the very ability to keep people with severe disabilities alive longer, the growing number of advanced elderly people, the rise in alcohol consumption, rising obesity levels, higher immigration from developing countries, growing relationship instability and the higher incidence of people living alone — are some factors which can be expected to be making even a population more intensive in its use of health services even to maintain its health status.

Current public spending on health in Ireland is broadly comparable to other countries in the share of national resources being devoted to it. That Ireland, nevertheless, has poor relative health outcomes suggests better use can be made of the resources being devoted to health. This is not just a challenge to the management of health organisations and the ethos of health professionals but underlines the need for co-responsibility for health to be exercised right across Irish society (in use of alcohol, diet, etc.)
(Source: NECS & NESDO 2005 *The Developmental Welfare State*)

Spending on health care, disability and sickness grew particularly strongly in Ireland compared to the rest of the EU during the 1990s. In 1993, expenditure on the function Sickness/Health Care was 34.8 per cent of all social protection expenditure in Ireland as against an EU 15 average of 28 per cent; by 2001, it was 43.4 per cent in Ireland as against an EU 15 average of 28 per cent. In 2001, spending in Ireland on the sickness/health care function as a proportion all social protection expenditure was higher than anywhere else in the EU 15 (*European Social Statistics, Social Protection: Expenditure and Receipts Data 1992-2001*).

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CABG/angioplasty by need

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Access to secondary care

NORTH-SOUTH COMPARABILITY LAY DESCRIPTION		Separate North and South components	
SOURCE REFERENCE		The rate of admissions to hospital for coronary artery bypass graft or angioplasty per 100,000 European standard population. This component is intended to measure met need for coronary artery bypass graft or angioplasty.	
INDICATOR NAMES		eHPI: SA2_3 DSR CABG NI; DSR CABG RoI	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Published?	Geography	Published?	Geography
Frequency	Latest Year	Frequency	Latest Year
Numerator		Numerator	
Definition	Geography	Definition	Geography
Source	Year	Source	Year
Denominator		Denominator	
Definition	Geography	Definition	Geography
Source	Year	Source	Year
DATA ISSUES		DATA ISSUES	
		Includes primary and secondary diagnoses.	
		The components are not directly comparable between Northern Ireland and Republic of Ireland due to different classification systems for procedures.	
		The crude rate was directly age and gender standardised to the European standard population.	
		Values for five or less cases in a particular combination of age, sex, and area were not disclosed. The value was assumed to be three.	
		Excludes admissions to private hospitals.	
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
Increasing access to services for people suffering from heart disease, cancer and renal failure by providing improved access to cardiac surgery, making available additional resources to meet the development of Trauma & Orthopaedic (T&O) departments in Antrim and Craigavon Area Hospital. ‘Developing Better Services – January 2004’ http://www.shssb.org/document_library/downloads/dbsnewsletter-Issue2.pdf		There are currently no specific strategic policies relevant to this component measure in the RoI	
Highlights that we have the longest waiting lists in the United Kingdom.			
This has been the subject of major initiatives in recent years involving non Northern Ireland			

CABG/angioplasty by need

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Access to secondary care

and non NHS providers as well as local hospital trusts.

Waiting list Targets since 2000

No Patient should be waiting in excess of 18 months (or 12 months for cardiac surgery) for admission to hospital.

PSA Targets: www.dhsspsni.gov.uk/pfa_2007-08.pdf

By April 2004 take forward the cardiac surgery and cardiology action plan by:

- Investing in staff and equipment for the local cardiac surgery centre; and
- Purchasing, where appropriate, additional procedures outside Northern Ireland.

By the end of March 2007, the HPSS should have met its targets that no-one on the inpatient/day case list should have been waiting more than six months. At April 2006 there were nearly 74,000.

Elective Care (consultant-led) as outlined in 'A Healthier Future': A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025

By March 2008, no patient should wait longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment.

www.dhsspsni.gov.uk/consultation_summary.pdf

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Cataract removal by need

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Access to secondary care

NORTH-SOUTH COMPARABILITY

Separate North and South components

LAY DESCRIPTION

The rate of admissions to hospital for cataract removals per 100,000 European standard population. This component is intended to measure met need for cataract removals.

SOURCE REFERENCE

eHPI: SA2_2

INDICATOR NAMES

DSR cataract NI; DSR cataract Rol

DATA DEFINITION – NORTHERN IRELAND

Directly age and gender standardised rate of admissions to hospital for cataract removals per 100,000 European standard population. ICD 10 codes C71, C72, C74, C75

Published?	No	Geography	N/a
Frequency	N/a	Latest Year	N/a
Numerator			
Definition	Number of admissions to hospital for cataract removals	Geography	LGD
Source	Hospital Inpatients System, DHSSPS	Year	2005/2006
Denominator			
Definition	Mid-year population estimate	Geography	LGD
Source	NISRA	Year	2005

DATA ISSUES

Includes primary and secondary diagnoses.

The components are not directly comparable between Northern Ireland and Republic of Ireland due to different classification systems for procedures.

The crude rate was directly age and gender standardised to the European standard population.

DATA DEFINITION – REPUBLIC OF IRELAND

Directly age and gender standardised rate of admissions to hospital for cataract removals per 100,000 European standard population. Australian Classification of Health Interventions (ACHI) Blocks 195-201.

Published?	No	Geography	N/a
Frequency	N/a	Latest Year	N/a
Numerator			
Definition	Number of admissions to hospital for cataract removals	Geography	County
Source	Hospital Inpatient Enquiry (HIPE)	Year	2005
Denominator			
Definition	Mid-year population estimate	Geography	County
Source	Public Health Information System	Year	2005

DATA ISSUES

Includes primary and secondary diagnoses.

The components are not directly comparable between Northern Ireland and Republic of Ireland due to different classification systems for procedures.

The crude rate was directly age and gender standardised to the European standard population.

Values for five or less cases in a particular combination of age, sex, and area were not disclosed. The value was assumed to be three.

Excludes admissions to private hospitals.

PUBLIC HEALTH IMPORTANCE

POLICY CONTEXT – NORTHERN IRELAND

Increasing access to services for people suffering from heart disease, cancer and renal failure by providing improved access to cardiac surgery, making available additional resources to meet the development of Trauma & Orthopaedic (T&O) departments in Antrim and Craigavon

POLICY CONTEXT – REPUBLIC OF IRELAND

There are currently no specific strategic policies relevant to this component measure in the Rol

Cataract removal by need

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Access to secondary care

Area Hospital. 'Developing Better Services – January 2004'
http://www.shssb.org/document_library/downloads/dbsnewsletter-Issue2.pdf

Highlights that we have the longest waiting lists in the United Kingdom.

This has been the subject of major initiatives in recent years involving non Northern Ireland and non NHS providers as well as local hospital trusts.

Waiting list Targets since 2000

No Patient should be waiting in excess of 18 months (or 12 months for cardiac surgery) for admission to hospital.

PSA Targets: www.dhsspsni.gov.uk/pfa_2007-08.pdf

By the end of March 2007, the HPSS should have met its targets that no-one on the inpatient/day case list should have been waiting more than six months. At April 2006 there were nearly 74,000.

Elective Care (consultant-led) as outlined in 'A Healthier Future': A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025

By March 2008, no patient should wait longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment.

www.dhsspsni.gov.uk/consultation_summary.pdf

[Return to Technical Details](#)

Joint replacement by need

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Access to secondary care

NORTH-SOUTH COMPARABILITY

Separate North and South components

LAY DESCRIPTION

The rate of admissions to hospital for knee or hip replacements per 100,000 European standard population. This component is intended to measure met need for knee or hip replacements.

SOURCE REFERENCE

eHPI: SA2_1

INDICATOR NAMES

DSR joint replace NI; DSR joint replace RoI

DATA DEFINITION – NORTHERN IRELAND

Directly age and gender standardised rate of admissions to hospital for knee or hip replacements per 100,000 European standard population.

ICD 10 codes W371, W378, W379, W381, W388, W389, W391, W398, W399, W401, W408, W409, W411, W418, W419, W421, W428, W429

Published?	No	Geography	N/a
Frequency	N/a	Latest Year	N/a
Numerator Definition	Number of admissions to hospital for knee or hip replacements	Geography	LGD
Source	Hospital Inpatients System, DHSSPS	Year	2005/2006
Denominator Definition	Mid-year population estimate	Geography	LGD
Source	NISRA	Year	2005

DATA ISSUES

Includes primary and secondary diagnoses.

The components are not directly comparable between Northern Ireland and Republic of Ireland due to different classification systems for procedures.

The crude rate was directly age and gender standardised to the European standard population.

DATA DEFINITION – REPUBLIC OF IRELAND

Directly age and gender standardised rate of admissions to hospital for knee or hip replacements 100,000 European standard population. Australian Classification of Health Interventions (ACHI)

Block 1489: 49318-00, 49319-00; Blocks 1518 & 1519: 49518-00, 49519-00, 49521-00, 49521-01, 49521-02, 49521-03, 49524-00, 49524-01, 49534-00

Published?	No	Geography	N/a
Frequency	N/a	Latest Year	N/a
Definition	Number of admissions to hospital for knee or hip replacements	Geography	County
Source	Hospital Inpatient Enquiry (HIPE)	Year	2005
Definition	Mid-year population estimate	Geography	County
Source	Public Health Information System	Year	2005

DATA ISSUES

Includes primary and secondary diagnoses.

The components are not directly comparable between Northern Ireland and Republic of Ireland due to different classification systems for procedures.

The crude rate was directly age and gender standardised to the European standard population.

Values for five or less cases in a particular combination of age, sex, and area were not disclosed. The value was assumed to be three.

Excludes admissions to private hospitals.

PUBLIC HEALTH IMPORTANCE

POLICY CONTEXT – NORTHERN IRELAND

Increasing access to services for people suffering from heart disease, cancer and renal failure by providing improved access to cardiac surgery, making available additional resources to meet the development of Trauma & Orthopaedic (T&O) departments in Antrim and Craigavon Area Hospital. **‘Developing Better Services – January 2004’**
http://www.shssb.org/document_library/downloads/dbsnewsletter-Issue2.pdf

POLICY CONTEXT – REPUBLIC OF IRELAND

NAPS (2002)
 NAP/Inclusion (2003-2005)

One of the targets concerning older people under the NAPS (2002) and NAP/Inclusion (2003-

Joint replacement by need

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Access to secondary care

Highlights that we have the longest waiting lists in the United Kingdom.

This has been the subject of major initiatives in recent years involving non Northern Ireland and non NHS providers as well as local hospital trusts.

Waiting list Targets since 2000

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Elective Care (consultant-led) as outlined in 'A Healthier Future': A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025

By March 2008, no patient should wait longer than 13 weeks for a first outpatient appointment, 13 weeks for a diagnostic test, and 21 weeks for inpatient or day case treatment.

www.dhsspsni.gov.uk/consultation_summary.pdf

2005) is:

Access to orthopaedic services will be improved so that no one is waiting longer than 12 months for a hip replacement.

Strategic Policy Developments

Under the National Treatment Purchase Fund, one of the aims is to improve the quality of life for persons over 65 years, by improving the waiting period for a hip replacement. A new on-line Patient Treatment Register is being developed by the Fund which will allow for more accurate identification of waiting lists and waiting times.

[Return to Technical Details](#)

Residential nursing care places for over 65s

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Access to social care

NORTH-SOUTH COMPARABILITY		One South only component
LAY DESCRIPTION		Number of residential and nursing care beds for people aged 65 years or over per 1,000 people
SOURCE REFERENCE		eHPI: SA3_2
INDICATOR NAME		Residential places 65+ Rol
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND
<p>Published? Geography</p> <p>Frequency Latest Year</p> <p>Numerator Geography</p> <p>Definition Year</p> <p>Source Geography</p> <p>Denominator Year</p> <p>Definition Geography</p> <p>Source Year</p>		<p>Number of residential and nursing care beds for people aged 65 year or over per 1,000 people. Beds included consist of public residential care beds for older people and private nursing home beds.</p> <p>Published? Partly Long Stay Activity Report (DOHC) Geography Regional Health Office</p> <p>Frequency Every year Latest Year 2006</p> <p>Numerator Geography County</p> <p>Definition Number of public residential care beds for older people plus private nursing home beds Year 2008</p> <p>Source HSE Geography County</p> <p>Denominator Population Year 2006</p> <p>Definition Census</p> <p>Source</p>
DATA ISSUES		<p>DATA ISSUES</p> <p>Public residential care beds for older people consist of:</p> <ul style="list-style-type: none"> • Continuing Care (long stay) • Convalescent • Respite • Palliative Care • Rehabilitation-specific • Dementia-specific • Assessment <p>Private nursing home beds are not specifically designated for people aged over 65, however, they are predominately occupied by persons aged over 65 years.</p>
PUBLIC HEALTH IMPORTANCE		
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND
<p>'Healthy Futures'</p> <p>http://www.sdcommission.org.uk/communitiesummit/contributor.php?display=17</p>		There are currently no specific strategic policies relevant to this component measure in the Rol

Residential nursing care places for over 65s

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Access to social care

<p>This problem is exacerbated by a lack of community provision leading to delayed hospital discharges. At 31 July 2004 there were 421 patients in hospital whose discharge was delayed. Of those patients who specified a care package, 56% were awaiting a nursing care package. In addition, at 31 March 2004 there were 920 people in the community (at home or in a residential or nursing home) awaiting a care package. Were the type of care package was specified, 70% of service users were awaiting a domiciliary care package, 17% a residential care package and 13% a nursing care package.</p>	
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Social services staff per capita

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Access to social care

NORTH-SOUTH COMPARABILITY	North only component																																																								
LAY DESCRIPTION	Number of social services staff per person																																																								
SOURCE REFERENCE	eHPI: SA3_1																																																								
INDICATOR NAME	Social serv staff/capita NI																																																								
DATA DEFINITION – NORTHERN IRELAND	DATA DEFINITION – REPUBLIC OF IRELAND																																																								
<p>Number of whole time equivalent social services staff per person. Excludes social services staff with a whole time equivalent of less than or equal to 0.03. Includes unqualified support staff but does not include staff specifically graded as home helps due to the variable nature of their employment.</p> <table><tr><td>Published?</td><td>Yes</td><td>Geography</td><td>Northern Ireland</td></tr><tr><td>Frequency</td><td>DHSSPS Workforce Census</td><td>Latest Year</td><td>2007</td></tr><tr><td>Numerator</td><td>Every year</td><td></td><td></td></tr><tr><td>Definition</td><td>Number of whole time equivalent health visitors</td><td>Geography</td><td>HSCT</td></tr><tr><td>Source</td><td>DHSSPS Workforce Census</td><td>Year</td><td>2007</td></tr><tr><td>Denominator</td><td></td><td></td><td></td></tr><tr><td>Definition</td><td>Mid-year population estimate</td><td>Geography</td><td>HSCT</td></tr><tr><td>Source</td><td>NISRA</td><td>Year</td><td>2007</td></tr></table>	Published?	Yes	Geography	Northern Ireland	Frequency	DHSSPS Workforce Census	Latest Year	2007	Numerator	Every year			Definition	Number of whole time equivalent health visitors	Geography	HSCT	Source	DHSSPS Workforce Census	Year	2007	Denominator				Definition	Mid-year population estimate	Geography	HSCT	Source	NISRA	Year	2007	<table><tr><td>Published?</td><td></td><td>Geography</td><td></td></tr><tr><td>Frequency</td><td></td><td>Latest Year</td><td></td></tr><tr><td>Definition</td><td></td><td>Geography</td><td></td></tr><tr><td>Source</td><td></td><td>Year</td><td></td></tr><tr><td>Definition</td><td></td><td>Geography</td><td></td></tr><tr><td>Source</td><td></td><td>Year</td><td></td></tr></table>	Published?		Geography		Frequency		Latest Year		Definition		Geography		Source		Year		Definition		Geography		Source		Year	
Published?	Yes	Geography	Northern Ireland																																																						
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<p>An LGD's value is assumed to be equal to its HSCT value. This will mask any LGD variation within that HSCT.</p>																																																									
PUBLIC HEALTH IMPORTANCE																																																									
POLICY CONTEXT – NORTHERN IRELAND	POLICY CONTEXT – REPUBLIC OF IRELAND																																																								
<p>Social Services Staff are instrumental in the implementation of strategies to develop community and primary care and the mental health strategy. Individual strategies in social services tend to focus on client groups such as children or elderly rather than the number of social work staff.</p>	<p>There are currently no specific strategic policies relevant to this component measure in the RoI</p>																																																								

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Ambulance response times

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Accessibility to Health Services

NORTH-SOUTH COMPARABILITY	North only component
LAY DESCRIPTION	The time taken by the first ambulance to respond to each incident
SOURCE REFERENCE	AIHSC
INDICATOR NAME	Ambulance response times NI

DATA DEFINITION – NORTHERN IRELAND	DATA DEFINITION – REPUBLIC OF IRELAND																																																																				
Median response time taken by the first ambulance to respond to each incident																																																																					
<table><tr><td>Published?</td><td>Yes</td><td>Geography</td><td>LGD, HSSB</td></tr><tr><td></td><td>www.nini.nisra.gov.uk</td><td></td><td></td></tr><tr><td>Frequency</td><td>Every year</td><td>Latest Year</td><td>2006</td></tr><tr><td>Numerator</td><td></td><td></td><td></td></tr><tr><td>Definition</td><td>N/a</td><td>Geography</td><td>N/a</td></tr><tr><td>Source</td><td>N/a</td><td>Year</td><td>N/a</td></tr><tr><td>Denominator</td><td></td><td></td><td></td></tr><tr><td>Definition</td><td>N/a</td><td>Geography</td><td>N/a</td></tr><tr><td>Source</td><td>N/a</td><td>Year</td><td>N/a</td></tr></table>	Published?	Yes	Geography	LGD, HSSB		www.nini.nisra.gov.uk			Frequency	Every year	Latest Year	2006	Numerator				Definition	N/a	Geography	N/a	Source	N/a	Year	N/a	Denominator				Definition	N/a	Geography	N/a	Source	N/a	Year	N/a	<table><tr><td>Published?</td><td></td><td>Geography</td><td></td></tr><tr><td>Frequency</td><td></td><td>Latest Year</td><td></td></tr><tr><td>Numerator</td><td></td><td></td><td></td></tr><tr><td>Definition</td><td></td><td>Geography</td><td></td></tr><tr><td>Source</td><td></td><td>Year</td><td></td></tr><tr><td>Denominator</td><td></td><td></td><td></td></tr><tr><td>Definition</td><td></td><td>Geography</td><td></td></tr><tr><td>Source</td><td></td><td>Year</td><td></td></tr></table>	Published?		Geography		Frequency		Latest Year		Numerator				Definition		Geography		Source		Year		Denominator				Definition		Geography		Source		Year	
Published?	Yes	Geography	LGD, HSSB																																																																		
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The median i.e. midpoint value is reported rather than the simple average as it is unaffected by atypically long or short response times.																																																																					
PUBLIC HEALTH IMPORTANCE																																																																					
Ambulances are vehicles that provide emergency medical services and facilitate access to health care by transporting patients. They can be part of public health care systems, voluntary or privately owned by for profit organisations. Charitable organisations like the Red Cross were established in response to military conflict prior to government funded ambulance services (Wikipedia, 2008). Speed of access to health care can influence outcomes, especially in situations where patients suffer from acute and emergency health problems.																																																																					
POLICY CONTEXT – NORTHERN IRELAND	POLICY CONTEXT – REPUBLIC OF IRELAND																																																																				
<p><i>A Healthier Future – A Twenty year Vision for Health and Wellbeing in Northern Ireland 2005-2025</i> (DHSSPS, 2004) http://www.dhsspsni.gov.uk refers to a major investment programme in NIAS to create additional capacity, improve technology and skills.</p> <p>Northern Ireland Ambulance Services (NIAS) as part of the Review of Public Administration became a Health and Social Care Trust in 2007. Performance of ambulance services is governed by ORCON (Operational Research Consultancy) or New Ambulance Performance Standards.</p> <p>The Northern Ireland Executive's first <i>Programme for Government 2008- 2011</i> www.pfobudgetni.gov.uk under Public Service (PSA) 16 Investing in the health and</p>	<p>The ambulance service in the Republic of Ireland (RoI) is part of the Health Service Executive (HSE) and continues to work towards a unified national service, having originated from individual regional services administered by the former health boards until 2005.</p> <p>In line with the national health strategy <i>Quality and Fairness- A Health System for you</i> and the <i>Strategic Review of the Ambulance Service</i> (DoHC, 2001) www.dohc.ie performance indicators were added to the <i>National Performance Monitoring Framework</i> in 2006, but these are not publicly available.</p> <p>There are currently no specific strategic policies relevant to this component measure in</p>																																																																				

education estates undertakes to continue strategic capital development programmes for NIAS: To respond by 2011 to 75 % of category A (life threatening) calls within eight minutes.	Rol.
REFERENCES http://en.wikipedia.org/wiki/Emergency_medical_services_in_the_United_Kingdom accessed 002/12/2008	

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Fire response times

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Accessibility to Health Services

NORTH-SOUTH COMPARABILITY All-island component

LAY DESCRIPTION Percentage of calls received for fires where the first attendance by the fire service is within ten minutes of notification of the address

SOURCE REFERENCE AIHSC

INDICATOR NAME Fire response times

DATA DEFINITION – NORTHERN IRELAND

Percentage of calls received for fires where the first attendance by the fire service is within ten minutes of notification of the address

Published?	No	Geography	N/a
Frequency	N/a	Latest Year	N/a
Numerator Definition	Number of calls received for fires where the first attendance by the fire service is within ten minutes of notification of the address	Geography	LGD
Source	Northern Ireland Fire and Rescue Service	Year	2005
Denominator Definition	Number of calls received for fires	Geography	LGD
Source	Northern Ireland Fire and Rescue Service	Year	2005

DATA ISSUES

The island percentage was calculated using the county and Local Government District percentages weighted by their populations.

DATA DEFINITION – REPUBLIC OF IRELAND

Percentage of calls received for fires where the first attendance by the fire service is within ten minutes of notification of the address

Published?	Yes www.lgsmb.ie Service Indicators in Local Authorities Report	Geography	Local Authority
Frequency	Every year	Latest Year	2007
Numerator Definition	Number of calls received for fires where the first attendance by the fire service is within ten minutes of notification of the address	Geography	County
Source	Local Government Services Management Board	Year	2005
Denominator Definition	Number of calls received for fires	Geography	County
Source	Local Government Services Management Board	Year	2005

DATA ISSUES

The island percentage was calculated using the county and Local Government District percentages weighted by their populations.

PUBLIC HEALTH IMPORTANCE

Fire services are an important provider of emergency response and rescue services. They contribute to public health by preventing and protecting against harm arising from fire and other emergencies. Historically a trusted, respected and easily recognised public service, fire services contribute to public health promotion and education campaigns including accident prevention, home and fire safety, work with young offenders and form an integral part of emergency preparedness (www.irishfireservice.com).

POLICY CONTEXT – NORTHERN IRELAND

In Northern Ireland, the Department of Health, Social Services and Public Safety through its Public Safety Unit (PSU) is responsible for the development of policy and legislation and for monitoring of service delivery by the Northern Ireland Fire and

POLICY CONTEXT – REPUBLIC OF IRELAND

Fire and emergency services in the Republic of Ireland are governed by the 1981 Fire Services Act and the responsibility of the Department of the Environment, Heritage and Local Government (DEHLG) www.environ.ie, which oversees the Fire Service Capital

Fire response times

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Accessibility to Health Services

Rescue Service (NIFRS). PSU liaises closely with fire and rescue service provision in England, Wales, Scotland and the Republic of Ireland to enhance co-operation and joint working between fire and other services in order to increase public safety in border areas, emergency planning and health protection services. Fire Safety and Fire and Rescue Services in Northern Ireland are carried out under the Fire and Rescue Services (NI) Order 2006.

The Fire Authority for Northern Ireland published a *Northern Ireland Emergency Response Standards and Integrated Risk Management Action Plan 2006/07* (Northern Ireland Fire and Rescue Service, 2006) www.nifrs.org. It summarises the introduction of integrated risk management planning and development of local standards of emergency cover

The Northern Ireland Executive's first *Programme for Government 2008- 2011* www.pfgbudgetni.gov.uk under Public Service (PSA) 16 Investing in the health and education estates undertakes:

- To reduce, by 2011, by 5% the number of accidental fires in dwellings.

Investment Programme and, together with the Department of Health and Children www.dohc.ie, ensures collaboration in emergency planning at national and international level. Local authorities maintain fire services and are accountable to DEHLG for delivering on local government service indicators, including the time it takes to mobilise full time and part time fire brigade stations, first attendance at emergency scenes within or outside of 10 minutes, and issuing of fire safety certificates, which are published annually in local government management services board reports www.lgmsb.ie.

The Irish Government's *National Development Plan 2007-2013 Transforming Ireland A Better Quality of Live for All* (2007) <http://www.ndp.ie> includes under the community infrastructure programme commitments to continue investing in the Fire Service Capital Investment Programme.

The *Ten- Year Framework Social Partnership Agreement 2006-2015 Towards 2016* (2006) www.taoiseach.gov.ie aims to work towards balanced regional and rural development, planning, physical and social infrastructure. It endorses the Fire Services Change Programme, which addresses the key issues identified by the *Review of Fire Safety and Fire Services in Ireland*, (DEHLG, 2005) www.envirom.ie, namely community fire safety, competency based approach to recruitment, retention and career progression, enhanced safety health and welfare and development of a risk based approach to emergency cover.

REFERENCES

<http://www.irishfireservices.com> accessed 02/12/2008

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Travel time to facilities

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Accessibility to Health Services

NORTH-SOUTH COMPARABILITY	North only component
LAY DESCRIPTION	The time it takes to travel to accident & emergency or major injury unit
SOURCE REFERENCE	AIHSC
INDICATOR NAME	Travel time AE NI
DATA DEFINITION – NORTHERN IRELAND	DATA DEFINITION – REPUBLIC OF IRELAND
<p>Travel time to accident & emergency or major injury unit</p> <p>Published? Yes www.ninis.nisra.gov.uk</p> <p>Geography Ward LGD HSSB</p> <p>Frequency Latest Year 2004</p> <p>Numerator</p> <p>Definition Geography LGD</p> <p>Source Year 2006-2007</p> <p>Denominator</p> <p>Definition Geography LGD</p> <p>Source Year 2006-2007</p>	<p>Published?</p> <p>Geography</p> <p>Frequency Latest Year</p> <p>Numerator</p> <p>Definition Geography</p> <p>Source Year</p> <p>Denominator</p> <p>Definition Geography</p> <p>Source Year</p>
DATA ISSUES The travel time model used to estimate the travel times is based on calculations at Census Output Area. Travel times for Local Government District have been aggregated to provide a population weighted (based on the Census 2001) average time to facilities. The travel time model is also set up for average speeds on different grades of road and assumes for this exercise that there is no road congestion.	DATA ISSUES
PUBLIC HEALTH IMPORTANCE	
Physical distance from and socio cultural barriers to health services can lead to late detection of ill health and poorer health outcomes. Rural and otherwise remote populations might therefore utilise health services differently from other populations, potentially leading to distorted perceptions of health care needs and contributing to health inequalities, especially for vulnerable groups including women with young children, older people, socio economically disadvantaged groups, ethnic minorities and people with disability. Co located, outreach, mobile and community based services can address physical barriers to access (Commission for Rural Communities, 2008), while centralisation of services in line with governance and quality assurance requirements can lead to increased travel times for some patients.	
POLICY CONTEXT – NORTHERN IRELAND	POLICY CONTEXT – REPUBLIC OF IRELAND
There are no specific strategic policies in relation to this component for Northern Ireland.	There are no specific strategic policies in relation to this component for the Republic of Ireland.
REFERENCES Commission for Rural Communities (2008). Distance Decay. Fact Sheet CRCFO (4), London. Return to Technical Details	

Waiting times for inpatient admission

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Accessibility to Health Services

NORTH-SOUTH COMPARABILITY		North only component	
LAY DESCRIPTION		The percentage of persons waiting more than three months for an inpatient appointment or consultation	
SOURCE REFERENCE		AIHSC	
INDICATOR NAME		Waiting times inpatient NO	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
The percentage of persons waiting in excess of three months for an inpatient appointment or consultation			
Published?	Yes www.dhsspsni.gov.uk	Geography	LGD Trust HSSB
Frequency	Every year	Latest Year	2007-2008
Numerator Definition	Number of patients waiting more than three months for admission	Geography	LGD
Source	Northern Ireland Health and Social Care Inequalities Monitoring System	Year	2006-2007
Denominator Definition	Number of patients waiting for admission	Geography	LGD
Source	Northern Ireland Health and Social Care Inequalities Monitoring System	Year	2006-2007
DATA ISSUES		DATA ISSUES	
The waiting times are based on completed waits for admission.			
PUBLIC HEALTH IMPORTANCE			
Health care utilisation, including admissions to hospital, reflects the burden of chronic disease in a population, but health care practice and service configuration as well as capacity are also important influences. Non communicable diseases including chronic conditions of ill health and disability now constitute the main burden of disease globally and especially so in developed countries with adverse effects on population health, health systems and economic and social development. In Europe, the leading causes of death include cardiovascular disease, cancers and disorders of the respiratory, digestive and neuropsychiatric systems, while the main contributions to morbidity come from cardiovascular disease, neuropsychiatric conditions and cancers. Chronic illnesses now command most health care resources despite being often under diagnosed and under treated. A small number of common risk factors, including tobacco use, alcohol abuse, raised blood pressure, raised cholesterol, being overweight, low fruit and vegetable intake and physical inactivity, are responsible for most of the burden of chronic illness in developed countries. Individuals hold some personal responsibility for healthy lifestyle behaviours, disease prevention and self management, but political commitment and sustainable policies to create supportive environments are also required, especially in order to address the apparent inequalities in disease risk for disadvantaged populations (WHO, 2004). Changes in the management of chronic illness and disability are necessary to optimise use of limited health care resources and improve population health outcomes (Wanless, 2002).			
Shifting the balance of care will require changes in location of services towards community based facilities, a greater focus on long term conditions and changing roles and responsibilities for service users and providers (Johnston, Lardner & Jepson, 2008). Access to primary care has the potential to reduce the need for costly acute hospital care, but both need to be provided and accessible according to need and not ability to pay in order to be equitable (Farrell, McAvoy, Wilde <i>et al.</i> 2008). Waiting times for planned admission to			

hospital have been monitored and managed increasingly actively in recognition of their importance for access to responsive healthcare based on identified need, but improving access to planned hospital care is dependent on managing increasing demands for acute emergency care, which has resulted from changing sociodemographic population profiles and worsening burdens of disease. Delays in accessing hospital care carries costs and risks for individuals and society in terms of deterioration of health including death, avoidable pain and disability, increasing cost and complexity of required treatment and financial losses due to reduced productivity and increased reliance on social welfare, but international comparisons are hampered by differences in measuring both waiting times and costs (Hurst & Siciliani, 2003).

POLICY CONTEXT – NORTHERN IRELAND

The *Programme for Government 2008- 2011* Public Service Agreement Framework (NIE, 2008) www.pfgbudgetni.gov.uk endeavours to promote health and address health inequalities by promoting healthy lifestyles, addressing the causes of poor health and wellbeing, thereby achieving measurable reductions in health inequalities and preventable illness. Since the introduction of targets, there has been continuous improvement in the speed of access to inpatient admissions. Under Public Service Agreement (PSA) 18 'Deliver High Quality Health and Social Services' it undertakes to promote independent living and a reduction in avoidable admissions to hospital. It aims:

- To reduce waiting times for inpatient admission of day case treatment to less than 17 weeks for all patients by March 2009.
- To ensure 98% of patients with cancer begin treatment within 31 days of a decision to treat and 95% of patients urgently referred with suspected cancer will begin treatment within 62 days.

The Northern Ireland public health strategy *Investing for Health* (DHSSPS, 2002) www.dhsspsni.gov.uk is an interagency framework for partnership working to improve health and wellbeing and to reduce health inequalities. Its two main goals are to improve people's health by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability, and to reduce inequalities in health between geographic areas, socio- economic and minority groups. It recognises the improvements in health and wellbeing achieved in recent decades, but identifies high levels of cardiovascular disease, respiratory disease and cancer contributed to by unhealthy lifestyles and socioeconomic conditions, leading to many people living much of their lives in poor health and dying prematurely with huge costs to individuals and society. It also refers to the importance of mental health and wellbeing and injury prevention to improve population health, address inequalities and reduce health service utilisation.

The primary care strategy *Caring for People Beyond Tomorrow* (DHSSPS, 2004) www.dhsspsni.gov.uk acknowledges the need for health promotion, enhanced social wellbeing and disease prevention to improve population health and reduce levels of chronic illness.

A Healthier Future – A Twenty year Vision for Health and Wellbeing in Northern Ireland 2005-2025 (DHSSPS, 2004) <http://www.dhsspsni.gov.uk> undertakes to prioritise public health to reduce mortality and morbidity relating to coronary heart disease, cancers, stroke and chronic respiratory disorders. It acknowledges the significant contribution of medication related problems and multiple morbidity especially in older people to high levels of acute hospital services use. It aims to increase efficiency by avoiding unnecessary hospital admissions and includes specific primary prevention targets. It recognizes that Northern Ireland has the longest waiting lists for access to health services despite improvements since a peak in 2002.

The Regional Cancer Framework- A Cancer Control Plan for Northern Ireland (DHSSPS, 2006) <http://www.dhsspsni.gov.uk> proposed the development of specific cancer service targets, including waiting times for treatment. It considered the impact on travel times especially from rural areas for accessing cancer services centralised for reasons of quality assurance, but also acknowledged that there are other barriers to accessing health services including perceived unsuitability or inappropriateness.

The Northern Ireland Audit Office's report on The Performance of the Health Service in

POLICY CONTEXT – REPUBLIC OF IRELAND

The national health strategy *Quality and Fairness- A Health System for you* (DoHC, 2001) www.dohc.ie identified the need for continuing actions on major lifestyle factors to promote health and wellbeing and prevent illness. It acknowledged the shortage of acute hospital beds, especially in light of increasing in the overall population and older people in particular, despite increases in day care procedures, use of new health technologies and reduced inpatient stay duration, but also pointed to variations in hospital efficiency and performance. This affects especially adversely patients without private health insurance; the strategy acknowledged that acute hospital bed utilization favours private patients. It announced the establishment of a National Treatment Purchase fund to improve co operation between the public and private health sector, an increase in acute hospital bed capacity, improvements in waiting list and overall hospital management as well as enhanced primary care services. It also envisaged changes to conditions of employment for hospital consultants to improve services for public patients. It also announced the initiation of public private partnerships to help with the development of the health service infrastructure. It ultimately aimed:

- To reduce waiting times for no public patient to less than three months from referral to scheduling of treatment.

The strategic aims of the *National Health Promotion Strategy 2000-2005* (DoHC, 2000) www.dohc.ie included the promotion of healthy lifestyles to reduce the burden of chronic illness. It made particular reference to hospital admission for mental health problems and rising suicide rates in Ireland, pointing to inequalities in hospital admission rates, which appear to be higher in people from lower socioeconomic groups. The strategy's review (NUI Galway, 2004) www.nuigalway.ie called for a system to monitor the implementation of national strategies, a national research and development plan to guide evidence based policy and practice and sustainable funding.

