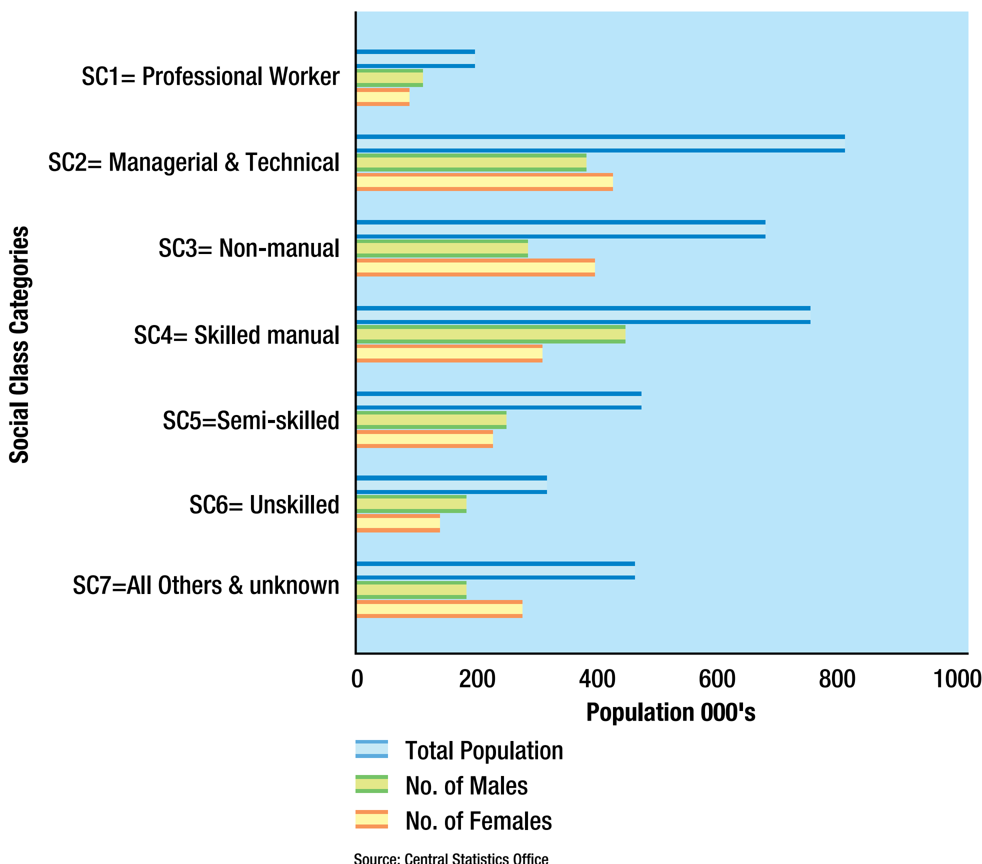
2.1 SOCIAL, ECONOMIC AND ENVIRONMENTAL FACTORS

In considering the extent to which external and structural factors determine our health it is important to establish a profile of the Irish population. The most recent national census in 1996 enumerated the Irish population at 3,626,087[26]. The number of people in each social class and the corresponding number of males and females are presented in figure 1.

Figure 1: Social Class distribution of the Irish Population for 1996



Source: Central Statistics Office

A range of social, economic[27] and environmental factors[28] together with issues of equity, equality and access impact on the physical, mental and social well-being of the Irish population. By considering the following factors a broader picture of the population's health can be constructed:

- Poverty
- Unemployment and income adequacy
- Education
- Access to health services and
- Environmental factors such as housing and water quality

The following is a presentation of the way these factors impact on health.

Although health has already been defined in Chapter 1 of this document in its widest sense, traditionally the measurement of population health has relied on the use of health indicators such as morbidity (illness) and mortality (death) data. While accepting that this provides a more narrow indication of ill-health (morbidity), for this Chapter it is proposed to present current morbidity and mortality data only in an attempt to reflect the health status of the population.

4.1 MORBIDITY

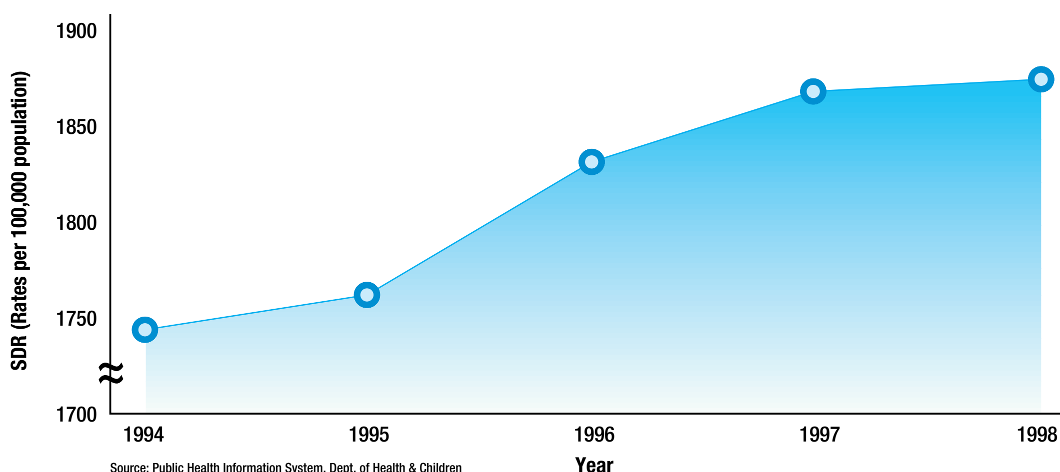
Self-perceived general health is a good predictor of population morbidity[52] and nearly 1 in 2 Irish adults surveyed reported excellent or very good health and this was higher for non-smokers[23]. As for Irish children, the vast majority reported that they were either very healthy or quite healthy. More boys than girls considered themselves as healthy[23].

