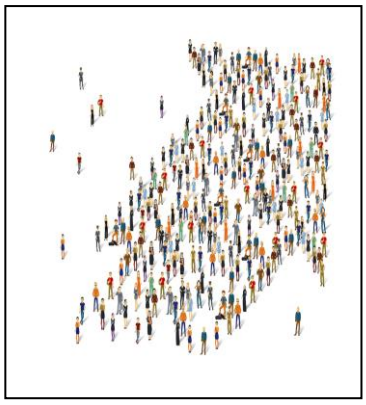
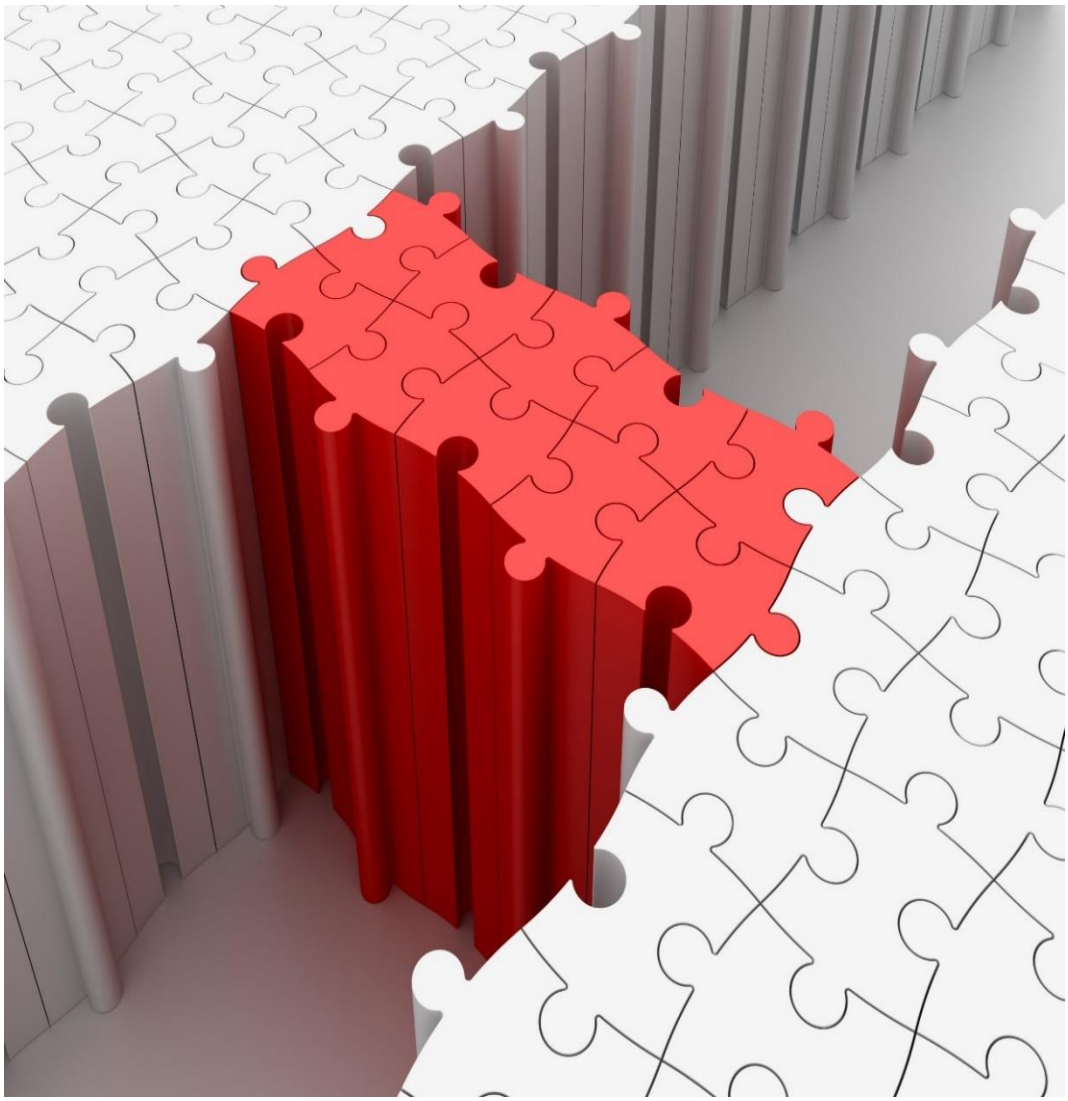
A Framework for Health Needs Assessment





WHAT

What is a Health Needs Assessment (HNA)?