The national Primary Care Strategy- A New Direction (DoHC, 2001) www.dohc.ie emphasised the importance of increasing health care and support capacity in communities to reduce crisis hospital admissions. It proposed the establishment of multidisciplinary primary care teams.

The National Treatment Purchase Fund (NTPF) www.ntpf.ie was established in 2002 with the aim of reducing waiting times for patients on public hospital waiting lists as quickly as possible. It is an independent statutory agency funded by the Department of Health and Children that purchases hospital treatment mainly from private hospitals in Ireland, but also in the United Kingdom and other European countries. Any patient waiting for more than three months for hospital treatment is eligible for referral to the fund either through a public health care provider or via self referral. A National Treatment Register www.nptr.ie has been established by NTPF to provide waiting time information for Irish hospitals.

Health Service Performance Monitoring is undertaken by the Department of Health and Children and the Health Service Executive through the National Performance Monitoring Framework which includes performance indicators to measure waiting times for surgical procedures amongst the elderly population and waiting times for inpatient admission amongst the general population. These data are not publicly available.

The *Strategy for Cancer Control in Ireland* (DoHC, 2006) <http://www.dohc.ie> calls for the development of information systems to monitor waiting times from diagnosis to commencing treatment for patients with cancer as part of a cancer policy indicator set.

<p>Northern Ireland (Comptroller and Auditor General, 2008) www.tso.co.uk acknowledges progress towards the Government's targets for improving access to health and social care services. In line with government targets, waiting times for inpatient admission were reduced to below 12 months in 2006 and 6 months in 2007.</p>	<p>The <i>New National Action Plan for Social Inclusion 2007- 2016</i> www.socialinclusion.ie (2006) recognises the existence of health inequalities and acknowledges the fact that people in poverty are twice as likely to suffer from a chronic illness. It proposes to reduce hospital admissions especially for the elderly through community based early intervention teams. This suggestion is endorsed in the <i>National Development Plan Transforming Ireland- A Better Quality of Life for All 2007- 2013</i> http://www.esri.ie, which provides investment to reconfigure, improve and expand health services.</p> <p>The Ten- Year Framework Social Partnership Agreement 2006-2015 <i>Towards 2016</i> (2006) www.taoiseach.gov.ie aims to improve the health and well being of the whole population and population sub-groups. It acknowledges the need to promote equity and to address a strong social class gradient in health status. It reaffirms government commitment to increasing inpatient hospital bed capacity and reducing waiting times for inpatient admission also via the NTPF.</p>
<p>REFERENCES</p> <p>World Health Organisation (2004). Towards a European Strategy on non communicable diseases. Copenhagen: Regional Committee for Europe.</p> <p>Wanless, D. (2002). Securing our future health: Taking a long term view. London: HM Treasury.</p> <p>Hurst, J., Sicilian, L. (2003) Tackling excessive waiting times for elective surgery: A comparison of policies in twelve OECD countries. Directorate for employment, labour and social affairs. OECD</p> <p>Johnston, L., Lardner, C., Jepson, R. (2008) Overview of evidence relating to shifting the balance of care: a contribution to the knowledge base. http://www.scotland.gov.uk accessed 02/10/2008</p> <p>Ham, C., York, N., Sutch, S., Shaw, R. (2003). Hospital bed utilisation in the NHS, Kaiser Permanente, and the US Medicare programme: analysis of routine data. BMJ Vol. 327, pp 1257- 1261.</p> <p>Farrell, C., McAvoy, H., Wilde, J. & Combat Poverty Agency (2008). <i>Tackling Health Inequalities- An All- Ireland Approach to Social Determinants</i>. Dublin: Combat Poverty Agency/ Institute of Public health in Ireland.</p>	

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All emergency admissions

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Effective primary/secondary care

NORTH-SOUTH COMPARABILITY		All-island component	
LAY DESCRIPTION		The rate of all emergency admissions to hospital per 100,000 European standard population	
SOURCE REFERENCE		eHPI: SA1_2	
INDICATOR NAME		DSR emer admissions	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Directly age and gender standardised rate of all emergency (i.e. non-elective) admissions to hospital per 100,000 European standard population		Directly age and gender standardised rate of all emergency (i.e. non-elective) admissions to hospital per 100,000 European standard population	
Published?	Yes, reported as standardised admission ratios. www.ninis.nisra.gov.uk	Geography	LGD, HSSB
Frequency	Every year	Latest Year	2006/2007
Numerator Definition	Number of emergency admissions to hospital	Geography	LGD
Source	Hospital Inpatients System, DHSSPS	Year	2006/2007
Denominator Definition	Mid-year population estimate	Geography	LGD
Source	NISRA	Year	2005
DATA ISSUES		DATA ISSUES	
Includes primary and secondary diagnoses.		Includes primary and secondary diagnoses.	
The crude rate was directly age and gender standardised to the European standard population.		The crude rate was directly age and gender standardised to the European standard population. Values for five or less cases in a particular combination of age, sex, and area were not disclosed. The value was assumed to be three.	
		Excludes admissions to private hospitals.	
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
Standardised admission rates for people living in wards with the highest deprivation levels are much greater than the Northern Ireland average. The difference is greatest for emergency admissions, where the rate of emergency admissions is 43% higher for all persons living in these wards than the Northern Ireland average rates. Demographic trends, medical advances, technological therapeutic developments, and increasing public expectations are all contributing to the unrelenting pressures that our doctors, nurses and other health professions face daily. Despite significant increases in activity and throughput in recent years, too many people have to wait long periods for hospital treatment, and patients requiring emergency admissions too often have to wait for a bed		In late 2004 the Minister for Health and Children announced a 10 Point Plan with a series of actions with the aim of improving the delivery of A & E services by taking a wide ranging approach, improving patient flows through A & E departments, freeing up of acute beds and providing appropriate longer term care for patients outside of the acute hospital setting. The Health Service Executive commissioned Tribal Secta to examine A&E services in Ireland. A report entitled A&E Mapping and Efficiency Review Across 10 National Hospitals - Overview was published in October 2005. This report presents the findings of a nationally commissioned piece of work across ten hospitals to identify how the application of best practice could improve the pathway of patients from admission from the emergency department to discharge.	

All emergency admissions

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Effective primary/secondary care

despite, or because of, hospitals working to full capacity.

“...development of integrated primary and community care services that prevent unnecessary hospital admissions, promote faster recovery from illness, supply timely discharge and maximize independent living in accordance with the principles of ‘People First’.”

www.ofmdfmi.gov.uk/antipovertynov06.pdf

Promoting the Efficient Use of Resources: By 2008 have achieved significant efficiency gains. A key objective will be the release of resources to be deployed flexibly in front line services through efficiency gains and service improvements of at least 2.5 per cent per annum from the 2004/5 baseline.

These efficiencies will be achieved by exercise to promote:

- Productive use of time/productivity
- Efficient procurement
- The sharing of back office functions
- Avoiding unnecessary hospital admissions

‘Developing Better Services’ is DHSSPSNI Strategy whereby the current configuration of 15 acute hospitals will be replaced by a network of nine acute hospitals supported by seven local hospitals, with additional local hospitals in other locations, as appropriate. There will be greater provision of generalist services within communities or on a day-patient or out-patient basis than is the case at present. These will include primary care services, chronic disease management, social services maintaining and enhancing independence, and much of the surgery currently provided on an inpatient basis.

There will be greater specialisation particularly within acute hospital services. This will promote the quality of services by ensuring that professionals deal with a ‘critical mass’ of similar cases to achieve sufficient expertise. New specialised medical technologies and techniques will keep more people alive who would otherwise die through illness or trauma.

http://www.dhsspsni.gov.uk/developing_better_services

http://www.dhsspsni.gov.uk/pfa_2007-08.pdf

Managing the demand on hospital services by promoting healthier ways of living, and by providing more responsive and accessible alternative services in the community so as to prevent unnecessary hospital admissions and facilitate prompt discharge.

Part of the effective target in priorities and budget 2005/2008 states “...that a wider range of conditions is expertly treated in the primary care setting (thereby reducing avoidable hospital admissions), that patients progress within the hospital smoothly and swiftly, and that they can be discharged back home or to suitable care as soon as clinically advisable.

www.planningni.gov.uk/corporate_services/business_planning/business_plans/CBP_05-08.pdf

maximising the appropriate utilisation of existing acute capacity.

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Emergency admissions for chronic conditions

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Effective primary/secondary care

NORTH-SOUTH COMPARABILITY	All-island component
LAY DESCRIPTION	The rate of emergency admissions to hospital for asthma and diabetes per 100,000 European standard population
SOURCE REFERENCE	eHPI: SA1_3
INDICATOR NAME	DSR emer adm asthma & diab
DATA DEFINITION – NORTHERN IRELAND	DATA DEFINITION – REPUBLIC OF IRELAND
Directly age and gender standardised rate of emergency admissions to hospital for asthma and diabetes (ICD 10 codes E10-E14, J45, J46) per 100,000 European standard population	Directly age and gender standardised rate of emergency admissions to hospital for asthma and diabetes (ICD 10 Australian Modification codes E10-E14, J45, J46) per 100,000 European standard population
Published? No Frequency N/a Numerator Definition Number of admissions to hospital for asthma and diabetes Source Hospital Inpatients System, DHSSPS Denominator Definition Mid-year population estimate Source NISRA	Published? No Frequency N/a Geography N/a Latest Year N/a Definition Number of admissions to hospital for asthma and diabetes Source Hospital Inpatient Enquiry (HIPE) Year 2005 Geography County Latest Year N/a
DATA ISSUES Includes primary and secondary diagnoses. The crude rate was directly age and gender standardised to the European standard population.	DATA ISSUES Includes primary and secondary diagnoses. The crude rate was directly age and gender standardised to the European standard population. Values for five or less cases in a particular combination of age, sex, and area were not disclosed. The value was assumed to be three. Excludes admissions to private hospitals.
PUBLIC HEALTH IMPORTANCE	
POLICY CONTEXT – NORTHERN IRELAND	POLICY CONTEXT – REPUBLIC OF IRELAND
Strategic Framework for Respiratory conditions 2006 http://www.dhsspsni.gov.uk/pcd_-_respiratory_framework.pdf Space to breathe – public information campaign 2007 www.spacetobreathe.org.uk/article.asp?aid=177 Chronic conditions will, over the next twenty years, be a major focus of attention for our health and social services. All chronic diseases will, where appropriate, be managed in communities with support from our hospital services. While our services will increasingly focus on chronic conditions, it is important to stress that the need for integration and team working applies equally to social care. We have made great	In November 2004 the Minister for Health and Children announced a 10 Point Plan with a series of actions with the aim of improving the delivery of A & E services by taking a wide ranging approach, improving patient flows through A & E departments, freeing up of acute beds and providing appropriate longer term care for patients outside of the acute hospital setting. The Health Service Executive commissioned Tribal Secta to examine A&E services in Ireland. A report entitled A&E Mapping and Efficiency Review Across 10 National Hospitals - Overview was published in October 2005. This report presents the findings of a nationally commissioned piece of work across ten hospitals to identify how the application of best practice could improve the pathway of patients from admission from the emergency department to discharge, maximising the appropriate utilisation of existing acute capacity.

Emergency admissions for chronic conditions

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Effective primary/secondary care

progress in recent years in protecting vulnerable members of our society. Increasingly, however, we are more aware of the risk of exploitation and abuse that some of us face.
http://www.dhsspsni.gov.uk/developing_better_services

By 2008 have established seven region-wide Chronic Condition Management (CCM) programmes.

Following approximately two years of development and consultation the DHSSPS NI published its Primary Care Strategic Framework - *Caring for People Beyond Tomorrow* - on 12 October 2005.

Caring for People Beyond Tomorrow sets out the Department's policy position through a Vision Statement for a future Primary Care Service, and a policy framework designed to steer the future development of policies and services in primary care.

Key aspects of the Strategic Framework are:

- A service focused on providing comprehensive person-centered care.
- A first point of contact that is readily accessible and responsive to meet people's needs day or night.
- A coordinated, integrated service employing a team approach with multi-agency linkages.
- An emphasis on engagement with people and communities about their care and the way services are designed and delivered.
- A focus on prevention, health education and effective self-care.

http://www.dhsspsni.gov.uk/developing_better_services

- Making primary care services more responsive by encompassing a wider range of services in the community.
- Making primary care services more accessible, by way of time to see practitioners, greater number of locations, enabling people to see appropriate practitioners and greater provision of information.
- Developing more effective partnerships and team working across organisational and professional boundaries, as a means of increasing the effectiveness of the services.
- More proactive engagement with service users about service planning, design and delivery.
- Improved premises and infrastructure, harnessing new technologies and clinical advancements.

Caring for People Beyond Tomorrow, the strategic framework for the development of primary health and social care, sets out a clear direction for the development of primary care. Boards, trusts and other primary care providers will be expected to contribute to the advancement and implementation of the implementation plan.

Two key drivers will be essential: greater coordination between health and social care practitioners, to ensure a multi-disciplinary approach to treatment and care; and more effective integration between primary, community and secondary care services, to deliver a greater number of services through more appropriate settings, closer to where people live and work.

Specifically, the primary care sector should continue to target at-risk patients and those with long-term conditions and expand and evaluate community-based services targeted at people with long-term conditions, who are frequent users of acute hospital services. Through the new

Emergency admissions for chronic conditions

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Effective primary/secondary care

GMS contract, Directed Enhanced Services will help to ensure a proactive approach to identify and provide managed care for people with chronic conditions. Furthermore, the Department has been facilitating the work of the Boards in seeking to develop a more regional approach.

www.dhsspsni.gov.uk/index/hss/priorities_for_action.htm

http://www.dhsspsni.gov.uk/pfa_2007-08.pdf

For people with chronic conditions, such as Asthma or diabetes, Boards and Trusts should work to ensure case management with personalised care plans which aim to provide the least invasive care in the least invasive settings – usually the patient's own home.

We will work to enable those with disabilities, mental health difficulties, chronic illness or terminal illness to achieve the highest possible standards of living and to be fully integrated within our society.

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GPs per capita

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Effective primary/secondary care

NORTH-SOUTH COMPARABILITY	Separate North and South components		
LAY DESCRIPTION	Number of General Practitioners per 100,000 people		
SOURCE REFERENCE	eHPI: SA1_1		
INDICATOR NAMES	GP per capita NI; GP per capita RoI		
DATA DEFINITION – NORTHERN IRELAND			
Number of General Practitioners (Unrestricted Principals or Equivalent) per 100,000 people			
Published?	Yes Central Services Agency: Family Practitioner Services Statistical Report 2006-2007	Geography	HSSB
Frequency	Every year	Latest Year	2006/2007
Numerator Definition	The number of General Practitioners (Unrestricted Principals or Equivalent)	Geography	HSSB
Source Denominator Definition	Central Services Agency	Year	2005
Source	Mid-year population estimate	Geography	LGD
	NISRA	Year	2005
DATA ISSUES			
The components are not directly comparable between Northern Ireland and Republic of Ireland as different methods are used to count the number of General Practitioners.			
An LGD's value is assumed to be equal to its HSSB value. This will mask any LGD variation within that HSSB.			
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND			
In line with the broad strategy of a primary care led service. Following approximately two years of development and consultation the DHSSPS NI published its Primary Care Strategic Framework - <i>Caring for People Beyond Tomorrow</i> - on 12 October 2005.,sets out the Department's policy position through a Vision Statement for a future Primary Care Service, and a policy framework designed to steer the future development of policies and services in primary care. www.dhsspsni.gov.uk/index/hss/primary_care-strategy.htm			
Key aspects of the Strategic Framework are: <ul style="list-style-type: none">• A service focused on providing comprehensive person-centered care.			
POLICY CONTEXT – REPUBLIC OF IRELAND			
Quality and Fairness (DoHC, 2001) Primary Care: A New Direction (DoHC, 2001)			
The Primary Care Strategy (2001) contains an action plan comprising a total of 20 actions including target dates for implementation of the primary care model throughout the country. It states that in ten years time, between 400 and 600 core primary care teams with wider providers networks will be in place. This is approximately two-thirds of the full implementation of the model.			

GPs per capita

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Effective primary/secondary care

- A first point of contact that is readily accessible and responsive to meet people's needs day or night.
- A coordinated, integrated service employing a team approach with multi-agency linkages.
- An emphasis on engagement with people and communities about their care and the way services are designed and delivered.
- A focus on prevention, health education and effective self-care.

Outcomes envisaged will include:

- Making primary care services more responsive by encompassing a wider range of services in the community.
- Making primary care services more accessible, by way of time to see practitioners, greater number of locations, enabling people to see appropriate practitioners and greater provision of information.
- Developing more effective partnerships and team working across organisational and professional boundaries, as a means of increasing the effectiveness of the services.
- More proactive engagement with service users about service planning, design and delivery.
- Improved premises and infrastructure, harnessing new technologies and clinical advancements.

Caring for People Beyond Tomorrow, the strategic framework for the development of primary health and social care, sets out a clear direction for the development of primary care. Boards, trusts and other primary care providers will be expected to contribute to the advancement and implementation of the implementation plan.

Two key drivers will be essential: greater coordination between health and social care practitioners, to ensure a multi-disciplinary approach to treatment and care; and more effective integration between primary, community and secondary care services, to deliver a greater number of services through more appropriate settings, closer to where people live and work.

Specifically, the primary care sector should continue to target at-risk patients and those with long-term conditions and expand and evaluate community-based services targeted at people with long-term conditions, who are frequent users of acute hospital services. Through the new GMS contract, Directed Enhanced Services will help to ensure a proactive approach to identify and provide managed care for people with chronic conditions. Furthermore, the Department has been facilitating the work of the Boards in seeking to develop a more regional approach.

www.dhsspsni.gov.uk/index/hss/priorities_for_action.htm

In June 2003 GPs voted throughout the United Kingdom to accept a new contract for the delivery of general medical services. This contract was the culmination of protracted negotiations which had lasted for approximately 2 years. And represents a landmark in the development of general practice. The new contract which came into effect on 1 April 2004 was accompanied by substantial uplift in investment of 33% year over the following three years.

The new contract is designed to bring about a range of improvements in primary care in providing demonstrable benefits to general practitioners, to other healthcare professionals, to the health service in general and most importantly to patients including:

- Improved access to services by local people through Health and Social Services Boards commissioning enhanced services to encourage the development of a wider

Strategic Policy Developments regarding Primary Care

The National Health Strategy, Quality and Fairness (2001), identified the central role primary care plays in a modern health system. In recognition of this central role a specific strategy namely 'Primary Care: A New Direction' was published in November 2001. This Strategy sets the direction for the development of primary care in Ireland. It proposes the delivery of a broad range of generalist services in the community by integrated multidisciplinary primary care teams and primary care networks. It sets out the vision for the future, building on existing strengths to develop a high quality, user-friendly service to meet people's health and personal social service needs.

The policy aim is to develop the capacity of primary care to meet the full range of health and personal social service needs appropriate to that setting. This will involve significantly enhanced funding for the development of primary care, in terms of staff, physical infrastructure, information and communications technology and diagnostic support. The Strategy proposes a new Model of Primary Care, based on an interdisciplinary, team based approach. Members of the primary care team will include GPs, nurses/midwives, health care assistants, home helps, physiotherapists, occupational therapists, social workers and administrative personnel, as well as other allied health professionals. <http://www.primarycare.ie/> accessed 16/6/06 (DoHC, 2001)

GPs per capita

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Effective primary/secondary care

range of services closer to home.

- Fairer funding to remove historic anomalies in the current system where funding follows the GPs in post rather than the needs of patients and the local community;
- GPs will be able to manage their workloads by enabling them to opt out of providing some services, for example, out-of-hours;
- Better management of chronic diseases through a new framework which will provide significant rewards to practices to recognise improvements in clinical standards:
- Improved organisational standards by rewarding practices which provide better records, more effective communication with patients and conduct patient surveys;

The major changes introduced by the contract will be in terms of

- Out-of-hours services
- Information and management technology
- Premises;
- Focus on quality;
- Patient experience;
- Range of services provided
-

More information is available at http://www.dhsspsni.gov.uk/hss/gp_contracts

Appointment access within 48 hours

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Operable lung cancer

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Effective primary/secondary care

NORTH-SOUTH COMPARABILITY		All-island component	
LAY DESCRIPTION		Operations for lung cancer within two years of diagnosis as a percentage of deaths due to lung cancer over a four year period	
SOURCE REFERENCE		eHPI: SA1_4	
INDICATOR NAME		Pct lung cancer proc	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
New lung cancer cases (ICD 10 C33 and C34) diagnosed during the period 2000-2003 that had tumour directed surgery before the end of the year following diagnosis as a percentage of deaths due to lung cancer during the period 2000-2003		New lung cancer cases (ICD 10 C33 and C34) diagnosed during the period 2000-2003 that had tumour directed surgery before the end of the year following diagnosis as a percentage of deaths due to lung cancer during the period 2000-2003	
Published?	No	Geography	N/a
Frequency	N/a	Latest Year	N/a
Numerator			
Definition	Number of new lung cancer cases diagnosed in 2000 that had tumour-directed treatment in 2000 or 2001 + Number of new lung cancer cases diagnosed in 2001 that had tumour-directed treatment in 2001 or 2002 + Number of new lung cancer cases diagnosed in 2002 that had tumour-directed treatment in 2002 or 2003	Geography	LGD
Source	Northern Ireland Cancer Registry	Year	2000-2003
Denominator			
Definition	Number of deaths due to lung cancer	Geography	LGD
Source	Northern Ireland Cancer Registry	Year	2000-2003
DATA ISSUES		DATA ISSUES	
Patients in the numerator have been followed up for varying lengths of time depending on what time of the year they were diagnosed.		Patients in the numerator have been followed up for varying lengths of time depending on what time of the year they were diagnosed.	
The percentage does not represent a true proportion because the population in the numerator is different than the population in the denominator eg the denominator will contain people who were diagnosed before 2000.		The percentage does not represent a true proportion because the population in the numerator is different than the population in the denominator eg the denominator will contain people who were diagnosed before 2000.	
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	

Operable lung cancer

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Effective primary/secondary care

This shows that the highest lung cancer incidence rate was in the most deprived areas, in particular among males living in such areas.

Lung Cancer.

The risk of someone living in rural areas developing lung cancer is markedly lower than for someone in non-rural areas (35% lower for males, 43% lower for females).

www.nican.n-i.nhs.uk/directory/uploads/4fe71191-547b-45d7-be72-952cfc4472b8/CSF_ProgressReport1_June2007.pdf

Lung cancer kills approximately 800 people here each year and accounts for one quarter of cancer deaths in people under 75. For women here the death rate is already twice the Western European average and increasing. According to the Chief Medical Officers (CMO) 2007, the death rate in 2005 was 824.

www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/index.htm

Northern Ireland Investing For Health

Prolonged exposure to environmental tobacco smoke increases by 30% a person's risk of lung cancer and heart disease.

It is thought that Radon in homes can lead to an increased risk of lung cancer and it is estimated that Radon could account for 60 of the 800 lung cancer deaths here per year. It is estimated that 4000 homes here have a level which exceeds that where action is required. Research also indicates that there are areas in the West and Southeast where Radon risk is elevated.

Our survival rate from cancer is in the middle range for European Countries but it is particularly poor for lung cancer and breast cancer. Smoking is responsible for almost one in three of all cancer deaths and 84% of all lung cancer deaths

www.dhsspsni.gov.uk/drugs_strategy.pdf

The Cancer Framework is a series of composite papers which will address the strategic direction of cancer care, quality standards and monitoring of progress to improve cancer care. Strategic Regional Cancer Framework: A Cancer Control Programme for Northern Ireland (2006) <http://www.dhsspsni.gov.uk/csf-2.pdf>. This was issued in 2006 as part of the Cancer Framework and the ongoing development of cancer services since the Campbell Report of 1996

Targets increased specialisation of surgery. Cancer Control Strategy 2006

www.dhsspsni.gov.uk/cancer_control.pdf

Cancer Services in Ireland: A National Strategy (DoHC, 1996)

A Strategy for Cancer Control in Ireland National Cancer Forum (DoHC, 2006)

The 1996 National Cancer Strategy set a target to reduce the death rate from cancer in the under-65 age group by 15% in the ten-year period from 1994. An evaluation commissioned by the Department of Health and Children on behalf of the National Cancer Forum found that the target of the 1996 National Cancer Strategy to reduce the death rate from cancer in the under-65 age group by 15% in the ten-year period from 1994 was achieved by 2001.

Cancer Mortality Prevalence

More than 7,500 deaths each year are due to cancer, accounting for about a quarter of all deaths. The serious problem of lung cancer in particular is evident from the fact that between 1994 and 2001 it was the commonest cause of cancer death overall (20%). It was also the commonest cause of cancer death among men (24%) (DoHC, 2006)

General Strategic Policy Developments regarding Cancer

The National Cancer Strategy was published in 1996 and was followed by a three year action plan in 1997. The main elements of the Strategy involved:

- reorganisation of cancer treatment services based on principles of best practice, patient-centredness and equity of access throughout the country. This involved organising services around three supra-regional centres and regional centres based in other health board areas;
- establishing screening and early detection programmes of proven value;
- using health promotion activities to emphasise the importance of healthy lifestyles;
- further developing specialist palliative care services;
- facilitating greater co-ordination of cancer research.

A second cancer strategy, A Strategy for Cancer Control in Ireland by the National Cancer Forum was launched by the Department of Health and Children in June, 2006. Its stated aims are to build on the major successes in cancer that have been delivered under the 1996 National Cancer Strategy and further progress implementation of this Strategy. In order to address the rapidly rising burden of cancer, it advocates a comprehensive cancer control policy programme. Cancer control is a whole population, integrated and cohesive approach to cancer that involves prevention, screening, diagnosis, treatment, and supportive and palliative care. It places a major emphasis on measurement of need and on addressing inequalities and implies that we must focus on ensuring that all elements of cancer policy and service are delivered to the maximum possible extent. The Strategy also focuses substantially on reform and reorganisation of the way we deliver cancer services,

The Cancer Control Strategy (2006) identified the ongoing need for policy guidance to be provided on many aspects of cancer control, particularly on screening, management of cancer patients, genetics, quality assurance, and research. The National Cancer Forum was established by the Minister on foot of a recommendation in the 1996 National Cancer Strategy. Its primary role is to provide ongoing and independent policy advice on cancer to the Minister and the Department of Health and Children. The evaluation of the first National Cancer Strategy concluded that the Forum played a pivotal role in the development and improvement of cancer services. It has also played an important role in the creation of national consensus around many aspects of cancer policy. The Cancer Control Strategy (2006) recommends that A third National Cancer Forum should be appointed by the Minister with terms of reference and composition reflecting the changed health system. In

Operable lung cancer

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Effective primary/secondary care

particular, it proposes that the Forum should now focus more on policy and its impact. According to the Strategy, cancer care is changing more rapidly now than at any time in the past and this generates a particular need to have a consistent high-quality source of credible leadership capable of creating a policy consensus in respect of priorities, necessary developments and deficiencies in service performance.

The Cancer Control Strategy also proposes that the HSE should present a report on policy indicators each year to the National Cancer Forum on a national basis and from each of the four Managed Cancer Control Networks. It stresses the importance for the Third National Cancer Forum to establish clear targets that are consistent with the vision of the 2006 Strategy. It explains that the first report on policy indicators from the HSE will allow targets to be set for each policy indicator. These targets should then be reviewed annually by the National Cancer Forum.

Recommendations In The Strategy for Cancer Control (2006) Regarding Lung Cancer

The Strategy (2006) proposes that the recommendations of the Report of the National Task Force on Obesity, 2005 should be implemented in full. In particular, it stressed the need for measures that raise awareness of the links between diet and cancer. It is estimated that around a third of all cancers are related to diet. Diet has been recognised as contributing to the development of cancers of the lung, colon, rectum, stomach, and prostate. The Strategy also discusses risks associated with high concentrations of radon gas, which when inhaled into the lung, radon may damage cells in the lung and eventually lead to lung cancer. It states that radon gas inhalation accounts for approximately 9% of all cases of lung cancer. The Strategy recommends that the public should be made aware that radon measurements can be undertaken by the Radiological Protection Institute of Ireland. Consideration should be given to providing financial support for testing in high-radon areas and for any necessary remedial work, on a means-tested basis.

Source: http://www.dohc.ie/publications/pdf/cancer_control_2006.pdf?direct=1 accessed 15/6/06

Cancer and Health Inequalities

The Strategy for Cancer Control in Ireland (DoHC, 2006) explains that the occurrence of cancer and the experience that people have of services for cancer demonstrate health inequalities. It identifies a number of reasons for these inequalities in cancer, including genetic factors and different exposure to risk factors such as smoking, alcohol and diet. Other factors include differences in the awareness of, and response to, cancer symptoms, lower uptake of screening and variations in access to high-quality services. The Strategy asserts the need for a consistent focus on risk factors for cancer, incidence of cancer, access to services, and outcome from services to help to reduce health inequalities between various groups. It proposes that the HSE should put in place arrangements to monitor inequalities in cancer risks, cancer occurrence, cancer services and cancer outcomes. It contends that a series of policy indicators within this Strategy will provide an important means of maintaining a policy focus on cancer inequalities.

Source: http://www.dohc.ie/publications/pdf/cancer_control_2006.pdf?direct=1 accessed 15/6/06

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Emergency admissions of over 75s

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Quality of social care

NORTH-SOUTH COMPARABILITY	All-island component		
LAY DESCRIPTION	The rate of emergency admissions to hospital of people aged 75 years or over per 100,000 European standard population		
SOURCE REFERENCE	eHPI: SA4_2		
INDICATOR NAME	DSR emer admissions 74+		
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Directly age and gender standardised rate of emergency (i.e. non-elective) admissions to hospital of people aged 75 years or over per 100,000 European standard population		Directly age and gender standardised rate of emergency (i.e. non-elective) admissions to hospital of people aged 75 years or over per 100,000 European standard population	
Published?	No	Published?	No
Frequency	N/a	Frequency	N/a
Numerator		Numerator	
Definition	Number of emergency admissions to hospital of people aged 75 years or over	Definition	Number of emergency admissions to hospital of people aged 75 years or over
Source	Hospital Inpatients System, DHSSPS	Source	Hospital Inpatient Enquiry (HIPE)
Denominator		Denominator	
Definition	Mid-year population estimate	Definition	Mid-year population estimate
Source	NISRA	Source	Public Health Information System
Geography	N/a	Geography	N/a
Latest Year	N/a	Latest Year	N/a
Geography	LGD	Geography	County
Year	2006/2007	Year	2005
Geography	LGD	Geography	County
Year	2005	Year	2005
DATA ISSUES		DATA ISSUES	
Includes primary and secondary diagnoses.		Includes primary and secondary diagnoses.	
The crude rate was directly age and gender standardised to the European standard population.		The crude rate was directly age and gender standardised to the European standard population. Values for five or less cases in a particular combination of age, sex, and area were not disclosed. The value was assumed to be three.	
		Excludes admissions to private hospitals.	
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
Standardised admission rates for people living in wards with the highest deprivation levels are much greater than the Northern Ireland average. The difference is greatest for emergency admissions, where the rate of emergency admissions is 43% higher for all persons living in these wards than the Northern Ireland average rates.		In November 2004 the Minister for Health and Children announced a 10 Point Plan with a series of actions with the aim of improving the delivery of A & E services by taking a wide ranging approach, improving patient flows through A & E departments, freeing up of acute beds and providing appropriate longer term care for patients outside of the acute hospital setting.	
Demographic trends, medical advances, technological therapeutic developments, and increasing public expectations are all contributing to the unrelenting pressures that our doctors, nurses and other health professions face daily. Despite significant increases in activity and throughput in recent years, too many people have to wait long periods for hospital treatment, and patients requiring emergency admissions too often have to wait for a bed despite, or because of, hospitals working to full capacity.		The Health Service Executive commissioned Tribal Secta to examine A&E services in Ireland. A report entitled A&E Mapping and Efficiency Review Across 10 National Hospitals - Overview was published in October 2005. This report presents the findings of a nationally commissioned piece of work across ten hospitals to identify how the application of best practice could improve the pathway of patients from admission from the emergency department to discharge, maximising the appropriate utilisation of existing acute capacity.	

Emergency admissions of over 75s

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Quality of social care

"...development of integrated primary and community care services that prevent unnecessary hospital admissions, promote faster recovery from illness, supply timely discharge and maximize independent living in accordance with the principles of 'People First'."

www.ofmdfmi.gov.uk/antipoverty/nov06.pdf

Promoting the Efficient Use of Resources: By 2008 have achieved significant efficiency gains. A key objective will be the release of resources to be deployed flexibly in front line services through efficiency gains and service improvements of at least 2.5 per cent per annum from the 2004/5 baseline.

These efficiencies will be achieved by exercise to promote:

- Productive use of time/productivity
- Efficient procurement
- The sharing of back office functions
- Avoiding unnecessary hospital admissions

'Developing Better Services' is DHSSPSNI Strategy whereby the current configuration of 15 acute hospitals will be replaced by a network of nine acute hospitals supported by seven local hospitals, with additional local hospitals in other locations, as appropriate. There will be greater provision of generalist services within communities or on a day-patient or out-patient basis than is the case at present. These will include primary care services, chronic disease management, social services maintaining and enhancing independence, and much of the surgery currently provided on an inpatient basis.

There will be greater specialisation particularly within acute hospital services. This will promote the quality of services by ensuring that professionals deal with a 'critical mass' of similar cases to achieve sufficient expertise. New specialised medical technologies and techniques will keep more people alive who would otherwise die through illness or trauma.

http://www.dhsspsni.gov.uk/developing_better_services

http://www.dhsspsni.gov.uk/pfa_2007-08.pdf

Managing the demand on hospital services by promoting healthier ways of living, and by providing more responsive and accessible alternative services in the community so as to prevent unnecessary hospital admissions and facilitate prompt discharge.

Part of the effective target in priorities and budget 2005/2008

www.planningni.gov.uk/corporate_services/business_planning/business_plans/CBP_05-08.pdf states "...that a wider range of conditions is expertly treated in the primary care setting (thereby reducing avoidable hospital admissions), that patients progress within the hospital smoothly and swiftly, and that they can be discharged back home or to suitable care as soon as clinically advisable.

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Childhood immunisation rates

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Utilisation of Health Service

NORTH-SOUTH COMPARABILITY	All-island component		
LAY DESCRIPTION	The percentage of children who have been vaccinated aged 24 months.		
SOURCE REFERENCE	AIHSC		
INDICATOR NAME	Rate child immunisation		
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
<p>The average percentage uptake of the vaccines against diphtheria (D3), pertussis (P3), tetanus (T3), Haemophilus influenzae type b (Hib3), meningococcal group C (MenC3), measles, mumps and rubella (MMR1) at age 24 months.</p> <p>The component is calculated as the average of the six vaccines' uptake percentages.</p>		<p>The average percentage uptake of the vaccines against diphtheria (D3), pertussis (P3), tetanus (T3), Haemophilus influenzae type b (Hib3), meningococcal group C (MenC3), measles, mumps and rubella (MMR1) at age 24 months.</p> <p>The component is calculated as the average of the six vaccines' uptake percentages.</p>	
Published?	Yes www.cdscni.org.uk	Geography	Northern Ireland
Frequency	Quarterly	Latest Year	2007
Numerator Definition	Number of children vaccinated at age 24 months	Geography	LGD
Source	Child Health System	Year	2005/2006
Denominator Definition	Number of children aged 24 months	Geography	LGD
Source	Child Health System	Year	2005/2006
DATA ISSUES		DATA ISSUES	
		Where necessary, Local Health Offices (LHO) were combined to form counties using the LHO percent weighted by the number of children born in the LHO during the relevant time period. This method will mask any sub-county variation in immunisation rates.	
		LHOs consisting of more than one county were split by assigning the LHO percent equally to each county. This method will mask any county variation within that LHO.	
PUBLIC HEALTH IMPORTANCE			
Vaccine preventable infectious diseases were a major cause of morbidity and mortality in children prior to the introduction of routine universally available immunisation programmes. Tuberculosis, measles, mumps, rubella, pertussis, poliomyelitis, tetanus, diphtheria, hepatitis B, influenza and bacterial pneumonia and meningitis continue to blight and take the lives of many children in developing countries, threatening achievement of the millennium goal on reducing child mortality by 4.4% annually (Edejer et al, 2005). Immunisation programmes are highly cost effective and safe health care interventions (Health Protection Agency, 2005), but inequalities in immunisation uptake are persistent and result in lower coverage in poorer and socially excluded people even in developed countries. Those who remain unimmunised are more likely to live in disadvantaged areas and less likely to use primary care services (Social Exclusion Unit, 2005).			