Examples of morbidity, which reflect the principal causes of death include cardiovascular disease (which includes heart disease, strokes and circulatory diseases), cancers and accidents.

4.1.1 CARDIOVASCULAR DISEASES

Standardised discharge rates for heart disease, strokes and circulatory diseases are only available from 1994 and too early to establish trends (figure 2).

Figure 2: Age-standardised discharge rates for cardiovascular diseases (ICD 390-459) for 1994 to 1998

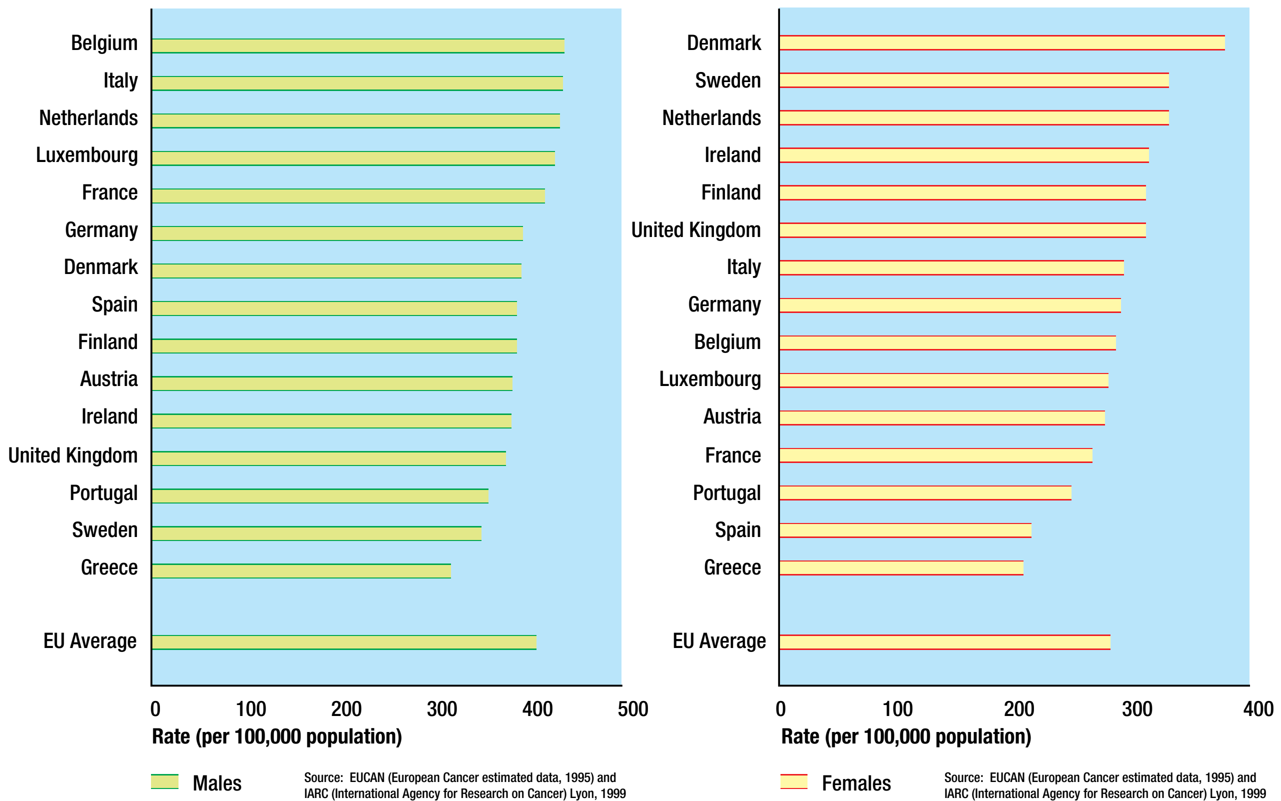


Source: Public Health Information System, Dept. of Health & Children

4.1.2 CANCERS

Age-Standardised Incidence Rates for all cancers (excluding non-melanoma skin cancer) are presented in figure 3 for Ireland and selected EU countries. Irish women have the fourth highest rate and Irish men the eleventh highest rate when compared to their EU counterparts.

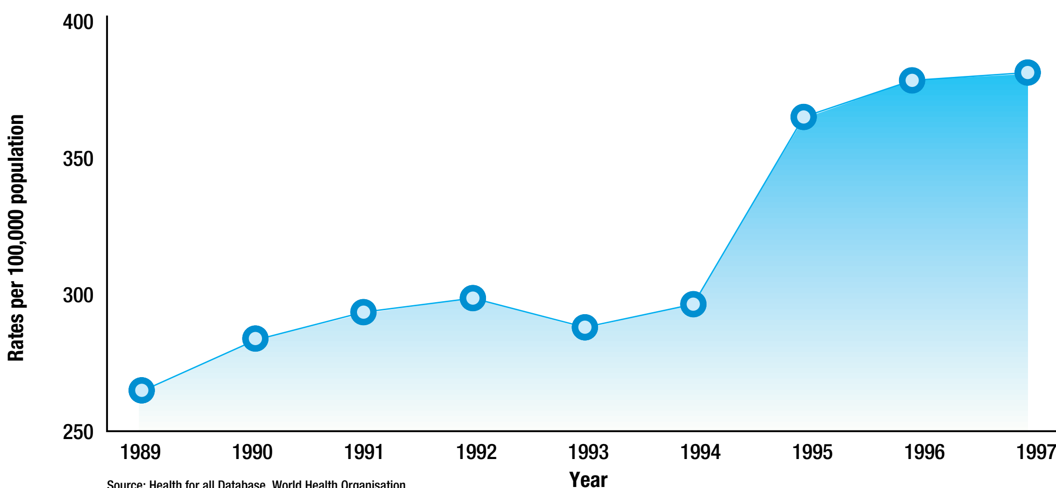
Figure 3: Age-Standardised incidence rates for all cancers excluding non-melanoma skin cancer, EU countries, 1995



