

National Consistency: Ireland

Class 1 - Demography and socio-economic situation

- ? **Population Status:** Our Central Statistics Office (CSO) provides population age groups for 5-year periods from 0 to 84. There is then a single category for 85 and upwards. This is also available by gender for the same period.

Deaths are available as total number and rates and by ICD code for principal causes of death. These are also available from CSO. Hospital admissions are recorded by the hospital inpatient enquiry system (HIPE) and are available by ICT code, age, gender and with a certain amount of DRG data available as well as length of stay. The data are available for national, sub-national and county level from the CSO and the Economic, Research, Social Institute (ERSI) who handle the HIPE Data.

- ? **Socio-economic factors:** There are recent surveys available on the level of education. Social class is routinely available from the census data into the categories required. Ethnicity however, is not well defined. The only information is on the number of people who come from different countries. Their ethnicity is not declared or collected in any systematic way. There are in fact no real reliable figures routinely collected but data on this topic is available from immigration sources and asylum seeker centres. Again there is a partial medical screening system and there are data available from that but not on a national level and not in any co-ordinated way. GDP is available and there is a poverty index available. Much debate about the criteria for definition of poverty and not good agreement between official and NGO sources.

Class 2 – Health Status

- ? **Mortality by cause specific:** Deaths available by ICD codes. Independent rates have been done but are not routinely published. Standardised death rates are available as are age-specific death rates but not easily available as regards to COPD. However, the information is probably collected and could be derived but is not published and has not been identified separately. PYLL are not routinely collected or available for any disease in this country. The Irish Thoracic Society has tried to collate some of these data and we recently published a report, which is analogous to the ERS document but is not part of any routine assessment or official documentation.
- ? **Morbidity respiratory system:** There are no national agreed prevalence data. Independent surveys by a number of people and organisations have looked at different groups. For instance, I coordinate the ISAAC survey and therefore there is some knowledge of asthma in children. There are several other selective surveys particularly around asthma and to a less extent COPD. There are no good data available on the severity of asthma in Ireland that I am

aware of. Apart from ISAAC, which I have mentioned, there are no real widespread surveys of asthma symptoms available, certainly on a national basis or indeed on any structured regional basis. There have been some general practitioner studies on individual practices and sometimes some group practices but there are no consistent data.

As regards prevalence of treatment there are some indirect data in so much as prescribing habits are known and there is a national drugs system, which however, only applies to the poorer one third of the population who receive their medicines free of charge. This is well collated and available on a national basis but obviously is selective. The rest of the population have a money-limit above which drugs are free and again there is some information from this source and certainly data is collected. We have a National Pharmo-economic Unit, which looks at specific problems at certain times but mainly commissioned to do so rather than any ongoing monitoring. There are no good surveys of COPD prevalence but there are a small number of telephone surveys, which have been funded by the Pharmaceutical Industry and give some numbers. Bronchial hyper-responsiveness is tested in many of the respiratory laboratories but really on an individual diagnostic level, in particular cases rather than routinely and therefore do not give any good idea of the prevalence of bronchial hyper-responsiveness. Prevalence of Atopy is really only available from ISAAC. While some dermatological surveys are also available on skin diseases in particular, they are not geared towards atopy or the identification of any respiratory connections. Specific allergies have not been studied nationally or even locally in any significant way. We have had an interest in air-pollution and have looked at the change in fungi and spores etc following the ban on the sale and use of bituminous coal but again this is very localised. Routine skin testing is done only in individual cases. IGE again only done on an individual basis in selected cases. There are no national levels available. Atopy in asthma has not been differentiated on a national level. Severity of asthma is performed on an individual basis but is not collected even where there is an asthma clinic and there are large numbers of these. I am not aware that they have actually defined their patient cohort in terms of severity.

Class 3 – Determinants of health

- ? **Biological Risk Factors:** While I agree that factors identified in 3.1.1 are important. These data are not available on a national basis. Clearly, the maternity hospitals collect this data but do not publish it and I had reason to look for it recently in another context and it proves difficult to get but it should be available. There is no doubt that obesity is a very topical and of serious concern and does affect respiratory diseases in ways not yet clear, not only in asthma, probably in cancer as well. It is difficult to see how routine data would be available but I suspect there would be increasing obesity clinics and that other diseases will be even more interested in getting this data and we should support that. Genetic susceptibilities perhaps a grandiose term for the information required here. I think there are many genetic

studies and we should probably try and piggy-back on some cohort studies but as defined in the definition, i.e. family history, we could have that and that data is routinely collected but is not routinely available.

- ? **Health Behaviours:** The importance of tobacco smoking in respiratory disease is such that it is probably necessary for all diseases even if it is not aetiologically of profound importance in causation but as suggested in the rationale there is good evidence for its role in asthma in a variety of ways and should be available. Reliable smoking statistics are perhaps not as available as supposed. I have a particular interest in this and have been looking at the different surveys and they are not immediately comparable and some consistency on an international basis would be desirable. The importance of second hand smoke on children is undoubted and this information is necessary but is not routinely available but can be guessed at from the prevalence data. More precise information would be very important; obviously in COPD it is crucial.