DATA DEFINITION – REPUBLIC OF IRELAND

The average percentage uptake of the vaccines against diphtheria (D3), pertussis (P3), tetanus (T3), Haemophilus influenzae type b (Hib3), meningococcal group C (MenC3), measles, mumps and rubella (MMR1) at age 24 months.
The component is calculated as the average of the six vaccines' uptake percentages.

Published?	Yes www.hspsc.ie	Geography	Local Health Office
Frequency	Quarterly	Latest Year	2007
Definition	Number of children vaccinated at age 24 months	Geography	Local Health Office
Source	Health Protection Surveillance Centre	Year	Q1 2007
Definition	Number of children aged 24 months	Geography	Local Health Office
Source	Health Protection Surveillance Centre	Year	Q1 2007

DATA ISSUES

Where necessary, Local Health Offices (LHO) were combined to form counties using the LHO percent weighted by the number of children born in the LHO during the relevant time period. This method will mask any sub-county variation in immunisation rates.

LHOs consisting of more than one county were split by assigning the LHO percent equally to each county. This method will mask any county variation within that LHO.

Childhood immunisation rates

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Utilisation of Health Service

POLICY CONTEXT – NORTHERN IRELAND	POLICY CONTEXT – REPUBLIC OF IRELAND
<p>The Department of Health (DH) in England through its Immunisation Unit on behalf of Wales, Scotland and Northern Ireland develops and implements immunisation policy. The National Health Service (NHS) facilitates this unified process. There is no legal compulsion for immunisation, nor a school entry requirement. The DH is advised by the independent expert Joint Committee on Vaccination and Immunisation (JCVI), which develops recommendations for new and alterations to existing immunisation programmes. The non governmental UK wide Health Protection Agency (HPA) provides scientific advice both to DH and JCVI. Funding for immunisation programmes and procurement is provided centrally. DH publishes a book, <i>Immunisation against Infectious Diseases</i> (2006) www.dh.gov.uk, which contains guidance on current policy and vaccine information. Vaccines are free at the point of delivery and uptake is monitored. Recent changes to the national immunisation programme include Haemophilus influenza type B (Hib) vaccination for preschool children, pneumococcal vaccination (PVC) for all children and phased introduction of a vaccine against human papilloma virus (HPV) to prevent cervical cancer (Salisbury, 2005).</p> <p>The Northern Ireland Health Promotion Agency www.hpa.org.uk supports vaccination programme delivery through public awareness campaigns and information materials.</p> <p>Following controversy in 1998, uptake rates for MMR vaccine of 91% at two years remain below the target of 95% and outbreaks of mumps and measles continue to occur. Uptake of all other childhood immunisations at one year of age exceeds targets at 96%. www.dhsspsni.gov.uk</p>	<p>The National Children's Strategy: Our Children - Their Lives (2000) www.omc.gov.ie mentioned the need for continued progress towards the national target of 95% uptake in the Primary Childhood Immunisation Programme.</p> <p>The schedule of immunisation programme is guided by the recommendations of the National Immunisation Advisory Committee of the Royal College of Physicians of Ireland (RCPI), which published a Report on Childhood Immunisation in 2001, recommending the achievement of a 95% uptake in the Primary Childhood Immunisation Programme (PCIP). It issued an updated document on National Immunisation Guidelines in 2002 http://www.dohc.ie.</p> <p>The National Health Strategy 'Quality and Fairness: A Health System for You' (2001) stated that national minimum standards and targets for immunisation uptake, surveillance and screening would be drawn up as a means of improving children's health. http://www.dohc.ie</p> <p>The National Immunisation Office established in 2006 is government funded by the Health Service Executive (HSE) and co ordinates the delivery of the national immunisation programme in Ireland, which is available free at the point of delivery through the HSE. www.immunisations.ie</p> <p>Recent changes to the national immunisation programme include Haemophilus influenza type B (Hib) vaccination for preschool children (2005), pneumococcal vaccination (PVC) and Hepatitis B (HepB) for all children born on or after the 1st July 2008. An introduction of a vaccine against human papilloma virus (HPV) to prevent cervical cancer is currently under consideration. Influenza and pneumococcal vaccines are routinely recommended for all adults over 65 yrs of age.</p> <p>Uptake rates for the PCIP at one year of age and for MMR at two years of age were 86%, well below the target of 95%, which is achieved in some regions, but not nationally. Outbreaks of mumps and measles continue to occur. http://hpsc.ie</p>
<p>REFERENCES</p> <p>Edejer, T.T.-T., Aikins, M., Black, R., Wolfson, L., Hutubessy, R., Evans, D.B. (2005) "Achieving the millennium development goals for health. Cost effectiveness analysis of strategies for child health in developing countries" in <i>British Medical Journal</i>, Vol 331, No 7526, pp1177</p> <p>Health Protection Agency (2005) "Vaccine preventable diseases modelling and economics". www.hpa.org.uk accessed 21 May 2005</p> <p>Salisbury, D.M. (2005) "Development of Immunisation Policy and its Implementation in the United Kingdom" in <i>Health Affairs</i>, Vol 24, No 3</p> <p>Social Exclusion Unit (2005) "Improving Services, Improving Lives: Evidence and Key Themes: A Social Exclusion Unit Interim Report". www.socialexclusion.gov.uk accessed 21 May 2005</p>	

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Directly standardised dental registration rate ratios

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Utilisation of Health Service

NORTH-SOUTH COMPARABILITY	North only component
LAY DESCRIPTION	How much more/less likely a person is to be registered with a dentist compared to the national average, having taken account of that area's age/gender profile
SOURCE REFERENCE	AIHSC
INDICATOR NAME	DSRR dental registration NI

DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND	
Directly Standardised dental registration rate ratios					
Published?	Yes www.ninis.nisra.gov.uk	Geography	Ward LGD PC	Published?	Geography
Frequency	Annually	Latest Year	2007	Frequency	Latest Year
Numerator Definition	Number of people registered with a dentist per LGD	Geography	LGD	Numerator Definition	Geography
Source	NINIS	Year	2006	Source	Year
Denominator Definition	Number of people registered with a dentist in Northern Ireland	Geography	LGD	Denominator Definition	Geography
Source	NINIS	Year	2006	Source	Year
DATA ISSUES				DATA ISSUES	
PUBLIC HEALTH IMPORTANCE					
<p>Oral health is an integral part of general health and well being through its potential to cause pain and suffering, interaction with nutrition, communication, quality of life as well as acute and chronic illness. Oral health and diseases share determinants and risk factors with other important contributors to the global burden of disease. Provision of oral and dental health services can improve quality of life and physical, psychological and social functioning (Sheiham, 2005). Oral diseases are largely preventable, and treatment costs are high, both in financial terms and human suffering. Oral health promotion and public health strategies need to address social determinants, recognising common risk factors for unhealthy behaviours and poor health outcomes. Despite improvements in oral health in many countries, challenging inequalities have emerged with lower income and socially disadvantaged groups experiencing higher levels of oral disease (Watt, 2005). Economic growth has not only resulted in an epidemiological transition from infectious to chronic illness, but also in a nutritional transition, leading to over consumption of energy dense fat and carbohydrate. This has contributed to a social gradient in food quality and health inequalities (WHO, 2003). An all Ireland oral health survey of schoolchildren has recommended innovative approaches to reducing decay levels and addressing inequalities in children's oral health (Whelton, Crowley, O'Mullane et al, 2003). A report on the impact of water fluoridation on oral health in both jurisdictions on the island of Ireland concluded that water fluoridation in deprived areas might alleviate oral health disparities as well as reducing the impact of insufficient numbers of dental practitioners (Co operation and Working Together, 2007). Eating fruit and vegetable increases fibre intake, reduces fat and refined sugar intake, helps to maintain a healthy weight and contributes to a balanced diet, promoting oral health (Health Promotion Agency, 2008).</p>					
POLICY CONTEXT – NORTHERN IRELAND				POLICY CONTEXT – REPUBLIC OF IRELAND	
<p>The Northern Ireland public health strategy <i>Investing for Health</i> (DHSSPS, 2002) www.dhsspsni.gov.uk is an interagency framework for partnership working to improve health and wellbeing and to reduce health inequalities. Its two main goals are to</p>				<p>One of the strategic aims of the <i>National Health Promotion Strategy 2000-2005</i> (DoHC, 2000) www.dohc.ie was to increase the percentage of the population who consume the recommended daily servings of food and maintain a healthy weight. It recognised the</p>	

Directly standardised dental registration rate ratios

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Utilisation of Health Service

improve people's health by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability, and to reduce inequalities in health between geographic areas, socio- economic and minority groups. It recognises the improvements in health and wellbeing achieved in recent decades and emphasises the continued importance to enable people to make healthier choices. It specifically aims:

- To increase the level of 5 year olds with no dental decay experience to 55% and to reduce the gap between the best and the worst decayed/ missing/ filled teeth scores by 20%.

The health strategy *A Healthier Future- A twenty year vision for health and wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2005) recognises the importance of healthy nutrition for the improvement of population health and wellbeing. It recognises the complex interplay of environmental and individual factors contributing to the burden of chronic diseases and considers the role of health and social care services in addressing these. It seeks:

- To increase the level of 5 year olds without dental decay to 75% and reduce the gap in oral health between socioeconomic groups

The *Primary Dental Care Strategy* (DHSSPS, 2006) aims to reform the current system and focus on disease prevention, improve access to and local relevance of services. Negotiations for a new contract for dentists are under way with the Dental practice Committee of the British Dental Association.

The *Oral Health Strategy for Northern Ireland* (DHSSPS, 2007) aims to improve the oral health of the Northern Ireland population, and to reduce inequalities in oral health. It makes recommendations in the areas of oral health promotion, the oral health of children and young people, and adult dental health, dental service development and monitoring of strategy implementation. It includes several targets for child and adult oral health, amongst them:

- By 2013, at least 50% of 5 year old children should be free from obvious dental decay experience, and
- To reduce the proportion of adults without any natural teeth to 8% or less by 2008.

The Northern Ireland Audit Office's report on *The Performance of the Health Service in Northern Ireland* (Comptroller and Auditor General, 2008) www.tso.co.uk states that oral health in Northern Ireland especially among children is the worst in the United Kingdom (UK) with little evidence for improvement in children under 5 years of age in the past decade. It cites poor lifestyle choices and social deprivation as the main reasons and acknowledges the water fluoridation programme in the Republic of Ireland (RoI) as the main reason for one of the lowest decay rates there compared to European levels.

need for an inter-sectoral and multi-disciplinary approach in the implementation of the aims and objectives of the strategy and identified the importance of facilitating the implementation of various related recommendations on nutrition and eating well as outlined in other policies including the *National Food and Nutrition Policy* (Nutrition Advisory Group, 1995),

Quality and Fairness- A Health System for You (DoHC, 2001) www.dohc.ie is based on the four national goals of better health for everyone, fair access, responsive and appropriate care delivery and high performance. It refers to the 1994 Dental Treatment Services Scheme (DTSS) which provides free basic dental treatment services for medical card holders, but does not require registration with a dental practitioner, posing difficulties in continuity of care for patients and probity in arranging payments for practitioners. While there is a free public dental services to all children younger than 16 years provided by the Health Service Executive (HSE) through school inspection and treatment services, private dentistry services are subsidised through the means tested Dental Treatment Benefit Scheme operated by the Department of Social Welfare www.welfare.ie.

The Department of Health and Children (DoHC) is developing a new *National Oral Health Policy* to provide for a revised regulatory regime for the dental sector and state funded dental schemes, integration of oral health in the wider health care delivery system, professional regulation, workforce and service planning especially for orthodontics and special needs dentistry.

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Blood pressure

Stage: Situation of health

Level: Health status (individual)

Theme: Health capital

NORTH-SOUTH COMPARABILITY	Separate North and South components
LAY DESCRIPTION	Percentage of people who have high blood pressure
SOURCE REFERENCE	eHPI: SH2_2
INDICATOR NAMES	Pct high BP NI; Pct high BP RoI

DATA DEFINITION – NORTHERN IRELAND			
Percentage of people aged 16 years or over who have ever been told by a doctor or nurse that they have high blood pressure			
Published?	Yes Health and Social Wellbeing Survey (HSWB)	Geography	Northern Ireland
Frequency	Every 4/5 years	Latest Year	2005/2006
Numerator Definition	Number of HSWB respondents aged 16 years or over who have ever been told by a doctor or nurse that they have high blood pressure	Geography	HSSB
Source	HSWB	Year	2005/2006
Denominator Definition	Number of HSWB respondents aged 16 years or over	Geography	HSSB
Source	HSWB	Year	2005/2006
DATA ISSUES			
The components are not directly comparable between Northern Ireland and Republic of Ireland because the Northern Ireland question includes current and past blood pressure while the Republic of Ireland question refers to current blood pressure.			
An LGD’s value is assumed to be equal to its HSSB value. This will mask any LGD variation within that HSSB.			
HSWB surveys people age 16 years or over while SLAN surveys people aged 18 years or over.			
PUBLIC HEALTH IMPORTANCE			

DATA DEFINITION – REPUBLIC OF IRELAND			
Percentage of people aged 18 year or over who self-report that their blood pressure level is high			
Published?	Yes Survey of Lifestyles, Attitudes and Nutrition (SLÁN)	Geography	Ireland
Frequency	Every four years	Latest Year	2007
Definition	Number of SLAN respondents aged 18 years or over who self-report that their blood pressure level is high	Geography	County
Source	SLÁN	Year	2002
Definition	Number of SLÁN respondents aged 18 years or over who self-report that that their blood pressure level is high or normal/low	Geography	County
Source	SLÁN	Year	2002
DATA ISSUES			
The components are not directly comparable between Northern Ireland and Republic of Ireland because the Northern Ireland question includes current and past blood pressure while the Republic of Ireland question refers to current blood pressure.			
Small numerator and denominator values at county level may give unreliable estimates.			
HSWB surveys people age 16 years or over while SLAN surveys people aged 18 years or over.			
POLICY CONTEXT – REPUBLIC OF IRELAND			
Department of Health and Children (1995) A Health Promotion Strategy - Making the Healthier Choice, the Easier Choice			

POLICY CONTEXT – NORTHERN IRELAND	
High blood pressure (also known as hypertension), along with obesity, cholesterol and alcohol	

Blood pressure

Stage: Situation of health

Level: Health status (individual)

Theme: Health capital

are risk factors in heart disease, stroke and mortality. Treatment is through diet, drugs (ranging from aspirin to Statins) and exercise.

Title:

Be active - Be healthy. Northern Ireland physical activity strategy 1996-2002

Published:

Health Promotion Agency (HPA), March, 1996, on behalf of the Northern Ireland Physical Activity Strategy Group (NIPAIG).

Description:

The overall aim of this strategy is to increase levels of health related physical activity particularly among those who exercise least. The need to develop such a strategy, which would focus on the sedentary population, was highlighted by the Northern Ireland Health and Activity Survey published in 1994. This survey revealed that over one quarter (29%) of the adult population would have difficulty in climbing stairs without some assistance or would only be capable of doing so unaided at a very slow pace. Be active - be healthy provides a framework for action to increase physical activity levels among the whole of the Northern Ireland population.

'Fit Futures' 2004 <http://www.investingforhealthni.gov.uk/fitfutures.asp> Fit Futures: Focus on Food, Activity and Young People is a cross-departmental taskforce that was established by the Ministerial Group on Public Health in August 2004 in response to concerns about the rising levels of overweight and obesity in children and young people. The role of the taskforce was to examine options for preventing the rise in levels of overweight and obesity in children and young people and to make recommendations to Ministerial Group on priorities for action.

Not as such – but part of QOF

Building Healthier Hearts The Report of the Cardiovascular Health Strategy Group (The Department of Health and Children, 1999)
Quality and Fairness (2001)

The First National Health Promotion Strategy Making the Healthier Choice, the Easier Choice (1995) contained the following goal with regards to the blood pressure risk factor: to achieve a situation where 75% of the population in the 35-64 age group will have a blood pressure less than 140/90mm Hg by the year 2005. It states that an outcome will be the publication of the Building Healthier Hearts Report.

In the Building Healthier Hearts Report (1999) preventive strategies/recommendations for patients with CHD or other atherosclerotic disease, based on European Task Force recommendations include:

- Blood pressure < 140/90 mm Hg | Total cholesterol < 5.0 mmol/l

By far the most common type of disease in the cardiovascular system occurs as a result of atherosclerosis or hardening of the arteries. Atherosclerosis of the arteries which supply blood and oxygen to the heart muscle results in coronary heart disease (CHD). The three principal risk factors for CHD are smoking, raised levels of cholesterol in the blood and raised blood pressure, all of which have a relationship to lifestyle, including diet and exercise. For Irish men under the age of 65 cardiovascular disease is the main cause of death. In women it is the second highest cause of death, after cancer. There has been a substantial decline in stroke mortality over a number of decades throughout the developed world. This reflects lifestyle and dietary changes, particularly a reduction in population salt intake, as well as improved detection and management of raised blood pressure (DoHC, 1999).

Strategic Policy Developments

Death rates from cardiovascular disease are falling, in line with the targets set in the national health strategy and in the national health promotion strategy for older people 'Adding Years to Life and Life to Years' (1998). The national health promotion strategy 'Making the Healthier Choice the Easier Choice' (1995) described the key settings in which action would take place to achieve health targets, together with action plans to address lifestyle issues and risk factors (DoHC, 1999).

The establishment of the Cardiovascular Health Strategy Group was part of an overall initiative on cardiovascular health and cardiac services announced by the Minister for Health and Children in January 1998. In 1999 the Group published the Building Healthier Hearts Report which sets out a strategic policy framework for addressing CHD. It explains that while individuals have responsibility for their own health behaviours, substantial demographic variations suggest that social and economic inequalities play an important part in the development of the disease. Measures to reduce such inequalities must therefore also be addressed. To achieve health gain a comprehensive approach addressing primary prevention, primary care, pre-hospital care, diagnostic and treatment services in acute hospitals, secondary prevention and rehabilitation is required. Recommendations for preventive strategies in patients with CHD or other atherosclerotic diseases based on European Task Force recommendations are outlined above (DoHC, 1999). Quality and Fairness (2001) stated that a Heart Health Task Force will monitor and evaluate the implementation of the prioritised cardiovascular health action plan

Blood pressure

Stage: Situation of health

Level: Health status (individual)

Theme: Health capital

prepared by the Advisory Forum on Cardiovascular Health. It's implementation will be monitored by the Heart Health Task Force, with reference to the Health Information and Quality Authority, and it will be evaluated in accordance with the principles set out in Building Healthier Hearts, the National Cardiovascular Strategy.

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Cholesterol

Stage: Situation of health
Level: Health status (Individual)
Theme: Health capital

NORTH-SOUTH COMPARABILITY	One South only component
LAY DESCRIPTION	Percentage of people who have high cholesterol
SOURCE REFERENCE	eHPI: SH2_3
INDICATOR NAME	Pct high cholesterol Rol

DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND			
Published?	Geography	Published?	Yes Survey of Lifestyles, Attitudes and Nutrition (SLÁN)	Geography	Ireland
Frequency	Latest Year	Frequency	Every four years	Latest Year	2007
Numerator Definition	Geography	Numerator Definition	Number of SLÁN respondents aged 18 years or over who self-report that their cholesterol level is high	Geography	County
Source	Year	Source	SLÁN	Year	2002
Denominator Definition	Geography	Denominator Definition	Number of SLÁN respondents aged 18 years or over who self-report that their cholesterol level is high or normal/low	Geography	County
Source	Year	Source	SLÁN	Year	2002
DATA ISSUES		DATA ISSUES			
		Small numerator and denominator values at county level may give unreliable estimates.			

PUBLIC HEALTH IMPORTANCE	
POLICY CONTEXT – NORTHERN IRELAND	
<p>Food and Nutrition strategy eating for health 1996 http://www.healthpromotionagency.org.uk/Resources/nutrition/eatingandhealth.htm Published by the Health Promotion Agency Northern Ireland on Food and Nutrition Strategy Group. This strategy builds upon the broad nutritional targets identified in the Regional Strategy for the Northern Ireland Health and Personal Social Services (1992-1997), by explaining why the food we eat is important and shows the potential for coordinated action to bring about desired changes. Within the strategy six key players are identified: food producers and processors; food retailers; caterers; nutrition educators, including health professionals; representatives of the education sector; and voluntary and community groups.</p> <p>Investing For Health Department of Health, Social Services and Public Safety (DHSSPS),</p>	
POLICY CONTEXT – REPUBLIC OF IRELAND	
<p>Department of Health and Children (1995) A Health Promotion Strategy - Making the Healthier Choice, the Easier Choice Building Healthier Hearts The Report of the Cardiovascular Health Strategy Group (The Department of Health and Children, 1999) Quality and Fairness (2001)</p> <p>The First National Health Promotion Strategy Making the Healthier Choice, the Easier Choice (1995) contained the following goal with regards to the cholesterol risk factor:</p> <p>To reduce mean serum cholesterol in the 35-64 age group from a present level of 5.6mmol/L by the year 2005. The outcome was the development of Awareness Campaigns.</p>	

Cholesterol

Stage: Situation of health

Level: Health status (Individual)

Theme: Health capital

March, 2002. <http://www.investingforhealthni.gov.uk/>

Investing for health presents a cross-departmental, multi-sectoral framework for action to improve health and wellbeing in Northern Ireland by setting out how the Northern Ireland Executive plans to achieve its aim 'to work for a healthier people' - one of its overarching priorities.

The strategy recognises the important contribution to be made by members of statutory and non-statutory groups, community and voluntary groups as well as all Departments, who through their involvement in the Ministerial Group on Public Health (MGPH) were responsible for its development.

Investing for health identifies the principles and values that should guide future action to improve health and highlights the cost of poor health to the individual, families and to the economy. The strategy aims to address a broad range of economic, social and environmental issues, all of which are recognised as major determinants of health and wellbeing. It also outlines the commitment of the Northern Ireland Executive to ensuring equality of opportunity and tackling social disadvantage within our community.

Student Eating survey 2005.

<http://www.foodstandards.gov.uk/multimedia/pdfs/nistudentsurvey2005.pdf>

In November 2005 the Agency employed ARK (Northern Ireland Social and Political Archive) to undertake a food attitudes and behaviour survey among university students in Northern Ireland. All students attending Queen's University and the University of Ulster received an email asking them to take part in an online survey hosted on the ARK server.

The research findings suggest that first year students are the most vulnerable in terms of their diet. Compared with any other year, first year students are the group most likely to eat pre-packed or convenience foods.

In contrast to other years, first year students are the group least likely to cook a main meal from fresh or raw ingredients, to know how to cook a variety of foods, to enjoy cooking, to eat less fresh fruit and vegetables than a year ago, to eat breakfast, to look at nutritional labels and to say that they lead a healthy lifestyle.

New Nutritional standards for schools 2007. Not less than **two portions** of fruit and vegetables should be available per day per child throughout the lunch service.

http://www.deni.gov.uk/new_nutritional_standards_for_school_lunches_and_other_food_in_schools-2.doc

'Fit Futures' 2004 <http://www.investingforhealthni.gov.uk/fitfutures.asp> Fit Futures: Focus on Food, Activity and Young People is a cross-departmental taskforce that was established by the Ministerial Group on Public Health in August 2004 in response to concerns about the rising levels of overweight and obesity in children and young people. The role of the taskforce was to examine options for preventing the rise in levels of overweight and obesity in children and young people and to make recommendations to Ministerial Group on priorities for action.

Food Standards Agency role in promoting healthy eating and researching nutrition.

<http://www.foodstandards.gov.uk/northernireland/>

In the Building Healthier Hearts Report (1999) preventive strategies/recommendations for patients with CHD or other atherosclerotic disease, based on European Task Force recommendations include:

- LDL cholesterol < 3.0 mmol/l

By far the most common type of disease in the cardiovascular system occurs as a result of atherosclerosis or hardening of the arteries. Atherosclerosis of the arteries which supply blood and oxygen to the heart muscle results in coronary heart disease (CHD). The three principal risk factors for CHD are smoking, raised levels of cholesterol in the blood and raised blood pressure, all of which have a relationship to lifestyle, including diet and exercise. For Irish men under the age of 65 cardiovascular disease is the main cause of death. In women it is the second highest cause of death, after cancer. There has been a substantial decline in stroke mortality over a number of decades throughout the developed world. This reflects lifestyle and dietary changes, particularly a reduction in population salt intake, as well as improved detection and management of raised blood pressure (DoHC, 1999).

Strategic Policy Developments

Death rates from cardiovascular disease are falling, in line with the targets set in the national health strategy and in the national health promotion strategy for older people 'Adding Years to Life and Life to Years' (1998). The national health promotion strategy 'Making the Healthier Choice the Easier Choice' (1995) described the key settings in which action would take place to achieve health targets, together with action plans to address lifestyle issues and risk factors (DoHC, 1999).

The establishment of the Cardiovascular Health Strategy Group was part of an overall initiative on cardiovascular health and cardiac services announced by the Minister for Health and Children in January 1998. In 1999 the Group published the Building Healthier Hearts Report which sets out a strategic policy framework for addressing CHD. It explains that while individuals have responsibility for their own health behaviours, substantial demographic variations suggest that social and economic inequalities play an important part in the development of the disease. Measures to reduce such inequalities must therefore also be addressed. To achieve health gain a comprehensive approach addressing primary prevention, primary care, pre-hospital care, diagnostic and treatment services in acute hospitals, secondary prevention and rehabilitation is required. Recommendations for preventive strategies in patients with CHD or other atherosclerotic diseases based on European Task Force recommendations are outlined above (DoHC, 1999). Quality and Fairness (2001) stated that a Heart Health Task Force will monitor and evaluate the implementation of the prioritised cardiovascular health action plan prepared by the Advisory Forum on Cardiovascular Health. It's implementation will be monitored by the Heart Health Task Force, with reference to the Health Information and Quality Authority, and it will be evaluated in accordance with the principles set out in Building Healthier Hearts, the National Cardiovascular Strategy.

Cholesterol

Stage: Situation of health

Level: Health status (Individual)

Theme: Health capital

July 2007 Survey of homelessness and food poverty

<http://www.foodstandards.gov.uk/news/newsarchive/2007/jul/homelessnessandfood>

Research published by the Food Standards Agency Northern Ireland (FSANI) shows that although most homeless people are getting enough to eat, the quality of their diet is poor. Key barriers to eating a balanced diet for those surveyed are their financial situation and education, as well as alcohol and drug abuse. FSANI commissioned research into food poverty and homelessness in Northern Ireland. The aim of this research was to deliver a better understanding of the impact of poverty and social exclusion on the diet of people who are homeless in Northern Ireland.

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Low birth weight

Stage: Situation of health

Level: Health status (Individual)

Theme: Health capital

NORTH-SOUTH COMPARABILITY	Separate North and South components		
LAY DESCRIPTION	Percentage of live births that weigh less than 2,500g		
SOURCE REFERENCE	eHPI: SH2_4		
INDICATOR NAMES	Pct lbw NI; Pct lbw RoI		
DATA DEFINITION – NORTHERN IRELAND			
Percentage of all live births weighing less than 2,500g			
Published?	Yes	Geography	Northern Ireland
	CMO Annual Report		Ireland
Frequency	Every year	Latest Year	2006
Numerator			
Definition	Number of live births weighing less than 2,500g	Geography	LGD
Source	Child Health System, HSSB	Year	2006
Denominator			
Definition	Number of live births	Geography	LGD
Source	Child Health System, HSSB	Year	2006
DATA ISSUES			
The components are not directly comparable between Northern Ireland and Republic of Ireland as the Northern Ireland numerator includes multiple births while the Republic of Ireland numerator excludes multiple births.			
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND			
Low Birth weight babies			
The low birth weigh rate at the population level is an indicator of a public health problem that includes long-term maternal malnutrition, ill health and poor health care. On an individual basis, low birth weigh is an important predictor of newborn health and survival.			
Used in acute funding formulas in NI. www.dhsspsni.gov.uk/capitation-cfrg-summary.pdf			
None			
POLICY CONTEXT – REPUBLIC OF IRELAND			
The National Health Strategy Quality and Fairness A Health System for You (DoHC 2001) National Anti-Poverty Strategy (NAPS) (2002) NAP/Inclusion (2003)			
In meeting the NAPS (2002) and NAP/Inclusion (2003) aims of reducing health inequalities and to eliminate the impact of deprivation and disadvantage on health status, one of the key targets is: to reduce the gap in low birth weight rates for children from the lowest and highest socio-economic group by 10% from the 2001 level, by 2007.			
The relevant data published by the HIPE & NPRS Unit of the ESRI (2006) point towards a trend during the 1990s towards an increasing prevalence of low birth weight babies. Several studies have found evidence of a link between the problem of low birth weight and socio-economic status. For instance, The ESRI (Nolan, 1994) has demonstrated that perinatal			

Low birth weight

Stage: Situation of health

Level: Health status (Individual)

Theme: Health capital

mortality and low birth weight are associated with socio-economic background. The National Health and Lifestyle Survey (SLÁN) (1999) found significantly less healthy lifestyles and low health status, including low birth weight among lower socio-economic groups than those in higher socio-economic groups.

The Institute of Public Health in Ireland was commissioned by the DoHC to prepare a report on the issue of low birth weight and socio-economic status in Ireland. In 2001 'Inequalities in Mortality 1989-1998: A Report on All- Ireland Mortality Data' was subsequently published by the Institute. The paper acknowledged its limited ability to provide clear strategic direction on tackling inequalities in low birth weight, in part due to limitations in the international evidence-base and effect of intergenerational factors. It refers to a lack of evaluation and efficacy data on what works in breaking the link between socio-economic group and poor birth outcome, and improving birth outcomes for the poorest members of society (OSI, 2005).

A Trinity College study on health inequalities showed that low birth weight was more likely in the unskilled manual and unemployed socio-economic group (TCD, 2001).

NAPS (2002) states that the problem of low birth weight is linked to one's socio-economic group, with the rate of low birth weight among unskilled manual groups twice that of the professional groups. The national health strategy Quality and Fairness (2001) refers to the NAPS (2002) and NAP/Inclusion (2003) target pertaining to low birth weight as one of the actions to improve children's health.

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Obesity

Stage: Situation of health
Level: Health status (Individual)
Theme: Health capital

NORTH-SOUTH COMPARABILITY		Separate North and South components	
LAY DESCRIPTION		Percentage of people who are obese	
SOURCE REFERENCE		eHPI: SH2_1	
INDICATOR NAMES		Pct obese NI; Pct obese Rol	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Percentage of people aged 16 years or over whose measured Body Mass Index is greater than or equal to 30		Percentage of people aged 18 years or over whose self-reported height and weight correspond to a Body Mass Index greater than or equal to 30	
Published?	Yes Health and Social Wellbeing Survey (HSWB)	Published?	Yes Survey of Lifestyles, Attitudes and Nutrition (SLÁN)
Frequency	Every 4/5 years	Frequency	Every four years
Numerator Definition	Number of HSWB respondents aged 16 years or over whose measured Body Mass Index is greater than or equal to 30	Definition	Number of SLAN respondents aged 18 years or over whose self-reported height and weight correspond to a Body Mass Index greater than or equal to 30
Source	HSWB	Source	SLÁN
Denominator Definition	Number of HSWB respondents aged 16 years or over	Definition	Number of SLÁN respondents aged 18 years or over
Source	HSWB	Source	SLÁN
DATA ISSUES		DATA ISSUES	
The components are not directly comparable between Northern Ireland and Republic of Ireland as different methods are used to assess height and weight. SLAN 2007 includes a physical examination of a subset of the sample. When these data are available at local level they will improve comparability of obesity data across the island.		The components are not directly comparable between Northern Ireland and Republic of Ireland as different methods are used to assess height and weight. SLAN 2007 includes a physical examination of a subset of the sample. When these data are available at local level they will improve comparability of obesity data across the island.	
An LGD's value is assumed to be equal to its HSSB value. This will mask any LGD variation within that HSSB.		Small numerator and denominator values at county level may give unreliable estimates.	
HSWB surveys people age 16 years or over while SLAN surveys people aged 18 years or over.		HSWB surveys people age 16 years or over while SLAN surveys people aged 18 years or over.	
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
Obesity is a condition where weight gain has got to the point that it poses a serious threat to health. Obesity is normally measured in terms of a person's Body Mass Index (BMI) is the		Cardiovascular Health Strategy 'Building Healthier Hearts' (1999) National Health Promotion Strategy 2000-2005 (2000)	

Obesity

Stage: Situation of health

Level: Health status (Individual)

Theme: Health capital

most widely used measure of obesity. It is calculated using a person's height and weight (weight in kg / height in meters squared). A healthy BMI is considered to be between 20 and 25. A person with a BMI greater than or equal to 25 and less than 30 is considered to be pre obese (overweight), while a BMI of 30 or more is defined as obese. Obesity can be further subdivided into those who are severely obese (BMI>35) and those who are morbidly obese (BMI>40). A BMI under 20 kg/m² is used as an estimation of those who are underweight.

www.ceregistration.com/portal/file/obesity5.htm

http://www.investingforhealthni.gov.uk/documents/further_obesity_info.pdf

The Fit Futures taskforce was established by the Ministerial Group on Public Health (MGPH) to examine options for tackling childhood obesity.

<http://www.healthpromotionagency.org.uk/Resources/corporate/investingforhealth/pdfs/IfH%20Update%20Report%202006.pdf>

Fit Futures: Focus on Food, Activity and Young People is a cross departmental taskforce that was established by the Ministerial Group on Public Health in August 2004 in response to concerns about the rising levels of overweight and obesity in children and young people. The role of the taskforce was to examine options for preventing the rise in levels of overweight and obesity in children and young people and to make recommendations to the Ministerial Group on priorities for action. The report of the Fit Futures taskforce was published in March 2006. It includes over 70 cross-departmental recommendations designed to deliver the PSA target. A response to the report from the MGPH, including an implementation plan, was published for consultation on 1 February 2007. However, action has already begun and significant progress has been made by the departments and others on a number of the report's recommendations.

The most common health problems linked to obesity are heart disease, diabetes, hypertension and osteoarthritis. According to National Audit Office figures, sustained weight loss of 5–10 kilograms (11–22lbs) could reduce the chances of fatal heart disease by 9% and could reduce the risk of cancer by more than a third. <http://www.dhsspsni.gov.uk/invest1.pdf>

Estimated Costs of Obesity

over 450 deaths per annum;

equivalent to over 4,000 expected years of life lost;

260,000 working days are lost

Approximate cost to the economy is £500 million. <http://www.dhsspsni.gov.uk/invest1.pdf>

Obesity levels in Northern Ireland are rising at an alarming rate with over half of all women and two-thirds of men either overweight or obese. Figures for children are even more worrying with around 20% or more of primary one children being overweight or obese.

