

RESTRICTED – EXECUTIVE COMMITTEE

Memorandum EC (00)

To: Executive Committee Members

From: Minister of Health, Social Services and Public Safety

A STRATEGY FOR PUBLIC HEALTH

Introduction

1. Good health is a basic human right and is matter of fundamental public concern. Ill health costs the economy and the public purse billions of pounds every year. While there have been significant advances in the prevention and treatment of disease over the past 100 years, the reality is that we have levels of premature death and illness here that are excessively high and still compare unfavourably with other developed countries. Put simply, we are sicker and die younger than people in most other parts of Western Europe.
2. Furthermore, ill health and premature death are highly correlated with poverty. If you are poor, you are more likely to be sick and to die younger. Consequently, any strategy to promote public health must include a strong element of action to counter inequality.
3. Public health is a key issue for the Executive Committee. We cannot ignore these quite shocking levels of ill-health and inequality in our community. Improving our population's health and well being is a problem that we can and must tackle but it will require determined action across all parts of Government. This paper outlines an approach to the development of a comprehensive strategy to deal with this issue.

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Causes of Ill Health

4. The underlying determinants of health and disease are complex. They include socio-economic factors such as poverty, housing, the environment, and working conditions. Lifestyle factors such as smoking, inappropriate diet and physical inactivity are estimated to contribute to about 1 in 3 deaths. The major causes of death and ill health throughout Ireland are coronary heart disease, cancer, stroke and accidents. More information on causes is at **Annex A**.

Comparisons with Other EU Regions

5. There is a substantial raft of data which bears out our poor health status. Our death rates from coronary heart disease and some cancers are amongst the highest in Western Europe. Young men here are more likely to die as the result of an accident. Teenage pregnancy rates are among the highest in Europe. Our population suffers a poorer quality of life and a lower life expectancy than those in other developed countries. Further details are at **Annex B**.

Inequalities

6. The great disparities in health between rich and poor in our society are an affront to equality and social justice. The evidence is clear: the better off you are, the longer you can expect to live. The correlation is particularly striking for coronary heart disease, infant mortality, and accidental death. Some 40 premature deaths could be avoided here every week if those living in the electoral wards with the highest death rates enjoyed the same health status as those in wards with the lowest rates. Further briefing is at **Annex C**.

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7. The inequalities in health are observed right across the socio-economic spectrum, not just between the two extremes. The relationship between socio-economic inequalities and health status has been acknowledged by all the devolved administrations in Great Britain, and in Ireland, and is reflected in inter-Departmental strategies already in place or in the course of preparation.
8. It is unacceptable that an individual's social class, often determined before birth, should be a key factor in deciding their health, wellbeing and life expectancy. The critical challenge to a new public health strategy is to narrow this health gap and give those in poorer sections of society a better prospect for their health and wellbeing.

Inter-Departmental Co-ordination

9. In charting the way forward it will be important to develop a strategic approach that sets out a series of programmes designed to secure short term, medium term and longer term gains. The programmes for short term gain include the need for continued screening and immunisation of the population at large to control the threat from some of the major causes of death and illness. The medium term programmes include action on food safety and health and safety at home, in the community and in the workplace. The longer term programmes are those where a return will be achieved only by changing attitudes and behaviours and overcoming some intractable obstacles. Other Departments and sectors need to be seized of these issues and to be signed up for the action required to deal with the risk factors. Clear objectives, meaningful goals and realistic targets need to be established and agreed. All of this requires a collaborative, cross-government approach.

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10. Because the causes of ill health are so diverse, many public policies impact on health. It has been estimated that action by HPSS organisations alone can contribute only some 10% to potential health gain. The wider determinants of health include factors in education, the environment, the home, the workplace and the community. An effective strategy will depend on other Departments and their agencies for the action needed to deliver improved health outcomes. We will need to strengthen linkages across programmes. These include, in particular, education, social development, housing, the environment, transport, employment and public safety. Public health must, therefore, be fully included at the core of the Programme for Government and in the arrangements for its financing and implementation.
11. Such an approach will require high level commitment and leadership. I would propose to re-constitute the Ministerial Group on Public Health, which was first established in 1997 and which was chaired by the then Health Minister and comprised senior officials from the previous six Departments. I would chair the Group and would invite representation at senior official level from all the devolved Departments. This would create a forum for tackling the public health issues on an inter-Departmental basis. To be effective, all those participating must be fully committed to the objectives and must have the full authority of their Minister to develop programmes of action which will operate on a cross-cutting basis.
12. Some inter-Departmental initiatives are already in place. Since 1995, action to promote and develop *early years services*, and action against *domestic violence*, has been carried forward effectively within an inter-Departmental framework. Co-ordinating machinery is also working well against *drug misuse*. Inter-agency initiatives are already in the

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- The pipeline to address the issues of *teenage parenthood, travellers' health, smoking, and home accidents*.
16. We also need to take account of recent and planned developments in
13. A number of initiatives have also been taken since 1998 to break down obstacles to inter-agency co-operation at local level. For example, *Health Action Zones* promote collaboration across organisational boundaries to combat persistent health problems. *After School Clubs* and *Healthy Living Centres*, both funded through the New Opportunities Fund, impact on health through schools and local communities. We will need to look at how best to consolidate these initiatives in the context of the new administrative structures.
14. We need also to ensure that all policy proposals that may impact on health are subjected to a systematic assessment before final decisions are taken. We are still at an early stage in developing a robust and practical methodological approach to *Health Impact Assessments* and *Health Inequalities Impact Assessments*. More work is needed to embed these relatively new procedures firmly in the policy making process across all Departments.
15. District councils, community networks, schools, occupational health systems and the voluntary sector all have an important part to play. Systems need to be in place at a regional and local level to ensure that they are fully included in developing and carrying forward the public health agenda, and that their contribution is maximised. The community development approach needs to be strengthened throughout the HPSS, and all HPSS agencies must be encouraged to reach the best practice levels already attained by some, and then to continue improving.

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The All-Ireland Dimension

16. We also need to take account of recent and planned developments in Ireland and GB and to explore opportunities for carrying forward elements of the new public health agenda on an all Ireland basis. On the environment, there are important cross border issues and an opportunity to take them forward as part of an Environmental Health Action Plan. The *Food Safety Promotion Board* is drawing up its first plan and preparing to recruit staff. The *Institute of Public Health in Ireland* is already working to improve health by contributing to the reduction in inequalities and to influence public policies in favour of health. Cross-border initiatives have also recently been taken in heart disease, cancer, and health promotion.

The International Dimension

17. Within Europe and in North America, some regions have already achieved impressive results through a high level commitment to the proactive approach to public health proposed in this paper. The Amsterdam Treaty is already raising the profile of European Union States' public health programmes and the European Commission launched its proposals for a new strategy for public health on 16 May. We should therefore establish strong international linkages to facilitate benchmarking, co-operation, sharing of best practice and joint research.

Promoting Equality

18. Underpinning the entire strategy must be a focus on improving the health of the most disadvantaged and marginalised groups and communities in our society. My Department's *New TSN Action Plan* represented a step forward towards reducing health

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inequalities. A key strand of that programme is to skew resources towards the needs of the most disadvantaged groups, and this strand will need to be embedded in all our public health programmes. We will in addition identify ways of strengthening the Plan and of fast tracking the process to achieve early wins.

Conclusion

19. The agenda for action is clear.
20. First, my Department and its agencies need to do more to integrate and focus health and personal social services programmes on tackling the key factors associated with ill health and premature death. I intend to look at the current arrangements across the HPSS for promoting health and to strengthen the capacity of those working for public health more generally.
21. Second, and critical to the success of the strategy, will be ensuring that other Departments' potential contributions to these programmes are maximised. In addition, we must develop more effective mechanisms to ensure that all public policies which impact on health are appraised and implemented in an inter-departmental framework. Public health is a genuinely cross-cutting issue and for these reasons, the inclusion of all sectors – public and private, voluntary and community, - is vital to the success of the strategy and more effective arrangements are needed to ensure this.
22. Finally, underpinning the new strategy, we must find ways of addressing the unacceptable inequalities in health that are evident across our society. In particular, we must ensure that our programmes are concentrated on those suffering the worst health, or who are most at risk.

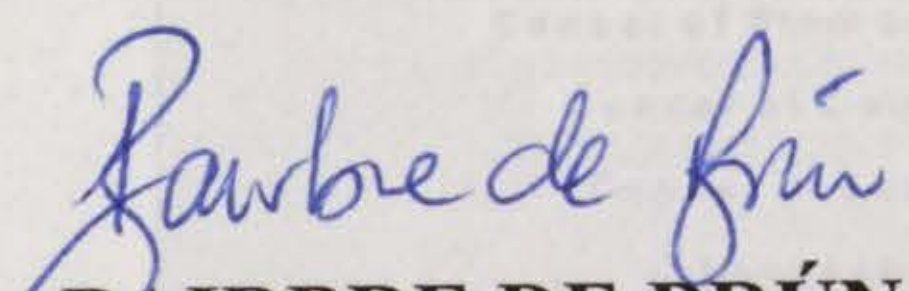
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23. As other countries have already done with success, we need now to begin to review fundamentally our public policies and structures in light of their health implications, and to put forward for public consultation a new and comprehensive public health strategy. Essentially, a three stage process on consultation and development is needed, as follows:

- in collaboration with other Departments and representatives from outside Government, produce a consultation paper on public health for publication and proposals for a full consultation process (target date October);
- stimulate public debate on the consultation paper, including media articles, public events, Assembly hearings and participation of voluntary and community sector representatives in working groups on specific issues (4 months or longer if necessary to ensure a fully inclusive process);
- finalise the strategy, including a time-tabled implementation plan, also for publication (3 months).

24. In conclusion, this is an issue that our Administration can and must address on a cross-departmental basis and the Executive Committee is asked, therefore, to endorse the proposal that work begins to take forward this work on an inter-Departmental basis as set out in this paper.


BAIRBRE DE BRÚN

Minister of Health, Social Services and Public Safety

June 2000

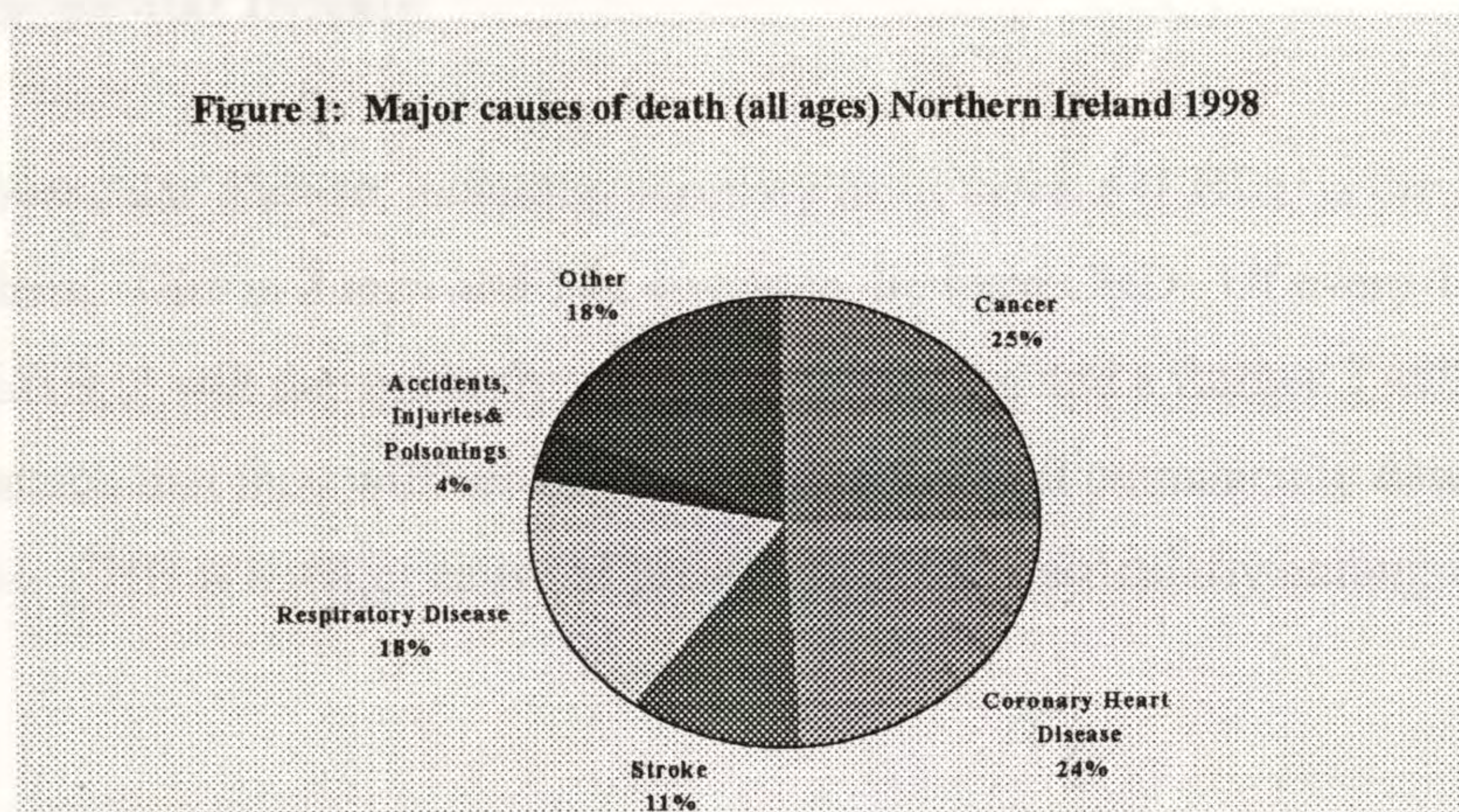
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POPULATION HEALTH INFORMATION:

