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03 September 2025

Deputy Richard Boyd Barrett, TD
Dáil Éireann
Leinster House
Kildare Street
Dublin 2

RE: PQ 42957/25

To ask the Minister for Health the estimated annual cost to the Health Service Executive of treating chronic diet related illnesses such as obesity, type 2 diabetes, cardiovascular disease and non-alcoholic fatty liver disease; and if he will provide a breakdown of cost estimates by illness type

Dear Deputy Boyd Barrett,

The Health Service Executive has been requested to reply directly to you in relation to the above parliamentary question, which you submitted to the Minister for Health for response. I have consulted with the National Clinical Advisor and Group Lead, Chronic Disease, (NCAGL CD), on your question and have been informed that the following outlines the position.

The information requested regarding the estimated annual cost to the Health Service Executive of treating chronic diet related illnesses such as obesity, type 2 diabetes, cardiovascular disease and non-alcoholic fatty liver disease, including a breakdown of costs estimates by chronic disease illness type, is not collated or reported nationally by the HSE National Clinical Programmes for Chronic Disease in the manner requested.

Chronic diseases place a large and complex burden on the health and social care services in Ireland. The impact on health service utilisation is particularly evident in the acute sector.[2] More specifically, four major chronic conditions accounted for 10% of all acute hospital discharges [either as the primary cause or as a contributory factor] and accounted for 21% of all acute hospital bed days in 2019[1]. Age is a significant driver of service utilisation within the acute sector in Ireland.[3] Furthermore, complexity profiles demonstrate that older patients generally have more multi-morbidity than younger cohorts.[4]

The shift from a hospital-centric model of healthcare delivery towards more comprehensive and accessible primary and community care service provision is enabling timely access to specialist care, such as chronic disease care, closer to people's homes in communities across the country.

In 2020, the Health Service Executive published The National Framework for the Integrated Prevention and Management of Chronic Disease (2020-2025)[1], which adopted a whole system approach to integrated care for people living with Type 2 diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD) and asthma. This framework describes a significant programme of reform in how we deliver chronic disease care. There is strong evidence to indicate that integrated care improves the quality of care, patient satisfaction and accessibility of services.[5]

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Core elements of the Model of Integrated Care for the Prevention & Management of Chronic Disease[1] include primary and secondary prevention, early detection and intervention, efficient and equitable access to community diagnostics, patient-centred assessment and on-going comprehensive medical treatment, all to be provided in the most appropriate setting, by the right team, as close to home as possible. This model is underpinned by an emphasis on empowering patients to live well with chronic disease (i.e., self-management support services) by providing them with the knowledge and tools to manage their symptoms effectively and to recognise early signs of deterioration so that they can seek medical intervention at an earlier stage.

The model aims to support people to live well within the community, with ready and equitable access to General Practitioner (GP) review, diagnostics, Health and Social Care Professional (HSCP) input and specialist opinion, as required. The focus is on keeping people well and on providing care as close to home as possible.

These reforms are now well underway as part of the HSE's Enhanced Community Care (ECC) Programme.[6] The ECC programme includes a number of components that, together, are enhancing and expanding the delivery of primary care services in the community. One key component of the Model is the establishment of 30 Community Specialist Teams (CSTs) working in community-based specialist ambulatory care. These hubs have been allocated integrated care consultants, specialist nurses and health and social care professionals (HSCPs) to enable timely access to specialist advice and care for people with living with Type 2 Diabetes, COPD, Asthma and Cardiovascular Disease. All patients with Chronic Disease who are referred appropriately by their GPs are eligible to be seen at the Chronic Disease Hubs.

I trust this information is of assistance to you, but should you have any further queries please do not hesitate to contact me.

Yours sincerely

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Anne Horgan
General Manager

References:

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4. Smyth B, Marsden P, Donohue F, Kavanagh P, Kitching A, Feely E et al. Planning for Health: trends and priorities to inform health service planning 2017. Dublin, Health Service Executive [2016]
5. Baxter S, Johnson M, Chambers D, Sutton A, Goyder E, Booth A. The effects of integrated care: a systematic review of UK and international evidence. BMC Health Serv Res.[2018] May 10;18(1):350
6. https://www.hse.ie/eng/services/publications/the-second-report-of-the-structured-chronic-disease-management-treatment-programme-in-general-practice.pdf