It is estimated that obesity causes around 450 deaths each year in Northern Ireland. Being obese reduces life expectancy and can also lead to considerable health problems – significantly increasing the risk of developing Northern Ireland's biggest killer disease – coronary heart disease and cancer. It also increases the risk of developing type 2 diabetes and can lead to depression and lack of self-esteem.

www.dhsspsni.gov.uk/cmoannualreport2006.pdf

The Clinical resource Efficiency Support Team (CREST) was established in 1998 to promote clinical efficiency in the health service in northern Ireland while ensuring the highest possible standard of clinical practice and to identify and disseminate ideas and examples of good

Obesity The Policy Challenges Report of The National Task force on Obesity (NTFO) (2005)
A Strategy for Cancer Control in Ireland National Cancer Forum (DoHC, 2006)

Prevalence of Obesity

Obesity is a major public health problem for both Ireland and Europe, and is described by the World Health Organisation as a 'global epidemic'. Currently, approximately 39% of Irish adults are overweight and 18% are obese. Obesity in Irish adults is increasing by at least 1% every year. In 2004, Ireland had the fourth highest prevalence of overweight and obesity in men in the EU and the seventh highest prevalence among women. It is estimated that over 300,000 children on the island of Ireland are overweight and obese and this is projected to increase annually by 10,000. Annually, approximately 2,000 premature deaths are attributed to obesity, at an estimated cost, in economic terms, of €4bn to the State.

Strategic Policy Developments

In March 2004 the Minister for Health and Children, Micheál Martin established the National Task force on Obesity (NTFO). The terms of reference of the Task force, having regard to current national policies, in particular the Cardiovascular Health Strategy 'Building Healthier Hearts' (1999) and the National Health Promotion Strategy 2000-2005 (2000), were to develop a strategy to halt the rise and reverse the prevalence of obesity. The main work of the Task force included investigating:

- the current rates and trends of obesity in Ireland
- the determinants of obesity in Irish society
- the current and future impact on the health services and society as a whole from the growing trend in obesity
- best practice in the prevention, detection and treatment of obesity
- how best to create the social and physical environments that make it easier for children and adults to eat more healthily and be more active on a regular basis.

The Task force presented a strategy document entitled 'Obesity The Policy Challenges' to the Minister for Health and Children in 2005. The recommendations contained within the NTFO's report have been informed by national strategies and policies, by EU initiatives and by WHO strategies, which Ireland has endorsed. In particular, the Health Promotion Strategy (2000), the Cardiovascular Health Strategy (1999), the National Play Policy (2004), the school syllabi for physical education, Social, Personal and Health Education (SPHE), Biology and Home Economics as well as the Breast feeding Policy (1994) have direct relationships with the NTFO's objective. In addition, as a member of the World Health Organisation, Ireland has signed up to strategies and policies that have a direct impact on the prevention and treatment of overweight and obesity. The Ottawa Charter (1996) and the Jakarta Declaration (1997) are the bases of health promotion principles endorsed by the Health Promotion Strategy. Ireland recently signed up to the WHO Global Strategy on Diet, Physical Activity and Health (2004), which has made recommendations in relation to the responsibility of WHO, Ireland and the public and private sector in the area of diet, physical activity, and health. All these strategies and policies have informed the principles underlying the recommendations of the NTFO. The report of NTFO contains over eighty recommendations, relating to actions across six broad sectors: high-level government, education, social and community, health, food, commodities, production and supply, and the physical environment. In developing its recommendations, the

Obesity

Stage: Situation of health

Level: Health status (Individual)

Theme: Health capital

clinical practice. Reports on diabetes care and the management of obesity have informed the thinking of the taskforce and highlights the need to ensure the efforts to prevent obesity and diabetes are integrated. www.crestni.org.uk/obesity-guidelines-report.pdf In 2005 the Northern Ireland Health and Social Wellbeing Survey found that 645 of adult males and 54% of adult females were either overweight or obese. www.dhsspsni.gov.uk/hwb_topline_bulletin.pdf

Young people who are diagnosed with diabetes face an increasing risk in early adulthood of the advancement of complications associated with diabetes such as kidney failure, blindness and heart disease. Reducing obesity is a key priority for government – by just halting the rise in obesity it is estimated the government could save over £200 million over the next 20 years. The government is striving to drive home the importance of exercise and a healthy diet in combating obesity. However, government cannot tackle this problem on its own – everyone has a part to play in ensuring our population is healthy. www.worlddiabetesday.org/download.cfm?DownloadFile=D72060C4-EA68-2137-A5E4367C82A39717

Rising levels of obesity and lower levels of physical activity will increasingly contribute to the burden of disease. Obesity is a contributory factor to a number of conditions such as stroke and cardiovascular disease. Obese men are more than 33% more likely to die from cancer and obese women more than 50% more likely to die from breast cancer. www.investingforhealthni.gov.uk/fitfutures.asp

We will seek to reverse the current increase in the level of obesity in men and women so that by 2025, the proportion of men who are obese is less than 15% and the proportion of women who are obese is less than 17%. (In 1997 17% of men and 20% of women were obese). Harm will also be avoided by stopping the increase in levels of obesity in children by 2010 and reducing it by 50% by 2025. <http://www.dhsspsni.gov.uk/healthyfuture-section1.pdf> A joint target has been set with the Departments of Education, and Culture, Arts and Leisure to stop the rise in obesity by 2010. <http://www.healthpromotionagency.org.uk/Resources/corporate/investingforhealth/pdfs/IfH%20Update%20Report%202006.pdf>

To stop the increase in the levels of obesity in men and women so that by 2010 the proportion of men who are obese is less than 17%, and of women less than 20%. In 1997, the proportion of men and women who were obese was 17% and 20% respectively but this trend is increasing. - <http://www.healthpromotionagency.org.uk/Resources/corporate/investingforhealth/pdfs/IfH%20Update%20Report%202006.pdf>

As an important step in that direction, I expect the HPSS to make a significant contribution to halting the increase in levels of obesity in our children. http://www.dhsspsni.gov.uk/pfa_06-08.doc

By 31 March 2008 contribute to stopping the increase in the levels of obesity in children through the implementation of integrated plans by Boards, Trusts and Investing for Health partnerships. http://www.dhsspsni.gov.uk/monitoring_06-2.doc

Task force has taken account of the complex, multi-sectoral and multifaceted determinants of diet and physical activity.

The Cancer Control Strategy (2006) proposes that the recommendations of the Report of the National Task Force on Obesity, 2005 should be implemented in full. In particular, it points to a need for measures that raise awareness of the links between diet and cancer. It is estimated that around a third of all cancers are related to diet. The Strategy also recommends that the health services should work with the food industry in order to encourage it to produce, market and improve access to attractive and healthy options. It highlights the importance of both health promotion and knowledge initiatives with regards to nutrition, and the need for affordable and accessible foods such as fruit and vegetables as key barriers to eating a healthier diet.

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Admissions to hospital for circulatory disease

Stage: Situation of Health
Level: Health Status (Individual)
Theme: Morbidity

NORTH-SOUTH COMPARABILITY	Separate North and South components
LAY DESCRIPTION	The rate of admissions to hospital for circulatory diseases per 100,000 European standard population
SOURCE REFERENCE	AIHSC
INDICATOR NAMES	Admissions circulatory NI; Admissions circulatory RoI

DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND			
Directly age and gender standardised rates of admissions (including day cases) to hospital for diseases of circulatory system per 100,000 European standard population. The following ICD codes are included: ICD-9; 390-459; ICD-10; I00-I99.				Directly age and gender standardised rates of admissions (including day cases) to hospital for diseases of circulatory system per 100,000 European standard population. The following ICD codes are included: ICD-9; 390-459; ICD-10; I00-I99.			
Published?	Yes www.dhsspsni.gov.uk	Geography	Hospital provider	Published?	No	Geography	N/a
Frequency	Every year	Latest Year	2007/2008	Frequency	N/a	Latest Year	N/a
Numerator Definition	Number of hospital admissions for circulatory diseases	Geography	LGD	Numerator Definition	Number of hospital admissions for circulatory diseases	Geography	County
Source	Hospital Inpatient System	Year	2005	Source	Hospital Inpatient Enquiry System	Year	2005
Denominator Definition	Mid-year population estimates	Geography	LGD	Denominator Definition	Mid-year population estimates	Geography	County
Source	NISRA	Year	2005	Source	Public Health Information System	Year	2005
DATA ISSUES				DATA ISSUES			
Includes primary and secondary diagnoses.				Includes primary and secondary diagnoses.			
The crude rate was directly age and gender standardised to the European standard population.				The crude rate was directly age and gender standardised to the European standard population. Values for five or less cases in a particular combination of age, sex, and area were not disclosed. The value was assumed to be three.			
				Excludes admissions to private hospitals.			

PUBLIC HEALTH IMPORTANCE
Health care utilisation, including admissions to hospital, reflects the burden of chronic disease in a population, but health care practice and service configuration as well as capacity are also important influences. Non communicable diseases including chronic conditions of ill health and disability now constitute the main burden of disease globally and especially so in developed countries with adverse effects on population health, health systems and economic and social development. In Europe, the leading causes of death include cardiovascular disease, cancers and disorders of the respiratory, digestive and neuropsychiatric systems, while the main contributions to morbidity come from cardiovascular disease, neuropsychiatric conditions and cancers. Circulatory or cardiovascular disease includes heart disease and stroke.
Chronic illnesses now command most health care resources despite being often underdiagnosed and undertreated. A small number of common risk factors, including tobacco use, alcohol abuse, raised blood pressure, raised cholesterol, being overweight, low fruit and vegetable intake and physical inactivity, are responsible for most of the burden of chronic illness in developed countries. Individuals hold some personal responsibility for healthy lifestyle behaviours, disease prevention and self management, but political commitment and sustainable policies to create supportive environments are also required, especially in order to address the apparent inequalities in disease risk for disadvantaged populations (WHO, 2004). In addition to the burden of chronic disease from neuropsychiatric disorders, mental health problems also increase the risk of admission to hospital in patients with cardiovascular disease (Smith <i>et al</i> , 2000).

Admissions to hospital for circulatory disease

Stage: Situation of Health

Level: Health Status (Individual)

Theme: Morbidity

Changes in the management of chronic illness and disability are necessary to optimise use of limited health care resources and improve population health outcomes (Wanless, 2002). Shifting the balance of care will require changes in location of services towards community based facilities, a greater focus on long term conditions and changing roles and responsibilities for service users and providers (Johnston, Lardner & Jepson, 2008). Integrated chronic disease management with an emphasis on self managed and intermediate care can reduce number of acute hospital bed days mainly by shortening length of stay. Differences in admission rates have been shown to be less important in relation to cardiovascular and respiratory disease as well as other chronic conditions (Ham, York, Sutch *et al*, 2003). Access to primary care has the potential to reduce the need for costly acute hospital care, but both need to be provided and accessible according to need and not ability to pay in order to be equitable (Farrell, McAvoy, Wilde *et al*, 2008).

POLICY CONTEXT – NORTHERN IRELAND

The Northern Ireland public health strategy *Investing for Health* (DHSSPS, 2002) www.dhsspsni.gov.uk is an interagency framework for partnership working to improve health and wellbeing and to reduce health inequalities. Its two main goals are to improve people's health by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability, and to reduce inequalities in health between geographic areas, socio-economic and minority groups. It recognises the improvements in health and wellbeing achieved in recent decades, but identifies high levels of cardiovascular disease, respiratory disease and cancer contributed to by unhealthy lifestyles and socioeconomic conditions, leading to many people living much of their lives in poor health and dying prematurely with huge costs to individuals and society. One of its objectives is to improve neighbourhoods and the wider environment:

- To reduce levels of respiratory and heart disease by meeting the health based objectives for clean air.

A Five Year Tobacco Action Plan 2003-2008 (DHSSPSNI, 2003) www.dhsspsni.gov.uk identifies twenty four multi agency action points to change public perception of tobacco use, prevention, helping smokers to quit and protecting the public from tobacco smoke, especially in disadvantaged adults, young people and pregnant women as key target groups.

The "Fit Futures" Taskforce was set up in 2004 to consider and evaluate options for tackling overweight and obesity in children and young people. Obesity, poor nutrition and inactivity are major risk factors for chronic diseases such as coronary heart disease, cancer and diabetes. A Public Service Agreement (PSA) target has now been set to stop the rise in obesity in children by 2010. Efforts are being made by the Department of Education to improve the nutritional value of school meals.

The primary care strategy *Caring for People Beyond Tomorrow* (DHSSPS, 2004) www.dhsspsni.gov.uk acknowledges the need for health promotion, enhanced social wellbeing and disease prevention to improve population health and reduce levels of chronic illness.

A Healthier Future – A Twenty year Vision for Health and Wellbeing in Northern Ireland 2005-2025 (DHSSPS, 2004) <http://www.dhsspsni.gov.uk> undertakes to prioritise public health to reduce mortality and morbidity relating to coronary heart disease, cancers, stroke and chronic respiratory disorders. It acknowledges the significant contribution of medication related problems and multiple morbidity especially in older people to high levels of acute hospital services use. It aims to increase efficiency by avoiding unnecessary hospital admissions and includes specific primary prevention targets:

- To increase the proportion of 11-16 year old children who do not smoke from 86.9% in 2003 to 95% in 2025,

POLICY CONTEXT – REPUBLIC OF IRELAND

The Cardiovascular Health Strategy *Building Healthier Hearts* (DoHC, 1999) www.dohc.ie aimed to prevent cardiovascular disease by reducing the population risk factor profile and detecting those at risk as well as treating those with established disease.

The strategic aims of the *National Health Promotion Strategy 2000-2005* (DoHC, 2000) www.dohc.ie included the promotion of healthy lifestyles to reduce the burden of chronic illness. It made particular reference to hospital admission for mental health problems and rising suicide rates in Ireland, pointing to inequalities in hospital admission rates, which appear to be higher in people from lower socioeconomic groups. One of the nine topics in the strategy was 'being smoke free'. It recommended:

- To increase the percentage of the population who remain non-smokers with a particular emphasis on narrowing the gap across social classes and to protect non-smokers from passive smoking.

The strategy's review (NUI Galway, 2004) www.nuigalway.ie called for a system to monitor the implementation of national strategies, a national research and development plan to guide evidence based policy and practice and sustainable funding.

Towards a Tobacco Free Society (DoHC, 2001) <http://www.dohc.ie> proposes an integrated strategy for tackling tobacco consumption and promoting a tobacco-free society.

The national health strategy *Quality and Fairness- A Health System for you* (DoHC, 2001) www.dohc.ie identified the need for continuing actions on major lifestyle factors to promote health and wellbeing, prevent illness and improve population health. It endorsed the National Cancer, Cardiovascular and Health Promotion Strategies. It acknowledged the shortage of acute hospital beds, especially in light of increasing in the overall population and older people in particular, despite increases in day care procedures, use of new health technologies and reduced inpatient stay duration, but also pointed to variations in hospital efficiency and performance. It announced the establishment of a National Treatment Purchase fund to improve co operation between the public and private health sector, to increase acute hospital bed capacity, to improve waiting list and overall hospital management. It also tasked the newly established Health Information and Quality Authority with developing chronic disease management programmes. It describes current and future policy and legislative developments with regards to smoking in Ireland to tackle cancer and cardiovascular disease and to promote healthier lifestyles. In continuing to implement the National Cancer, Cardiovascular and Health Promotion Strategies it calls for enhanced health promotion initiatives aimed at addressing the risk factors associated with cancers and cardiovascular disease such as smoking and targeting a reduction in smoking for young women, supported by appropriate fiscal policies.

The national Primary Care Strategy- A New Direction (DoHC, 2001) www.dohc.ie

Admissions to hospital for circulatory disease

Stage: Situation of Health

Level: Health Status (Individual)

Theme: Morbidity

- To increase the proportion of adults who do not smoke from 74% in 2002/03 to 95% in 2025,
- To reverse the current trends on levels of obesity for men, women and children, and
- To reduce levels of alcohol consumption.

The *Programme for Government 2008- 2011* Public Service Agreement Framework (NIE, 2008) www.pfgbudgetni.gov.uk endeavours to promote health and address health inequalities by promoting healthy lifestyles, addressing the causes of poor health and wellbeing, thereby achieving measurable reductions in health inequalities and preventable illness. Under Public Service Agreement (PSA) 18 'Deliver High Quality Health and Social Services' it undertakes to promote independent living and a reduction in avoidable admissions to hospital. It aims:

- To reduce unplanned hospital admissions for case managed patients with severe chronic disease (e.g. heart disease and respiratory conditions), and
- By 2011 to ensure a 10% reduction in mortality and disability from stroke.

A *Service Framework for Cardiovascular Health and Wellbeing* (DHSSPS, 2008) www.dhsspsni.gov.uk will be published towards the end of 2008 and is expected to include performance indicators and targets for standards of good practice in the areas of disease prevention and management.

emphasised the importance of increasing health care and support capacity in communities to reduce crisis hospital admissions. It proposed the establishment of multidisciplinary primary care teams.

The *Office of Tobacco Control* (OTC) was established as a statutory structure in May 2002 to increase the capacity of government and the health services to tackle the problem of smoking.

The *Public Health (Tobacco) Act (2002)* and the *Public Health (Tobacco) Amendment Act (2004)* legislation www.irishstatutebook.ie place restrictions and conditions on the advertising, sale and consumption of tobacco. It includes the ban on smoking in indoor work and public places implemented in Ireland in 2004.

In 2005, Ireland became the 101st country to ratify the World Health Organisation (WHO) Framework Convention on Tobacco www.who.int.

The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie (2006) recognises the existence of health inequalities and acknowledges the fact that people in poverty are twice as likely to suffer from a chronic illness. It proposes to reduce hospital admissions especially for the elderly through community based early intervention teams. This suggestion is endorsed in the *National Development Plan Transforming Ireland- A Better Quality of Life for All 2007- 2013* <http://www.esri.ie>, which provides investment to reconfigure, improve and expand health services.

The Ten- Year Framework Social Partnership Agreement 2006-2015 *Towards 2016* (2006) www.taoiseach.gov.ie aims to improve the health and well being of the whole population and population sub-groups. It acknowledges the need to promote equity and to address a strong social class gradient in health status. It states that those in the lowest socio-economic group have the highest death rates and the lowest survival rates for major preventative diseases such as cancer or cardiovascular conditions. It undertakes to narrow this gap and influence the major factors which determine the health and well-being of the population by targeting resources to those most in need.

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Admissions to hospital for respiratory conditions

Stage: Situation of Health

Level: Health Status (Individual)

Theme: Morbidity

NORTH-SOUTH COMPARABILITY	Separate North and South components
LAY DESCRIPTION	The rate of admissions to hospital for respiratory conditions per 100,000 European standard population
SOURCE REFERENCE	AIHSC
INDICATOR NAMES	Admissions respiratory NI; Admissions respiratory RoI

DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND			
Directly age and gender standardised rate of admissions (including day cases) to hospital for diseases of respiratory system per 100,000 European standard population.				Directly age and gender standardised rate of admissions (including day cases) to hospital for diseases of respiratory system per 100,000 European standard population.			
The following ICD codes are included: ICD-9; 460-519; ICD-10; J00-J99. The data include primary and secondary diagnoses.				The following ICD codes are included: ICD-9; 460-519; ICD-10; J00-J99. The data include primary and secondary diagnoses.			
Published?	Yes	Geography	Hospital provider	Published?	No	Geography	N/a
	www.dhsspsni.gov.uk						
Frequency	Every year	Latest Year	2007/2008	Frequency	N/a	Latest Year	N/a
Numerator				Numerator			
Definition	Number of hospital admissions	Geography	LGD	Definition	Number of hospital admissions	Geography	County
Source	Hospital Inpatient System	Year	2005	Source	Hospital Inpatient Enquiry System	Year	2005
Denominator				Denominator			
Definition	Mid-year population estimates	Geography	LGD	Definition	Mid-year population estimate	Geography	County
Source	NISRA	Year	2005	Source	Public Health Information System	Year	2005
DATA ISSUES				DATA ISSUES			
Includes primary and secondary diagnoses.				Includes primary and secondary diagnoses.			
The crude rate was directly age and gender standardised to the European standard population.				The crude rate was directly age and gender standardised to the European standard population. Values for five or less cases in a particular combination of age, sex, and area were not disclosed. The value was assumed to be three.			
				Excludes admissions to private hospitals.			

PUBLIC HEALTH IMPORTANCE
Health care utilisation, including admissions to hospital, reflects the burden of chronic disease in a population, but health care practice and service configuration as well as capacity are also important influences. Non communicable diseases including chronic conditions of ill health and disability now constitute the main burden of disease globally and especially so in developed countries with adverse effects on population health, health systems and economic and social development. In Europe, the leading causes of death include cardiovascular disease, cancers and disorders of the respiratory, digestive and neuropsychiatric systems, while the main contributions to morbidity come from cardiovascular disease, neuropsychiatric conditions and cancers.
Chronic illnesses now command most health care resources despite being often underdiagnosed and undertreated. A small number of common risk factors, including tobacco use, alcohol abuse, raised blood pressure, raised cholesterol, being overweight, low fruit and vegetable intake and physical inactivity, are responsible for most of the burden of chronic illness in developed countries. Individuals hold some personal responsibility for healthy lifestyle behaviours, disease prevention and self management, but political commitment and

Admissions to hospital for respiratory conditions

Stage: Situation of Health

Level: Health Status (Individual)

Theme: Morbidity

sustainable policies to create supportive environments are also required, especially in order to address the apparent inequalities in disease risk for disadvantaged populations (WHO, 2004). Admissions to hospital from chronic respiratory conditions including COPD, asthma and lung cancer is one of the leading causes for acute hospital bed utilisation as well as health care resource utilisation (Alder, Mayhew, Moody *et al*, 2005).

Changes in the management of chronic illness and disability are necessary to optimise use of limited health care resources and improve population health outcomes (Wanless, 2002). Shifting the balance of care will require changes in location of services towards community based facilities, a greater focus on long term conditions and changing roles and responsibilities for service users and providers (Johnston, Lardner & Jepson, 2008). Integrated chronic disease management with an emphasis on self managed and intermediate care can reduce number of acute hospital bed days mainly by shortening length of stay. Differences in admission rates have been shown to be less important in relation to cardiovascular and respiratory disease as well as other chronic conditions (Ham, York, Sutch *et al*, 2003). Access to primary care has the potential to reduce the need for costly acute hospital care, but both need to be provided and accessible according to need and not ability to pay in order to be equitable (Farrell, McAvoy, Wilde *et al*, 2008). Community based nursing outreach programmes might improve mortality and quality of life for patients with moderate Chronic Obstructive Pulmonary Disease (COPD), but appears not to reduce hospital admissions (Smith, Appleton, Adams *et al*, 2001).

POLICY CONTEXT – NORTHERN IRELAND

The Northern Ireland public health strategy *Investing for Health* (DHSSPS, 2002) www.dhsspsni.gov.uk is an interagency framework for partnership working to improve health and wellbeing and to reduce health inequalities. Its two main goals are to improve people's health by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability, and to reduce inequalities in health between geographic areas, socio- economic and minority groups. It recognises the improvements in health and wellbeing achieved in recent decades, but identifies high levels of cardiovascular disease, respiratory disease and cancer contributed to by unhealthy lifestyles and socioeconomic conditions, leading to many people living much of their lives in poor health and dying prematurely with huge costs to individuals and society. One of its objectives is to improve neighbourhoods and the wider environment:

- To reduce levels of respiratory and heart disease by meeting the health based objectives for clean air.

A Five Year Tobacco Action Plan 2003-2008 (DHSSPSNI, 2003) www.dhsspsni.gov.uk identifies twenty four multi agency action points to change public perception of tobacco use, prevention, helping smokers to quit and protecting the public from tobacco smoke, especially in disadvantaged adults, young people and pregnant women as key target groups.

The primary care strategy *Caring for People Beyond Tomorrow* (DHSSPS, 2004) www.dhsspsni.gov.uk acknowledges the need for health promotion, enhanced social wellbeing and disease prevention to improve population health and reduce levels of chronic illness.

A Healthier Future – A Twenty year Vision for Health and Wellbeing in Northern Ireland 2005-2025 (DHSSPS, 2004) <http://www.dhsspsni.gov.uk> undertakes to prioritise public health to reduce mortality and morbidity relating to coronary heart disease, cancers, stroke and chronic respiratory disorders. It acknowledges the significant contribution of medication related problems and multiple morbidity especially in older people to high levels of acute hospital services use. It aims to increase efficiency by avoiding unnecessary hospital admissions and includes specific primary prevention targets:

- To increase the proportion of 11-16 year old children who do not smoke from 86.9% in 2003 to 95% in 2025, and

POLICY CONTEXT – REPUBLIC OF IRELAND

The strategic aims of the *National Health Promotion Strategy 2000-2005* (DoHC, 2000) www.dohc.ie included the promotion of healthy lifestyles to reduce the burden of chronic illness. It made particular reference to hospital admission for mental health problems and rising suicide rates in Ireland, pointing to inequalities in hospital admission rates, which appear to be higher in people from lower socioeconomic groups. One of the nine topics in the strategy was 'being smoke free'. It recommended:

- To increase the percentage of the population who remain non- smokers with a particular emphasis on narrowing the gap across social classes and to protect non- smokers from passive smoking.

The strategy's review (NUI Galway, 2004) www.nuigalway.ie called for a system to monitor the implementation of national strategies, a national research and development plan to guide evidence based policy and practice and sustainable funding.

Towards a Tobacco Free Society (DoHC, 2001) <http://www.dohc.ie> proposes an integrated strategy for tackling tobacco consumption and promoting a tobacco-free society.

The national health strategy *Quality and Fairness- A Health System for you* (DoHC, 2001) www.dohc.ie identified the need for continuing actions on major lifestyle factors to promote health and wellbeing, prevent illness and improve population health. It endorsed the National Cancer, Cardiovascular and Health Promotion Strategies. It acknowledged the shortage of acute hospital beds, especially in light of increasing in the overall population and older people in particular, despite increases in day care procedures, use of new health technologies and reduced inpatient stay duration, but also pointed to variations in hospital efficiency and performance. It announced the establishment of a National Treatment Purchase fund to improve co operation between the public and private health sector, to increase acute hospital bed capacity, to improve waiting list and overall hospital management. It also tasked the newly established Health Information and Quality Authority with developing chronic disease management programmes. It describes current and future policy and legislative developments with regards to smoking in Ireland to tackle cancer and cardiovascular disease and to promote healthier lifestyles. In continuing to implement the National Cancer, Cardiovascular and Health Promotion Strategies it calls for enhanced health promotion initiatives aimed at addressing the risk factors associated with cancers and cardiovascular disease such as smoking and targeting a reduction in smoking for young women, supported by appropriate fiscal policies.

Admissions to hospital for respiratory conditions

Stage: Situation of Health

Level: Health Status (Individual)

Theme: Morbidity

- To increase the proportion of adults who do not smoke from 74% in 2002/03 to 95% in 2025.

The *Strategic Framework for Respiratory Conditions* (DHSSPS, 2006)

<http://www.dhsspsni.gov.uk> recommended recording of smoking status, professional advice to quit and access to smoking cessation services.

The *Regional Cancer Framework- A Cancer Control Plan for Northern Ireland* (DHSSPS, 2006) <http://www.dhsspsni.gov.uk> proposes to reduce smoking levels in younger people, improve smoking cessation services and public education, utilise community and primary care services.

The *Programme for Government 2008- 2011* Public Service Agreement Framework (NIE, 2008) www.pfgbudgetni.gov.uk endeavours to promote health and address health inequalities by promoting healthy lifestyles, addressing the causes of poor health and wellbeing, thereby achieving measurable reductions in health inequalities and preventable illness. Under Public Service Agreement (PSA) 18 'Deliver High Quality Health and Social Services' it undertakes to promote independent living and a reduction in avoidable admissions to hospital. It aims:

- To reduce unplanned hospital admissions for case managed patients with severe chronic disease (e.g. heart disease and respiratory conditions).

Under PSA 8 'Promoting health and addressing health inequalities' it aims:

- To reduce to 21% and 25% respectively the proportion of adults and manual worker subsets who smoke by 2011.

The national Primary Care Strategy- A New Direction (DoHC, 2001) www.dohc.ie emphasised the importance of increasing health care and support capacity in communities to reduce crisis hospital admissions. It proposed the establishment of multidisciplinary primary care teams.

The *Office of Tobacco Control* (OTC) was established as a statutory structure in May 2002 to increase the capacity of government and the health services to tackle the problem of smoking.

The *Public Health (Tobacco) Act (2002)* and the *Public Health (Tobacco) Amendment Act (2004)* legislation www.irishstatutebook.ie place restrictions and conditions on the advertising, sale and consumption of tobacco. It includes the ban on smoking in indoor work and public places implemented in Ireland in 2004.

In 2005, Ireland became the 101st country to ratify the World Health Organisation (WHO) Framework Convention on Tobacco www.who.int.

The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie (2006) recognises the existence of health inequalities and acknowledges the fact that people in poverty are twice as likely to suffer from a chronic illness. It proposes to reduce hospital admissions especially for the elderly through community based early intervention teams. This suggestion is endorsed in the *National Development Plan Transforming Ireland- A Better Quality of Life for All 2007- 2013* <http://www.esri.ie>, which provides investment to reconfigure, improve and expand health services.

The Ten- Year Framework Social Partnership Agreement 2006-2015 *Towards 2016* (2006) www.taoiseach.gov.ie aims to improve the health and well being of the whole population and population sub-groups. It acknowledges the need to promote equity and to address a strong social class gradient in health status. It states that those in the lowest socio-economic group have the highest death rates and the lowest survival rates for major preventable diseases. It undertakes to narrow this gap and influence the major factors which determine the health and well-being of the population by targeting resources to those most in need.

The *Strategy for Cancer Control in Ireland* (DoHC, 2006) <http://www.dohc.ie> describes the ban on smoking in indoor public places, which was implemented in Ireland in 2004, as a very significant success and an example of how Ireland can play a leadership role in cancer control internationally. It makes a number of recommendations with regards to tobacco:

- Compliance with all provisions of the Public Health (Tobacco) Acts 2002 and 2004 should be monitored.
- Excise duty on cigarettes should be substantially increased each year above the rate of inflation.
- Nicotine replacement therapy should be made available free of charge to all medical card holders.

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Admissions to hospital for respiratory conditions

Stage: Situation of Health

Level: Health Status (Individual)

Theme: Morbidity

Ham, C., York, N., Sutch, S., Shaw, R. (2003). Hospital bed utilisation in the NHS, Kaiser Permanente, and the US Medicare programme: analysis of routine data. *BMJ* Vol. 327, pp 1257- 1261.

Farrell, C., McAvoy, H., Wilde, J. & Combat Poverty Agency (2008). *Tackling Health Inequalities- An All- Ireland Approach to Social Determinants*. Dublin: Combat Poverty Agency/ Institute of Public health in Ireland.

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Alder, J., Mayhew, L., Moody, S., Morris, R., Shah, R. (2005). *The chronic disease burden- An analysis of health risks and health care usage*. London: Cass Business School.

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Admissions to hospital

Stage: Situation of Health

Level: Health Status (Individual)

Theme: Morbidity

NORTH-SOUTH COMPARABILITY	Separate North and South components
LAY DESCRIPTION	The rate of all admissions to hospital per 100,000 European standard population
SOURCE REFERENCE	AIHSC
INDICATOR NAMES	Admissions hospital NI; Admissions hospital RoI

DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND			
Directly age and gender standardised rate of all admissions (including day cases) to hospital per 100,000 European standard population				Directly age and gender standardised rate of all admissions (including day cases) to hospital per 100,000 European standard population			
Published?	Yes www.dhsspsni.gov.uk	Geography	Hospital provider	Published?	Yes Public Health information System (PHIS) – Information Unit, Department of Health & Children, Table 13	Geography	County
Frequency	Every year	Latest Year	2007/2008	Frequency	Every year	Latest Year	2005
Numerator Definition	Number of hospital admissions	Geography	LGD	Numerator Definition	Number of hospital admissions	Geography	County
Source	Hospital Inpatient System	Year	2005	Source	Hospital Inpatient Enquiry System (HIPE)	Year	2005
Denominator Definition	Mid-year population estimates	Geography	LGD	Denominator Definition	Mid-year population estimate	Geography	County
Source	NISRA	Year	2005	Source	Public Health information System	Year	2005
DATA ISSUES				DATA ISSUES			
The crude rate was directly age and gender standardised to the European standard population.				The crude rate was directly age and gender standardised to the European standard population. Values for five or less cases in a particular combination of age, sex, and area were not disclosed. The value was assumed to be three.			
				Excludes admissions to private hospitals.			

PUBLIC HEALTH IMPORTANCE

Health care utilisation, including admissions to hospital, reflects the burden of chronic disease in a population, but health care practice and service configuration as well as capacity are also important influences. Non communicable diseases including chronic conditions of ill health and disability now constitute the main burden of disease globally and especially so in developed countries with adverse effects on population health, health systems and economic and social development. In Europe, the leading causes of death include cardiovascular disease, cancers and disorders of the respiratory, digestive and neuropsychiatric systems, while the main contributions to morbidity come from cardiovascular disease, neuropsychiatric conditions and cancers.

Chronic illnesses now command most health care resources despite being often underdiagnosed and undertreated. A small number of common risk factors, including tobacco use, alcohol abuse, raised blood pressure, raised cholesterol, being overweight, low fruit and vegetable intake and physical inactivity, are responsible for most of the burden of chronic illness in developed countries. Individuals hold some personal responsibility for healthy lifestyle behaviours, disease prevention and self management, but political commitment and sustainable policies to create supportive environments are also required, especially in order to address the apparent inequalities in disease risk for disadvantaged populations (WHO, 2004). In addition to the burden of chronic disease from neuropsychiatric disorders, mental health problems also increase the risk of admission to hospital in patients with cardiovascular disease (Smith *et al*, 2000). Changes in the management of chronic illness and disability are necessary to optimise use of limited health care resources and improve population health outcomes (Wanless, 2002). Shifting the balance of care will require changes in location of services towards community based facilities, a greater focus on long term

Admissions to hospital

Stage: Situation of Health

Level: Health Status (Individual)

Theme: Morbidity

conditions and changing roles and responsibilities for service users and providers (Johnston, Lardner & Jepson, 2008). Integrated chronic disease management with an emphasis on self managed and intermediate care can reduce number of acute hospital bed days mainly by shortening length of stay. Differences in admission rates have been shown to be less important in relation to cardiovascular and respiratory disease as well as other chronic conditions (Ham, York, Sutcliffe *et al*, 2003). Access to primary care has the potential to reduce the need for costly acute hospital care, but both need to be provided and accessible according to need and not ability to pay in order to be equitable (Farrell, McAvoey, Wilde *et al*, 2008).

