CRITIQUE OF *SHAPING A HEALTHIER FUTURE*: A STRATEGY FOR EFFECTIVE HEALTHCARE IN THE 1990S

MIRIAM M. WILEY

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The conduct of this study has depended heavily on the openness and generosity of the large number of individuals consulted who all gave willingly of their time for this purpose. We would like to express our sincere gratitude to these respondents who are listed in Appendix A, although we readily acknowledge that all views expressed in this report are those of the authors and cannot be credited either individually or collectively to any of these respondents or the organisations they represent. We would like to gratefully acknowledge the input of officials in the Department of Health and Children who provided information on progress with the implementation of *Shaping a healthier future* and, in particular, thank members of the Department's Change Management Unit for assistance provided throughout the conduct of this study. The contribution of Deirdre Whitaker, Mary Cleary and Rynagh MacCarthy and their colleagues at the ESRI for assistance in bringing this report to publication is greatly appreciated.

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EXECUTIVE SUMMARY

The **Critique of *Shaping a healthier future,* A strategy for effective healthcare in the 1990s** was commissioned by the Department of Health and Children as part of the preparations being undertaken for the development of a new Health Strategy in 2001. The first stage of this study is focused on the Health Strategy Development Process and involves an assessment of the process applied to the development of the 1994 Health Strategy *Shaping a healthier future,* in addition to an exploration of how that assessment might inform the process being developed for the advancement of the Health Strategy planned for publication in 2001. A review of the 1994 Health Strategy Targets and Objectives constitutes the second part of the study which is concerned with a review of the achievements of the Four-Year Action Plan 1994-1997 with particular reference to the accomplishments of the proposed targets and objectives against available evidence.

Shaping a healthier future: Review of Strategy Development Process

HEALTH STRATEGY DEVELOPMENT PROCESS

The publication of the Health Strategy *Shaping a healthier future* in 1994 was a significant innovation both for the Department of Health and the wider public service and was generally well received at the time. Given the absence of written documentation of the process undergone in the development of this Strategy, the material to chart this process could only be compiled in discussions with individuals directly involved with the development of the Strategy at that time. In addition to interviewing these individuals, it was considered essential to consult with a wide range of commentators both within and outside of the Department of Health and Children together with organisational representatives regarding their views on the process, content and implementation of the 1994 Strategy, together with their expectations for the development of the 2001 Health Strategy. The majority of those consulted would suggest that the 1994 Health Strategy has "stood the test of time" reasonably well, though the announcement of the development of a "new" Health Strategy has also been broadly welcomed. The main points arising in this review may be summarised as follows:

- Effective collaboration between the political and civil service leadership in the Department of Health ensured the production of a comprehensive health strategy in 1994 which was broadly welcomed throughout the health services and adopted by successive governments.
- A small, dedicated Department of Health team, working closely with the Management Advisory Committee, the Minister's office and selected key stakeholders ensured the completion of the Health Strategy document within a short period of 6-9 months.
- Given the very limited time frame set for the preparation of this Health Strategy, there was no formal consultative process undertaken. For a number of strategic areas for which policy statements had been published prior to 1994, a process of consultation had been undertaken with the relevant constituencies which was considered a useful knowledge base in the absence of a formal consultative process.
- Informal communication with key opinion formers within the health services facilitated broad acceptance of the final document.

- The two-pronged approach to the presentation of the Strategy document was particularly effective in ensuring that the essential elements of the policy proposals were clearly presented in the "white" pages while the specifics of the objectives and targets for achievement were included in the Four-Year Action Plan 1994-1997 presented in the "blue" pages.
- A high level of consensus is in evidence that the communications strategy adopted for the dissemination of the Strategy framework and proposals throughout the health services was particularly effective. The so called "cascading" approach whereby information was relayed through successive layers within the system meant that all parties to the process felt included and assumed ownership of the Strategy. In addition, there was large scale distribution of document summaries, videos etc. The fact that officials from the Department of Health and the Health Boards embarked on an extensive campaign to ensure that the information was relayed throughout all sectors seems to have been particularly well received.

The approach adopted to the development of the 1994 Health Strategy would have been considered the most feasible within the prevailing environment of the time. The success of the approach would also have to be acknowledged, given the production of a consensus Strategy which has guided health system development in the interim. Clearly, however, there is no perfect process which, by its very nature, must be subject to adaptation with changing circumstances. In discussions with a wide range of commentators, the following criticisms have been raised regarding the development of the 1994 Health Strategy:

- The problem most frequently noted by those interviewed regarding the 1994 Health Strategy was the absence of an explicit *monitoring* and *implementation* framework. While the Strategy adopted the view that these tasks were to be pursued at Health Board level, observers felt that the absence of a more in-depth approach to these issues resulted in patchy, *ad hoc* and disparate efforts to implement different aspects of the Strategy which varied by Health Board and by sector. The absence of any monitoring procedures meant that deficiencies could not be pursued on a timely basis to ensure any effective standardisation of implementation nationally.
- While the concepts of health and social gain proposed as key objectives of the 1994 Health Strategy were broadly welcomed as worthwhile, the absence of specifics on measurement and application have led some commentators to conclude that these objectives were more aspirational and philosophical than operational in nature.
- Commentators were also generally of the view that far from considering the principles of equity, quality of care and accountability as having been accomplished since the publication of the 1994 Health Strategy, as much remains to be done towards their achievement it would be expected that these principles would feature prominently in the 2001 Strategy with greater emphasis on responsiveness, implementation, performance and delivery.
- There was a view put forward by some medical service providers, in particular, that the 1994 document was "more style than substance"; the absence of any detailed discussion of resource issues was put forward as support for this perspective.
- Lack of standardisation and variations in the specificity of the targets and objectives proposed for the Four-Year Action Plan was considered problematic and detracted from any attempted coherence within this plan. It has also been suggested by some commentators that in certain areas the targets and objectives proposed would not have been considered particularly challenging for any health service or policy innovation.

The 2001 Health Strategy: Key Factors for the Development Process

The experience of the 1994 Health Strategy, combined with the considerable experience gained by the subsequent production of sectoral and population specific Strategies, now provides an important platform from which to embark on the development of the 2001 Health Strategy. Given this experience, combined with the views expressed by commentators in the course of the consultations undertaken for this study, a number of key factors emerge as being important to this development process, including the following:

- The scope of the process must be clearly specified at the outset.
- A project management plan needs to be developed and agreed.
- The consultation process needs to be open, transparent, balanced, manageable and effective.
- A small team of individuals committed to the development of the Strategy and involved throughout the process is critical.
- Clarity of vision is essential; it is important that all parties to the health system can identify with the strategic vision being proposed for health system development.
- Ensuring appropriate responsiveness to unplanned events demands an acceptable degree of flexibility for Strategy development and outcome.
- Targets and objectives must be appropriate and specified in an achievable manner.
- Adequate procedures for monitoring and evaluation are essential.
- An expansive and inclusive communications programme utilising the power of state-of-the-art technology is a prerequisite for ensuring that health system participants, consumers and the public at large take “ownership” of the Health Strategy for 2001 and beyond.

REVIEW OF THE 1994 HEALTH STRATEGY TARGETS AND OBJECTIVES

The Four-Year Action Plan presented by *Shaping a healthier future* incorporates in excess of 200 targets over 17 different areas. This Action Plan was very innovative for the period and constituted a first attempt at incorporating some sort of performance monitoring process within a health system which had traditionally been more accustomed to crisis management. While a number of issues arise in the assessment of this plan, we must not lose sight of the fact that the specification of a range of targets which the health system made a commitment to achieving within specified time limits represented an enormous advancement for planning and policy development over this period.

Assessment of the Four-Year Action Plan 1994-1997

From the review undertaken for this study it is clear that there has been substantial advancement towards the achievement of the majority of the targets proposed by the 1994 Health Strategy. In assessing the fate of the 1994-1997 Action Plan, a number of issues arise:

- There is substantial variation in the scope, range and specificity of the targets presented for the different areas. It is understood that at the time of development, there was no attempt to apply any type of standardisation framework to the development of these targets, probably in part due to the very tight time schedule prevailing. The result is that while those proposing targets in some service areas chose to use the opportunity afforded by the Action Plan to put together a challenging package of targets and objectives, others were less ambitious and chose “safer” options which were probably on course for achievement anyway. The absence of a standardisation framework also makes it difficult to quantify the success rate within and between areas.
- The 1994-1997 Action Plan is a very “flat” document, i.e. there is no ranking of priority targets either within or between areas. The resource implications were also generally not addressed. It seems reasonable to assume that all targets would not have equal value. It therefore seems important that there should be a means of applying some type of priority ranking, particularly where choices have to be made regarding resource investment. The approach to this ranking must be transparent

and reflect agreed priorities for development within the individual service area and health policy in general.

- Ideally, the presentation of any target would incorporate the means of achievement, the centre(s) of responsibility and the information for assessment. From the information presented in this report, it is evident that there are substantial gaps in the data available to assess progress towards the achievement of particular targets. Even where information is available and targets have not been achieved as proposed, it may not be clear where difficulties have arisen, for example, has the implementation process failed or has the policy changed? It is also preferable that the monitoring of progress towards the achievement of such targets should be part of an ongoing performance assessment process rather than a once off exercise undertaken every few years. Where assessment is ongoing, steps can be taken to correct the implementation approach, adjust the policy or fill the information gaps as required at an earlier and potentially more useful stage of the process.
- It is important that any "Action Plan" is time bound. It is also important, however, that there is some flexibility built into any plan to enable revision, reorganisation or reprioritisation if required by some unexpected event or development. In the health system, particularly, the unexpected is more the norm which poses substantial challenges for the planning process and the implementation of any type of performance management approach. A balance must be sought, however, between the specification of goals and objectives which are important to ensure there is direction and achievement and the flexibility necessary to ensure that the unexpected is also addressed. It would be important, therefore, to ensure that an update or revision mechanism is incorporated into any plan to ensure that the proposed targets and objectives are consistent with current priorities for health system development.

Future "Action Plan" Development

The development and implementation of the 1994-1997 Action Plan represents a most valuable source of experience which may very usefully inform the development of the 2001 Health Strategy. Irrespective of the overall framework for this Strategy, it is reasonable to expect that some type of target setting exercise will be incorporated into this process. It is evident from recent policy documents published by the Department of Health and Children that while target setting may be more or less specific, depending on the area, it is nevertheless considered important to advance policy beyond the aspirational to a more goal oriented approach if performance and implementation are to be improved. In current policy development, target setting tends to follow the SMART approach (i.e. targets should be Specific, Measurable, Achievable, Realistic, Time bound) and this would clearly be expected to be a course given serious attention by the 2001 Strategy development team. Given the experience of the 1994-1997 Action Plan, however, there are some important findings which might usefully be taken into consideration in the development of the 2001 Health Strategy including the following:

- The development of a **standardisation framework** which could be applied to the rating of targets/objectives within and between topic areas.
- The application of a **priority ranking** to proposed targets/objectives would ensure that all parties to the system have a common understanding of the level of importance attached to a particular issue, especially where choices have to be made in terms of resource investment or policy development. It would be reasonable to expect that this ranking could be reassessed periodically to ensure that the process of prioritisation is consistent with current needs and developments within the health services.
- While recognising that it is difficult to achieve and may not always be possible to achieve, it is nevertheless important that the **resource consequences** of the proposed targets/objectives are assessed at some level. This assessment does not necessarily have to be in monetary terms, which continues to be an ongoing challenge for the health system, but should address the resources most relevant to

the issue of interest. For example, for many service areas currently, shortages of skilled personnel are posing huge difficulties so, where commitments are being proposed which have staffing implications, then this is an important resource consequence which needs to be addressed.

- The **centre of responsibility** for the achievement of proposed targets/objectives needs to be clearly identified. This is particularly important where proposals are being made involving Health Boards or other agencies to ensure that those with key responsibility share the same level of commitment.
- The **means of achieving/delivering on proposed targets/objectives** also need to be addressed. For example, will new legislation be required, or changes in work practices and approaches to service provision? If targets are developed independently of any consideration of how they are going to be achieved, feasibility may become questionable which, in turn, raises issues regarding credibility.
- The **way in which the achievement of targets/objectives is to be assessed/monitored/evaluated**, the **necessary information base** and the **time period** for assessment/achievement/evaluation need to be clearly addressed. It is not useful to present targets that cannot be assessed because there is no expectation that the required information will become available within the specified time period. Any target specification exercise carries with it associated responsibility for ensuring that the information required to monitor implementation is available in the required format over the proposed time period.
- One of the most difficult challenges faced in any target specification process is ensuring that the targets conform with the SMART objectives while at the same time retaining a level of **flexibility** which may be required to respond to unexpected events. While it is necessary to attempt to plan and anticipate the priority issues for health system development over the next few years, it is probable that the prevailing consensus on this priority ranking will vary considerably over this time frame. It is therefore important to attempt to combine stability with flexibility and responsiveness. Flexibility may therefore need to be applied both to the specification and ranking of targets and objectives. It would also be important to ensure that where new and unexpected developments arise, the facility to add/delete from the ranking of targets/objectives is retained.

Conclusion

In conclusion, it is worth noting the view of one commentator whose hope for the 2001 Health Strategy was that it would represent a "vision of one health service for all" rather than the 10 health services which are considered to currently operate through the Health Board system. This fragmentation may also be seen to be manifested in the perception that experience of health and the health services may be influenced by a wide range of factors including income, geographical location, age, ethnicity, insurance status etc. There is no doubting the enormity of the challenge faced in attempting to draw together the huge diversity prevailing in the wide range of needs and demands for better health and improved health and personal social services within a broadly-based coherent development plan. Clarification of the key features of the process considered essential to the advancement of this plan seems like a good place to start.

The Four-Year Action Plan proposed in *Shaping a healthier future* undoubtedly provided an essential reference point for the development of the health services since the mid-1990s. As such, this plan may be credited with providing an anchor for the health system while ensuring that focus was maintained on those objectives considered key to developments over this period. Because of substantial diversity within this system, it is important that all sectors can progress with reference to an integrated agenda which, since 1994, has been provided by *Shaping a healthier future*. Notwithstanding the diversity in range and scope, available evidence indicates that substantial progress has been made towards the achievement of the targets proposed in the Four-Year Action Plan. While recognising that this agenda is far from complete and that deficiencies remain to be addressed, it must also be acknowledged that the achievements over the period are commendable.

There is no doubt that the scope and scale of the contemporary health system, together with the increasingly rapid pace of development, will pose enormous challenges for any attempt to specify a planning exercise over a multi-annual period in the 2001 Health Strategy. It is readily recognised that this is, however, an important process in order to provide focus to the development of the health system, to ensure transparency of policy objectives and facilitate the application of accountability to the appropriate centres of responsibility. The involvement of the key constituencies within the health system in the development of the Health Strategy for the new millennium is therefore essential if those with front-line responsibility are to take ownership of the proposals advanced as this will be an essential pre-condition for successful implementation, together with the achievement of the strategic objectives.

PART I:

HEALTH STRATEGY DEVELOPMENT PROCESS

MIRIAM M. WILEY

1. INTRODUCTION

The **Critique of *Shaping a healthier future,* A strategy for effective healthcare in the 1990s** presented in this report was commissioned by the Department of Health and Children in late 2000. This study was proposed with the following objectives:

- To review the objectives and targets set out in the 1994 Health Strategy *Shaping a healthier future* and evaluate the extent to which they have been achieved.
- To offer an assessment which will provide lessons for the development of the new strategy in 2001, largely in terms of assessing the strengths and weaknesses of the approaches adopted in *Shaping a healthier future*.

The commission awarded to The Economic and Social Research Institute (ESRI) was based on a proposal to undertake this project in two stages. The first stage of the study which is presented as Part I of this report, incorporates an assessment of a range of issues including:

- The appropriateness/success/deficiencies of the process applied to the development of *Shaping a healthier future*;
- The adequacy/achievements of the resulting Health Strategy;
- The priorities for a renewed process concerned with the development of a new Health Strategy.

The second stage of the study which is presented as Part II of this report includes the:

- Specification of the Health Strategy targets and objectives; and the
- Assessment of the 1994 Health Strategy targets and objectives against available evidence.

Scope and Content of Part I

Given the broad scope and very limited time constraints proposed for this report, the tools and sources that could be applied were also limited. The importance placed on the documentation of the process undergone in the development of the 1994 Health Strategy meant that a lot of this material could only be compiled in discussions with individuals directly involved with the development of this Strategy at that time. Given the prior experience of Strategy formulation, these discussions also covered priorities in the approach and content considered important for the development of the 2001 Strategy. In addition, it was considered essential to consult with a wide range of individuals both within and outside of the Department of Health and Children and organisational representatives regarding their views on the process, content and implementation of the 1994 Strategy, together with their expectations for the development of the 2001 Strategy.

We have been very fortunate that all of the people we sought to interview for this study were very generous with their time and provided us with essential information which has facilitated an enhanced understanding of the process applied to the development of the 1994 Strategy and priorities for the process and content which may be applied for the development of the 2001 Strategy. Over 30 individuals were consulted and these are listed for information in Appendix A. It is important to stress, however, that the views expressed in this report are those of the authors and cannot be credited to these or any other individuals.

A range of documentary material has also been consulted in the course of this study. The references attached list the literature consulted. In addition, the files available in the Department of Health and Children were also provided for consultation and these are listed in Appendix B. It should be recognised, however, that while every effort has been made to ensure that materials and individuals essential to the production of this report have been consulted, the time constraints did not allow an exhaustive literature search or a comprehensive consultation process. What is therefore presented here is our best estimate of the priority issues arising from the development of the 1994 Strategy which may be considered to have relevance to the production of the 2001 Strategy. Chapter II which follows presents an assessment of the process, content and implementation of the 1994 Health Strategy *Shaping a healthier future* and Chapter III compiles available information on recommended approaches and priorities for application to the process of developing the 2001 Strategy. An assessment of socio-economic inequalities and the implications for health strategy development is presented in Chapter IV by Dr. Richard Layte and Professor Brian Nolan. The conclusions and recommendations are summarised in the final Chapter V.

Scope and Content of Part II

Over 200 targets across seventeen areas are proposed in the Four-Year Action Plan 1994-1997 incorporated in *Shaping a healthier future*. Available and accessible information has been complied here to facilitate an assessment of progress towards the achievement of these targets since the launch of the 1994 Health Strategy. There is substantial difference between the seventeen areas identified in the action plan in the nature and range of targets and objectives proposed. Given such a wide range of variation, the evidence that may be used to assess the level of achievement in any or all areas also varies. What information is available and accessible has been used as a basis for the assessment included in Part II of this report. It must be acknowledged that the compilation of this assessment depended very heavily on information provided by the Department of Health and Children, partly because of the very broad scope and the limited time available, but also because of the access provided to substantial information sources. It must be recognised, however, that there remain serious gaps in the information available or provided to undertake a comprehensive assessment. As the range, number and specificity of targets and objectives varies considerably by area, so too the available information varies in terms of relevance, scope and specificity. Even where quantified targets were proposed, the availability of the information required to assess the level of achievement is in many cases not available. Less specific targets are, of course, by their nature very difficult to assess, even when drawing on a range of information sources.

Given available information, this report documents the process pursued in the development of the 1994 Health Strategy together with advancements towards the achievement of the targets incorporated in the Four-Year Action Plan proposed in *Shaping a healthier future*. Factors emerging from this review which might usefully inform the development of a new Health Strategy in 2001 are also explored. The time available for this study has, unfortunately been very constrained so the scope has had to be limited accordingly. It would have to be readily acknowledged, however, that given the necessary resources, any attempt at a comprehensive and scientific evaluation of the process applied to the development *of Shaping a healthier future* and the achievements of the Four-Year Action Plan would have to go further and, in particular, address the experience and perceptions of client groups, service providers and other relevant constituencies.

2. *SHAPING A HEALTHIER FUTURE*: A STRATEGY FOR EFFECTIVE HEALTHCARE IN THE 1990S: A REVIEW OF PROCESS, CONTENT AND IMPLEMENTATION

Introduction

In the early 1990s the Irish health system was still very much in a *maintenance* phase following the constraint and curtailment which characterised the system throughout the public expenditure crises of the 1980s. By the time Mr Brendan Howlin T.D. was appointed Minister for Health in 1993 there was an emerging view in the Department of Health that it would be necessary to clarify an agenda for health service *development* if the system was to be brought forward from the difficulties of the previous decade. On entering office, the Minister for Health and his political adviser Dr. Tim Collins placed a high priority on the production and publication of a strategy which would be used to shape health service development in subsequent years. In mid-1993 a confluence of opinion therefore emerged whereby the political and civil service leadership within the Department of Health shared the view that a clear statement of strategy was an essential starting point for the specification of a broad agenda for health service development through the 1990s.

Outline of the Health Strategy *Shaping a healthier future*

The 1994 Health Strategy is divided into two distinct parts:

- Chapters 1-5 (the "white" pages) are concerned with the health system framework, policy issues and approach to strategic development;
- The Four-Year Action Plan 1994-1997 (the "blue" pages) where the specific targets and objectives for each service area are presented.

This two pronged approach to Strategy presentation facilitated clarity by ensuring that the essence of the proposals for strategic development was clearly differentiated from the specifics of the Action Plan. While recognising that the document needed to advance beyond the inspirational to the specific, the integration of strategy with targets could potentially be confusing for the reader. The presentation of strategy and targets in two different parts of the one document fulfilled the objective of concretising the strategic aims of the process while at the same time ensuring that the detail did not cloud the overall vision being proposed. To facilitate an appreciation for the main areas covered in the 1994 Health Strategy document, the structure of the report is summarised in Box 1.

Box 1
Structure of the 1994 Health Strategy *Shaping a healthier future*

Chapter One

Starting Points (p.7-12)
Overview of system together with exploration of underlying principles.

Chapter Two

The Services (p.15-27)
Concepts guiding service development outlined; three main causes of premature mortality targeted for action.

Chapter Three

The Framework (p.29-37)
Underlying organisational structures reviewed and reconsidered.

Chapter Four

The Participants (p.39-41)
User satisfaction and human resource issues considered.

Chapter Five

The Next Steps (p.43-45)
Proposals for implementation and consultation on the strategy.

Four-Year Action Plan 1994-1997 (p.47-75)
Introduction
Health Promotion
General practitioner services
Dental services
Women's health
Family planning
Children's health
Childcare and family support services
Travellers' health
Addressing drug misuse
Food and medicine control
Acute hospital services
HIV/AIDS patients
Ill and dependent elderly
Palliative care
People with mental illness
People with mental handicap
People with physical or sensory handicap
The Wider Dimension

Shaping a healthier future: Health Strategy Development Process

When the decision to develop a Health Strategy was made by the Department of Health in 1993, the Secretary of the Department put together a very small team of Department officials to undertake the development of this strategy. It was made clear from the outset that the Management Advisory Committee (MAC) would be directly involved through all stages of the process. The Minister and his adviser were also committed to direct involvement in this process. What would seem to have emerged therefore was a very productive collaboration between the office of the Minister and the Secretary within the Department. All those consulted were consistent in their view that the Minister's political adviser (Dr. Tim Collins) played a particularly important role in facilitating consensus in the views and objectives forthcoming from different perspectives within the Department and the wider political system.

When the decision was taken to proceed with the development of a Health Strategy, a very short time frame was envisaged. When the process began in earnest in late 1993, it is estimated that the document took approximately 6-9 months to finalise. Given such a short time frame, it was therefore not envisaged that any extensive consultation process would be undertaken; rather, a top-down approach to strategy development from within the Department of Health was adopted. It is interesting that the direct precedent of the 1994 Health Strategy, **Health – The Wider Dimensions** which was published in 1986 was also produced by an internal Department of Health team with very limited external consultation. To provide some background to the decision to proceed with the development of the 1994 Health Strategy as primarily an internal Department of Health undertaking, a number of factors regarding the context in which this decision was made are worth noting:

- The 1994 Health Strategy was considered an innovative undertaking for a government department at the time as it pre-dated such initiatives as the Strategic Management Initiative (SMI) and the production of similar strategy statements by other government departments which have subsequently become more commonplace;
- The culture of consultation and partnership which currently prevails for public service initiatives can be traced back to the mid-late 1990s' with the implementation of the SMI and successive programmes for government; these initiatives generally post-dated the 1994 Health Strategy;
- Prior to 1993-94 a number of very important policy documents had been published by the Department of Health relating to, for example, the general medical services, the psychiatric services, the elderly and the Commission on Health Funding. In each case, an extensive consultation process had been undertaken. The Report of the Commission on Health Funding in 1989, in particular, involved an extensive review of the structure and functioning of the health system with all parties to the process represented. The 1994 Health Strategy was therefore considered an opportunity to build on the consultation process that had been undertaken in each of these sectoral areas and integrate the views and priorities for development of the health services at the national level.

It is important to note, however, that while a formal consultation process was not launched in preparation for the development of the 1994 Health Strategy, there was substantial informal contact with a number of groups, chiefly the Health Board Chief Executive Officers. While there were a number of plenary meetings involving the CEOs during which draft proposals for the Strategy were discussed, there was also very regular contact with two of the Health Board CEOs who were considered to be representative of the group. This ensured that in addition to providing an opportunity for input to the Strategy, albeit at an informal level, the CEOs were also being given an opportunity to assess proposals prior to the finalisation of the document. In this way the support of the CEOs, which would be crucial to the success of any Strategy, was ensured.

It would also seem that there was informal contact between Department of Health officials and a number of other key groups with regard to some of the proposals being put forward in the document. The discussions with any of the groups representing health service providers, in particular, for the purpose of this report did not generate any substantial criticism of this approach as they seem to hold the view that the final vision portrayed was reasonably representative of the issues and proposals which had been the substance of discussions with the Department over this time period. Where informal consultation was required and pursued, this ensured that the final package would not meet resistance from any of the sources essential to the advancement of the Strategy when finally launched.