4.1.3 ROAD TRAFFIC ACCIDENTS

Since 1989 the rate of persons injured in road traffic accidents has steadily increased (figure 4). It is important to note that the level of injury accidents increased markedly from 1995 due to a significant change in the reporting procedure.

Figure 4: Persons injured in road traffic accidents (rates from 1989 to 1997)

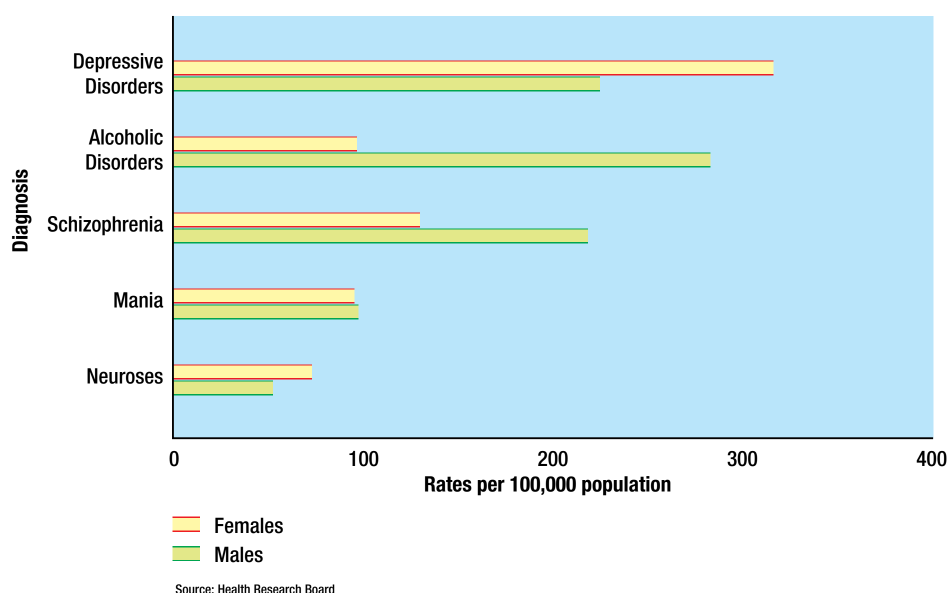


4.1.4 MENTAL HEALTH

There are several mental health conditions that are managed in the community but the magnitude and profile of this is difficult to determine. Data reveals that depressive disorders are the most common cause for females being admitted to psychiatric hospitals whereas in contrast alcoholic disorders are the most common cause for male admissions (figure 5).

In terms of lifestyle practices SLÁN provides data related to perceived requirements for better health. The majority of respondents from both genders ranked "less stress" as the top requirement for better health.

Figure 5: Rate of admissions to psychiatric hospitals by main diagnosis for males and females, 1998



Source: Health Research Board

4.1.5 SEXUALLY TRANSMITTED DISEASES

The number of notified cases of sexually transmitted diseases (STD) has continued to increase in the last number of years and has risen from 2,581 in 1989 to 7,436 in 1998[53].

4.1.6 DRUG MISUSE

In 1998, 58% of cases (3,504) in drug treatment centres were under 25 years of age[54]. The mean age of clients admitted to treatment (24.3 years) is the lowest in the EU[55].