A HNA is a systematic method of identifying the health needs of a specified population, including the identification of unmet health needs, and prioritising, using evidence-based methodology and a partnership approach, the actions to address this unmet need equitably, including specifying how these actions will be monitored and evaluated.

WHY

Why conduct a HNA?

The main reason for undertaking a HNA is to gather information in a systematic way to inform service planning to maximise health outcomes and ensure health equity.

A HNA provides an opportunity to partner with specific populations, enabling and empowering them to contribute to service planning and resource allocation.

A HNA provides an opportunity for cross-sectoral collaboration and co-design of innovative interventions.

WHO

Who is the subject of the HNA?

A HNA covers a defined population, which can be everyone within a geographical area or people with a particular characteristic or health condition.

HOW

How do you conduct a HNA?

A HNA is conducted within a framework, which includes six defined, and not necessarily linear, steps. The framework, introduced in this document, is called the 6P HNA Framework, and can be applied to a HNA for any population type.

Partnership is a key core step underpinning each of the other five steps: **Prepare**; **Population**; **Picture**; **Prioritise** and **Plan**.

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Reader Information

Acknowledgments:	The National Health Service Improvement Team would like to acknowledge and thank the HNA Framework Subgroup members for their time and valuable contributions to the development of this draft HNA Framework document. We are grateful to the HSE Population-Based Planning (PBP) Working and Steering Groups for their respective expertise and input to the document.
Developed by:	The development of this document was led by the National Health Service Improvement Team, Public Health, HSE, as part of a Population-Based Planning (PBP) programme of work to support the implementation of the HSE Health Regions. Document development was undertaken with a HNA Framework Subgroup, led by the National Health Service Improvement Team. The HNA Framework Subgroup was comprised of representatives from national and regional Public Health teams across the Public Health domains of Health Service Improvement, Health Improvement and Health Intelligence. Approval of this document and future versions rests with the HSE Population-Based Planning (PBP) Steering Group. This document was reviewed by the PBP Working Group prior to Steering Group approval, in accordance with the PBP governance structure.
Title:	A Framework for Health Needs Assessment.
Version Number:	1.0
Published Date:	24 June 2024
Cite this document as:	National Health Service Improvement Team, Public Health, HSE. A Framework for Health Needs Assessment. 2024.
For further information contact:	NationalHealthServiceImprovement@hse.ie
Associated documents:	To be added when developed.
Revision date:	June 2025

Version Control

Date	Version	Created by	Reviewed by	Final document approved by
24/04/2024	0.1	National Health Service Improvement Team, Public Health, HSE with a HNA Subgroup	PBP Working Group PBP Steering Group	PBP Steering Group
24/06/2024	1.0	As above.	PBP Steering Group	PBP Steering Group

Foreword

The Rationale for a Health Needs Assessment Framework

The aim of Sláintecare is to deliver the right care in the right place and at the right time for all (1). Six HSE Health Regions have been established to achieve this aim by focussing on person-centred health and social care services, integrated hospital and community services, local decision-making and national standards and services planned for the needs of the local community (2). A strategic objective of Sláintecare HSE Health Regions Implementation is to support a population-based approach to service planning and delivery, addressing the fundamental causes of inequity based on a '*holistic assessment of needs, equitable funding and prioritisation of health and social care services'* (2 p.12). In order for the Health Regions to prioritise and plan services that deliver care that meets the needs of populations, it is essential to have good information on what those population needs are, and to see populations and communities as equal partners in prioritising and planning services that meet both their needs and their preferences. Health Needs Assessment (HNA) is therefore a key tool/method in our population-based planning (PBP) approach.