POLICY CONTEXT – NORTHERN IRELAND

The Northern Ireland public health strategy *Investing for Health* (DHSSPS, 2002) www.dhsspsni.gov.uk is an interagency framework for partnership working to improve health and wellbeing and to reduce health inequalities. Its two main goals are to improve people's health by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability, and to reduce inequalities in health between geographic areas, socio-economic and minority groups. It recognises the improvements in health and wellbeing achieved in recent decades, but identifies high levels of cardiovascular disease, respiratory disease and cancer contributed to by unhealthy lifestyles and socioeconomic conditions, leading to many people living much of their lives in poor health and dying prematurely with huge costs to individuals and society. One of its objectives is to improve neighbourhoods and the wider environment:

- To reduce levels of respiratory and heart disease by meeting the health based objectives for clean air.

It also refers to the importance of mental health and wellbeing and injury prevention to improve population health, address inequalities and reduce health service utilisation.

A Five Year Tobacco Action Plan 2003-2008 (DHSSPSNI, 2003) www.dhsspsni.gov.uk identifies twenty four multi agency action points to change public perception of tobacco use, prevention, helping smokers to quit and protecting the public from tobacco smoke, especially in disadvantaged adults, young people and pregnant women as key target groups.

The "Fit Futures" Taskforce was set up in 2004 to consider and evaluate options for tackling overweight and obesity in children and young people. Obesity, poor nutrition and inactivity are major risk factors for chronic diseases such as coronary heart disease, cancer and diabetes. A Public Service Agreement (PSA) target has now been set to stop the rise in obesity in children by 2010. Efforts are being made by the Department of Education to improve the nutritional value of school meals.

The primary care strategy *Caring for People Beyond Tomorrow* (DHSSPS, 2004) www.dhsspsni.gov.uk acknowledges the need for health promotion, enhanced social wellbeing and disease prevention to improve population health and reduce levels of chronic illness.

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- To increase the proportion of 11-16 year old children who do not smoke from 86.9% in 2003 to 95% in 2025,

POLICY CONTEXT – REPUBLIC OF IRELAND

The strategic aims of the *National Health Promotion Strategy 2000-2005* (DoHC, 2000) www.dohc.ie included the promotion of healthy lifestyles to reduce the burden of chronic illness. It made particular reference to hospital admission for mental health problems and rising suicide rates in Ireland, pointing to inequalities in hospital admission rates, which appear to be higher in people from lower socioeconomic groups. One of the nine topics in the strategy was 'being smoke free'. It recommended:

- To increase the percentage of the population who remain non-smokers with a particular emphasis on narrowing the gap across social classes and to protect non-smokers from passive smoking.

The strategy's review (NUI Galway, 2004) www.nuigalway.ie called for a system to monitor the implementation of national strategies, a national research and development plan to guide evidence based policy and practice and sustainable funding.

Towards a Tobacco Free Society (DoHC, 2001) <http://www.dohc.ie> proposes an integrated strategy for tackling tobacco consumption and promoting a tobacco-free society.

The national health strategy *Quality and Fairness- A Health System for you* (DoHC, 2001) www.dohc.ie identified the need for continuing actions on major lifestyle factors to promote health and wellbeing, prevent illness and improve population health. It endorsed the National Cancer, Cardiovascular and Health Promotion Strategies. It acknowledged the shortage of acute hospital beds, especially in light of increasing in the overall population and older people in particular, despite increases in day care procedures, use of new health technologies and reduced inpatient stay duration, but also pointed to variations in hospital efficiency and performance. It announced the establishment of a National Treatment Purchase fund to improve co operation between the public and private health sector, to increase acute hospital bed capacity, to improve waiting list and overall hospital management. It also tasked the newly established Health Information and Quality Authority with developing chronic disease management programmes. It describes current and future policy and legislative developments with regards to smoking in Ireland to tackle cancer and cardiovascular disease and to promote healthier lifestyles. In continuing to implement the National Cancer, Cardiovascular and Health Promotion Strategies it calls for enhanced health promotion initiatives aimed at addressing the risk factors associated with cancers and cardiovascular disease such as smoking and targeting a reduction in smoking for young women, supported by appropriate fiscal policies.

The national Primary Care Strategy- *A New Direction* (DoHC, 2001) www.dohc.ie emphasised the importance of increasing health care and support capacity in communities to reduce crisis hospital admissions. It proposed the establishment of multidisciplinary primary care teams.

The *Office of Tobacco Control* (OTC) was established as a statutory structure in May 2002 to increase the capacity of government and the health services to tackle the problem of smoking.

Admissions to hospital

Stage: Situation of Health

Level: Health Status (Individual)

Theme: Morbidity

- To increase the proportion of adults who do not smoke from 74% in 2002/03 to 95% in 2025,
- To reverse the current trends on levels of obesity for men, women and children, and
- To reduce levels of alcohol consumption.

The *Strategic Framework for Respiratory Conditions* (DHSSPS, 2006) <http://www.dhsspsni.gov.uk> recommended recording of smoking status, professional advice to quit and access to smoking cessation services.

The *Programme for Government 2008- 2011* Public Service Agreement Framework (NIE, 2008) www.pfgbudgetni.gov.uk endeavours to promote health and address health inequalities by promoting healthy lifestyles, addressing the causes of poor health and wellbeing, thereby achieving measurable reductions in health inequalities and preventable illness. Under Public Service Agreement (PSA) 18 'Deliver High Quality Health and Social Services' it undertakes to promote independent living and a reduction in avoidable admissions to hospital. It aims:

- To reduce unplanned hospital admissions for case managed patients with severe chronic disease (e.g. heart disease and respiratory conditions).

The *Public Health (Tobacco) Act (2002)* and the *Public Health (Tobacco) Amendment Act (2004)* legislation www.irishstatutebook.ie place restrictions and conditions on the advertising, sale and consumption of tobacco. It includes the ban on smoking in indoor work and public places implemented in Ireland in 2004.

In 2005, Ireland became the 101st country to ratify the World Health Organisation (WHO) Framework Convention on Tobacco www.who.int.

The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie (2006) recognises the existence of health inequalities and acknowledges the fact that people in poverty are twice as likely to suffer from a chronic illness. It proposes to reduce hospital admissions especially for the elderly through community based early intervention teams. This suggestion is endorsed in the *National Development Plan Transforming Ireland- A Better Quality of Life for All 2007- 2013* <http://www.esri.ie>, which provides investment to reconfigure, improve and expand health services.

The Ten- Year Framework Social Partnership Agreement 2006-2015 *Towards 2016* (2006) www.taoiseach.gov.ie aims to improve the health and well being of the whole population and population sub-groups. It acknowledges the need to promote equity and to address a strong social class gradient in health status. It states that those in the lowest socio-economic group have the highest death rates and the lowest survival rates for major preventative diseases such as cancer or cardiovascular conditions. It undertakes to narrow this gap and influence the major factors which determine the health and well-being of the population by targeting resources to those most in need.

The *Strategy for Cancer Control in Ireland* (DoHC, 2006) <http://www.dohc.ie> describes the ban on smoking in indoor public places, which was implemented in Ireland in 2004, as a very significant success and an example of how Ireland can play a leadership role in cancer control internationally. It makes a number of recommendations with regards to tobacco:

- Compliance with all provisions of the Public Health (Tobacco) Acts 2002 and 2004 should be monitored.
- Excise duty on cigarettes should be substantially increased each year above the rate of inflation.
- Nicotine replacement therapy should be made available free of charge to all medical card holders.

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Lung cancer incidence rates

Stage: Situation of Health

Level: Health Status (Individual)

Theme: Morbidity

NORTH-SOUTH COMPARABILITY	All-island component			
LAY DESCRIPTION	The number of new cases of lung cancer per 100,000 European standard population			
SOURCE REFERENCE	AIHSC			
INDICATOR NAME	SIR lung cancer			
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND		
Directly age standardised rates per 100,000 European standard population of the incidence of lung and bronchus cancers 1998-2000.		Directly age standardised rates per 100,000 European standard population of the incidence of lung and bronchus cancers 1998-2000.		
The following ICD codes were included: ICD-10; C34		The following ICD codes were included: ICD-9; 162, 162.2-162.9		
Published?	Yes www.qub.ac.uk/nicr	Geography	LGD	
Frequency	Every year	Latest Year	2006	
Numerator Definition	Number of new cases of lung cancer	Geography	LGD	
Source	NICR	Year	1998-2000	
Denominator Definition	Mid-year population estimates	Geography	LGD	
Source	NISRA	Year	1998-2000	
DATA ISSUES		DATA ISSUES		
PUBLIC HEALTH IMPORTANCE				
<p>Tobacco smoking remains the single greatest cause of preventable illness and premature death in the United Kingdom (Secretaries of State, 1998). Tobacco is the single largest cause of cancer, accounting for 30% of all cancer deaths in developed countries and causing 90% of all lung cancer, which has particularly low cure- and five year survival rates. Environmental tobacco smoke is also carcinogenic (DoHC, 2006). Tobacco smoke also causes lung and cardiovascular disease. It worsens asthma and osteoporosis. It affects the growth of unborn babies and the health of children. Smoking is addictive and most smokers take up the habit as children and teenagers. Those from disadvantaged groups of the population are most at risk (Acheson, 1998).</p> <p>With higher levels of smoking in deprived populations, tobacco is the principal cause of the gap in life expectancy between rich and poor (Secretaries of State, 1998). Among 1000 20 year old smokers, one is likely to be murdered, six will die in accidents, but 250 will die in middle age from smoking and a further 250 in old age (Peto et al, 1994). The costs to individuals and societies in terms of ill health, impaired quality and loss of life, financial burden on health services and lost productivity are immense. The occurrence of cancer and the experience that people have of services for cancer demonstrate health inequalities. These are due to genetic factors and different exposure to risk factors such as smoking, alcohol consumption and poor nutrition. Other factors include differences in the awareness of, and response to, cancer symptoms, lower uptake of screening programmes and variations in access to health services. While cancer will become more common due to an ageing population and a growing burden of chronic illness, changes in lifestyles like reduced tobacco use and improvements in prevention can lead to reduced incidence rates for some cancers (French, Catney & Gavin, 2006).</p>				
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND		
The Northern Ireland public health strategy <i>Investing for Health</i> (DHSSPS, 2002)				

Lung cancer incidence rates

Stage: Situation of Health

Level: Health Status (Individual)

Theme: Morbidity

www.dhsspsni.gov.uk is an interagency framework for partnership working to improve health and wellbeing and to reduce health inequalities. Its two main goals are to improve people's health by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability, and to reduce inequalities in health between geographic areas, socio- economic and minority groups. It recognises the improvements in health and wellbeing achieved in recent decades, but identifies high levels of cardiovascular disease, respiratory disease and cancer contributed to by unhealthy lifestyles and socioeconomic conditions, leading to many people living much of their lives in poor health and dying prematurely. It specifically proposes actions to reduce smoking levels in the population.

Cancer Research UK is a leading independent organisation dedicated to cancer research. Cancer Research Northern Ireland is part of Cancer Research UK. The Cancer Research UK's policy document 'The Cancer Challenge- Cancer Research UK's Agenda for Change' (September, 2004) www.cancerresearchuk.org contains recommendations for Government action in the areas of cancer prevention and public health, improving cancer treatment, science, research and technology and charity law, regulation and finance.

The primary care strategy *Caring for People Beyond Tomorrow* (DHSSPS, 2004) www.dhsspsni.gov.uk acknowledges the need for health promotion, enhanced social wellbeing and disease prevention to improve population health and reduce levels of chronic illness.

A Five Year Tobacco Action Plan 2003-2008 (DHSSPSNI, 2003) www.dhsspsni.gov.uk identifies twenty four multi agency action points to change public perception of tobacco use, prevention, helping smokers to quit and protecting the public from tobacco smoke, especially in disadvantaged adults, young people and pregnant women as key target groups. Since the introduction of the smoking ban in April 2007, smoking is no longer permitted in enclosed public spaces, including workplaces.

A Healthier Future – A Twenty year Vision for Health and Wellbeing in Northern Ireland 2005-2025 (DHSSPS, 2004) <http://www.dhsspsni.gov.uk> undertakes to prioritise public health to reduce mortality and morbidity relating to coronary heart disease, cancers, stroke and chronic respiratory disorders. It commits to preventing people starting to smoke, helping people to quit and protecting non-smokers from the harmful effects of environmental tobacco smoke. It includes specific primary prevention targets:

- To reduce the standardised death rate per 100,000 people under 80 years of age for cancer by 20% from 178 deaths for males in 2002 and 143 deaths for females to 142 deaths and 115 deaths respectively,
- To increase the 5-year cancer survival rates to the levels of the best European countries,
- To increase the proportion of 11-16 year old children who do not smoke from 86.9% in 2003 to 95% in 2025,
- To increase the proportion of adults who do not smoke from 74% in 2002/03 to 95% in 2025.

The Regional Cancer Framework- A Cancer Control Plan for Northern Ireland (DHSSPS, 2006) <http://www.dhsspsni.gov.uk> provides a focus on cancer prevention,

The strategic aims of the *National Health Promotion Strategy 2000-2005* (DoHC, 2000) www.dohc.ie included the promotion of healthy lifestyles to reduce the burden of chronic illness including cancer. Its review (NUI Galway, 2004) www.nuigalway.ie called for a system to monitor the implementation of national strategies, a national research and development plan to guide evidence based policy and practice and sustainable funding. One of its nine topics is 'being smoke free'. It recommended:

- To increase the percentage of the population who remain non- smokers with a particular emphasis on narrowing the gap across social classes and to protect non- smokers from passive smoking.

The national *Health Strategy Quality and Fairness* (DoHC, 2001) <http://www.dohc.ie> describes current and future policy and legislative developments with regards to smoking in Ireland to tackle cancer and cardiovascular disease and to promote healthier lifestyles. In continuing to implement the National Cancer, Cardiovascular and Health Promotion Strategies, it calls for enhanced health promotion initiatives aimed at addressing the risk factors associated with cancers and cardiovascular disease such as smoking and targeting a reduction in smoking for young women, supported by appropriate fiscal policies. It acknowledges the relatively high incidence of lung cancer in Ireland compared to the European average and recognises the importance of cancer control as part of a modern health service.

Towards a Tobacco Free Society (DoHC, 2001) <http://www.dohc.ie> proposes an integrated strategy for tackling tobacco consumption and promoting a tobacco-free society.

The *Office of Tobacco Control* (OTC) was established as a statutory structure in May 2002 to increase the capacity of government and the health services to tackle the problem of smoking.

The *Public Health (Tobacco) Act (2002)* and the *Public Health (Tobacco) Amendment Act (2004)* legislation www.irishstatutebook.ie place restrictions and conditions on the advertising, sale and consumption of tobacco. It includes the ban on smoking in indoor work and public places implemented in Ireland in 2004.

In 2005, Ireland became the 101st country to ratify the World Health Organisation (WHO) Framework Convention on Tobacco www.who.int.

The *National Cancer Forum* was established in line with a recommendation in the *National Cancer Strategy* (DoHC, 1996). Its primary role is to provide ongoing and independent policy advice on cancer to the Minister and the Department of Health and Children.

A Strategy for Cancer Control in Ireland (DoHC, 2006) www.dohc.ie has been developed by the second National Cancer Forum in cooperation with the Health Information and Quality Authority, the Health Research Board, the Irish Cancer Society, Irish Health Service Accreditation Board and the Health Service Executive. It aims to build on the *National Cancer Strategy* (DoHC, 1996) www.dohc.ie and further progress implementation of its recommendations. It advocates a comprehensive cancer control policy programme, which is a whole population, integrated and cohesive approach to cancer that involves prevention, screening, diagnosis, treatment, and supportive and palliative care. It acknowledges inequalities in cancer risk, incidence, services and outcomes which must be monitored and addressed. In relation to cancer prevention, it aims:

- To reduce the age-standardised and – where appropriate – age-specific, incidence of cancer in Ireland relative to other EU25 countries through health

Lung cancer incidence rates

Stage: Situation of Health

Level: Health Status (Individual)

Theme: Morbidity

early detection and screening. It determines to remove inequalities in cancer incidence and access to services. It proposes to reduce smoking levels in younger people, improve smoking cessation services and public education, utilise community and primary care services. It emphasises the need to improve nutrition, physical activity and obesity prevention to reduce cancer incidence. In endorsing *A Healthier Future- a Twenty year Vision for Health and Wellbeing in Northern Ireland*, the Cancer Control Programme foresees:

- To achieve a 25% reduction in age- adjusted cancer incidence by 2025.

The *Strategic Framework for Respiratory Conditions* (DHSSPS, 2006)

<http://www.dhsspsni.gov.uk> recommended recording of smoking status, professional advice to quit and access to smoking cessation services.

The *Programme for Government 2008- 2011* Public Service Agreement Framework (NIE, 2008) www.pfqbudgetni.gov.uk endeavours to promote health and address health inequalities by promoting healthy lifestyles, addressing the causes of poor health and wellbeing, thereby achieving measurable reductions in health inequalities and preventable illness. Under Public Service Agreement (PSA) 8 it promotes uptake of screening and immunisation programmes to prevent avoidable disease and reduce mortality rates:

- To reduce to 21% and 25% respectively the proportion of adults and manual worker subsets who smoke by 2011.

The Cancer Services Framework due to be published in early 2009 will make recommendations and set associated targets for preventative action in tobacco smoking, healthy eating, physical activity, obesity and alcohol consumption.

promotion and preventive activities.

It describes the ban on smoking in indoor public places, which was implemented in Ireland in 2004, as a very significant success and an example of how Ireland can play a leadership role in cancer control internationally. It makes a number of recommendations with regards to tobacco:

- Compliance with all provisions of the Public Health (Tobacco) Acts 2002 and 2004 should be monitored.
- Excise duty on cigarettes should be substantially increased each year above the rate of inflation.
- Nicotine replacement therapy should be made available free of charge to all medical card holders.

It emphasises the importance of measurement of need and addressing inequalities. It also focuses on reform and reorganisation of the way cancer services are delivered, identifying the ongoing need for policy guidance to be provided on many aspects of cancer control, particularly on screening, management of cancer patients, genetics, quality assurance, and research. It proposes that the recommendations of the *Report of the National Task Force on Obesity*, (DoHC, 2005) www.dohc.ie, the *Strategic Task Force on Alcohol* (STFA, 2002) www.dohc.ie and the *Review of the National Health Promotion Strategy* (NUI Galway, 2004) www.nuigalway.ie should be implemented in full. In particular, it stressed the need for measures that raise awareness of the links between tobacco, alcohol, nutrition, lack of physical activity, exposure to ultraviolet radiation and cancer. It also discusses risks associated with high concentrations of radon gas, which when inhaled may lead to lung cancer. It states that radon gas inhalation accounts for approximately 9% of all cases of lung cancer and recommends that the public should be made aware that radon measurements can be undertaken by the Radiological Protection Institute of Ireland. Consideration should be given to providing financial support for testing in high-radon areas and for any necessary remedial work, on a means-tested basis. It also recommends that a third National Cancer Forum should be appointed by the Minister with terms of reference and composition reflecting the changed health system.

The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie (2006) and *The National Development Plan Transforming Ireland- A Better Quality of Life for All 2007- 2013* <http://www.esri.ie> endorse the Strategy's recommendations for cancer control.

The Ten- Year Framework Social Partnership Agreement 2006-2015 *Towards 2016* (2006) www.taoiseach.gov.ie aims to improve the health and well being of the whole population and population sub-groups. It acknowledges the need to promote equity and to address a strong social class gradient in health status. It states that those in the lowest socio-economic group have the highest death rates and the lowest survival rates for major preventative diseases such as cancer or cardiovascular conditions. It undertakes to narrow this gap and influence the major factors which determine the health and well-being of the population by targeting resources to those most in need.

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Prevalence of mood and anxiety disorders

Stage: Situation of Health
Level: Health Status (Individual)
Theme: Morbidity

NORTH-SOUTH COMPARABILITY	All-island component
LAY DESCRIPTION	The percentage of people suffering from mood and anxiety disorders estimated using prescription data.
SOURCE REFERENCE	AIHSC
INDICATOR NAME	Prev mood anxiety disorder

DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND			
The number of individuals suffering from mood or anxiety disorders is estimated using prescription data broken down by GP practice. From the volume of anxiolytic and anti-depressant drugs prescribed in each practice, the number of patients taking this medication can be estimated. These data are then attributed to geographical area using the practice list				Percentage of people participating in the GMS Scheme, Long Term Illness Scheme, and Drug Payment Scheme who are prescribed drugs for anxiety and/or depression (Anatomical Therapeutic Chemical classification codes NO6A and NO5B)			
Published?	Yes www.ninis.nisra.gov.uk	Geography	HSSB, Parliamentary Constituency, LGD	Published?	Yes HSE Primary Care Reimbursement Service Statistical Analysis of Claims and Payments	Geography	Ireland
Frequency	Every year	Latest Year	2006	Frequency	Every year	Latest Year	2007
Numerator Definition	Volume of anxiolytic and anti-depressant drugs prescribed	Geography	2007	Numerator Definition	Number of people participating in the GMS Scheme, Long Term Illness Scheme, and Drug Payment Scheme who are prescribed drugs for anxiety and/or depression	Geography	County
Source	Central Services Agency	Year	2007	Source	HSE Primary Care Reimbursement Service	Year	2005
Denominator Definition	Mid-year population estimate	Geography	LGD	Denominator Definition	Mid-year population estimate	Geography	County
Source	NISRA	Year	2007	Source	Public Health Information System	Year	2005
DATA ISSUES				DATA ISSUES			
				In principle, the GMS Scheme, Long Term Illness Scheme, and Drug Payment Scheme covers the entire population but some people may choose not to participate			

PUBLIC HEALTH IMPORTANCE

Mental health is central to health and wellbeing of humans throughout the lifecourse. It constitutes an essential resource for people, enabling them to realise their potential and fulfil their responsibilities, as well as society, contributing to prosperity and social justice. Mood and anxiety disorders are the most common expression of impaired mental and emotional health and wellbeing, but often go unrecognised, unreported and untreated. Mental ill health affects every fourth European Union citizen, leading to significant losses to the economic, social, educational as well as criminal and justice systems. Stigmatisation, discrimination and violation of human rights and the dignity of mentally ill people continue to exist and disproportionately affect those living in disadvantaged socio economic circumstances (European Commission, 2005). Global trends indicate that the burden of mental ill health will grow significantly. Depression is expected to become the most common cause of disease in developed countries and already constitutes the leading cause of disability globally. It impairs quality of life, compounds other health problems and can lead to suicide (Worley, 2006). Risk factors for poor mental health are complex and include poverty, unemployment, bereavement, breakdown and tensions in relationships, social isolation, legal and workplace problems. Physical illness and other individual factors, a family history of poor mental health, childhood abuse, alcohol and drug use can also play a central role. Protective factors

Prevalence of mood and anxiety disorders

Stage: Situation of Health

Level: Health Status (Individual)

Theme: Morbidity

include self esteem and social connectedness with friends and family and religious or spiritual commitment (WHO, 2004). It is critical for success that interventions take into account these factors as part of promoting mental health and wellbeing (WHO, 2001).

POLICY CONTEXT – NORTHERN IRELAND

The Northern Ireland public health strategy *Investing for Health* (DHSSPS, 2002) www.dhsspsni.gov.uk is an interagency framework for partnership working to improve health and wellbeing and to reduce health inequalities. Its two main goals are to improve people's health by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability, and to reduce inequalities in health between geographic areas, socio- economic and minority groups. It recognises the improvements in health and wellbeing achieved in recent decades, but emphasises the need to promote mental health and emotional wellbeing:

- To reduce the proportion of people with a potential psychiatric disorder (as measured by the General Health Questionnaire 12 score) by a tenth by 2010.

The interagency and cross sectoral *Investing for Health Northern Ireland Suicide Prevention Strategy and Action Plan 2006- 2011* (DHSSPS, 2006) www.dhsspsni.gov.uk builds on the *Promoting Mental Health Strategy and Action Plan* (DHSSPS, 2003) www.dhsspsni.gov.uk, which aims to address the wider determinants on mental health by strengthening individuals as well as communities and reducing structural barriers to mental health. It provides an interagency and crosssectoral action plan for policy development, awareness raising, skills development and suicide prevention.

The *Bamford Review of Mental Health and Learning Disability* (2007) www.rmhdni.gov.uk envisions to give priority to the challenges of mental health and reduce incidence, prevalence and mortality as well as extent and severity of problems associated with mental ill-health. Central to the vision is a valuing of people with mental health needs, their rights to full citizenship, equality of opportunity and self determination. It anticipates a process of reform, renewal and modernisation of services.

The *Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2004) www.dhsspsni.gov.uk emphasises the Government's ongoing commitment to the overarching interdepartmental public health policy for Northern Ireland, *Investing for Health* (DHSSPS, 2002) www.dhsspsni.gov.uk, for promoting population health and wellbeing and reducing health inequalities. It proposes frameworks to improve the management of seven chronic conditions, including depression and stress.

The strategic framework for primary care services in Northern Ireland *Caring for people beyond tomorrow* (DHSSPS, 2005) www.dhsspsni.gov.uk recognises the importance of mental health. Under the goal to improve access to emergency primary care services, it includes community mental health services as essential service provision out of hours. The *Government's Anti- Poverty and Social Inclusion Strategy for Northern Ireland* (OFMDFM, 2007) www.ofmdfm.gov.uk aims to improve, amongst others, the mental health and wellbeing of all young people. It recognises that the promotion of social inclusion needs to address the particular needs of people with or at risk of mental health difficulties.

Lifetime Opportunities- Government's Anti- Poverty and Social Inclusion Strategy for Northern Ireland (NIE, 2005) <http://www.ofmdfmni.gov.uk> takes a lifecycle cross departmental approach to eliminate poverty and promote social inclusion. It undertakes to tackle area-based deprivation, rural poverty and inequality in the labour market; address conflict and community division; combat health inequalities and help people to

POLICY CONTEXT – REPUBLIC OF IRELAND

The National Children's Strategy (DoHC, 2000) www.dohc.ie emphasises the importance of mental health for child development and points to rising levels of mental health problems for children and young people in Ireland due to changes in social and environmental factors. It calls for an expansion of preventative and early intervention as well as treatment mental health services for children, young people and their families.

The National Health Strategy *Quality and Fairness* (DoHC, 2001) www.dohc.ie states that of particular concern in recent years has been the increase in the number of young males committing suicide. The Strategy commits to the principles of promoting, protecting and improving health, reducing premature mortality and intensifying suicide prevention programmes. It acknowledges the importance of mental health to wellbeing and foresees increasing demand for mental health services in Ireland due to changes in society, improving acceptability and quality of service provision. It announced an action programme on mental health to include an intensified suicide prevention programme

The National Strategy for *Primary Care- A New Direction* (DoHC, 2001) www.dohc.ie recognises mental health services as an integral part of primary and community care service provision.

The National Strategy for Action on Suicide Prevention *Reach Out 2005-2014* (DoHC & HSE, 2005) www.nosp.ie builds on the work of the National Task Force on Suicide (1998) and takes account of the important strategic and operational initiatives developed by the former health boards in response. Four levels of priority actions are to be undertaken, monitored by the National Office for Suicide Prevention, including a general population approach to promote positive mental health and well-being and bring about positive attitude change towards mental health, problem solving and coping in the general population, high risk and vulnerable groups. It contains a series of objectives and actions regarding positive mental health promotion, deliberate self-harm, mental health services, alcohol and substance abuse, prisons, the unemployed and people who have experienced abuse.

A new national policy framework for mental health services has been published in the Report of the Expert Group on Mental Health Policy *A Vision for Change* (2006) www.dohc.ie. It sets out a comprehensive policy framework for Irish mental health services for the next 7-10 years addressing the mental health challenges facing society. It calls for the establishing of child and adolescent mental health services (CAMHS) teams as well as adult Community Mental Health Teams (CMHTs).

The *State of the Nation's Children Report* (National Children's Office, 2006) www.nco.ie refers to the *National Health Promotion Strategy 2000-2005* (DoHC, 2000) www.dohc.ie, which notes that mental health is as important as physical health to overall well-being, linking positive mental health to a reduction in suicide and aiming to promote positive mental health as well as to reduce the percentage of the population experiencing poor mental health. It refers to the capacity-building and personal development elements of the Social, Personal and Health Education (SPHE) curriculum as representing important mental health promotion opportunities for school-aged children (Department of Education and Science, 2001). It emphasises the provisions in the Education Act (Government of Ireland, 1998), which place an

Prevalence of mood and anxiety disorders

Stage: Situation of Health

Level: Health Status (Individual)

Theme: Morbidity

break out of the cycles of deprivation at different stages of the lifecycle from early years to retirement. It recognises the impact of deprivation on length and quality of life and endorses the Government's programme for social inclusion to address, amongst others, mental health problems. Amongst its aims is:

- To improve the mental health and wellbeing of young people aged between 16 and 24 by a fifth between 2001 and 2025.

The Northern Ireland Executive's first *Programme for Government 2008- 2011* www.pfgbudgetni.gov.uk prioritises the promotion of tolerance, inclusion and health and wellbeing for all to create the conditions for economic growth and deliver health improvements. Under Public Service Agreement (PSA) 7 it undertakes to make peoples' lives better by driving a programme across Government to reduce poverty and address inequality and disadvantage. It envisages speedier access to mental health and learning disability services and fewer long stay psychiatric patients. Its targets are:

- To ensure a 10% reduction in admissions to mental health hospitals by 2011, and
- To ensure a 13 week maximum waiting time for defined psychotherapy services.

Under PSA 8 it aims for the promotion of healthy lifestyles, addressing the causes of poor health and wellbeing and achieving measurable reductions in health inequalities and preventable illness. It undertakes to roll out a suicide prevention helpline, expand self-harm mentoring and improve life and coping skills of those at risk of suicide and incorporates the *for Health Northern Ireland Suicide Prevention Strategy and Action Plan 2006- 2011* (DHSSPS, 2006) www.dhsspsni.gov.uk aim:

- To reduce the suicide rate by 15% by 2011.

The Northern Ireland Audit Office's report on The Performance of the Health Service in Northern Ireland (Comptroller and Auditor General, 2008) www.tso.co.uk acknowledges the possible pathways leading to suicide, including mental ill health, psychological, socio economic, interpersonal and genetic factors.

obligation on schools to promote the social and personal development of students.

The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie (2006) recognises the existence of health inequalities and acknowledges the fact that people in poverty are twice as likely to suffer from a chronic illness and poor mental health. It endorses the recommendations of *A Vision for Change* and aims:

- To establish one CAMHS teams for 100,000 population by 2008 and two by 2013, and
- To establish two adult CMHTs per 100,000 population by 2013.

The *National Development Plan Transforming Ireland- A Better Quality of Life for All 2007- 2013* <http://www.esri.ie>, provides investment to reconfigure, improve and expand health services and:

- To reduce inpatient stays in mental hospitals.

The National Women's Strategy (Department of Justice, Equality and Law Reform, 2007) www.irigov.ie/justice recognises the central importance of mental health to overall wellbeing and proposes several actions for mental health promotion.

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Directly standardised mortality rates for people aged under 75

Stage: Health Status
Level: Appropriate care (Intermediate)
Theme: Mortality

NORTH-SOUTH COMPARABILITY	All-island component		
LAY DESCRIPTION	The number of deaths from persons aged less than 75 years per 100,000 European standard population		
SOURCE REFERENCE	AIHSC		
INDICATOR NAME	DSR U75		
DATA DEFINITION – NORTHERN IRELAND			
Directly age and gender standardised rates per 100,000 European standard population of deaths of people aged less than 75 years.			
Published?	Yes Crude death rates by sex and age www.nisra.gov.uk	Geography	LGD
Frequency	Annually	Latest Year	2007
Numerator Definition	Number of deaths of persons aged less than 75 years	Geography	LGD
Source	NISRA	Year	2004
Denominator Definition	Population aged less than 75 years	Geography	LGD
Source	Mid-year population estimates NISRA	Year	2004
DATA ISSUES			
PUBLIC HEALTH IMPORTANCE			
<p>The duration of human life is a broad reflection of population health and wellbeing, which is influenced by many determinants including gender, ethnicity, early life experiences, mental health, work and employment, social and material living conditions, health behaviours, public policies and services, the environment as well as cultural and political conditions (Farrell, McAvoy, Wilde & Combat Poverty Agency, 2008). Unequal living conditions result from ‘poor social policies, unfair economic arrangements and bad politics’ and lead to a high burden of illness and premature loss of life by design and not as natural phenomena and differences between people. Social justice is therefore a matter of life and death (WHO, 2008).</p> <p>Standardised mortality rates describe how much more or less a person from a particular geographical area is likely to die compared to the average in a reference population, often taken from a national or international context, considering differences in population age and gender profiles. In light of increasing life expectancy, death before the age of 75 years is considered premature (DHSSPS, 2004). Premature mortality due to injury and illness is therefore a measure of socioeconomic disadvantage amenable to change through improved policy decisions and services, enabling individuals to realise their potential towards greater equity in lifetime opportunities and health outcomes.</p>			
POLICY CONTEXT – NORTHERN IRELAND			
The Northern Ireland public health strategy <i>Investing for Health</i> (DHSSPS, 2002) www.dhsspsni.gov.uk is an interagency framework for partnership working to improve health and wellbeing and to reduce health inequalities. Its two main goals are to			
POLICY CONTEXT – REPUBLIC OF IRELAND			
The National Health Strategy <i>Quality and Fairness</i> (DoHC, 2001) www.dohc.ie recognises that individual traits, lifestyle choices, social and community networks, and wider socio-economic and cultural factors all mediate the individual's need for health and			

Directly standardised mortality rates for people aged under 75

Stage: Health Status

Level: Appropriate care (Intermediate)

Theme: Mortality

improve people's health by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability, and to reduce inequalities in health between geographic areas, socio- economic and minority groups. It recognises the improvements in health and wellbeing achieved in recent decades, but identifies high levels of cardiovascular disease, respiratory disease and cancer contributed to by unhealthy lifestyles and socioeconomic conditions, leading to many people living much of their lives in poor health and dying prematurely. It also considers the importance of mental health, violence and accidents.

It aims:

- To improve levels of life expectancy towards the levels of the best EU countries by increasing life expectancy by at least 3 years for men and 2 years for women between 2000- 2010.

The Investing for Health Strategy *Fit Futures- Focus on Food, Activity and Young People* (Investing for Health, 2005) www.investingforhealthni.gov.uk examines options for preventing the rise in levels of overweight and obesity in children and young people. It recognises the detrimental role rising levels of obesity have on health, wellbeing, life expectancy and economic productivity. Its recommendations focus on developing coherent and healthy public policy, providing accessible and acceptable choices, supporting healthy early childhood development, creating healthy school and community environments as well as supporting research. It summarises the broad range of synergistic socioeconomic policies that need to support healthy nutrition and stipulates the inclusion of home economics in the secondary school key stage 3 curriculum. It endorses the Public Service Agreement (PSA) target:

- To halt the rise of obesity in children by 2010.

The health strategy *A Healthier Future- A twenty year vision for health and wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2005) www.dhsspsni.gov.uk recognises the complex interplay of environmental and individual factors contributing to the burden of chronic diseases and considers the role of health and social care services in addressing these. It seeks to prioritise public health, reducing mortality and morbidity due to coronary heart disease, cancers, stroke and chronic respiratory disorders.

Lifetime Opportunities- Government's Anti- Poverty and Social Inclusion Strategy for Northern Ireland (NIE, 2005) <http://www.ofmdfmi.gov.uk> takes a lifecycle cross departmental approach to eliminate poverty and promote social inclusion. It undertakes to tackle area-based deprivation, rural poverty and inequality in the labour market; address conflict and community division; combat health inequalities and help people to break out of the cycles of deprivation at different stages of the lifecycle from early years to retirement. It recognises the impact of deprivation on length and quality of life. Amongst it targets is:

- To reduce disability and long-term health problems and increase life expectancy by promoting road safety by 2020.
- To reduce gap in life expectancy between those living in the fifth most deprived areas and the Northern Ireland average by two thirds for both men and women between 2000 and 2025.