It would seem that the involvement of external expertise was limited to a number of meetings with a small number of British and Welsh experts. A similar exercise in strategy development had been undertaken in Wales around the same time so a number of meetings were held with experts who had been involved through the Welsh Health Planning Office and reports suggest that these sources were very helpful. The World Health Organisation's (WHO) *Health for All* initiative was, of course, being actively pursued over this period and was an obvious reference point for the development of any health strategy at the national level.

It is interesting to note that internal consultation within the Department of Health was also very limited. While Units were asked to outline targets and objectives for inclusion in the Four-Year Action Plan, the detailed discussions on the policy end of the document were generally limited to the MAC and the small team directly involved in Strategy preparation. It seems, however, that there were a number of meetings of the Principal Officers Forum during which different versions of the document were presented for information.

A number of plenary meetings incorporating all involved with the Strategy development including the MAC and the Minster for Health and his adviser provided opportunities for a very thorough examination of the proposals from a range of perspectives as they were being developed. The information available suggests that the Minister was committed to substantial involvement with the production of this Strategy which meant that the political acceptability was addressed throughout the development process. The direct involvement of the Minister, the MAC and the CEOs, at a more informal level, throughout the Strategy development process ensured that those with administrative, executive and political responsibility for putting the proposals in place were all committed to the final package when *Shaping a healthier future* was eventually published.

The launch of *Shaping a healthier future* in April 1994 was accompanied by one of the most sophisticated and successful communications campaigns undertaken by the Department of Health up to that time. With the publication of this Strategy, an explicit decision had been taken that a so called "cascading" approach would be adopted to dissemination whereby the information would be relayed through all sectors of the health system. The publicity material which accompanied the core Strategy document, including a concise summary and a video, were professionally produced to a high standard. On the day of the launch, senior Department of Health officials met with key groups from the health services to present an outline of the Strategy. In the weeks which followed, officials from the Department and the Health Boards met with groups throughout the health system to ensure that the essential messages of the Strategy were relayed in some sort of standardised manner. It is interesting in speaking with individuals who were involved in any capacity in these presentations as they can recall the experience very immediately which would suggest some effectiveness for this technique. This substantial investment in a professional and extensive communications process ensured that health service staff at all levels felt valued because of the effort taken to inform them of this Strategy and they, in turn, took ownership of the Health Strategy as presented.

Shaping a healthier future: Health Strategy Content

In the opening chapter of *Shaping a healthier future*, it is proposed that "the main theme of the Health Strategy is the reorientation of the system towards improving the effectiveness of the health and personal social services by reshaping the way that services are planned and delivered" (Department of Health, 1994, p.9). To achieve this objective, it was proposed that the Health Strategy would be underpinned by a number of key principles: **equity**, **quality of service** and **accountability**.

In recognising that "achieving equity in the healthcare system will involve not only ensuring fairness, but also being seen to be fair" (p.10), the Strategy proposes that the achievement of greater equity will involve:

- Implementing uniform rules for eligibility and charges for services across the country.
- Measures to reduce waiting-times for those availing of public services.
- Giving special attention to certain disadvantaged groups.

In proposing that "the services must meet the highest possible quality standards within the resources that are available" (p.11), the Strategy recognised two dimensions to this process. Firstly, the technical quality of the service must be ensured and secondly, the importance of the consumer's perception of the quality of the service must be readily acknowledged.

The specification of the principle of accountability took account of a number of dimensions which could be inter-related. Adequate and appropriate arrangements to ensure legal and financial accountability are essential elements of any health system. In addition, the issue of clinical accountability which is specific to the health system requires that the decision makers and service providers are accountable to their clients.

A general conclusion that may be drawn from the consultations undertaken for the production of this report would suggest that the health system still has a considerable way to go in the advancement of these principles. With specific reference to **equity**, while recognising that progress has been made in the clarification of some eligibility issues, the majority view forthcoming was that equity probably constitutes the most challenging issue currently for the Irish health system. This would apply to equity in the broadest sense, incorporating equity of access, equity of experience and specifically geographical equity. While the waiting lists have become the most concrete manifestation of equity problems in the health services, the growing belief that patients with health insurance have a fast track option which is unrelated to medical need is cause for ever increasing concern about the fate of public patients in need to medical care, whether of an urgent or elective nature. A more comprehensive discussion of the fundamental issues arising with regard to socio-economic inequalities in health specifically is presented by Layte and Nolan in Section IV.

It is acknowledged that following the publication of the 1994 Health Strategy the awareness of the importance of "the pursuit of excellence" has occupied a more central function within the health system, particularly with regard to service delivery. The very limited progress towards the implementation of any standardised measures or controls at the system level is, however, readily acknowledged. While there have been innovations at the individual practitioner, specialist or institutional level, a comprehensive and integrated approach to quality assessment, monitoring and enforcement has not yet been developed within the health system. While acknowledging the production of the Patient's Charter, the failure to implement any type of system-wide approach concerned with the consumers perceptions of quality issues and responsiveness to consumer concerns about quality must be recognised and addressed.

The substantial progress made in the improvement of financial accountability within the health system was generally welcomed by the individuals and groups consulted. In particular, the Health Amendment legislation (1996) is considered a particularly powerful instrument of enforcement of improved accountability. There was also, however, a general consensus that progress towards the application of clinical accountability, in particular, was almost non-existent. While there may be isolated examples of some innovations in particular specialities or departments, and the recently established Quality Forum is to be welcomed, the lack of any system-level advancement in applications in this area is considered particularly problematic.

Shaping a healthier future places considerable emphasis on the proposal that "the concepts of **health gain** and **social gain**, allied to greatly improved data collection and analysis, will be used to focus the prevention, treatment and care services more clearly on improvements in health status or the quality of life" (p.16). It is interesting that while commentators generally seemed to welcome this proposal, they tended to view the use of these concepts as more "philosophical than operational". While any attempt to define, measure and apply the concepts of health and social gain in quantitative terms will inevitably cause considerable difficulties, the more "ideological" interpretation seemed to be quite successfully portrayed through the communications strategy accompanying the 1994 Strategy. As a result, the adoption of these concepts as "guiding lights" for health system development was broadly welcomed by those working in the health services, as well as the consumers.

It is particularly interesting that many commentators expressed the view that the concept of "social gain" has been particularly helpful is assisting developments in such areas as continuing care and the development of services for the intellectually disabled because it provided a reference point against which advancements could be proposed and supported. It is certainly the case that the major areas of development within the health system since 1994, whether at regional or national level, have been framed within the concepts of health and social gain. While acknowledging the general view that the adoption of these concepts has provided a positive "philosophical" platform for health system development, the difficulties with specification of the concepts and, consequently, problems with measuring progress towards achievement must also be recognised. Against this background, the application of any type of performance measurement techniques would therefore be hugely problematic.

The 1994 Health Strategy adopted a disease-based approach by prioritising the three foremost causes of premature mortality, i.e. **cardiovascular disease**, **cancer** and **accidents**. For cardiovascular disease and cancer, specific strategies have now been produced by the Department of Health and Children and constitute the basis for policy making and service provision with regard to prevention, diagnosis and treatment. The level of accidental death continues to pose enormous problems not just for the health services but for Irish society. It is generally recognised that any improvement in this area will require a renewed commitment to inter-sectoral Cupertino if risk reduction is to be achieved.

Shaping a healthier future: Health Strategy Implementation

The issue of implementation is addressed in the most limited fashion in the 1994 Strategy and essentially involves noting the development of the Four-Year Action Plan, targets and objectives which "must now be translated into more detailed targets and programmes at national and at regional level and, where appropriate, beyond" (p44). The approach adopted by the Strategy was to invite consultation following publication. It was then expected that each Health Board would develop a detailed plan outlining proposals to implement the Strategy within the region of responsibility. While Health Boards did furnish plans for the implementation of the Strategy, the extent to which these plans provided the basis for ongoing evaluation of progress implementation is open to question.

What is generally recognised and welcomed by the relevant commentators, however, is the practice of preparing business plans and service plans which has been successfully implemented both within the Department of Health and Children and throughout the Health Boards and health service agencies. It has been suggested that these plans provide very valuable tools for monitoring progress towards the implementation of policy objectives at the national and regional level.

It must be recognised, however, that a widely held view forthcoming from many of those consulted for this study was that the absence of any detailed plans for implementation, monitoring and evaluation was a weakness of the 1994 Strategy. In reporting this opinion, it is also important to note that the development of the 1994 Strategy was based on the understanding that these functions were appropriate to the Health Boards charged with implementation and that any attempt to tie these authorities into such a rigid planning framework would have been inappropriate. While respecting the autonomy of the Health Boards, it does, however, seem reasonable to assume that the presentation of a sectoral level strategy would address the challenges of implementation, monitoring and evaluation at a more advanced level. An additional barrier to the development of these initiatives arises due to the inadequacies of the information and management systems currently prevailing in the health system. While the importance of substantial development in these areas was clearly recognised as being important to the achievement of the targets and objectives put forward in *Shaping a healthier future*, the level of development to date is generally considered to fall far short of what is required for the application of the tools and techniques necessary for the implementation of effective monitoring and evaluation initiatives.

Conclusion

The 1994 Health Strategy was the first of its kind and represented a novel and unique initiative aimed at setting a broadly based agenda for the development of the Irish health system over a defined time period. The resulting Strategy was testimony to the successful collaboration between the political and civil service leadership in the Department of Health and the small but highly skilled team with responsibility for crafting the final document. *Shaping a healthier future* was generally welcomed throughout the health system which was a considerable achievement in an environment still suffering from the cutbacks and constraint of the previous decade. Commentators were generally of the view that the 1994 Strategy has stood the test of time well and provided a useful and constructive platform for much of the development within the health services since the mid-1990s.

With regard to the process applied to the development of the 1994 Health Strategy, a number of factors contributing to a successful outcome were identified including:

- Full commitment from the Minister, the Secretary and the MAC, and the CEOs.
- A small core group of Department officials had responsibility for drawing up the Strategy with full involvement of the MAC and "hands on" involvement from the Minister and his adviser.
- Internal and external consultation was limited but informal consultation pursued with key groups of decisions makers as required.
- Clearly defined and limited time frame.
- Extensive and effective communications strategy accompanied Strategy launch facilitating broadly based "ownership" of proposals and objectives.

While recognising the achievements of the 1994 Strategy, it would have to be considered more of a beginning than an end point. The decision to revisit this Strategy is therefore welcomed in the context of the ongoing rapid pace of development of the health services within an expanding economy and a growing and ageing population base. In looking towards the development of a new Health Strategy, commentators were therefore generally of the view that, far from considering the 1994 principles of equity, quality of care and accountability accomplished, it would be expected that these principles would continue to feature prominently in the 2001 Strategy which would also be expected to place greater emphasis on implementation, performance measurement, evaluation and delivery.

3. THE 2001 HEALTH STRATEGY: PRIORITIES FOR THE DEVELOPMENT PROCESS

"A new strategy must be flexible enough to adapt to [these] changes and to regularly renew itself to maintain it's relevance" (Fulop *et al.*, 2000).

The production of a Health Strategy which maps the development of a dynamic health system in the short to medium term towards the objective of improved population health while maintaining flexibility to respond to unexpected events is an enormously challenging objective. It is precisely because of the enormity of this challenge that the objectives and the scope of the proposed Strategy must be clearly specified from the outset. Our task here is not to present a blueprint for the 2001 Strategy but, rather, to identify issues arising in the review of the process of developing the 1994 Health Strategy which may be of some relevance to the current undertaking. Since the 1994 experience, the Department of Health and Children and the wider public service has generated enormous experience of strategy development and implementation. In fact, the recently published *National Childre's Strategy* by the Department of Health and Children is probably one of the foremost examples of effectiveness in terms of process and content with implementation now proceeding as planned. In this section, a brief overview of the context of strategy development will first be presented, followed by a review of the issues proposed for consideration in the specification of the scope and process of strategy development.

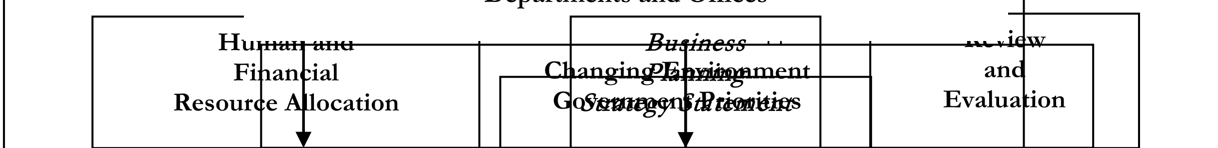
Context of Strategy Development

"[Strategy] statements on their own have limited value. They must be at the hub of a range of management activities, including business planning, performance management, budgetary planning and human resource strategy." (Boyle and Fleming, 2000 p. 94.)

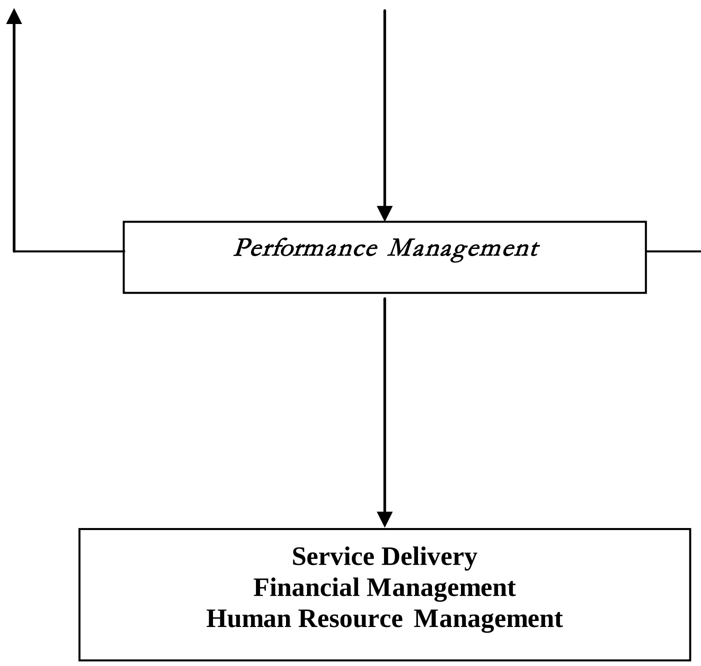
The broader context in which Strategy statements may be placed is summarised in Box 2 from Boyle and Fleming (2000). This presentation indicates clearly that while Strategy statements cannot be expected to address all aspects of policy development and implementation, it is essential that the necessary linkages are made to critical tasks including business planning, performance management, service delivery, financial and human resource management and review and evaluation procedures. The specific elements proposed for inclusion in a Strategy statement, regardless of the sector, are listed in Box 3. This specification notes the importance of developing the appropriate links between the critical tasks listed above, in addition to the exploration of the substantive and inter-sectoral issues relevant to the particular area.

BOX 2

The Central Role of Strategy Statements in the Management of Government Departments and Offices



Source: Boyle and Fleming (2000).



Box 3

Key elements for incorporation in strategy statements

1. Mission statement
2. Mandate and environmental analysis
3. Customer/client interests and needs
4. Identification and management of cross-departmental issues
5. Goals/high-level objectives
6. Critical success factors
7. Resource allocation/reallocation issues
8. Internal capability to realise the departmental goals
9. Embedding the strategic management process in departments, including the *business planning process* and *civil service change* programme
10. Cross-functional linkages within departments
11. Performance measures/indicators
12. Relations with agencies operating under the aegis of the department
13. Extending the SMI to the wider public service
14. Monitoring/reporting/corrective action

Source: Link*, 1998.*

Scope and Process

The decision regarding the *focus* of the 2001 Strategy is critical. The concept of health, in itself, can be broadened to touch most aspects of peoples lives – employment (of lack therefore), housing, income, leisure etc. An important question, therefore, is what boundaries, if any, to place around this concept.

The *points of reference* for this concept must also be chosen with great care. The Strategy might focus on the "health of the nation", the "health system", the "health services" or any number of combinations. It must be recognised that the scope of activities of the Department of Health and Children has expanded considerably, even since the publication of the 1994 Health Strategy. The change in the name of the Department, in itself, is indicative of this broadening of responsibilities. While there is increasing recognition of the inter-sectoral nature of responsibilities for specific population groups, for example children, and for specific issues, like food safety, the specific and exclusive responsibilities of individual Departments, including the Department of Health and Children, may change in response to changing needs and policy commitments.

The scope envisaged for the 2001 Health Strategy must be clearly specified at the commencement of the process of development to ensure that all involved are aware of the challenges and constraints and that the expectations of consumers, client groups and all health system participants will be realistic from the outset.

The experience of the 1994 Strategy and, in particular, the more recent and very positive experience of the National Children's Strategy would suggest a number of important factors to be addressed in the establishment of the Strategy development process. At the outset, it is essential that the **project management** framework is clearly specified. This will involve definition of the project objective, outline of the project plan, specification of project execution including the key participants and, finally, clarification of the time frame for project completion and delivery.

Given commitments to the ethos of partnership and consultation in the public service generally and the health services specifically, an open and inclusive **consultation process** will be an essential starting point for the development of the 2001 Strategy. The Minister for Health has announced that this consultative process will be undertaken in association with the National Partnership Forum. The Department of Health and Children has undertaken widespread consultation for many of the more recent Strategy statements and the experience of the National Children's

Strategy, in particular, would suggest that to be effective this process must be transparent, open, inclusive and very well managed.

A **small core team** of individuals committed to the task of Strategy preparation is essential. It is reasonable to expect that different groups/committees may have responsibility for different tasks, for example managing and conducting the consultative process would be one such task. It is, however, important that the small team of individuals responsible for actually producing the Strategy document are involved/familiar with all stages of the process. There is no doubt that this is very demanding on the individuals involved but it seems nevertheless essential to ensure that the key people maintain an understanding of the core vision, issues and priorities as they develop. It may also be worth noting that this team may include an external expert(s) as required but ongoing involvement throughout the process remains important.

Clarification of the overall **vision** for the Strategy at an early stage also seems to be a key determinant of success. It may be interesting to note one of the points made by a respondent interviewed for this study was that he was concerned for the development of the 2001 Strategy because he had been informed that the process was beginning from a "blank page". While it is important that participants feel they have an opportunity to impact on Strategy development, it also seems necessary to ensure that all involved feel they are working to a shared agenda. Even if the so called "vision" and the framework evolves with the process, it still seems necessary to establish an agreed starting point from which to move forward.

One of the most challenging tasks for Strategy development is the need to **balance the aspirational and the specific**. The 1994 Health Strategy addressed this need by clearly dividing the policy component from the Four-Year Action Plan which presented targets and objectives ranging in specificity for the different divisions within the health system. The National Children's Strategy adopted a slightly different approach by classifying objectives according to the main themes underlying the strategic vision. As discussed elsewhere (Section IV), it is important that where targets are proposed they are specific, measurable, achievable, realistic and time bound. It therefore seems important that in presenting a set of targets, they are clearly seen to fit with the overall strategic framework and that the range of resources required to ensure delivery, whether of a financial or other nature, can be secured.

A particular difficulty for the development of any Strategy is maintaining **adequate flexibility to ensure appropriate responsiveness to unexpected events**. Subsequent to the publication of the 1994 Strategy there have been many unexpected events which have posed considerable challenges for the health services including issues arising with regard to food safety, blood safety, child abuse, asylum seekers, clinical competence, manpower shortages, etc. A health system, by its very nature is a dynamic entity in a constant stage of change. Ensuring that this change is positive, directed and in the best interests of consumers and providers is the challenge presented to policy makers.

The integration of procedures for **monitoring and evaluation** of Strategy commitments is essential. All too often, the production of Strategy statements has been seen as an end in itself. If the public and the key stakeholders are to have confidence in the integrity and credibility of Strategic commitments, the framework for monitoring and evaluating progress towards achievement must be well developed.

The **communications programme** which accompanied the launch of the 1994 Strategy is almost universally regarded as having been very effective in relaying the "strategic vision" throughout all sectors of the health system and, most importantly, ensuring that these participants gained "ownership" of the targets and objectives proposed. In proceeding with this programme, it is interesting that the focus of attention was more internal to the health services, with the involvement of the Health Boards, though some effort was also made to broaden the scope to clients and consumers. More recent initiatives undertaken in association with, for example, the Women's Health Policy and the National Children's Strategy, have more clearly prioritised the inclusiveness of the relevant population groups for the consultative and communications programmes undertaken. For the development of the 2001 Health

Strategy and the launch of the final product, harnessing the immediacy and power of **state-of-the-art information technology** will undoubtedly be essential. Use of the internet and the world wide web will be a requirement, rather than an option, both for the consultative and communications programme put in place for the 2001 Health Strategy.

Conclusion

In conclusion, it is again important to stress that, in keeping with the terms of reference for this project, our focus here has been limited to the **process** of Strategy development, rather than the content. In addressing this task, the substantial prior experience of the Department of Health and Children, and the wider public service generally, provides an important and developing knowledge base for strategy development. This experience indicates clearly that the development of a strategy for any sector cannot be a stand alone undertaking but must be very explicitly linked into the critical tasks of service and business planning, performance management, service delivery, financial and human resource management and review and evaluation procedures if success is to be achieved.

The scope of the process for strategy development must be clearly specified at the outset to ensure that the expectations of all participants are realistic and that the skill mix of those involved is appropriate to the task. Given clarification of the scope of the undertaking, a definitive project management plan must be developed and agreed. This will ensure commitment of the relevant participants to delivery within agreed time lines. The development of the 2001 Health Strategy will involve a broadly based consultation process which, to be effective, needs to be open, inclusive, balanced and manageable. The involvement of a small core team throughout the Strategy development process is important to ensure that the evolution of vision, framework, priorities, targets and objectives are integrated cohesively within the final Strategy statement. It is also important that objectives are specified in an achievable manner and accompanied by appropriate monitoring and evaluation procedures if the target audience is to have confidence in the commitments of the Strategy. Providing for planned development, while at the same time ensuring adequate flexibility for responsiveness to unexpected events, is undoubtedly a challenge but nonetheless a requirement for the development of any Health Strategy. The level and pace of development in information technology poses challenges for ensuring that the integrity and intelligibility of information is maintained through all modes of transmission. Ensuring that the power of such transmission capabilities can be harnessed to transmit the core messages of a new Health Strategy in a positive way will, however, be an essential task for the communications programme which is now an inevitable rather than an optional component in any strategy development process.

The importance of addressing the issue of socio-economic inequalities in the context of a Health Strategy is explored in some detail in the next section by Layte and Nolan. In particular, potential areas of interface with the National Anti-Poverty Strategy (NAPS) is addressed.

4. THE HEALTH STRATEGY AND SOCIO-ECONOMIC INEQUALITIES IN HEALTH

RICHARD LAYTE AND BRIAN NOLAN

Introduction

Shaping a healthier future (Department of Health, 1994) has been successful in orientating health policy and denoting particular areas in need of attention and development. However, a rather limited role was given to socio-economic inequalities and the processes underlying these in the strategy document, and this area has been of growing concern both in Ireland and elsewhere. Health inequalities and designing policies towards reducing them will thus have much greater prominence in a new strategy, so this section highlights some central features of this complex but critical area.

In the first section here we describe the limited role given to inequalities in health in *Shaping a healthier future* and how this emerged. We also discuss the emergence of the National Anti-Poverty Strategy (NAPS, 1997) process as it relates to health and how this interfaces with current strategy developments in the Department of Health and Children.

We then turn in the second section to a brief overview of the evidence that currently exists in the Irish context and elsewhere on inequalities in health. This is intended to bring out the scale and importance of these inequalities, the multi-faceted nature of their causes, and the limited information available at present to understand these processes, design policies to tackle them, and monitor progress over time.

In the third section we draw out some of implications that aiming to reduce health inequalities would have for health targets and health policy, focusing in particular on the importance of inter-Departmental policy programmes and multi-sectoral approaches.

In the fourth section we turn to the actual process that should underlie the development of health targets in this area, and discuss the process emerging via the NAPS working groups on health. We argue in particular that there is an urgent need for a co-ordinated information system that delivers timely and accurate policy relevant information using indicators appropriate to the study of inequalities in health.

Health Policy and Inequalities

For decades health policy in Ireland, as in many other countries, has been based on the implicit presumption that the provision of more and better health care services was the most direct means of improving population health, and that the major causes of variations in health across the population were to be found in the distribution of health behaviours such as smoking, drug use, eating patterns and lack of physical exercise.

Such assumptions were built into the 1994 Health Strategy. Although inequalities were mentioned within the underlying principles of the strategy (p. 10), this was only in reference to the goal of equity in health care provision and the need to provide care on the basis of need rather than ability to pay or geographic region. Similarly, in discussing the causes of premature mortality (p. 19), the primary causes of all of the prime conditions were attributed to differential health behaviours. The health targets set out later in the strategy document are thus dominated by target levels of health behaviours to be achieved.

In fact, there is a great deal of research showing that health behaviours offer only a small part of the explanation for variation in mortality and morbidity across socio-economic groups and that, as we will go on to see, socio-economic circumstances should be given much more prominence. This emphasis on health behaviours is not by any means limited to Ireland, but it has been particularly strong here. Health promotion targeting health behaviours are obviously of considerable importance, but constitute only one element in the broader strategy required to effectively target health inequalities.