A Framework for Health Needs Assessment

In the simplest definitional terms, a framework represents a structure of support upon which to build (3,4,5). This framework describes the six key steps to undertake a HNA, to facilitate a consistent approach by those involved in the planning of services at all levels. These steps are described as the 6P HNA Framework. This is a generic HNA framework and can be used to support the HNA process for whichever population is chosen as the subject of the HNA, whether that be everyone within a geographical area or people with a particular characteristic or health condition.

The '6P HNA Framework' consists of:

Prepare: Decide whether to proceed with a full HNA, identifying resources and partners, reviewing literature, and securing senior leadership support.

Population: Define the specific population of interest to set clear aims and scope.

Partnership: Engage stakeholders collaboratively to ensure inclusive and effective identification of needs, priorities and supporting implementation of priorities.

Picture: Collect and analyse quantitative and qualitative data including assets to form a comprehensive picture of local needs.

Prioritise: Identify and rank priorities for action based on impact, changeability, acceptability and resource feasibility

Plan: Develop detailed implementation, monitoring, and evaluation plans with clear responsibilities and timelines.

There are multiple types of HNAs described internationally (e.g. joint strategic needs assessments, healthcare needs assessments, community health needs assessments), and different terms are used in reference to possible approaches to HNA (e.g. epidemiological, comparative, corporate) (6). The development of this framework was informed by review of the various literature, guidance and resources from Ireland and internationally on the various HNA types, nomenclature and approaches, to support the design of the generic and flexible framework presented in this document. Additional resources will be produced to support the implementation of this HNA Framework.

We would like to express sincere thanks to all involved in the development of this HNA Framework, which will be of particular value in informing the planning and operational functions of the HSE Health Regions by providing a framework for identifying and prioritising health needs of the population, and in guiding the provision of equitable and accessible services, in support of the implementation of Sláintecare.

Signed

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Introduction

What is Health Needs Assessment?

A Health Needs Assessment (HNA) is a systematic method of identifying the health needs of a specified population, including the identification of unmet need, and prioritising, using evidence-based methodology and a partnership approach, the actions to address these health needs equitably, and specifying how these actions will be monitored and evaluated (7,8).

HNAs are a recognised means of providing evidence about a population to enable population-based planning (PBP) and to help target health inequities (9). They can support the identification and prioritisation of health needs of populations and sub-populations within the HSE Health Regions, to inform equitable service planning design and development, as well as resource allocation.

HNAs can be considered at national, regional and local level for different types of populations, which may be defined by geography, a particular setting, a medical condition, social determinants, or other factors. For example:

- People in a defined geographical area such as a whole population at a local, regional, or national level.
- People in particular settings such as schools, prisons, or residential care facilities.
- People with shared social experiences or determinants of health. This could include for example poverty, social exclusion and adverse health behaviours.
- People with a defined medical condition such as diabetes.

Figure 1 provides a visual representation of these different types of populations.

