Joint Action on Chronic Diseases and Promoting Healthy Ageing Across the Life Cycle

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Good Practice in the Field of Health Promotion and Primary Prevention

Ireland Country Review

Prepared by the Institute of Public Health, the European Women's Health Institute and Health Service Executive Ireland

CHRODIS
ADDRESSING CHRONIC DISEASES & HEALTHY AGEING ACROSS THE LIFE CYCLE

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This Country Review has been developed based on the questionnaire 'Good practice in the field of Health Promotion and Primary Prevention' developed by EuroHealthNet, as part of Work Package 5, Task 1 of JA-CHRODIS.

Background

JA-CHRODIS is a European collaborative initiative that brings together over 60 partners from 26 European Union Member States. The collaborative partners are from areas including the national and regional departments of health and research institutions. They work together to identify, validate, exchange and disseminate good practice approaches for chronic diseases across EU Member States, and facilitate the uptake of these approaches across local, regional and national borders. The focus of JA-CHRODIS is on health promotion and primary prevention, with an additional focus on the management of diabetes and multi-morbid chronic conditions. One of the key deliverables will be a 'Platform for Knowledge Exchange', which will include both an online help-desk for policy makers and an information portal which provides an up-to-date repository of best practices and the best knowledge on chronic care.

Work Package (WP) 5 focuses on these objectives in relation to the package's theme: *Good Practice in the Field of Health Promotion and Primary Prevention*. Furthermore, **the objectives of WP 5 are to promote the exchange, scaling up, and transfer of highly promising, cost-effective and innovative health promotion and primary prevention practices for older populations.** This will involve the identification, review, and validation of health promotion and primary prevention interventions for **cardiovascular diseases, stroke, and type 2 diabetes and their modifiable behavioural and social risk factors**. WP 5 will not only take into account lifestyles and health-related behaviours, but also the wider social and economic determinants that influence them.

The following **Country Review** provides an **overview of the health promotion and primary prevention situation and approaches for cardiovascular disease, stroke and type 2 diabetes in Ireland**. This review outlines relevant policies; implementation mechanisms; good practices, and whether and how they have been identified; and forecasting and cost-effectiveness studies that have been undertaken on the topic in Ireland. The authors of this report have also identified current gaps and needs of promotion and primary prevention of chronic diseases. The information in this report will contribute to subsequent WP tasks, namely the identification, exchange and transfer of promising practices to promote health and prevent cardiovascular disease (including stroke) and type 2 diabetes in Ireland.

Overview

Ireland has experienced significant improvement in health in the last three decades resulting in a major progress in key markers of population health namely a major reduction in CVD mortality and an increase in life expectancy.

However, Ireland has been in recession now for six years with dramatic reductions experienced in funding for the health services as well as a major drop in disposable income.

Nonetheless major and significant developments have been brought about in Ireland in recent years. *Healthy Ireland – A Framework for Improved Health and Wellbeing (2013)* is a new departure to ensure effective co-operation and collaboration across the government, the health system and the whole of society. *Future Health* sets out a strategic vision for reform of the health system. Ireland declared in 2013 the intention to be *Tobacco Free by 2025*. Within the health service, in partnership with Royal College of Physicians of Ireland, *National Clinical programmes* have been established to identify good practice and standardise care with a recent focus on preventing chronic diseases.

However important challenges in prevention and treatment of chronic disease remain not least being the rising level of obesity and the lack of physical activity, major concern about the level of alcohol consumption and the continuing consumption of tobacco within the population

The Health Promotion and Chronic Disease Prevention Landscape

Policy design and implementation

The Government, the Minister for Health, and the Department of Health (DoH) have overall responsibility for the development of health policy in Ireland. The DoH's primary role is to support the Minister of Health in the formulation and evaluation of policies, in other government departments, the voluntary sector and other interested parties. In Ireland, health promotion and primary prevention policies are initiated and developed centrally by the DoH, in cooperation with a wide range of stakeholders depending on the policy topic. Stakeholders are usually represented on a committee to oversee and engage in the development of policy. Committee members generally include health service personnel; public health representatives; clinicians; academics and representatives from the non-governmental sector with a particular interest in the policy; and patient representatives.

The Health Service Executive (HSE) is responsible for the strategic planning and management of health and social services in Ireland, with the core purpose of providing

effective, safe, and high quality health and personal social services to the population of Ireland. The enactment of the Health Service Executive (Governance) Act 2013 has strengthened the accountability arrangements between the Health Service and the Minister for Health. In this context, a Directorate has been established as the governing body for the Health Service. A formal scheme of delegations clearly defines the line of accountability for each service area. The National Service Plan is the annual contract between the Health Service and the Minister. It sets out the type and volume of services to be provided within the budget allocated. The HSE has developed many of its own policy frameworks to guide HSE operations and implementation in the context of broader DoH Policy. Operational Plans set out the detail in relation to the services to be delivered by each service Division (Acute, Health and Wellbeing, Primary Care, Mental Health and Social Care) and by the National Ambulance Service. Each Director is accountable for delivery of the plan in their area of responsibility. This includes an explicit requirement to deliver a balanced budget.

The key role of the DoH in implementing national policy is evidenced in both the Changing Cardiovascular Health document and Healthy Ireland - a Framework for Improved Health and Wellbeing (2013) document which is outlined further on page 7. Under the Healthy Ireland Framework, governance for health considerations across policy domains will be led at the highest level of government and the Cabinet Committee on Social Policy, chaired by the Taoiseach (Prime Minister) and supported by a multi-stakeholder Healthy Ireland Council, acting as a national advisory forum on implementation. One of the structures that was identified to provide accountability mechanisms and support to the implementation of Healthy Ireland is a high level Cross Sectoral Group. The group is representative of the stakeholders involved in the implementation of Healthy Ireland and will provide strategic direction and monitor progress. An important element is the Healthy Ireland Outcomes Framework which is currently being developed as a collaborative process, involving engagement with a range of partners to identify relevant indicators. The Outcomes Framework will set out specific indicators, against which named delivery partners will be required to demonstrate improvements. Relevant bodies are identified as lead agencies for each recommendation in the cardiovascular health strategy. The DoH is identified as the lead organisation in all recommendations on the primary prevention of cardiovascular disease. However, other agencies are tasked with responsibilities as appropriate. For example, the Health Research Board is identified as the lead organisation to enable appropriate research skills availability, for evaluation of a structured programme for cardiovascular risk assessment in the Irish population.

Main public bodies and other organisations

The DoH has overall responsibility for health promotion and prevention at a policy level in Ireland. The HSE is responsible for the strategic planning and delivery of health services at a national, regional and local level in Ireland. The Health and Wellbeing Division in the HSE was established based on two fundamental policy shifts within the health service – Future Health, which describes the new structures currently being established for the healthcare

system, and Healthy Ireland, the Government Framework to improve the health and wellbeing of the Irish population. The Health and Wellbeing Division is now one of seven HSE Directorates. The following organigram, which is available at www.hse.ie/eng/services/list/5/publichealth/publichealthdepts/about/organigram.pdf, details the organisational structure of the Health and Wellbeing Directorate. As part of the Directorate, there are 23 Health Promotion and Improvement Offices serving all counties in the Republic of Ireland, organised according to HSE regions: HSE South, HSE West, HSE Dublin North East, HSE Dublin Mid Leinster. In addition, there are eight Departments of Public Health.

The Royal College of Physicians of Ireland, a postgraduate training body, promotes clinical leadership by partnering with the HSE in the development of Clinical Programmes.

The Institute of Public Health promotes cooperation for public health between Northern Ireland (NI) and the Republic of Ireland (RoI) through supporting the development of public policy designed to improve population health and reduce health inequalities. Their work influences policies directly related to health such as those being developed and led by the Departments of Health and national health agencies of the North and South. They also support ongoing development of wider public policies which influence population health, such as social policy, transport, education and the built environment as well as those policies related to vulnerable groups in society. Specifically, a core strand of IPH work focuses on strengthening prevention through:

- providing support to the Department of Health, Social Services & Public Safety (NI) and the DoH (ROI) by contributing to policy and information support to strengthen effective preventive action to meet government targets.
- strengthening the development and use of the growing evidence base on public health interventions to reduce health inequalities.

Several other NGOs are involved in implementing policies and programmes relevant to the primary prevention of cardiovascular disease, stroke and type 2 diabetes in Ireland. These include:

- Irish Heart Foundation
- Diabetes Federation of Ireland
- Asthma Society of Ireland
- Irish Thoracic Society
- Irish Cancer Society
- Alcohol Action Ireland
- CARDI (Centre for Ageing Research and Development in Ireland)
- ASH (Action on Smoking and Health)
- Age and Opportunity
- Age Action Ireland

Strategies and programmes

There is now one overarching government-level policy on health promotion and primary prevention in Ireland: *Healthy Ireland – A Framework for Improved Health and Wellbeing (2013).* Healthy Ireland is a new departure in Irish health policy; while it draws on existing policies, it proposes new arrangements to ensure effective co-operation and collaboration across the government, the health system and the whole of society. It is designed to bring about real measurable change and is based on an understanding of the broad determinants of health. It sets out a vision of a Healthy Ireland, where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone's responsibility. The Healthy Ireland Framework describes four high-level goals:

- Increase the proportion of people who are healthy at all stages of life
- Reduce health inequalities
- Protect the public from threats to health and wellbeing
- Create an environment where every individual and sector of society can play their part in achieving a healthy Ireland.
- *Future Health – A Strategic Framework for Reform of the Health Service 2012 – 2015* was also developed by the DoH and launched in 2012. Future Health sets out a strategic vision for reform of the health system and identifies the key high-level actions needed to systematically deliver on the framework. This framework, based on commitments in the Programme for Government, outlines the main healthcare reforms that will be introduced in the coming years with a focus on the four pillars of reform: Structural, Financial, Service, and Health and Wellbeing. A core element of this reform was to shift emphasis towards condition prevention and it signalled a new model of service delivery with Health and Wellbeing now making up a core pillar in the HSE structure. This new model of delivery saw health promotion and improvement, public health, environmental health and national clinical screening programmes brought together under the one Health and Wellbeing Division to streamline existing services. The Future Health Framework also highlighted that Health and Wellbeing would be embedded in all other Divisions established in the HSE.