The goal of equity in access to health care is itself a distinct and important one, both for its own sake and as one way of combating health inequalities. However, it has also been interpreted to date in an unduly limited fashion, seen in practice in geographic terms as relating to resources and availability of services by region. This again is common elsewhere, but fails to adequately address the underlying concern that access to services be equitable across the income distribution or socio-economic groups. This equity objective also needs to be taken directly into account in the way targets and policies are framed.

Concerns over the extent of socio-economic inequalities in health have been receiving greater attention in Ireland, partly reflecting broader trends internationally but also the increased emphasis in domestic policy debate on combating poverty and social exclusion, as crystallised in the emergence of the National Anti-Poverty Strategy (NAPS). This culminated in a commitment under the new partnership agreement – the *Programme for Prosperity and Fairness* (PPF) (Department of the Taoiseach, 2000) – to develop health targets within the NAPS framework. The PPF itself includes the improvement of the health status of the population and the monitoring of socio-economic inequalities in health as two of its core objectives (p. 93). So far, three working groups have been established [within] the Institute of Public Health to examine:

- Equity of access to healthcare
- The impact of public policy on inequalities in health
- Existing health information deficiencies

These working groups are set to recommend specific health targets by June 2001 that, if adopted by the government, can be added to the next NAPS strategy document later this year.

The inclusion of health targets in the NAPS is not the only sign that inequalities in health are now seen as a central concern. The annual report of the Chief Medical Officer of the Department of Health and Children in 1999 stated that "(one) issue above all others is central to our understanding of the experience of our population's health and ill-health, namely the question of health inequality" (Department of Health and Children, 1999, p. 3). The report went on to say that:

> *The multi-dimensional nature of health and ill-health points inexorably to the fact that the solution to what presents as health problems lies in the wider community and that, while the health services have a part to play in our response to this issue, health service provision must be viewed as only one element within a broader context which recognizes the role of multiple influences and participants* (p4).

This changing emphasis has yet to be fully reflected in health policy in Ireland, but as the next section will argue should, as the Chief Medical Officer suggests, become a central focus in future.

The Importance of Socio-Economic Inequalities in Health

The previous section has detailed the increasing emphasis given to inequalities in health in recent years. In this section we briefly review some of the evidence about inequalities in health and the processes involved: this has major implications for the structure of health targets and health policy on which we will be concentrating in the next section.

Across industrialised countries, those who are disadvantaged in terms of income, education or occupational level also tend to be disadvantaged in terms of health status and length of life. Research across a range of countries has consistently shown that those at the bottom of the social class ladder have at least twice the risk of serious illness and premature death as those at the top. Moreover, between the top and the bottom health standards show a continuous social gradient, so those near the top of the ladder have more disease than those at the top, but less than those below them, a pattern repeated all the way down the scale. Research on this subject has been ongoing in a number of countries, but British evidence has been particularly influential internationally. The publication of the Black Report (Townsend and Davidson, 1982) was a watershed in highlighting both the persistence of socio-economic health inequalities and more recently, Sir Donald Acheson's Independent Inquiry into Inequalities in Health (Department of Health, 1998) reports the findings of a large number of studies and documents specific policy proposals (to which we return below).

Research in Ireland on inequalities in mortality rates has not been as extensive as in the UK, but analyses have been published based on matching the population in different socio-economic groups in the 1981 and 1991 census to the numbers of deaths for men around the same time (Nolan, 1990; O'Shea, 1997). As Table 1 illustrates, they show a clear class gradient with the unskilled manual group having about two and a half times the mortality rate of the professional group. Differences in the socio-economic groupings employed do not allow us to directly compare the results with those for other countries but the pattern looks broadly similar to that found in Britain and indeed in many other European Union countries. [1]

Table 1: Standardised Mortality Ratio by Socio-economic Group, Ireland, Men Aged 15-64 All Causes 1981 and 1991[2]

Social Class	SMR	
	1981	1991
Professional	65	53
Employers and Managers	62	63
Salaried Employees	71	68
Non-Manual Employees	105	86
Skilled Manual	91	85
Semi-Skilled Manual	117	111
Unskilled	163	139
Farmers	79	88
Farm Labourers	86	104
Unknown	174	268

Breaking down these mortality ratios by cause, Table 2 shows that the ratio of deaths between the professional and unskilled manual classes is not however uniform. Whereas malignant neoplasms are 10 per cent more likely among the unskilled manual than the professional group, this differential increases to 142 per cent more for respiratory and 193 per cent more for digestive disorders. Such patterns suggest that there are particular mechanisms that need to be addressed to decrease this inequality in mortality.

Table 2: Ratio Between SMRs for Professional and Unskilled Classes by Different Causes of Death 1991[3]

[1] Unfortunately female deaths are classified according to their own occupation where this is known, by that of their husband where not, or as full-time carers. Nonetheless, research in the UK has shown that similar differentials exist for women (Davey Smith, Blane, and Bartley 1994).
[2] Figures recalculated from Nolan (1990) and O'Shea (1997).
[3] Figures calculated from O'Shea (1997).

Cause of Death	Ratio Professional to Unskilled Manual
Diseases of the Circulatory System	1.28
Malignant Neoplasms	1.10
Injury or Poisoning	1.51
Respiratory	2.42
Digestive	2.93

Turning from mortality to morbidity, relatively little research has been carried out on socio-economic inequalities in morbidity in Ireland. Indeed, there are no nationally representative published statistics on the health status of the Irish population that can be used as benchmarks from which we can measure the success or failure of public health measures generally. There are a number of national registers related to particular conditions or types of disease such as the National Cancer Registry, but there are comparatively few nationally representative surveys which include health-related information.

Several national surveys carried out by the ESRI do contain some information on self-reported health status, and (Layte, 2000) for example used the 1994 ESRI survey to examine inequalities in the prevalence of chronic illness among men. Table 3 shows clearly that there is a distinct gradation in the rate of chronic illness among men with those at the top of the social class scale having rates of self-reported chronic illness almost one third lower than men from the unskilled manual class.

Table 3: Standardised Morbidity Ratio by EGP Social Class – Rate of Chronic Illness Among Men

Social Class	SMR
Professional and Managerial	53.84
Routine Non Manual	106.68
Self-Employed	106.72
Farmer	106.08
Skilled	113.71
Unskilled	142.58

This brief overview makes clear, even though evidence is limited, that pronounced and persistent inequalities in health exist in Ireland. What are the underlying causes and how can they best be tackled? As discussed in section one, health care services undoubtedly have an important role to play in improving population health and quality of life, but inequities in access to or utilisation of health care services are not the most important determinant of health inequalities. Instead, the social and economic conditions that affect whether people become ill are crucial.

The social gradient in health reflects material disadvantage and the effects of insecurity, anxiety and lack of social integration. Having few resources and assets, often combined with insecure employment and recurrent unemployment, leads to not only material deprivation in terms of poor housing and diet, but also higher levels of anxiety, resignation and fatalism and increased prevalence of coping behaviours such as smoking and drinking. The longer people live in stressful economic and social circumstances, the greater the physiological wear and tear and the less likely they are to enjoy a healthy old age. Even in employment, continuing anxiety and lack of control over one's work situation, particularly when accompanied by chronic insecurity and low self-esteem can have powerful effects on the health of the individual, their social networks and their family. Chronic stress affects the cardiovascular and immune systems and leads in the medium to long term to increased risk of depression, susceptibility to infection, diabetes, hypertension and harmful patterns of cholesterol and fats in the blood that are associated with heart attack and stroke.

Worryingly, evidence also shows that the foundations of adult health are laid in prenatal life and early childhood. Slow growth and a lack of emotional support during this period raise the lifetime risk of poor physical health and reduce physical, cognitive and emotional functioning in adulthood. Poor social and economic circumstances present the greatest threat to a child's growth. A mother's experience of low income, deprivation and chronic insecurity during pregnancy leads to reduced prenatal and infant development, which itself is associated with reduced cardiovascular, respiratory, kidney and pancreatic functioning in adulthood. Parental poverty also leads to higher levels of depression and mental exhaustion which impacts on child development through decreased stimulation of the child and weak emotional attachment. Poor mental, social and emotional development in childhood sets the child on a path of disruptive behaviour in school and low educational attainment and thence to an increased risk of unemployment, insecure work, low social status and poverty. In adulthood then, the health disadvantages of childhood are compounded by further disadvantages, and the disadvantages of one generation are passed on to the next.

This understanding of the scale and causes of health inequalities has major implications for the development of a new health strategy. Rather than seeing health policy as aimed solely at providing more/better health services and persuading individuals to adopt better health behaviours to reduce health inequalities, health policy will also have to aim to create the right *socio-economic structures* and *integrated communities* for health. The implications for the development of a new health strategy are taken up in the next section.

Socio-Economic Inequalities and the Structure of Health Targets

We have emphasised that the main causes of the social gradient in mortality and morbidity are not to be found in access to healthcare services or solely in differentials in health behaviours between social groups. Instead, to reduce health inequalities health policy needs to be seen as just one part of a coordinated policy response that crosses departmental boundaries. This means that any health strategy would of necessity involve innovation in policy formulation and delivery structures.

The National Anti-Poverty Strategy provides a current example where such innovation is being attempted. The institutional structures of the NAPS operate at a number of levels. At the political level, a cabinet sub-committee was established, chaired by the Taoiseach, including ministers from all departments whose briefs were relevant to tackling poverty, but with a key role taken by the Minister for Social, Community and Family Affairs. At the administrative level the NAPS Inter-Departmental Policy Committee was established, jointly chaired by the Department of the Taoiseach and the Department of Social, Community and Family Affairs and staffed by senior civil servants who were to be responsible for ensuring that the NAPS provisions relevant to their departments were implemented. In addition the Combat Poverty Agency and the National Economic and Social Forum were to be responsible for overseeing the evaluation and implementation of NAPS respectively. At the local and regional level it was envisaged that social inclusiveness and equality of opportunity would be fostered through a renewed system of local government. In particular, Community and Enterprise Groups would be responsible for developing plans, including local area action plans which would focus on social exclusion, which may involve the development of local anti-poverty strategies.

However, although the NAPS process has greatly improved the engagement of departments in issues related to poverty, a recent evaluation concluded that this process has not as yet resulted in a coordinated policy response for a number of reasons:[4]

- Insufficient involvement of key individuals, organisations and sectors
- Inadequate structure
- Inadequate resourcing of NAPS Unit and anti-poverty work in general
- Weak political backing
- Inadequate public awareness raising and education
- Lack of ongoing evaluation

If targets were introduced to reduce or eradicate inequalities in health, this would also require a cross-departmental structure not only to produce a coherent strategy, but also to have any chance of successful implementation. The role of the Department of Health and Children in this process would be substantial and quite different from that which it has performed to date. At present the Department's remit is the provision of

[4] See Johnston and O'Brien (2000) p. 42.

health care services and the promotion of healthy lifestyles, rather than the development of health- promoting socio-economic and community structures. A coherent health strategy aimed at reducing health inequalities would:

- Seek to develop an understanding in the health care professions and in society generally of the main determinants of health using evidence from the Irish context and more widely.
- "Take ownership" of responsibility for reducing socio-economic inequalities in health.
- Broaden the scope and availability of primary care services. Primary care services account for only a small proportion of health expenditure and are seriously underdeveloped. Instead, this would become a central element in promoting health and social gain by first investigating best practice and seeking to implement healthy work, community and social structures.
- Place the Department of Health and Children in a central role in organising a multi-sectoral strategy to reduce health inequalities.

In this context it is useful to briefly review two health strategies designed to influence socio-economic inequalities that have been developed elsewhere, namely by the UK and the World Health Organisation. Both programmes were informed by current research on inequalities in health and attempted to structure health targets and policies to influence these inequalities at a number of levels.

In 1998, the British Government published a report from the Independent Inquiry into Inequalities in Health chaired by Sir Donald Acheson (Department of Health, 1998), which laid out the extent of and causes of inequalities in the UK context. The report found wide inequalities in health among socio-economic, gender and ethnic groups and laid out 39 main recommendations to reduce inequalities. These included suggestions for changes in tax and benefit systems, the education system including pre-school education, housing and the environment, mobility, transport and pollution and a large number of recommendations aimed at mothers, children and families. The following are just a selection of the policies suggested:

- Establish mechanisms to monitor inequalities in health and evaluate the effectiveness of measures taken to reduce them.
- Recommend a high priority is given to policies aimed at improving health and reducing health inequalities in women of childbearing age, expectant mothers and young children.
- Up-rate benefits and pensions according to principles which protect, and where possible, improve the standard of living of those who depend on them and which narrow the gap between their standard of living and the average.
- Improve nutrition provided at school including provision of free dinners and fruit.
- Assess the impact of employment policies on health and inequalities in health.
- Increase availability of social housing for the less well-off and take into account social networks and access to goods and services.
- Develop a high quality, affordable and integrated public transport system.
- Provide affordable, high quality day care and pre-school education with extra resources for disadvantaged communities.

Also in 1998, the World Health Organisation, European Region adopted a strategy for the new century entitled "Health21" (WHO, 1998), based on the original "Health for All" principles launched in 1984 and revised in 1991. As the title suggests the new strategy had 21 items and placed emphasis on equity and national and local inter-sectoral collaboration. Examples of targets from the strategy include:

- The gap in life expectancy between socio-economic groups should be reduced by at least 25 per cent.
- The values for major indicators of morbidity, disability and mortality in groups across the socio-economic gradient should be equitably distributed.
- Socio-economic conditions that produce adverse health effects, notably differences in income, educational achievement and access to the labour market, should be substantially improved.
- The proportion of the population living in poverty should be greatly reduced.

- People having special needs as a result of their health, social or economic circumstances should be protected from exclusion and given easy access to appropriate care.

These provide concrete examples of both the nature and scope of the targets required in this particularly challenging area. It is not part of our brief to recommend specific targets best suited to the Irish context, but we will discuss in the next section criteria against which such targets should be assessed in the course of development.

The Targeting and Strategy Process

Developing a health strategy is a complex undertaking and there is no one best approach. However, a research literature (c.f. Van Herten and Gunning-Shepers, 2000) has examined at a general level what makes for an effective process of policy and strategy development, and abstracted some underlying principles. It is worth considering the process already in train for development of the health strategy and the health elements of the NAPS in this light.

First and foremost, policy should emerge after a period of research and discussion that examines in depth the patterns of the phenomena of interest and seeks to explain these patterns through systematic evaluation of evidence. This means carrying out independent and scientifically valid research that will form the basis of understanding. Social and economic policy relies upon accurate information and research to supply the "levers" needed for effective intervention. For example, the Independent Inquiry into Inequalities in Health in the UK spent a year assessing a wide range of evidence that was already available from a large number of research projects in the UK before coming to conclusions in its final report.

In contrast, the NAPS working party groups on health in progress at the time of writing will have barely six months to understand the nature of the processes at work using an extremely limited information base before developing targets for health. Similarly, the Department of Health and Children will be developing a new health strategy document for mid-2001, but again with a very limited research and information base and with a relationship to the NAPS process which is at present unclear. There is a fundamental weakness in the data available on health in Ireland at present, and the urgent need for research to inform policy and for data against which success in meeting targets can be monitored.

Setting concrete targets is the next stage in the process. These targets need to satisfy a number of criteria if they are to be effective. It is commonly accepted that targets should be:

- Specific
- Measurable
- Achievable
- Realistic
- Time bound

While these may appear obvious or innocuous at first sight, it is striking that the majority of the sub-targets currently adopted in the NAPS do not meet these criteria (see Nolan, 2000). Particularly given the paucity of baseline information, it will be difficult to develop specific and measurable targets in the area of health inequalities. The best approach to adopt at this stage would be a parallel process, which both sets specific and measurable targets in terms of outcomes on which baseline information is available, and seeks at the same time to significantly improve the range of data being gathered. Throughout the healthcare system a large quantity of data is collected that could be invaluable for use in research on health inequalities and monitoring progress. However, at present it is of little use in that context because the appropriate, or even minimal, socio-economic information is not obtained on individuals, for example when use of health services is recorded. As a priority, the health strategy should establish a consultation process to review current and future information needs. Minimum specifications for types of socio-economic data to be collected should be established so that more efficient use can be made of current information. Greater coordination in information systems should also be promoted, since much more could be achieved if databases were much more closely integrated.

To be effective, targets directed at tackling inequality must be accompanied by specific and detailed plans of action and implementation, again using the understanding distilled from the research base to develop the most appropriate means. Once again, the limitations of the current Irish knowledge base cannot be allowed to delay the development of concrete policy initiatives: it will be necessary to draw on what has been learned elsewhere about causal processes and effective policies, while at the same time seeking to improve the domestic knowledge base.

The next phase is the implementation of the strategy, which will as we have emphasised entail institutional innovation and a new role for the Department of Health and Children. Following implementation it is crucial that a monitoring process be established, and progress reviewed after a set period. The review can assess not only whether the targets have been achieved, but also whether they were appropriate at inception and possibly need to be revised. The review and monitoring process can also assess whether the initial understanding of the processes involved was correct and the implications this has for the strategy. Finally, the monitoring process would assess whether the means taken to achieve the targets was efficient and cost effective in a broad sense. In the light of all of these considerations targets and strategy can then be revised or confirmed.

Conclusions

The health strategy published in 1994 paid relatively little attention to socio-economic health inequalities, an area that has now come much more to the fore and will probably receive much greater prominence in a new health strategy for Ireland, as it has elsewhere. *Shaping a healthier future* also placed most of its emphasis on delivering more and better health services and on promoting healthy behaviours. Setting targets for equity in terms of access to and use of the health services, and designing funding and delivery systems that allow those targets to be attained, is indeed of central importance in its own right. However, while ensuring equity in access and promoting healthy living have important roles to play, tackling health inequalities effectively requires a much more broad-ranging approach and a new role for the Department of Health and Children.

While the evidence for Ireland is limited, it suffices to show that pronounced and persistent health inequalities exist here as in other industrialised countries. Health inequalities reflect underlying differences in socio-economic circumstances, and new institutional mechanisms will have to be found to allow the Department of Health and Children to lead a coordinated and coherent cross-departmental strategy aimed at reducing those inequalities.

Examples of the way such a strategy has been formulated elsewhere, discussed in this chapter, can be drawn on in focusing Ireland's new health strategy firmly on reducing health inequalities, but a great deal of new thinking also remains to be done. This is the case in terms of establishing baselines and targets, improving our understanding of processes, and designing structures that suit the domestic policy context and can be effective. The National Anti-Poverty Strategy, though itself still evolving towards greater effectiveness, offers some interesting examples of institutional innovation.

5. CONCLUSIONS AND RECOMMENDATIONS

As indicated in the introduction to this report, Part I of the study commissioned by the Department of Health and Children had a dual mandate incorporating, firstly, an assessment of the process applied to the development of the 1994 Health Strategy and, secondly, an exploration of how that assessment can inform the process being developed for the advancement of the 2001 Health Strategy. Part II of this study which follows is concerned with a review of the achievements of the Four-Year Action Plan 1994-1997 with particular reference to the accomplishments of the targets and objectives against available evidence. In this section we therefore begin with a review of the issues arising from the assessment of the process applied for the development of the 1994 Strategy and follow with a summary of the factors considered important to the development of the process of Health Strategy formulation in 2001.

Shaping a healthier future: Review of Strategy Development Process

The scope and content of *Shaping a healthier future* was summarised in Chapter I. Chapter II reviewed available information on the process of development, content and implementation of this Health Strategy. The publication of this Strategy was a significant innovation both for the Department of Health and the wider public service and was generally well received at the time. The majority of commentators would also suggest that this Strategy has "stood the test of time" reasonably well, though the announcement of the development of a "new" Health Strategy has also been broadly welcomed. While the specifics of the process applied to the development of the 1994 Health Strategy were discussed in some detail, the main advantages which might be seen to apply to this process may be summarised as follows:

- Effective collaboration between the political and civil service leadership to ensure the production of a comprehensive health strategy which was broadly welcomed throughout the health services and adopted by successive governments.
- A small, dedicated Department of Health team, working closely with the MAC, the Minister's office and selected key stakeholders ensured the completion of the Strategy document within a short time period of 6-9 months.
- Informal communication with key opinion formers within the health services facilitated broad acceptance of the final document.
- The consultative process undertaken in a number of strategic areas which preceded the development of the 1994 Health Strategy provided an important knowledge base in the absence of a formal consultative process.
- The two-pronged approach to the presentation of the Strategy document was particularly effective in ensuring that the essential elements of the policy proposals were clearly presented in the "white" pages while the specifics of the objectives and targets for achievement were included in the Four-Year Action Plan presented in the "blue" pages.
- General consensus that the communications strategy adopted for the dissemination of the Strategy framework and proposals throughout the health services was particularly effective. The so called "cascading" approach whereby information was relayed through successive layers within the system meant that all parties to the process felt included and assumed ownership of the Strategy. In addition, there was large scale distribution of document summaries, videos etc.

The fact that officials from the Department of Health and the Health Boards embarked on an extensive campaign to ensure that the information was relayed throughout all sectors seems to have been particularly well received.

The approach adopted to the development of the 1994 Health Strategy would have been considered the most feasible within the prevailing environment of the time. The success of the approach would also have to be acknowledged, given the production of a consensus Strategy which has guided health system development in the interim. Clearly, however, there is no perfect process which, by it's very nature, must be subject to adaptation with changing circumstances. In our discussions with a wide range of commentators, the following criticisms have been raised regarding the development of the 1994 Health Strategy:

- The problem most frequently noted by those interviewed regarding the 1994 Health Strategy was the absence of an explicit *monitoring* and *implementation* framework. While the Strategy adopted the view that these tasks were to be pursued at Health Board level, observers felt that the absence of a more indepth approach to these issues resulted in patchy, ad hoc and disparate efforts to implement different aspects of the Strategy which varied by Health Board and by sector. The absence of any monitoring procedures meant that deficiencies could not be pursued on a timely basis to ensure any effective standardisation of implementation nationally.
- While the concepts of health and social gain were broadly welcomed as worthwhile, the absence of specifics on measurement and application have led some commentators to conclude that these objectives were more aspirational and philosophical than operational in nature.
- Commentators were also generally of the view that far from considering the principles of equity, quality of care and accountability as having been accomplished since the publication of the 1994 Health Strategy, as much remains to be done towards their achievement it would be expected that these principles would feature prominently in the 2001 Strategy with greater emphasis on responsiveness, implementation, performance and delivery.
- There was a view put forward by some medical service providers, in particular, that the 1994 document was "more style than substance"; the absence of any detailed discussion of resource issues was put forward as support for this perspective.
- Lack of standardisation and variations in the specificity of the targets and objectives proposed for the Four-Year Action Plan was considered problematic and detracted from any attempted coherence within this plan. It has also been suggested by some commentators that in some areas the targets and objectives proposed would not have been considered particularly challenging for any health service or policy innovation.

The 2001 Health Strategy: Key Factors for the Development Process

The experience of the 1994 Health Strategy, combined with the considerable experience gained by the subsequent production of sectoral and population specific Strategies, now provides an important platform from which to embark on the development of the 2001 Health Strategy. Given this experience, combined with the views expressed by commentators in the course of the consultations undertaken for this study, a number of key factors emerge as being important to this development process, including the following:

- The scope of the process must be clearly specified at the outset.
- A project management plan needs to be developed and agreed.
- The consultation process needs to be open, transparent, balanced, manageable and effective.

- A small team of individuals committed to the development of the Strategy and involved throughout the process is critical.
- Clarity of vision is essential; it is important that all parties to the health system can identify with the strategic vision being proposed for health system development.
- Ensuring appropriate responsiveness to unplanned events demands an acceptable degree of flexibility for Strategy development and outcome.
- Targets and objectives must be appropriate and specified in an achievable manner.
- Adequate procedures for monitoring and evaluation are essential.
- An expansive and inclusive communications programme utilising the power of state-of-the-art technology is a prerequisite for ensuring that health system participants, consumers and the public at large take "ownership" of the Health Strategy for 2001 and beyond.

In conclusion, it is worth noting the view of one commentator whose hope for the 2001 Strategy was that it would represent a "vision of one health service for all" rather than the 10 health services which are considered to currently operate through the Health Board system. This fragmentation may also be seen to be manifested in the perception that experience of health and the health services may be influenced by a wide range of factors including income, geographical location, age, ethnicity, insurance status etc. There is no doubting the enormity of the challenge faced in attempting to draw together the huge diversity prevailing in the wide range of needs and demands for better health and improved health and personal social services within a broadly-based coherent development plan. While clarification of the key features of the process required in the advancement of this plan may only be the beginning, it seems like a good place to start.

PART II:

REVIEW OF 1994 HEALTH STRATEGY TARGETS AND OBJECTIVES

MIRIAM M. WILEY

PHILOMENA DOWLING

SECTION 1: INTRODUCTION

The Four-Year Action Plan 1994-1997 proposed in the 1994 Health Strategy *Shaping a healthier future* is the starting point for this part of the report. For the targets and objectives specified in this action plan, the available evidence is assembled here for the purpose of assessing achievements over the interim period.

As previously indicated, there is substantial variation in the range and specificity of the targets proposed and the information available for assessment. The application of any sort of consistent framework of analysis across the areas addressed did not therefore prove feasible. While this is regrettable, each area together with the available evidence is presented on it's own merits so assessments at the target or area level are generally possible.

The breath and scope of the Four-Year Action Plan proposed in *Shaping a healthier future* is commendable for the substantial goals proposed for the health service through the mid to late 1990s. These same characteristics however contribute to the difficulties in undertaking a comprehensive assessment of achievements of this plan in the absence of an ongoing programme of monitoring and evaluation. The inclusion of the Action Plan in the 1994 Health Strategy was however both an innovative and essential component of *Shaping a healthier future* and the information presented here indicates substantial progress towards achievement of the targets proposed.