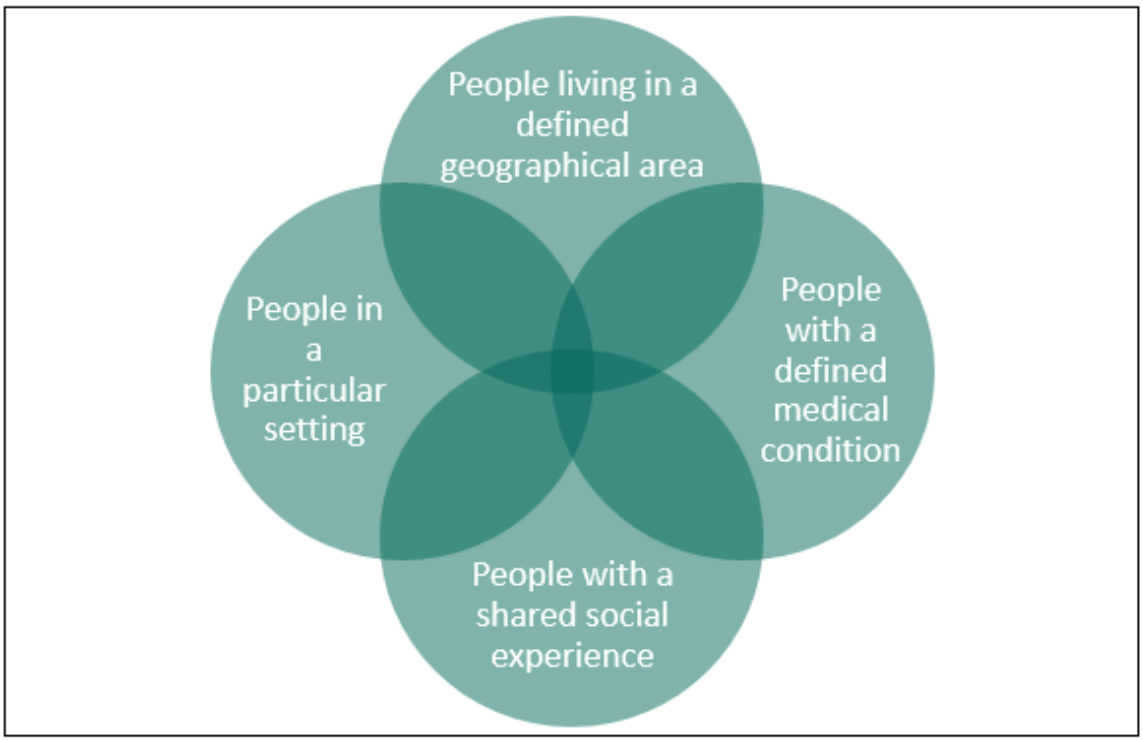

Figure 1. Examples of populations that may be the subject of a HNA.

How HNAs Benefit Population-Based Planning

There are several ways in which HNAs may benefit PBP, as summarised below (7).

Better targeting of resources

- Identify unmet need by enabling a better understanding of how the current health services are meeting, or not meeting, current need.
- Identify what service provision should continue as is, what services require enhanced funding, and areas where investment should be reduced or withdrawn due to limited effectiveness or impact.
- Enable prioritisation of limited resources to where they will have most impact by identifying effective, efficient actions that reduce inequities and promote equitable access to care.

Engagement with communities

- Enable a better understanding of communities' perspectives on their needs and priorities.

- Enable communities to participate in service prioritisation and planning, and resource allocation, to develop solutions more aligned with individual and community needs and preferences.

Cross-sectoral collaboration

- Collaboration with communities and other sectors in the public, private and philanthropic domains. Sectors involved in collaboration for HNAs will depend on the aim, objectives, scope and population of the HNA. Examples may include, but are not limited to, education, housing, social protection, businesses, community groups and/or non-governmental organisations. This collaboration ensures a comprehensive population health approach to identifying and addressing population health needs and health determinants that cannot be addressed by health and social care services alone, aligning with the World Health Organization (WHO) Health in All Policies (HiAP) approach to addressing health and health equity (10). This collaboration is a dynamic iterative process centred on collective learning to inform planning and actions.

Engagement with healthcare staff

- Enable a better understanding of health care professionals' (HCPs) perspectives on their needs and priorities.
- Enable HCPs to contribute to targeted service planning and resource allocation.
- Creation of a shared language for HNA with HCPs.

Need, Demand and Supply

Need, demand and supply are fundamental concepts in HNA.

Need

Need is a nuanced concept which has been described by Bradshaw (11), through four need types:

- **Felt needs (wants)** - these are dependent on a community or individuals perceptions of their needs, which may be affected by factors such as the degree

of health literacy or understanding of the benefit of interventions or if services are inaccessible or unaffordable.