The *Programme for Government 2008- 2011* Public Service Agreement Framework (NIE, 2008) www.pfgbudgetni.gov.uk endeavours to promote health and address health inequalities by promoting healthy lifestyles, addressing the causes of poor health and wellbeing, thereby achieving measurable reductions in health inequalities

social services as well as also affecting life expectancy. It acknowledges existing geographical inequalities in health status and particularly recognises the need to improve travellers' life expectancy. It undertakes:

- To reduce the gap in premature mortality between the lowest and highest socio- economic groups should be reduced by at least 10 % for circulatory diseases, cancers, injuries and poisonings by 2007.

The *Report of the National Task Force on Obesity – The Policy Challenges* (DoHC, 2005) www.dohc.ie acknowledges and quantifies the association of obesity with premature death, excessive morbidity and economic loss. It makes recommendations relating to government, education, social and community, health, industry and the physical environment sectors. It calls on all state agencies and government departments to develop health impact assessment based healthy eating and physical activity strategies. It points to unhealthy environmental conditions including insufficient amenities, a reduction in physical labour and increased mechanization, poorly regulated market forces and personal issues surrounding self-efficacy and self-esteem as factors which contribute to this complex issue.

The *Strategy for Cancer Control in Ireland* (DoHC, 2006) www.dohc.ie envisions a system of cancer control to reduce cancer incidence, morbidity and mortality rates relative to other EU countries by 2015. It undertakes to increase awareness and practice of health promoting and cancer preventing behaviours, including access to cancer detection and screening.

The *Ten- Year Framework Social Partnership Agreement 2006-2015 Towards 2016* www.taoiseach.gov.ie underpins the NESC vision and places a focus on employability, access to employment and income, improved health outcomes and support for caring responsibilities.

The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie recognises that health inequalities manifest themselves in premature mortality among children from lower socio-economic groups and through emerging issues such as exercise, nutrition and obesity. It acknowledges the need to better understand and address the continuing health and mortality inequalities that exist for travellers. It proposes that a number of indicators are used to measure progress in achieving social inclusion covering areas such as income, levels of deprivation, early school leaving, jobless households, long-term unemployment, and life expectancy. Following publication of the *National Women's Strategy* (DoHC, 2007) and in light of life expectancy for men being among the lowest in Europe, it states that the Department of Health and Children will also publish a *Men's Health Policy and Action Plan* in 2007.

The *National Women's Strategy 2007- 2016* (Department of Justice. Equality and Law Reform, 2007) www.justice.ie acknowledges that women continue to experience a longer life expectancy and have a slightly lower risk of certain headline diseases than their male counterparts in Ireland, but experience fewer "Healthy Life Years", are more likely to suffer from chronic conditions and to die from cancers than their EU counterparts. They are also very much more likely than men to experience domestic violence.

Directly standardised mortality rates for people aged under 75

Stage: Health Status

Level: Appropriate care (Intermediate)

Theme: Mortality

and preventable illness. Under Public Service Agreement (PSA) 8 it promotes uptake of screening and immunisation programmes to prevent avoidable disease and reduce mortality rates:

- To achieve a long term reduction of 70% in the incidence of cervical cancer and
- To achieve a 10% reduction in mortality from bowel cancer by 2011.

It endorses the *Investing for Health* targets for reducing life expectancy differentials due to deprivation.

Under PSA 14 *Promoting Safer Roads* it aims:

- To reduce the number of people killed or seriously injured by 33% of the average for 1996- 2000 by 2012, and
- To reduce the number of children killed or seriously injured by 50% of the average for 1996- 2000.

Under PSA 18 *Deliver High Quality Health and Social Services* it undertakes to provide timely and appropriate access to high quality, integrated and cost- effective health and social services, to deliver improved outcomes and:

- To ensure a 10% reduction in mortality and disability from stroke by 2011.

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Infant Mortality Rates

Stage: Health Status

Level: Appropriate care (Intermediate)

Theme: Mortality

NORTH-SOUTH COMPARABILITY		One all-Ireland component	
LAY DESCRIPTION		The number of infant deaths per 1,000 live births. Infant deaths refer to all deaths within the first year of life.	
SOURCE REFERENCE		AIHSC	
INDICATOR NAME		Rate infant mortality	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
The number of infant deaths per 1,000 live births. Infant deaths refer to all deaths within the first year of life.		The number of infant deaths per 1,000 live births. Infant deaths refer to all deaths within the first year of life.	
Published?	Yes www.ninis.nisra.gov.uk	Geography	LGD PC
Frequency	Every year	Latest Year	2001-2006
Numerator Definition	Number of deaths within the first year of life	Geography	LGD
Source	NISRA	Year	2001-2005
Denominator Definition	Number of live births	Geography	LGD
Source	NISRA	Year	2001-2005
DATA ISSUES		DATA ISSUES	
PUBLIC HEALTH IMPORTANCE			
<p>Infant mortality is a sensitive measure of the overall health of a population. It reflects the causes of death during early childhood and other factors that influence health and wellbeing, including economic development, living conditions, social policies, health service quality and general living conditions (Reidpath & Allotey, 2003). Common causes of infant deaths in Western Europe at the beginning of the 20th century were infection, poor nutrition and ‘overlying’. While mortality rates in older children improved, infant mortality was initially less responsive to improvements in social and physical environments. In the UK, attempts at ‘educating’ mothers were introduced, and with growing recognition that poverty and poor maternal health were root causes, monetary benefits to mothers and free meals and meals at infant welfare centres became available (Blair, Stewart- Brown, Waterston et al, 2003).</p> <p>Infant mortality remains a traditional measure of population health, but in less developed countries the under- five mortality rate (U-5MR) might better reflect the health experience of children, as infants might be protected form the worst effects of malnutrition and infectious diseases by prolonged breastfeeding (Spencer, 2000). Infant mortality is defined as the number of deaths of infants (one year of age or younger) per 1000 live births. The method of calculating IMR may vary between countries based on the way they define a live birth. The World Health Organization (WHO) defines a live birth as any born human being who demonstrates independent signs of life, including breathing, voluntary muscle movement, or heartbeat.</p> <p>The world infant mortality rate declined from 126 in 1960 to 57 in 2001, but is inversely related to per capita Gross Domestic Product. In 2001, the Infant Mortality Rate for Less Developed Countries (91) was about 10 times as large as it was for More Developed Countries (8). For Least Developed Countries, the Infant Mortality Rate is 17 times as high as it is for More Developed Countries (Wikipedia, 2008). Infant mortality, like low birth weight, is therefore a marker of overall population health. It is socioeconomically patterned and link to deprivation and low levels of maternal education (WHO, 2008). Low birth weight increases the risk of death in infancy (Institute of Public Health, 2006). Under Article 24 of the UN</p>			

Infant Mortality Rates

Stage: Health Status

Level: Appropriate care (Intermediate)

Theme: Mortality

Convention on the Rights of the Child, all undersigned nations are obliged to reduce infant and child mortality.

POLICY CONTEXT – NORTHERN IRELAND

The Northern Ireland public health strategy *Investing for Health* (DHSSPS, 2002) www.dhsspsni.gov.uk is an interagency framework for partnership working to improve health and wellbeing and to reduce health inequalities. Its two main goals are to improve people's health by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability, and to reduce inequalities in health between geographic areas, socio- economic and minority groups.

The health strategy *A Healthier Future- A twenty year vision for health and wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2005) www.dhsspsni.gov.uk recognises the complex interplay of environmental and individual factors contributing to the burden of chronic diseases and considers the role of health and social care services in addressing these. It acknowledges the contribution of health and social care services to reducing infant mortality rates through improvements in care and treatment, immunisations and improved advice from health and social service professionals.

Lifetime Opportunities- Government's Anti- Poverty and Social Inclusion Strategy for Northern Ireland (NIE, 2005) <http://www.ofmdfmi.gov.uk> takes a lifecycle cross departmental approach to eliminate poverty and promote social inclusion. It undertakes to tackle area-based deprivation, rural poverty and inequality in the labour market; address conflict and community division; combat health inequalities and help people to break out of the cycles of deprivation at different stages of the lifecycle from early years to retirement.

The *Programme for Government 2008- 2011 Public Service Agreement Framework* (NIE, 2008) www.pfgbudgetni.gov.uk endeavours to promote health and address health inequalities by promoting healthy lifestyles, addressing the causes of poor health and wellbeing, thereby achieving measurable reductions in health inequalities, preventable illness and death. Under Public Service Agreement (PSA) 7 "Making Peoples' Lives Better", it proposes action to provide for measurable reductions in the levels of poverty and especially child poverty in line with the targets set out in *Lifetime Opportunities- Government's Anti- Poverty and Social Inclusion Strategy for Northern Ireland* (NIE, 2005) <http://www.ofmdfmi.gov.uk>.

POLICY CONTEXT – REPUBLIC OF IRELAND

The National Health Strategy *Quality and Fairness* (DoHC, 2001) www.dohc.ie recognises that individual traits, lifestyle choices, social and community networks, and wider socio-economic and cultural factors all mediate the individual's need for health and social services as well as also affecting life expectancy. It particularly recognises the need to improve travellers' life expectancy.

The *State of the Nation's Children Report* (National Children's Office, 2006) www.nco.ie reports ongoing improvements in Infant mortality Rates in Ireland and points at the large inequality gap for babies born into the travelling community.

The *Ten- Year Framework Social Partnership Agreement 2006-2015 Towards 2016* www.taoiseach.gov.ie calls for improved health outcomes and support for caring responsibilities. In line with the UN convention on the Rights of the Child and the National Children's Strategy (DoHC, 2000) www.nco.ie it states that:

- Every child should grow up in a family with access to sufficient resources, supports and services, to nurture and care for the child, and foster the child's development and full and equal participation in society.

The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie acknowledges that health inequalities manifest themselves in a higher incidence of low birth weight and premature mortality among children from lower socio-economic groups and through emerging issues such as exercise, nutrition and obesity. It includes goals:

- To reduce the number of those experiencing consistent poverty to between 2% and 4% by 2012, with the aim to eliminate consistent poverty by 2016,
- To maintain the value of child income support measures, social welfare rates and income support.

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Female life expectancy at birth

Stage: Health Status

Level: Appropriate care (Intermediate)

Theme: Mortality

NORTH-SOUTH COMPARABILITY	All-island component
LAY DESCRIPTION	Life expectancy at birth is the average number of years a newborn can expect to live if age-specific mortality rates remain constant
SOURCE REFERENCE	AIHSC
INDICATOR NAMES	Life expectancy Male; Life expectancy Female

DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND			
Average number of years a newborn can expect to live if age-specific mortality rates remain constant				Average number of years a newborn can expect to live if age-specific mortality rates remain constant			
Published?	Yes www.ninis.nisra.gov.uk	Geography	Ward LGD PC HSSB	Published?	Yes Irish Life Tables www.cso.ie	Geography	Ireland
Frequency	Every year covering a three year range	Latest Year	2004-2006	Frequency	Every 5 years covering a three year range	Latest Year	2001-2003
Numerator Definition	Number of deaths	Geography	LGD	Numerator Definition	Number of deaths	Geography	County
Source	NISRA	Year	2002-2004	Source	CSO	Year	2002-2004
Denominator Definition	Population	Geography	LGD	Denominator Definition	Population	Geography	County
Source	NISRA	Year	2002-2004	Source	CSO, Public Health Information System	Year	2002-2004
DATA ISSUES				DATA ISSUES			
Life expectancy was calculated from life tables with single-year age bands from 0-4 and five-year age bands thereafter.				Life expectancy was calculated from life tables with single-year age bands from 0-4 and five-year age bands thereafter.			
Life expectancy in the Republic of Ireland is not routinely available at county level.				Life expectancy in the Republic of Ireland is not routinely available at county level.			

PUBLIC HEALTH IMPORTANCE

The duration of human life is a broad reflection of population health and wellbeing, which is influenced by many determinants including gender, ethnicity, early life experiences, mental health, work and employment, social and material living conditions, health behaviours, public policies and services, the environment as well as cultural and political conditions (Farrell, McAvoy, Wilde & Combat Poverty Agency, 2008).

Unequal living conditions result from 'poor social policies, unfair economic arrangements and bad politics' and lead to a high burden of illness and premature loss of life by design and not as natural phenomena and differences between people. Social justice is therefore a matter of life and death (WHO, 2008). Life expectancy is a statistical measure of the average [life span](#) of a specified population. It describes the expected age to be reached before death by nation, gender, year of birth or other [demographic](#) variables if current age-specific mortality rates continue. Life expectancy increased dramatically in the 20th century in many countries, but there are exceptions especially in Sub Saharan Africa (due to HIV and AIDS) and states in the former Soviet Union (due to collapse of social infrastructure). People born in Swaziland live an average of 32 years compared to 82 years in [Japan](#) with a current global average of 66 years. These changes and inequities are the result of a combination of social, economic and environmental factors including nutrition and public health.

Female life expectancy at birth

Stage: Health Status

Level: Appropriate care (Intermediate)

Theme: Mortality

The most important single factor in the increase has been the reduction of death in infancy and early childhood. Therefore, calculating life expectancy from birth emphasises contributions to improvement in health in childhood (Wikipedia, 2008). In light of increasing life expectancy, death before the age of 75 years is considered premature in developed countries including Northern and the Republic of Ireland (DHSSPS, 2004). Life expectancy at birth is therefore a measure of socioeconomic conditions amenable to change through improved policy decisions and services, enabling individuals to realise their potential towards greater equity in lifetime opportunities and health outcomes.

POLICY CONTEXT – NORTHERN IRELAND

The Northern Ireland public health strategy *Investing for Health* (DHSSPS, 2002) www.dhsspsni.gov.uk is an interagency framework for partnership working to improve health and wellbeing and to reduce health inequalities. Its two main goals are to improve people's health by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability, and to reduce inequalities in health between geographic areas, socio-economic and minority groups. It recognises the improvements in health and wellbeing achieved in recent decades, but identifies high levels of cardiovascular disease, respiratory disease and cancer contributed to by unhealthy lifestyles and socioeconomic conditions, leading to many people living much of their lives in poor health and dying prematurely. It also considers the importance of mental health, violence and accidents.

It aims:

- To improve levels of life expectancy towards the levels of the best EU countries by increasing life expectancy by at least 3 years for men and 2 years for women between 2000- 2010.

The Investing for Health Strategy *Fit Futures- Focus on Food, Activity and Young People* (Investing for Health, 2005) www.investingforhealthni.gov.uk examines options for preventing the rise in levels of overweight and obesity in children and young people. It recognises the detrimental role rising levels of obesity have on health, wellbeing, life expectancy and economic productivity. Its recommendations focus on developing coherent and healthy public policy, providing accessible and acceptable choices, supporting healthy early childhood development, creating healthy school and community environments as well as supporting research. It summarises the broad range of synergistic socioeconomic policies that need to support healthy nutrition and stipulates the inclusion of home economics in the secondary school key stage 3 curriculum. It endorses the Public Service Agreement (PSA) target:

- To halt the rise of obesity in children by 2010.

The health strategy *A Healthier Future- A twenty year vision for health and wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2005) www.dhsspsni.gov.uk recognises the complex interplay of environmental and individual factors contributing to the burden of chronic diseases and considers the role of health and social care services in addressing these. It seeks to prioritise public health, reducing mortality and morbidity due to coronary heart disease, cancers, stroke and chronic respiratory disorders. *Lifetime Opportunities- Government's Anti- Poverty and Social Inclusion Strategy for Northern Ireland* (NIE, 2005) <http://www.ofmdfmrni.gov.uk> takes a lifecycle cross departmental approach to eliminate poverty and promote social inclusion. It undertakes to tackle area-based deprivation, rural poverty and inequality in the labour market; address conflict and community division; combat health inequalities and help people to break out of the cycles of deprivation at different stages of the lifecycle from early years to retirement. It recognises the impact of deprivation on length and quality of life. Amongst its targets is:

- To reduce disability and long-term health problems and increase life expectancy by promoting road safety by 2020.

POLICY CONTEXT – REPUBLIC OF IRELAND

The National Health Strategy *Quality and Fairness* (DoHC, 2001) www.dohc.ie recognises that individual traits, lifestyle choices, social and community networks, and wider socio-economic and cultural factors all mediate the individual's need for health and social services as well as also affecting life expectancy. It acknowledges existing geographical inequalities in health status and particularly recognises the need to improve travellers' life expectancy. It undertakes:

- To reduce the gap in premature mortality between the lowest and highest socio-economic groups should be reduced by at least 10 % for circulatory diseases, cancers, injuries and poisonings by 2007.

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The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie recognises that health inequalities manifest themselves in premature mortality among children from lower socio-economic groups and through emerging issues such as exercise, nutrition and obesity. It acknowledges the need to better understand and address the continuing health and mortality inequalities that exist for travelers. It proposes that a number of indicators are used to measure progress in achieving social inclusion covering areas such as income, levels of deprivation, early school leaving, jobless households, long-term unemployment, and life expectancy. Following publication of the *National Women's Strategy* (DoHC, 2007) and in light of life expectancy for men being among the lowest in Europe, it states that the Department of Health and Children will also publish a *Men's Health Policy and Action Plan* in 2007.

The *National Women's Strategy 2007- 2016* (Department of Justice, Equality and Law

Female life expectancy at birth

Stage: Health Status

Level: Appropriate care (Intermediate)

Theme: Mortality

- To reduce gap in life expectancy between those living in the fifth most deprived areas and the Northern Ireland average by two thirds for both men and women between 2000 and 2025.

The *Programme for Government 2008- 2011* Public Service Agreement Framework (NIE, 2008) www.pfgbudgetni.gov.uk endeavours to promote health and address health inequalities by promoting healthy lifestyles, addressing the causes of poor health and wellbeing, thereby achieving measurable reductions in health inequalities and preventable illness. Under Public Service Agreement (PSA) 8 *Promoting Health and Addressing Health Inequalities* it promotes uptake of screening and immunisation programmes to prevent avoidable disease and reduce premature mortality:

- To achieve a long term reduction of 70% in the incidence of cervical cancer and
- To achieve a 10% reduction in mortality from bowel cancer by 2011.

In the context of promoting smoking cessation and measures to tackle obesity and physical inactivity, particularly in children, and to reduce health inequalities, it endorses the *Investing for Health* targets for reducing life expectancy differentials due to deprivation (PSA 8) and aims:

- To increase average life expectancy by 2 and 3 years for women and men respectively, and facilitate a 50% reduction in the life expectancy differential between the most disadvantaged areas and the Northern Ireland average.

Under PSA 14 *Promoting Safer Roads* it aims:

- To reduce the number of people killed or seriously injured by 33% of the average for 1996- 2000 by 2012, and
- To reduce the number of children killed or seriously injured by 50% of the average for 1996- 2000.

Reform, 2007) www.justice.ie acknowledges that women continue to experience a longer life expectancy and have a slightly lower risk of certain headline diseases than their male counterparts in Ireland, but experience fewer "Healthy Life Years", are more likely to suffer from chronic conditions and to die from cancers than their EU counterparts. They are also very much more likely than men to experience domestic violence.

REFERENCES

Farrell, C., McAvoy, H., Wilde, J., Combat Poverty Agency (2008). *Tackling Health Inequalities- An All Ireland Approach to Social Determinants*. Dublin: Combat Poverty Agency/ Institute of Public Health.

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<http://en.wikipedia.org> accessed 24 September 2008

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Male life expectancy at birth

Stage: Health Status

Level: Appropriate care (Intermediate)

Theme: Mortality

NORTH-SOUTH COMPARABILITY	All-island component
LAY DESCRIPTION	Life expectancy at birth is the average number of years a newborn can expect to live if age-specific mortality rates remain constant
SOURCE REFERENCE	AIHSC
INDICATOR NAMES	Life expectancy Male; Life expectancy Female

DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND			
Average number of years a newborn can expect to live if age-specific mortality rates remain constant				Average number of years a newborn can expect to live if age-specific mortality rates remain constant			
Published?	Yes www.ninis.nisra.gov.uk	Geography	Ward LGD PC HSSB	Published?	Yes Irish Life Tables www.cso.ie	Geography	Ireland
Frequency	Every year covering a three year range	Latest Year	2004-2006	Frequency	Every 5 years covering a three year range	Latest Year	2001-2003
Numerator Definition	Number of deaths	Geography	LGD	Numerator Definition	Number of deaths	Geography	County
Source	NISRA	Year	2002-2004	Source	CSO	Year	2002-2004
Denominator Definition	Population	Geography	LGD	Denominator Definition	Population	Geography	County
Source	NISRA	Year	2002-2004	Source	CSO, Public Health Information System	Year	2002-2004
DATA ISSUES				DATA ISSUES			
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Life expectancy in the Republic of Ireland is not routinely available at county level.				Life expectancy in the Republic of Ireland is not routinely available at county level.			
PUBLIC HEALTH IMPORTANCE							
The duration of human life is a broad reflection of population health and wellbeing, which is influenced by many determinants including gender, ethnicity, early life experiences, mental health, work and employment, social and material living conditions, health behaviours, public policies and services, the environment as well as cultural and political conditions (Farrell, McAvoy, Wilde & Combat Poverty Agency, 2008).							
Unequal living conditions result from ‘poor social policies, unfair economic arrangements and bad politics’ and lead to a high burden of illness and premature loss of life by design and not as natural phenomena and differences between people. Social justice is therefore a matter of life and death (WHO, 2008). Life expectancy is a statistical measure of the average life span of a specified population. It describes the expected age to be reached before death by nation, gender, year of birth or other demographic variables if current age-specific mortality rates continue. Life expectancy increased dramatically in the 20th century in many countries, but there are exceptions especially in Sub Saharan Africa (due to HIV and AIDS) and states in the former Soviet Union (due to collapse of social infrastructure). People born in Swaziland live an average of 32 years compared to 82 years in Japan with a current global average of 66 years. These changes and inequities are the result of a combination of social, economic and environmental factors including nutrition and public health.							

Male life expectancy at birth

Stage: Health Status

Level: Appropriate care (Intermediate)

Theme: Mortality

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POLICY CONTEXT – NORTHERN IRELAND

The Northern Ireland public health strategy *Investing for Health* (DHSSPS, 2002) www.dhsspsni.gov.uk is an interagency framework for partnership working to improve health and wellbeing and to reduce health inequalities. Its two main goals are to improve people's health by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability, and to reduce inequalities in health between geographic areas, socio-economic and minority groups. It recognises the improvements in health and wellbeing achieved in recent decades, but identifies high levels of cardiovascular disease, respiratory disease and cancer contributed to by unhealthy lifestyles and socioeconomic conditions, leading to many people living much of their lives in poor health and dying prematurely. It also considers the importance of mental health, violence and accidents.

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- To reduce disability and long-term health problems and increase life

POLICY CONTEXT – REPUBLIC OF IRELAND

The National Health Strategy *Quality and Fairness* (DoHC, 2001) www.dohc.ie recognises that individual traits, lifestyle choices, social and community networks, and wider socio-economic and cultural factors all mediate the individual's need for health and social services as well as also affecting life expectancy. It acknowledges existing geographical inequalities in health status and particularly recognises the need to improve travellers' life expectancy. It undertakes:

- To reduce the gap in premature mortality between the lowest and highest socio-economic groups should be reduced by at least 10 % for circulatory diseases, cancers, injuries and poisonings by 2007.

The *Report of the National Task Force on Obesity – The Policy Challenges* (DoHC, 2005) www.dohc.ie acknowledges and quantifies the association of obesity with premature death, excessive morbidity and economic loss. It makes recommendations relating to government, education, social and community, health, industry and the physical environment sectors. It calls on all state agencies and government departments to develop health impact assessment based healthy eating and physical activity strategies. It points to unhealthy environmental conditions including insufficient amenities, a reduction in physical labour and increased mechanization, poorly regulated market forces and personal issues surrounding self-efficacy and self-esteem as factors which contribute to this complex issue.

The *Strategy for Cancer Control in Ireland* (DoHC, 2006) www.dohc.ie envisions a system of cancer control to reduce cancer incidence, morbidity and mortality rates relative to other EU countries by 2015. It undertakes to increase awareness and practice of health promoting and cancer preventing behaviours, including access to cancer detection and screening.

The *Ten- Year Framework Social Partnership Agreement 2006-2015 Towards 2016* www.taoiseach.gov.ie underpins the NESC vision and places a focus on employability, access to employment and income, improved health outcomes and support for caring responsibilities.

The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie recognises that health inequalities manifest themselves in premature mortality among children from lower socio-economic groups and through emerging issues such as exercise, nutrition and obesity. It acknowledges the need to better understand and address the continuing health and mortality inequalities that exist for travelers. It proposes that a number of indicators are used to measure progress in achieving social inclusion covering areas such as income, levels of deprivation, early school leaving, jobless households, long-term unemployment, and life expectancy. Following publication of the *National Women's Strategy* (DoHC, 2007) and in light of life expectancy for men being among the lowest in Europe, it states that the Department of Health and Children will also publish a *Men's Health Policy and Action Plan* in 2007.

The *National Women's Strategy 2007- 2016* (Department of Justice, Equality and Law

Male life expectancy at birth

Stage: Health Status

Level: Appropriate care (Intermediate)

Theme: Mortality

- expectancy by promoting road safety by 2020.
- To reduce gap in life expectancy between those living in the fifth most deprived areas and the Northern Ireland average by two thirds for both men and women between 2000 and 2025.

The *Programme for Government 2008- 2011* Public Service Agreement Framework (NIE, 2008) www.pfgbudgetni.gov.uk endeavours to promote health and address health inequalities by promoting healthy lifestyles, addressing the causes of poor health and wellbeing, thereby achieving measurable reductions in health inequalities and preventable illness. Under Public Service Agreement (PSA) 8 *Promoting Health and Addressing Health Inequalities* it promotes uptake of screening and immunisation programmes to prevent avoidable disease and reduce premature mortality:

- To achieve a long term reduction of 70% in the incidence of cervical cancer and
- To achieve a 10% reduction in mortality from bowel cancer by 2011.

In the context of promoting smoking cessation and measures to tackle obesity and physical inactivity, particularly in children, and to reduce health inequalities, it endorses the *Investing for Health* targets for reducing life expectancy differentials due to deprivation (PSA 8) and aims:

- To increase average life expectancy by 2 and 3 years for women and men respectively, and facilitate a 50% reduction in the life expectancy differential between the most disadvantaged areas and the Northern Ireland average.

Under PSA 14 *Promoting Safer Roads* it aims:

- To reduce the number of people killed or seriously injured by 33% of the average for 1996- 2000 by 2012, and
- To reduce the number of children killed or seriously injured by 50% of the average for 1996- 2000.

Reform, 2007) www.justice.ie acknowledges that women continue to experience a longer life expectancy and have a slightly lower risk of certain headline diseases than their male counterparts in Ireland, but experience fewer "Healthy Life Years", are more likely to suffer from chronic conditions and to die from cancers than their EU counterparts. They are also very much more likely than men to experience domestic violence.

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Benefits for diseases of the circulatory system

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

NORTH-SOUTH COMPARABILITY	Separate North and South components						
LAY DESCRIPTION	Percentage of the working age population aged 15-64 years in receipt of benefits for diseases of the circulatory system						
SOURCE REFERENCE	eHPI: SH3_1						
INDICATOR NAMES	Pct benef circulatory NI; Pct benef circulatory RoI						
DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND			
Percentage of the working age population aged 15-64 years in receipt of Incapacity Benefit for diseases of the circulatory system (ICD 10 codes I00-I99)				Percentage of the working age population aged 15-64 years in receipt of Disability Benefit for diseases of the circulatory system			
Published?	Yes www.dsdni.gov.uk	Geography	Northern Ireland	Published?	No	Geography	N/a
Frequency	Quarterly	Latest Year	2007	Frequency	N/a	Latest Year	N/a
Numerator				Numerator			
Definition	Number of people in receipt of Incapacity Benefit for diseases of the circulatory system (ICD 10 codes I00-I99)	Geography	LGD	Definition	Number of people in receipt of Disability Benefit for diseases of the circulatory system	Geography	County
Source	Department for Social Development	Year	2006	Source	Department of Social and Family Affairs	Year	2006
Denominator				Denominator			
Definition	Number of people aged 15-64 years	Geography	LGD	Definition	Number of people aged 15-64 years	Geography	County
Source	NISRA	Year	2006	Source	Census	Year	2006
DATA ISSUES				DATA ISSUES			
The components are not directly comparable between Northern Ireland and Republic of Ireland as they refer to different social welfare systems.				The components are not directly comparable between Northern Ireland and Republic of Ireland as they refer to different social welfare systems.			
				Recipients were assigned to physical morbidity categories based on non-ICD medical diagnosis			
PUBLIC HEALTH IMPORTANCE							
Within the EU, the Minimum Income Recommendation includes that welfare benefits for employable people (i.e., whose age, health and family situation permit labour market participation) should be conditional on availability for work, vocational training or other economic and social integration measures — ‘not as a punishment but as an opportunity to improve their labour market perspectives’ (Amitsis, 2003). The OECD points to ‘a paradigm shift taking place within OECD countries in the approach taken towards disability, with more emphasis on separating the concepts of ‘disability’ and ‘ability to work’. Integration into the workforce rather than passive compensation for loss of income is becoming the more important policy objective (OECD, 2002).							
POLICY CONTEXT – NORTHERN IRELAND				POLICY CONTEXT – REPUBLIC OF IRELAND			
The Government’s public health strategy <i>Investing for Health</i> (DHSSPS, 2002) www.dhssps.gov.uk states the need to tackle poverty and social exclusion by addressing poverty, low income and unemployment. It also emphasis the importance of				The National Health Strategy <i>Quality and Fairness</i> (DoHC, 2001) www.dohc.ie recognizes that individual traits, lifestyle choices, social and community networks, and wider socio-economic and cultural factors all mediate the individual’s need for health and			

Benefits for diseases of the circulatory system

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

enabling people to make healthy choices and reducing levels of morbidity and mortality from chronic ill health and injuries by improving environmental, housing and workplace conditions.

The *Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2004) www.dhsspsni.gov.uk emphasises the need for cross departmental and interagency partnerships to ensure that those least able to access the labour market are provided with meaningful employment opportunities by supporting the unemployed, improving skills and promoting the health and wellbeing of those seeking employment.

The *Shared Future Policy and Strategic Framework for Good Relations in Northern Ireland* (OFMDFM, 2005) www.ofmdfm.gov.uk undertakes to establish a society with equal opportunity for all.

The Social security in Northern Ireland is governed by the principle of parity with Great Britain. Policy change is therefore UK wide. The Green Paper *A new deal for welfare: Empowering people to work* (Department for Work and Pensions (DWP), 2006) www.dwp.gov.uk states the Government's responsibility to ensure that citizens have the right and are supported to enter the world of work. It undertakes to break down barriers that prevent many from fulfilling their potential, impede social mobility and through economic inactivity put people at risk of or into poverty and disadvantage. It states that a third of new claimants cite mental health conditions as the primary cause of their incapacity, while another third come not from work but from other benefits like jobseeker's allowance and income support. It emphasises the need for reform to end the "social injustice inflicted by the poverty trap of benefit dependency". It aims:

- To reduce by 1 million the number of incapacity benefits (in the United Kingdom) by reducing the number of people who leave the workplace due to illness; increasing the number leaving benefits; and better addressing the needs of all those on benefit, with additional payment to the most severely disabled people.

Lifetime Opportunities Government's Anti- Poverty and Social inclusion Strategy for Northern Ireland (OFMDFM, 2006) www.ofmdfm.gov.uk endeavours to ensure that everyone has the opportunity to fully participate in economic, social and cultural life. For those not in a position to enter employment it reiterates the need for support via the benefits system.

Pathways to Work (DEL, DSD & DHSSPS, 2007) is an interdepartmental initiatives to support people with health conditions to towards meaningful employment decisions.

The *Welfare Reform Bill* (DSD, 2007) www.dsdni.gov.uk introduces reform to the Northern Ireland Social Care System for people on benefits for ill health and aims to contribute to increasing the employment rate for people of working age, increasing social inclusion by creating opportunities for disadvantaged people. It replaces incapacity benefits with a new Employment and Support allowance in line with the remainder of the United Kingdom.

This recommendation is included in the Northern Ireland's Programme for Government 2008- 2011 www.pfbudgetni.gov.uk under Public Service Agreement (PSA) 3, which

social services.

The National Economic and Social Council (NESC) advises the Irish Government on efficient development of the economy and achievement of social justice as well as social partnership agreements. *The Developmental Welfare State* (NESC, 2005) www.nesc.ie suggests to build consensus across social partners, government and society in a coherent debate that addresses Ireland's social deficits towards integrated policies for employment, social inclusion and economic reform. It challenges the focus on total employment growth and unemployment reduction, calling for an assessment of training and lifelong learning practices, creation of equal opportunity in the labour market and effectiveness of social inclusion and antipoverty strategies.

The *NESC Strategy 2006: People, Productivity and Purpose* (NESC, 2005) www.nesc.ie emphasises the importance of greater participation, social protection and care , more social mobility and successful handling of diversity. It recommends to aim less for targeted programmes for disadvantaged groups and more for the responsiveness and flexibility of publicly funded services, securing adequate income and improving participation. It criticises the benefit traps created by erosion of income eligibility thresholds and the contingency basis of benefits, which can encourage people to cling to a status which secures income at such low levels that many recipients are vulnerable to poverty, debt and low self- esteem. It recommends that benefit recipients, like the unemployed, should be regularly reassessed to identify opportunities and reassess options for improvements to their situation. It also recommends to increase benefits and maintain them in line with Gross Average Industrial Earnings.

The *Ten- Year Framework Social Partnership Agreement 2006-2015 Towards 2016* www.taoiseach.gov.ie underpins the NESC vision and places a focus on employability, access to employment and income, improved health outcomes and support for caring responsibilities. It especially recognises the needs of young adults for education, training and employment, health and social services, in respect of people with disabilities, it states that the National Disability Strategy (National Disability Authority, 2004) www.nda.ie will be implemented with particular regard to health and education services, income and measures to promote employment

The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie proposes to support working age people and people with disabilities , through activation measures and service provision to increase employment and participation. It commits:

- To maintaining the relative value of the lowest social welfare rate at € 185.80, in 2007 terms until 2016, resources permitting,
- To increasing the employment and participation of people with disabilities by bringing an additional 7,000 into employment by 2010, raise the employment rate of people with disabilities from 37% to 45% and the overall participation rate in education, training and employment to 50% by 2016 and
- To reduce by 20% the number of those whose total income is derived from long term social welfare payments by 2016.

Benefits for diseases of the circulatory system

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

aims to increase employment levels subject to economic conditions and reduce economic inactivity by addressing the barriers to employment and providing effective careers advice. The target is:

- To assist 70,000 working age benefit clients to move into employment by March 2011.

Under PSA 7, which aims to make people's lives better by driving a programme across government to reduce poverty and address inequality and disadvantage, it undertakes to continue to modernise benefit services with several associated targets.