THE MAJOR CAUSES OF DEATH AND ILL HEALTH

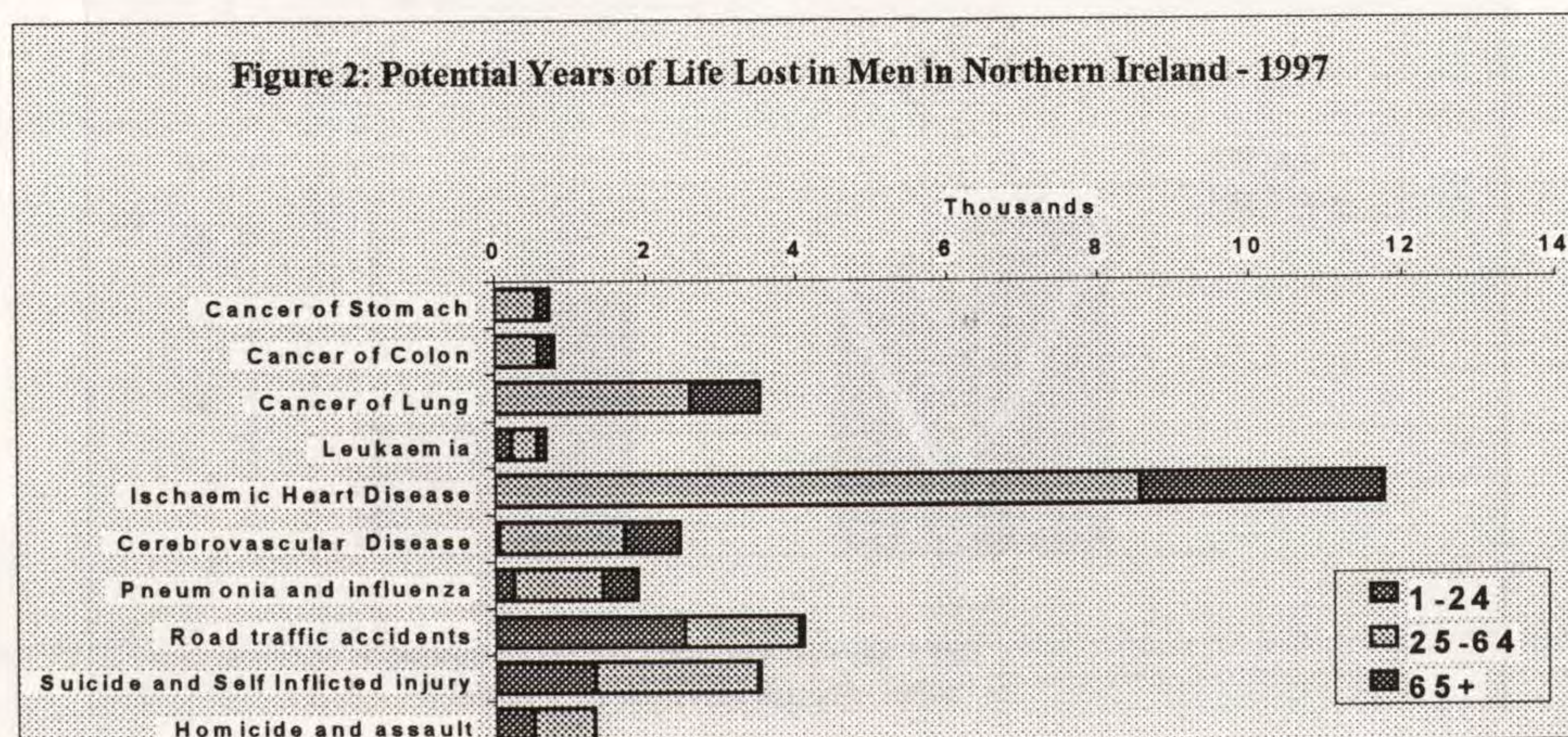
The major killers are heart disease, stroke and cancer, which together account for 6 of every 10 deaths. (Figure 1)

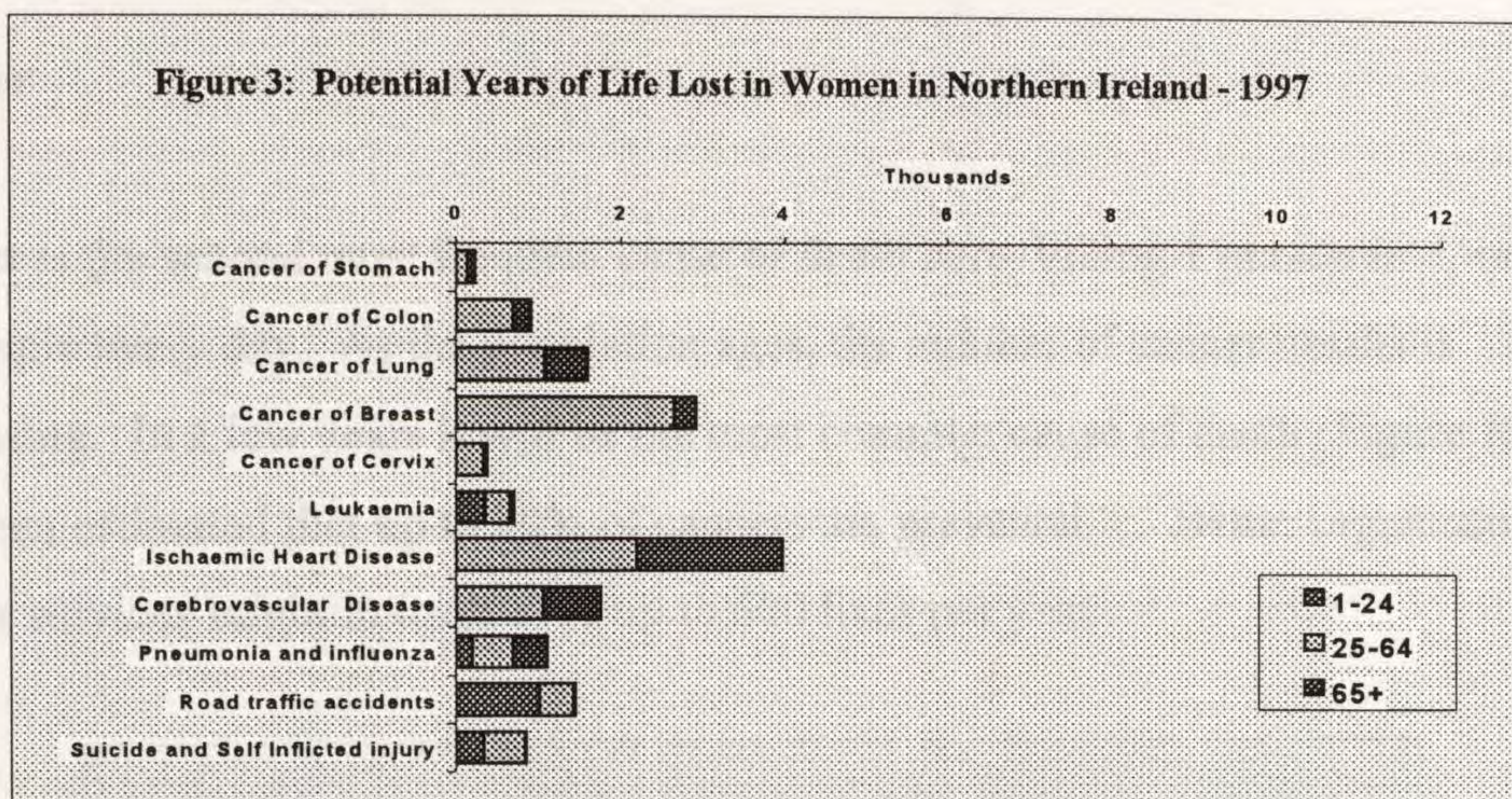
Figure 1: Major causes of death (all ages) Northern Ireland 1998



Other major causes of premature death include accidents and mental illness. Many thousands of years of life are lost as a result of these diseases (Figures 2 & 3)