Future Health set out key priorities with actions to deliver in 2014:

- Reconfigure and realign work practices, programmes and teams to deliver against the actions in the Healthy Ireland framework.

- Reduce the chronic disease burden of the population by delivering on priority areas including tobacco; diet and nutrition, including obesity reduction; alcohol misuse; physical activity; positive mental health; and good sexual health, through key settings and targeted at key risk groups.
- Develop more integrated and efficient service delivery models for the health of the population
- Enforce legislation and promote activities to assess, correct, control and prevent those factors in the environment which can potentially adversely affect the health of the population, including enforcing the Public Health (Tobacco) Act and other tobacco control legislation.

At the heart of the government's plan to reform the Health Services, there is a commitment to a single tier model of health care delivered through universal health insurance. The aim is to develop an efficient and effective single-tier health service which promotes equitable access to high quality care on the basis of need. The Future Health Framework places specific emphasis on developing and strengthening the primary care sector in Ireland with enhanced chronic condition management and programme and service integration. The government has established a Universal Primary Care Project Team to drive reform of primary care and oversee the following projects:

- Planning, costing and legislative preparation for the extension of free GP care;
- Development of chronic disease management in primary care;
- Promotion of capital investment in primary care centres;
- Preparation for a new GP Contract to facilitate universal free GP care and intensive chronic disease management;
- Development of a transparent, objective formula for resource allocation in primary care; and
- Preparation for new governance and funding arrangements for primary care.

In addition to the articulated focus on chronic disease management programmes to improve patient access and care in an integrated manner across service settings, this increased emphasis on primary care is coupled with increased opportunity for primary prevention intervention in the community. The introduction of free GP Care to those aged under 6 years represents the first phase in the provision of free GP care for the entire population and is part of the Government Health Reform Programme. This allows for increased opportunities for health promotion and improved surveillance of health status among children in this age group.

Policies with a specific focus on chronic conditions

Tackling Chronic Disease – a Policy Framework for the Management of Chronic Disease (2008) is a high-level policy currently used to inform chronic condition thinking and support practice in Ireland. It is intended that a new policy will supersede the current Tackling Chronic Disease Framework. The new policy is currently in the early stages of development and is expected by the end of 2015. It will have a main focus on strengthening primary care to ensure appropriate chronic disease management; prevention will be incorporated and recommendations on prevention within this Framework will build on those currently being identified in the Healthy Ireland Outcomes Framework. It is envisaged that there will be an acknowledgement of common lifestyle related factors with additional recommendations on disease specific prevention measures.

In addition, *Changing Cardiovascular Health*, the National Cardiovascular Health Policy (2010-2019), provides a framework for the prevention, detection and treatment of cardiovascular disease including stroke. The DoH is named as the lead organisation in implementing the policy, tasked with the responsibility of prioritising actions that promote the health behaviour profiles underpinning cardiovascular health, with specific targets to actively pursue and achieve within a 10-year period. The prioritised areas are:

- maintaining a healthy body weight
- healthy eating and physical activity
- reducing salt intake
- refraining from or quitting smoking
- consuming alcohol responsibly

The policy recognises that health behaviour and risk factor modification require a two-pronged approach: *a population approach*, which requires intersectoral action focused on reducing the level of key risk factors in the population, and *a high-risk approach*, which targets individuals who are at greater risk for cardiovascular disease. Emphasis is placed on support for promoting health and prohibiting activities that maintain or foster unhealthy behaviours. Reduction in inequalities in cardiovascular health across society is an underlying principle.

The National Diabetes Working Group made a number of policy guidance recommendations in *Diabetes: Prevention and Model for Patient Care*, the most recent national level strategy specifically targeting diabetes, published in 2005. These recommendations relate to the model of care for people with diabetes as well as recommendations for how services prevent and manage diabetes in the population. As with *Changing Cardiovascular Health* this policy recommends that a combination of population and high-risk approaches should be incorporated into a diabetes prevention programme. Other recommendations are specified as:

- Ongoing research into the effectiveness of screening for diabetes and preventable strategies should take account of emerging evidence in this area
- Patient education should be integrated into diabetes prevention programmes
- Because risk factors for diabetes are similar to those for cardiovascular disease, preventative strategies should be aligned so as to reduce the risk factors common to both conditions. Particular attention should be given to strategies aimed at preventing type 2 diabetes in the general population and in high risk groups
- Podiatry services should be developed as a priority issue to prevent foot care complications in diabetic patients
- The report of the National Task Force on Obesity should be implemented
- Strategies should also be developed to identify people who do not know they have diabetes
- Services should focus on reducing health inequalities due to diabetes. Groups such as children and young people, ethnic minorities, pregnant women and other vulnerable groups require particular attention
- There is substantial evidence of the effectiveness of screening for diabetic retinopathy and on this basis, a structured retinopathy screening programme has been identified as a priority for Irish diabetic patients.
- Within the HSE National Clinical Programmes address chronic diseases.

Monitoring and evaluation frameworks

Healthy Ireland was developed as an overarching framework, guiding policy and practice on all aspects of health and wellbeing in Ireland. The Healthy Ireland Framework highlights preliminary key performance indicators and targets specifically related to a reduction in mortality and premature morbidity from major chronic conditions including cardiovascular and chronic respiratory disease, diabetes, obesity and cancer. Further to this, the framework identifies specific targets for lifestyle related risk factors including:

- Increasing the number of adults and children with a healthy weight
- Increasing the proportion of adults eating the recommended five or more servings of fruit and vegetables per day
- Reduction in daily salt consumption
- Reduction in smoking prevalence among adults
- Reduction in smoking initiation among young people
- Decrease in alcohol consumption across the population
- Increase the proportion of the population undertaking regular physical activity across each life stage.

Performance indicators are cross-referenced with those identified in other policies relevant to chronic condition prevention as detailed above. It is planned that a rigorous indicator identification, assessment and specification exercise will underpin the process of developing the Healthy Ireland Outcomes Framework. The identification and specification of a comprehensive set of indicators will allow progress to be measured on improving the health and wellbeing of the Irish population across the life course. Once published, the Outcomes Framework will be subject to period review and revision processes. Furthermore, as information systems change or develop, indicators may be subject to a prioritisation process on the basis of EU requirements, statutory requirements and policy priorities.

In addition, the *National Health Service Plan* states that priority for 2014 will be the development of a three year health service implementation plan for Healthy Ireland.

Changing Cardiovascular Health provides specific timeframes for most of the identified recommendations. For example, in recommendation 4.4 it stresses that evaluation of a structured programme for cardiovascular risk ascertainment and management in the primary care setting should be completed and recommendations delivered in the first half of the lifetime of the policy (2010-2014). While there are recommendations setting out deliverables to enable the evaluation of the strategy, there is no specific evaluation approach outlined in the cardiovascular strategy.

Diabetes: Prevention and Model for Patient Care is a high level governmental document which makes a number of key policy guidance recommendations; however, timeframes and target indicators are not specified and there is little discussion of evaluation approaches.

Specific focus on older populations

A number of policy documents have addressed issues relevant to ageing and older people in Ireland to a greater or lesser extent and in a variety of policy areas in recent years. The National Positive Ageing Strategy *Positive Ageing – Starts Now* was published in 2013 as a specific policy document dedicated to addressing the needs and preferences of older people in a comprehensive manner in Ireland. It advocates a whole-of-government and whole-of-society approach to health and wellbeing adopted by *Healthy Ireland* and addresses the broader determinants of health. As such, it is a new departure in policy-making for ageing in Ireland. It aims to address the following priority areas:

- Healthy ageing
- Health and personal social services
- Carers
- Employment and retirement
- Education and lifelong learning
- Volunteering
- Cultural and social participation
- Transport

- Financial security
- Housing
- The built environment
- Safety and security
- Elder abuse

Other core policies/operational plans relating to chronic condition prevention

A number of other core policies relating to lifestyle risk factors, gender and specific age groups have also been developed in Ireland and are currently being implemented.

- Tobacco-Free Ireland – Report of the Tobacco Policy Review Group (2013)
- Steering Group Report on a National Substance Misuse Strategy (Feb 2012)
- National Drugs Strategy (Interim) 2009-2016
- Better Outcomes, Brighter Futures – the National Policy Framework for Children and Young People 2014-2020

Actions from Tobacco-Free Ireland and the National Substance Misuse Strategy are being progressed through the enactment of legislation including the Alcohol Bill 2013 and various elements of tobacco legislation in Ireland.

A further two policies are currently under development by the DoH and other key stakeholder groups under the Healthy Ireland umbrella: the National Physical Activity Plan is expected to be launched in October 2014 and a new Obesity Policy is expected to be launched in autumn 2015.

Several other policies/operational plans have addressed chronic conditions in a variety of ways since 2000 – some examples that are documented below have been superseded by policies discussed above. The policies and operational plans listed below (in order of publication) are not considered here in detail as they are not currently part of the policy landscape in Ireland, although they have helped to inform it.

1) National Men's Health Policy 2008-2013 (currently under review – evaluation report expected in 2015).
2) HSE Framework for Action on Obesity 2008-2012
3) The Health Promotion Strategic Framework 2011
4) Healthy Eating Guidelines in Ireland, DoH (2011)
5) The Health Service Executive – Population Health Strategy (2008)
6) The National Health Promotion Strategy 2000 - 2005
7) The Health Service Executive – Chronic Illness Framework (2008)
8) The Strategy for Cancer Control in Ireland (2006)

9) Quality and Fairness – A Health System for You (2001)
10) Primary Care – A New Direction (2001)

Focus on health inequalities in policy

Healthy Ireland is based on an understanding of the broader determinants of health and recognises that health and wellbeing are affected by all aspects of a person's life; economic status, education, housing and the physical environment in which people live and work. Critically, it also recognises that health and wellbeing are affected by governmental decisions and actions as well as individual choices. This understanding forms the basis of the whole-of-government and whole-of-society approach underpinning Healthy Ireland, highlighting that risk factors of major diseases are often managed by other government sectors as well as by other factors in society. Healthy Ireland has the support of all government departments and has established clear structures to ensure direction, accountability, good governance and support for collaborative cross-sectoral working. It recognises that inter-sectoral work is challenging and seeks to address such challenges through the use of validated tools and support mechanisms including inter-ministerial and inter-departmental committees, cross-sector action teams, joined-up workforce development and legislative frameworks. Health Impact Assessment will also be a key tool in advancing the cross-sectoral agenda and the Irish Government has committed to incorporating poverty impact assessment as part of a social impact assessment tool to advance the actions in Healthy Ireland.