4.1.7 HIV/AIDS

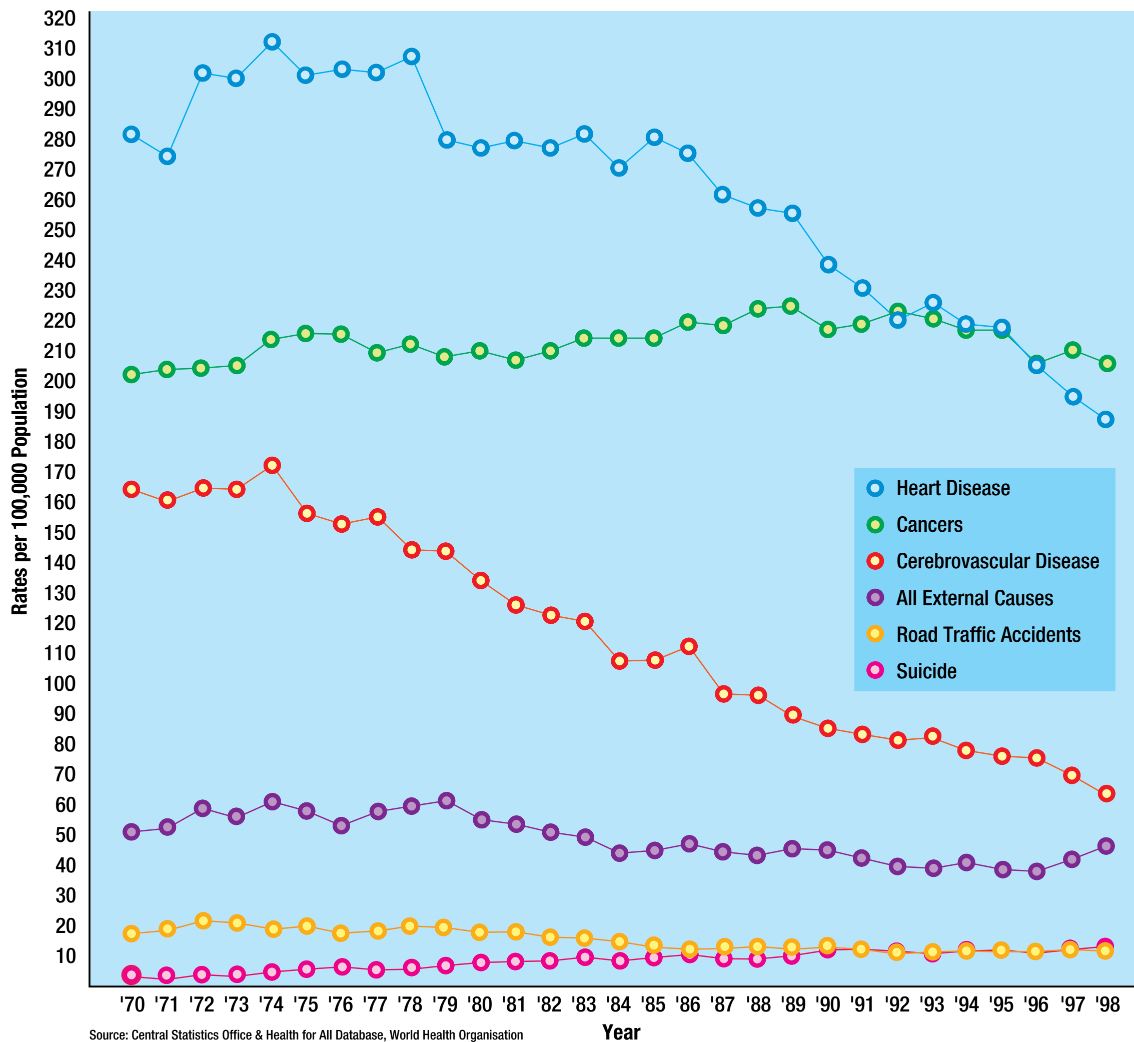
In 1999 the highest number of new HIV cases were reported since data collection began in 1985. The cases of AIDS have gradually increased since 1982, peaked in 1996 and have levelled out in recent years. When compared with the EU, Ireland has one of the lowest rates for AIDS[53].

4.2 MORTALITY

Consistent with morbidity data, the principal causes of death in Ireland continue to be cardiovascular disease, cancers and accidents.

Age-standardised mortality rates (SMR) are presented as a rate per 100,000 per year and take into account varying age distribution between populations. SMR for the principal causes of death are presented in figure 6A for all ages.

Figure 6A: Age-Standardised mortality rates for principal causes of death (all ages)



Source: Central Statistics Office & Health for All Database, World Health Organisation

4.2.1 CARDIOVASCULAR DISEASE

There has been a long term significant decline in the rates of mortality from heart disease, strokes and other circulatory diseases (figure 6A).

4.2.2 CANCERS

Mortality from cancers has remained relatively stable since the early 70's (figure 6A). There is however, evidence of a gradual reduction since 1990.

4.2.3 ALL EXTERNAL CAUSES

Standardised mortality rates for accidents excluding road traffic accidents (e.g. poisoning, violence and suicide) show a gradual decline in trend since 1979 (figure 6B).