Figure 2: Potential Years of Life Lost in Men in Northern Ireland - 1997

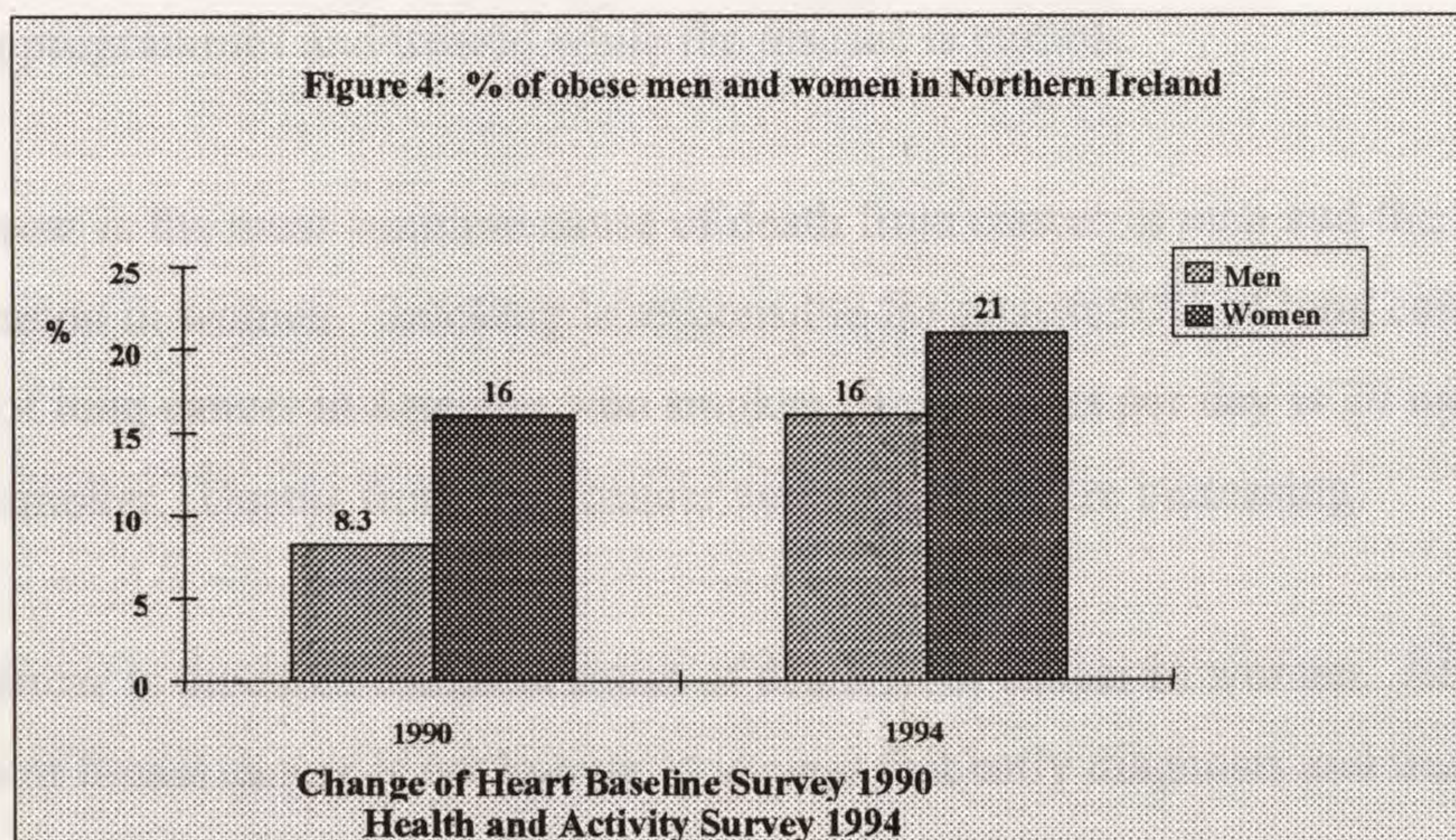




Cardiovascular Disease

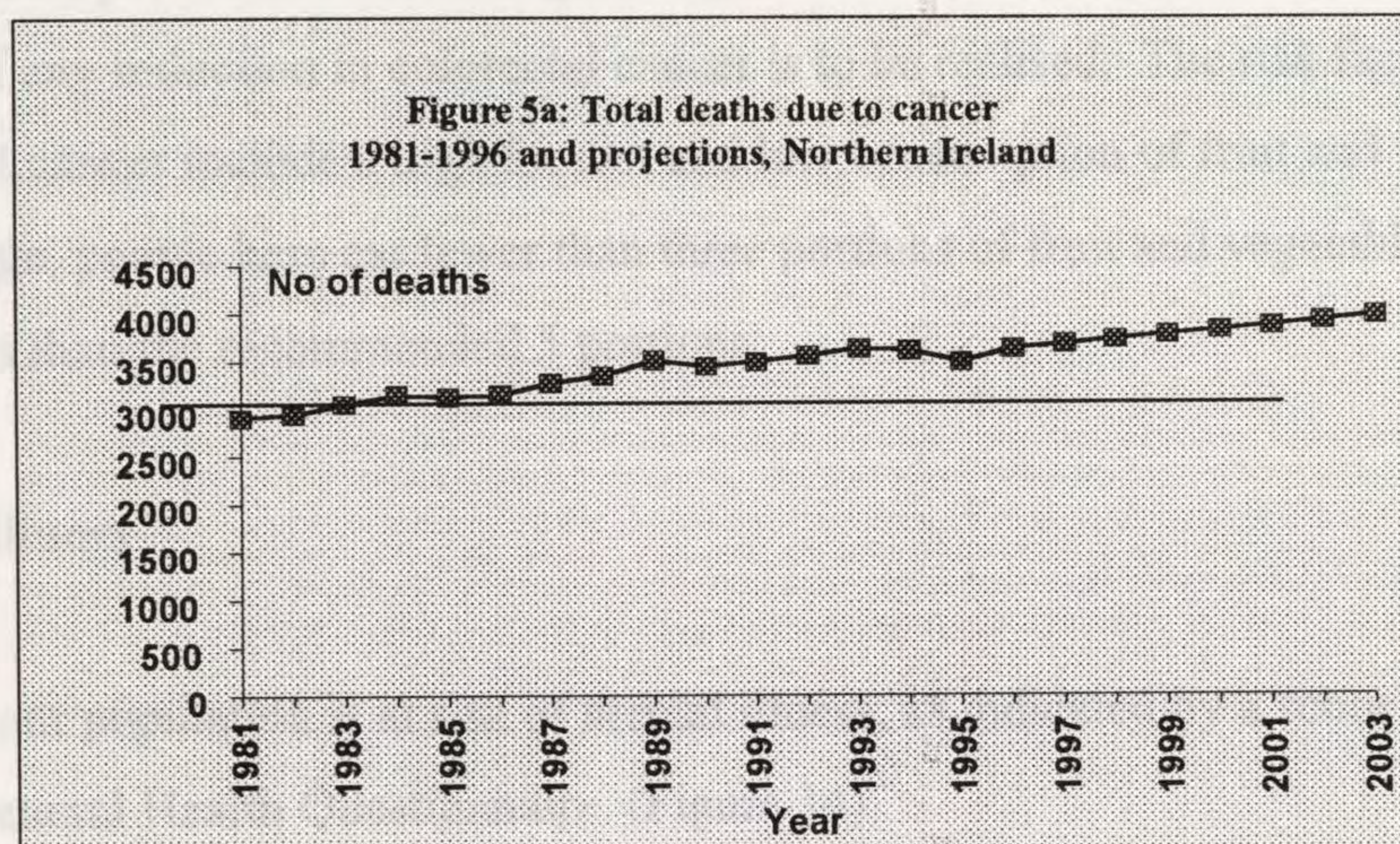
Cardiovascular disease, including coronary heart disease (CHD), is the single biggest killer here. One in 3 men and 1 in 4 women die from CHD. Of every 10 people who have CHD, 2 will die suddenly without any warning and a further 2 will suffer a silent heart attack that they will not know about but that will permanently damage heart muscle. CHD is a major cause of premature death, particularly among men aged 25-65.

The major risk factors for CHD include smoking, obesity, high blood cholesterol and inactivity. Smoking doubles the risk of heart disease. Levels of obesity are increasing dramatically. (Figure 4)



Cancer

Cancer is the second most frequent cause of death here, killing 1 person in 4, or about 10 people every day. As the population ages, the number of cancer deaths is increasing. In a few years it will be the most common cause of death (Figure 5a). It has been estimated that up to 80% of cancers are preventable. Better organisation of cancer services might in itself save up to 600 lives per year.



There are different types of cancer. For many of these, science has not yet determined the cause or any means of prevention. Treatment therefore remains the mainstay in preventing premature deaths. For others, the cause is clearer and appropriate lifestyle choices will prevent many deaths. Some cancers can be identified early through screening programmes and treated while the disease is curable.

Lung cancer is the most common cause of death from cancer in men and the second most common in women. Smoking is responsible for almost 90% of lung cancers. The risk of lung cancer in a person who smokes 20 cigarettes per day is 20 times that of a non-smoker. Deaths from lung cancer among women are increasing.

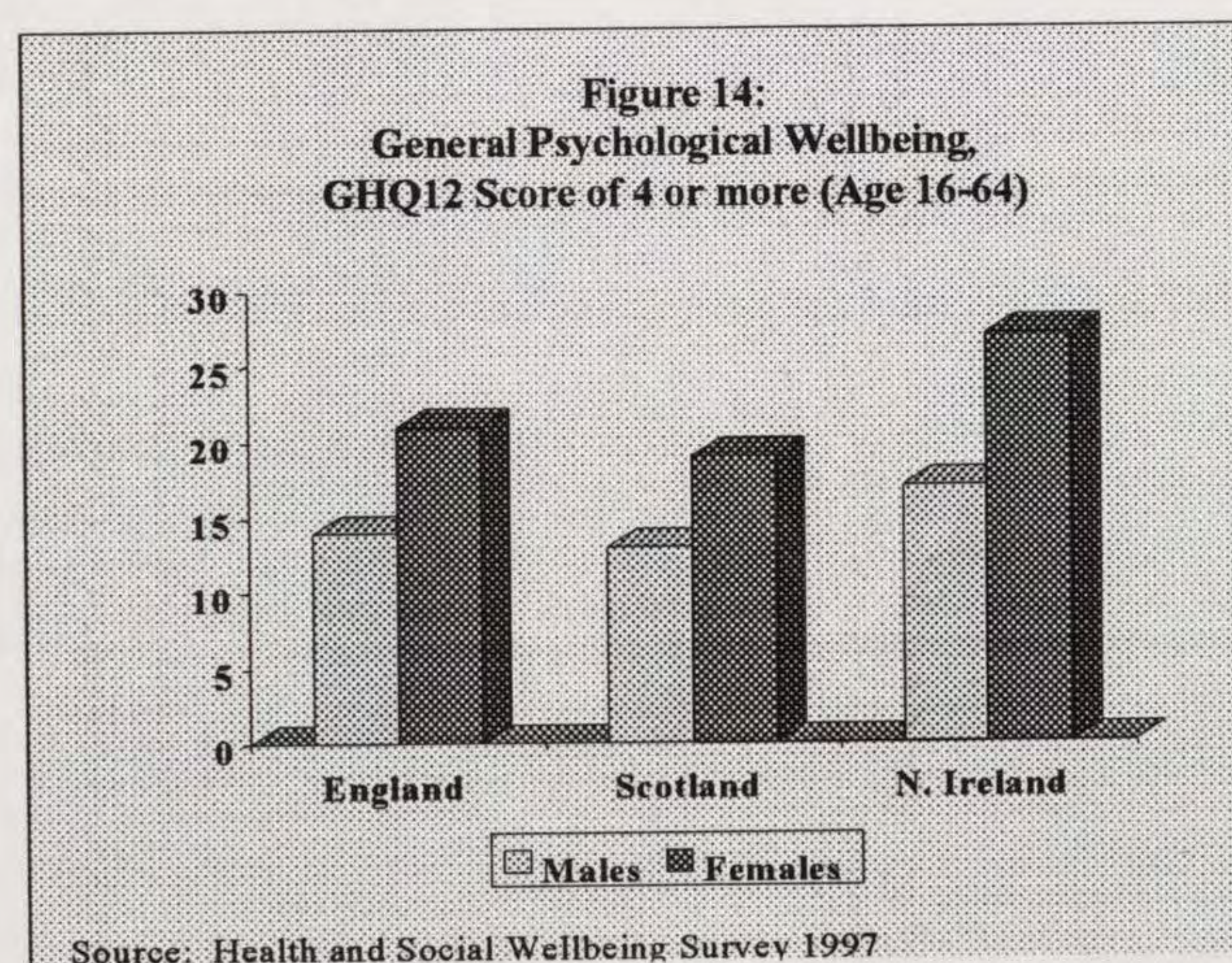
Breast cancer is the most common cause of death from cancer in women. Although the cause of breast cancer is not known, it is clear that early diagnosis and treatment

saves lives. Rates of survival with breast cancer are much better if diagnosis is made early when the tumour is treatable. Early diagnosis is possible through the breast screening programme that has been in place for many years. On average, 70% of eligible women attend the programme but in some disadvantaged areas uptake rates are as low as 30%.

Colorectal Cancer strikes about 600 people every year, one of the highest rates in Western Europe. The rate is falling among women but not men. Diet must remain a priority if any reduction in colorectal cancer is to be realised. The risk factors for colorectal cancer include a high fat diet and low consumption of fruit and vegetables. On average, people here eat fewer than three portions of fruit and vegetables each day, much less than the recommended 5 portions.