Two particular strategies specifically targeted vulnerable groups in Ireland since 2000:

- The *HSE National Intercultural Health Strategy 2007-2012* (Health Service Executive, 2008) provides a comprehensive framework through which the health and care needs of people from diverse ethnic and cultural backgrounds may be addressed. Key themes of the NIHS focus on:
  - Enhancing aspects of access to services and service delivery
  - Improving collection and application of data to allow for evidence based planning around health needs and outcomes of people from minority ethnic communities
  - Provision of training and support to staff as they work towards delivery of a culturally competent health service
  - Implementation of recommendations of the strategy undertaken on a phased, prioritised basis

- *Traveller Health – A National Strategy 2000-2005* was commissioned by the DoH in RoI, in conjunction with the DoH, Social Services and Public Safety in Northern

Ireland, specifically to address the health needs of the disadvantaged traveller community throughout Ireland. It proposed six key actions:

1) In-service training for HSE staff, prepared in consultation with representative Traveller organisations, on matters concerning Traveller culture and societal attitudes.
2) Research on Travellers' health needs, founded on sound ethical principles of social research, will be encouraged and supported.
3) Positive steps will be taken to encourage active partnership and participation of Travellers and their representative organisations in determining health priorities for their community and in the decision-making that accompanies the allocation of resources.
4) The planning and provision of health services relating to Travellers will be carried out in partnership with the Traveller community.
5) A system of Traveller-proofing will be introduced to ensure that Travellers' interests are reflected in all national and regional health initiatives which impact the health of Travellers.
6) Emphasis will be placed on building a community development approach which incorporates a permanent role for peer-led services and the development of new roles for Travellers within the health services as planners, service providers and promoters, as appropriate.

The *Changing Cardiovascular Health* policy highlights the need for population health approaches as well as high-risk approaches which focus on those in contact with health services. The population health approach is defined as population based prevention strategies combining elements of wider public policy (addressing core determinants of health, such as poverty, education, food production and marketing, environment and transport policy) and primary prevention, which focuses on reducing the incidence of disease through factors that increase risk, such as cigarette smoking and high blood pressure. The strategy acknowledges that the burden of cardiovascular disease and the lifestyle factors that contribute to them are borne disproportionately by those in lower socioeconomic groups and that best available evidence suggests that the differential may be increasing. It then advocates measures to increase population health, measures which permeate across all socioeconomic groups, but with a specific focus on reducing inequity. It calls for a reduction in inequalities as a guiding principle towards achieving improvements in health behaviours.

There is a clear documented understanding of the need to reduce health inequalities in relation to diabetes in the 2006 strategy *Diabetes: Prevention and Model for Patient Care,* although recommendations do not provide specific detail on how to advance this.

Do policies consider economic arguments?

Healthy Ireland recognises that chronic conditions and their risk factors are major drivers of healthcare costs, as well as associated economic losses, and that improved population health status can make a substantial contribution to the economic recovery of the Irish State. It highlights that the annual economic costs of obesity is approximately €1.13 billion; the costs of alcohol use and misuse has an associated €3.7 billion burden and the cost of treating tobacco related diseases amounts to between €1-2 billion per year. 6-15% of the total Irish health budget is spent on treating tobacco related disease. There are also significant productivity losses due to excess absenteeism associated with alcohol and tobacco consumption, including sick days, tobacco breaks and lost output due to premature mortality. Furthermore, the mental health effects of the economic recession are expected to result in an increase in suicide and alcohol related deaths.

Changing Cardiovascular Health identifies the need to build clinical and cost-benefit effectiveness analysis into the evaluation of the population approach recommended in this strategy. In particular, it highlights the role of health technology assessment and systematic risk ascertainment for different population groups (compared to usual care). It also advocates for the development of research support skills in health economics to ensure the information needs of the strategy are enabled through research.

Although reference is made to the impending burden of the increasing prevalence of diabetes in national policy, this has not been informed by a clear economic estimate of the impact and there is no clear economic argument which has been put forward for preventing diabetes in Ireland.

A key focus on early years intervention as outlined in *Better Outcomes, Brighter Futures – the National Policy Framework for Children and Young People 2014-2020* highlights a shift in public policy thinking towards the importance of investment in early years and throughout childhood to address major health challenges, interrupt both current and future crises and improve health outcomes in later life.

Financing

A budget of €50,000 was allocated initially to the Healthy Ireland fund directly from general taxation. However, there is no dedicated funding stream for implementation of other recent policies and given the fiscal challenges posed by the recession in Ireland, policies are developed 'cost neutral' with emphasis placed on best use of existing resources.

Health care is generally financed from four main sources including general taxation, social insurance, private health insurance and out-of-pocket payments. Social insurance contributions, which are compulsory and generally shared between the employer and employee, tend to be earmarked for specific purposes; however, it is not a major source of health sector finance in Ireland. As in other countries, revenue from general taxation in Ireland is not earmarked specifically for the health services, which means that it must

compete with other areas of public expenditure for attention. The share of total health expenditure funded through private sources (out of pocket payments by individuals and households, private insurance payments and other sources of finance, e.g. voluntary donations) is much smaller than that accounted for by public sources.

Financial context 2014

The Health Service is facing the most severe financial challenge in 2014 resulting from a reduction to its funding base and the requirement of a significant additional savings target. Budget 2014 means that the Health Service will have an overall gross vote reduction of €272m and a savings target of €619m for 2014. This challenge comes at a time when the demand for health services is increasing every year, which in turn is driving costs upwards.

Identifying Good Practices

This section relates to strategies and services provided by the statutory service in Ireland – the Department of Health (DOH) and the Health Service Executive (HSE). A useful review of approaches for prevention in statutory and non-governmental sectors (NGOs) in Ireland is set out in the following link:
http://www.escardio.org/communities/EACPR/prevention-in-your-country/Pages/country-of-the-month-ireland.aspx

POLICY LEVEL: Department of Health

1) Healthy Ireland (HI) framework

This important framework, part of health reform in Ireland, has been described already under Strategies and programmes above and further information can be found at:
http://health.gov.ie/wp-content/uploads/2014/03/HealthyIrelandBrochureWA2.pdf.

The HI framework draws on evidence and good practice from around the world, and addresses the determinants of health as well as specific risk factors while using the political dimension to bring about change in health and wellbeing through the involvement of the whole community, the whole of government, and all of society acting in unison.

Three examples are worthy of particular mention:

a. **Tobacco Control**

For many years Ireland has prioritised tobacco control and utilised the WHO recommendation and framework as set out in the Framework Convention on Tobacco Control (FCTC http://whqlibdoc.who.int/publications/2003/9241591013.pdf) and the accompanying MPOWER model. The most recent evolution in this policy is to declare that Ireland will be **Tobacco Free Ireland by 2025** (http://health.gov.ie/wp-content/uploads/2014/03/TobaccoFreeIreland.pdf). *Tobacco Free Ireland* contains a suite of measures based on international evidence including measures to protect children from the harms of tobacco; enforce, regulate and legislate tobacco activities and products; educate citizens about the dangers of tobacco; and assist those who smoke to stop.

b. Special Action Group on Obesity (SAGO)

Within the policy context of the Task Force on Obesity, the Minister for Health set up a Special Action Group on Obesity (SAGO) in 2010, comprising representatives from the Department of Health, Department of Children and Youth Affairs, Department of Education and Skills, Health Service Executive, Food Safety Authority of Ireland and Safefood. SAGO was set up to examine and progress areas including: calorie posting in restaurants, the investigation of a tax on sugar-sweetened drinks, nutritional labelling, marketing of food and drink to children, the supply of healthy food products in vending machines, the detection and treatment of obesity, healthy eating guidelines and the promotion of physical activity. In mid-2014, key prioritised areas are: a) food supply and availability, b) prevention of obesity, c) treatment of obesity and d) information and research.
http://webcache.googleusercontent.com/search?q=cache:kBlVqCyXrNcJ:www.oireachtas.ie/parliament/media/committees/healthandchildren/Joint-Committee-on-Health-and-Children-10th-October-2012.doc+&cd=2&hl=en&ct=clnk&gl=ie

c. Physical activity

Since the launch of HI, a cross governmental approach to increasing physical activity has been targeted for development. A major plan, the National Physical Activity Plan, agreed upon with other government departments, will be launched in the last quarter of 2014.

2) National strategies

A number of national strategies addressing major diseases have used a combination of approaches:

a) needs assessment to put an Irish context on subsequent debates among participants
b) international literature and guidelines including the WHO

c) consideration of what is achievable politically

Examples of national disease strategies include

Building Healthier Hearts (1999)
http://www.thehealthwell.info/node/76649

Changing Cardiovascular Health (2010)
http://health.gov.ie/blog/publications/changing-cardiovascular-health-national-cardiovascular-health-policy-2010-2019

The former was reviewed in a number of documents over the first 6 years (1999 – 2005 with the last audit (Ireland: Take Heart) available at: www.hse.ie/eng/services/publications/topics/heart/ireland_take_heart.pdf.