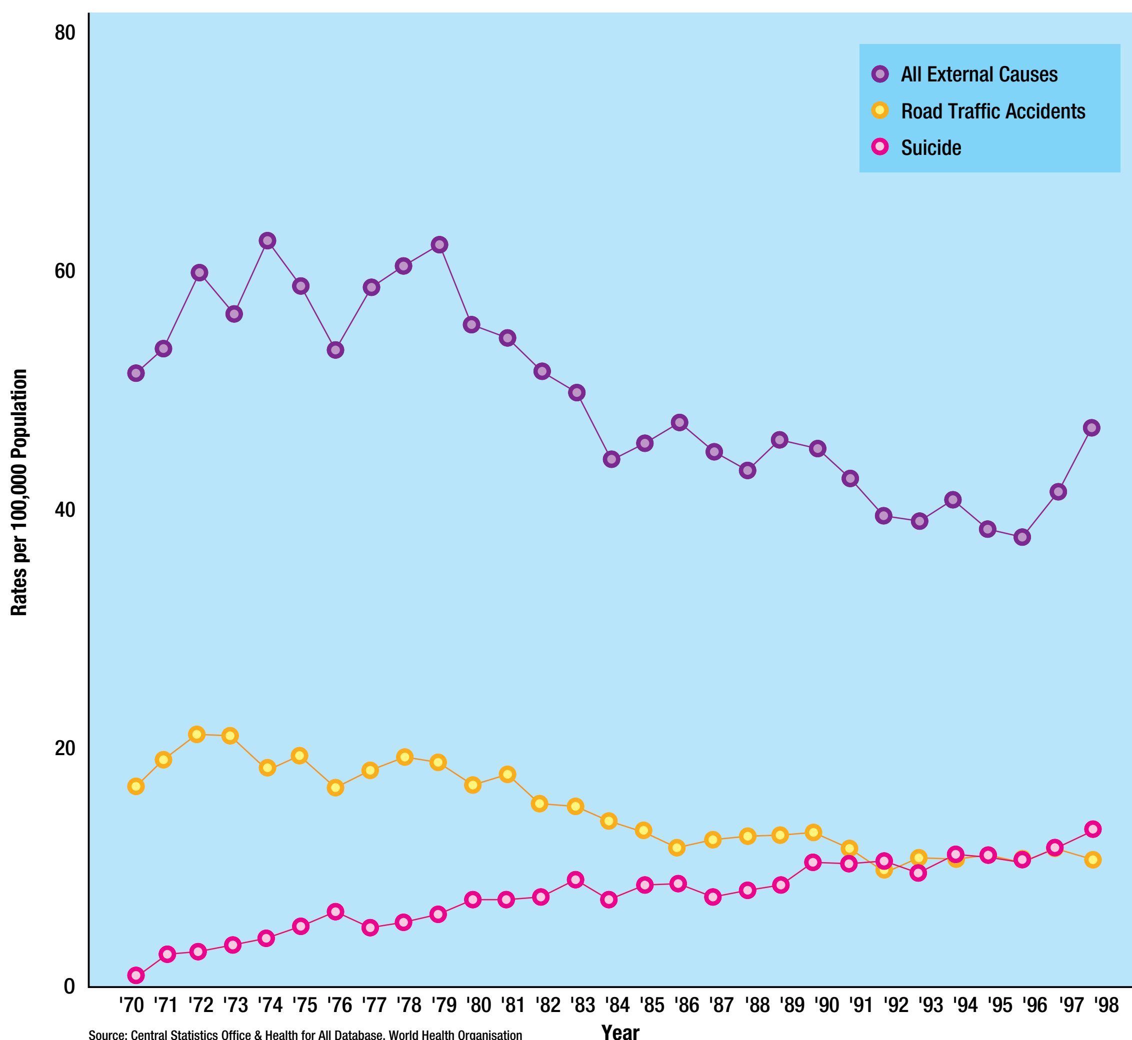
4.2.4 ROAD TRAFFIC ACCIDENTS

Standardised mortality rates for road traffic accidents show a decline from 1972 to 1992 but then plateau from 1992 to 1998 (figure 6B).

4.2.5 SUICIDE RATES

Suicide rates in contrast to road traffic accidents show a significant increase since the 1970's (figure 6B)

Figure 6B: Age-Standardised mortality rates for all external causes, suicides and road traffic accidents (all ages)



Source: Central Statistics Office & Health for All Database, World Health Organisation

4.2.6 AIDS

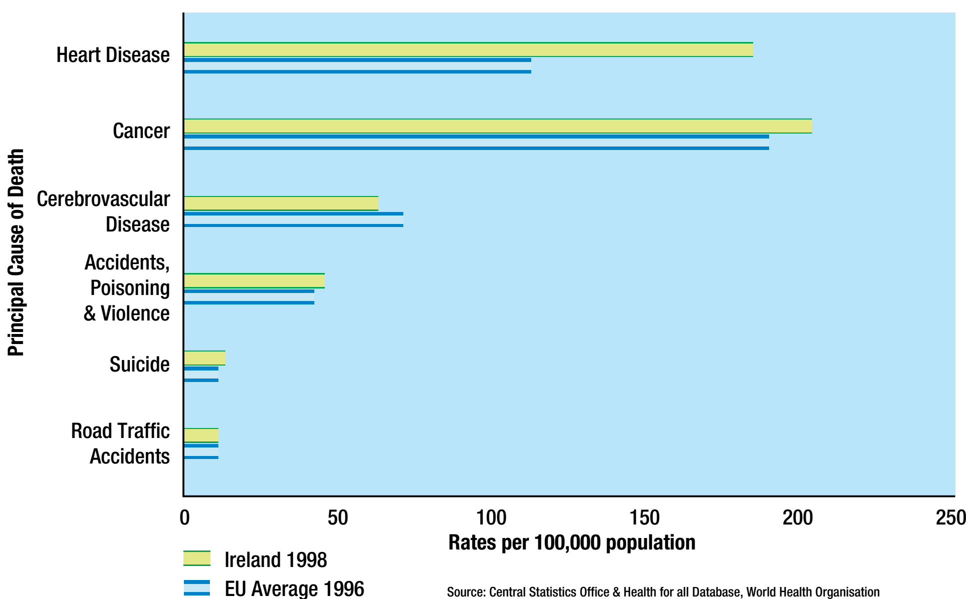
Standardised mortality rates for AIDS are not available but statistics collated by the Department of Health and Children provide cumulative data. Since 1982, 349 deaths have been registered. The highest number of deaths from AIDS was 46 in 1995 and appears to be declining with 7, 21 and 17 in 1997, 1998 and 1999 respectively[53].

4.2.7 EU COMPARISON

Ireland's all-age standardised mortality rates for heart disease and cancers are higher than the EU average (figure 7).

Ireland has a high rate of premature mortality (deaths before the age of 65 years) for cardiovascular disease, cancers and accidents[56]. When compared with the EU Ireland has a greater premature mortality rate for cardiovascular disease[56].