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Benefits for diseases of the musculoskeletal system

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

NORTH-SOUTH COMPARABILITY	Separate North and South components		
LAY DESCRIPTION	Percentage of the working age population aged 15-64 years in receipt of benefits for diseases of the musculoskeletal system		
SOURCE REFERENCE	eHPI: SH3_4		
INDICATOR NAMES	Pct benef musculoskel NI; Pct benef musculoskel RoI		
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Percentage of the working age population aged 15-64 years in receipt of Incapacity Benefit for diseases of the musculoskeletal system (ICD 10 codes M00-M99)		Percentage of the working age population aged 15-64 years in receipt of Disability Benefit for diseases of the musculoskeletal system	
Published?	Yes www.dsdni.gov.uk	Published?	No
Frequency	Quarterly	Frequency	N/a
Numerator		Numerator	
Definition	Number of people in receipt of Incapacity Benefit for diseases of the musculoskeletal system (ICD 10 codes M00-M99)	Definition	Number of people in receipt of Disability Benefit for diseases of the musculoskeletal system
Source	Department for Social Development	Source	Department of Social and Family Affairs
Denominator		Denominator	
Definition	Number of people aged 15-64 years	Definition	Number of people aged 15-64 years
Source	NISRA	Source	Census
Geography		Geography	County
Latest Year		Latest Year	2006
DATA ISSUES		DATA ISSUES	
The components are not directly comparable between Northern Ireland and Republic of Ireland as they refer to different social welfare systems.		The components are not directly comparable between Northern Ireland and Republic of Ireland as they refer to different social welfare systems.	
PUBLIC HEALTH IMPORTANCE		PUBLIC HEALTH IMPORTANCE	
Within the EU, the Minimum Income Recommendation includes that welfare benefits for employable people (i.e., whose age, health and family situation permit labour market participation) should be conditional on availability for work, vocational training or other economic and social integration measures — ‘not as a punishment but as an opportunity to improve their labour market perspectives’ (Amitsis, 2003). The OECD points to ‘a paradigm shift taking place within OECD countries in the approach taken towards disability, with more emphasis on separating the concepts of ‘disability’ and ‘ability to work’. Integration into the workforce rather than passive compensation for loss of income is becoming the more important policy objective (OECD, 2002).		Recipients were assigned to physical morbidity categories based on non-ICD medical diagnosis	
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
The Government's public health strategy <i>Investing for Health</i> (DHSSPS, 2002) www.dhssps.gov.uk states the need to tackle poverty and social exclusion by		The National Health Strategy <i>Quality and Fairness</i> (DoHC, 2001) www.dohc.ie recognizes that individual traits, lifestyle choices, social and community networks, and	

Benefits for diseases of the musculoskeletal system

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

addressing poverty, low income and unemployment. It also emphasis the importance of enabling people to make healthy choices and reducing levels of morbidity and mortality from chronic ill health and injuries by improving environmental, housing and workplace conditions.

The *Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2004) www.dhsspsni.gov.uk emphasises the need for cross departmental and interagency partnerships to ensure that those least able to access the labour market are provided with meaningful employment opportunities by supporting the unemployed, improving skills and promoting the health and wellbeing of those seeking employment.

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- To reduce by 1 million the number of incapacity benefits (in the United Kingdom) by reducing the number of people who leave the workplace due to illness; increasing the number leaving benefits; and better addressing the needs of all those on benefit, with additional payment to the most severely disabled people.

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wider socio-economic and cultural factors all mediate the individual's need for health and social services.

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- To reduce by 20% the number of those whose total income is derived from long term social welfare payments by 2016.

Benefits for diseases of the musculoskeletal system

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

This recommendation is included in the Northern Ireland's Programme for Government 2008- 2011 www.pfgbudgetni.gov.uk under Public Service Agreement (PSA) 3, which aims to increase employment levels subject to economic conditions and reduce economic inactivity by addressing the barriers to employment and providing effective careers advice. The target is:

- To assist 70,000 working age benefit clients to move into employment by March 2011.

Under PSA 7, which aims to make people's lives better by driving a programme across government to reduce poverty and address inequality and disadvantage, it undertakes to continue to modernise benefit services with several associated targets.

REFERENCES

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Benefits for diseases of the nervous system

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

NORTH-SOUTH COMPARABILITY Separate North and South components

LAY DESCRIPTION Percentage of the working age population aged 15-64 years in receipt of benefits for diseases of the nervous system

SOURCE REFERENCE eHPI: SH3_5

INDICATOR NAMES Pct benef nervous sys NI; Pct benef nervous sys RoI

DATA DEFINITION – NORTHERN IRELAND

Percentage of the working age population aged 15-64 years in receipt of Incapacity Benefit for diseases of the nervous system (ICD 10 codes G00-G99)

Published?	Yes www.dsdni.gov.uk	Geography	Northern Ireland
Frequency	Quarterly	Latest Year	2007
Numerator Definition	Number of people in receipt of Incapacity Benefit for diseases of the nervous system (ICD 10 codes G00-G99)	Geography	LGD
Source	Department for Social Development	Year	2006
Denominator Definition	Number of people aged 15-64 years	Geography	LGD
Source	NISRA	Year	2006

DATA ISSUES

The components are not directly comparable between Northern Ireland and Republic of Ireland as they refer to different social welfare systems.

DATA DEFINITION – REPUBLIC OF IRELAND

Percentage of the working age population aged 15-64 years in receipt of Disability Benefit for diseases of the nervous system

Published?	No	Geography	N/a
Frequency	N/a	Latest Year	N/a
Definition	Number of people in receipt of Disability Benefit for diseases of the nervous system	Geography	County
Source	Department of Social and Family Affairs	Year	2006
Definition Source	Number of people aged 15-64 years	Geography	County
Source	Census	Year	2006

DATA ISSUES

The components are not directly comparable between Northern Ireland and Republic of Ireland as they refer to different social welfare systems.

Recipients were assigned to physical morbidity categories based on non-ICD medical diagnosis

PUBLIC HEALTH IMPORTANCE

Within the EU, the Minimum Income Recommendation includes that welfare benefits for employable people (i.e., whose age, health and family situation permit labour market participation) should be conditional on availability for work, vocational training or other economic and social integration measures — 'not as a punishment but as an opportunity to improve their labour market perspectives' (Amitsis, 2003). The OECD points to 'a paradigm shift taking place within OECD countries in the approach taken towards disability, with more emphasis on separating the concepts of 'disability' and 'ability to work'. Integration into the workforce rather than passive compensation for loss of income is becoming the more important policy objective (OECD, 2002).

POLICY CONTEXT – NORTHERN IRELAND

The Government's public health strategy *Investing for Health* (DHSSPS, 2002) www.dhssps.gov.uk states the need to tackle poverty and social exclusion by addressing poverty, low income and unemployment. It also emphasizes the importance of

POLICY CONTEXT – REPUBLIC OF IRELAND

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Benefits for diseases of the nervous system

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

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Benefits for diseases of the nervous system

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

economic inactivity by addressing the barriers to employment and providing effective careers advice. The target is:

- To assist 70,000 working age benefit clients to move into employment by March 2011.

Under PSA 7, which aims to make people's lives better by driving a programme across government to reduce poverty and address inequality and disadvantage, it undertakes to continue to modernise benefit services with several associated targets.

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Benefits for injury, poisoning, and other consequences of external causes

Stage: Situation of health
Level: Health status (Individual)
Theme: Physical morbidity

NORTH-SOUTH COMPARABILITY	Separate North and South components
LAY DESCRIPTION	Percentage of the working age population aged 15-64 years in receipt of benefits for injury, poisoning, and external causes
SOURCE REFERENCE	eHPI: SH3_2
INDICATOR NAMES	Pct benef ext causes NI; Pct benef ext causes RoI

DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND			
Percentage of the working age population aged 15-64 years in receipt of Incapacity Benefit for injury, poisoning, and external causes (ICD 10 codes S00-U22)				Percentage of the working age population aged 15-64 years in receipt of Disability Benefit for injury, poisoning, and external causes			
Published?	Yes www.dsdni.gov.uk	Geography	Northern Ireland	Published?	No	Geography	N/a
Frequency	Quarterly	Latest Year	2007	Frequency	N/a	Latest Year	N/a
Numerator Definition	Number of people in receipt of Incapacity Benefit for injury, poisoning, and external causes (ICD 10 codes S00-U22)	Geography	LGD	Definition	Number of people in receipt of Disability Benefit for injury, poisoning, and external causes	Geography	County
Source Denominator	Department for Social Development	Year	2006	Source	Department of Social and Family Affairs	Year	2006
Definition Source	Number of people aged 15-64 years NISRA	Geography Year	LGD 2006	Definition Source	Number of people aged 15-64 years Census	Geography Year	County 2006
DATA ISSUES				DATA ISSUES			
The components are not directly comparable between Northern Ireland and Republic of Ireland as they refer to different social welfare systems.				The components are not directly comparable between Northern Ireland and Republic of Ireland as they refer to different social welfare systems.			
				Recipients were assigned to physical morbidity categories based on non-ICD medical diagnosis			
PUBLIC HEALTH IMPORTANCE							
Within the EU, the Minimum Income Recommendation includes that welfare benefits for employable people (i.e., whose age, health and family situation permit labour market participation) should be conditional on availability for work, vocational training or other economic and social integration measures — ‘not as a punishment but as an opportunity to improve their labour market perspectives’ (Amitsis, 2003). The OECD points to ‘a paradigm shift taking place within OECD countries in the approach taken towards disability, with more emphasis on separating the concepts of ‘disability’ and ‘ability to work’. Integration into the workforce rather than passive compensation for loss of income is becoming the more important policy objective (OECD, 2002).							
POLICY CONTEXT – NORTHERN IRELAND				POLICY CONTEXT – REPUBLIC OF IRELAND			
The Government’s public health strategy <i>Investing for Health</i> (DHSSPS, 2002) www.dhssps.gov.uk states the need to tackle poverty and social exclusion by				The National Health Strategy <i>Quality and Fairness</i> (DoHC, 2001) www.dohc.ie recognizes that individual traits, lifestyle choices, social and community networks, and			

Benefits for injury, poisoning, and other consequences of external causes

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

addressing poverty, low income and unemployment. It also emphasises the importance of enabling people to make healthy choices and reducing levels of morbidity and mortality from chronic ill health and injuries by improving environmental, housing and workplace conditions.

The *Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2004) www.dhsspsni.gov.uk emphasises the need for cross departmental and interagency partnerships to ensure that those least able to access the labour market are provided with meaningful employment opportunities by supporting the unemployed, improving skills and promoting the health and wellbeing of those seeking employment.

The *Shared Future Policy and Strategic Framework for Good Relations in Northern Ireland* (OFMDFM, 2005) www.ofmdfm.gov.uk undertakes to establish a society with equal opportunity for all.

The Social security in Northern Ireland is governed by the principle of parity with Great Britain. Policy change is therefore UK wide. The Green Paper *A new deal for welfare: Empowering people to work* (Department for Work and Pensions (DWP), 2006 www.dwp.gov.uk) states the Government's responsibility to ensure that citizens have the right and are supported to enter the world of work. It undertakes to break down barriers that prevent many from fulfilling their potential, impede social mobility and through economic inactivity put people at risk of or into poverty and disadvantage. It states that a third of new claimants cite mental health conditions as the primary cause of their incapacity, while another third come not from work but from other benefits like jobseeker's allowance and income support. It emphasises the need for reform to end the "social injustice inflicted by the poverty trap of benefit dependency". It aims:

- To reduce by 1 million the number of incapacity benefits (in the United Kingdom) by reducing the number of people who leave the workplace due to illness; increasing the number leaving benefits; and better addressing the needs of all those on benefit, with additional payment to the most severely disabled people.

Lifetime Opportunities Government's Anti- Poverty and Social inclusion Strategy for Northern Ireland (OFMDFM, 2006) www.ofmdfm.gov.uk endeavours to ensure that everyone has the opportunity to fully participate in economic, social and cultural life. For those not in a position to enter employment it reiterates the need for support via the benefits system.

Pathways to Work (DEL, DSD & DHSSPS, 2007) is an interdepartmental initiatives to support people with health conditions to towards meaningful employment decisions.

The *Welfare Reform Bill* (DSD, 2007) www.dsdni.gov.uk introduces reform to the Northern Ireland Social Care System for people on benefits for ill health and aims to contribute to increasing the employment rate for people of working age, increasing social inclusion by creating opportunities for disadvantaged people. It replaces incapacity benefits with a new Employment and Support allowance in line with the remainder of the United Kingdom.

This recommendation is included in the Northern Ireland's Programme for Government 2008- 2011 www.pfgbudgetni.gov.uk under Public Service Agreement (PSA) 3, which

wider socio-economic and cultural factors all mediate the individual's need for health and social services.

The National Economic and Social Council (NESC) advises the Irish Government on efficient development of the economy and achievement of social justice as well as social partnership agreements. *The Developmental Welfare State* (NESC, 2005) www.nesc.ie suggests to build consensus across social partners, government and society in a coherent debate that addresses Ireland's social deficits towards integrated policies for employment, social inclusion and economic reform. It challenges the focus on total employment growth and unemployment reduction, calling for an assessment of training and lifelong learning practices, creation of equal opportunity in the labour market and effectiveness of social inclusion and antipoverty strategies.

The *NESC Strategy 2006: People, Productivity and Purpose* (NESC, 2005) www.nesc.ie emphasises the importance of greater participation, social protection and care , more social mobility and successful handling of diversity. It recommends to aim less for targeted programmes for disadvantaged groups and more for the responsiveness and flexibility of publicly funded services, securing adequate income and improving participation. It criticises the benefit traps created by erosion of income eligibility thresholds and the contingency basis of benefits, which can encourage people to cling to a status which secures income at such low levels that many recipients are vulnerable to poverty, debt and low self- esteem. It recommends that benefit recipients, like the unemployed, should be regularly reassessed to identify opportunities and reassess options for improvements to their situation. It also recommends to increase benefits and maintain them in line with Gross Average Industrial Earnings.

The *Ten- Year Framework Social Partnership Agreement 2006-2015 Towards 2016* www.taoiseach.gov.ie underpins the NESC vision and places a focus on employability, access to employment and income, improved health outcomes and support for caring responsibilities. It especially recognises the needs of young adults for education, training and employment, health and social services, in respect of people with disabilities, it states that the National Disability Strategy (National Disability Authority, 2004) www.nda.ie will be implemented with particular regard to health and education services, income and measures to promote employment

The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie proposes to support working age people and people with disabilities , through activation measures and service provision to increase employment and participation. It commits:

- To maintaining the relative value of the lowest social welfare rate at € 185.80, in 2007 terms until 2016, resources permitting,
- To increasing the employment and participation of people with disabilities by bringing an additional 7,000 into employment by 2010, raise the employment rate of people with disabilities from 37% to 45% and the overall participation rate in education, training and employment to 50% by 2016 and
- To reduce by 20% the number of those whose total income is derived from long term social welfare payments by 2016.

Benefits for injury, poisoning, and other consequences of external causes

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

aims to increase employment levels subject to economic conditions and reduce economic inactivity by addressing the barriers to employment and providing effective careers advice. The target is:

- To assist 70,000 working age benefit clients to move into employment by March 2011.

Under PSA 7, which aims to make people's lives better by driving a programme across government to reduce poverty and address inequality and disadvantage, it undertakes to continue to modernise benefit services with several associated targets.

REFERENCES

Organisation for Economic Co-operation and Development (2003). "Society at a Glance" in *OECD Social Indicators*, Edition 2002. Paris, OECD Publications Service.

Amitsis, G. (2003). Background Report: "Connecting Welfare Diversity within the European Social Model". International Conference of the Hellenic Presidency of the European Union.

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Benefits for mental and behavioural disorders

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

NORTH-SOUTH COMPARABILITY	Separate North and South components				
LAY DESCRIPTION	Percentage of the working age population aged 15-64 years in receipt of benefits for mental and behavioural disorders				
SOURCE REFERENCE	eHPI: SH3_3				
INDICATOR NAMES	Pct benef mental beh NI; Pct benef mental beh RoI				
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND			
Percentage of the working age population aged 15-64 years in receipt of Incapacity Benefit for mental and behavioural disorders (ICD 10 codes F00-F99)		Percentage of the working age population aged 15-64 years in receipt of Disability Benefit for mental and behavioural disorders			
Published?	Yes www.dsdni.gov.uk	Published?	No	Geography	N/a
Frequency	Quarterly	Frequency	N/a	Latest Year	N/a
Numerator	Number of people in receipt of Incapacity Benefit for mental and behavioural disorders	Definition	Number of people in receipt of Disability Benefit for mental and behavioural disorders	Geography	County
Source	Department for Social Development	Source	Department of Social and Family Affairs	Year	2006
Denominator	Number of people aged 15-64 years	Definition	Number of people aged 15-64 years	Geography	County
Source	NISRA	Source	Census	Year	2006
DATA ISSUES		DATA ISSUES			
The components are not directly comparable between Northern Ireland and Republic of Ireland as they refer to different social welfare systems.		The components are not directly comparable between Northern Ireland and Republic of Ireland as they refer to different social welfare systems.			
		Recipients were assigned to physical morbidity categories based on non-ICD medical diagnosis.			
PUBLIC HEALTH IMPORTANCE					
Within the EU, the Minimum Income Recommendation includes that welfare benefits for employable people (i.e., whose age, health and family situation permit labour market participation) should be conditional on availability for work, vocational training or other economic and social integration measures — ‘not as a punishment but as an opportunity to improve their labour market perspectives’ (Amitsis, 2003). The OECD points to ‘a paradigm shift taking place within OECD countries in the approach taken towards disability, with more emphasis on separating the concepts of ‘disability’ and ‘ability to work’. Integration into the workforce rather than passive compensation for loss of income is becoming the more important policy objective (OECD, 2002).					
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND			
The Government’s public health strategy <i>Investing for Health</i> (DHSSPS, 2002) www.dhssps.gov.uk states the need to tackle poverty and social exclusion by addressing poverty, low income and unemployment. It also emphasis the importance of		The National Health Strategy <i>Quality and Fairness</i> (DoHC, 2001) www.dohc.ie recognizes that individual traits, lifestyle choices, social and community networks, and			

Benefits for mental and behavioural disorders

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

enabling people to make healthy choices and reducing levels of morbidity and mortality from chronic ill health and injuries by improving environmental, housing and workplace conditions.

The *Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2004) www.dhsspsni.gov.uk emphasises the need for cross departmental and interagency partnerships to ensure that those least able to access the labour market are provided with meaningful employment opportunities by supporting the unemployed, improving skills and promoting the health and wellbeing of those seeking employment.

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- To reduce by 1 million the number of incapacity benefits (in the United Kingdom) by reducing the number of people who leave the workplace due to illness; increasing the number leaving benefits; and better addressing the needs of all those on benefit, with additional payment to the most severely disabled people.

Lifetime Opportunities Government's Anti- Poverty and Social inclusion Strategy for Northern Ireland (OFMDFM, 2006) www.ofmdfm.gov.uk endeavours to ensure that everyone has the opportunity to fully participate in economic, social and cultural life. For those not in a position to enter employment it reiterates the need for support via the benefits system.

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This recommendation is included in the Northern Ireland's Programme for Government 2008- 2011 www.pfqbudgetni.gov.uk under Public Service Agreement (PSA) 3, which

wider socio-economic and cultural factors all mediate the individual's need for health and social services.

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The *NESC Strategy 2006: People, Productivity and Purpose* (NESC, 2005) www.nesc.ie emphasises the importance of greater participation, social protection and care , more social mobility and successful handling of diversity. It recommends to aim less for targeted programmes for disadvantaged groups and more for the responsiveness and flexibility of publicly funded services, securing adequate income and improving participation. It criticises the benefit traps created by erosion of income eligibility thresholds and the contingency basis of benefits, which can encourage people to cling to a status which secures income at such low levels that many recipients are vulnerable to poverty, debt and low self- esteem. It recommends that benefit recipients, like the unemployed, should be regularly reassessed to identify opportunities and reassess options for improvements to their situation. It also recommends to increase benefits and maintain them in line with Gross Average Industrial Earnings.

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The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie proposes to support working age people and people with disabilities , through activation measures and service provision to increase employment and participation. It commits:

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- To reduce by 20% the number of those whose total income is derived from long term social welfare payments by 2016.

Benefits for mental and behavioural disorders

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

aims to increase employment levels subject to economic conditions and reduce economic inactivity by addressing the barriers to employment and providing effective careers advice. The target is:

- To assist 70,000 working age benefit clients to move into employment by March 2011.

Under PSA 7, which aims to make people's lives better by driving a programme across government to reduce poverty and address inequality and disadvantage, it undertakes to continue to modernise benefit services with several associated targets.

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Benefits for other conditions

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

NORTH-SOUTH COMPARABILITY	Separate North and South components
LAY DESCRIPTION	Percentage of the working age population aged 15-64 years in receipt of benefits for other physical conditions
SOURCE REFERENCE	eHPI: SH3_6
INDICATOR NAMES	Pct benef other cond NI; Pct benef other cond RoI

Benefits for other conditions

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

www.dhssps.gov.uk states the need to tackle poverty and social exclusion by addressing poverty, low income and unemployment. It also emphasises the importance of enabling people to make healthy choices and reducing levels of morbidity and mortality from chronic ill health and injuries by improving environmental, housing and workplace conditions.

The *Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2004) www.dhsspsni.gov.uk emphasises the need for cross departmental and interagency partnerships to ensure that those least able to access the labour market are provided with meaningful employment opportunities by supporting the unemployed, improving skills and promoting the health and wellbeing of those seeking employment.

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The National Health Strategy *Quality and Fairness* (DoHC, 2001) www.dohc.ie recognizes that individual traits, lifestyle choices, social and community networks, and wider socio-economic and cultural factors all mediate the individual's need for health and social services.

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- To increasing the employment and participation of people with disabilities by bringing an additional 7,000 into employment by 2010

Benefits for other conditions

Stage: Situation of health

Level: Health status (Individual)

Theme: Physical morbidity

This recommendation is included in the Northern Ireland's Programme for Government 2008- 2011 www.pfgbudgetni.gov.uk under Public Service Agreement (PSA) 3, which aims to increase employment levels subject to economic conditions and reduce economic inactivity by addressing the barriers to employment and providing effective careers advice. The target is:

- To assist 70,000 working age benefit clients to move into employment by March 2011.

Under PSA 7, which aims to make people's lives better by driving a programme across government to reduce poverty and address inequality and disadvantage, it undertakes to continue to modernise benefit services with several associated targets.

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Years of life lost

Stage: Situation of health

Level: Health status (Individual)

Theme: Premature mortality

NORTH-SOUTH COMPARABILITY	On all-island component
LAY DESCRIPTION	The rate of potential years of life lost up to 75 years of age through premature mortality of people aged less than 75 years per 1,000 population
SOURCE REFERENCE	eHPI: SH4_1
INDICATOR NAME	PYLL
DATA DEFINITION – NORTHERN IRELAND	DATA DEFINITION – REPUBLIC OF IRELAND
Directly age and gender standardised rate of years of life lost up to age 75 years age through premature mortality of people aged less than 75 years per 1,000 European standard population	Directly age and gender standardised rate of years of life lost up to age 75 years age through premature mortality of people aged less than 75 years per 1,000 European standard population
Published? Yes, but not age and gender standardised www.ninis.nisra.gov.uk	Published? Yes, up to age 65 years, 69 years, and based on life expectancy PHIS Table 10
Frequency Every year	Frequency Every year
Numerator Number of years of potential life lost up to age 75 years age through premature mortality of people aged less than 75 years	Numerator Number of years of potential life lost up to age 75 years age through premature mortality of people aged less than 75 years
Definition NISRA	Definition CSO
Source Mid-year population estimate	Source Mid-year population estimate
Denominator NISRA	Denominator Census and PHIS
Year 2002-2004	Year 2002-2004
Geography LGD, Parliamentary Constituency, HSSB	Geography County
Latest Year 2004-2006	Latest Year 2005
Geography LGD	Geography County
Year 2002-2004	Year 2002-2004
Geography LGD	Geography County
Year 2002-2004	Year 2002-2004
DATA ISSUES	DATA ISSUES
The crude rate was directly age and gender standardised to the European standard population	The crude rate was directly age and gender standardised to the European standard population
PUBLIC HEALTH IMPORTANCE	
POLICY CONTEXT – NORTHERN IRELAND	POLICY CONTEXT – REPUBLIC OF IRELAND
The cost of premature death can be examined further through the concept of potential years of life lost (PYLL) used to measure the contribution made by specific causes to premature death (before age 75). www.ninis.nisra.gov.uk/mapxtreme/viewdata/Health_and_Care/Health/Potential_Years_Life_Lost/PYLL_2002-2004.xls	Adding Years to Life and Life to Years A Health Promotion Strategy for Older People (NCAOP & DoHC, 1998) National Health Strategy: Quality and Fairness: A Health System for You (2001) NAPS (2002) NAP/Inclusion (2003)
IFH 29% cancer and 16% CHD	Under NAPS (2002) and NAP/Inclusion 2003-2005 one of the key targets to reduce health inequalities is as follows:
None	

Years of life lost

Stage: Situation of health

Level: Health status (Individual)

Theme: Premature mortality

- Reduce the gap in premature mortality between the lowest and highest socio-economic groups by at least 10 per cent for circulatory diseases, cancers and injuries and poisoning by 2007.
- The gap in life expectancy between the Traveller Community and the whole population will be reduced by at least 10 per cent by 2007.

Irish Life Expectancy Trends

Life expectancy at birth has substantially increased for Irish women and men over the past four decades, however life expectancy for older people has shown only modest improvements. Irish life expectancy at age 65 years was still the lowest of all 15 EU countries in 1997. Gender differences in mortality are emerging as a fundamental inequality in health. Life expectancy is still poorer for men. In 1950, the male/female difference in life expectancy at birth was 2.5 years. It is now over 5.5 years. The difference in life expectancy at age 65 was 1 year and now approaches 4 years (DoHC, 2001).

Life expectancy at age 75 is eight years for a man and ten years for a woman. These are very important figures. They emphasise why health is so central for 75 year olds: decisions made about health matters have implications for on average about ten years. This is a substantial portion of an individual's life span. It should be a high priority to make their quality of life during that period as good as possible (Coakley 2003 Healthy Ageing Conference National Council on Ageing and Older People). Life expectancy at birth in Ireland is lower than the EU average as are mortality rates for ischaemic heart disease and cancer, although the position on these is steadily improving (NAP/Inclusion 2003). Life expectancy in 2001 was the lowest in the EU 15, the infant mortality rate the highest, and standardised death rates from diseases of the circulatory system, cancer and diseases of the respiratory system (collectively accounting for three quarters of all deaths in the EU) consistently among the highest for both men and women. Overall, these data indicate that health-related outcomes in Ireland leave considerable room for improvement by international standards (The Social Situation in the European Union, 2003, cited in NESC & NESDO, 2005).

Strategic Policy Developments

In 1995, the National Council on Ageing and Older People proposed the phased development of a Healthy Ageing programme. The Programme aims to promote the health and independence of older people.

The objectives of the programme are to:

- improve life expectancy at age 65 and beyond
- improve the health status of people aged 65 and beyond
- improve the lives and autonomy of older people who are already affected by illness and impairment.

(NCAOP & DoHC, 1998)

The current national health strategy Quality and Fairness (2001) identifies injuries as a common cause of premature mortality. It states that this area has been somewhat neglected as a focus for policy development because of the view that accidents are unpreventable random occurrences and points out that in fact, there is wide scope for prevention.

Years of life lost

Stage: Situation of health

Level: Health status (Individual)

Theme: Premature mortality

The problem of health inequalities in Ireland has become widely recognised in the relevant policy arena in recent years. For instance, the overall health objective outlined in NAPS (2002) is to reduce the inequalities that exist in the health of the population by making health and health inequalities central to public policy, by acting on the social factors influencing health, by improving access to health and personal social services for people who are poor or socially excluded, and by improving the information and research base in relation to health status and service access for these groups. In addition, NAPS/Inclusion (2003) states that a clear social class gradient exists for the major causes of mortality, with those at the lowest socio-economic level having the worst outcomes; this also applies to key life style factors which determine an individual's health status. The report outlines a commitment to continue to improve access to services for the less well off and develop greater emphasis on, and support for, healthier lifestyles as well as ensuring that the health of the population is placed at the centre of public policy in line with the objectives of the National Health Strategy: Quality and Fairness: A Health System for You (2001).

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Benefits for mental health conditions

Stage: Situation of health

Level: Health status (Individual)

Theme: Psychological morbidity

NORTH-SOUTH COMPARABILITY		Separate North and South components	
LAY DESCRIPTION		Percentage of the working age population aged 15-64 years in receipt of benefits for depression and/or anxiety	
SOURCE REFERENCE		eHPI: SH1_2	
INDICATOR NAMES		Pct benef dep/anxiety NI; Pct benef dep/anxiety RoI	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Percentage of the working age population aged 15-64 years in receipt of Incapacity Benefit for depression and/or anxiety (ICD 10 codes F30-F39; F40-F48)		Percentage of the working age population aged 15-64 years in receipt of Disability Benefit for depression and/or anxiety	
Published?	No	Published?	No
Frequency	N/a	Frequency	N/a
Numerator		Numerator	
Definition	Number of people aged 15-64 years in receipt of Incapacity Benefit for depression and/or anxiety	Definition	Number of people aged 15-64 years in receipt of Disability Benefit for depression and/or anxiety
Source	Department for Social Development	Source	Department of Social and Family Affairs
Denominator		Denominator	
Definition	Number of people aged 15-64 years	Definition	Number of people aged 15-64 years
Source	NISRA	Source	Census
Geography	LGD	Geography	County
Latest Year	2006	Latest Year	2006
DATA ISSUES		DATA ISSUES	
The components are not directly comparable between Northern Ireland and Republic of Ireland as they refer to different social welfare systems.		The components are not directly comparable between Northern Ireland and Republic of Ireland as they refer to different social welfare systems.	
PUBLIC HEALTH IMPORTANCE		PUBLIC HEALTH IMPORTANCE	
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
The provision of social security is governed by the principle of parity with Great Britain. Policy change is therefore UK wide.		'Social' Benefits	
The proportion of the working age population in receipt of incapacity benefits in the UK has increased from around 3% in the 1960's to over 7% today. In Northern Ireland the figure is 10.7% (2007 Welfare Reform Bill Impact Assessment) Much of this increase is explained by long term claimants. Major initiatives including 'Pathways to Work' and the New Deal for Disabled People' have been introduced to try to move people who are economically inactive back to work.		The OECD defines a benefit as social if it a support received by households or individuals in 'circumstances adversely affecting their welfare'. They, therefore, list: old-age cash benefits and services to the elderly; disability cash benefits and services to people with disabilities; occupational injury and disease benefits; sickness benefits; unemployment compensation and active labour market policies; housing benefits; public health expenditure; and other contingencies (e.g. cash benefits to people on low incomes) (NESC & NESDO 2005).	
In 2006 the welfare reform Green Paper 'A new deal for welfare: Empowering people to work' was published. Specific concerns were raised by organizations such as MIND and the Mental Health Foundation on the impact of any changes on those with mental health conditions.		The main aims of Ireland's income support policy continue to be: the provision of real increases in social welfare payments, especially for those who are unable to work or who are retired; and ensuring that social welfare payments and income tax provision are structured in ways that contribute to making work pay and reconciling work and family life.	

Benefits for mental health conditions

Stage: Situation of health

Level: Health status (Individual)

Theme: Psychological morbidity

The Impact Assessment specifically stressed

'A responsibility to deliver equality of opportunity to employment for everyone. In addition to the obvious costs, long term wordlessness creates poverty, which translates readily between generations creating social exclusion, limiting aspirations and mobility'

The June 2000 Regional Value For Money Audit in mental health Services summarized the position as follows

' For more than thirty years in has been Government policy in the United Kingdom to reduce the number of long stay psychiatric beds in hospitals and move to a wide range of mental health services for adults into community based alternatives to hospital admission'

At the time of that review Northern Ireland inpatient beds were characterized by occupancy levels, short length of stay and high re-admission rates.

The re-admission rate per facility ranged from eight to forty percent. Case-mix differences alone were not regarded as responsible for this wide range and possible reasons given were differences in admission criteria and the effectiveness of community support
http://www.dhsspsni.gov.uk/mental_health_services_in_ni_vfm_review_regional_summary.pdf

Developments since then have focused on increasing access to the specialist services for acute mental health and reducing the needs for acute beds. Developing child and adolescent community mental health teams (CAMHS) and increased adolescent bed capacity. The provision of a medium secure unit in the Province and specialist services for users with eating disorders and problems with drugs or alcohol.

The DHSSPS consulted on a draft mental health strategy 'Minding Our health' in April 2000. <http://www.dhsspsni.gov.uk/mohstrategy.pdf>. In 2003 the DHSSPS NI published their 'Promoting Mental health Strategy and Action Plan 2003-2008' <http://www.dhsspsni.gov.uk/eqia-promoting-mentalhealth.pdf> with emphasis on the structural and social causes of mental ill health and the need to address these on a multi-agency basis.

Linked strategies are the Suicide and the new Drugs and Alcohol Strategy www.dhsspsni.gov.uk/phnисуicidepreventionstrategy_action_plan-3.pdf, <http://www.dhsspsni.gov.uk/nsdad-finalversion-may06.pdf>

The targets on Incapacity Benefit within the DSD are around clearance times, error rates and financial accuracy rates.

There is a UK target to reduce Incapacity Benefit caseload by one million by 2016.

In Investing For health

To reduce the proportion of people with a potential psychiatric disorder (as measured by the GHQ-12* score) by a tenth by 2010 - as measured in the 2001 Health and Well Being Survey

(Office for Social Inclusion/Department of Social and Family Affairs 2005 Implementation Report for Ireland on the NAP/Inclusion 2003-2005).

Ireland's 'Differentiated' or 'Clientelist' Welfare State

There is a core structure to Ireland's welfare state that has been built up over the decades. In this core structure, the social support which the state delivers or subsidises takes one of the three routes referred to above, i.e. access to the support is:

- (i) universal and simply by virtue of membership of Irish society,
- (ii) conditional on a record of insurance contributions from employment or on the status of being an income taxpayer,
- (iii) targeted on people in need and who establish that they are by satisfying a means-test of their household's resources or verifying that they are below an income threshold (NESC & NESDO (2005) The Developmental Welfare State).

Comparative Public Health Spending & Health-Related Outcomes

The rise in public health spending in Ireland since 1997 has been dramatic, yet there is a generalised concern that the public health services have not only not improved but deteriorated. Partly as a result, a major reform programme began in 2005 whose impact will need some years before it can be assessed. By 2002, public spending on health as a proportion of GDP/GNP put Ireland in the top third of EU 15 member states, while its per capita spending in constant purchasing power terms was the 6th highest of the 14 countries listed (Denmark, Sweden, Finland, Austria, Netherlands, Germany, France, Belgium, United Kingdom, Ireland, Italy, Greece, Spain, Portugal). Individual traits, lifestyle choices, social and community networks, and wider socio-economic and cultural factors all mediate the individual's need for health services (DoHC, 2001) and, thus, the levels of health service usage that support any given health outcome.

Major changes in socio-economic conditions and lifestyle over the past two decades have accompanied the large increase in public health spending that has occurred. Falling unemployment, lower levels of deprivation, rising educational attainment, more self-direction in the workplace and less smoking, for example, can be expected to have made major contributions to improving people's health status. On the other hand, the very ability to keep people with severe disabilities alive longer, the growing number of advanced elderly people, the rise in alcohol consumption, rising obesity levels, higher immigration from developing countries, growing relationship instability and the higher incidence of people living alone — are some factors which can be expected to be making even a population more intensive in its use of health services even to maintain its health status.