3) Other areas

While not immediately relevant to "Identifying Good Practices" we would like to mention two areas that impinge on improving health and wellbeing of older people

a. National positive ageing strategy was launched in 2013 with four main goals, one of which aims to prevent and reduce disability, chronic disease and premature mortality as people age by supporting the development and implementation of policies to reduce associated lifestyle factors. (http://health.gov.ie/wp-content/uploads/2014/03/National_Positive_Ageing_Strategy_English.pdf)

b. The National Clinical Effectiveness Committee (NCEC) was set up by the Department of Health in Ireland as a 'clearing house for nationally agreed guidelines.' It is a relatively new development and has signed off on a small number of guidelines so far. To date, these are treatment focussed only. (http://health.gov.ie/wp-content/uploads/2014/04/NCEC-2013-Annual-Report.pdf)

IMPLEMENTATION: Health Service Executive

4) National Clinical Programmes

In 2010, the introduction of Clinical Programmes, in partnership with the Royal College of Physicians of Ireland, was a major reform in the health service. These programmes, led predominantly by hospital clinicians, focussed on identifying good practice and

standardising care. The programmes, which were CVD/diabetes oriented, included the a) Acute Coronary Syndrome Programme, b) Stroke Programme, c) Heart Failure, d) Diabetes Programme and later the e) Prevention of Chronic Disease Programme. The mechanism of work was also based on literature review, international professional guidelines, and review of sources such as NICE and SIGN (Scotland), followed by reaching consensus with an Advisory Board from the Royal College of Physicians of Ireland (reports are available upon request).

For example, the National Clinical Programme for Diabetes aims to 'save the lives, eyes and limbs of patients with diabetes'. The specific objectives of the programme are to 1) reduce mortality by 10% and 2) reduce morbidity (reduce blindness by 40%, amputations by 40% cardiovascular events by 20%), although specific timeframes are not documented and the role of primary prevention in reducing diabetes morbidity is not specified. Information on other Clinical programmes is available at http://www.hse.ie/eng/about/clinicalprogrammes/. With most of the attention given to standardising treatment in this Programme as with others, less attention was directed to primary prevention and health promotion until recently. Changes in the HSE has brought renewed focus on chronic disease prevention and management, especially CVD, diabetes, respiratory conditions and cancer. Initial work will centre on a) how to utilise and train clinical staff in evidence-based brief advise/ brief intervention techniques to *Make Every Contact Count*, and b) developing evidence-based generic systems of self-care. Early detection and generic disease management are also being studied.

5) Specific Risk Factors

a. Tobacco Control

The HSE's Tobacco Control framework draws on the WHO Framework Convention on Tobacco Control (FCTC). The national expert group, including representation from the Department of Health, the Office of Tobacco Control and relevant non-governmental organisations, has identified six standards based on the MPOWER model and a total of 61 actions (http://www.hse.ie/eng/about/Who/TobaccoControl/framework/framework.pdf).

Consequently, the following are examples of best practice and evidence-based actions and interventions to protect people from tobacco smoke and which offer help to quit tobacco use.

i. Tobacco Free Campus Initiative

The HSE has committed to develop and implement a tobacco free policy in line with the European Network of Smoke Free Health Care Services' (ENSH) standards for all services within the HSE. This includes a commitment that all HSE campuses will become tobacco-free by 2015. The Tobacco Free Campus policy will help change social norms around tobacco use, treat tobacco addiction as a healthcare issue, and promote smoking cessation by actively advising, encouraging and supporting people to quit smoking.

ii. The social marketing Quit campaign

The 'QUIT' campaign, comprising TV, radio, outdoor billboard and online social marketing, aims to reduce the number of smokers in Ireland and reduce the level of illness and deaths caused by tobacco use (www.quit.ie). This well thought-out social marketing campaign, was innovative in mounting a bid to compete for funding within the HSE and has subsequently become the model for resourcing other communications campaigns. Initially, extensive evidence was presented which was then followed by rigorous oversight of the competitive process by a communications advisory group within the Health Service Executive. (http://www.quit.ie/?gclid=COLj0Kjg_MACFSps2wodkUoASw). This campaign has won two awards for Advertising Effectiveness at the ADFX 2014 Irish Advertising Awards. With research proving that one in every two smokers will die of a tobacco-related disease, it is estimated that the latest QUIT campaign (January to June 2014) saved 1,500 lives in just two months. A dedicated smoking cessation support website (www.quit.ie) offers information and support to help smokers quit.

iii. HSE's smoking cessation services and training

The HSE provides and promotes a wide range of cessation services. Support is available on-line through a dedicated website www.quit.ie, by social media via Facebook and by phoning a Freefone number and SMS text message. Also, smoking cessation support is provided using brief intervention and motivational interviewing through HSE quit clinics and courses. In primary care, supports are provided by GPs, pharmacists, dentists, and through medication and tobacco replacement therapies. In addition, HSE local smoking cessation specialists offer individual and group smoking cessation support by appointment.

In 2013, the HSE developed national standards for a smoking cessation support programme to enable smoking cessation practitioners to deliver a standard appropriate programme of cessation support to people wanting to quit. This enables health care providers delivering tobacco cessation support/services to adhere to a set of nationally agreed standards/guidelines so as to ensure consistency in smoking cessation service provision. These national standards for a structured support programme were informed by the NICE

programme guidance on smoking cessation (2006), the New Zealand smoking cessation guidelines (2007), the National Health Service (NHS) Health Scotland and ASH Scotland planning and providing specialist smoking cessation services document (2010), the NHS Local stop smoking services delivery and monitoring guidance (2011/12) and the NHS standard treatment programme (2011), all of which are recognised as being evidenced based and cost effective. (http://www.hse.ie/eng/about/Who/TobaccoControl/cessation/tobaccocessationnationalstandard.pdf)

In 2014, a customized, evidence-based, smoking cessation training and assessment programme was developed and provided to smoking cessation practitioners in Ireland to enable them to deliver smoking cessation programmes and to support a world class standard. The NHS Centre for Smoking Cessation and Training (NCSCT) developed the training. The NHS Centre for Smoking Cessation and Training (NCSCT) is a consortium led by University College London which includes NHS Leeds and the NCSCT Community Interest Company.

iv. Evaluation of the National Smokers Quitline 2008 to 2011

An evaluation of the HSE's National Smokers Quitline for the years 2008 to 2011 was published in 2012 and informed future service provision and improvements. The recommendations from the evaluation resulted in the establishment of a new QUIT 'one-stop shop' for smoking cessation services, which will provide one-to-one smoking cessation support via a live freefone helpline, on-line chat, social media (e.g. Facebook and Twitter) and SMS text message (reports are available upon request). This new service will commence in October 2014.

b. Obesity/Physical Activity

i. Weight Management Treatment Algorithms

The HSE and Irish College of General Practitioners (ICGP) have developed a number of Weight Management Treatment Algorithms and accompanying BMI charts to inform primary care staff of the steps to be taken with regard to managing obesity; from raising the issue and carrying out an initial assessment, through to counselling strategies, dietary advice, pharmacotherapy and referral. The algorithms developed to date are:

- Weight management treatment algorithm for children http://www.icgp.ie/go/library/catalogue/item/7858CA75-D4E4-48A4-8F6F9C845CDABAA2

- Weight management guidelines before, during and after pregnancy http://www.icgp.ie/go/library/catalogue/item/73ACFC19-4195-4F57-91E5F973ED955D72
- Weight management treatment algorithm for adults http://www.icgp.ie/go/library/catalogue/item/DF2B8347-BCBE-4C31-94546BC305B29780

ii.Obesity campaigns

Safefood is an all-island body responsible for promoting awareness and knowledge of food safety and nutrition issues on the island of Ireland while working with partners across the island. In collaboration with the HSE, examples of Safefood campaigns include:

Let's Take on Childhood Obesity - a three year programme starting in 2013 targeting six healthy habits that parents and children can adopt (http://www.safefood.eu/Home) as well as an earlier Little Steps campaign (www.littlesteps.eu/)

"Stop the Spread", *Weigh2Live* and *Operation Transformation* (www.rte.ie/ot/) targeting adult obesity (www.safefood.eu/Stop-The-Spread.aspx)

iii. The National Guidelines on Physical Activity for Ireland -'Get Ireland Active' (2009)

In the policy context of the Task Force on Obesity, the National Guidelines on Physical Activity for Ireland 'Get Ireland Active' (2009) were developed to support the promotion of physical activity in Ireland and highlight the recommendations for physical activity for children, young people, adults, older people and people with disabilities. These guidelines are based on evidence and international expert opinion.
http://www.getirelandactive.ie/content/wp-content/uploads/2011/12/Get-Ireland-Active-Guidelines-GIA.pdf

To promote the National Physical Activity Guidelines, a one-stop dedicated website was launched which focuses on how to get involved in physical activity in Ireland (www.getirelandactive.ie). The website is designed to encourage people to become more active by a) creating awareness of the range of activities and opportunities for physical activity that exist locally, regionally and nationally; and b) providing advice on how to get started, tips on how to get more active, and motivation to keep them going.

The website was developed in partnership with sporting bodies and partnerships, NGOs, Government departments as well as the HSE. Moderation and promotion of the site by HSE in partnership with all of the Local Sports Partnerships ensures that a comprehensive list of physical activity opportunities at the county, regional and national level are available and updated regularly on the site.

An important further element in promoting physical activity is the National Physical Activity Plan. The Plan will take on a whole-of-government approach, and is anticipated to be launched in the last quarter in 2014.

6) Health Promotion Practice in Ireland

Health promotion and prevention in Ireland is structured on the five elements of the Ottawa charter (http://www.who.int/healthpromotion/conferences/previous/ottawa/en/).

In addition to the initiatives mentioned above, the following examples of health promotion programmes aim to address risk factors and prevent disease based on the settings approach, promoting the health of the population and addressing the social determinants of health towards achieving greater equity in health.

a. The Health Promoting School Initiative

The Health Promoting School Initiative is a nationally agreed model for supporting health in the school setting and is the preferred approach to promoting health in both primary and secondary schools in Ireland. It is an internationally recognised and evidence informed-concept (the European Network of Health Promoting Schools (ENHPS), Council of Europe, the European Commission and WHO). It aims to foster the health and wellbeing of the school community in a planned and coordinated way.
http://www.healthpromotion.ie/hp-files/docs/HPM00839.pdf
http://www.healthpromotion.ie/hp-files/docs/HPM00840.pdf

b. The Health Promoting Health Services

The Health Promoting Health Service is based on the WHO Health Promoting Hospitals concept which was first introduced to Ireland in 1992. The Health Promoting Health Services aims to improve health and wellbeing of staff, patients and the community in which hospitals and health care settings are situated.