Figure 7: Age-Standardised mortality rates by principal causes for EU countries (All ages)



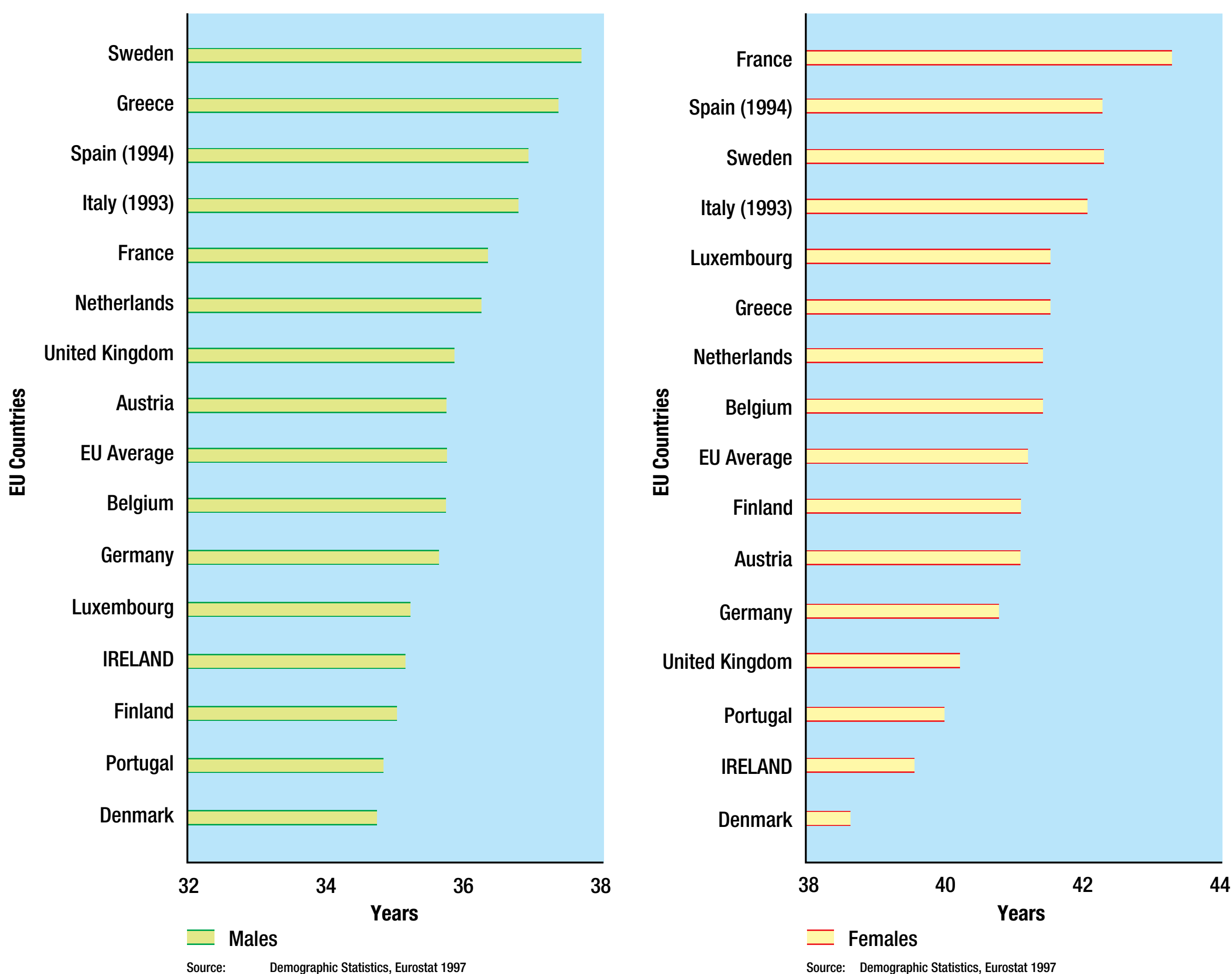
Source: Central Statistics Office & Health for all Database, World Health Organisation

4.3 LIFE EXPECTANCY

In the last 50 years life expectancy has increased by 8.5 years for Irish men and 11.5 years for Irish women. Currently life expectancy for males at birth is 73.0 years and for females 78.6 years[56].

When compared with other EU countries, life expectancy at age 40 is fourth lowest for Irish males and second lowest for females (figure 8). In 1995, Ireland had the lowest life expectancy of all 15 EU countries at age 65 years for both men and women[56].

Figure 8: Life expectancy at age 40 (1995)



Source: Demographic Statistics, Eurostat 1997

Source: Demographic Statistics, Eurostat 1997

4.4 SUMMARY

Life expectancy for both Irish males and females has improved in recent years partly due to better health and social provision for infants and children. However many health indicators still compare poorly with other EU countries. Principal causes of death have also changed as in many other European countries from infection and senility to heart disease and cancers.

Appendix THIS IS A GENERAL OVERVIEW OF OUTCOMES FROM THE FIRST NATIONAL HEALTH PROMOTION STRATEGY, '...MAKING THE HEALTHIER CHOICE, THE EASIER CHOICE.'[14]

1. KEY SETTINGS	2. PRIORITY POPULATION GROUPS	3. RISK FACTORS AND LIFESTYLE
i) The family ii) The community iii) The school iv) The health services v) The workplace	i) Children ii) Sexually active people iii) Women iv) Maternal health v) Disadvantaged vi) Elderly	i) Alcohol abuse and substance abuse ii) Nutrition iii) Breast-feeding iv) Exercise v) Cholesterol and blood pressure vi) Diabetes Mellitus vii) HIV/AIDS viii)Mental Health ix) Oral health x) Safety

1. KEY SETTINGS: GOALS AND OUTCOMES

I) The family	Overview of outcomes:
Goal: Development of health promotion programmes in the family.	• Development and Support for Parenting and Family Support Initiatives and Programmes. e.g. Family Communications and Self-esteem, Community Mothers Scheme.