Current public spending on health in Ireland is broadly comparable to other countries in the share of national resources being devoted to it. That Ireland, nevertheless, has poor relative health outcomes suggests better use can be made of the resources being devoted to health. This is not just a challenge to the management of health organisations and the ethos of health professionals but underlines the need for co-responsibility for health to be exercised right across Irish society (in use of alcohol, diet, etc.) (Source: NECS & NESDO 2005 The Developmental Welfare State)

Income Transfer/Cash Benefits for the Ill/Disabled

Households headed by an ill/disabled person have one of the highest risks of poverty. The core income transfer/cash benefit schemes for the ill/disabled, administered by the Department of

Benefits for mental health conditions

Stage: Situation of health

Level: Health status (Individual)

Theme: Psychological morbidity

Social and Family Affairs, are:

- (i) Disability Benefit (Social Insurance based - short-term, contribution based, payment)
- (ii) Disability Allowance (Social Assistance based - long-term, means tested, payment) (NOTE: during the 1990s the numbers in receipt of disability allowance rose significantly)
- (iii) Disablement Benefit (Social Insurance based)
- (iv) Invalidity Pension (Social Insurance based - long-term, contribution based payment)
- (v) Occupational Injury Benefit (Social Insurance based)
- (vi) Blind Pension (Social Assistance based).

Spending on health care, disability and sickness grew particularly strongly in Ireland compared to the rest of the EU during the 1990s. In 1993, expenditure on the function Sickness/Health Care was 34.8 per cent of all social protection expenditure in Ireland as against an EU 15 average of 28 per cent; by 2001, it was 43.4 per cent in Ireland as against an EU 15 average of 28 per cent. In 2001, spending in Ireland on the sickness/health care function as a proportion all social protection expenditure was higher than anywhere else in the EU 15 (European Social Statistics, Social Protection: Expenditure and Receipts Data 1992-2001).

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Prescribing for anxiety/depression

Stage: Situation of health

Level: Health status (Individual)

Theme: Psychological morbidity

NORTH-SOUTH COMPARABILITY	Separate North and South components		
LAY DESCRIPTION	Prevalence of the prescribing of drugs for anxiety and/or depression		
SOURCE REFERENCE	eHPI: SH1_3		
INDICATOR NAMES	Pct antidepress per capita NI; Pct antidepressant RoI		
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
The number of defined daily doses of drugs for anxiety and/or depression (British National Formulary codes 4.1.2 and 4.3) prescribed per person		Percentage of people participating in the GMS Scheme, Long Term Illness Scheme, and Drug Payment Scheme who are prescribed drugs for anxiety and/or depression (Anatomical Therapeutic Chemical classification codes NO6A and NO5B)	
Published?	No	Published?	Yes
Geography	N/a	Geography	Ireland
Frequency	N/a	Frequency	Every year
Numerator		Numerator	Number of people participating in the GMS Scheme, Long Term Illness Scheme, and Drug Payment Scheme who are prescribed drugs for anxiety and/or depression
Definition	The number of defined daily doses of drugs for anxiety and/or depression (British National Formulary codes 4.1.2 and 4.3) prescribed in an area	Definition	Mid-year population estimate
Source	Central Services Agency	Source	Public Health Information System
Denominator	Mid-year population estimate	Denominator	
Year	2007	Year	2005
Geography	LGD	Geography	County
Year	2007	Year	2005
DATA ISSUES		DATA ISSUES	
The components are not directly comparable between Northern Ireland and Republic of Ireland as they measure different things; defined daily doses per person cannot be compared to a percentage of people.		The components are not directly comparable between Northern Ireland and Republic of Ireland as they measure different things; defined daily doses per person cannot be compared to a percentage of people. In principle, the GMS Scheme, Long Term Illness Scheme, and Drug Payment Scheme covers the entire population but some people may choose not to participate.	
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
Appleby identified high level of prescriptions per head in NI as the second highest in the UK (only Wales is higher per capita)+18% v England 2003		Building on Experience. National Drugs Strategy 2001 – 2008 (Department of Tourism, Sport & Recreation, 2001)	

Prescribing for anxiety/depression

Stage: Situation of health

Level: Health status (Individual)

Theme: Psychological morbidity

Increased 43% in last ten years

Anti depress identified as an area of higher level prescriptions. In 2005 1.4 million anti depressant items were issued in NI or 0.78 per head

The DHSSPS consulted on a draft mental health strategy 'Minding Our health ' in April 2000. <http://www.dhsspsni.gov.uk/mohstrategy.pdf>. In 2003 the DHSSPS NI published their 'Promoting Mental health Strategy and Action Plan 2003-2008' <http://www.dhsspsni.gov.uk/egia-promoting-mentalhealth.pdf> with emphasis on the structural and social causes of mental ill health and the need to address these on a multi-agency basis.

Linked strategies are the Suicide and the new Drugs and Alcohol Strategy www.dhsspsni.gov.uk/phnисуicidepreventionstrategy_action_plan-3.pdf, <http://www.dhsspsni.gov.uk/nsdad-finalversion-may06.pdf>

www.dhsspsni.gov.uk/phnисуicidepreventionstrategy_action_plan-3.pdf **Suicide Strategy**
www.healthpromotionagency.org.uk/Resources/strategies/mindingourhealth.htm **Mental Health Conditions**

The CMO Annual Report states that the number of suicides particularly among young men continues to be an area of concern in Northern Ireland. In 2005 there were over 200 suicides. Eighty per cent (4 out of every 5) occurred in men and half of them were in young men under 35 years of age. Suicide in young men is a complex area and as well as poor mental health many other factors such as substance misuse, social deprivation, unemployment, poor family circumstances and availability of means play a role. Action to decrease suicide requires a broad approach with coordination and cooperation of many agencies across a range of services, much wider than just health and social services.
www.dhsspsni.gov.uk/index/phealth/cmoannualreport/cmoreport-2003.htm

Need to monitor and regulate the prescribing of anti-depressants to the under 18 age group.
www.dhsspsni.gov.uk/phnисуicidepreventionstrategy_action_plan-3.pdf

Tricyclics, otherwise known as antidepressants, are generally used in the treatment of depression and depressive conditions.

- Benzodiazepines are a form of tranquilliser.
(National Drugs Strategy 2001)

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Psychiatric admissions

Stage: Situation of health

Level: Health status (individual)

Theme: Psychological morbidity

NORTH-SOUTH COMPARABILITY All-island component

LAY DESCRIPTION Number of admissions to hospital for anxiety or depression per 1,000 people

SOURCE REFERENCE eHPI: SH1_4

INDICATOR NAME Rate adm psych hosp

DATA DEFINITION – NORTHERN IRELAND

Number of admissions to hospital for anxiety or depression per 1,000 people. ICD 10 codes F30-F39 and F40-F48.

Published?	Partly NINIS publishes admissions for F39 and F41.9 www.ninis.nisra.gov.uk	Geography	LGD, HSSB
Frequency	Every year	Latest Year	2006/2007
Numerator Definition	Number of admissions to hospital for anxiety or depression	Geography	LGD
Source	Hospital Inpatient System, DHSSPS	Year	2004/2005
Denominator Definition	Mid-year population estimate	Geography	LGD
Source	NISRA	Year	2005

DATA ISSUES

PUBLIC HEALTH IMPORTANCE

POLICY CONTEXT – NORTHERN IRELAND

The June 2000 Regional Value For Money Audit in mental health Services summarized the position as follows

‘ For more than thirty years in has been Government policy in the United Kingdom to reduce the number of long stay psychiatric beds in hospitals and move to a wide range of mental health services for adults into community based alternatives to hospital admission’

At the time of that review Northern Ireland inpatient beds were characterized by occupancy levels, short length of stay and high re-admission rates.

The re-admission rate per facility ranged from eight to forty percent. Case-mix differences alone were not regarded as responsible for this wide range and possible reasons given were differences in admission criteria and the effectiveness of community support

http://www.dhsspsni.gov.uk/mental_health_services_in_ni_vfm_review_regional_summary.pdf

DATA DEFINITION – REPUBLIC OF IRELAND

Number of admissions to hospital for anxiety or depression per 1,000 people. ICD 10 codes F30-F39 and F40-F48.

Published?	Yes Activities of the Irish Psychiatric Units and Hospitals	Geography	Individual Units, Catchment Areas
Frequency	Every year	Latest Year	2006
Numerator Definition	Number of admissions to hospital for anxiety or depression	Geography	County
Source	National Psychiatric Inpatient Recording System	Year	2005
Denominator Definition	Mid-year population estimate	Geography	County
Source	Public Health Information System	Year	2005

DATA ISSUES

POLICY CONTEXT – REPUBLIC OF IRELAND

Planning for the Future (1984)

National Health Strategy Quality and Fairness (2001)

A Vision for Change Report of the Expert Group on Mental Health Policy (2006)

- The Report of the Expert Group on Mental Health Policy, A Vision for Change (2006) recommends that all mental health promotion programmes and initiatives should be evaluated against locally agreed targets and standards.
- It states that Community Mental Health Teams should be accountable to Mental Health Catchment Area Management Teams in achieving targets.
- It recommends that the National Mental Health Service Directorate should be specifically represented in the institutional arrangements which implement the National Action Plan against Poverty and Social Exclusion, with specific targets to monitor action in achieving greater social inclusion for those with mental health problems.

According to the National Health Strategy Quality and Fairness (2001) more than one in four

Psychiatric admissions

Stage: Situation of health

Level: Health status (individual)

Theme: Psychological morbidity

Developments since then have focused on increasing access to the specialist services for acute mental health and reducing the needs for acute beds. Developing child and adolescent community mental health teams (CAMHS) and increased adolescent bed capacity. The provision of a medium secure unit in the Province and specialist services for users with eating disorders and problems with drugs or alcohol.

The DHSSPS consulted on a draft mental health strategy 'Minding Our health' in April 2000. <http://www.dhsspsni.gov.uk/mohstrategy.pdf>. In 2003 the DHSSPS NI published their 'Promoting Mental health Strategy and Action Plan 2003-2008' <http://www.dhsspsni.gov.uk/eqia-promoting-mentalhealth.pdf> with emphasis on the structural and social causes of mental ill health and the need to address these on a multi-agency basis.

Linked strategies are the Suicide and the new Drugs and Alcohol Strategy www.dhsspsni.gov.uk/phnisuicidepreventionstrategy_action_plan-3.pdf, <http://www.dhsspsni.gov.uk/nsdad-finalversion-may06.pdf>

By March 2008 to ensure that each GP practice has an appropriate professional trained awareness or suicide awareness line with the Suicide Prevention Strategy http://www.dhsspsni.gov.uk/pfa_2007-08.pdf www.dhsspsni.gov.uk/phnisuicidepreventionstrategy_action_plan-3.pdf **Suicide Strategy**

To reduce the proportion of people with potential psychiatric disorder (as measured by the GHQ-12 score) by a tenth by 2010. <http://www.northernifhpartners.co.uk/publications/iffreview.pdf>

adults will suffer from mental illness at some point during their lives. Twenty-five per cent of families are likely to have at least one member who suffers from mental illness. The Strategy (2001) states that mental health is recognized increasingly as a major challenge facing health services in the twenty-first century. Psychiatric admissions can be used as an indicator of mental health and are more likely to be seen in the lower socio-economic groups (TCD, 2001 cited in DoHC, 2001).

Strategic Policy Developments

The Mental Treatment Act (1945) and associated regulations have constituted the main legislative framework for adult mental health services up to the beginning of the twenty first century. The Mental Health Act (2001) provides the current legislative basis for Irish mental health. A significant policy framework setting out a vision for mental health services in Ireland entitled Planning for the Future was published in 1984. While the overall approach and recommendations of this document was widely recognised as visionary, many of its recommendations were not implemented (see <http://www.mentalhealthireland.ie>). Planning for the Future (1984) recommended the closure of the old psychiatric hospitals and their replacement with acute psychiatric units in general hospitals and a range of community-based residential accommodation, however few health boards areas have as yet completed the process (DoHC, 2001).

One of the Objectives under National Goal Number 1: Better health for everyone of the National Health Strategy Quality and Fairness (2001) refers to specific quality of life issues to be targeted. Under this objective, the development of a new action programme for mental health is discussed. The Strategy states that this programme will build on recent initiatives in mental health services, particularly in the areas of attitudes to mental illness, strengthening advocacy for people with mental illness and providing services in areas where gaps have been identified.

Key actions to improve mental health services and promote awareness of mental health are:

- The Mental Health Commission will be established by end 2001 to begin the implementation of the Mental Health Act, 2001
- A national policy framework for the further modernisation of mental health services, updating Planning for the Future (1984), will be prepared
- Services aimed at specific groups will be further developed including:
 - older people
 - those who would benefit from community-based alcohol treatment programmes
- A report on services for people with eating disorders will be prepared by the Working Group on Child and Adolescent Services
 - Programmes to promote positive attitudes to mental health will be introduced
 - Independent patient advocacy services will be encouraged and resourced
 - Suicide prevention programmes will be intensified.

An Expert Group on Mental Health Policy was established, in August 2003 to prepare a new national policy framework for the mental health services, updating the 1984 policy document Planning for the Future (See <http://www.mentalhealthpolicy.ie>). The terms of reference of the Expert Group also include recommending how the services might best be organised and delivered, and indicating the potential cost of its recommendations. Extensive consultation with service users, families and service providers informed this policy. At the end of 2004 two

Psychiatric admissions

Stage: Situation of health

Level: Health status (individual)

Theme: Psychological morbidity

reports on the consultation process undertaken on behalf of the Group which comprised written submissions, questionnaires, two public consultation days and a one-to-one consultation with service users in the Adult Mental Health Services were published, namely 'Speaking Your Mind' and 'What we Heard'.

In January, 2006 a new national policy framework for mental health services was published by the Report of the Expert Group on Mental Health Policy, A Vision for Change. This document sets out a comprehensive policy framework for Irish mental health services for the next 7-10 years addressing the mental health challenges facing society - not least of which is the significant suicide rate, particularly among young people.

A Vision for Change proposes a framework for promoting mental health at all levels of society and for delivering specialist care to everyone who needs it. It recognises both the strengths and inadequacies of existing services and outlines a strategy for building on the innovations heralded by Planning for the Future (1984). It details a series of actions for developing a comprehensive person-centred model of mental health service provision. This policy proposes that solutions for people with mental health needs lie in establishing effective partnerships, between health service managers and health care providers on the one hand, and service users and their carers on the other, in a community-wide context. It proposes specific ways in which managers and professionals can blend their expertise more effectively, forge working relationships with resources that already exist to support service users in the broader community, and involve service users as legitimate collaborators in their own recovery.

In total, the new Strategy contains 17 key recommendations with regards to mental health policy.

National Reporting Systems

The Mental Health Research Division (MHRD) of the Health Research Board (HRB) carries out national and international research, information gathering and the dissemination of research outcomes on mental health and mental illness in Ireland. The results of this research inform national policy, health service management, clinical practice and international academic research.

The MHRD manages and reports on two national psychiatric databases, the National Psychiatric In-Patient Reporting System and COMCAR, which inform on policy and planning for mental health services nationally and regionally.

The National Psychiatric In-Patient Reporting System (NPIRS) is the only national psychiatric inpatient database in Ireland. It was established in 1963, arising from the recommendations of the report of the Commission of Enquiry on Mental Illness (Department of Health, 1966). The database records data on all admissions to, and discharges from, psychiatric inpatient facilities in Ireland annually, through the Patient Administration System (PAS), which is used in more than 10 hospitals nationally and has replaced paper-based reporting systems. In response to changing patterns of patient care, the HRB has developed a new database, COMCAR, designed to collect information and record activity in psychiatric services at Community Care level, including outpatient clinics, day centres and day hospitals.

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Suicide

Stage: Situation of health

Level: Health status (individual)

Theme: Psychological morbidity

NORTH-SOUTH COMPARABILITY	All-island component
LAY DESCRIPTION	The number of suicides per 100,000 people
SOURCE REFERENCE	eHPI: SA4_1
INDICATOR NAME	Rate suicide

DATA DEFINITION – NORTHERN IRELAND

The rate of suicides occurring per 100,000 population

Published?	Yes	Geography	LGD, HSSB
	Registrar General's Annual Report		
Frequency	Every year	Latest Year	2006
Numerator Definition	Number of suicides occurring	Geography	LGD
Source	Registrar General	Year	2001-2004
Denominator Definition	Mid-year population estimate	Geography	LGD
Source	NISRA	Year	2001-2004

DATA ISSUES

The suicide prevention strategies in the Republic of Ireland and Northern Ireland expressed concern about the accuracy of suicide data. The following factors are likely to affect the accuracy of suicide data:

- There may be difficulty in determining the intent behind a death and some suicide deaths are likely to be recorded as deaths of undetermined intent. This would underestimate the rate of suicide.
- Similarly, there may be different practices in different areas in classifying the intent behind a death and some suicide deaths may be classified as deaths of undetermined intent. Again, this would underestimate the rate of suicide.
- There can be substantial delays in registering suicide deaths due to the time taken to complete inquests so it is advisable to allow a number of years time lag before reporting a particular year's suicide data. This will improve the completeness of the data.

DATA DEFINITION – REPUBLIC OF IRELAND

The rate of suicides occurring per 100,000 population

Published?	Yes	Geography	County
	CSO Vital Statistics		
Frequency	Every year	Latest Year	2005
Numerator Definition	Number of suicides occurring	Geography	County
Source	CSO Vital Statistics	Year	2001-2004
Denominator Definition	Mid-year population estimate	Geography	County
Source	Public Health Information System	Year	2001-2004

DATA ISSUES

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Suicide

Stage: Situation of health

Level: Health status (individual)

Theme: Psychological morbidity

PUBLIC HEALTH IMPORTANCE

Suicide causes almost half of all violent deaths and results in almost one million fatalities a year globally, representing 1.4% of the global burden of disease (WHO, 2004). Mental ill health affects every fourth European Union citizen, leading to significant losses to the economic, social, educational as well as criminal and justice systems. Stigmatisation, discrimination and violation of human rights and the dignity of mentally ill people continues to exist (European Commission, 2005). In most European countries, more people die from suicide than from road traffic crashes. It has been estimated that failed suicide attempts outnumber deaths 10-20 times, causing injury, emotional and mental trauma.

While more men than women commit suicide, more women than men attempt to their own lives (WHO, 2004). It disproportionately affects those living in disadvantaged socio economic circumstances (Tomlinson, 2007). Of particular concern has been the recent rise in suicidal behaviour amongst children and young people. Risk factors for suicidal behaviour are complex and include poverty, unemployment, bereavement, breakdown and tensions in relationships, social isolation, legal and workplace problems. Physical illness and pain, a family history of suicide, childhood abuse, alcohol and drug use and mental disorders can also play a central role. Protective factors include self esteem and social connectedness with friends and family and religious or spiritual commitment (WHO, 2004). It is important that interventions take into account these factors as part of promoting mental health and wellbeing.

POLICY CONTEXT – NORTHERN IRELAND

One of the objectives of the overarching interdepartmental public health policy for Northern Ireland, *Investing for Health* (DHSSPS, 2002) www.dhsspsni.gov.uk is the promotion of mental health and emotional well-being at individual and community level. It discusses the importance of addressing suicide and attempted suicide especially amongst young people and the methodological challenges of setting targets and monitoring the impact of interventions.

The interagency and cross sectoral *Investing for Health Northern Ireland Suicide Prevention Strategy and Action Plan 2006- 2011* (DHSSPS, 2006) www.dhsspsni.gov.uk builds on the ten suicide prevention action points contained in the *Promoting Mental Health Strategy and Action Plan* (DHSSPS, 2003) www.dhsspsni.gov.uk

- To obtain a 10% reduction in the overall suicide rate by 2008; and
- To reduce the overall suicide rate by a further 5% by 2011.

It emphasises the need to change public attitudes towards mental health and suicide; to provide professional suicide and depression awareness training; to improve suicide and self-harm data collection; to reduce self harm and improve services for people who have self harmed; to develop bereavement and community support services.

Its implementation will be overseen by a cross sectoral implementation body and supported by progress in the delivery of the *Bamford Review of Mental Health and Learning Disability* (2007) www.rmhlndni.gov.uk.

The *Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2004) www.dhsspsni.gov.uk emphasises the Government's ongoing commitment to the overarching interdepartmental public health policy for Northern Ireland, *Investing for Health* (DHSSPS, 2002) www.dhsspsni.gov.uk, for promoting population health and wellbeing and reducing health inequalities. It aims:

- To reduce the number of suicides for all persons and for males aged 15-44 years per 100,000 in 2002 by 50%.

POLICY CONTEXT – REPUBLIC OF IRELAND

The National Health Strategy *Quality and Fairness* (DoHC, 2001) www.dohc.ie states that of particular concern in recent years has been the increase in the number of young males committing suicide. The Strategy commits to the principles of promoting, protecting and improving health, reducing premature mortality and intensifying suicide prevention programmes.

The *Health (Miscellaneous Provisions) Act* (2001) www.irishstatutebook.ie requires the Minister for Health and Children to report to the Oireachtas each year on the measures taken to address the problem of suicide.

The National Strategy for Action on Suicide Prevention *Reach Out* 2005-2014 (DoHC & HSE, 2005) www.nosp.ie builds on the work of the National Task Force on Suicide (1998) and takes account of the important strategic and operational initiatives developed by the former health boards in response. Four levels of priority actions are to be undertaken, monitored by the National Office for Suicide Prevention:

(1) General population approach

Goal: To promote positive mental health and well-being and bring about positive attitude change towards mental health, problem solving and coping in the general population. This approach contains a series of objectives and actions pertaining to the following areas: The Family; Schools; Youth Organisations and Services; Third Level Education Settings; Workplaces; Sports Clubs and Organisations; Voluntary and Community Organisations; Church and Religious Groups; Media; Reducing Stigma and Promoting Mental Health; Primary Care and General Practice.

(2) Targeted approach

Goal: To reduce the risk of suicidal behaviour among high risk groups and vulnerable people. This section contains a series of objectives and actions with regards to: Deliberate Self-Harm; Mental Health Services; Alcohol and Substance Abuse; Marginalised Groups; Prisons; An Garda Síochána; Unemployed People; People who have experienced Abuse; Young Men; Older People; Restricting and Reducing Access to Means.

Suicide

Stage: Situation of health

Level: Health status (individual)

Theme: Psychological morbidity

The Government's Anti- Poverty and Social Inclusion Strategy for Northern Ireland (OFMDFM, 2007) www.ofmdfm.gov.uk aims to improve, amongst others, the mental health and wellbeing of all young people. It recognises that the promotion of social inclusion needs to address the particular needs of people with or at risk of mental health difficulties.

The Northern Ireland Executive's first *Programme for Government 2008- 2011* www.pfgbudgetni.gov.uk prioritises the promotion of tolerance, inclusion and health and wellbeing for all to create the conditions for economic growth and deliver health improvements. Under Public Service Agreement (PSA) 8 it aims for the promotion of healthy lifestyles, addressing the causes of poor health and wellbeing and achieving measurable reductions in health inequalities and preventable illness.

It undertakes to roll out a suicide prevention helpline, expand self- harm mentoring and improve life and coping skills of those at risk of suicide and incorporates the *for Health Northern Ireland Suicide Prevention Strategy and Action Plan 2006- 2011* (DHSSPS, 2006) www.dhsspsni.gov.uk aim:

- To reduce the suicide rate by 15% by 2011.

(3) Responding to suicide

Goal: To minimise the distress felt among families, friends and in a community following a death by suicide and ensure that individuals are not isolated or left vulnerable so that the risk of any related suicidal behaviour is reduced. Objectives and actions in this regard are under the following two headings: Support following Suicide, and Coroner Service.

(4) Information and research

Goal: To improve access to information relating to suicidal behaviour and on where and how to get help, and to encourage suicide research and improve access to research findings. Specific objectives and actions pertaining to both information and research are outlined.

A new national policy framework for mental health services has been published in the Report of the Expert Group on Mental Health Policy *A Vision for Change* (2006) www.dohc.ie . It sets out a comprehensive policy framework for Irish mental health services for the next 7-10 years addressing the mental health challenges facing society - not least of which is the significant suicide rate, particularly among young people.

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Live Births

Theme: Demographic and Socio-economic Characteristics

NORTH-SOUTH COMPARABILITY	All-island component
LAY DESCRIPTION	The number of live births
SOURCE REFERENCE	PHIS V9 Table 04: Fertility: Births: Numbers, Crude Rates, Total Fertility Rates and Percent outside Marriage (INIsPHO eData); NI DPH Core Table 04b: Births (Live and Still) to Maternal Residents by District Council Areas, Health Boards, and National (INIsPHO eData).
INDICATOR NAME	Number of Live Births

DATA DEFINITION – NORTHERN IRELAND				DATA DEFINITION – REPUBLIC OF IRELAND			
Published?	Yes www.nisra.gov.uk	Geography	Northern Ireland LGD HSSB Ward OA	Published?	Yes www.cso.ie	Geography	Ireland County
Frequency	Every year	Latest Year	2007	Frequency	Every year	Latest Year	2007
Numerator				Numerator			
Definition	Number of Live Births	Geography	LGD	Definition	Number of Live Births	Geography	County
Source	INIsPHO	Year	2005	Source	CSO	Year	2003
Denominator				Denominator			
Definition	N/a	Geography	N/a	Definition	N/a	Geography	N/a
Source	N/a	Year	N/a	Source	N/a	Year	N/a
DATA ISSUES				DATA ISSUES			
PUBLIC HEALTH IMPORTANCE							
POLICY CONTEXT – NORTHERN IRELAND				POLICY CONTEXT – REPUBLIC OF IRELAND			

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Teenage birth rates

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Utilisation of Health Service

NORTH-SOUTH COMPARABILITY		All-island component	
LAY DESCRIPTION		Number of births to mothers aged 19 years or less per 1,000 female population aged 13 to 19 years.	
SOURCE REFERENCE		AIHSC	
INDICATOR NAME		Rate teenage birth	
</			

Teenage birth rates

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Utilisation of Health Service

are to improve people's health by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability, and to reduce inequalities in health between geographic areas, socio- economic and minority groups. It recognises high levels of teenage pregnancy in Northern Ireland compared to European levels especially in geographical areas of deprivation. It endeavours to reduce child poverty, increase social inclusion, improve learning and support regeneration.

Referred to in *Investing for Health* and based on the report of the working group on teenage pregnancy and parenthood *Myths and Reality* (DHSSPS, 2001), www.dhsspsni.gov.uk, the *Teenage Pregnancy and Parenthood Strategy and Action Plan 2002- 2007* (DHSSPS, 2002) www.dhsspsni.gov.uk aimed to reduce unplanned births to teenage mothers and to minimise adverse consequences to teenage parents and their children. While lower than the UK average, teenage birth rates remain high in Northern Ireland compared to the European average, but have been decreasing since a high in 1999. Its action plan covered policy development, information and education, parent and child communication, improved services, training and support services as well as research. It had the targets:

- To reduce by 20% the rate of births to teenage mothers from 2000 to 2007, and
- To ensure all teenage mothers of compulsory school age complete formal education.

The *Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005- 2025* (DHSSPS, 2004) www.dhsspsni.gov.uk emphasises the Government's ongoing commitment to the overarching interdepartmental public health policy for Northern Ireland, *Investing for Health* (DHSSPS, 2002) www.dhsspsni.gov.uk, for promoting population health and wellbeing and reducing health inequalities. It undertakes to ensure implementation of relevant strategies to improve sexual health by 2010.

Lifetime Opportunities- Government's Anti- Poverty and Social Inclusion Strategy for Northern Ireland (NIE, 2005) <http://www.ofmdfmi.gov.uk> takes a lifecycle cross departmental approach to eliminate poverty and promote social inclusion. It undertakes to tackle area-based deprivation, rural poverty and inequality in the labour market; address conflict and community division; combat health inequalities and help people to break out of the cycles of deprivation at different stages of the lifecycle from early years to retirement. It recognises the impact of deprivation on length and quality of life. It endorses the aims of the *Teenage Pregnancy and Parenthood Strategy and Action Plan 2002- 2007* (DHSSPS, 2002) www.dhsspsni.gov.uk.

The Northern Ireland Executive's first *Programme for Government 2008- 2011* www.pfgbudgetni.gov.uk prioritises the promotion of tolerance, inclusion and health and wellbeing for all to create the conditions for economic growth and deliver health improvements. Under Public Service Agreement (PSA) 8 it aims for the promotion of healthy lifestyles, addressing the causes of poor health and wellbeing and achieving measurable reductions in health inequalities and preventable illness. It aims:

- By 2010, achieve a 30% reduction in the rate of births to mothers under 17.

The Northern Ireland Audit Office's report on The Performance of the Health Service in Northern Ireland (Comptroller and Auditor General, 2008) www.tso.co.uk

The National Children's Strategy (DoHC, 2000) www.dohc.ie emphasises the importance of cross sectoral programmes to promote sexual health and reduce teenage pregnancy as part of the implementation of the *National Health Promotion Strategy 2000-2005*.

The National Health Strategy *Quality and Fairness* (DoHC, 2001) www.dohc.ie commits to the principles of promoting, protecting and improving health endorses the strategic aims and objectives for improving sexual health contained in the *National Health Promotion Strategy 2000-2005*.

The Crisis Pregnancy Agency was established in 2001 to reduce the number of crisis pregnancies through education, advice and contraceptive services, to reduce the number of women opting for abortions by offering alternatives and to provide counselling and medical services after crisis pregnancy. It undertook also to improve support to teenage parents.

The *National Action Plan against Poverty and Social Exclusion 2003- 2005* included commitments to reduce the number of teenage pregnancies (Department of Social and Family Affairs, 2003) www.welfare.ie. The *New National Action Plan for Social Inclusion 2007- 2016* www.socialinclusion.ie (2006) recognises the existence of health inequalities and acknowledges

The need to address child poverty and lone parenthood.

The *State of the Nation's Children Report* (National Children's Office, 2006) www.nco.ie presents data on the health and wellbeing of children and young people in Ireland under the headings of demography, relationships, outcomes and supports. It recognises the strong correlation between teenage pregnancy and deprivation and notes the continuous decrease in births to teenage mothers since 2001.

The *National Development Plan Transforming Ireland- A Better Quality of Life for All 2007- 2013* www.esri.ie, provides investment to reconfigure, improve and expand health services. It describes investment to address lone parenthood as outlined in the *New National Action Plan for Social Inclusion 2007- 2016*. This theme is carried through into the National Social Partnership Agreement *Towards 2007- 2016* www.taoiseach.gov.ie.

The National Women's Strategy (Department of Justice, Equality and Law Reform, 2007) www.irlgov.ie makes reference to existing lone and teenage parent support programmes.

Teenage birth rates

Stage: Situation of health

Level: Appropriate care (Intermediate)

Theme: Utilisation of Health Service

acknowledges that progress towards the Government's targets for reducing teenage pregnancy are achievable.

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Social Class

Theme: Demographic and Socio-economic Characteristics

NORTH-SOUTH COMPARABILITY	Separate North and South components		
LAY DESCRIPTION	The number of people by social classification		
SOURCE REFERENCE	Other Indicators		
INDICATOR NAMES	<div> Higher managerial Male NI Lower managerial Male NI Intermediate occup Male NI Small employer Male NI Lower supervisory Male NI Semi-routine occup Male NI Routine occup Male NI Never worked & unemp Male NI Not classified Male NI Higher managerial Female NI Lower managerial Female NI Intermediate occup Female NI Small employer Female NI Lower supervisory Female NI Semi-routine occup Female NI Routine occup Female NI Never worked & unemp Female NI Not classified Female NI </div> <div> Prof workers Male RoI Managerial and tech Male RoI Non-manual Male RoI Skilled manual Male RoI Semi-skilled Male RoI Unskilled Male RoI All others occupied Male RoI Prof workers Female RoI Managerial and tech Female RoI Non-manual Female RoI Skilled manual Female RoI Semi-skilled Female RoI Unskilled Female RoI All others occupied Female RoI </div>		
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
The number of people by National Statistics Socio-economic Classifications		The number of people by social class	
Published?	Yes www.nisra.gov.uk	Published?	Yes www.cso.ie
Geography	LGD	Geography	Administrative county ED Province National
Frequency	Every 10 years	Frequency	Every 5 years
Numerator		Numerator	
Definition	Number of persons by National Statistics Socio-economic Classification (NS-SEC)	Definition	Number of persons by social class
Source	NISRA	Source	CSO
Denominator		Denominator	
Definition	Population count	Definition	Population count
Source	NISRA	Source	CSO
Year	2001	Year	2006
Geography	LGD	Geography	County
Year	2001	Year	2006
DATA ISSUES		DATA ISSUES	
PUBLIC HEALTH IMPORTANCE		PUBLIC HEALTH IMPORTANCE	
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
REFERENCES		REFERENCES	

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Population

Theme: Demographic and Socio-economic Characteristics

NORTH-SOUTH COMPARABILITY		All-island component	
LAY DESCRIPTION		The population count of Ireland and Northern Ireland	
SOURCE REFERENCE		CSO Population by County, Age and Gender (2006) (INIsPHO eData); NISRA Mid Year Population Estimates by Gender, HSSB & Single Year Age (1981-2006) (INIsPHO eData)	
INDICATOR NAME		Pop 2006	
DATA DEFINITION – NORTHERN IRELAND		DATA DEFINITION – REPUBLIC OF IRELAND	
Published?	Yes www.nisra.gov.uk	Geography	Northern Ireland, HSSB, ELB, LGD, PC
Frequency	Census – every 10 years Mid-year estimates - every year	Latest Year	2007
Numerator Definition	Number of people within each LGD	Geography	LGD
Source	INIsPHO	Year	2006
Denominator Definition	N/a	Geography	N/a
Source	N/a	Year	N/a
DATA ISSUES		DATA ISSUES	
The mid-year population estimates are generally quoted in rounded form, this is because population counts from the census and subsequent updates involving births, deaths and migration cannot be precise. In general the precision of the population estimates could be considered to be no better than to the nearest 100.			
PUBLIC HEALTH IMPORTANCE			
POLICY CONTEXT – NORTHERN IRELAND		POLICY CONTEXT – REPUBLIC OF IRELAND	
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Appendix 1. Interpretation of findings

Technical descriptions of some of the issues associated with interpreting findings are given below.

1. Statistical precision

Indicator values are prone to statistical error (the difference between an estimated value and the true value). The statistical error associated with an indicator depends on the population subgroup (eg the population of a county or LGD) that it refers to. Such differences in levels of statistical error can distort what we see in maps and charts. They can make some relationships involving indicators and attributes appear 'real' (practically meaningful or statistically significant) when they are in fact spurious; other relationships that are 'real' can be masked. These differences in statistical error can even distort the shape of plots or the colour patterns we see in maps.

For example:

- Many indicator value estimates are derived from sample surveys, and different sample sizes from different population subgroups will lead to different levels of precision in the indicator values for these subgroups
- Different population subgroups have different population sizes which means that rate estimates for these subgroups will also have different confidence limits
- The true value of a percentage or a rate can influence the level of statistical error of any estimate.

2. Scales and legends

The scale used on chart axes and in maps can also distort our perceptions:

- The range of values allowed on chart axes can accentuate relationships making them appear more 'real' than they actually are.
- The radial arms of spider plots of scaled data show the position of the value (in a population subgroup) relative to the minimum and maximum values of that component. Because these minimum and maximum depend on the component, relative positions of different population subgroups on different radial arms are not directly comparable.