From Standards to Practice: Guidance Document for Hospitals on Health and Wellbeing Standards

These standards were developed as a result of the publication *National Standards for Safer Better Healthcare* by the Health Information Quality Authority (HIQA), which aims at protecting patients and improving services, and forms the basis for future licensing of all healthcare facilities in Ireland. The document *From Standards to Practice: Guidance Document for Hospitals on Health and Wellbeing Standards* supports hospitals to gather information and evidence to verify their assessments against the "National Standards for Safer Better Healthcare" and against the WHO "Standards for Health Promotion in Hospitals". The document also helps hospitals to illustrate comprehensive examples of evidence of health promotion activities in acute hospitals and provides a way to standardise the approach to health promotion across the health services. The document describes standards relating to tobacco, alcohol and substance misuse, breastfeeding, obesity, active travel, food and nutrition, physical activity, sexual health, health literacy, and mental wellbeing.
http://www.hse.ie/eng/about/Who/qualityandpatientsafety/Standards/standardsguidance/qaadnIdocuments/GuidanceDocumentHospitals.pdf

c. The Healthy Cities Project

The Healthy Cities Project in Ireland is based on the WHO European Healthy Cities project which aims to enhance the health of a city, its environment and its people through all groups and agencies working together. The primary goal of the WHO European Healthy Cities Network is to put health high on the social, economic and political agenda of city governments. It recognises that health is the business of all sectors, and local governments are in a unique leadership position, with power to protect and promote their citizens' health and wellbeing and can move beyond the health sector to include health considerations in economic, regeneration and urban development efforts. Currently, Ireland has three WHO designated Healthy Cities (Galway, Cork and Waterford) and has a newly established National Network for Healthy Cities.
http://www.hse.ie/eng/services/list/5/publichealth/publichealthdepts/howweimprovehealth/WHO_Healthy_Cities.html

Forecasting Studies

Chronic conditions in an Irish context

The 2013 edition of *Health at a Glance* by the Organisation for Economic Cooperation and Development (OECD) shows that Ireland continues to make substantive headway in improving health outcomes from chronic conditions. Mortality due to cancer fell by 21%, ischemic heart disease by 59% and cerebrovascular disease by 54% between 1990 and 2011. In all three instances, the rate of decline was greater than the OECD average. Life expectancy in Ireland has increased by a full four years since 2000 to reach 80.6 years today, over the OECD average of 80.1 years.

At 16.2 births per 1,000 people in 2011, Ireland reports the highest birth rate of any of the 27 EU countries. Nonetheless, Irish fertility rates continue to decline with a reduction of 2.2 per cent in 2011 since the peak in 2009 (ESRI, 2011) and while the percentage of those aged 65 years and over in Ireland is low compared to other European countries, Ireland's population is ageing rapidly. Latest figures predict the number of people aged 65 and over will rise from 532,000 in 2011 to almost 1.4 million by 2046 (Central Stastics Office, 2014). More significantly, a marked rise in the number of people aged 80 and over is forecasted, with the numbers expected to rise from 128,000 in 2011 to 470,000 in 2046. A population structure with declining fertility rates, almost a quarter of people over the age of 65 years and a substantial proportion of those in the oldest old age category will, in the future, have significant social and economic implications at an individual, family and societal level. The impact of ageing on health and social care services has been well documented and strategies to reduce this burden are important, especially under constrained fiscal environments.

The Institute of Public Health in Ireland (IPH) has developed a systematic and rigorous approach to estimating and forecasting the prevalence of chronic conditions for national and local areas across the Republic of Ireland and Northern Ireland. The method combines the most recently available national survey data and local population data to prepare synthetic estimates for local areas. To date, IPH has published data on the prevalence of chronic conditions among adults (CHD, hypertension, stroke, diabetes, musculoskeletal conditions, and chronic airflow obstruction) and children (asthma, eczema, sight problems, and hearing problems) (*see references for details*).

Four of these research projects are summarised below as they are specifically related to the CHRODIS project, including summary findings on the prevalence and forecasts for CHD, hypertension, stroke and diabetes (detail at http://www.publichealth.ie/publications?page=1).

CHD Briefing

In 2010 it was estimated that more than 79,000 (2.4%) adults aged 18+ years in RoI have been told by a doctor in the previous 12 months that they have CHD (clinically diagnosed CHD). This excludes undiagnosed CHD and is likely to be an underestimate of the number of people with the condition. Clinically diagnosed CHD is more common among older people. In 2010 almost 9% of adults aged 65 years or over had clinically diagnosed CHD. Rates of clinically diagnosed CHD were similar among men and women.

By 2020 the number of adults with clinically diagnosed CHD is expected to rise to more than 103,000 (2.9%). This represents a 31% increase (an additional 24,000 adults) in ten years. Approximately one-quarter of this increase is due to increases in risk factor levels associated with ageing). Rates of clinically diagnosed CHD were prepared for 32 Local Health Offices in RoI. Comparing 95% confidence intervals reveals no significant differences between Local Health Office areas. However, because of differences in population sizes, there is substantial variation in the number of adults aged 18+ years in each area with clinically diagnosed CHD.

It is noteworthy that these projections are estimated against a backdrop of substantial improvements in CHD outcomes in Ireland in the past three decades. Between 1985 and 2000, CHD mortality rates fell by 47% in those aged between 18-84 years. It was estimated that approximately half of this decrease can be attributed to treatment effects (43.6%) and half (48.1%) can be attributed to favourable population risk factor modification trends; specifically declining smoking prevalence (25.6%), mean cholesterol concentrations (30.2%) and blood pressure levels (6%), but offset by increases in adverse population trends related to obesity, diabetes, and inactivity (-13.8%) (Bennett et al., 2006). One consequence of the declining mortality from CHD is an increase in morbidity (i.e. the prevalence of heart disease in the population). Thus, effective intervention and treatment results in a cohort of patients who survive with the disease and are likely to require further treatment. This has significant implications for the organisation and delivery of health services for this growing body of patients. When taken in conjunction with projected demographic changes in the Irish population structure, this points to a significant burden on the health services to cater for an increasingly ageing population, many of whom will have CHD.

Hypertension Briefing

In 2010 it was estimated that more than 950,000 (62.2%) adults aged 45+ years in RoI had hypertension. This estimate consists of 356,000 (23.3%) adults aged 45+ years who had been told by a doctor in the previous 12 months that they have hypertension (clinically diagnosed hypertension) and 595,000 (38.9%) adults aged 45+ years with undiagnosed hypertension.

Undiagnosed hypertension among adults aged 45+ years exceeded the broad 'rule of halves' that states that approximately half of hypertension cases are undiagnosed. More than 67,000 (3.7%) adults aged 18-44 years in RoI had clinically diagnosed hypertension. It was not possible to estimate undiagnosed hypertension in this age group as the data source - Survey of Lifestyle and Nutrition (SLÁN) 2007 - did not include a measure of undiagnosed

hypertension among adults aged 18-44 years. Hypertension was more common among older people. In 2010 almost three-quarters of adults aged 65+ years had hypertension while almost one-half of adults aged 45-54 years had hypertension. Rates of clinically diagnosed hypertension were similar among men (3.7%) and women (3.7%) aged 18-44 years and among men (23.0%) and women (23.5%) aged 45+ years. However, undiagnosed hypertension among adults aged 45+ years is more common among men (47.0%) than women (31.5%).

By 2020 the number of adults aged 45+ years with hypertension is expected to rise to more than 1,220,000 (63.1%). This represents a 28% increase (an additional 270,000 adults aged 45+ years) in ten years. By 2020 the rate of clinically diagnosed hypertension among adults aged 18-44 years is expected to rise to 4.0%. This represents a 24% increase (an additional 103,000 adults aged 18+ years) in ten years.) The rate of clinically diagnosed hypertension for all adults aged 18+ years is expected to rise to 14.6% (526,000 people). Although the rate is expected to increase, the corresponding number of adults aged 18-44 years with clinically diagnosed hypertension is expected to remain approximately the same at more than 66,000. This is because the number of people in the population aged 18-44 years is expected to decrease.

Stroke Briefing

In 2010 it was estimated that almost 23,000 (0.7%; 95% CI = (0.0%, 1.5%)) adults aged 18+ years in RoI had a stroke in the previous 12 months that had been diagnosed by a doctor (clinically diagnosed stroke). This excludes undiagnosed stroke and therefore may be an underestimate of the total number of people with the condition. Clinically diagnosed stroke was more common among older people. In 2010 almost 2% of adults aged 55 years or over had a stroke in the previous 12 months that had been diagnosed by a doctor. Rates of clinically diagnosed stroke were similar among men (0.7%; 95% CI = (0.0%, 1.5%)) and women (0.7%; 95% CI = (0.0%, 1.6%)). By 2020 the number of adults with clinically diagnosed stroke is expected to rise to almost 29,000 (0.8%; 95% CI = (0.0%, 1.7%)). This represents a 27% increase (an additional 6,000 adults) in ten years. Approximately three-tenths of this increase is due to increases in the size of the population and seven-tenths is due to population ageing (including the increase in risk factor levels associated with ageing). Rates of clinically diagnosed stroke were prepared for 32 Local Health Offices in RoI. Comparing 95% confidence intervals revealed no significant differences in the rates in Local Health Office areas. However, because of differences in population sizes, there was significant variation in the number of adults aged 18+ years in each area with clinically diagnosed stroke. Clinical diagnosis rates in RoI relate to stroke that occurred in the previous 12 months and are not directly comparable with clinical diagnosis rates in NI which relate to stroke that occurred at any time in the past.

By 2020 the number of adults with clinically diagnosed stroke is expected to rise to more than 29,000 (2.0%; 95% CI = (0.7%, 3.3%)). This represents a 23% increase (an additional 5,000 adults) in ten years. Approximately one-third of this increase is due to increases in the

size of the population and two-thirds is due to population ageing (including the increases in risk factor levels associated with ageing).