Mental Illness

More of our population is at risk of mental illness, as indicated by a score of 4 or more on the General Health Questionnaire. (Figure 14)



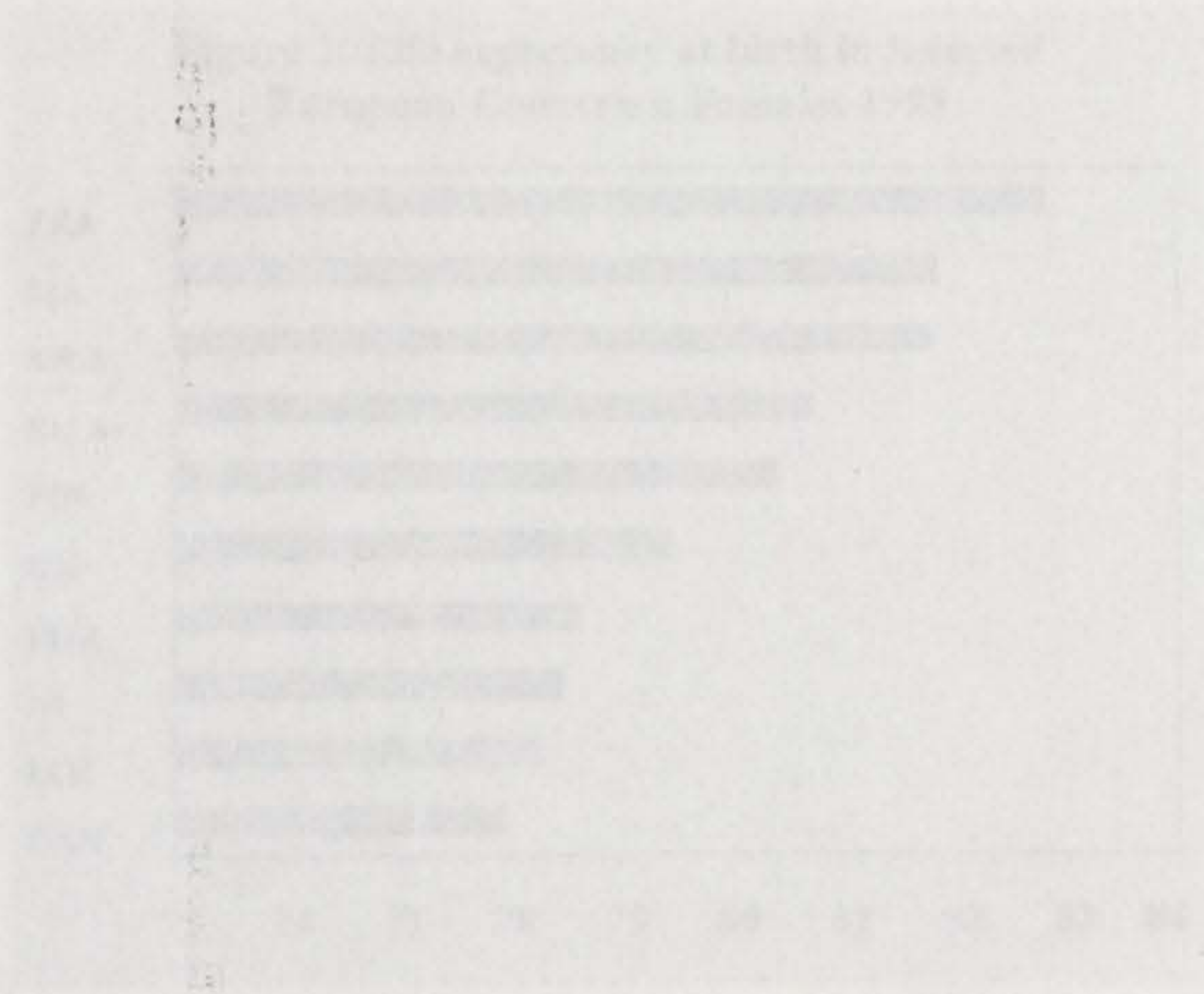
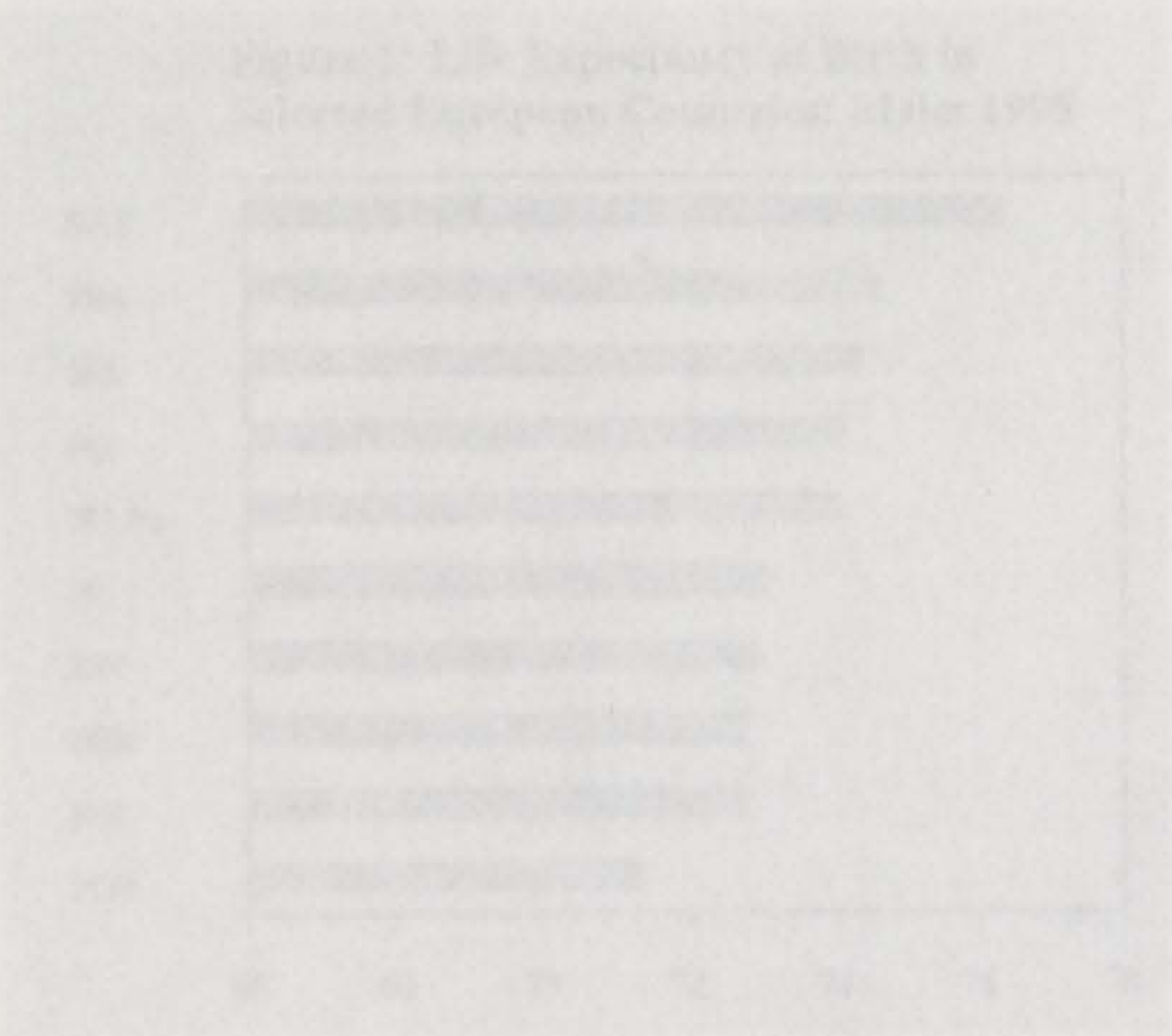
Mental illness is one of the most common forms of ill health. It is responsible for enormous costs to the individual and to society. The most devastating manifestation of mental illness is suicide, the 4th largest contributor to potential years of life lost. In the year 1997/98 there were 124 registered deaths from suicide, 96 among men and 28

among women. Of these, 28 were among young people under age 25. In some instances there were clusters of deaths in areas that are socially deprived.

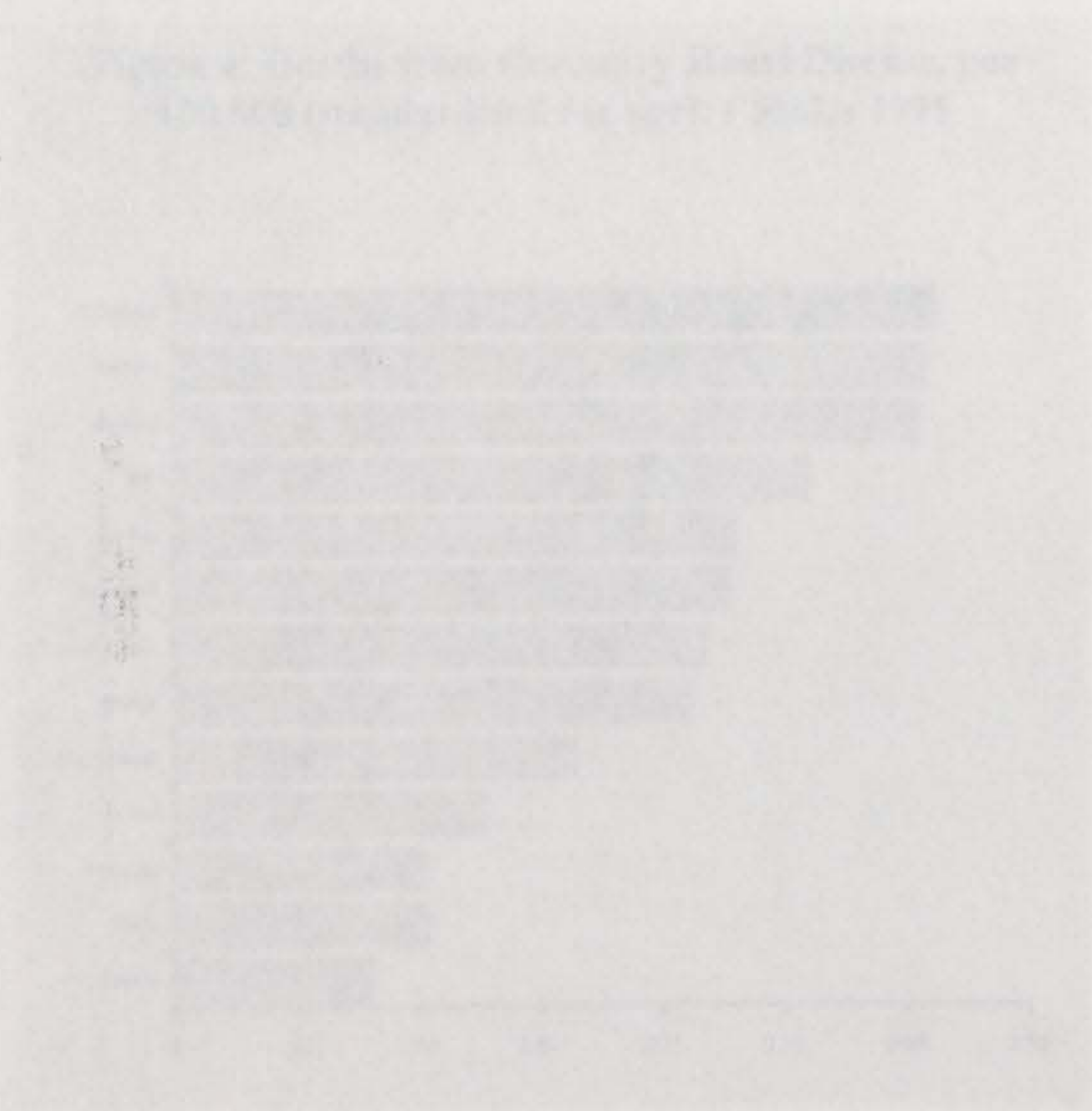
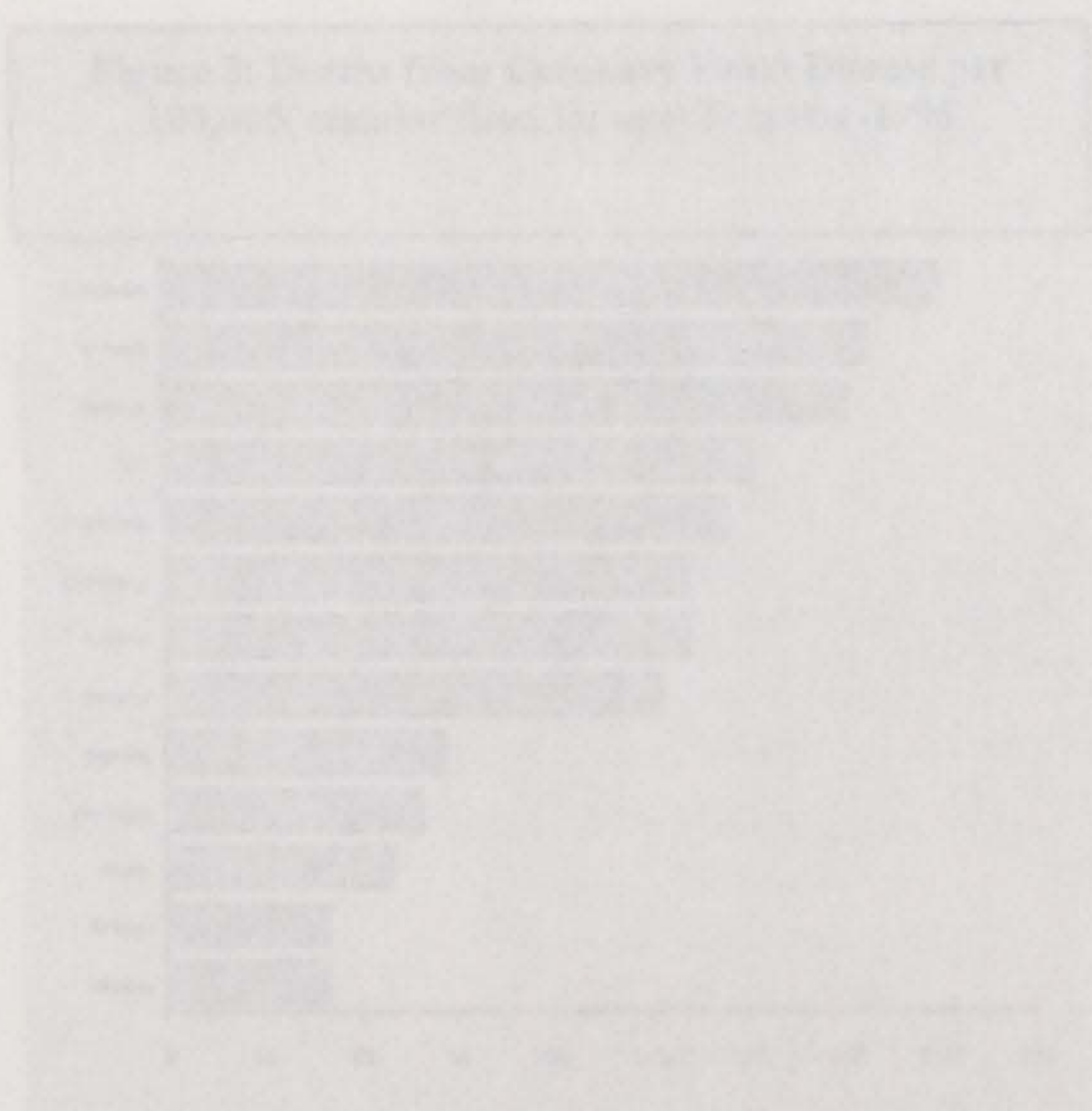
POPULATION HEALTH INFORMATION