SECTION 2: HEALTH PROMOTION

A base line survey of health related behaviours among adults (SLAN survey) and school going children (HBSC Survey) was carried out across the Republic of Ireland in 1998. The main aim of the survey was to produce reliable baseline data for a representative cross-section of the Irish population which will inform the Department of Health and Children's future policy and programme planning. Another aim was to establish a survey protocol which will enable lifestyle factors to be re-measured so that trends can be identified and changes monitored to assist national and regional setting of priorities in health promotion activities.

Smoking

TARGET:

- *To reduce the percentage of those who smoke by at least 1 percentage point per year so that more than 80 per cent of the population aged fifteen and over are non-smokers by the year 2000.*

To be achieved by:

- *Extending the environmental controls over tobacco, especially in the workplace.*

The Tobacco (Health Promotion and Protection) Regulations 1995, operative from the 1st January 1996, extended prohibitions and restrictions on smoking in public areas and facilities including public access areas in specific workplaces.

- *Reducing the allowable budgets for advertising of tobacco products and sponsorship of tobacco manufactures and distributors by five per cent per annum.*

Cuts of 5 per cent were made in the allowable advertising/sponsorship budgets of tobacco companies in the period 1996 to 1999. Allowable advertising and sponsorship budgets for tobacco companies for 2000 were 50 per cent of the 1999 figure and no expenditure on advertising and sponsorship other than limited retail and trade advertising was permitted after July 2000.

- *Continuing and intensifying multi-media anti-tobacco campaigns and health education campaigns.*

Tobacco Products (Control of Advertising, Sponsorship and Sales Promotion) (Amendment No. 2) Regulations 2000 prohibit and restrict publication or distribution of State newspapers, periodicals and magazines containing advertisements for tobacco products.

Anti-Smoking Initiatives

The Health Promotion Unit of the Department of Health and Children supports an extensive range of anti-smoking initiatives. The current anti-smoking campaign *Break the Habit for Good* emphasises the positive effect quitting smoking can have on the individual and was launched in December 1998. The campaign involves national and local initiatives which offer support for those people wishing to give up smoking. The campaign was developed in conjunction with the Irish Cancer Society and the Health Boards.

An additional element of this campaign has been developed to target the growing numbers of female teenagers who continue to take up smoking. While it is part of the *Break the Habit for Good* programme, it is a specific initiative designed with a special focus. The campaign concentrates on issues which are considered to be perceived as more immediately important to young women such as their physical attributes. The simple message of this campaign is that smokers are less attractive, and it uses a range of "anti-cosmetics" presented by a character called NICO, who highlights the negative effects smoking can have on physical appearance e.g. yellowed teeth and wrinkled skin. The NICO campaign uses TV, radio and outdoor advertising to highlight the unappealing aspects of smoking. The Health Promotion Unit also supported the Irish Masters Snooker Championship in March 2001 through the joint sponsorship of the venture in association with City West Hotel.

- *Introduction of government fiscal policies that take account of the need to discourage smoking.*

In the budget in December 1999 an increase of 50p was put on the price of a packet of twenty cigarettes as recommended in the *Strategy Report – Building Healthier Hearts*. This was the largest increase in tobacco taxes on cigarettes in the history of the state.

The Minister for Health and Children also supports the removal of tobacco products from the Consumer Price Index and has raised this with the Taoiseach and is seeking the support of the social partners. The Department of Finance has agreed to look at this possibility. The Minister expressed support in writing to the relevant EU Commissioner for such a measure to be introduced Europe wide.

- *Continue action by doctors and other health professionals to encourage a decrease in smoking.*

During 2000 the Heart Health Task Force endorsed the recommendation of the Advisory Forum that Nicotine Replacement Therapies be included in the list of drugs which may be prescribed within the General Medical Services Scheme. The introduction of these therapies was to take effect from April 2001.

Alcohol

TARGETS:

- ❑ *To establish baseline data for monitoring progress in achieving the targets established during 1994.*
- ❑ *To promote moderation in the consumption of alcohol and to reduce the risks to physical, mental and family health that can arise from alcohol misuse.*
- ❑ *To ensure that 75 per cent of the population aged fifteen years and over know and understand the recommended sensible limits for alcohol consumption.*
- ❑ *To reduce substantially over ten years the proportion of those who exceed the recommended sensible limits for alcohol consumption.*

To be achieved by:

- *Implementation of a national policy on alcohol.*
- *A series of information/education campaigns and programmes to raise people's awareness about sensible drinking.*

The National Alcohol Policy was published in 1996.

The main findings of the SLAN survey undertaken in 1998 with regard to alcohol consumption patterns is that there has been a shift in patterns of drinking in Ireland. Most adults now drink alcohol. Twenty-seven per cent of males and 21 per cent of females consume more than the recommended weekly limits of sensible consumption.

In line with recommendations on information and education contained in the National Alcohol Policy, the following has occurred:

- ➢ An Alcohol Awareness Campaign was launched in April 1998 *(Control Your Drinking before it Controls You*); this was designed to make people reflect on their drinking habits and to encourage moderation.
- ➢ A new Alcohol Awareness Campaign, *Less is More*, specifically aimed at young high-risk drinkers was launched in February 2001. This focuses on preventing underage drinking and encourages moderation for those who do drink. Part of this campaign included the launch of a web site, www.coolchoices.ie which informs young people (aged about 12-18 years) about alcohol and reminds them that there are alternatives to alcohol and points them to those alternatives.

- Work is ongoing on the development of the school curriculum, based on a life skills approach which includes an alcohol awareness module. Education programmes have been developed so that young people may be more informed and better equipped to make informed decisions when faced with the issue of alcohol.

Children are targeted through the substance misuse prevention programme called *Walk Tall* which was developed and delivered in co-operation with the Department of Education and Science, the Health Boards and the teachers. Ninety-five per cent of primary schools have now received training in this programme.

Adolescents are targeted through the Substance Abuse Prevention Programme (SAPP) called *On My Own Two Feet* which will form part of the Social, Personal and Health Education curriculum. To date, two-thirds of post primary schools have received training in this programme. The SAPP programme is also available for youth leaders working in local communities and at-risk youth groups. Training is available for professionals and parents at community level through the regional health boards, with the purpose of helping long term prevention of alcohol and drug misuse.

- The Health Promotion Unit has, in conjunction with the Drinks Industry Group, recently developed a responsible server-training programme for those who serve alcohol. Appropriate responses to the problems of drunkenness, safe transport for customers and the prevention of serving those underage are central to this training programme.

Nutrition and Diet

TARGETS:

- *To encourage changes in the Irish diet by the year 2000 so as to include the recommended amount of essential nutrients and to provide the right levels of energy.*
- *To address the need for a reduction in fat consumption and an increase in fibre intake.*

To be achieved by:

- *Developing a long-term food and nutrition policy.*

The *Recommendations for a Food and Nutrition Policy for Ireland* developed by the Nutrition Advisory Group (1995) form part of the ongoing health promotion activities in relation to nutrition, together with the more recent Strategy reports on *Building Healthier Hearts* (1999), and the National Health Promotion Strategy (2000). A new Nutrition Action Plan is being developed for 2001-2004.

- *Implementing the five-year framework (including a series of healthy eating guides-lines) for action on nutrition which was developed by the Department of Health and Children.*

The five-year Framework for Action was implemented and reviewed by the National Nutrition Surveillance Centre, National University of Ireland, Galway (1997). The overall review concluded that the framework:

- Increased the profile for nutrition.
- Had an impact on dietary behaviour.
- Facilitated the training and education of health and education specialists.
- Was innovative in taking a cross-sectoral approach.

- *Maintaining a national nutrition surveillance system.*

The National Nutrition Surveillance System was established in 1996 in NUI Galway and is ongoing.

- *Building, in co-operation with the Department of Education, on the Health Promotion Unit's programme on nutrition in schools.*

Nutrition Education at Primary Schools (NEAPS) is currently being reviewed at Health Board level to establish current activity levels.

- *Extending the Community-based initiative on nutrition for lower socio-economic groups.*

The Community-based initiative on nutrition has been evaluated and revised. It is now called Healthy Food Made Easy and has been extended to most Health Boards for implementation by Community Nutritionists.

- *Continuing to promote good nutrition through the annual National Healthy Eating Week and publication of leaflets on nutrition and healthy eating.*

The annual National Healthy Eating Campaign is launched in May of each year with a National Healthy Eating Week. The aim of the National Healthy Eating Campaign is to promote awareness of the specific healthy eating message and to provide practical information to facilitate the general public to achieve this goal. While a specific message is chosen for each annual campaign, this message is promoted within the context of the Food Pyramid and the general healthy eating guidelines. The period 1998-2002 has focused on reducing fat intake. Running from the 13th to the 19th May 2001, the theme of this year's campaign was *Ready, Steady, Go for Low Fat Healthy Eating*, and focused on eating for a healthy heart and being more active. The National Healthy Eating Campaign is a nation-wide initiative and its key target audience is the general public. The objective is to promote healthy eating as part of a yearlong campaign, by means of a national public relations mass media Healthy Eating Campaign. The Community Nutrition Service Team provides yearlong activities at Health Board level. The messages addressed during National Healthy Eating Week are often revisited and reinforced at other opportunities throughout the year, for example, during the National Ploughing Championships.

- *Introducing an information programme on the dangers of obesity.*

The issues of obesity and overweight have been the focus of the healthy eating campaign in 1994 and again in 1999. The four-year campaign on reducing fat also includes a focus on being a healthy weight.

- *Involving doctors and other health professionals in promoting changes in diet.*

Doctors and other health professionals have been involved in promoting healthy eating through:

- National Healthy Eating week and the National Healthy Eating Campaign.
- Training and education workshops at national and health board level.
- Access to healthy eating materials for use with patients.
- Initiatives undertaken in Health Care facilities.

In addition, to help achieve the nutrition and diet targets, key developments in the area of nutrition include:

- The establishment of a Community Nutrition Service in all health boards to implement nutrition activities.
- A refocusing on nutrition health promotion activities towards socially disadvantaged groups since 1998, in association with the Community Nutrition Service.
- The development of a national nutrition education tool – the Food Pyramid – and its consistent use in all campaigns and nutrition materials since 1993.
- Access to updated nutrition lifestyle information from the SLAN survey on dietary habits of the Irish Population.

Exercise

Cholesterol and Blood Pressure

TARGETS:

- *To achieve a 30 per cent increase of the proportion of the population aged 15 and over who engage in an accumulated thirty minutes of light physical exercise most days of the week by the year 2000.*
- *To achieve a 20 per cent increase in the proportion of the population aged 15 and over who engage in moderate exercise for at least 20 minutes, three times a week, by the year 2000.*
- *To examine in detail appropriate targets for cholesterol and blood pressure in the health promotion strategy.*

To be achieved by:

- *Joint action by the Departments of Health and Children, Education and the Environment with community and statutory groups (such as Cospóir) to encourage participation in sport and to promote the value of regular exercise.*
- *Continuation of the* **Be Active be Alive** *programme and information programmes generally.*

As part of the implementation of *Building Healthier Hearts*, the report of the Cardiovascular Health Strategy Group, a general campaign on Heart Health – *Ireland needs a Change of Heart* was launched. This mass media campaign primarily targeted the individual and aimed to influence lifestyle choices which affect heart health such as smoking, diet and physical activity. It also raised public awareness of the existence of a National five-year Programme to reduce the incidence of heart disease in Ireland. The first phase comprised TV, Radio, outdoor advertising and a heart health handbook. The Heart Health handbook, *A Handy Guide to a Healthier Heart*, is a sixteen page comprehensive handbook which has been produced to advise the public on the lifestyle changes each individual can make to improve their heart health. A copy of this handbook was sent to each household in the country in October 2000.

The aim of phase two of the campaign is to promote awareness of the benefits of physical activity for good heart health and to encourage people to become more active in their daily lives. Phase two will run from May to October 2001 and will use television, radio as well as outdoor advertising to focus on physical activity as a theme. A guide to becoming physically active will be produced and made widely available. A number of public relations initiatives will also take place at national and regional level.

SECTION 3: GENERAL PRACTITIONER AND COMMUNITY HEALTH SERVICES

The 1994 Action Plan was motivated by the development of a General Practitioner service which would be better organised and supported in fulfilling a wider and more integrated role in the health care system.

TARGETS:

- *Introduction of incentives for the improved organisation of general practice so that patients have easier access to a wider range of services provided by their family doctor.*

A number of initiatives have been taken to improve the availability of an appropriate and structured out of hours general practice service. Examples include the DUBDOC scheme under which GPs provide an out of hours service from the campus of St. James's Hospital, Dublin and CAREDOC, a pilot co-operative scheme in the South Eastern Health Board area.

In 1998 a joint Department of Health and Children/Health Board Working Group was established to remedy certain anomalies which arose with the interpretation and application of the guidelines for medical card eligibility, particularly the guidelines for the retention of medical cards by persons who are long-term unemployed. Revised guidelines are being issued on the report of the Working Group. The 1999 Budget provided for a doubling of the income guidelines for medical cards for persons aged 70 years and older and the 2000 Budget made provision for medical cards for all aged 70 years and older.

The Drugs Payment Scheme, a new community drugs scheme was introduced in July 1999 to replace two previous drug schemes. The new scheme is designed to be more streamlined, user friendly and to improve significantly the cash flow for families and individuals incurring ongoing expenditures on medicines.

- *The establishment of single-centre or multi-centre group practices on a pilot basis to provide a comprehensive range of primary healthcare services with close links to the hospital services.*

General practice is still characterised by fragmented organisation. There are approximately 2,200 practising GPs operating from 1,800 separate practices. Half of the practices in the State are single-handed. This arises from the socio-cultural traditions of general practice as private ventures operated by self-employed persons. Incentives have been introduced to assist with the recruitment of practice nurses, secretaries, managers, and other support facilities (including computerisation) and these have improved the level of services available in the general practice setting, even in a single-handed practice. Despite these incentives, however, less than 500 practices have practice nurses and there are only around 900 practice secretaries.

Monies provided under the GP Capital Development Fund attach a priority to projects submitted by GPs that relate to developing group or partnership practices. There are throughout the country a number of what might be described as "flagship" practices where there are a number of doctors working together and with other healthcare specialists offering a range of services in a modern practice environment that utilises IT and good linkages with hospitals etc. It is envisaged that one positive effect of these practices is to demonstrate to colleagues in the area what might be possible and therefore act as an incentive for them to similarly develop their practices.

Monies provided to implement the Cardiovascular Strategy which envisages an enhanced role for primary care in cardiovascular prevention and treatment will assist in moving general practice towards greater integration with practice nurses, public health nurses, secondary care and health promotion agencies.

But the most significant future factor in the General Practitioner area will be the implementation of the Health Board CEOs' Review entitled *The Blueprint Document for the Future Development of General Practice.* This Review makes a number of significant proposals with the emphasis placed on enhancing existing services, improving general practice capacity in an explicit service oriented fashion and establishing structured quality assurance standards. In addition, this Review addresses remaining serious infrastructural problems in general practice including out of hours commitments; inadequate development of the primary care team; too few multi-handed multi-disciplinary practices; underuse of computerisation and underdevelopment of electronic communications; and workload issues etc. Basic principles governing development are also enumerated, including accountability. The Review is especially concerned with charting the way forward and places considerable emphasis on the co-operative approach with stakeholders. Attention is also devoted in the Review to realistically assessing the capacity of general practice to deliver on requirements.

- ❑ *The general practice units established in each health board will make arrangements with individual practices to provide additional services where this would be done more cost-effectively than at present.*

The GP Units in each health board have developed into Primary Care Units reflecting the Department of Health and Children's objective that general practice should be better developed and viewed as part of the primary care team concept operating in a more integrated healthcare sector. Progress on greater integration of general practice into the wider healthcare sector requires as a necessary preliminary step that it is better integrated into a more developed primary care framework. All the Units see this as one of their major roles.

- ❑ *The Departments of Public Health Medicine in each health board will liaise closely with general practitioners on exchanging epidemiological data.*

There is some progress here but it is variable throughout the country. Greater computerisation is an important prerequisite to ensuring that the repository of epidemiological information found in general practice can be accessed and utilised meaningfully by Public Health Departments (see below)

- ❑ *Computerisation in General Practice.*

While the target of computerising 80 per cent of general practices has been achieved, the Department of Health and Children has moved away from a simple quantitative measure of computerisation in general practice to one of quality. Available evidence shows that quality-based usage of computerisation is relatively low. In order to address this the Department of Health and Children established the National GP IT Group to promote and co-ordinate greater use of IT and communications technology in general practice. The Group has initiated a major IT training programme for GPs as well as addressing many of the technical issues that affect IT in general practice such as coding standards, messaging, quality standards for software etc. There has also been significant progress made on identifying and resolving key infrastructural issues in communications technology. The Group also started their own website to promote greater and better IT usage in general practice.

- ❑ *The general practice units will seek to introduce a system of patient registration thus expanding the general practitioner's role into areas such as preventative medicine, including vaccination programmes.*

Patient registration remains something that the Department of Health and Children is anxious to achieve as it relates directly to the quality and provision of epidemiological data that can be obtained from general practice. However, it can only be achieved in agreement with general practitioners who are prepared to make available details of their private client list. This is not something that has happened generally to date. The CEOs' Review of General Practice reaffirms the desirability of patient registration and offers a way forward in that area as part of overall reforms.

- *The development of a detailed information network for general practitioners, including the establishment of a national drugs information unit, so as to promote better quality and more cost effective prescribing.*

The National Centre for PharmocoEconomics and the National Medicines Information Board have both been established in these areas.

- *The Irish College of General Practitioners (ICGP) will be supported in the development of quality assurance measures for general practice.*
- *Vocational and post-graduate education of doctors will be supported and co-ordinated so as to maintain the highest possible standards among general practitioners.*

The Department of Health and Children provides ongoing support to the Irish College of General Practitioners on a range of areas that are designed to improve educational and vocational/postgraduate training of general practitioners, including significant funding from CME courses and the Postgraduate Resource Centre. The website of the College provides a comprehensive account of the various programmes undertaken by the College.

However, it is worth noting that the CEOs' Review identified Quality as a crucial area to be further developed in a more structured way and it proposes a major programme involving the College to this end. Advancing linkages between general practitioners and hospitals, particularly in the acute area, is an important objective involving the improvement of co-operation between hospitals and general practitioners by:

- Involving general practitioners in activities which are currently undertaken by hospitals but are more appropriate to a community setting.
- Developing protocols of combined care for specific conditions between consultants and general practitioners.
- Giving general practitioners access to appropriate investigative facilities and other services within hospitals.
- Involving general practitioners in the care of specific groups, including a domiciliary care programme for people who are terminally ill; a screening programme for children whose health status may be vulnerable; caring for elderly people at home who otherwise would have to go to hospital.

The development of a more integrated primary care system remains an ongoing challenge. Computerisation is a critical factor, especially better electronic communications between general practice and other healthcare areas. A number of initiatives are underway, though there is variation between health board areas.

Health Centres

TARGET:

- *More health centres to be provided and priority given to the improvement of existing centres where necessary.*

Under the National Development Plan (NDP), provision is made to enable health boards to undertake a programme of development of new and upgrading of existing health centres. The objective is to ensure that the health service and personal social service needs of local communities are met in an appropriate and customer-friendly setting. Boards are advised of general indicative funding which would be provided during 2001-2006 for community health service developments. On this basis, boards are proceeding with the implementation of the NDP for health centre developments.

SECTION 4: DENTAL SERVICES

The Four-Year Action Plan (1994-1997) was committed to tackling the deficiencies in the public dental service in the context of an integrated dental development plan which would also involve the phased extension of eligibility to children under 16 years.

TARGETS:

- *To tackle the deficiencies in the public dental services.*
- *To reduce the level of dental disease in children.*

The last national survey of oral health in children was carried out in 1984. Since the launch of the Health Action Plan, a number of regional surveys have been carried out by health boards. These surveys indicate that the level of dental disease in children has been reduced. A national survey of children is at the planning stage with fieldwork to commence in 2002.

- *Improve the level of oral health in the population overall.*

A national survey of adult dental health is underway and will be completed before the end of 2001. This survey will give a detailed picture of the dental health status of the whole population. The indications are that the dental health of the population is improving. There is now for the first time in the history of the State universal entitlement to basic dental care for practically the whole adult population irrespective of income status.

- *Provide adequate treatment services to children and to all medical cardholders.*

A major improvement had been made in the availability of dental treatment to medical cardholders with the full implementation of the Dental Treatment Services Scheme. The level of treatment services to children has still not reached an optimal level in many parts of the country, because of a shortage of dental personnel. There is a shortage of dental personnel especially in the border region and in western counties. In the Dublin region there is a severe shortage of dental nurses in the area boards and in the Dublin Dental Hospital. There is a large disparity between the salaries of dentists and dental nurses in the health boards and in the private sector.

- *Increase efficiency of water fluoridation schemes, continuous upgrading of existing water fluoridation plants and appropriate increases in the number of water fluoridation plants.*

Since 1994 there has been significant capital funding allocations to health boards for Fluoridation schemes.

- *Wider use of fluorides in general and especially in the less than optimally fluoridated areas, by such means as schools-based fluoride-rinsing schemes and by more frequent and regular use of fluoride toothpaste.*

The promotion of the wider use of fluorides in the general population through activities of the oral healthcare industry has been an established feature of marketing campaigns. Health boards have established fluoride mouth-rinsing programmes in some areas not covered by water fluoridation. A number of health boards have started new schemes and in some areas supervised tooth brushing has been introduced.

The Epidemiology and Health Services Research Contract is investigating all aspects of fluoride use in this country. Research is ongoing and will be completed by 2002.

- *Development of oral health education programmes aimed at the family, at population groups and at individuals through the media and in healthcare and educational settings.*

A series of initiatives have been implemented in collaboration with health boards, the Dental Foundation and Health Promotion Unit. These initiatives are being evaluated under the Epidemiology and Health Services research contract by N.U.I. Galway.

- *The phased extension of eligibility for public dental services to children under 16 years.*

Since 1994 regulations have been in place extending eligibility for public dental services to children up to 16 year of age. Increased funding has been provided to increase staffing levels in health boards.

- *The phased improvement of primary and secondary orthodontic care for all children.*

The full funding of the Dental Health Action Plan components to improve primary and secondary orthodontic care for all children has been implemented. Consultants in orthodontics have been appointed to nine of the ten health boards and to St. James's Hospital. Funding for 30 support dental teams has also been provided. Difficulties have arisen in the staffing of regional orthodontic units throughout the country. The Dental Council has recognised orthodontics as a speciality within dentistry. There is a reluctance to allow any dentist other than a fully trained specialist to work within the units unless they are on formal training programmes approved by the Dental Council. A new grade of specialist is being negotiated at the HSEA. This will allow staff to be recruited directly into the regional orthodontic units.

Training programmes to increase the number of specialists are also under negotiation between the Dental Schools, the Irish Committee for Specialist Training in Dentistry, the Dentistry Council and the Post-Graduate Medical and Dental Board. These changes have resulted in regional units being able to reach their targets.

- *The expansion of hospital oral surgery services to provide services adequately for those who require specialised treatment.*

Increased funding has been provided to all health boards to improve availability of hospital oral surgery services. Consultant Oral Surgeon posts were approved in three health boards. At present there is only one in post. Additional facilities for oral surgery were included in the refurbished Dublin Dental Hospital. A review of the oral and maxillo-facial surgery needs of the Eastern region was completed in 1999. A plan to meet these requirements is being implemented including the building of a day care oral and maxillo-facial surgery unit at St. James' hospital. The Dental Council has also recognised Oral Surgery as a speciality within dentistry. This will result in the need to create a grade of specialist oral surgeon in the health boards. In addition regional hospitals outside the Dublin and Cork areas will need to appoint consultant oral and maxillo-facial surgeons. Two such posts have been approved for the Western and Mid Western Health Boards and have recently been advertised.

- *The phased introduction of new arrangements for the provision of dental care to eligible adults.*

The Dental Treatment Services scheme was introduced in 1994 to provide dental treatment for adult medical cardholders. The scheme was fully phased in through 2000.

- *Improvements in the school dental services to ensure the systematic screening of children in 3 designated classes in primary and post-primary schools.*

This basic level of care is available in most health boards. In some geographically isolated areas in the border areas and in the Western Health Board these targets are not being achieved because of staff shortages. Evaluation of this target is being carried out under the Epidemiology and Health Services Research contract.

- *The establishment of a standardised database in each health board for monitoring changes in oral health.*

A National Adult Dental Survey is currently underway in all health boards in 2001. This is being followed by a Children's Dental Survey in 2002 which will be repeated on a ten yearly basis in each health board for different age groups. The adult survey will also be repeated on a ten-year basis. This will provide health boards with a standardised database for monitoring changes in oral health.

Oral Health Goals to Be Achieved by the Year 2000

TARGETS:

- *At least 85 per cent of five-year olds in optimally fluoridated areas and at least 60 per cent of five-year olds in less than optimally fluoridated areas will be free of dental caries (baby teeth only).*

There are no national figures for the percentage of 5-year-old children that are free of dental decay. These will only be available after the children's survey in 2002 is completed. However, there is some useful indicator data from a survey carried out in the Eastern Region in 1993. In the fully fluoridated Dublin areas 74 per cent of 5-year-olds were free of dental decay. In the partially fluoridated county areas 52 per cent of 5-year-olds were free of dental decay.