Diabetes Briefing

In 2010 it was estimated that more than 135,000 (8.9%) adults aged 45+ years in RoI had diabetes. This estimate consists of more than 94,000 (6.2%) adults aged 45+ years who had clinically diagnosed diabetes in the previous 12 months and more than 41,000 (2.7%) adults aged 45+ years with undiagnosed diabetes. More than 12,000 (0.7%) adults aged 18-44 years in RoI had clinically diagnosed diabetes. SLÁN 2007 did not include data on undiagnosed diabetes among adults aged 18-44 years. Diabetes is more common among older people. In 2010 more than one in ten adults aged 55+ years had diabetes. Rates of clinically diagnosed diabetes are similar among men and women (0.7%) aged 18-44 years and among men (6.0%) and women (6.3%) aged 45+ years. However, undiagnosed diabetes among adults aged 45+ years was more common among men (4.0%) than women (1.5%).

By 2020 the number of adults aged 45+ years with diabetes is expected to rise to more than 175,000 (9.1%). This represents a 30% increase (an additional 40,000 adults aged 45+ years) in ten years. By 2020 the rate of clinically diagnosed diabetes among adults aged 18-44 years is expected to marginally rise to 0.73%. Although the rate is expected to increase, the corresponding number of adults aged 18-44 years with clinically diagnosed diabetes is expected to remain approximately the same at 12,000. This is because the number of people in the population aged 18-44 years is expected to decrease.

Acknowledgement of forecasting studies in policy

The Healthy Ireland strategy takes full account of the IPH chronic conditions forecasting studies and recognises the importance in developing a whole-of-government and whole-of-society approach to reduce the predicted burden of these chronic conditions in an Irish context.

Cost-Effectiveness Studies

There are few studies on cost-effectiveness of primary prevention of chronic conditions in an Irish context. Two studies that specifically relate to risk factors for CHD, stroke and diabetes have been identified.

Proposed tax on sugar sweetened drinks

The Institute of Public Health in Ireland (IPH) was requested by the DoH to undertake a Health Impact Assessment (HIA) of a proposed tax on sugar sweetened drinks (SSDs) in 2012. The public health priority for this proposal was to consider the potential of such a tax to address the problem of overweight and obesity in Ireland. The HIA was overseen by the Special Action Group on Obesity (SAGO) and guided by a steering group. The HIA process involved a population profile, a stakeholder consultation event and a literature review. This information, paralleled by a modelling exercise undertaken by Dr. Mike Rayner and his team

at University of Oxford, was presented to the steering group to inform their conclusions. Summary of findings from the economic modelling exercise are available on page 92 of the Technical Report: http://www.publichealth.ie/document/iph-report/proposed-sugar-sweetened-drinks-tax-health-impact-assessment-technical-report.

The cost of overweight and obesity on the island of Ireland

This study provides the first estimates of the cost of overweight and obesity on the island of Ireland based on a comprehensive review and analyses of relevant data. While the personal and social costs of the current epidemic of overweight and obesity can never be fully quantified, the estimated economic costs are high, estimated for 2009 at approximately €1.13 billion in the Republic of Ireland and approximately €0.51 billion in Northern Ireland. Overweight and obesity combined account for an estimated 2.7% and 2.8% of total health expenditure in the Republic of Ireland and Northern Ireland respectively. These findings are consistent with estimates from a number of European countries over the past decade. A summary report of the main findings from the study is available for download at: http://www.safefood.eu/Publications/Research-reports/The-cost-of-overweight-and-obesity-on-the-Island-o.aspx.

Some further studies incorporating economic analysis of risk factors have been identified that may be of interest and are outlined below.

The PPACTE study looked at the impact of certain tobacco control measures in Ireland and across a set of European countries. Two studies were conducted as deliverables of the PPACTE study:

- *IrelandSS* – an adapted version of the dynamic simulation model SimSmoke, aimed to examine the impact of tobacco control policies implemented since 1998, individually and in combination, and the potential impact of stricter policy alternatives on smoking prevalence and related mortality in Ireland. Preliminary results suggest that policies have not had the effect anticipated by experts and evidenced elsewhere in the literature (Currie et al 2013). With more recent data, there is consideration of whether the policies are taking longer to affect smoking rates than expected, or whether the combination of past policies was insufficient (e.g. inadequate cessation treatment or anti-smuggling policy).
- *Demand for Tobacco in Europe - An Econometric Analysis of 11 Countries for the PPACTE Project* - As pricing policy is seen as the most important intervention in tobacco control to reduce smoking, this study analysed price elasticity and other key determinants of demand for tobacco in 11 European countries. Ireland contributed to this work and Irish specific findings are detailed in section 7.4 of the report. The study evaluated to what extent demand for the selected tobacco products can be controlled by price and other policy measures. Results imply that price policy and other tobacco control policies are clearly effective in reducing the consumption of cigarettes. However, they also suggest that the planning of tobacco control policies should pay attention to methods so as to more effectively highlight the harmful

health effects of tobacco products other than cigarettes. In addition, to better counteract the impact of increasing real disposable income on tobacco consumption, tobacco control policies need to take developments in real disposable income into account. The full report is available for download at: http://www.thl.fi/thl-client/pdfs/79f62ba5-c1ac-4170-b22f-f7b9131ad0f1 (Nguyen et al 2012).

The economic evaluation of the removal of tobacco promotional displays in Ireland was carried out by Quinn et al. (2011) to evaluate the short-term economic impact of legislation implemented in July 2009 which removed point of sale tobacco promotional displays in Ireland (i.e. tobacco displays and other point of sale tobacco advertising), on cigarette sales across a range of categories of retail outlets. The study found no change was observed in sales data in any retail category over and above seasonal patterns and an underlying downward trend over time. Similarly, where available data enabled statistical analysis, there was no significant effect in the short term (up to 12 months after implementation) on retail sales of tobacco products, over and above seasonal and long-term trends. It concluded that recent claims of substantial revenue losses and closures of small retailers as a direct result of the removal of point of sale tobacco promotional displays in Ireland are not borne out by the data. The removal of point of sale displays is aimed at reducing the pernicious effects of tobacco advertising on children and is therefore likely to have an impact on sales over a much more protracted time period. This should enable retailers to adapt over time, perhaps using such regulations as an opportunity to play a role in promoting healthier products in the local community.

Gaps and Needs

Leadership/Strategic Vision

There are clearly identified leaders in the public health sector, within the DoH and in the Health Service Executive who progress the development and implementation of policy relating to health promotion and primary prevention. In addition, the Institute of Public Health promotes cooperation for public health on the island of Ireland through three key areas of work:

- Strengthening public health intelligence
- Building public health capacity
- Policy and programme development and evaluation

Healthy Ireland has been established as an overarching policy framework in Ireland which encompasses health promotion and the primary prevention of chronic conditions in general. As well, additional policies are currently under development to target specific lifestyle behaviours under the umbrella of Healthy Ireland. There are also separate policies on CVD and diabetes as outlined in the above section: Policy design and implementation.

Undoubtedly, Healthy Ireland represents a paradigm shift in Irish health policy by setting out a vision and mechanism for a whole-of-government and whole-of-society approach to achieve improvements in health and wellbeing across Irish society. It is based on an understanding of the broader determinants of health and recognises that health and wellbeing are affected by all aspects of a person's life and critically, it also recognises that health and wellbeing are affected by governmental decisions and actions as well as individual choices. Healthy Ireland reflects the approach recommended by the World Health Organization's Commission on Social Determinants of Health (CSDH, 2008) to address health inequalities at a population level, leading towards governmental action to address the social determinants of health.

Despite having a clear leadership structure and policy framework now in place at a national level, several years of health service restructuring during a time of economic austerity and reduced funding for health services in general led to many challenges to deliver on national policy agendas. In addition, there is currently no Irish body with responsibility for systematically identifying research and policy priorities in primary prevention of chronic conditions and this was highlighted by some stakeholders as a challenge in progressing work in this area. It is argued that political priorities have dictated the agenda with a primary focus on lifestyle related topics and that political leadership on primary prevention has been ad hoc over the last 20 years. In particular, Ireland has a strong record on tobacco policy. One of the strengths of tobacco policy has been both ministerial and departmental leadership and a commitment to enact strong legislative actions to realise the vision of a Tobacco-Free Ireland. 15 of the 22 actions in Tobacco-Free Ireland require a legislative component. The leadership shown by Ireland in the context of the European presidency in 2012/13, which coincided with the development of the European Tobacco Products Directive, has been critical to moving forward tobacco control policy in Ireland and at a European level (http://www.eu2013.ie/news/news-items/20130621postepscohealth/).

However, many other primary prevention areas are not afforded the same policy priority as tobacco. The tendency for "lifestyle drift" was recognised as a gap in primary prevention in Ireland. It was reported that policy generally starts off recognising the need for action on upstream social determinants only to drift downstream and focus completely on individual lifestyle. To address this there is now a key focus on the settings approach in health promotion and improvement in the Health Service Executive and it is argued that this must be kept to the forefront when implementing future policy.

To date, government reports defining strategic priorities on primary prevention of chronic conditions have been relatively ad hoc and there is no current mechanism for identifying priorities on an on-going basis. The DoH plans to develop a new chronic conditions framework in 2015 which will identify priority areas for actions related to chronic conditions and will include specific actions on prevention, aligned with Healthy Ireland.

IPH recognises the instrumental role that the European Commission can have on influencing new priorities and initiating leadership on key public health issues in Member States

through joint actions, research funding programmes and by fostering Europe-wide action in the development of strategic plans.

The publication of Healthy Ireland in 2012 marked a significant adoption of a whole of government approach to health and prioritised health and wellbeing of the Irish population. Nonetheless challenges remain, not least being the state of the country's financial situation and managing the political environment of difficult choices and vested interests.

Cross-governmental action

Healthy Ireland supports a whole-of-government and a health in all policies approach to address the determinants and predictors of health and wellbeing, many of which fall outside the health sector, e.g. housing, transportation, education, workplaces and environment along with an individual's socio-economic status. The implementation of Healthy Ireland is overseen by the Cabinet Committee on Social Policy. The Health and Wellbeing Programme in the HSE was established to drive project planning and co-ordination. One of the structures that has been identified to provide accountability mechanisms and to support the implementation of Healthy Ireland is a high level Cross Sectoral Group. Membership of the Cross Sectoral Group is comprised of one representative from each governmental department/ stakeholder organisation listed below. The group is therefore representative of the stakeholders involved in the implementation of Healthy Ireland.