NORTHERN IRELAND VS OTHER EU REGIONS

LIFE EXPECTANCY



CORONARY HEART DISEASE



POPULATION HEALTH INFORMATION

NORTHERN IRELAND VS OTHER EU REGIONS

LIFE EXPECTANCY

Figure 1: Life Expectancy at Birth in Selected European Countries: Males 1995

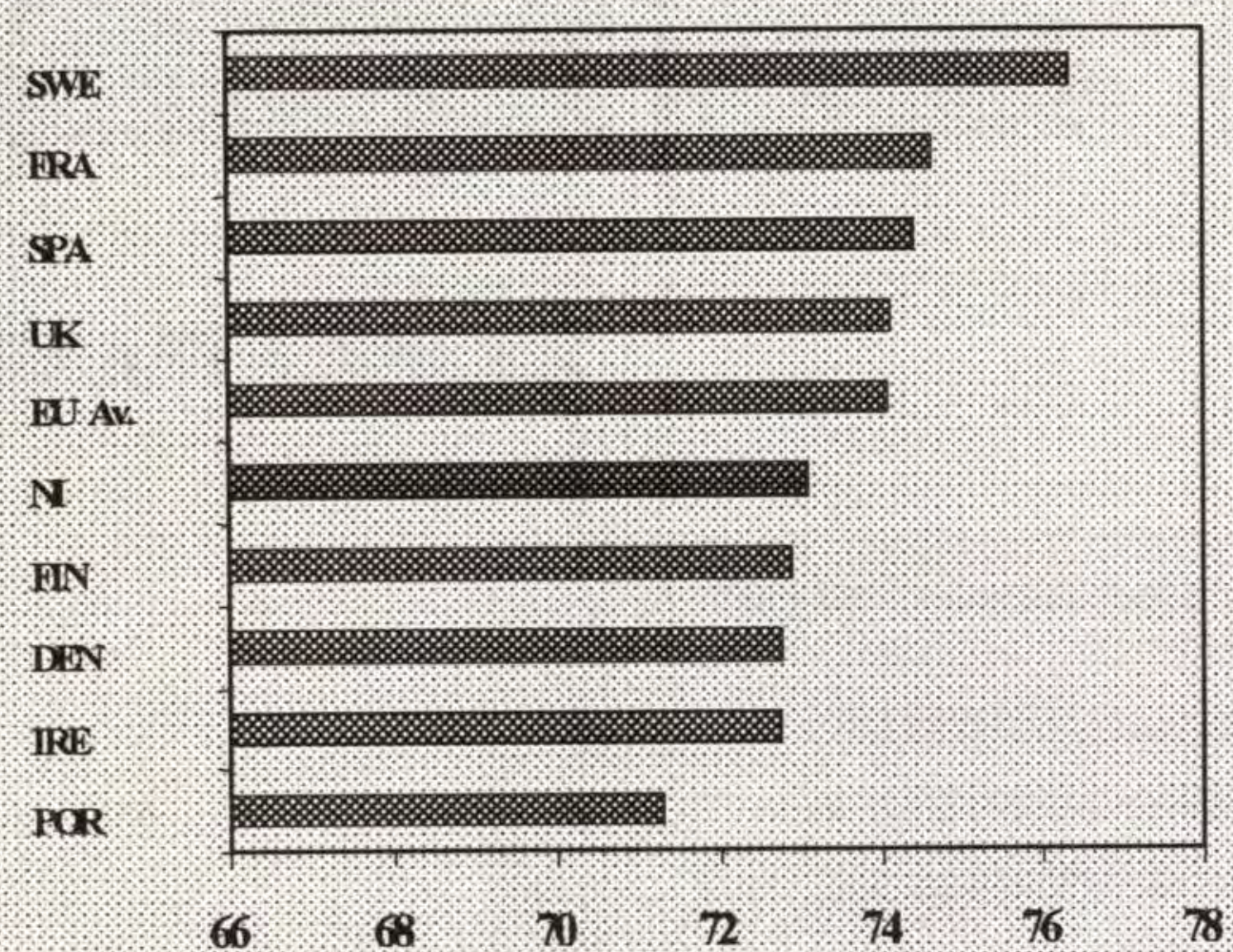
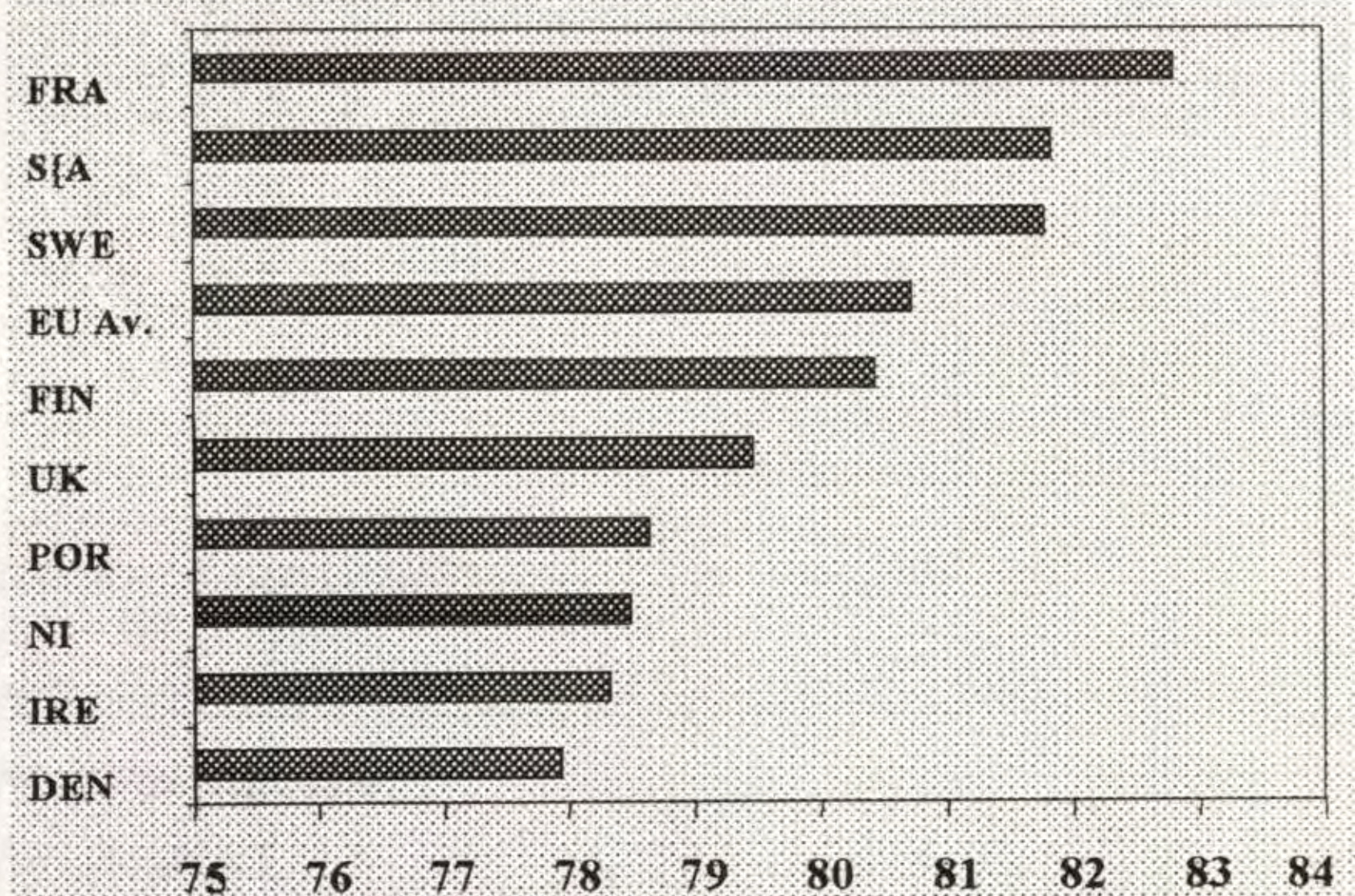


Figure 2: Life expectancy at birth in Selected European Countries: Females 1995



CORONARY HEART DISEASE

Figure 3: Deaths from Coronary Heart Disease per 100,000 (standardised for age) Females -1995