- ❑ *Twelve-year old children will have on average no more than 1 decayed, missing or filled permanent tooth in optimally fluoridated areas and on average no more than 2 decayed, missing or filled permanent teeth in less than optimally fluoridated areas.*

While there are no national figures for his parameter there are some good indicator data for a number of health boards. The indications are that by 1997 three health boards were close to achieving this target. For example, in the Eastern Regional Health Authority, 12-year-old children in fluoridated areas were found to have 1.1DMFT (decayed, missing or filled permanent teeth), while 12-year-old children in non-fluoridated areas had a higher average value of 1.8DMFT.

- ❑ *The average number of natural teeth present in 16-24 year olds will be 27.7.*
- ❑ *No more than 2 per cent of 35-44 year olds will have no natural teeth.*
- ❑ *No more than 42 per cent of people aged 65 years and over will have no natural teeth.*

With regard to remaining targets for adults there is no reliable data. The relevant information will not be available until the survey of adults is completed sometime in 2002.

SECTION 5: WOMEN'S HEALTH

The development of a plan for women's health was the starting point for the 1994 Action Plan in this area. The policy document *A Plan for Women's Heath 1997-1999* was published by the Department of Health in 1997.

TARGETS:

To provide a policy that is based on a comprehensive view of women and the issues that affect their health.
The objectives include:

- *To ensure that women's health needs are identified and planned for in a comprehensive way.*
- *To ensure that women receive the health and welfare services that they need at the right time and in a way that respects their dignity and individuality. They must have ease of access to and continuity of care.*
- *To promote greater consultation with women about their health and welfare needs. This must be done at national, regional and local level.*
- *To promote within the health services a greater participation by women both in the more senior positions and at the representative levels.*

A Plan for Women's Health

The national policy on women's health was developed in response to concerns that women's health needs were not always being met by the health services in the past. The Plan responds to the issues raised during a nation-wide consultation process with women, a process which involved conferences, workshops, exhibitions and seminars on the full range of women's health issues. This consultation process also provided clear evidence of the quality of thinking and knowledge among health care consumers and injected a different dimension into health care policy for women.

A *Plan for Women's Health* published in 1997 is the blueprint for improving and developing the health care services required by women and has as its main objectives:

- To maximise the health and social gain of Irish women.
- To create a women-friendly health service.
- To increase consultation with, and representation of, women in the health services.

The National Plan for Women's Health focuses on 12 key issues and provides a commitment to action in relation to each of these areas. The actions proposed are consistent with other policy initiatives in the health services such as the National Cancer Strategy, the Health Promotion Policy, the National Alcohol Policy, the Management Development Strategy for the Health and Personal Social Services and the Cardiovascular Strategy.

Women's Health Council

Following the publication of the *Women's Health Policy* by the Department of Health and Children, the Women's Health Council was established in June 1997 to respond to the demand by women for increased representation and consultation in the health services. The Council involves a partnership between consumers, healthcare professionals, policy makers and other representative groups. Following the success of the consultative process undertaken in the formulation of the Plan, women wanted to maintain a level of participation in the policy making process and to be assured of a permanent voice in the future. The Council ensures that participation and has as its main functions:

- To develop a centre of expertise on women's health.
- To foster research into women's health.
- To evaluate the success of the Plan for Women's Health in meeting the objectives.
- To advise the Minister on women's health issues generally.

The Women's Health Council published its first annual report and first research report in October 1999.

Implementation by the Health Boards of relevant aspects of the Women's Health Plan is underway. Priorities have been developed within the Department of Health and Children in relation to each of the major issues affecting the health of women. In 1999 specific funding was provided for the first time to the Health Boards for the implementation of the recommendations contained in the *Women's Health Plan*. Further funding has been provided for services for women victims of violence.

Regional Women's Health Advisory Committees

There is a regional committee on women's health in each health board area. They were established in accordance with a recommendation in the Women's Health Plan to prepare, adopt and implement regional plans for women's health, taking account of the priorities of the National Plan. These committees have published Regional Plans on women's health and are at various stages of implementing their recommendations. In 1999, earmarked funding was provided for the first time to health boards for the implementation of the recommendations in *A Plan for Women's Health*. Additional funding has also been provided in subsequent years.

The Women's Health Council has commissioned a review of the implementation of *A Plan for Wome's Health* in accordance with the recommendation contained in the Plan that the Council evaluate the success of the Plan in meeting objectives. This Review will be completed shortly.

- *To expand the services for women who are victims of rape and domestic violence and to co-ordinate these services more effectively with other health services.*

In October 1996, the Government set up a Task Force on *Violence Against Women*. The report on the Task Force was published in May 1997. The Task Force, in over 100 recommendations, set out a national strategy to tackle the problem of Violence Against Women involving three strands:

- A network of quality services for abused women and their children.
- Intervention programmes for violent men which confront violent behaviour.
- Active education programmes.

In accordance with the recommendations of the Task Force, a Steering Committee on Violence Against Women has been established at national level to oversee the implementation of the recommendations of the Task Force. The National Steering Committee (NSC) is chaired by the Minister of State at the Department of Justice, Equality and Law Reform. It comprises representatives from the relevant Government Departments, the Health Boards, the medical and legal professions, An Garda Síochána, the Probation and Welfare Service, and the Clergy. Non-governmental organisations were also represented including The Dublin Rape Crisis Centres, Irish Countrywomen's Association, National Network of Rape Crisis Centres, National Network of Women's Refuges and Support Services, National Women's Council of Ireland and Women's Aid.

The NSC was established in an effort to bring together the expertise of the many non-governmental organisations, statutory bodies and Government Departments which deliver services to women who have been victims of violence.

The role of the Committee is to provide a cohesive, comprehensive and multi-disciplinary response to the problem of violence against women.

In addition, Regional Planning Committees on Violence Against Women in each health board area have been established in accordance with a recommendation contained in the *Report on Violence Against Women*. The role of each Regional Committee is, together with the NSC, to identify the services in their respective areas, identify gaps in service provision and put forward a plan to deal with the gaps identified. They will also develop and build on local networks and services.

The Department of Health and Children provides funding to the health boards through which Refuges and Rape Crisis Centres are funded each year.

- *All aspects of the cervical screening services to be reviewed by an expert group. The Minister proposes to reorganise the service taking account of the group's recommendations.*

The 1996 report of the Department of Health and Children Cervical Screening Committee affirmed that cervical screening is a worthwhile health preventive measure when delivered as part of an organised screening programme.

A national cervical screening programme under which women in the 25-60 age group are screened free-of-charge at minimum intervals of five years is being introduced on a phased basis. Phase 1 of a national programme commenced in the Mid Western Health Board area in October 2000. It will cover approximately 67,000 women in the target area age group. In addition to funding the Phase 1 programme, funding has also been provided for the expansion of laboratory and colposcopy services to meet the anticipated increase in the number of smears arising from the programme.

An Expert Advisory Group is overseeing the implementation of Phase 1. The Group is also responsible for advising in relation to best practice including quality assurance and the use of new technologies.

The question of extending the programme to the rest of the country is currently being examined in conjunction with the Expert Advisory Group and the CEOs of the Health Boards.

- *To set up a national breast cancer screening service once the findings of the Mater Hospital Foundation study have been evaluated.*

Under the 1997 National Cancer Strategy, the National Steering committee planned the delivery of a screening service for breast cancer to be offered to women, the goal of which is the reduction of mortality in women. The National Breast Screening Programme was initiated early in 1999 following the establishment of "Breast Check" as a corporate body under Section 11 of the Health Act, 1970. Two central units are delivering the service, the Eccles Unit on the Mater Hospital campus and the Merrion Unit at St. Vincent's Hospital. There are also three mobile units which provide an outreach service to the community. The target group for initial screening is women in the 50-64 age group within the Eastern, North Eastern and Midland Health Board areas. The goal is to achieve a world class programme and reduce mortality by 20 per cent in the cohort of women screened in the period 2000-2010. Programme expansion will be considered following the first year activity report. In 1999, £3.8m Capital and £2.9m Revenue funding was made available, with provision for £1.1m Capital and £5.3m Revenue funding in 2000.

SECTION 6: FAMILY PLANNING

In 1994 it was proposed that an accessible and comprehensive family planning service was to be developed in each health board on a phased basis by the end of 1995.

TARGETS:

- *Availability of education, counselling and advice on all legal methods of contraception.*
- *Ready access to natural methods of family planning; medical contraceptives, non-medical contraceptives; male and female sterilisation services.*
- *Advice, counselling and the provision of certain services in relation to infertility.*
- *Where there is a need for the family planning services provided by general practitioners to be complemented, it is envisaged that this would be achieved by the establishment and maintenance, either by the health boards, or by other bodies acting on their behalf, of designated family planning clinics in major urban areas.*
- *Each health board to evaluate the current family planning needs and services in its area and determine the services which it will have to provide or have provided on its behalf in order to have an accessible and comprehensive family planning service.*

Family Planning Policy Guidelines were prepared and issued to all health boards in March 1995. Also in 1995 a range of contraceptive services including IUDs, diaphragms and spermicides was extended free of charge to medical cardholders.

When the Guidelines were issued, health boards were required to evaluate the family planning services available in their functional areas and to prepare proposals for further service development. Health boards identified a range of shortcomings, principal among which were:

- Lack of choice of service provider – many women preferred a health board or other form of family planning clinic rather than a GP provided service.
- Choice was also limited by number of practices without a female medical practitioner.
- A substantial minority of GPs did not hold a Family Planning certificate or had not undergone other relevant training in this area.
- Lack of printed material on family planning.
- Sterilisation services not readily available.
- Non-medical contraception (e.g. IUD, diaphragm) was not offered as an alternative to medical contraception (primarily the pill).

The process of developing and improving family planning services has been ongoing since the Guidelines were issued, and additional funding of some £6m has been provided to health boards for the development of these services since 1995. Many general practitioners have undergone training in relation to family planning and an increased number of practices now have a female doctor. While female sterilisation is an inpatient procedure, some male sterilisations are undertaken at GP level. Family Planning advice is also available through maternity hospitals and, in some regions, health boards have arranged for the provision of services through clinics run by non-statutory organisations. The Department of Health and Children intends in 2001 to undertake a review with the health boards of current levels of service provision in order to establish to what extent the objectives of the 1995 guidelines have been achieved. This will also help to inform future policy in this area.

It should be noted that the guidelines did not address the issue of advice or services in relation to infertility and the Department of Health and Children has not issued advice to health boards in this regard. The whole issue of assisted human reproduction is being considered by an expert group established by the Minister for this purpose in 2000.

It should be noted that health boards have been asked in recent years to broaden the scope of family planning services. The Government wishes to address the issue of unwanted pregnancy primarily insofar as it leads to abortion, and additional funding has been allocated in 1999, 2000 and 2001 on this basis. Research, such as the *Women and Crisis Pregnancy* report published in 1998, has identified a range of issues regarding the availability of family planning and related services as well as the attitudes of young people to sexual behaviour.

The type of issues which health boards have been asked to bear in mind when developing policy therefore include the provision of services which are accessible to young people and which meet their needs in relation to issues such as confidentiality and hours of operation.

Education/promotional activities which focus on such issues as the need for responsible sexual behaviour of young people at risk, increasing awareness on the use of contraception, promotion of male contraception responsibility, increasing awareness of pregnancy counselling services and the cultivation of more responsible attitudes to alcohol, with particular regard to alcohol and sexual activity, have been advocated. Health boards have also been asked to consider steps to increase women's awareness of post-abortion counselling and of the need for medical check-ups. Such check-ups also provide an opportunity for women to obtain advice on appropriate contraception for the future and thereby reduce the incidence of future unwanted pregnancies.

SECTION 7: CHILDREN'S HEALTH

A detailed review of the pre-school and child health services was planned in 1994 in addition to improvements in other services taking account of reports on maternity and infant care and immunisation.

TARGETS:

- *A detailed review of the pre-school and child health services.*

The Department of Health and Children was represented on the Partnership 2000 Expert Working Group on Childcare and on the subsequent Interdepartmental Committee on Childcare. Following this process, the Government allocated £250m to develop childcare over the next seven years under the National Development Plan 2000-2006. The main objectives of the new measures are to maintain and increase the number of childcare facilities, increase the number of childcare places and improve the quality of services available. The Department of Justice, Equality and Law Reform has the lead role in this area.

- *Improvements in other services taking into account the existing reports on maternity and infant care and on immunisation.*

Agreement was reached in 1999 with the Irish Medical Organisation on the implementation of the recommendations of the Report of the Maternity and Infant Care Scheme. This Scheme, which is free of charge, provides for prenatal and postnatal care for women and for babies up to six weeks of age. A recommendation by the Review Group is delivered through the system of combined care, i.e. where the expectant mother is under the care of both her general practitioner and hospital obstetrician. The Review Group recommended a revised schedule of visits and this recommendation has been implemented.

Information leaflets on the scheme, designed for expectant mothers and General Practitioners, have been developed and supplied to the health boards for circulation, with a view to maximising uptake of the scheme.

- *Consideration to be given to finding the best means of monitoring the progress of young children and identifying health problems as early as possible; the best approach to immunisation; and for babies, the promotion of breastfeeding.*

The Chief Executive Officers of the Health Boards initiated the review which resulted in the launch of the report "*Best Health for Children – Developing a Partnership with Families"* in December 1999.

The report outlines a core child health surveillance programme for children in the 1-12 years age group. The aims of the core programme are to ensure that all children have an opportunity to realise their full potential in terms of good health, well-being and development and to identify remedies at the earliest possible date and to treat them in a timely fashion.

The Department of Health and Children is supportive of the approach set out in the recent report in relation to the development of child health services. Funding has been allocated to the health boards and ERHA in 2001 to assist the commencement of the implementation of the recommendations of the report. In addition, a pilot programme involving the development of a parent-held child health record is underway in the Mid Western Health Board. The pilot and the evaluation stage will be completed in 2001.

A National Conjoint Child Health Committee established by the CEOs is overseeing the implementation of the recommendations of the report.

Infant Care

TARGETS:

- *Every baby will have a visit from the Public Health Nurse as soon as possible after discharge from the maternity hospital/unit, ideally during the first 24 hours.*

The policy is that all babies are visited by a Public Health Nurse after discharge from a maternity hospital and, in as far as practicable, this visit takes place within 24 hours of discharge. However, this may be dependant on the PHNs existing workload and on the day of discharge i.e. if the baby is discharged on Friday it may not be possible to arrange a visit before Monday.

- *Every baby will have two designated visits to the general practitioner, one at two weeks and the other at six weeks after birth.*

The Maternity and Infant Care Scheme provides for pre-natal and post-natal care for all women regardless of means and for two designated visits for the baby to the General Practitioner two weeks and six week after birth.

- *Liaison arrangements between the general practitioner and the Public Health Nurse will be strengthened to ensure continuing care as required.*

The *Report of the Commission on Nursing – A Blueprint for the Future* identified the increasing difficulty in aligning public health nursing services with general practitioner services in an area. The Commission recommended that the Department of Health and Children issue a revised strategy on the role of public health nursing.

The report *Public Health Nursing: A Review (1997)*, also addressed the issue of liaison arrangements between the general practitioner and the public health nurse. It was recommended that this report should contribute to the deliberations on a revised strategy. It is anticipated that work on devising a revised strategy will get under way in the near future.

Immunisation Programmes

TARGETS:

- *Rationalisation of the National Immunisation Programme in accordance with the recommendations of the Review Group on Immunisation.*
- *Elimination of communicable diseases such as pertussis, measles, mumps, rubella, poliomyelitis and Hib-related diseases by:*
  - Achieving and maintaining a minimum of 95 per cent uptake of the National Immunisation Programme in each Community Care Area.
  - Introducing the mechanisms to ensure that each child has completed the programme of immunisation appropriate to him/her, in accordance with the National Schedule of Immunisation, by age of 15 months for DPT/Polio/Hib/ and 24 months for MMR.
- *Improving the notification and recall system to ensure that parents have their children immunised by their due dates.*
- *Promoting the benefits of immunisation to the public and to health professionals.*
- *Targeting parents in areas where the uptake of immunisation is low and/or levels of communicable diseases are high.*
- *Improving co-ordination between maternity hospital/units, vaccinating doctors and parents.*
- *Improving co-operation between National Schools and health boards to ensure that children entering school are immunised fully.*
- *Ensuring that current pre-school services are maintained.*

The agreement between the Department of Health and Children and the Irish Medical Organisation (in December 1995) in respect of the contract between health boards and general practitioners for the delivery of the Primary Childhood Immunisation Programme (PCIP) implemented the recommendations of the Review Group on Primary Childhood Immunisation. This agreement was updated in October

2000 to incorporate the Meningococcal C immunisation programme. Under the PCIP parents are offered free immunisation for their children against a range of potentially serious childhood diseases. The PCIP is delivered by general practitioners in accordance with the Review Groups recommendations.

The recommended childhood immunisation schedule is determined by the National Immunisation Committee of the RCPI. The current schedule recommends immunisation against DTP/Oral Polio/Hib and meningitis at 2,4 and 6 months and MMR at 15 months. The rate of uptake is below target at approximately 85 per cent in respect of DTP/Oral Polio/Hib while for MMR it is lower at approximately 76 per cent.

The Department of Health and Children is concerned about primary immunisation uptake generally, because of the resulting risk of unimmunised children contracting the potentially serious diseases concerned. In February 2000 the Department of Health and Children wrote to the health board CEOs, saying that it regarded this as a very serious situation and requesting them to make every effort to achieve the national targets of 95 per cent in the programme in 2000.

The issues highlighted were:

- The need for analysis of reasons for low uptake.
- The need to validate their immunisation databases.
- The need to ensure that appropriate Regional and Local Management arrangements were in place.
- The need to devise strategies tailored to local needs, employing innovative approaches if considered necessary. They were reminded of the terms of the agreement governing delivery by general practitioners of the immunisation programme, which states *inter alia* "nothing in this agreement shall be construed as preventing the health board from making special arrangements where the uptake of immunisation among particular groups or in geographical areas is unacceptably low".

The Health Boards were asked to address these issues as a matter of urgency and to report to the Department of Health and Children on the steps being taken. Following receipt of these replies the Secretary General met with the health boards on a number of occasions during 2000 to further address the issues identified.

More recently a new immunisation initiative was put in place at the Ministers request. This will involve the setting up of a National Immunisation Steering Committee by the Chief Executive Officers of the Health Boards to address issues relating to the Primary Childhood Immunisation Programme and other immunisation campaigns. The work of this group will include consideration of the protocols for administration of vaccines, whether new mechanisms need to be developed to guard against possible use of vaccine which has passed its expiry date, and to ensure that vaccines are administered in accordance with best practice. It is anticipated that the National Immunisation Steering Committee will make the recommendations to the Minister in the latter half of 2001.

An industrial dispute involving PHNs was only resolved in 2000 and this unfortunately may have had a negative impact on uptake while underway though this is expected to improve from late 2000 onwards.

Breastfeeding

TARGETS:

To increase the use of breastfeeding so that:

- *The initiation rate will have risen to 35 per cent by 1996 and 50 per cent by the year 2000.*
- *By the year 2000, 30 per cent of babies will still be breast-fed at the age of four months.*
- *Further actions consequent upon the recommendations of the National Committee to Promote Breastfeeding.*

The strategy being pursued by the Health Promotion Unit in relation to breastfeeding is in accordance with the recommendations of the National

Breastfeeding Policy. The Health Promotion Strategy published in July, 2000 calls for a more structured approach to the implementation of the recommendations set out in the National Breastfeeding Policy and recommends the appointment of a National Breastfeeding Co-ordinator. The National Co-ordinator was appointed in June 2001 and will advise the Health Promotion Unit on the effectiveness of current policy actions in Ireland and on measures required to increase breastfeeding rates. Finalised breastfeeding rates for 2000 are not yet available.

The establishment of a National Committee on Breastfeeding has also been considered and arrangements are being made for the appointment of such a committee. This committee will work with the National Breastfeeding Co-ordinator, in partnership with community workers, in the effective implementation of the National Breastfeeding Policy.

The Department has also supported the implementation of the Baby Friendly Hospital Initiative (BFHI) which is a global campaign led by the World Health Organisation and UNICEF to encourage hospitals and health workers to support mothers to breastfeed. It was launched in Ireland in 1998. Participation in this initiative was recommended in the National Breastfeeding Policy for Ireland.

The Health Promotion Unit is committed to continue its support for the implementation of the recommendations of the National Breastfeeding Policy.

SECTION 8: CHILDCARE AND FAMILY SUPPORT SERVICES

The Four-Year Action Plan aimed to ensure that support services for children at risk and families in difficulty would be strengthened in co-operation with the relevant voluntary bodies and in accordance with the principles underpinning the Child Care Act.

TARGETS:

- *Support services for children at risk and families will be strengthened in co-operation with the relevant voluntary and statutory bodies.*
- *All sections of the Child Care Act to be implemented by the end of 1996.*
- *Priority will be given to those provisions which confer new and improved powers on health boards, the Gardaí and the Courts to intervene more effectively in cases of child abuse and neglect.*

The Child Care Act was fully implemented by the end 1996 in the context of a substantial investment programme. In particular:

- Better support has been provided for vulnerable families in conjunction with voluntary bodies;
- Improvements in the linkages between health boards, the Gardaí and schools in relation to the prevention and investigation of child abuse have occurred.
- A major homelessness programme has been initiated
- Counselling and treatment services for children who have been damaged by abuse have been improved.
- A system of supervision of Pre-School Services has been established.
- Increased supports have been provided for foster parents.

Services, including specialised residential centres, to cater for disturbed and damaged children and adolescents are being developed.

- *Improvements in the linkages between health board, the Gardaí and school for the prevention and investigation of child abuse.*

Joint Garda/Health Board guidelines were developed and introduced in 1995. Subsequently, in 1998 a Working Group was established to review the existing child protection guidelines and to prepare revised guidelines aimed at improving the identification and management of child abuse.

The Working Group comprised representatives of all the key interests involved with children. This Group produced *Children First – National Guidelines for the Protection and Welfare of Children*, which sets out national guidelines, standard definitions of abuse, standardised reporting procedures and good practice guidelines for health board personnel and gardaí as well as dealing with family support and prevention. Implementation of the guidelines is ongoing and additional professional and administrative staff have been appointed in all health boards.

A revised joint Garda/Health Board child protection protocol has been developed and is due to become operational in early 2001. Training in a number of areas covered by *Children First* has commenced, which includes joint training between health boards and An Garda Síochána, and will continue through 2001. Local and Regional Child Protection Committees are being established in each health board area to foster co-operation between bodies involved with children including schools and An Garda

Síochána. Revised child protection guidelines are due to be issued to all schools in early 2001. These reflect the national guidelines and the Department of Education and Science will provide in-service training for designated teachers on child protection issues during 2001 with support from health boards.

- *A discussion paper will be issued in 1994 on the question of providing for mandatory reporting by designated professionals of all forms of child abuse. This will form the basis of consultations with relevant interests with a view to achieving as much common ground as possible on mandatory reporting.*

A discussion document entitled *Putting Children First – A Discussion Document on Mandatory Reporting* was published in 1996. A number of submissions were made following publication of the document and a consultative forum was held in 1996 for all interested parties. This was followed by the publication of *Putting Children First – promoting and protecting the Rights of Children* in 1997. This document stressed that the issue of reporting child abuse could not be seen in isolation and that other areas such as health, education and poverty need to be addressed in the context of protecting children from abuse and exploitation. It was decided that the introduction of mandatory reporting of child abuse in the immediate future would not be in the best interests of children. It was considered that the childcare services needed continued development before mandatory reporting could be introduced.

The present position is that a White Paper on the Mandatory Reporting of Child Abuse was drafted in 2000 and a Memorandum for Government was circulated to Government Departments for observations. Detailed observations, some of a significant nature were received, and discussions are currently ongoing with the Attorney General's Office in relation to some of the legal issues raised.

- *Staff development and training for those who will have responsibility for the operation of childcare legislation.*

Health boards have been provided with additional investment over the last number of years for further development and training within each area. The need for such training has also been re-emphasised in *Children First – National Guidelines for the Protection and Welfare of Children* which states:

Training aims to promote effective interventions in the care and protection of children. Effective child protection depends on the skills, knowledge and values of personnel working with children and families as well as intra-agency co-operation. Relevant training and education is an essential prerequisite to achieving this. All agencies involved with children have a responsibility to ensure that such training is available on an ongoing basis.

As a result, health boards are now required to develop a strategy for training in childcare and protection. This strategy will set out the training aims, learning outcomes, target groups, proposed initiatives, performance indicators and evolution processes involved. Training in childcare and protection will be available at two levels – basic level and advanced level – in order to meet a diversity of needs within the health boards and other agencies who provide services to children and families. This process has already begun:

- All health boards have identified training as one of the core issues to address.
- Every Board has appointed a Training Resource Person and every Board now has specialised Child Care Training Officers for the first time. A network of training officers is also being established to ensure consistency of approach.
- Child Care Training Co-ordinators are developing a framework for the provision of appropriate training.
- Regional Child Protection Committees are presently being established in all health boards. One of the functions of these committees will be to identify an inter-disciplinary and inter-agency training strategy.

Adoption

TARGETS:

Changes will be introduced in adoption law and procedure to:

- *Provide arrangements to facilitate contact between adopted persons and their birth parents.*

A lengthy consultation took place in 2000 and arising from that, the heads of a bill on adoption information, post-adoption contact and associated issues will go to Government shortly. This has proved to be an extremely complex and sensitive area of social policy.

- *Amend current legislation on the recognition of foreign adoptions in order to bring it into line with the recently agreed Hague Convention on the subject.*

Draft Heads of a Bill to enable Ireland to ratify the Hague Convention have been developed. Extra resources have been put into the health boards to enable them to deal with the rapid growth in demand in this area. A standardised framework for assessment for inter-country adoption in relation to education, preparation and assessment for inter-country adoption, based on the Standardised Framework, has been developed and introduced.