- **Expressed needs (demands)** - when felt needs are translated into health seeking behaviour, which is affected by the supply of services, media influences, and individual characteristics. When services are demanded but not needed, such as antibiotics for viral infections, then resources are wasted.
- **Normative needs** - which are needs defined by experts that individuals and communities may not be aware of, but would benefit from.
- **Comparative needs** – this involves comparing the care or services received by different groups through benchmarking or comparison with standards or evidence based guidance for best practice.

Demand

Demand is not a proxy for need, as it only reflects an individual or population's perception of need that is translated into health-seeking behaviour. It is influenced by a multiplicity of factors, including (12):

- Accessibility of services
- Availability of services
- Affordability of services
- Awareness of services
- Cultural, social and media influences

Supply

Supply represents the total amount of resources, such as healthcare, available to consumers.

Supply depends on:

- Resources available
- Willingness of providers to provide resources
- Ability of providers to provide resources
- Interests and priorities of health professionals, politicians, interest groups, patient advocates and other stakeholders

Needs are considered met when there is enough supply to meet needs or unmet when there is insufficient supply to meet needs.

The overlap between need, supply and demand is illustrated in Figure 2.

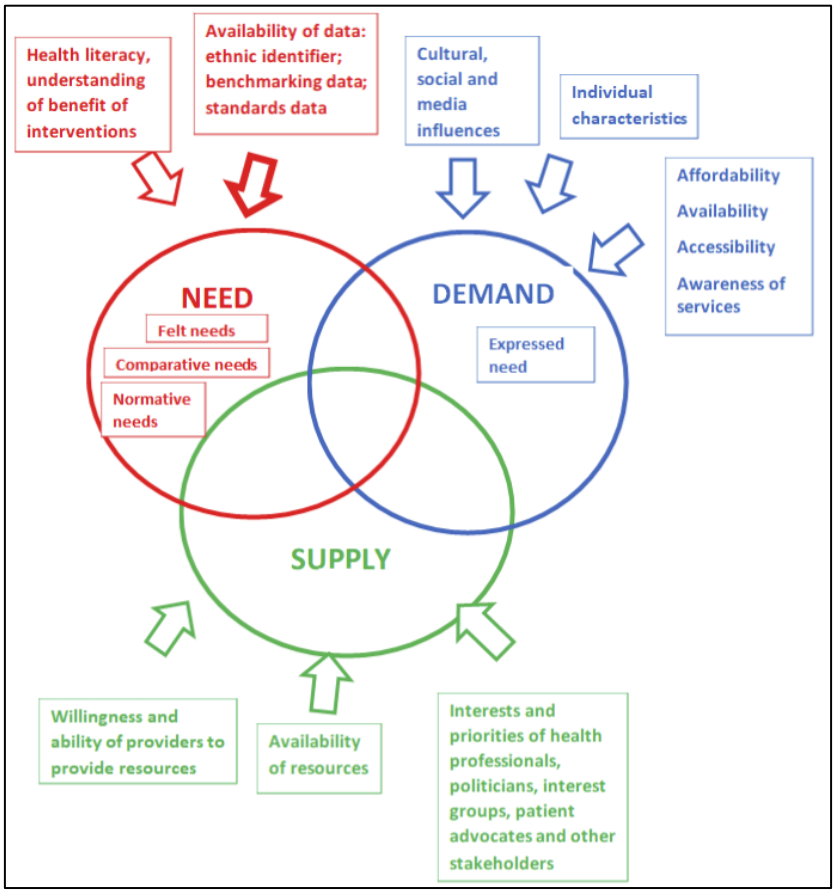

Figure 2. Overlap of Need, Demand and Supply.

Source: Hayes C adapted from Stevens A and Rafter J (Eds.) (13).

A Population Health Approach to Need

This HNA framework takes a population health approach to health needs assessment, recognising that healthcare needs are inextricably linked to the wider determinants of health and that a population health approach to assessing health needs promotes health equity.