II) The community	Overview of outcomes:
Goal: Development of health promotion programmes in the community.	• Being Well programme; Food and Health programme; Drugs Questions, Local Answers • Other national and regional initiatives supported and developed in conjunction with voluntary and statutory agencies, for example, The National Youth Health Programme; Dublin Healthy Cities Project.

III) The school/college	Overview of outcomes:
Goal: Development of health promotion programmes in college/school.	• Development and implementation of programmes and initiatives in partnership with the Department of Education and Science, for example, the Health Promoting Schools Project, the Substance Abuse Prevention Programme and Social, Personal and Health Education • General and topic based programmes developed and supported, for example, Nutrition Education at Primary School • Teacher Training and Parenting Programmes • Implementation of the Pilot Health Promoting College Project.

IV) The health services	Overview of outcomes:
Goal: Development of health promotion programmes in the health services.	• Statutory obligation on Health Boards to establish Health Promotion Departments and designate funding for Health Promotion • Establishment of Health Promoting Hospitals Network • Training and development for health professionals.

V) The workplace	Overview of outcomes:
Goal: Development of health promotion programmes in the workplace.	• Publication of 'healthy bodies – healthy work' Policy Document • National Conference on Health Promotion in the Workplace • Pilot projects in Health Boards • Models of Good Practise published through European Network • Pilot project implemented to establish the basic criteria for Work Place Health Promotion in Small to Medium Enterprise • Happy Heart at Work and Happy Heart Eat Out.

2. PRIORITY POPULATION GROUPS: GOALS AND OUTCOMES.

I) Children:	Overview of outcomes:
Goal: Maximise young people's health potential with reference to physical activity, anti-smoking, substance misuse, healthy nutrition and healthy relationships.	• Various school and community based projects and programmes supported, for example, Knowledge is Power and Smoke Busters • Appointment of Youth Health Promotion Project Officer.
Goal: Achieve an uptake of 95% for National Immunisation Schedule.	• Development of new schedule • Awareness campaign.

ii) Sexually active people:	Overview of outcomes:
Goal: Promoting safer sexual practices.	• Support for the implementation of Relationships and Sexuality Education • Participation in the implementation of the Report of the National Aids Strategy Committee • Development of 'Knowledge is Power' – HIV/AIDS Education Pack for exploring the issue with young people • Convenience Advertising Campaign • World AIDS Day Campaign • Production of AIDS Education Video • Development of Information leaflets relating to STI's/D's and contraception.
Goal: Achieving a reduction in the risk of disability by providing a range of information on topics such as the influence of age on pregnancy; family planning; and genetic counselling.	• Development of mass media campaigns, information leaflets, booklets and posters.

iii) Women:	Overview of outcomes:
Goal: Ensure that women's health needs are identified.	• Discussion Document - Developing A Policy For Women's Health • Establishment of Women's Health Council • Publication of a Plan for Womens Health.
Goal: Where appropriate health promotion programmes put in place to address these needs.	• Investment in Women's Health at regional level • Food and Health programme.

iv) Maternal Health:	Overview of outcomes:
Goal: Encourage the avoidance of smoking, alcohol and drug misuse before and during pregnancy.	• Range of information materials produced and supplied to expectant and new mothers • Brief Intervention Training provided at regional level for Health Professionals in contact with pregnant women.
Goal: Promote breast-feeding.	• Baby Friendly Hospital Initiative established • Implementation of the National Breastfeeding Policy • Support for voluntary organisations • Training pack, including video, for health professionals.
Goal: Promote healthy nutrition before and during pregnancy.	• Training pack/video for health professionals produced • Folic Acid Public Awarness Campaign in conjunction with the Irish Country Women's Association.
Goal: Encourage improvements in parenting skills.	• Parenting Programmes developed and supported at national and regional level.
Goal: Increase the numbers who understand the value of immunisation and accident prevention and first aid.	• Immunisation campaign • First Aid Chart produced • Accident Prevention Awareness Campaigns at regional level.

v) Disadvantaged:	Overview of outcomes:
Goal: Reduce inequalities in health status by giving priority in health promotion activities to vulnerable groups, e.g. lower socio-economic.	• At a national and at a regional level, Health Promotion personnel have participated in the development, support and implementation of initiatives targeting disadvantage in partnership with relevant bodies • Contribution to the National Anti Poverty Strategy • Research into the health needs of young people at risk leading to the publication of Youth as a Resource: Promoting the Health of Young People at Risk.

vi) Elderly:	Overview of outcomes:
Goal: Increase the proportion of the elderly who enjoy an active, independent and healthy old age.	• Publication of Policy Document 'Adding Years to Life and Life to Years' • Relevant sections of the Plan for Women's Health implemented • The promotion of physical activity.