The Adoption Act 1998 provides for a new statutory procedure for consulting the father of a child born outside marriage before the child is placed for adoption, so as to afford him an opportunity to exercise his right to apply for guardianship, access and/or custody of the child. It also amends the statutory provisions relating to the recognition of foreign adoptions and it prohibits private adoption.

The Department of Health and Children commissioned an independent review of assessment procedures for inter-country adoption in the health boards in late 1998. The report *Towards a Standardised Framework for Inter-country Adoption Assessment Procedures* was published in July 1999. The report's recommendations have been approved by Government and additional funding was approved in 1999 and 2000 for implementation. A *Handbook for Applicants* and *A Handbook for Practitioners* were published and circulated to Health Boards in September 2000.

Travellers' Health

TARGETS:

A special programme will be implemented to address the particular health needs of the travelling community including:

- *Establishment of a Task Force on the Travelling Community by the Minister for Equality and Law Reform.*

The Task Force was established and produced it's Report in 1995.

- *A joint study by the Department of Health and Children and the Task Force will be undertaken on travellers' health with particular emphasis on access to appropriate health services. Following the completion of this study a number of initiatives will be undertaken.*

This study was carried out in 1995.

- *The development, in consultation with traveller groups, of a health education programme aimed specially at travellers. This programme would incorporate homemaking skills, advice on nutrition, family planning, dental care, safety and consanguinity.*
- *The development of models of traveller participation in health promotion and prevention, to ensure the health education programme is delivered to maximum effect.*

A number of health education/promotion initiatives have been pursued in recent years, specially focusing on Traveller health. The success of these initiatives is closely related to the extent of the involvement of Traveller organisations in the drafting, design and dissemination of the material. Videos and posters have been shown to be the most effective media.

- *Ensuring that health boards make special arrangements to encourage and permit travellers to avail of primary care services, in particular GP services, dental care, ante- and postnatal care, family planning, child immunisation and, where appropriate, hospital-based services.*

A number of primary health care projects for Travellers have been developed in the Eastern Region. Community health workers, working with public health nurses, dentists, dental health nurses and other health professionals, have been responsible for remarkable improvements in levels of access to child health services (including immunisation), women's health services (including screening and family planning) and oral/dental health services.

- *Simplifying services under the GMS including eligibility, immunisation and general health records to ensure better continuity of care from one health board to another.*

The Minister for Health and Children has appointed a Traveller Health Advisory Committee which has made recommendations regarding the improvement of Travellers' access to GMS services.

- *Liaising closely with other relevant statutory and voluntary agencies providing services to travellers to ensure better targeting of services.*

All Health Boards have established Traveller Health Units whose membership is drawn from various sectors of the boards and from local Traveller organisations and the Traveller community.

SECTION 9: DRUG MISUSE

Commitment to implementing the Government's strategy on addressing drug misuse is declared in the 1994 Action Plan. This strategy is based on the development of appropriate preventive, treatment and rehabilitation services.

TARGETS:

- *Development of primary prevention programmes in schools.*

In partnership with the Department of Education and Science almost 95 per cent of post primary schools have received training in the Substance Abuse Prevention Programme (SAPP) *On My Own Two Feet*. The SAPP programme has been incorporated into Social, Personal and Health Education and integrated into the Curriculum of the Junior Cycle. The programme is supported by a partnership arrangement between the Department of Education and Science, the Department of Health and Children, the Regional Health Boards, Marino Institute and the National Council for Curriculum and Assessment. Ten Regional Development Officers and one National Co-ordinator have been seconded by the Support Service to work in partnership with Health Education and Health Promotion Officers at a regional level.

At Primary level the *Walk Tall* drug education and prevention training programme has been delivered to almost 2,800 primary schools. In many regions there has been an active partnership between the health promotion department of the health board and the *Walk Tall* trainers. The Health Promotion Unit is also involved with this programme in an advisory and consultative role. It is planned to implement SPHE at primary level though the support structure to provide on-going support has not yet been decided.

In addition to the class room based prevention work on-going through the above programmes, many of the health boards are supporting the development of Substance Misuse Policy for schools. Schools are facilitated to develop policy with support from Health Promotion Officers which are both comprehensive, consultative and wide-ranging in terms of initiatives and interventions.

To support programmes delivered in the school setting by teachers, the Health Promotion Unit has also developed Community based initiatives including *Drugs Questions Local Answers and Family Communication and Self Esteem* which targets the general community and parents. Similarly, through the National Youth Health Programme, youth workers are trained in health promotion techniques to deliver health messages to young people in the out of school setting which complement those delivered in the school setting.

- *Prevention targeted at selected groups.*

Special interventions are aimed at "at risk" groups, e.g. injecting drug users, heroin smokers, pregnant drug misusers. All Boards have a Drugs Co-ordinator who works closely with health promotion officers to develop appropriate responses to the drugs problem in the respective boards. A National Drugs Strategy Team was mandated to implement the Government's Strategy on Reducing the Demand for Drugs and the Team is chaired by an official from the Department of Health and Children. Local Drugs Task Forces were established in the 14 areas experiencing the highest levels of problem drug use (13 in the Eastern Regional Health Authority and 1 in Cork city). Over 200 actions have been undertaken in these areas to date.

- *Dissemination of information through public campaigns.*

The Health Promotion Unit of the Department of Health and Children has developed a range of materials and awareness initiatives to support a range of educational programmes. These include:

- Design, publication and dissemination of Drugs information posters, leaflets and booklets aimed at both young people and parents.
- Support for the European Drug Prevention Week – a public awareness week aimed at enhancing the awareness levels of the general public through media initiatives combined with a wide ranging programme of events at both National and Regional level.
- In 2001, the Health promotion Unit launched a three-year alcohol awareness campaign *Less is More.* In year one the campaign will target young people up to the age of 25 and will develop over the following two years to incorporate the remainder of the population.

❑ *The provision of increased detoxification and rehabilitation facilities.*

The most serious drugs problem is in the Eastern Region with around 86 per cent of the total number of reported cases of treated drug misuse in the National Drug Treatment Reporting System being treated in this area. There has been a significant expansion of services in the East since 1994.

The ERHA's total budget for drugs and AIDS services in 2000 was in excess of £22m. Detoxification may be provided on an outpatient or inpatient basis. A number of drug misusers are detoxed on an outpatient basis using methadone. There are, 27 detoxification beds in the Eastern area where patients are referred when the need for inpatient detoxification treatment is clinically indicated. The three Dublin Area Health Boards have contracted with the Rutland Centre in Dublin, Cuan Mhuire in Athy and the Merchant's Quay Project at High Park, Drumcondra to provide additional post-detoxification services.

In addition, a 12-bed stabilisation unit will open in the grounds of Cherry Orchard Hospital and a 20-bed downstream detoxification facility will open in St. Mary's Hospital, Phoenix Park. These facilities will shorten the time needed in detoxification facilities. In Health Boards outside the East, detoxification is provided through psychiatric hospitals or through residential facilities such as Aislinn in Kilkenny or Cuan Mhuire in Bruree.

Health Boards acknowledge the need for rehabilitation and aftercare as part of an integrated programme of care for drug misusers. It is important to state, however that the success of treatment and rehabilitation outcomes for people who are chronically addicted to heroin are varied. Heroin misusers may present for detoxification several times. Failure is often associated with unemployment or the onset of drug use at an early stage.

Rehabilitation facilities are provided in the Northern Area Board at the Soilse Project in Henrietta Place. The Board also supports the SAOL project for female drug misusers in the inner city. The Crinan project in the inner city is also funded by the Area Health Boards and by Local Drugs Task Forces. Funding is also provided for rehabilitation services at Merchant's Quay, Cuan Mhuire and Coolmine.

Health Board schemes closely link with the VEC, Community Employment Schemes, FÁS (the Employment and Training Authority) and other back to work schemes in order to maximise the chances of drug misusers who are stabilised by getting employment and becoming socially reintegrated.

In other health boards support is given to agencies which provide rehabilitation services which complement the treatment services of the Boards, e.g. Aislinn Adolescent Treatment Centre in Ballyragget, Kilkenny and Cuan Mhuire in Bruree, Co. Limerick.

❑ *Enhanced support for voluntary groups and for services at local level.*

Health Boards work in partnership with a range of voluntary groups in order to provide an appropriate response to the drug problem. Funding is provided to groups such as Merchant's Quay, Coolmine, Rutland Centre and Cuan Mhuire and Community Awareness of Drugs in the East. In other health boards the same principle applies that groups whose work complements that of statutory services are financially supported, e.g. Aislinn Adolscent Treatment in Ballyragget, Anchor Treatment Centre in Cork, Cuan Mhuire in Bruree, Co. Limerick. In the East and South the Health Boards provide a co-ordinator for the 14 Drugs Task Forces whose action plans include significant community and voluntary group involvement.

- *The provision of at least four additional primary care clinics to service catchment areas in the Dublin area where harm reduction and assessment services will be provided to drug misusers.*

Treatment services are provided to drug misusers in the East at around 60 different locations. These comprise 4 large treatment centres and smaller satellite treatment clinics. A mobile clinic also provides low dose methadone and needle exchange, counselling and support to "hard to reach" groups such as women sex workers.

- *The involvement of general practitioners in the implementation of the methadone protocol.*

The Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations were introduced in 1998 placing tight control on the prescription and dispensing of methadone to drug misusers. General practitioners and community pharmacies were recruited by health boards to provide methadone treatment services to drug misusers who reside in their locality. At the end of November 2000 there were 135 GPs in the east and 29 in other Health Boards providing such services. In addition a number of GPs provide services on a contract basis in health board drug treatment centres and satellite clinics. At the end of November 2000 there were 4,966 people on the Central Methadone Treatment List, with 4,871 of these residing in the East and 95 in other Health Boards.

SECTION 10: FOOD AND MEDICINE CONTROL AND SAFETY OF BLOOD AND BLOOD PRODUCTS

For the 1994-1997 period, the Department of Health committed to updating the legislative controls relating to food and medicine. In addition, a national surveillance programme for controlling food borne diseases was to be developed and safe practices for the use of drugs and medicines encouraged.

Food

TARGETS:

- *The Department of Health and Children will revise the legislative controls relating to food and medicine in Ireland.*

An Interdepartmental Group, chaired by the Department of Finance, reviewed food and safety controls and reported in November 1996. This was submitted to Government arising from which the Government agreed a re-arrangement of certain Ministerial and administrative responsibilities for individual products with legislative amendments as appropriate and secondly the establishment of a Food Safety Authority reporting to the Minister for Health.

- *Develop a programme for controlling food-borne diseases/infections and safe practices for the use of drugs and medicines.*

The Food Safety Authority of Ireland (FSAI) was established in 1999 as a statutory, independent and science-based body with the mission of protecting consumers' health by ensuring that food consumed, distributed, marketed or produced in Ireland meets the highest standards of food safety and hygiene. The FSAI has service contracts in place with the main stakeholders in the food sector and has agreed a food sampling and analysis programme.

The original target refers to a national surveillance programme for the control of food-borne infections. The National Disease Surveillance Unit was established, which includes food-borne infections within its scope.

One of the functions of the Food Safety Promotion Board, one of the North/South Implementation Bodies, is the promotion of cross-border co-operation in relation to the surveillance of food-borne disease.

- *Aim to meet EU obligations for the harmonisation of legislation and the modernisation of control measures.*

The Food Unit is working towards the transposition of EU legislation, as it becomes required. Significant progress has been recorded on the harmonisation of legislation and the modernisation of control measures.

- *Establish a new food unit in the Department of Health and Children and a Food Safety Board.*

Since the mid-1990s, the Food Unit has existed as a separate unit within the Department of Health and Children and significant additional staffing resources have been made available to it. In addition, two food agencies have been established, the Food Safety Authority of Ireland (FSAI), which is responsible for enforcement and compliance with food safety legislation, and the Food Safety Promotion Board (FSPB), which is responsible for the promotion of food safety and co-operation in regard to food safety on the island of Ireland.

- *Upgrade food laboratory services.*

The Department of Health and Children has invested significant resources in the food laboratory services across the country.

- *Achieve accreditation to international standards of the food laboratories designated for the purpose of EU directives.*

The ten laboratories in the country, which are under the aegis of the Health Boards, have received international laboratory accreditation in line with EU obligations. Class 3 containment facilities, to deal with e.g. *E.Coli* 157, are being brought into commission in some laboratories.

- *Conduct negotiations at EU level for new legislation and scientific co-operation.*

The Food Unit of the Department of Health and Children, the Food Safety Authority (FSAI) and various other Departments are actively involved in negotiations at EU level on the whole range of EU legislative and scientific co-operation measures. Food safety is now a priority area of the European Union. In early 2000, the Commission published its White Paper on Food Safety, which includes a proposal for a new European Food Authority and a 70-point legislative programme. The Department of Health and Children is co-ordinating the Irish response to the initiative.

- *Guide local management on their obligations for the enforcement of new controls.*

The Department of Health and Children, in conjunction with the FSAI, holds regular meetings with local management regarding the new control requirements under the legislation. The FSAI issue standard guidelines to all enforcement agencies regarding the implementation of food legislation across the country. In the context of the Department of Health and Children's Business planning process, the Food Unit has identified as its primary policy objective the need to ensure that an appropriate legal framework, relevant structures and adequate resources are in place to facilitate the protection of the public in relation to food safety. It has identified the following steps as being necessary to achieve that objective:

- To develop policy in relation to food safety including contributing to its development at EU level and revising legislative requirements as necessary.
- To put in place appropriate arrangements and structures for the implementation of policy in relation to food safety at national level which provides the highest level of protection for public health.
- Ensuring Ireland's concerns in relation to food safety are addressed in complying with Ireland's international (non-EU) obligations.
- To continue to oversee the development of the FSAI.
- To support the implementation of the British Irish Agreement Act, 1999 in relation to the Implementation Body, the Food Safety Promotion Board (FSPB).

The Food Unit's primary objective and the steps proposed to achieve the objective are all consistent with the thrust of the targets set in this area in the 1994 Health Strategy but are now more policy-oriented.

Pharmacy and Medicine Controls

TARGETS:

- *A new Pharmacy Act to consolidate existing legislation, to introduce more effective controls on the practice of pharmacy and to conform to current international standards.*
- *A new Medicines Act to update and expand the existing controls under the Sale of Food and Drugs Acts and the Health Act, 1947 and to have regard to our obligations as a member of the EU.*
- *The continuing emphasis on good quality prescribing by doctors.*

- *Public education programmes on the appropriate use of medicines.*

Little progress is reported on new legislation in this area. Apart from a resource problem, the legislation was delayed while a more general review of "fitness to practice" was undertaken. While some legislative changes have been enacted the current view is that an overall review of medicines legislation is necessary to provide more effectively for the implementation of the various EU Directives and Regulations on medicinal products. The Department of Health and Children report that it is hoped to make progress on this issue in 2001.

New regulations on the control of pharmacies was put in place and this has had the desired effect of pharmacies locating in what were previously considered less attractive areas. Unfortunately, these regulations have been challenged on two fronts – the courts and the competition authority – and will need to be re-negotiated with the Irish Pharmaceutical Union (IPU).

The Irish Medicines Board (IMB) has been established. Under the Irish Medicines Board Act, 1995, the Board is the competent authority for the licensing, supervision and control of medicinal products placed on the market in Ireland.

Safety of Blood and Blood Products

TARGETS:

- *The Minister for Health will continue to take whatever action is necessary to ensure the highest possible safety standards for blood and blood products.*

The Minister is continuing to take all actions necessary to ensure the highest possible safety standards.

- *Report by an expert group established by the Minister on matters relating to the infection of the Anti-D Immunoglobulin product manufactured by the Blood Transfusion Board.*
- *The report of the expert group to be acted on urgently.*

The Expert Group reported to the Minister in January 1995. The recommendations of the Group in relation to blood safety were acted on as a matter of urgency, in conjunction with the recommendations of the Tribunal of Inquiry into the Blood Transfusion Service Board (see Appendix C). A summary of the main recommendations of the Expert Group is given in Appendix D.

SECTION 11: ACUTE HOSPITAL SERVICES

The Four-Year Action Plan determined that the role of each acute hospital would be defined as part of a co-ordinated network of services delivering high quality care in the appropriate setting in an equitable and cost-effective manner.

The development of the acute hospital services to include:

- A strong network of local and general hospitals which serve defined catchment areas and which will provide for general medical services.
- A number of larger regional hospitals where more specialised services are available and which provide a broad range of regional specialities to the region they serve.
- A small number of highly specialised tertiary or supra-regional units which serve much wider catchment areas and concentrate resources nationally to the best effect.

TARGETS:

- *Development of a comprehensive general acute hospital service within each health board area through a network of hospitals which will operate as a co-ordinated, complementary grouping. This will mean a precise determination of the role of each acute hospital as part of this grouping. It may also mean a redefining of the existing roles of some hospitals.*
- *Making the hospital service more responsive in the provision to general practitioners of an appropriate referral service; and in association with this, examining the use of services which should be provided by the general practitioner and developing measures to address this.*
- *Continual development and testing of emergency plans, to which the acute hospital service is central, to ensure the most effective response when a major emergency occurs.*

Investment in the day to day operation of the acute hospital programme has more than doubled since 1994. Revenue expenditure in this programme has increased by £1.4 billion over the period 1994 to 2001.

Improving the overall quality of hospital facilities throughout the country is a key national objective and planning for new and enhanced facilities for patients has been an important aspect of the Department of Health and Children's work since 1994. Over this period, a wide range of new units have been brought into service throughout the country while others are nearing completion.

The National Development Plan provides for capital investment of £1 billion to improve hospital infrastructure over the period 2000-2006. These resources will support further major developments which are currently at planning, design or early construction stages. In addition, there has been investment in hospitals which enables a programme of priority equipment replacement, essential maintenance and fire precaution works.

Over the period since 1994 activity levels in hospitals have increased as follows:

	1994	1999	1994-1999
In-patients	522,887	531,456	1.6% increase
Day Cases	193,018	296,631	53% increase

In addition there are approximately 1.89 million attendances at out-patient clinics per annum.

Equitable Access

TARGETS:

- *Greater transparency to be achieved through the designation of specific public and private beds thereby allowing closer monitoring of the relative accessibility of the service to each patient category and ensuring remedial action is taken if necessary.*
- *A detailed review of the Waiting List Initiative to be completed.*
- *Elimination of waiting times over 12 months for adults in the specialities with the biggest problems and 6 months for children in the case of ENT and ophthalmology.*

There has been an investment of almost £140 million in the Waiting List Initiative during the period 1994 to 2001. The Waiting List Initiative aims to reduce the in-patient waiting times in the 9 target specialities which include cardiac surgery, ENT, gynaecology, ophthalmology, orthopaedics, plastic surgery, general surgery, urology and vascular. The Waiting List Initiative is being continued on an annual basis.

The objective of the Waiting List Initiative is that in the target specialities, adults should not have to wait more than 12 months and children six months for a designated procedure. To achieve this the approach has been to develop a structured programme, involving all elements of the health care system, operating in an integrated and co-ordinated manner, to ensure the efficient, effective and timely delivery of elective procedures.

A Review Group on the Waiting List Initiative reported in 1998. This report found that the target waiting times for adults and children in the specialities noted were generally not being achieved. A number of short, medium and longer-term recommendations were put forward by this group relating to organisational and management issues in acute hospitals and to the interactions with other parts of the health system, including GP and community services.

Policy guidelines on issues which affect waiting lists such as liaison with GPs, and the management and validation of waiting lists were also issued subsequent to the report of the Review Group. Considerable progress has been made by a number of agencies in putting in place the measures and processes recommended.

In addition, funding has been provided to hospitals to address issues which affect waiting lists such as A&E service developments, the provision of additional funding for Winter Initiatives which assist in the freeing up of hospitals beds for elective services.

Review of Bed Capacity

A review of overall bed capacity in both acute and non-acute settings has been initiated in line with the commitment contained in the *Programme for Prosperity and Fairness*. The Review is being conducted by the Department of Health and Children in conjunction with the Department of Finance and in consultation with the Social Partners. The Minister for Health and Children presented the interim findings of the Review to Government last year and identified a range of short to medium term investment proposals aimed at addressing existing service difficulties. Further work is being undertaken to develop a longer-term investment strategy for the acute and sub-acute sectors.

Cardiac Surgery

Following a review of the distribution of cardiac surgery services nationally, it was decided to develop two additional centres, one each in Dublin and Galway, in addition to the two prior existing centres in Cork and Dublin. The provision of cardiac surgery for children is also being expanded at the two centres currently providing services.

Additional investment has been undertaken in recent years to support the development of cardiac care infrastructure under the Cardiovascular Health Strategy.

National Cancer Strategy

In the 1994 Health Strategy *Shaping a healthier future* cancer was identified as one of the main causes of premature mortality in Ireland. The National Cancer Strategy was published in 1996 and an Action Plan on its implementation was published in 1997.

The National Cancer Strategy has set a target of reducing the proportion of deaths from cancer in the under 65 age group by 15 per cent in the period 1994 to 2004.

The two underlying principles of the National Cancer Strategy are

- To take all measures possible to reduce rates of illness and death from cancer.
- To ensure that those who develop cancer receive the most effective care and treatment.

At national level, the main infrastructural elements of this Strategy have been put in place. These comprise:

- Establishment of a National Cancer Forum.
- Appointment of Regional Directors of Cancer Services (one in each health board area, three in the ERHA) to oversee the establishment of cancer services in their areas.
- Establishment of an Expert Steering Group to organise a National Programme of Screening for Breast Cancer.
- An Advisory Committee to oversee the establishment of a National Cervical Screening Programme.
- Co-ordination of multi-disciplinary multi-institutional research by the Health Research Board.
- Funding has been provided in 2001 to enable a number of health agencies to commence the development of centres of excellence for the care and treatment of symptomatic breast disease.
- A review group is examining the question of the further development of Radiotherapy services.
- Targeted funding has been allocated over the past two years to enable all health boards to commence development on counselling services for cancer patients.
- A review of palliative care services has been completed and is about to be finalised.
- Establishment of Ireland-Northern Ireland-NCI (National Cancer Institute) Cancer Consortium. This will result in the development of joint cancer research projects, scholar exchange programmes and a range of other collaborative activities.

The National Breast Screening Programme was initiated early in 1999 following the establishment of "Breast Check". This initiative, together with the National Cervical Screening programme which was initiated in 2000, are described in more detail in the section on Women's Health.

Data collected by the National Cancer Registry will play a central role in the ongoing development of cancer services.

Over £60 million non-capital funding has been allocated to date under the National Cancer Strategy. The main areas of development include the appointment of additional consultant posts in key areas, together with support staff. A number of these have already taken up post, while others are at various stages of recruitment.

Heart/Lung Transplant Programme

The government is committed to supporting the establishment of a heart and lung transplant programme in Ireland. At present, Irish patients requiring this service are treated in the UK. The Mater Hospital has been designated as the surgical site for the Irish programme and a project team is planning the development as part of a wider development programme for the hospital. Key consultant personnel have been appointed, including a transplant surgeon and respiratory physician. Pending the development of an Irish programme, an agreement was entered into with Freeman Hospital, Newcastle for the treatment of Irish patients requiring a lung or heart and lung transplant. The overall implementation of the programme is now being directed by a Consultative Group chaired by the Eastern Regional Health Authority.

Renal Services

The implementation of a three-year action plan for the development of renal services commenced in 2000. The Minister for Health and Children intends to establish a Renal

Strategy Group which will set out a national framework for future service delivery and build on the three-year Development Programme already underway. Capital and revenue funding have been made available for this development which is intended to provide for additional haemodialysis places, consultant nephrologist appointments and the development of the CAPD programme (home dialysis).

Hospital Accreditation

The Department of Health and Children has supported the development of a hospital accreditation scheme for public hospitals. Accreditation is an internationally recognised process which combines self-assessment and external peer review of an organisation's performance against a set of pre-determined standards. The objective is to encourage health agencies to focus on ways to continuously improve the health care delivery system. Development work on an Irish scheme, which will operate initially in eight major acute teaching hospitals in Dublin, Cork and Galway, is now complete. The scheme is designed to be patient-focused, promote continuous quality improvement and safety. In addition, it is also designed to be independent, voluntary and authoritative and aims to achieve international recognition.

A team of Irish surveyors has been assembled and trained. The first hospital survey is planned for early 2002, with the remaining seven hospitals to be surveyed in the following six months.

To proceed to rollout the project from its current development phase it will be necessary to establish an Accrediting Body to run the scheme. The Minister for Health and Children will be bringing proposals to Government in this area in the near future. Funding of £2.5m has been allocated to date to support the development of the programme.

Accident and Emergency Services

- *Bringing about a significant improvement in the quality of ambulance service through the implementation of the Report of the 1993 Review Group.*
- *The ambulance service to be regarded as a pre-hospital service with strong ties to the acute general hospitals.*

Following acceptance in 1994 of a Report of a Review Group on Ambulance Services, the Department of Health and Children has embarked on a phased programme of improvements to the ambulance services. Service developments include improved training for ambulance personnel, a cardiac ambulance service, upgrading of the ambulance fleet, and new command and control centres. In addition, the Department established the Pre-Hospital Emergency Care Council whose functions relate to:

- Standards in education and training ambulance personnel.
- Determining levels of competence for the national qualification for emergency medical technician.
- Making recommendations in relation to pre-hospital protocols and standard operating procedures.

A national standard patient report form has been implemented by all health boards. Standard operating procedures against which quality of care can be assessed have been prepared. The Pre-Hospital Emergency Care Council has been established on a statutory basis to further develop professional and performance standards in pre-hospital care.