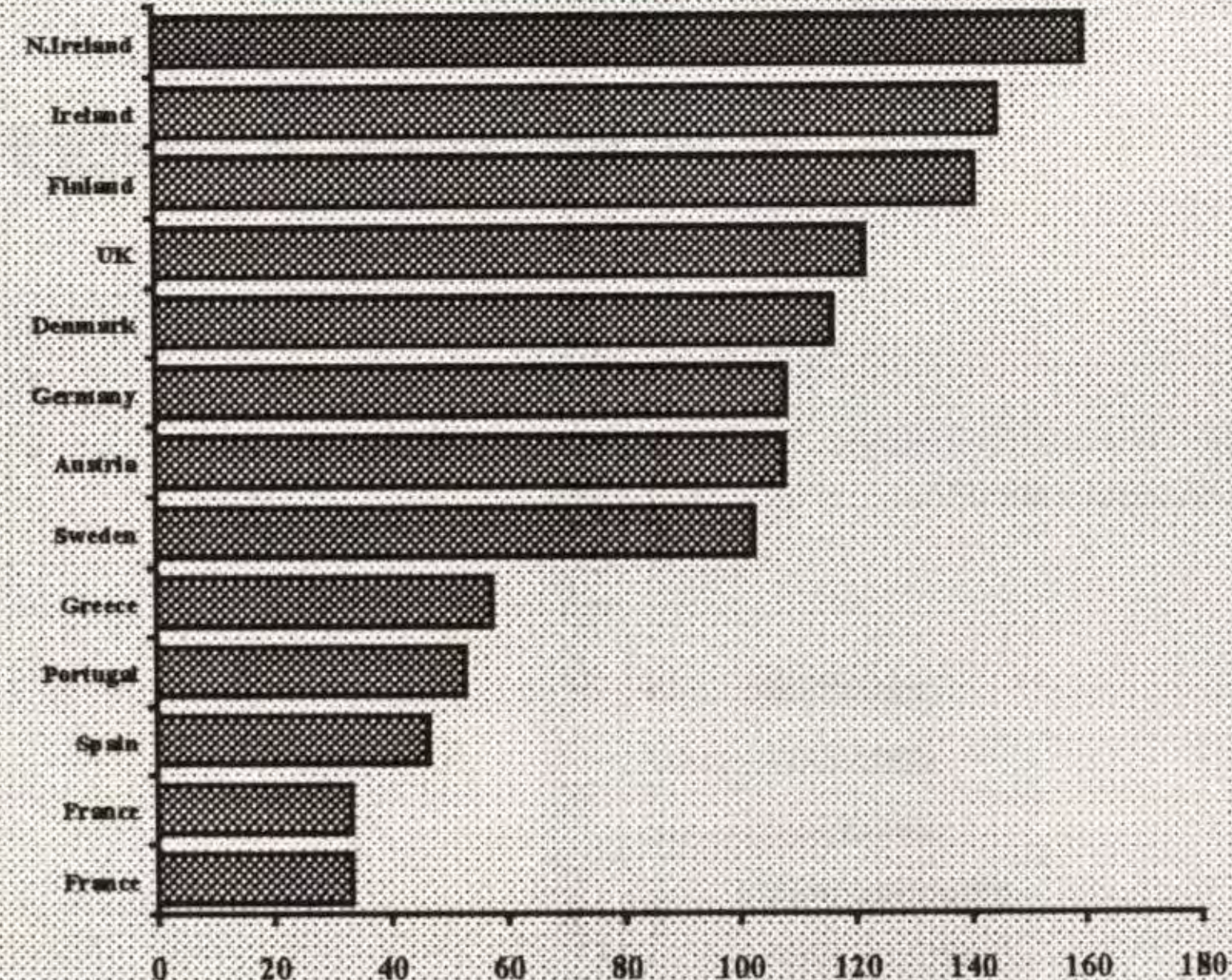
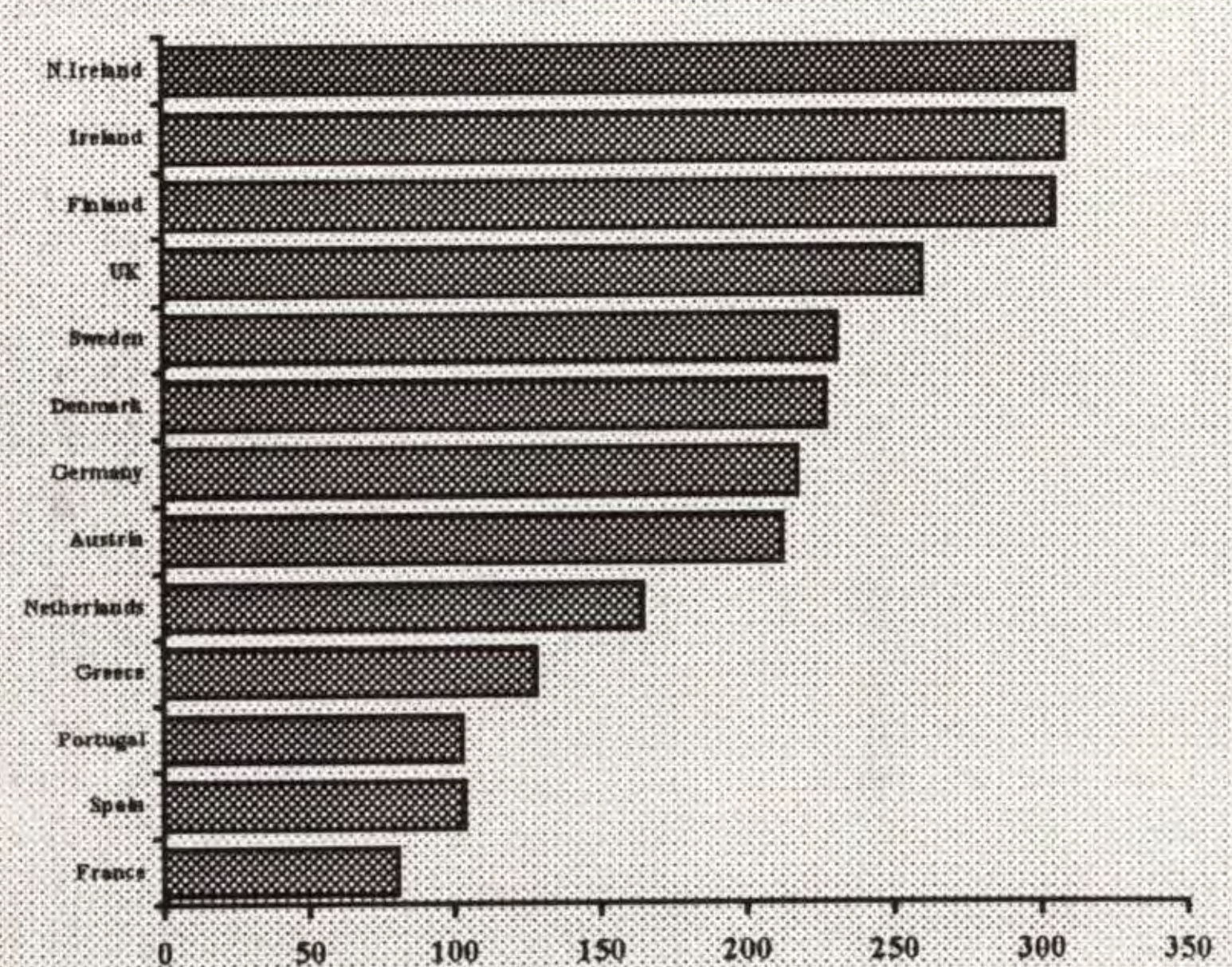


Figure 4: Deaths from Coronary Heart Disease, per 100,000 (standardised for age): - Males 1995



LUNG CANCER

Figure 5: Deaths from lung cancer per 100,000
(standardised for age): Males 1995

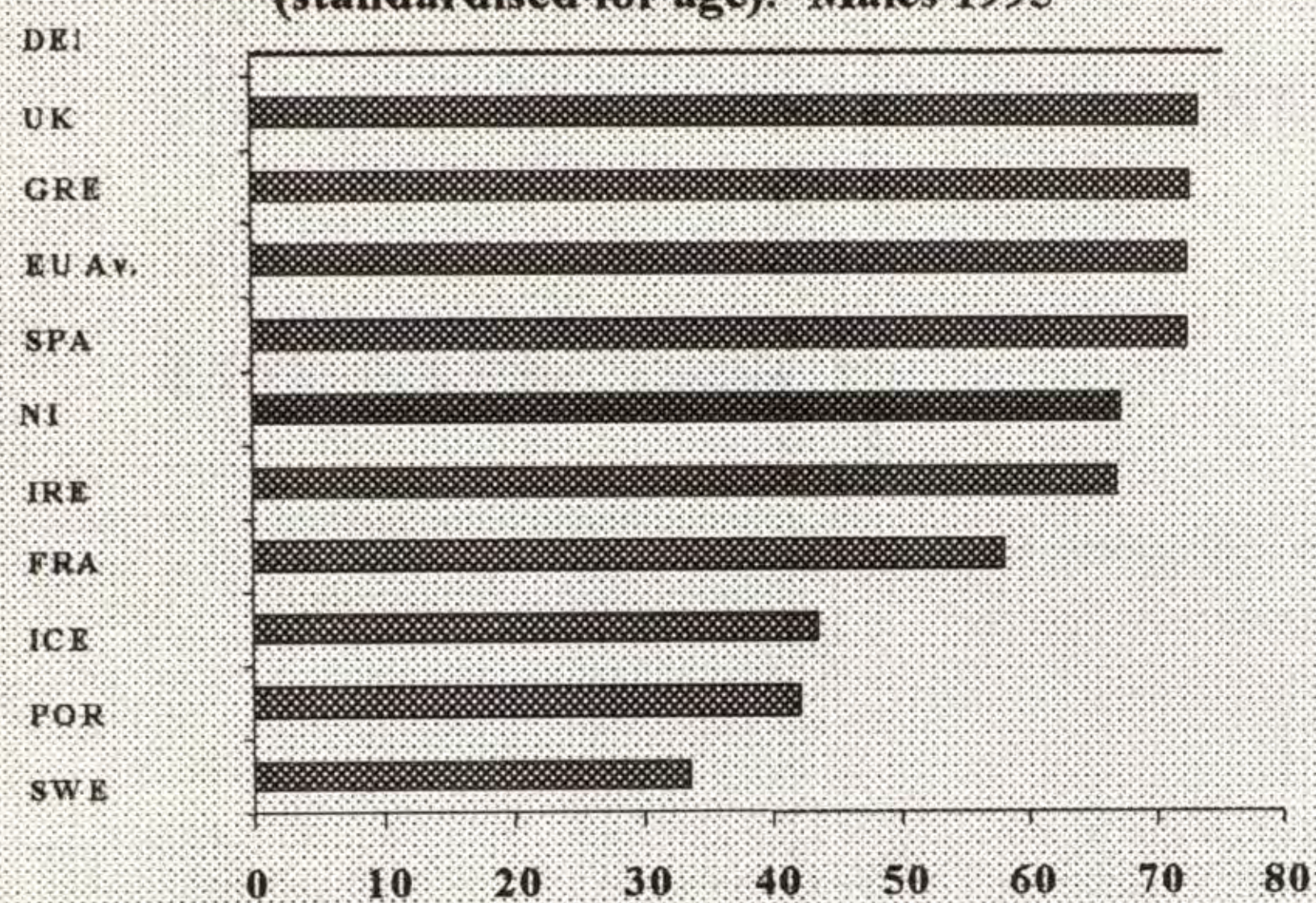
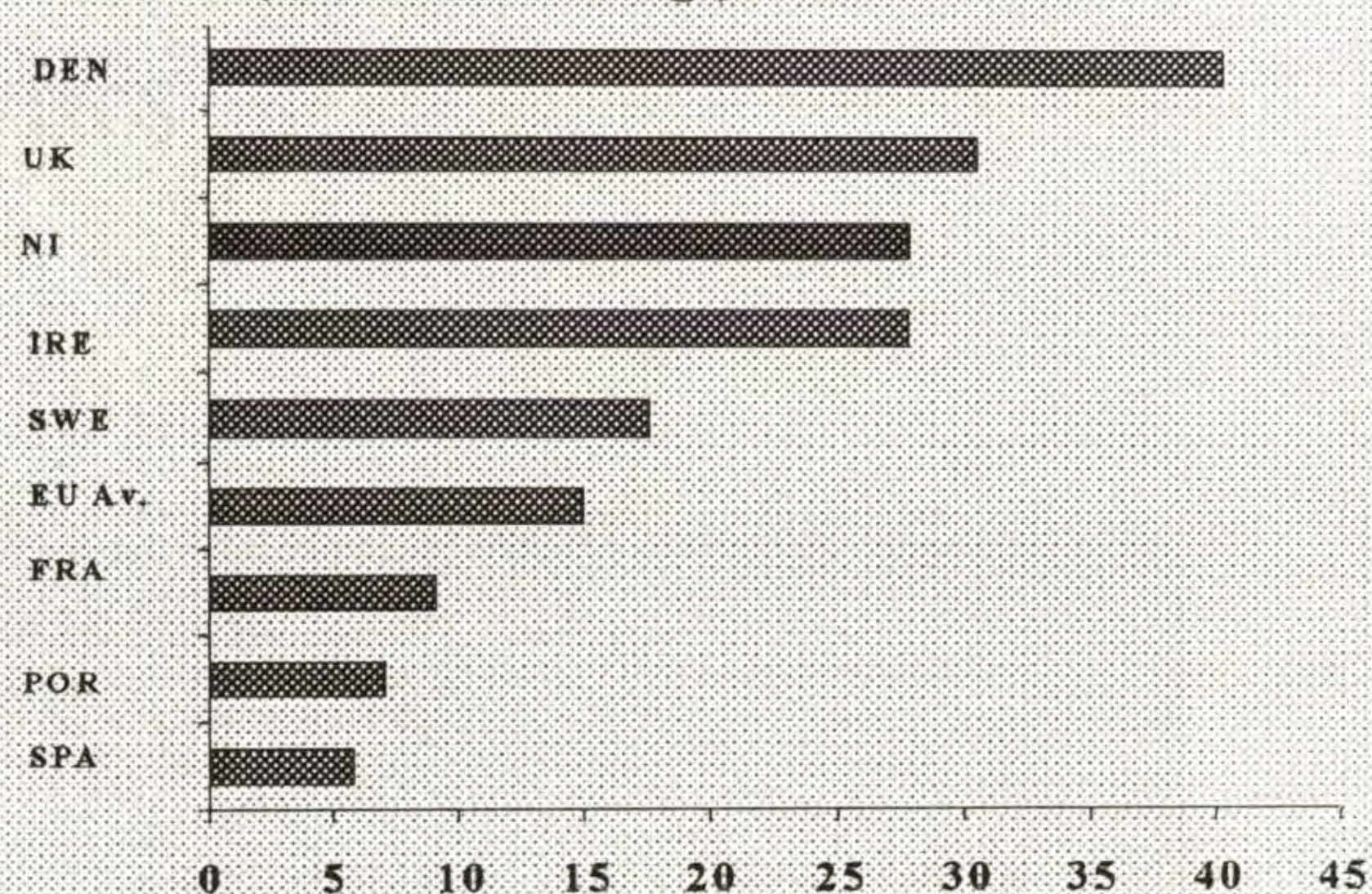
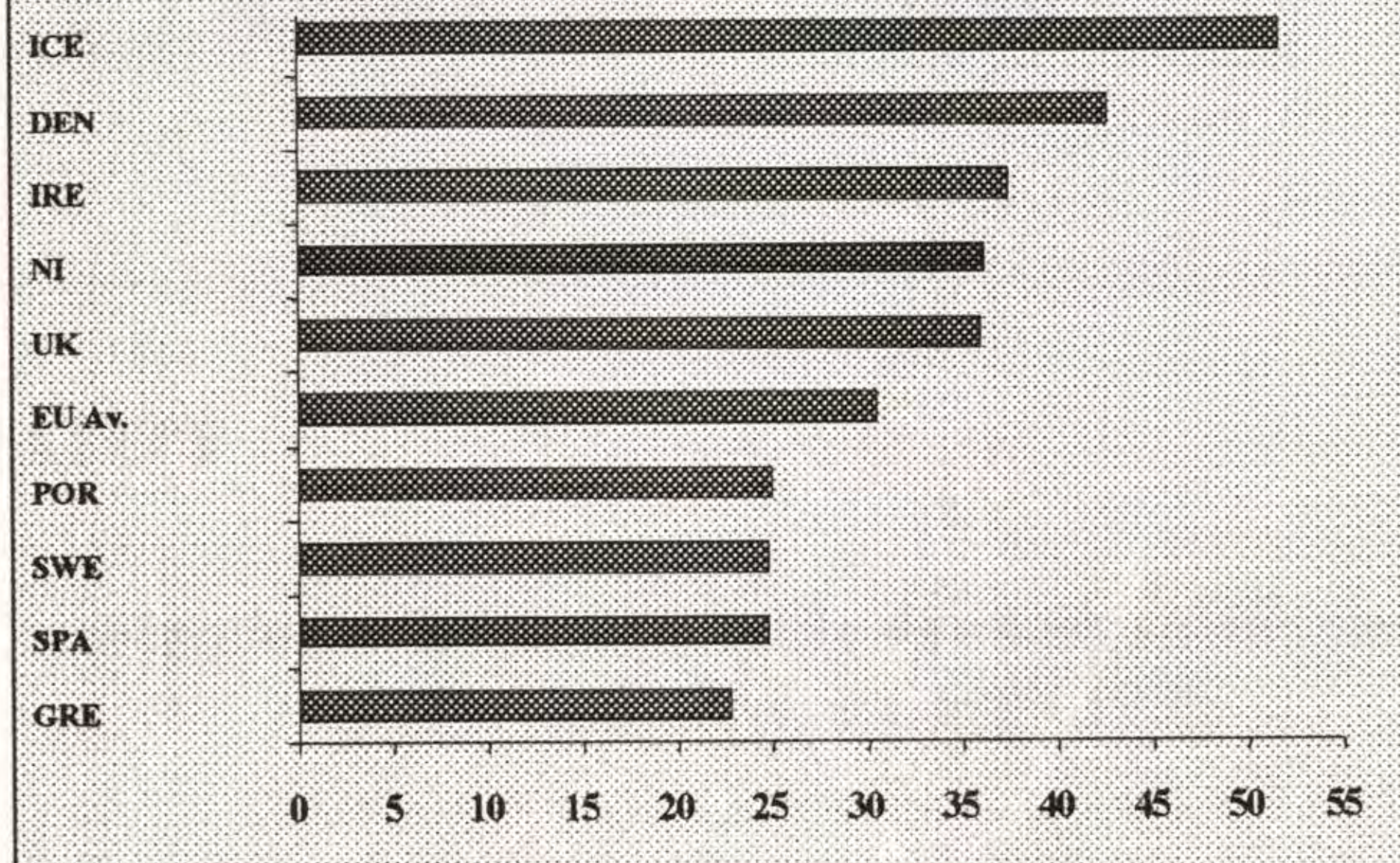