1. Dept of An Taoiseach
2. Dept of Public Expenditure and Reform
3. Dept of Social Protection
4. Dept of Transport, Tourism & Sport
5. Dept of Education & Skills
6. Dept of Environment, Community & Local Government
7. Dept of Jobs, Enterprise and Innovation
8. Dept of Justice and Equality
9. Dept of Arts, Heritage and the Gaeltacht
10. Dept of Agriculture, Food & the Marine
11. Dept of Children and Youth Affairs
12. Dept of Communications, Energy & Natural Resources
13. Central Statistics Office
14. Health Research Board
15. Environmental Protection Agency
16. Institute of Public Health
17. Centre for Effective Services
18. Health Service Executive
19. Department of Health

20. CCMA (Irish Contact Centre and Management Association)
21. Health & Safety Authority

The government has committed to incorporating poverty impact assessment as part of an integrated social impact assessment as outlined in Healthy Ireland. The development and implementation of social impact assessment tools was identified as a key performance indictor. As there is no baseline indicator in Ireland for Social Impact Assessment, the Health and Wellbeing Programme is currently working with the Social Inclusion Unit in the Department of Social Protection to facilitate the development of integrated Social Impact Assessment (SIA) as a feature of policy development and policy impact analysis. IPH are advising on this process and health impacts will be a core feature of this new tool.

Once developed, health and wellbeing impacts will be assessed locally and an integrated Social Impact Assessment approach at the local level will be mandated. Tools and supports for local authorities will be developed to assist them in working across sectors at the national and county level in undertaking health and wellbeing assessments.

The National Positive Ageing Strategy is the overarching blueprint for age related policy and service delivery across government and society in Ireland. It is aligned with Healthy Ireland and advocates for the whole-of-government and whole-of-society approach to health and wellbeing adopted by Healthy Ireland. It provides a framework to enable better engagement to identify and address issues that require co-operation among, in the first instance, a number of government departments. This will promote coherence and integration in policy making and planning and a better identification of crossover points with other relevant national priorities and strategies. It will also ensure that issues affecting older people are mainstreamed in policy-making at all levels and across all sectors.

Recognition of the impact of other sectors on the broader determinants of health is, however, a notable gap in policy from other governmental departments. It is intended that Healthy Ireland will help address these gaps at the policy level in future years. However, implementation of Healthy Ireland is at an early stage and the effectiveness of the cross-governmental actions it outlines remains to be seen. It is promising that mechanisms are already in place and work on Social Impact Assessment is progressing.

Implementation and training

While the relatively new national clinical programmes placed emphasis on standardising treatment at the hospital and primary care level, the focus was placed on treatment, with considerably less emphasis on health promotion and primary prevention. With the publication of Healthy Ireland and the setting up of a Division of Health and Wellbeing in the HSE there is renewed interest in maximising the power of the clinical programmes to standardise preventive approaches in hospital and primary care.

For example, the HSE would like to employ the best approach to ‘Making Every Contact Count’. So areas of need towards achieving this are a) to clarify the evidence regarding taking a generic approach to brief advice/ brief intervention for lifestyle risk factors, b) to

identify the evidence regarding training of staff generically in the techniques of brief advice/ brief intervention rather than in each risk factor individually. Furthermore there is a need to persuade and achieve credibility among clinicians for the emphasis on addressing behaviour change systematically with patients. Also important is the environment to persuade clinicians of the importance of standardising the advice on vaccination to reduce morbidity, such as influenza after a heart attack and pertussis vaccination in pregnancy.

Financing and resourcing

The demands of clinical provision in a health service often take precedence over the provision of primary prevention and health promotion in terms of funding and resourcing. Consequently, health promotion and primary prevention need dedicated financing and resourcing to ensure growth and development. For example, when Ireland went into recession in 2008, with health funding suffering many years of cutbacks (as described earlier), clinical staff in a number of areas such as cardiac rehabilitation units in hospitals (an out-patient service in Ireland) were redeployed to frontline activity such as Emergency Department care.

Undoubtedly, there is insufficient resourcing for health promotion and primary prevention in Ireland. The flow of funds is not stable and has been particularly affected by the recent economic recession. The Irish health system endured radical resource cuts during the recession. From 2009 to 2013 financing of the Health Service Executive fell by 22%. Staffing of public services has also fallen by 10% of total staffing from its peak in 2007 (Health Service Executive, 2013). The Health Service is now facing the most severe financial challenge resulting from a reduction to its funding base and a significant additional savings target being required. Budget 2014 means that the Health Service will have an overall gross vote reduction of €272m and a savings target of €619m for 2014. Austerity has forced the Irish Government to scrutinise all health-related activities and costs, not a bad thing in and of itself, however, the depth of cuts required over a protracted period means that easy cost saving measures have now been exhausted and structural reform as outlined in *Future Health,* including a reorientation of chronic condition management from acute care to primary care, is now necessary to reduce the risks of genuine harm through loss of entitlements and service cuts (Thomas and Barry, 2014). This challenge comes at a time when the demand for health services is increasing every year, which in turn is driving costs upwards.

Funding allocation is not well publicised and it was not possible to obtain definitive figures on the proportion of the health budget devoted to prevention, although it was widely acknowledged among stakeholders interviewed for the CHRODIS WP5 project that prevention only accounts for a small proportion of the overall health expenditure, in line with figures reported in other countries. It was also reported that certain risk factors absorb a disproportionate amount of the prevention budget compared to others, depending on governmental priorities and again, that funding is concentrated on lifestyle risk factors rather than investment in broader determinants of health.

As documented, Healthy Ireland received once-off funding for development of the policy and establishment of mechanisms to implement the policy. However, there is no dedicated funding stream for implementation or evaluation of Healthy Ireland or for other recent policies relevant to prevention. Given the fiscal challenges posed by the recession in Ireland, the general approach has been that policies are developed 'cost neutral' with emphasis placed on best use of existing resources.

The Health Research Board (HRB) is the primary funder for research into prevention in Ireland. Almost all competitive HRB schemes welcome proposals in this area. However, the experience to date has been that the number of applications being submitted is small, in particular in the area of health promotion. The HRB is working to increase interest in this type of work and to provide support for the development of methodologies appropriate to primary prevention interventions through its new Trials Methodology Network and its Clinical Research Facilities. Other than the HRB, there is a small amount of funding for research relevant to chronic disease prevention from other organisations, but the reality is that there is current under-investment in these areas. This issue was clearly identified in Hiney et al. (2011) and has been one of the drivers for the strategic planning of HRB research investment since 2010.

Primary care

The current contract with General Practitioners (GPs) in Ireland is largely a reactive one, i.e. payment is based on care of sick people (with some exceptions such as payments for immunisation). There is a need to modernise this contract to include proactive care of people who visit GPs. Areas which need to be developed and negotiated include early detection and treatment of key risk factors such as blood pressure. Also important is the area of documenting lifestyle risk factors followed by brief advice/intervention and treatment as appropriate.

Data, monitoring and evaluation

The area of capturing data on health promotion and primary prevention activity and the outcome of that activity requires development. The sectors of importance for this development are primary care, the settings based health promotion services (work place, school, community) and hospital based specialist health promotion services. To address this gap there are a number of areas which require considerable development such as:

a) Clarification of essential data items to be collected within key areas
b) Development of ICT (Information and Communications Technology) systems to enable systematic collection and recording of data to promote and enhance service delivery and improve health outcomes:
    i. In hospital and primary care systems there is a need to modify existing software and coding classification. Note that International Classification of Diseases (ICD) has limited coverage of lifestyle risk factor status and little, if any, ability to capture behaviour change interventions.

ii. In other health environments such as public health nursing in the community, and in settings based and specialist health promotion, there is a need for initial development of robust systems.

c) Linkage of ICT systems to permit evaluation of programmes and to promote better planning as well as service delivery

d) Agreed standards and performance indicators for health promotion and primary prevention to establish quality assurance of this work

It has been acknowledged that to date, the health system in Ireland has not articulated its key research priorities particularly well. In terms of national research priorities, research for policy and practice has been assigned a key underpinning/enabling role in the *National Prioritisation Action Plan* (NPAP). The Report of the Research Prioritisation Steering Group (2011) identified the need to develop infrastructure to progress an integrated national system of clinical and translational research capacity that can help Ireland capture the local and global benefits of investment in health related research.

Despite the number of data sources, there is still a lack of baseline population health data. There are significant limitations in the available data on chronic conditions and their risk factors, particularly at the regional and local level:

- At present, sufficient data are not routinely collected. Alongside patient registers, a comprehensive and standardised system for monitoring prevalence and risk factors (overweight/obesity, nutrition, physical activity and smoking) at the national and sub-national level should be established, agreed and maintained. These data should be consistently defined and measured over time and across studies, and should be based on physical measurements rather than subjective self-reports.
- Relevant data on social determinants of health should be incorporated into clinical, service and public health information systems – including chronic disease patient registers and local data collections – and be used to help plan, deliver and evaluate chronic disease prevention and management programmes.
- Performance indicators which can be used to measure differences in disease prevention and management between population subgroups should be developed and used to plan and monitor efforts to reduce health inequalities.
- Recording of inequality measures in health information systems and other datasets is problematic and there is no standard approach to assessing health inequalities at a national level in Ireland. Measures are used interchangeably and often yield high numbers of missing cases.

The importance of population health research as a driver for quality, efficacy and efficiency in health care delivery and improvement of the health of the population is not always understood at the governmental level or by the public. As a result, despite concerted government efforts over the past decade to develop overall research capacity in Ireland, there is still significant underinvestment in population health research. The 2011 HRB report by Hiney et al. identified a number of structural gaps that are hindering progress in this area in Ireland including an investment focus on biomedical research, inappropriate funding models and lack of incentive for interdisciplinary research.