A recent scoping review of community health needs assessment described need as a '*multifaceted concept with no universal definition*' and identified a differentiation in the literature review between '*healthcare need*' and '*health need*' (14 p.5). '*Healthcare*

needs' have been described as the *'capacity to benefit from services'*, therefore healthcare need, primarily focussed on healthcare services, is assumed to exist where there is an acceptable and effective intervention or potential for health gain (9).

In contrast '*health needs*' incorporate the wider social and environmental determinants of health, including for example housing, employment, deprivation, education, and health literacy. (Appendix; Figure 5)

Distinguishing between the health needs of a population and its sub-populations is important in the planning and provision of local health services, to achieve health equity, as the health needs of some individuals may not reflect those of the wider community (9). In addition, certain vulnerable and marginalised groups may require healthcare but not present to health services due to social and environmental issues, including health literacy, affecting access to those services (9).

Fundamental to an equitable assessment of health needs is partnering inclusively with people and communities in identifying '*What matters to you?*' to ensure that all members of the community, particularly those historically underrepresented marginalised and underserved, have an opportunity to express their needs (15). The right to health includes addressing the availability, accessibility, acceptability and quality of health services, with attention to the underlying determinants of health. To reduce the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage (16). The HNA process should ascertain whether identified population health needs are met by existing resources and services, identify the gaps in meeting those needs and produce a list of priority actions to meet the identified unmet need (17).

The 6P HNA Framework

Overview

The key steps involved in conducting a Health Needs Assessment (HNA) are presented in this document as a six-step framework, each step beginning with the letter P, which is referred to as the 6P HNA Framework. (Figure 3) It should be noted that these steps are not necessarily linear, with steps occurring iteratively and many occurring concurrently. Partnership, particularly with the population or community who are the core focus of the HNA, underpins each of the other five steps. As mentioned, further in-depth resources will be developed over 2024 as part of the HNA Toolkit, to support each of these steps.