Figure 6: Deaths from lung cancer per 100,000
(standardised for age): Females 1995



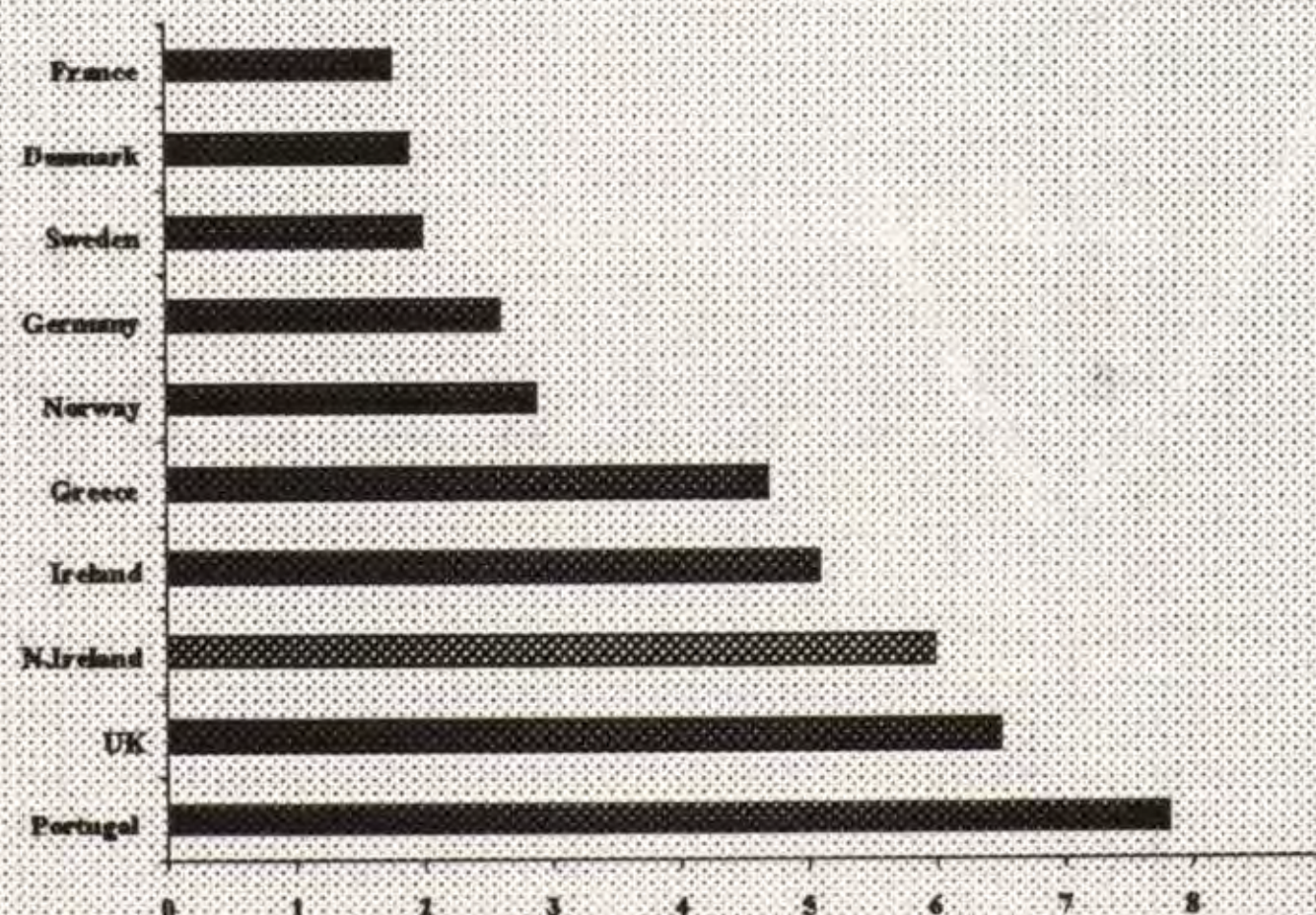
BREAST CANCER

Figure 7: Deaths from Breast Cancer per 100,000
(standardised for age): Women 1995



TEENAGE PREGNANCY

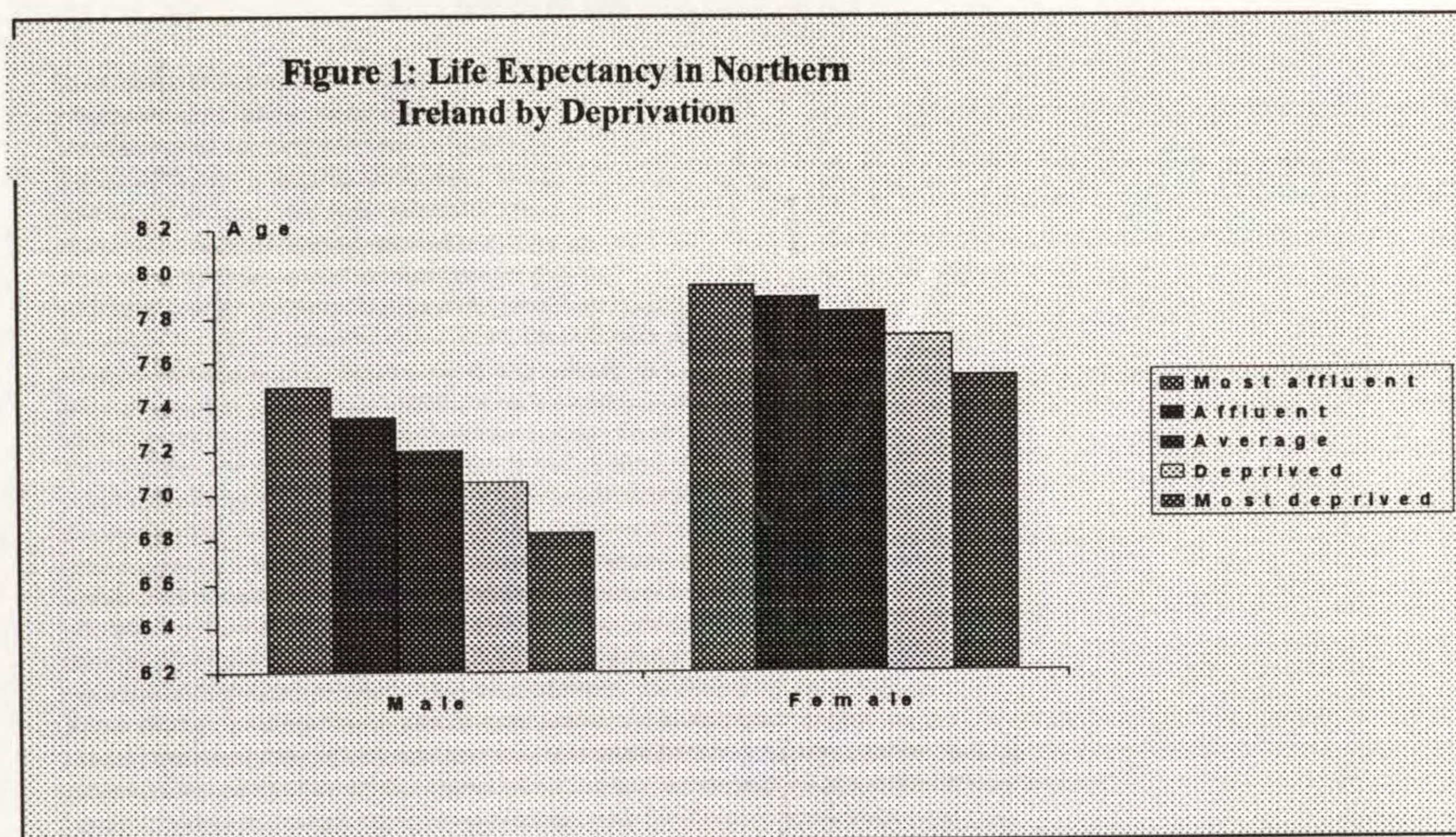
Figure 14: Teenage pregnancy in Europe
Live births/1,000 females aged 15-19