At present, data on the population prevalence of chronic conditions and their risk factors are not routinely collected at the national, regional and local level. While there is substantial data being collected across the Island of Ireland, this is very fragmented, and the value of this data is hampered by:

- very limited use and/or linkage of existing datasets, compounded by lack of comparability of available datasets
- lack of harmonised standards across datasets
- difficulty in storage and access to existing datasets in the public system
- strident data protection legislation
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To address the gap in the evidence base on chronic conditions in Ireland, IPH developed a systematic and rigorous approach to estimating and forecasting the prevalence of leading chronic conditions for national and local areas. The method combines the most recently available national survey data and local population data towards preparing synthetic estimates for local areas. IPH work has a particular focus on reducing health inequalities and addressing the broader social determinants of health. The IPH's Community Profiles tool (http://www.thehealthwell.info/community-profiles) encourages and enables free public access to data and tools that allow users to cross-reference health data and broader determinants data.

Further research into the impact of the chronic diseases on the population, the health and social care system, and the economy is required. This research should consider the magnitude of the burden of these conditions (including financial costs); how it is distributed across the population; how that burden might change in the future; and the implications for the health and social care workforce and its training requirements.

Another weakness in national datasets includes limited or no Irish research data in the primary, continuing and community care sectors. Therefore, a more formalised approach needs to be taken, including the development of national leadership in this area. It is intended that the HI-RDIP will address many of these gaps.

Even if there was a high level of awareness of the need to cross-reference health data and broader administrative data sets, the difficulties posed by Data Protection Legislation would

hamper this. It is hoped that Healthy Ireland will take a lead on this issue. Further concerns have been raised in relation to amendments to the EU Data Directive. It is argued that:

- The amendment to Article 81 (2) makes the exemption from giving consent for the use of data concerning health in research very narrow. This will prevent valuable health research that is currently legal and already tightly regulated under European and Member State law.
- while the Article 81 (2a) amendment enables Member States to legislate for an exemption, the permitted exemption is very narrow:
    - The exemption could only apply to the use of pseudonymised, not identifiable, data.
    - A very high bar is set for research using pseudonymised data to be eligible for the exemption, which lacks any assessment of proportionality or reasonableness.
- The concept of high public interest in Recital 123a is problematic as it suggests that the exemption should only be used in a very limited set of circumstances and it is likely to be problematic for many studies, particularly because the results and impact of the study are not known at the outset.
- The amendment to Article 83 (1) makes the exemption from giving consent for the use of health data in research very narrow, which will prevent valuable research that is currently legal.

The *Healthy Ireland Research, Data and Innovation Plan* (HI-RDIP) is currently under development to map existing research and identify gaps in research relevant to inform the implementation and evaluation of *Healthy Ireland*. It is hoped that implementation of this Plan will address the serious deficit of primary prevention research that exists in Ireland. Research prioritisation has been identified as a fundamental requirement for implementation of the Plan. The primary aim of the Plan is to generate and guide the use of high-quality, relevant research and data to improve health and wellbeing across the whole population to ensure goals, programmes and policy and programming decisions are based on evidence, best practice approaches, and integrated with service delivery to maximise impact. The initial process of mapping existing evidence and highlighting research gaps is under way and further steps will focus on the specific objectives of the Plan:

1. Create a supportive infrastructure through leadership, governance and coordination to drive knowledge and innovation for health and wellbeing in Ireland.
2. Increase the quantity and quality of relevant knowledge.
3. Improve capacities to generate, analyse and use knowledge.
4. Build strategic and cross-sectoral collaborations locally, nationally and internationally.

5. Monitor and evaluate programmes and services.
6. Enhance knowledge utilisation through translation and exchange.

The Plan acknowledges the need to develop collaborations between data-rich organisations (such as the Central Statistics Office and Health Service Executive) and those with relevant skills and expertise to conduct analysis, while ensuring all appropriate safeguards are in place. The IPH HealthWell portal is a good model for how diverse data sources could be cross-referenced.

In addition, a Healthy Ireland survey is being developed under the umbrella of Healthy Ireland, to provide robust research and evidence on gaps in the current evidence base on health and wellbeing in Ireland. Field work is due to take place in 2014 with results expected in the first quarter of 2015. In this context, the development of a national Healthy Ireland Survey will generate data that will highlight significant patterns and trends in Irish lifestyles in the context of the Healthy Ireland Framework. The Healthy Ireland Survey will report on key indicators of lifestyle factors, such as smoking, alcohol consumption, physical activity, diet, sexual health and wellbeing to monitor the key trends and policy impacts in those areas. The aim is to collect a core set of data, on an annual basis for three years, on the health status and other health related variables of a nationally representative sample of the general Irish population aged 15 years and over in private households. It will facilitate the inclusion of module topics to reflect the broad social determinants of health and wellbeing. It is intended that the sample be sufficiently large and structured in such a way as to make comparisons between various sub-groupings of the population possible to enable cross-referencing of data among different demographic and SES groups.

It is intended that the Healthy Ireland Survey will add to the substantial evidence base now being generated through government investment in two population level longitudinal surveys – Growing up in Ireland (GUI) and The Irish Longitudinal Study on Ageing (TILDA). GUI is a nationally representative study of children taking place over seven years and following the progress of two groups of children: 8,500 nine year olds and 11,000 nine month olds. TILDA is a nationally representative study of those aged 50 years and over in Ireland and their partners. Both studies provide a wealth of data on health and broader aspects of childhood and ageing.

The Institute of Public Health is also involved in an all-Ireland initiative to provide a mechanism for greater collaboration among researchers on ageing. The Centre for Ageing Research Development in Ireland (CARDI) is hosted by the Institute. CARDI is a non-profit organisation developed by leaders from the ageing field across Ireland (North and South) including age focused researchers, academics, statutory, voluntary and community sector representatives. CARDI funds, publishes and disseminates research on topics relating to ageing and older people.

Evaluation (policy level)

Unfortunately, health policy reviews are also relatively ad hoc and rarely publically available in Ireland and approaches to health policy evaluation vary. IPH could only identify one formal evaluation of a national level policy in Ireland relevant to primary prevention since 2000 – The Report of the Intersectoral Group on the Implementation of the Recommendations of the National Task Force on Obesity (Department of Health, 2009). Findings indicated substantial progress in the case of 30 of the recommendations (32%), partial implementation had occurred on 29 (31%), action was still progressing on 26 (28%), while no progress could be reported on 8 (9%) of the recommendations.

Implementation and evaluation

It is generally acknowledged among policy and academic stakeholders that Ireland now has a strong policy underpinning and current governmental commitment to advance a whole-of-government and whole-of-society approach to promoting health and wellbeing. However, experience to date indicates that there is insufficient investment in and support for the implementation of policy in Ireland. Several years of health service restructuring during a time of economic austerity and reduced funding for health services in general led to many challenges for delivering on national policy agendas. While there is currently no dedicated support unit for policy implementation or evaluation research in the DoH, this would provide an important support structure for the implementation of Healthy Ireland.

It has been argued that:

- Current HSE Performance Indicators are not robust for health promotion
- There is a lack of co-ordination in development and implementation of programmes
- There is an identified lack of structure and support for monitoring and evaluation of health promotion programmes
- There is an identified lack of IT infrastructure to support health promotion programmes

In the context of the development of the Outcomes Framework for Healthy Ireland then it is important that health promotion is recognised as a complex field which requires commitment across sectors and investment in infrastructure to support programme development, monitoring and evaluation.

It was reported that there is insufficient awareness and support for evaluating primary prevention interventions in Ireland. IPH has developed the Physical Activity and Nutrition Intervention Tool (PANI) (http://www.thehealthwell.info/pani) to increase awareness and support for evaluating interventions specifically related to physical activity and nutrition. PANI helps policy makers and practitioners to identify and critically compare interventions from across the Island of Ireland and Britain that are designed to achieve specific objectives in particular populations. However, to date there is no other database established for collating information on health promotion interventions or assessing implementation or evaluation outcomes. This is acknowledged as a major gap in health promotion practice in Ireland and the Health Research Board identified the lack of systematic evaluation of

community-based interventions as a weakness in population health research. This has been attributed to a lack of investment in evaluation and inadequate supports to develop appropriate infrastructure.

Knowledge Development

Better knowledge of effectiveness and cost effectiveness of specific programmes at an international or multicentre level would be beneficial. An environment of sharing of the evaluation of key 'best buy' programmes in different settings and countries would be useful.A key strategic goal of the HRB in Ireland is to enhance research capacity and leadership to conduct high-quality population health sciences research. The importance of building research capacity across population health sciences is also recognised in the *National Prioritisation Action Plan*, where the HRB leads on a number of actions aimed at addressing capacity deficits in this area. To address these deficits, the HRB has developed new, or modified existing, funding supports to enhance the capacity of the health research system to both generate high quality evidence and to utilise this evidence in the practice and policy environments. Initiatives of particular relevance to CHRODIS include:

- HRB SPHeRE PhD Scholars Programme
- Training Fellowship for Health Professionals (HPF)
- Cochrane Training Fellowship
- NCI Cancer Prevention Fellowships
- HRB Interdisciplinary Capacity Enhancement Awards

In addition to capacity enhancement, the HRB have developed two research centres to conduct research on prevention and health promotion – the HRB Centres for Diet and Health and Primary Care. The HRB is also supporting a number of Research Leaders in Population Health and Health Services Research, based in universities but working with the health system. In order to improve knowledge dissemination and exchange among stakeholders, the HRB has created/funded participation in a number of 'fora for researchers and practice, policy makers'. Examples include the SPHeRE network of HSR/Population Health researchers, the DEDIPAC network of researchers in diet and health, and the Trials Methodology network to facilitate complex population health interventions and support the development of new methodologies.

While there currently is not sufficient research emphasis on primary prevention of chronic conditions in Ireland, this is improving. The HRB SPHeRE Programme is establishing a national consultative forum of practitioners, policy makers and academics to consolidate the capacity that currently exists and to explore how the situation can be improved. The publications of the Healthy Ireland report in 2013 and of its *Research and Data Plan* in 2014 are significant milestones for this area. A recently-formed Research Evaluation and Policy Group at University College Dublin (UCD) are also seeking to bring together academics, policy makers and practitioners to develop capacity in community based evaluation interventions and increase visibility for this area.