3. RISK FACTORS AND LIFESTYLES: GOALS AND OUTCOMES

I) Alcohol and substance misuse:	Overview of outcomes:
Goal: Develop a national policy to promote moderation in alcohol consumption and reduce risks to physical, mental and family health associated with alcohol misuse – such policy to be adopted and aunched during 1995.	• Publication of the National Alcohol Policy, including an Action Plan and identification of key players.
Goal: Ensure that 75% of the population aged 15 years and over knows and understands the recommended sensible limits for alcohol consumption within the next 4 years.	• Various campaigns developed over lifetime of policy document • Support for the development of Substance Abuse Prevention Programme for schools, Drink Awareness for Youth Programme and the Youth Work Support Pack for Dealing with the Drugs Issue within the youth sector • Development of Family, Communication and Self-esteem Parenting Programme; Being Well and Drugs Questions, Local Answers • National and regional initiatives developed and supported such as the production of information booklets, posters, campaigns and programmes.
Goal: Reduce substantially over the next 10 years the proportion of those who exceed the recommended sensible limits of alcohol consumption.	• Programmes and initiatives such as those listed above have aimed to promote sensible attitudes to alcohol • The SLÁN survey provided the first baseline marker to establish the number who drink over the weekly limits (14 and 21 units) and the number who engage in high risk drinking (binge drinking on a single occasion).
Goal: A reduction in the percentage of cigarette smokers in the population by at least 1% per annum so that more than 80% of the population aged 15 years and over are non-smokers by the year 2000.	• Preventative, Educational and Cessation initiatives have been implemented at regional level to reduce the number of young people taking up smoking and provide assistance to those who want to stop • Development of National Smoking Campaigns in partnership with relevant voluntary organisations.
Goal: All pupils leaving school will have received information and education programmes on the dangers of substance misuse in the context of a comprehensive health.	• In partnership with the Department of Education & Science the Substance Abuse Programme has been developed and implemented • Support for National, Regional and local initiatives to prevent substance misuse, for example, campaign development, programme implementation and policy formulation.

ii) Nutrition:	Overview of outcomes:
Goal: Ongoing implementation within the next five years of the Department of Health 'Healthy Eating Guidelines'.	• Implementation and review of the Nutrition Health Promotion Framework for Action • Annual National Healthy Eating Campaigns - supported and evaluated regionally and nationally • Establishment of Community Nutrition Service at regional level • Nutrition and Oral Health Project - piloted, evaluated and implemented • Food and Health community based programme developed and evaluated • Happy Heart Nutrition Initiative in partnership with the Irish Heart Foundation.

iii) Breast feeding:	Overview of outcomes:
Goal: Initiation rate of 35% by 1996 & 50% by the year 2000 and an overall breast feeding rate of 30% at 4 months by the year 2000.	• Implementation of National Breastfeeding Policy.
Goal: Among the lower socio-economic groups breast feeding initiation rate of 20% by 1996 and 30% by the year 2000.	• Interventions developed at a regional level targeting lower socio-economic groups.

iv) Exercise:	Overview of outcomes:
Goal: 30% increase in the proportion of the population ages 15 years and over engaging in an accumulated 30 minutes of light physical exercise most days of the week by the year 2000.	• Publication of Promoting Increased Physical Activity; A Strategy for Health Boards In Ireland.
Goal: 20% increase in the proportion of the population aged 15 years and over who engage in moderate exercise for at least 20 minutes three times per week by the year 2000.	• Campaigns promoting increased physical activity • Building Healthier Hearts Report published.

v) Cholesterol and Blood Pressure:	Overview of outcomes:
Goal: To achieve a situation where 75% of the population in the 35-64 age group will have a blood pressure less than 140-90mm Hg by the year 2005.	• Publication of Building Healthier Hearts Report • Support for initiatives at national and regional level by both voluntary and statutory agencies to promote heart health.
Goal: Reduce mean serum cholesterol in the 35-64 age group from a present level of 5.6mmol/L to 5.2mmol/L by the year 2005.	• Awareness Campaigns.

vi) Diabetes Mellitus:	Overview of outcomes:
Goal: Improve quality and quantity of life expectancy.	• Regional pilot scheme of Combined Care Initiative.
Goal: Improve the prevention and cure of diabetes and it's complications.	• Establishment of the Community Nutrition Service to provide community based assessment and education.

vii) HIV/AIDS:	Overview of outcomes:
Goal: Decrease the percentage of the population engaging in behaviours which risk HIV transmission and the transmission of other sexually transmitted diseases.	• Educational programmes • Convenience advertising • Targeted campaigns • Information leaflets • Training for health professionals. • Support for the implementation of the report of the National Aids Stategy Group • Collaboration with voluntary organisations • Participation in European HIV/AIDS Prevention Networks.

viii) Mental Health:	Overview of outcomes:
Goal: Promote positive mental health in co-operation with the voluntary mental health bodies and the health boards.	• In conjunction with statutory and voluntary organisations a range of initiatives have been supported at a regional and national level to promote positive mental health • Establishment of the Task Force on Suicide and publication of the Report of the National Task Force on Suicide.

Ix) Oral Health:	Overview of outcomes:
Goal: Improve the level of oral health in the population overall.	• Implementation of the 1994 Four Year Dental Health Action Plan • A review of the Dental Treatment Services Scheme • Provision for the appointment of 30 dental auxiliary personnel by the health boards, assigned specifically to oral health promotion and with a particular emphasis on special needs groups • The establishment of an Oral Health Promotion Evaluation within Epidemiology, Oral Health Services Research and Specified Consultancy Services Contract • Development of an Oral Health component within National Research Programmes • Establishment of specialist certificate in Health Promotion (Oral Health) offered through Distance Education by the centre for Health Promotion Studies, NUI Galway and the Dental Health Foundation of Ireland.

x) Safety:	Overview of Outcomes:
Goal: 10% reduction in mortality due to accidents within the next 10 years.	• Support for regional and national initiatives aimed at reducing the number of accidents, particularly road and home accidents.
Goal: Significant reduction in morbidity particularly among children.	• National Accident Prevention Campaign for Children. • Educational and awareness raising measures.