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Deputy Ken O'Flynn
Dáil Éireann
Leinster House
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10th October 2025

PQ48352/25- To ask the Minister for Health to provide the most recent estimates, of the prevalence of undiagnosed hypertension and high cholesterol among adults over 65, by age cohort; if she accepts the findings of the report which indicates rates of 36% and 45% respectively; and the measures being taken to address this "critical unmet need." - Ken O'Flynn.

Dear Deputy O'Flynn,

The Health Service Executive (HSE) has been requested to reply directly to you in the context of the above Parliamentary Question, which you submitted to the Minister for Health for response.

The latest TILDA report, Wave 6 Report Shaping the Future: Longitudinal Trends and Opportunities for Transformation in Health and Social Care in Ireland was published on 11th September 2025.

At Wave 6, 43% of adults aged 50 years and older reported a diagnosis of hypertension, increasing with age: 33% (50–64 years), 43% (65–74 years), and 53% (75+ years). Also at Wave 6, 46% of adults aged 50 years and older reported a diagnosis of hypercholesterolaemia, consistent across age groups (50–64 years: 43%; 65–74 years: 47%; 75+ years: 47%). Among those without a reported diagnosis, 45% met clinical criteria, indicating substantial undiagnosed disease. TILDA Wave 6 highlights that a significant proportion of older adults remain undiagnosed or undertreated for hypertension and hypercholesterolaemia. While management of diagnosed cases has improved over time, critical gaps in detection, treatment adherence, and lifestyle modification persist, underscoring the ongoing need for targeted public health interventions. Integrated care is vital to address multimorbidity, support vulnerable groups, and build a sustainable health service focused on prevention and improved health outcomes.

Measures being taken to support the prevention and management of chronic disease:

Since 2020, the HSE has reformed chronic disease care through the **National Framework for Integrated Prevention and Management of Chronic Disease**, which promotes a whole-system, person-centred approach. Its **Integrated Model of Care** delivers end-to-end services—

preventive, diagnostic, treatment, and support—collaboratively and as close to home as possible.

The HSE's **Self-Management Support** and **Making Every Contact Count** frameworks are central to the chronic disease model of care, focusing on wellness promotion, risk factor reduction, early detection, timely intervention, and support for rehabilitation or palliation. These frameworks empower patients to self-care and manage their risk factors at home. The model of care targets health inequities by prioritising vulnerable groups, including older adults and those from lower socioeconomic backgrounds, who experience higher rates of risk factors, chronic disease, multimorbidity, and poorer outcomes.

HSE **Integrated Care Hubs** are central to cardiovascular care, delivering prevention, early detection, and long-term management in the community to improve outcomes and patient experience.

The CDM Programme is for adults (aged 18 years and above), with a medical card/ GP visit card/ Health Amendment Act card. The Programme is comprised of three components:

1. Opportunistic case finding.

2. An annual preventive programme for patients at high risk of CVD or diabetes.

3. A structured treatment programme for those diagnosed with the one of the eight chronic diseases included in the Programme.

Opportunistic case finding supports identifying individuals with risk criteria for chronic disease to see if they have the condition or are at high risk of cardiovascular disease/ diabetes, but are unaware of it hence, it supports early detection, early intervention and improved outcomes. Individuals identified by their GP as being at high risk of CVD or diabetes, will be enrolled in the Prevention Programme to receive an annual preventive GP and Practice Nurse visit to address risk factors. Following the Opportunistic Case Finding visit, patients with a newly diagnosed chronic condition are entered into the Treatment Programme and get two reviews each with the Practice Nurse and GP on an annual basis.

The **Prevention Programme** is for adults aged 45+ with a medical card, GP visit card or a Health Amendment Act card identified at high risk of cardiovascular disease or diabetes. Adults aged 18+ with a medical card, GP visit card or a Health Amendment Act card and diagnosed with stage 1 hypertension are also supported in the prevention programme.

The **Treatment Programme** was initially rolled out to over 70-year-olds, with extension to the over 65-year-olds commencing from January 2021 and further extension to all adults over 18 years of age from January 2022. The Treatment Programme is open to all adults who have a General Medical Services /Doctor Visit Card/Health Amendment Act Card who have been diagnosed with at least one of the following chronic diseases; Type 2 diabetes mellitus, Ischemic heart disease, Atrial fibrillation, Heart failure, Cerebrovascular accident (CVA), Transient ischaemic attack (TIA), Chronic Obstructive Pulmonary Disease (COPD), Asthma. The

Treatment Programme requires GPs to carry out a number of specified physical examinations and clinical measurements at each of the twice-yearly visits.

The **Chronic Disease Management (CDM) Programme** requires GPs to create a care plan with each patient, updated at each visit, supporting self-management through anticipatory care, agreed treatment goals, and actions for deterioration.

I hope this provides you with some assistance.

Yours sincerely

Regina Black
General Manager
National Heart Programme, Office of the Chief Clinical Officer