- ? **Living and Working Conditions:** The role of airways pollutants in asthma is known but relative importance is unsure. Certainly there is great interest and information on this would be valuable but is probably not the main factor. Our own experience in Ireland is that when we became smoke-free in 1990 and since then the prevalence of asthma has increased as pollution has declined. While one is not suggesting cause and effect there are various factors around this, which have to be taken into consideration. Therefore looking at individual agents, although they are known to affect bronchial hyper-responsiveness etc may not be very fruitful. The whole question of exposure to damp is an important one again perhaps not well understood. Occupational asthma is of great importance and the identification of different occupations not already recognised is important and will only be achieved if there is good data on exposures. Little is known on a national basis on how many people switch jobs because of exposure but this would be valuable information.

Class 4 – Health Systems

- ? **Health promotion:** There are no good data on the level of exposure in different houses. Occasionally when there is suspicion some adhoc measurements are made but there are no consistent measurements either locally, regionally or nationally. Again, the individual exposures are not known. It may be very difficult to collect data. Health promotion and respiratory diseases obviously are crucial. Smoking cessation is just becoming organised on a regional basis. Whilst good data are not published on its penetration to date, this will increasingly be available, but is not collected at present. What is told to individual asthma patients is obviously unclear but in general there would not be data on this. There are some numbers available on successes in cessation but to the best of my knowledge, they have not been broken down into success in different respiratory diseases. Cardiologists have

looked at success in terms of post-thoracic surgery, post-cardiac surgery and also cardiothoracic surgeons.

- ? **Health Protection:** Health protection is obviously very important and good strides have been made in Ireland to protect from tobacco exposure both in terms of restriction of smoking and in particular recent workplace ban where there is no smoking allowed in any workplace including pubs, restaurants etc. Occupational risk is covered under the Health & Safety but with the new agents, this is often late by the time it can be effective. There is great public awareness of the possibility of an adverse effect from air pollution but point studies have not been done to date and therefore data is not available.
- ? **Health Care Resources:** Health care resources data are available in terms of primary health care centres. Paediatricians in primary health care centres are not a feature of Irish medicine but general practitioners with an interest in child diseases increasingly form part of the Group Practice Centres but these are not well developed at present. The number of specialised asthma education nurses and indeed with a wider role in asthma is developing rapidly and is available in many of the centres and is planned to be in all centres but at present, the data is probably available but not routinely published. The number of Respiratory units is a matter of record.

There are few if any allergy units as such and certainly none dedicated exclusively to respiratory diseases. There are one or two practitioners who have a special interest in allergy who are respiratory physicians. The manpower figures are known and mostly published. Hospital clinicians are governed by an organisation called Comhairle na nOspideal which regulates the number and type of posts and they regularly publish the manpower statistics for each speciality including respiratory medicine. There are no good data on the use of management plans or peak flows at home although of course these are used by a number of practitioners. There are no data on the number who have access to allergy testing. Allergy testing is done in many of the Respiratory Units but there are no published data on this. Likewise, the pulmonary function testing activity in all of the individual respiratory labs in the hospitals are of course published internally and are available in reports from these hospitals but are not collected nationally.

The hospital activity statistics are collected by the HIPE system and the number of admissions is known. There is very little known about their treatment or outcomes. Again, the Emergency Room visits are collected and outcome is known there, obviously in terms of whether they went home, what they were given going home and how they were admitted.

A number of the hospitals also have Respiratory Assessment Units who take patients from the Emergency Room. There are no data on a national level for this but individual hospitals such as our own have published their results. Length of stay is known for different diseases.

Outpatient care at the primary care level is not published on a national or local level. Obviously the outpatient data for the Respiratory Units is known and internally published in each of the hospitals but nothing on a national or regional level or on any individual disease basis.

There are no real allergy units and therefore no data. The use of medicines is not collected on a national basis but is collected for people with medical cards, which is approximately one third of the population who get free medicine. There are also other sources including the national pharma-economics unit who have also looked at health care costs on individual projects but not at national level where there seems to be very poor costing. There is a method of repayment to hospitals based on diagnostic related groupings (DRGs) but this only represents about 15% of the funding and is poorly collated nationally. Estimates of the total cost of medicines for asthma and COPD are available but are not reliable and are not national. No overall cost of asthma healthcare is reliably available but the Asthma Society will have made estimates intermittently. Also, the Health Insurance which covers about 40% of the population do have some figures but they are not published and are not well defined in terms of individual diseases. There is little information on subjective indicators of health in asthma or COPD. Again outcome measurement is very poor and apart from individual surveys, there are no national data available.

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