POPULATION HEALTH INFORMATION

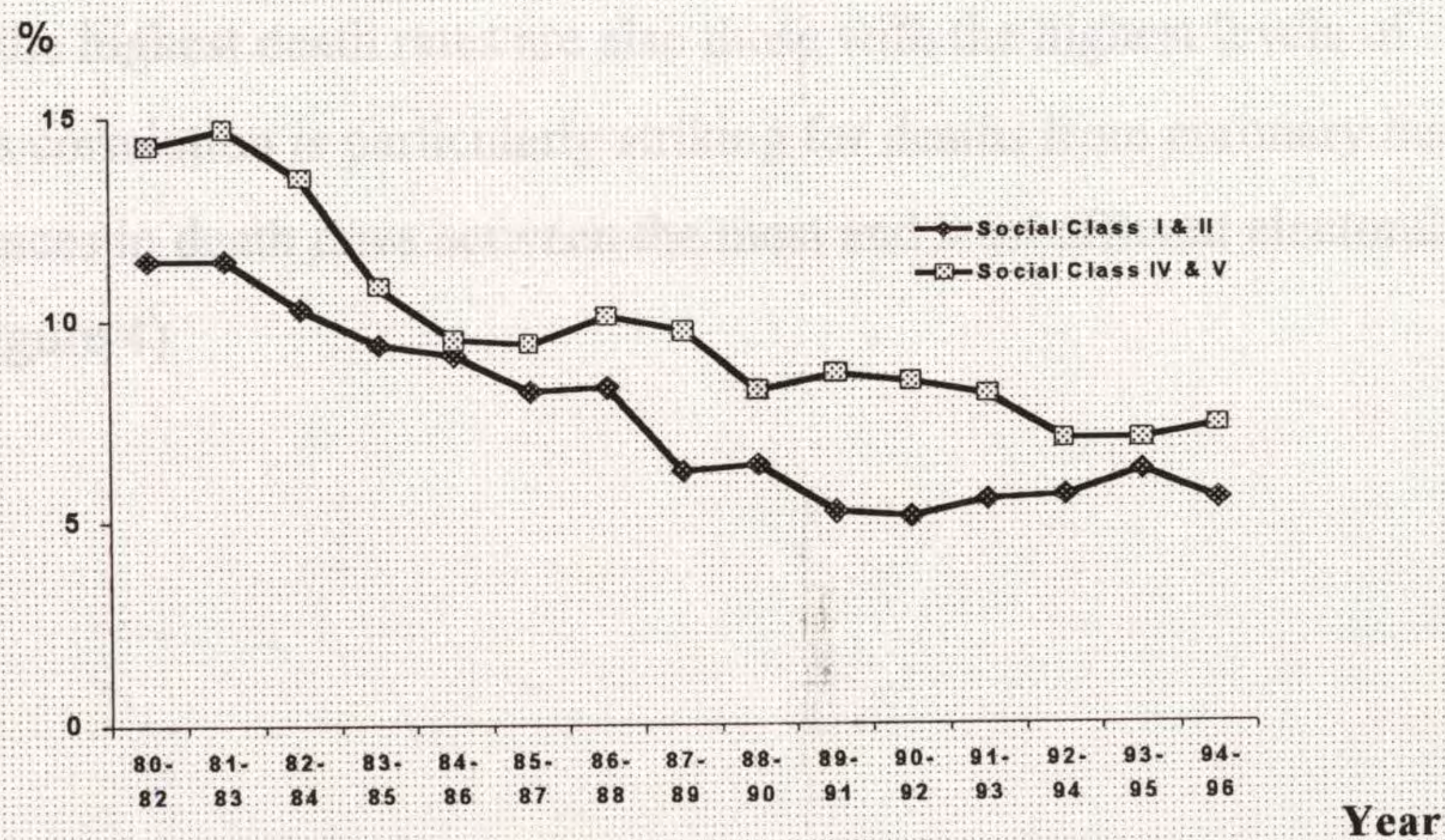
INEQUALITIES

LIFE EXPECTANCY



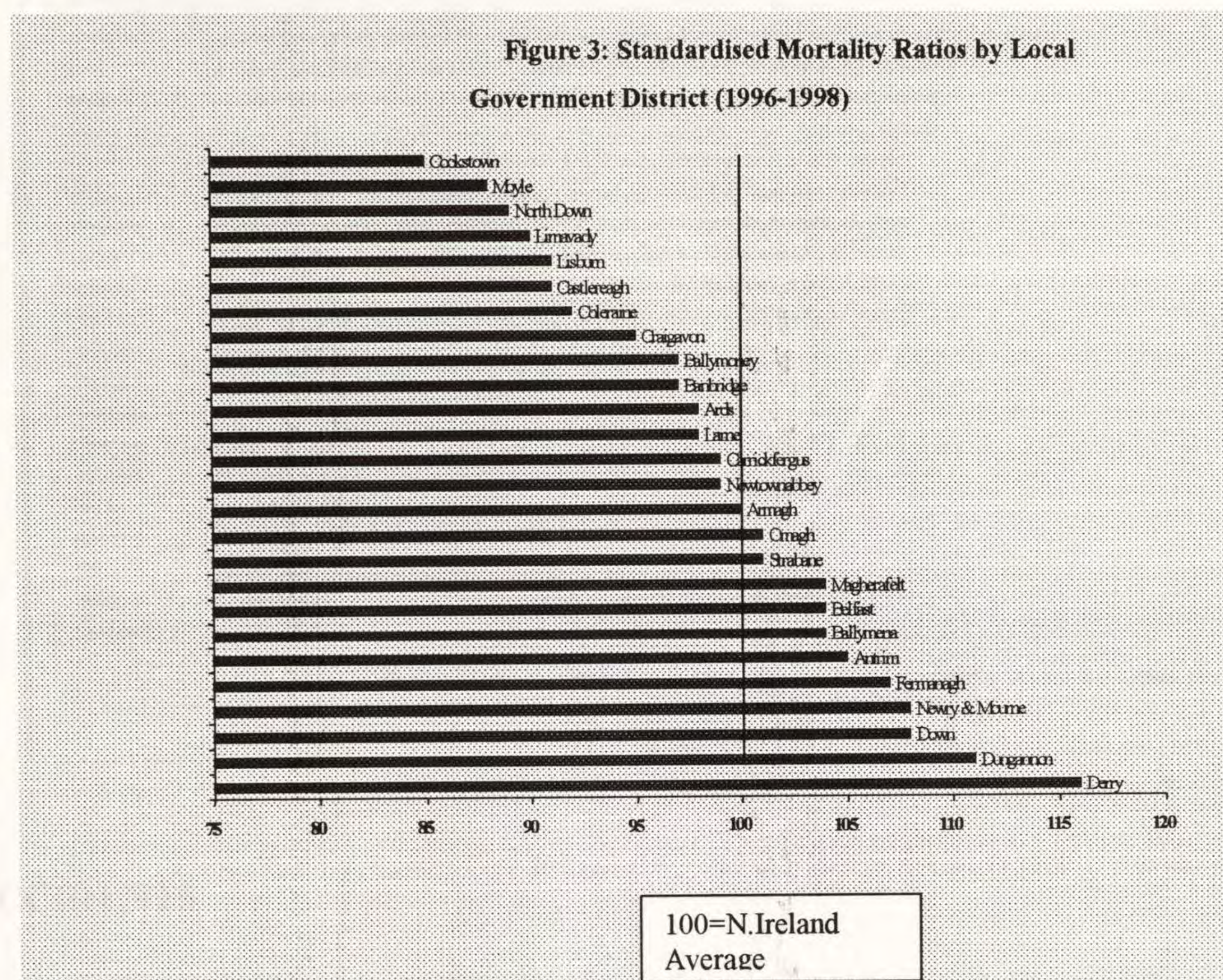
INFANT MORTALITY

Figure 2: Infant mortality rates by social class in Northern Ireland 1980-1996



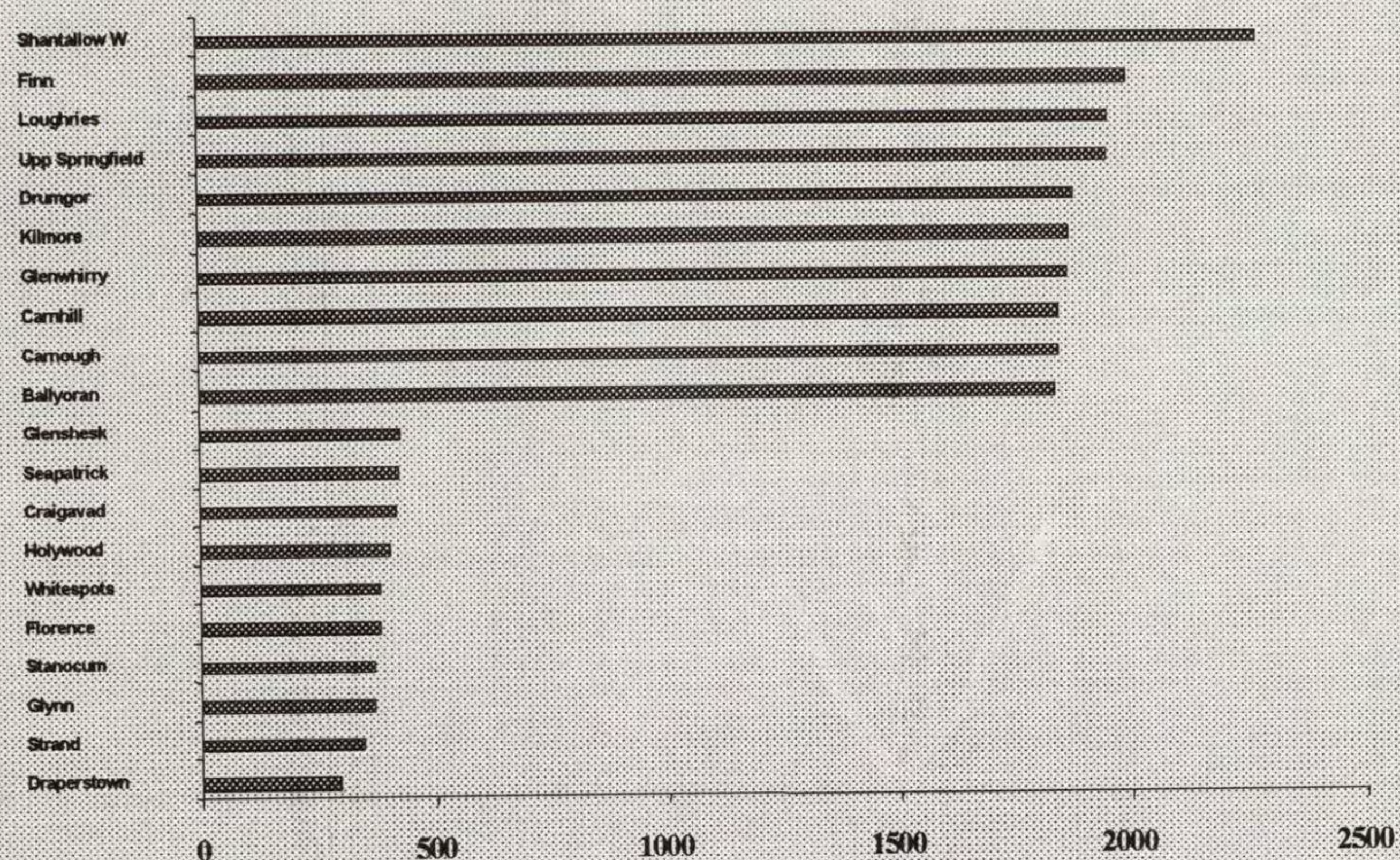
DEATH RATES BY WHERE YOU LIVE

About 2000 lives could be saved each year if those living in the electoral wards with the highest death rates had the health status of those in the wards with the lowest death rates.



The wards with the highest death rates are also those with the highest levels of deprivation. This correlation is particularly striking for deaths from coronary heart disease. Differences in death rates between the most and least affluent electoral wards are dramatic. (Figure 4).

**Figure 4: Electoral Wards with Highest and Lowest Rates
of Coronary Heart Disease
(Deaths per 100,000 65-74 year olds 1991-1997)**



ACCIDENTS

Accidents are a major cause of death and disability among children and young people. Accidental deaths demonstrate a steeper social gradient than any other cause of death in childhood. The most deprived children are 16 times more likely to die as a result of a house fire and 5 times more likely to be injured as pedestrian than the most affluent.