Given increases in the number of people presenting at A&E Departments, additional funding and facilities has been provided. Associated developments have included enhanced staffing levels, the provision of observation beds/treatment areas adjacent to the A&E Department, the development of GP services, the development of rapid diagnostic facilities and more recently the provision of alternative care facilities for in-patients no longer requiring acute care.

Eastern Regional Health Authority

A significant organisational reform in the health sector during the period since the publication of *Shaping a healthier future* was the establishment of the Eastern Regional Health Authority (ERHA) and the three Area Health Boards to replace the Eastern Health Board.

From March 2000, the ERHA has had statutory responsibility for health and personal social services for the 1.3 million people who live in Dublin, Kildare and Wicklow. The ERHA's responsibility includes the strategic planning of services, commissioning of services and funding of services through service agreements with the three Area Health Boards, the voluntary hospitals and other voluntary agencies. It is also charged with monitoring and evaluating the services provided by these agencies.

These arrangements provide for the involvement of the large voluntary hospitals in the planning and co-ordination of services in the region through for example, membership of the Authority and the development of funding arrangements, service agreements and annual provider planning between the hospitals and the agency with statutory responsibility for the provision of all health services in the region (ERHA).

Cost-Effectiveness Procedures

TARGETS:

- ❑ *To promote even greater co-operation between health agencies so that their very significant joint buying power can be utilised and effective practices can be transferred from one agency to another.*
- ❑ *Consideration to be given, in conjunction with health agencies, as to how incentives might best be applied so that providers are rewarded and that the services ultimately benefit.*

The Healthcare Materials Management Board (HMMB) was established in 1998 under the auspices of the Chief Executive Officers of the health boards and voluntary hospitals. The Board is responsible for the co-ordination of national initiatives, for example medical equipment and introducing best practice guidelines. The Board recently published a *Health Service Procurement Policy* which is designed to ensure a common approach for all health agencies in the procurement of products, equipment and services. Regional Materials Managers have been appointed in all health board areas to ensure that best practice is observed in the procurement and material management area.

- ❑ *Incentives to be built in to the Value for Money programmes if they are to be sustained.*

A comprehensive Value for Money Audit of the entire health service began in May 2000 and is expected to be completed by mid-2001. This follows on from the Government's *Action Programme for the Millennium*. Part of the audit will address the management information systems of the Department of Health and Children and health agencies in regard to the provision of timely and accurate information required to monitor the essential areas of activity.

Other Initiatives

A number of additional initiatives have been undertaken since the publication of *Shaping a healthier future* towards the objective of reform and consolidation of the planning and delivery framework for the acute hospital services. These relate to:

- The establishment of an Inquiry which will review Post Mortem policy, practices and procedures in the State since 1970 particularly relating to organ removal, retention and disposal.
- Advancement of health personnel development including enactment of the Commission on Nursing, Medical Manpower Forum, Clinicians in Management, Office for Health Management.
- Promotion of governance through working with hospitals to improve governance at hospital board level.
- Development of hospital networks and support for hospitals collaborating and co-ordinating their services in the interest of optimising patient care.
- Development of Technology Assessment including, for example, the assessment of MRI requirements which has resulted in the provision of MRI facilities in a number of additional hospitals.

SECTION 12: HIV/AIDS PATIENTS

The AIDS strategy proposed for implementation by the Department of Health in 1994 was based on surveillance, prevention, care and management and anti-discrimination.

This strategy has the following objectives:

- To obtain a clearer picture of the prevalence of HIV infection in the community.
- To prevent the spread of HIV infection.
- To provide appropriate care and management at domiciliary, community and hospital level for those with HIV/AIDS.
- To ensure that persons with HIV/AIDS are not discriminated against.

A review of the National AIDS Strategy took place in 1999/2000 and a report *AIDS Strategy 2000* was published in June 2000. It shows that significant progress has been made since the publication of the first strategy in 1992 and also since the publication of the National Health Strategy in 1994.

Surveillance

TARGETS:

- *Maintain the existing linked testing programme and ensure the improved dissemination of information to Regional AIDS Co-ordinators by the end of 1994.*

Reporting of AIDS cases is carried out through the Regional AIDS Co-ordinators, who in turn report these cases to the National Disease Surveillance centre for inclusion in national statistics, which are published twice per year.

Regional AIDS Co-ordinators continue to play a key role in the collection and dissemination of information on AIDS.

- *Extend the existing unlinked anonymous surveillance programme on ante-natal bloods to sexually transmitted diseases (STD) clinics by the end of 1994.*
- *Introduce pilot unlinked anonymous HIV surveillance programmes for hospital outpatient attendances by the end of 1995.*

The Surveillance sub-committee of the National AIDS Committee examined the feasibility of commencing an anonymous programme in each of these areas. It decided, however, that because other estimates of the incidence of HIV were being obtained in various population groups e.g. through testing of all blood donors in the Blood Transfusion Service Board, the benefits of conducting additional studies in hospitals were minimal relative to the resources necessary to implement such studies.

The sub-committee examined the benefit of unlinked testing of blood from STD clinic attendees. Several attempts to get such a programme underway were taken, but due to ever increasing demands on Genito- Urinary medicine and STD services and cost/benefit factors it was decided not to commence a programme.

Another area which was defined for surveillance of HIV infection in "high risk" groups was drug treatment clinics. A survey was carried out among a random sample of 20 per cent of attendees at the Eastern Health Board methadone maintenance clinics in 1998. The HIV seroprevalance rate in this cohort was 8.3 per cent based on confirmed laboratory reports.

- *Continue to improve the reporting systems for AIDS cases and deaths during the period of the Plan.*

This improvement has taken place, with twice yearly reports being circulated by the Department of Health and Children on HIV/AIDS statistics. This function will transfer in 2001 to the National Disease Surveillance Centre.

Prevention

TARGETS:

- *Continue and enhance the existing primary education programmes on HIV/AIDS.*
- *Enhance risk-reduction programmes aimed at specific groups. This will include the provision of additional satellite clinics for drug abusers.*

To tackle the major health and social problems posed by the opiate problem in Dublin the Eastern Health Board (now ERHA) has developed a comprehensive programme of treatment and care for opiate misusers over recent years including the establishment of drug treatment services at 60 locations. These services include education and counselling, methadone maintenance, needle exchange, testing for hepatitis B and C and HIV, rehabilitation and aftercare.

Care and Management

TARGETS:

- *Develop domiciliary services for persons with AIDS.*

People who are in contact with health and social services are informed by officers such as Community Welfare Officers of the range of supports and benefits which are available.

Health Boards are responsible for the payment of Supplementary Welfare Allowance. Welfare entitlements have not been standardised as each case is dealt with on the basis of the needs of that individual. The Drugs/AIDS Teams in the Eastern Health Board include Community Welfare Officers and in the Southern Health Board, a Community Welfare Officer, based in Cork City, deals with HIV/AIDS issues.

- *Provide additional respite facilities and services.*

Facilities were developed at Cherry Orchard Hospital in 1990 to provide respite and terminal care to people with HIV/AIDS. The facility has been operating to full capacity (16 beds) and a waiting list is maintained. In 1998 the Eastern Health Board examined the changing needs in this area, taking account of new treatments. The ERHA will further evaluate the situation, particularly in the context of the appointment of an Infectious Disease Consultant in 2000, with a sessional commitment to the Authority.

The Hospice service in both the East and Southern Area Boards provides appropriate inpatient or other support services as required.

- *Develop support structures to enable general practitioners and other community-based personnel to provide appropriate care for HIV/AIDS sufferers.*

Although GPs were willing to treat patients with HIV it has transpired that of necessity, patients must access specialist care in outpatient clinics of hospitals because of the complex nature of new drug therapy regimes. Combination antiretroviral therapy with three or more agents is offered to those attending HIV/AIDS treatment clinics where such treatment is clinically indicated. Monitoring of the effects of drug therapy is done at frequent intervals, using such tests as viral loading testing. Liaison nurses greatly improve communication and co-ordination of services between hospital and community.

- *Phase in the recommendations of Comhairle na nOspideal on consultant services for AIDS patients.*
- *Recruitment of consultants in infectious diseases in the Eastern and Southern Health Boards and a consultant in palliative medicine in Dublin.*

The following consultant posts have been filled:

Two posts at St. James's Hospital (Genito-Urinary Medicine and Infectious Diseases) with some sessions in the Eastern Health Board. A third post will be filled in 2001.

One post at Mater/Beaumont (Infectious Diseases). Another post will be filled in Beaumont Hospital in 2001.

One post at Our Lady's Hospital for Sick Children, Crumlin (Infectious Diseases).

One post at Cork University Hospital (Infectious Diseases).

During 2001 a Consultant in Infectious Diseases will also be appointed in the Western Health Board.

Sessional Sexually Transmitted Diseases (STD) clinic arrangements have been put in place between the North Western Health Board and the Royal Victoria Hospital, Belfast.

A Palliative Care Consultant, based in Our Lady's Hospice in Harold's Cross, Dublin has overall responsibility for management of HIV/AIDS patients. In September 1999, 5 of the 145 patients in the hospice had AIDS related illnesses.

Three Consultant Psychiatrists, with responsibility for Drug Misuse oversee the clinical management of treatment services for drug misusers in the Eastern Regional Health Authority area. A fourth Consultant post will be filled in 2001.

A Consultant-led dedicated unit in the Dublin Dental Hospital provides specialist services for people with HIV/AIDS.

To cater for the increased workload and to ensure that the Virus Reference Laboratory in Dublin complies with quality assurance standards Comhairle na nOspideal has given approval for the appointment of a Consultant Microbiologist in the Virus Reference Laboratory to support the Director of the Laboratory who is a Microbiologist/Virologist. Another Comhairle Report on Haematology Services recommended that a consultant virologist post be shared between the Blood Transfusion Service Board (BTSB), now renamed the Irish Blood Transfusion Service (IBTS) and the Virus Reference Laboratory (VRL), with a commitment to a Dublin teaching hospital. This recommendation has been approved by the Minister and a consultant will be appointed in 2001.

Anti-Discrimination

TARGET:

- *Situation to be kept under review in consultation with other agencies to ensure that persons with HIV/AIDS are not discriminated against.*

The Discrimination Sub-Committee report in the *AIDS Strategy 2000* outlines the progress made in tackling discrimination. It concluded that it was not necessary for the Sub-Committee to continue meeting as most of the issues which caused problems in 1992 had been dealt with. NASC, however, will continue to keep the matter under review and the Committee will be reconvened, if necessary.

SECTION 13: ILL AND DEPENDENT ELDERLY

The 1994 Action Plan prioritised strengthening home, community and hospital services to provide the required support to ill or dependent elderly people and their carers.

TARGETS:

- *Priority will be given to strengthening home, community and hospital services for elderly people who are ill or dependent, and to assist those who care for them.*

In the period up to (and including) 2001, approximately £8m additional revenue funding was provided to improve home and community support through the recruitment of additional nurses, care attendants and para-medical staff e.g. physiotherapists, occupational therapists and chiropodists. In the same period up to 20 new Day Care Centres were opened, each providing on average 25 places per day or 125 places per week.

- *Promotion of healthy ageing, with the assistance of the National Council for the Elderly and in co-operation with the statutory and voluntary bodies involved with older people.*
- *Strengthening the role of the general practitioner, the public health nurse, the home help and other primary care professionals in supporting older people and their carers who live at home.*

In the period up to (and including) 2001, approximately £4.3m additional revenue funding was provided to strengthen the home help service by the recruitment of additional home helps to provide a service to new clients or increase the level of service to existing clients. Management structures in this area were also improved. In the 3 years 1999-2001, a sum of £4m was allocated for the purpose of providing assistance to informal family carers.

- *To ensure that not less than 90 per cent of those over 75 years of age continue to live at home.*

It is estimated that 95 per cent of those aged 65 years or over continue to live at home but, in the absence of precise information on the age profile of older people in public and private nursing home care, the number of those over 75 years of age continuing to live at home cannot be confirmed.

- *Increasing the number of specialist departments of medicine of old age so that every general hospital either has such a department or has access to one.*

This objective is reported to have been achieved.

- *Providing additional places for convalescent care for elderly people who do not need acute medical care.*

Most of the new community nursing units include a number of convalescent beds in their complement but, by far, the biggest development for older people who do not need acute medial care, has been the "winter initiative" scheme of the past few years. In the current phase of the scheme, 5000 such beds are being provided at a cost of £10m.

- *Ensuring that adequate funding is available to meet in full the requirements of the Health (Nursing Homes) Act, 1990 by the end of 1996.*

Funding up to the level requested by the Health Boards was provided on an increasing scale up to the stage where funding provided for the year 2000 was £38m. The sum provided for year 2001 is £52m which takes account of the 25 per cent increase in rate subvention with effect from 1 April 2001.

- *Providing eight small scale nursing units in the community by the end of 1997 to replace unsuitable accommodation and to meet the needs of the expanding population of older people.*

Since publication of *Shaping a healthier future* in 1994 small scale community nursing units have been provided in places such as Dublin (Navan Road, South Circular Road, Sir Patrick Duns, St. Clare's Ballymun, Dalkey), Carraroe, Wexford (Ely House), Edenderry, Drogheda, Killybegs, Ballyconnell, Clonmel, Fermoy and Achill.

- *The Department of Health and Children will commission a study on the implications for the health services of the projected increase in the elderly population over the next ten years.*

In October 1995, the National Council for the Elderly published a Report (No. 42) entitled *Health and Social Care Implications of Population Ageing in Ireland 1991-2011*. Proceedings of a conference on this topic were published subsequently.

SECTION 14: PALLIATIVE CARE

The 1994 Health Strategy recognised the importance of palliative care for terminally ill patients and supported the continued development of these services.

TARGETS:

- *Proper recognition will be given to the importance of palliative care for terminally ill patients, and the continued development of these services will be promoted in a structured manner.*
- *Enhanced role of general practitioners in developing appropriate palliative care services.*

The Programme for Government contains a commitment to develop a national hospice plan. Currently the provision of hospice (palliative) care is undertaken by a wide range of service providers, both statutory and voluntary. The National Cancer Strategy, 1996 noted links with local hospice/homecare teams were more advanced. The World Health Organisation has made palliative care a priority in its Global Cancer Control Programme.

A development programme for palliative care services was funded as part of the Action Plan 1997-1999 under the National Cancer Strategy. £2.2m was provided in 1997, £2.45m in 1998 and £1.8m in 1999. The funding has been used to establish new consultant posts in palliative care medicine in the Mid Western, South Eastern and Western Health Board areas. Additional nursing, paramedical and administrative staff have also been appointed.

Additional funding of £5.625m is being made available in 2001 for improvements in palliative care services. Of this £1.8m is being provided to continue the initiative which commenced in 2000 which will result in a minimum of one consultant-led, multidisciplinary team in palliative medicine in each health board. This will mean that between 2000 and 2001 an additional eight consultant-led teams will have been put in place. A sum of £0.825m is being provided for further improvements in palliative care services.

The Minister established a National Advisory Committee on Palliative Care Services in September 1997. The Committee has looked at the role of all health care professionals including general practitioners in palliative care services and has made recommendations which will be available on publication of the report.

In preparation for the publication of the Committee's Report, a further £3.3m was allocated to palliative care services in 2000. This will provide six additional posts of consultant in palliative care medicine; one each in the Southern, North Western, North Eastern and Midland Health Board Regions and two in the Eastern Regional Health Authority Area. This is intended to provide a consultant service in each health board region and additional nursing staff to expand the home-care and day-care services.

SECTION 15: PEOPLE WITH MENTAL ILLNESS

Ongoing development and implementation of the policy of service development in appropriate settings for people with mental illness or infirmity was incorporated in the Four-Year Action Plan.

TARGETS:

- *To restore the mentally ill to as independent and normal a life as possible.*
- *The service should provide care in a way that causes minimum disruption to the lives of the mentally ill and that of their families.*

The recommendations of the report, *Planning for the Future,* (1984) are considered to be still valid, i.e. that mental health services should be:

- Comprehensive
- Integrated with other health services
- Based as far as possible in the community
- Organised in sectors close to the people being served.

- *A research project to be undertaken (1994-1995) by the Department of Health and Children and the Southern Health Board, to assess the effect that more active intervention by the mental health services has on the suicide rate and those attempting suicide. Depending on the results of this report, further research may be necessary into the effectiveness of the methodology in other parts of the country.*

The need for reliable and concrete information on which to build a national strategy to address the growing problem of suicide was one of the key factors in the establishment of the National Task Force on Suicide in 1995. The terms of reference for this Task Force were to define the extent of the suicide and attempted suicide problem in Ireland and to make recommendations on how the problem might be addressed.

The report of the National Task Force on Suicide was published in 1998. Since the publication of the report, there has been a positive and committed response among both the statutory and voluntary sector towards finding ways of tackling the tragic problem of suicide. A Suicide Research Group has been established by the Health Boards and membership of the Group includes experts in the areas of mental health, public health and research. The main responsibilities of the Suicide Research Group are to review ongoing trends in suicide and parasuicide, to co-ordinate research into suicide and to make appropriate recommendations to the Chief Executive Officers of Health Boards.

The National Suicide Research Foundation was founded in January 1995 and was initially funded by the Department of Health and Children, the Southern Health Board and the Mid-Western Health Board. It became a Research Unit of the Health Research Board in 1997. In 1999, £200,000 was provided to the NSRF to establish a National Parasuicide Register.

This year £830,000 will go towards suicide prevention programmes in the Health Boards and towards research aimed at improving our understanding of this disturbing social problem.

Priorities for further enhancement of services for people with a mental illness or infirmity include:

- *To promote mental health, principally through support for the work of groups like the Mental Health Association of Ireland, GROW, AWARE and the Schizophrenia Association of Ireland and other groups active in this field.*

The provision of additional funding has assisted voluntary and statutory bodies to develop their medium and long term strategies.

- *Support for Departments of Psychiatry in general hospitals. A further nine departments to open in 1997.*

There are currently eighteen acute psychiatric units attached to general hospitals and another ten are at various stages of development. A further four are under consideration as part of the National Development Plan.

- *Integration of mental health and primary health services and in particular to strengthen the role of general practitioners in the care of the mentally ill.*

As community-based mental health services continue to develop, the role of the primary health services has become more integrated in the provision of mental health services.

- *Provision of a comprehensive specialist psychiatric service for children and adolescents in each Health Board.*

Considerable funding has been allocated to develop this service in recent years. There are now a minimum of two Consultant-led child and adolescent multi-disciplinary teams in each Health Board and project teams have been established in respect of three in-patient facilities which are being developed in Cork, Limerick and Galway.

- *Development of specialist assessment and community support services in each health board for people suffering from dementia, including Alzheimer's disease, and their carers.*

The provision of care for older people with dementia is a shared responsibility between community-based services, specialist geriatric services and mental health services. Patients in the community need a range of supports including day-care, respite and nursing services. When no longer able to remain at home, older people with dementia should be cared for in appropriate extended care facilities. The priority requirements in this area relate to the need to further develop consultant teams, the provision of residential units for older people with dementia, day hospitals, day centres, flexible respite care services both in residential units and in the patient's home, and assistance to voluntary agencies.

A number of initiatives have been taken in relation to the improvement of dementia services. Significant additional funding of £4m has been made available in the period 1999-2001 for the express purpose of providing assistance to carers. Additional funding of £1.7m has been made available to the Alzheimer's Society of Ireland for expansion of their services, particularly day-care.

A number of new Community Nursing Units for older people have been constructed in recent years providing respite and day-care for people with dementia. A further 30 such Units are expected to be put in place during the lifetime of the National Development Plan. In addition, purpose-built Units for the care of older people who are mentally infirm will be constructed under the NDP in a number of locations including Galway, Newcastlewest and Carndonagh. All new acute psychiatric units now being planned have provision for a number of beds specifically to cater for the mental health needs of older people.

The development of specialist departments of medicine for older people in general hospitals has been one of the most significant advances in the care of older people and those with dementia. There are 27 such departments at present. This specialist department ensures prompt admission of patients to hospital, specialist assessment, diagnosis and treatment, rehabilitation and where day hospitals exist, continuing support on discharge. A day hospital also provides for the investigation, treatment and rehabilitation where appropriate, of people without the necessity for in-patient admission. It is clear therefore, that the provision of adequate assessment, rehabilitation and day hospital facilities is crucial to the provision of a timely, accessible, less disruptive acute treatment service for older people. It would also significantly reduce the inappropriate use of acute hospital beds. The development of rehabilitation facilities is particularly important if older people with health problems are to be returned to the community capable of independent living.

The National Council on Ageing and Older People recommends that a consultant-led old age psychiatry service should be at the core of the development of mental health services for older people. When the *Review of The Years Ahead* was published in 1997, there were four consultant-led psychiatry of old age services. Additional resources have since been provided to expand the provision of specialist services in the psychiatry of old age. It is planned that by the end of 2001 some 14 consultant services will be in place.

There is a need to further develop services for people with dementia and their carers, particularly in relation to meeting the preferences of older people to be supported in their own homes. It is intended to continue recent initiatives based on allocating additional developmental resources towards the build-up of community supports for older people, including those with dementia.

- *Provision of appropriate facilities for the care of the mentally ill whose behaviour is at risk to themselves or to others.*

A Working Group was established to examine the needs of the disturbed mentally ill. Following the meeting of the Working Group a policy document was drafted and circulated to the Health Boards for comment. The document was endorsed by the Health Boards, and provision has been made as part of the NDP to develop intensive care units for the care of these patients.

- *The mental health services will encourage treatment for alcoholism on a non-residential basis, with the intervention of trained personnel in the community, in co-operation with general practitioners.*

In order to encourage the treatment of alcoholism on a non-residential basis funding has been provided to the health boards for the provision of trained personnel to work in the community services and in co-operation with general practitioners.

- *Introduction of a new Mental Health Act to give greater protection to the civil rights of the small number of people who have to be detained for treatment and to bring our legislation into conformity with the European Convention on Human Rights.*

Following the publication of the 1995 White Paper on mental health, a new Mental Health Bill was drafted and published in December 1999. The Bill has passed through the Committee Stage in the Dáil and will shortly go to Report Stage.

Considerable progress was made in providing acute psychiatric units at general hospitals and there are now 18 units in operation. Significant progress has also been made towards providing a community orientated mental health service as an alternative for persons with mental illness. New mental health centres, day hospitals and other day facilities have been set up and at the same time additional community-based residential accommodation has been made available. The number of community residences established in 1984 stood at 121 providing 900 places increasing to 368 in 1994 providing 2,685 places and at December 31st, 1999 stood at 392 residences providing 2,923 places. In addition, the number of day hospitals and day centres increased from 32 in 1984 to 176 in 1999. Capital funding of approximately £180m will be provided for mental health services over the lifetime of the National Development Plan (NDP). This funding will go towards the further development of acute psychiatric units and the enhancement of community-based residences and facilities.

SECTION 16: PEOPLE WITH MENTAL HANDICAP

The 1994 Action Plan was committed to the ongoing development of appropriate residential and community-based facilities for people with mental handicap, with particular emphasis on addressing unmet needs.

TARGETS:

- *Establishment of a national database on the needs of people with mental handicap, to ensure that the services which are being provided meet the changing needs of people with mental handicap and their families.*

  This database will:

  - Improve the accuracy of data available to health boards on the population of people with mental handicap.
  - Enable the current needs of clients with mental handicap to be assessed more accurately.
  - Support planning for the future development of services for clients.

  The National Intellectual Disability Database has been established and is being used to assist in identifying the needs of persons with an intellectual disability, the planning of services to meet those needs and to monitor progress as additional resources come on stream. Two annual reports have been published to date.

- *Expansion of residential and day-care places.*
- *Provision of flexible home support schemes and respite care facilities.*
- *Continuation of the programme to relocate people with mental handicap who are currently in psychiatric hospitals or appropriate care settings.*
- *A service development and implementation policy development for people with mental handicap who have disturbed behaviour.*
- *Policy development for services for people with autism*

  In addition to the development of a range of new residential, respite and day places and other support services for both children and adults, the programme to transfer persons with an intellectual disability from psychiatric hospital and other inappropriate settings is ongoing, as is the development of specific services to meet the needs of persons with autism and those who present with significant behavioural problems.

- *Commencement of a capital programme for training of persons with disability.*

  Since 1997 particularly, ongoing revenue and capital investment has been made available for the development of services. This was accelerated in 2000, with additional funding amounting to £68.7m (capital and revenue) allocated to the services. Between 1997 and 2000, additional funding of £121.1m was provided. Investment in 2001 will amount to £83m, (capital and revenue).

- *Provision of Hepatitis B vaccination for staff working in the mental handicap services and client groups who are considered to be at risk.*

  There is an ongoing programme to provide hepatitis B vaccinations for staff working in the services and for client groups who are considered to be at risk.

- *Assist in reducing the incidence of mental handicap by providing genetic counselling services. A new medical genetic counselling service to be established at Our Lady's Hospital for Sick Children, Crumlin, and supported by a genetic laboratory based at the hospital.*

The genetic counselling service has also been established in Our Lady's Hospital for Sick Children, Crumlin.

SECTION 17: PEOPLE WITH PHYSICAL/SENSORY HANDICAP

Continued development of services for people with a physical or sensory handicap on the basis of locally assessed need constituted the platform for targets proposed for this area in the 1994 Health Strategy.

TARGETS:

- *Provision of extra facilities for day care, respite care, home care and personal support services, and residential care/independent living opportunities.*

Since 1997, additional funding has been allocated for the provision of approximately 470 new day care places. A total of £20.5m additional funding is committed to the development of home support services, including personal assistance services to facilitate independent living and 51 long-term additional residential places have been created.

- *Provision of additional residential facilities for the young chronic sick.*

One new unit, with 25 places has been provided in Peamount Hospital in Dublin and the planning for similar units throughout the country is ongoing with development commencing as funding becomes available.

- *Improve the organisation and co-ordination of services.*

Co-ordinating Committees for Physical and Sensory Disability Services were established in each of the health board areas in 1998. The health board, voluntary sector service providers and service users are represented on each of these committees and one of their primary functions is to advise the CEO's of the relevant health boards on priority services for development.

- *Development of information on the service needs of clients – this will be facilitated by the establishment of a national database on physical handicap.*

The work of the National Physical and Sensory Disability Database Development Committee, which was established in December 1998, has progressed to the stage where 4 pilot sites have been identified to test the viability of the recommendations prior to their being finalised. It is currently envisaged that the Report of the Committee will be finalised in October 2001.

- *Improvement of vocational training standards and facilities with a view to greater economic integration of people with a disability in society.*
- *Employment of additional occupational therapists, speech therapists and physiotherapists.*

Between 1997 and 2000, an additional 54 Occupational Therapists, 37 Speech and Language Therapists and 33 Physiotherapy posts have been created in the health boards.

- *Improvement of the counselling and psychological support services for people with disabilities and their families.*

Additional funding of approximately £600,000 has been allocated by the health boards, in consultation with their regional co-ordinating committees, for the development of the family support and counselling services. Funding has also been invested in psychology services.

- *Address the funding base for voluntary bodies who provide services and support to persons with a physical/sensory disability.*

Additional funding in the region of £20m has been provided to address core under-funding of existing services for people with physical and sensory disabilities provided by voluntary agencies. A Review of appropriate levels of staffing in a number of specified agencies has been completed and is to be circulated to the health boards for comment. A Working Group was established in June 2000 to consider and make recommendations on the funding of voluntary agencies providing health and personal social services to people with physical and sensory disabilities.

- *Improve the availability of technical aids and appliances.*

Additional funding of £5m on-going revenue funding has been provided to address the aids and appliances needs of individuals with physical and sensory disabilities.

- *Steps to be taken to help reduce the incidence of Neural Tube Defects (NTDs) by increasing the awareness among women of child-bearing age of the need to have adequate folic acid in their diet.*

The Health Promotion Unit provides free leaflets on this issue to the public by way of General Practitioner's surgeries and health centres and are in the process of providing a web page on the internet as part of their ongoing campaign to increase awareness among women of child bearing age of the need to have folic acid in their diet.

SECTION 18: CONCLUSIONS

The Four-Year Action Plan 1994-1997 presented by *Shaping a healthier future* incorporates in excess of 200 targets over 17 different areas. This Action Plan was very innovative for the period and constituted a first attempt at incorporating some sort of performance monitoring process within a health system which had traditionally been more accustomed to crisis management. While a number of issues arise in the assessment of this plan, we must not lose sight of the fact that the specification of a range of targets which the health system made a commitment to achieving within specified time limits represented an enormous advancement for planning and policy development over this period.

Available information has been compiled here to provide an assessment of progress towards achieving the Action Plan targets and objectives. It is clear from this review that there has been substantial advancement towards the achievement of the majority of the targets proposed by the 1994 Health Strategy. In reviewing the fate of the 1994-1997 Action Plan, a number of issues arise which may be summarised as follows:

- There is substantial variation in the scope, range and specificity of the targets presented for the different areas. It is understood that at the time of development, there was no attempt to apply any type of standardisation framework to the development of these targets, probably in part due to the very tight time schedule prevailing. The result is that while some sections chose to use the opportunity afforded by the Action Plan to put together a challenging package of targets and objectives, others were less ambitious and chose "safer" options which were probably on course for achievement anyway. The absence of a standardisation framework also makes it difficult to quantify the success rate within and between areas.
- The 1994-1997 Action Plan is a very "flat" document, i.e. there is no ranking of priority targets either within or between areas. The resource implications were also generally not addressed. It seems reasonable to assume that all targets would not have equal value. It therefore seems important that there should be a means of applying some type of priority ranking, particularly where choices have to be made regarding resource investment. The approach to this ranking must be transparent and reflect agreed priorities for development within the individual service area and health policy in general.
- Ideally, the presentation of any target would incorporate the means of achievement, the centre(s) of responsibility and the information for assessment. From the information presented in this report, it is evident that there are substantial gaps in the data available to assess progress towards the achievement of particular targets. Even where information is available and targets have not been achieved as proposed, it may not be clear where difficulties have arisen, for example, has the implementation process failed or has the policy changed? It is also preferable that the monitoring of progress towards the achievement of such targets should be part of an ongoing performance assessment process rather than a once off exercise undertaken every few years. Where assessment is ongoing, steps can be taken to correct the implementation approach, adjust the policy or fill the information gaps as required at an earlier and potentially more useful stage of the process.
- It is important that any "Action Plan" is time bound. It is also important, however, that there is some flexibility built into any plan to enable revision, reorganisation or reprioritisation if required by some unexpected event or development. In the

health system particularly, the unexpected is more the norm which poses substantial challenges for the planning process and the implementation of any type of performance management approach. A balance must be sought, however, between the specification of goals and objectives which are important to ensure there is direction and achievement and the flexibility necessary to ensure that the unexpected is also addressed. In 1994, for example, it would not have been expected that issues like food safety, childcare and the safety of blood products would become the key issues they are to-day for health and government policy. While these issues are addressed at some level in the Action Plan, the targets proposed at that time do not reflect the high level of priority attached to these areas currently. It would be important, therefore, to ensure that an update or revision mechanism is incorporated into any plan to ensure that the proposed targets and objectives are consistent with current priorities for health system development.

The development and implementation of the 1994-1997 Action Plan represents a most valuable source of experience which may very usefully inform the development of the 2001 Health Strategy. While the overall framework for this Strategy has not yet been finalised, it is reasonable to expect that some type of target setting exercise will be incorporated into this process. It is evident from recent policy documents published by the Department of Health and Children that while target setting may be more or less specific, depending on the area, it is nevertheless considered important to advance policy beyond the aspirational to a more goal oriented approach if performance and implementation are to be improved. In current policy development, target setting tends to follow the SMART approach (i.e. targets should be Specific, Measurable, Achievable, Realistic, Time bound) and this would clearly be expected to be a course given serious attention by the Strategy development team. Given the experience of the 1994-1997 Action Plan, however, there are a number of factors arising which might usefully be taken into consideration as part of this process:

- The development of a **standardisation framework** which might be applied to the rating of targets/objectives within and between areas.
- A **priority ranking** which may be applied to proposed targets/objectives would ensure that all parties to the system have a common understanding of the level of importance attached to a particular issue, especially where choices have to be made in terms of resource investment or policy development. It would be reasonable to expect that this ranking could be reassessed periodically to ensure that the process of prioritisation is consistent with current needs and developments within the health services.
- While recognising that it is difficult to achieve and may not always be possible to achieve, it is nevertheless important that the **resource consequences** of the proposed targets/objectives are assessed at some level. This assessment does not necessarily have to be in monetary terms, which continues to be an ongoing challenge for the health system, but should address the resources most relevant to the issue of interest. For example, for many service areas currently, shortages of skilled personnel are posing huge difficulties so where commitments are being proposed which have staffing implications, then this is an important resource consequence which needs to be addressed.
- The **centre of responsibility** for the achievement of proposed targets/objectives needs to be clearly identified. This is particularly important where proposals are being made involving Health Boards or other agencies to ensure that those with key responsibility share the same level of commitment.
- The **means of achieving/delivering on proposed targets/objectives** also needs to be addressed. For example, will new legislation be required, or changes in work practices and approaches to service provision? If targets are developed independently of any consideration of how they are going to be achieved, feasibility may become questionable which, in turn, raises issues regarding credibility.
- The **way in which the achievement of targets/objectives is to be assessed/monitored/evaluated**, the **necessary information base** and the **time**

period for assessment/achievement/evaluation need to be clearly addressed. It is not useful to present targets that cannot be assessed where there is no expectation that the required information will become available within the specified time period. Any target specification exercise carries with it associated responsibility for ensuring that the information required to monitor implementation is available in the required format over the proposed time period.

- One of the most difficult challenges faced in any target specification process is ensuring that the targets conform with the SMART objectives while at the same time retaining a level of **flexibility** which may be required to respond to unexpected events. This becomes very apparent if we reflect on the priority issues prevailing within the health system currently and consider to what extent they reflect the expectations forthcoming in the early 1990s. It is therefore important to recognise that while it is important to attempt to plan and anticipate the priority issues for health system development over the next few years, it is probable that the prevailing consensus on this priority ranking will vary considerably over this time frame. It is therefore important to attempt to combine stability with flexibility and responsiveness. While prioritisation may vary over time, it is less likely that the importance of specific targets/objectives dissipates completely. The flexibility may therefore need to be applied more to the ranking of priorities than the scope of targets/objectives specified. It would, however, be important to ensure that where new and unexpected developments arise, the facility to add/delete from the ranking of targets/objectives is retained.

The Four-Year Action Plan proposed in *Shaping a healthier future* undoubtedly provided an essential reference point for the development of the health services since the mid-1990s. As such, this plan may be credited with providing an anchor for the health system while ensuring that focus was maintained on those objectives considered key to developments over this period. Because of substantial diversity within this system, it is important that all sectors can progress with reference to an integrated agenda which, since 1994, has been provided by *Shaping a healthier future*. Notwithstanding the diversity in range and scope, available evidence indicates that substantial progress has been made towards the achievement of the targets proposed in the Four-Year Action Plan. While recognising that this agenda is far from complete and that deficiencies remain to be addressed, it must also be acknowledged that the achievements over the period are commendable.

There is no doubt that the scope and scale of the contemporary health system, together with the increasingly rapid pace of development, pose enormous challenges for any attempt to specify a planning exercise over a multi-annual period. It is readily recognised that this is, however, an important process in order to provide focus to the development of the health system, to ensure transparency of policy objectives and facilitate the application of accountability to the appropriate centres of responsibility. The involvement of the key constituencies within the health system in the development of this plan is therefore crucial if those with front-line responsibility are to take ownership of any proposed targets/objectives as this will be an essential pre-condition for the achievement of a successful outcome.

REFERENCES

BOYLE, R., and S. FLEMING, 2000. *The Role of Strategy Statements*, CPMR Research Report 2, Dublin: Institute of Public Administration,

DAVEY SMITH, G., D. BLANE, and M. BARTLEY, 1994. "Explanations for Socio-Economic Differentials in Mortality: Evidence from Britain and Elsewhere", *European Journal of Public Health*, Vol. 4, pp. 132-144.

DEPARTMENT OF HEALTH 1992. *The Health of the Nation, A Consultative Document for Health in England*, London: HMSO.

DEPARTMENT OF HEALTH 1994. *Shaping a healthier future*: A strategy for effective healthcare in the 1990s, Dublin: Stationery Office.

DEPARTMENT OF HEALTH 1998. *The Health of the Nation – a policy assessed*, London: The Stationery Office.

DEPARTMENT OF HEALTH 1998. *Independent Inquiry into Inequalities in Health Report*, London: The Stationery Office.

DEPARTMENT OF HEALTH AND CHILDREN 1999. *Annual Report of the Chief Medical Officer 1999*, Dublin: The Stationery Office.

DEPARTMENT OF HEALTH AND CHILDREN 2000. *The National Children's Strategy: Our Children – Their Lives*, Dublin: Stationery Office.

DEPARTMENT OF THE TAOISEACH 2000. *Programme for Prosperity and Fairness*, Dublin: The Stationery Office.

FULOP, N., J. ELSTON, M. HENSHER, M. McKEE, and R. WALTERS, 2000. "Lessons for Health Strategies in Europe", *European Journal of Public Health*, Vol. 10, pp. 11-17

HEALTH SERVICES NATIONAL PARTNERSHIP FORUM, 1999. *Health Services Partnership Agreement*, June.

JOHNSTON, H. and T. O'BRIEN, 2000. *Planning for a More Inclusive Society: An Initial Assessment of the National Anti-Poverty Strategy*, Dublin: Combat Poverty Agency.

LAYTE, R., 2000. *Explaining Material Inequalities in Health: The Importance of Theoretically Based Measures*. Dublin: ESRI Working Paper.

LINK, 1998. *Implementation Group guidelines for the preparation of strategy statements under the Public Service Management Act, 1997*, Link – the Newsletter of the Strategic Management Initiative, April.

NATIONAL ANTI-POVERTY STRATEGY, 1997. *Sharing in Progress: National Anti-Poverty Strategy*, Dublin: Government Publications Office.

NOLAN, B., 1990. "Socio-Economic Mortality Differentials in Ireland", *The Economic and Social Review*, Vol. 21, No. 2, pp. 193-208.

NOLAN, B., 2000. *Targeting Poverty in the National Anti-Poverty Strategy*, Paper to Combat Poverty Agency Conference on Assessing the National Anti-Poverty Strategy, Dublin, May.

O'SHEA, E., 1997. "Male Mortality Differentials by Socio-Economic Group in Ireland", *Social Science and Medicine*, Vol. 45, No. 6, pp. 803-809.

TOWNSEND, P. and N. DAVIDSON, 1982. *Inequalities in Health (The Black Report)*, Middlesex: Penguin.

VAN HERTEN, L. M. and L.J. GUNNING-SHEPERS, 2000. "Targets as a Tool in Health Policy. Part II: Guidelines for Application", *Health Policy*, Vol. 53, pp. 13-23.

WORLD HEALTH ORGANISATION, 1998. (WHO), *HEALTH21: The Health for All Policy Framework for the WHO European Region*, Copenhagen: WHO.

Appendix A: Individuals and Organisations Consulted in the Course of the Study

Mr. Frank Ahern, Director, Department of Health and Children.
Mr. Paul Barron, Assistant Secretary, Department of Health and Children.
Mr. Vincent Barton, Principal Officer, Department of Health and Children
Dr. Declan Bedford, Chair, Public Health Committee, Irish Medical Organisation.
Mr. John Collins, Principal Officer, Department of Health and Children.
Dr. Tim Collins, Drury Communications.
Dr. Sean Denyer, Director of Public Health, North Western Health Board.
Mr. Donal Devitt, Assistant Secretary, Department of Health and Children.
Dr. John Devlin, Deputy Chief Medical Officer, Department of Health and Children.
Mr. Denis Doherty, Chief Executive Officer, Midland Health Board and Director, Office for Health Management.
Mr. Eugene Donoghue, Chief Executive Officer, An Bord Altranais.
Ms. Mary Dowling, Assistant Principal Officer, Department of Health and Children.
Mr. J.A. Enright, Assistant Secretary, Department of Health and Children.
Mr. Finbar Fitzpatrick, Chief Executive, Irish Hospital Consultants Association.
Dr. Kate Ganter, Chair, Hospital Consultants Committee, Irish Medical Organisation.
Mr. Charlie Hardy, Principal Officer, Department of Health and Children.
Ms. Anna-May Harkin, Assistant Principal Officer, Department of Health and Children.
Mr. Pat Harvey, Chief Executive Officer, North Western Health Board; Chairman of the CEOs Group; Joint-Chairman of the Health Service National Partnership Forum.
Mr. Fintan Hourihan, Irish Medical Organisation.
Dr. Fenton Howell, Specialist in Public Health Medicine, North Eastern Health Board.
Mr. John Hurley, Secretary General, Department of Finance.
Mr. Michael Kelly, Secretary General, Department of Health and Children.
Dr. Jim Kiely, Chief Medical Officer, Department of Health and Children.
Mr. Fergal Lynch, Principal Officer, Department of Health and Children.
Mr. Tom Mooney, Deputy Secretary, Department of Health and Children.
Mr. Fionan O'Cuinneagain, Chief Executive, Irish College of General Practitioners.
Mr. Tom O'Mahony, Assistant Secretary, Department of the Environment and Local Government.
Mr. Donal O'Shea, Regional Chief Executive, Eastern Regional Health Authority.
Dr. John Pinkerton, Centre for Child Care Research, Queen's University Belfast.
Mr. Dermot Smyth, A/Assistant Secretary, Department of Health and Children.
Ms. Frances Spillane, Director, Department of Health and Children.
Dr. Cillian Twomey, Geriatrician; Hospital Consultants Committee, Irish Medical Organisation and President, European Union of Medical Specialists.

APPENDIX B: DEPARTMENT OF HEALTH FILES REVIEWED

PL 28/1	Preparation of "National Health Strategy" Document 1993
PL 28/4	Health Strategy Co-ordinators
PL 28/5	Health Strategy Co-ordinators
PL 28/7	Official Responses to the Health Strategy
PL 28/8	Strategic Management Initiative
PL 28/9	Submissions Received in Response to the Health Strategy
PL 28/10	Health Boards Strategy Implementation Plans
PL 28/11	1st Anniversary of publication of Health Strategy Progress Reports – Health Boards
PL 28/12	1st Anniversary of Publication of Health Strategy Progress Reports
PL 28/13	1st Anniversary Report on Implementation
PL 28/15	Health Strategy – Health Boards Mid-Term Review
PL 28/16	Health Strategy Mid-Term Review – Department.
PL 28/16	(Mid) Second Review of Health Strategy
PL 28/17	Health Strategy – 3rd Year Review

APPENDIX C: RECOMMENDATIONS OF THE TRIBUNAL OF INQUIRY INTO THE BLOOD TRANSFUSION SERVICE BOARD

1. Immediate Developments at the BTSB

In May 1995, the Government agreed to fund a major consultancy exercise at the BTSB which was undertaken by Bain and Company, an international strategy consulting firm. The Government agreed to fund this exercise in order to improve the management and organisation of the BTSB. In May 1995 the Board unanimously adopted the recommendations in the Report, which involved major reorganisation and restructuring. Substantial progress has been made in implementing the Report's recommendations.

2. Tribunal of Inquiry into the Blood Transfusion Service Board

The Tribunal of Inquiry into the Blood Transfusion Service Board was established in October 1996 and published its report (Finlay Report) in March 1997. The report made six key recommendations. Substantial progress has been made in meeting these recommendations, as outlined below.

2.1 IBTS DEVELOPMENT PLANS

A multi-million pound investment programme was approved to support the reorganisation and redevelopment of the Irish Blood Transfusion Board nationally. The primary objective is to ensure that the IBTS is resourced to provide a transfusion service in line with best international standards. Significant additional resources were made available to the IBTS to support the following programmes:

- Provision of a new national headquarters at a cost of approximately £36m (including design, project management, site management, construction, validation and equipping);
- Development of a new components processing laboratory and other improvements at the Cork Centre;
- Implementation of a new IT system at a total cost of £4m (also recommended by the Bain report, see above);
- The introduction of new technologies to improve the safety of the blood supply, at a total annual cost of £4.7m;
- Additional staff appointments;

During 1998 approval was given to recruit additional medical consultants. The Department of Health and Children also approved the recruitment of four additional Quality Assurance staff, including two posts for the Cork centre. The annual cost of the development programme, excluding the capital funding, was approximately £6.5m.

2.2 MONITORING OF THE IBTS BY THE IRISH MEDICINES BOARD

The Finlay Tribunal Report recommended that the Irish Medicines Board (IMB) formally the National Drugs Advisory Board should carry out more regular inspections of the IBTS and these arrangements have been put in place. The report also recommended that the IMB would prepare an annual report for submission to the Minister in relation to its inspections of the IBTS. Three such reports have been received and published to date. A number of operational deficiencies were identified by the IMB during its inspections and these either have been addressed, or are currently being addressed, by the IBTS as a matter of priority.

2.3 NATIONAL HAEMOVIGILANCE PROGRAMME

The Minister officially launched the National Haemovigilance Office in November 1999. The main function of this Office is to receive, analyse and report adverse reactions to blood and blood products. In preparation for the establishment of a National Haemovigilance Office, the Department of Health and Children requested hospitals to put necessary arrangements in place to ensure that abnormal reactions to blood components are reported. To achieve this important objective, the Department of Health and Children provided dedicated resources to hospitals to develop and strengthen transfusion medicine, including their haemoviligance support service. In 1999 revenue funding of £1.35m was made available to hospitals to improve transfusion practice and to support the implementation of the National Haemovigilance Programme. A further £ 250,000 revenue funding was providing in 2000.

The first Annual Report of the National Haemoviligance Office, based on the period 1 October 1999 to 31 December 1999, has now been published.

2.4 NATIONAL BLOOD USERS' GROUP

In July 1998 the Minister established a National Blood Users' Group comprising a number of specialists with a particular interest in blood utilisation. The functions of the group are to develop blood utilisation guidelines and address patients' attitudes and concerns about transfusion. The Group will issue Guidelines on the Transfusion of Red Blood cells in Surgical Patients in 2001. This will be followed with guidelines on neonatal and paediatric transfusion; use of platelets and plasma; administration of blood products; use of blood products in the management of massive haemorrhage, and others.

2.5 BLOOD SERVICE CONSUMERS' COUNCIL

The Tribunal report recommended that the establishment of a blood service consumers' council could make a major contribution to the maintenance of public confidence in the supply of blood products. The Department of Health and Children is currently finalising proposals on the role and functions of this council having regard to the separate roles and functions of the Irish Medicines Board, the Consultative Council on Hepatitis C and the National Blood Users' Group.

2.6 PRODUCT RECALL

The IBTS has issued revised operating procedures to all hospitals covering the receipting, recall and tracing procedures for blood and blood products. The revised procedures were developed in consultation with the Irish Medicines Board.

2.7 REPLACEMENT OF BLOOD OR BLOOD PRODUCTS

The IBTS has arrangements in place, should the need arise, for the immediate replacement of blood components such as red cells, platelets and plasma. As regards other blood products, the IBTS and the IMB are finalising arrangements for alternative supplies of licensed blood products.

Factor 8 and Factor 9 are clotting factor products used in the treatment of haemophilia. Until recently, the only products available were produced from human plasma. At the end of 1997, the Department of Health and Children approved the replacement of plasma-derived Factor 8 with a recombinant product which offers a greater margin of safety with regard to the transmission of infections. The replacement process was put into effect in early 1998. The Department of Health and Children also approved in advance the replacement of the plasma-derived Factor 9 product. As soon as the recombinant product became available in 1999 it replaced the plasma-derived product. Ireland remains a world leader in the changeover to these products.

The Department of Health and Children's allocation to health agencies in respect of Factors 8 and 9 increased by almost £13m over the period 1998-1999, due principally to the higher cost of the recombinant products, and the fact that recombinant Factor 9 replaced the plasma-derived product on a ratio of 1.3 to 1.

3. Developments in Transfusion Medicine

Since November 1999 all blood donations collected by the Irish Blood Transfusion Service (IBTS) are screened by PCR for Hepatitis C. PCR testing is a further safeguard aimed at improving the detection of Hepatitis C during the window period. The typical length of the window period without PCR testing is 10-14 weeks. Following the introduction of PCR testing, this window period is reduced to on average 25 days. In order to introduce this test as rapidly as possible, the IBTS contracted with the Scottish National Blood Transfusion Service (SNBTS) in Edinburgh to conduct the test on its behalf. The SNBTS was selected as it has an aggressive programme for the introduction of PCR testing for all donations. The introduction of PCR to detect HIV is being arranged at present.

4. Transfusion Surveillance

In March 1999 the Blood Policy Division issued a circular to the CEO of each Health Board, advising Health Boards and hospitals that necessary arrangements should be put in place to ensure that abnormal reactions to blood and blood components were reported to the National Haemoviligance Office, BTSB. The appointment of Transfusion Surveillance Officers was proposed to investigate reactions to blood transfusions and report such reactions, as appropriate. The establishment of Transfusion Committees was also recommended to promote best transfusion practice and to develop hospital based transfusion protocols and transfusion training. The circular also recommended that multidisciplinary transfusion committees should lead to the audit of hospital blood component usage. Resources are being made available to support this programme.

5. Health Services for Persons with Hepatitis C

Persons who contacted Hepatitis C through the administration within the State of blood and blood products are entitled to a range of primary and hospital-based services, free of charge.

5.1 PRIMARY HEALTH CARE SERVICES

The Health (Amendment) Act, 1996 provides for the Health Boards to make available a comprehensive range of services to eligible persons. Services available include: GP services; drugs; medicines and appliances; dental, ophthalmic and aural services; counselling services; home support and home nursing; other necessary services. Liaison officers were appointed in each Health Board to co-ordinate the services provided under the Act, and to provide a contact point for Hepatitis C patients and the four support groups (Positive Action, Transfusion Positive, Irish Haemophilia Society and the Irish Kidney Association). The Department of Health and Children continues to maintain contact with the representative organisations and the Health Board liaison officers to ensure that any problems that arise are resolved quickly and effectively.

5.2 HOSPITAL SERVICES

Hospital services continue to be provided in seven designated Adult Liver Units in Beaumont, St. James', the Mater and St. Vincent's Hospitals in Dublin; Cork University Hospital; University College Galway and St. Luke's Hospital, Kilkenny. In 1999, it was decided to fund a designated Liver Unit at our Lady's Hospital for Sick Children, Crumlin, for the provision of services to children with Hepatitis C.

Appendix D: Summary of the Main Recommendations of the Expert Group on the Blood Transfusion Service Board (January 1995)

The report of the Expert Group recommended that:

- All hospitals should designate a named person with responsibility for product recall;
- The BTSB should take the lead role in matters affecting blood and blood products, while counselling and advice about treatment options should be done by those with relevant expertise;
- There must be clearly defined mechanisms for ensuring the views of medical personnel are channelled effectively to the Board of the BTSB.

The above recommendations have all been implemented.