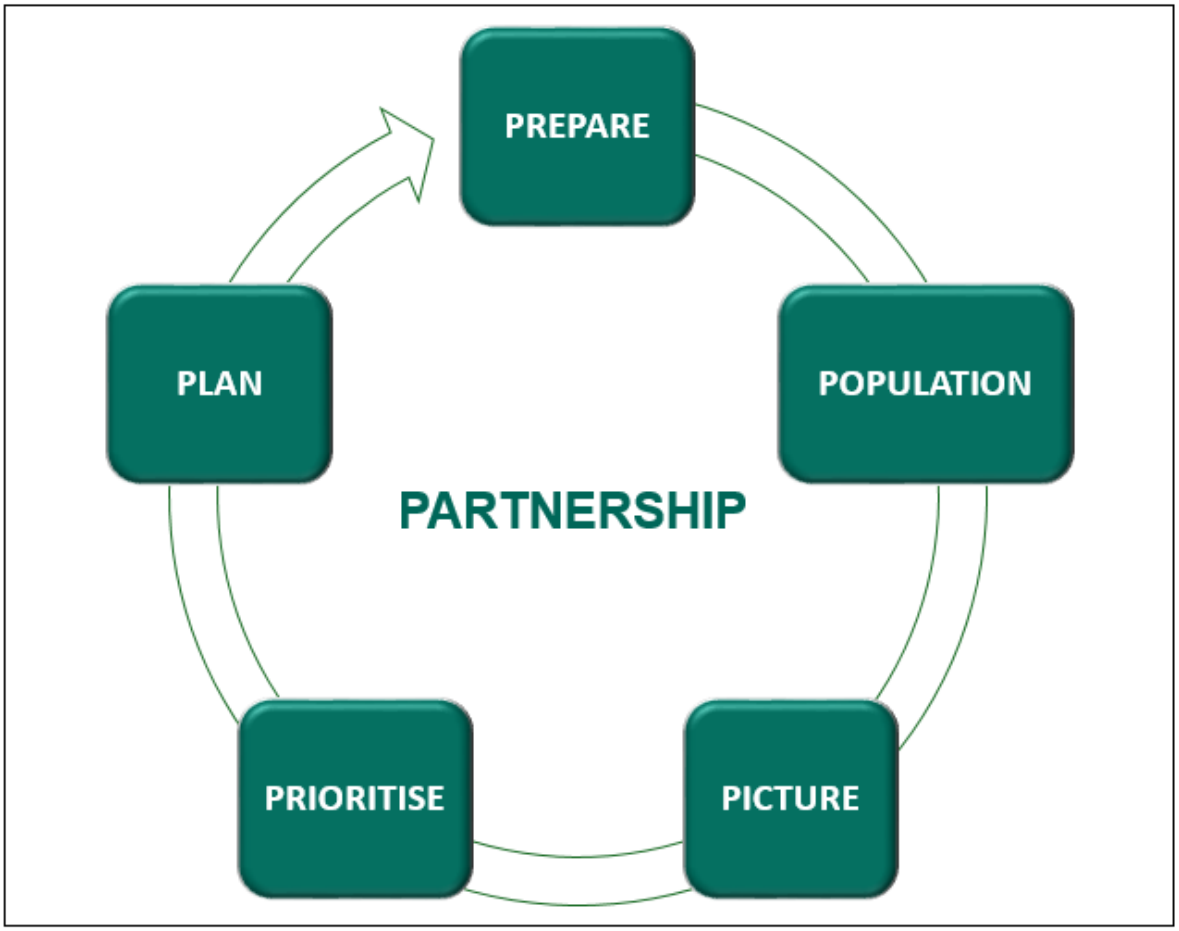

Figure 3. Steps in Conducting a Health Needs Assessment; The 6P HNA Framework.

PREPARE

The stimulus to consider whether to undertake a HNA, such as the identification of a health issue, may come to attention from several sources, including:

- A population health profile - which is a quantitative description, using data already available, on aspects of the population's health such as demographics, health status and health resources
- Input from stakeholders (including service users, families, communities, advocacy groups)
- Government or health service priority setting
- New evidence from scientific and / professional literature

An initial action therefore, is to decide whether to proceed with a full HNA, which is resource intensive; or whether another approach such as comprehensive population health profile with consultation may be sufficient to address the question or issue identified.

Factors that may influence this decision include:

- Whether work has already been completed which can be used to understand the needs of the population - for example, a similar HNA may already have been undertaken.
- Whether the resources needed to carry out a HNA are available – such as appropriately skilled project team with time available to conduct the HNA. The potential for collaboration with others involved in similar work or with a shared interest should be considered to avoid duplication and increase resource capacity.
- Prioritisation - there may be more than one HNA under consideration or requested at a point in time, and therefore prioritisation may be required in the context of the need for, and available resources to undertake, a HNA.

If a decision is made to proceed with a full HNA, the following are key considerations in the Preparation stage.

Identify the population and other key partners at the outset

The population of interest should be identified, to co-define the aims, objectives and scope of a HNA. An integral aim of a HNA is to ensure equity in resource allocation, therefore the voice of the population of interest must be included. Some underserved or socially excluded populations require a creative, inclusive, flexible approach to ensure collaborative engagement is achieved (18). For any population of interest, the degree of health literacy should be considered from the outset, to help inform the approach to partnership for the HNA (The Partnership step is addressed in detail further on in this document). A stakeholder identification and analysis exercise can support the identification of key partners outside of the population of interest.

Identify the evidence base and best practice / standard of care

A review of the published health literature and grey literature will provide a national and international perspective on the topic and evidence in relation to the effectiveness of possible interventions.

Best practice guidelines for service provision / standard of care may be used to compare existing services for the population of interest to identify the requirements to reach best practice recommendations. Suitable comparators for benchmarking should be considered. This review will inform the overall approach and choice of data to be collected in the Picture step.

Ensure integrated sponsorship of senior leaders

Senior stakeholder engagement and co-sponsorship of the HNA by, for example, senior accountable leaders for services is crucial in the planning and scoping stage to facilitate the implementation of recommendations arising from the HNA.

POPULATION

Every HNA addresses a defined population, and as mentioned, the aims, objectives and scope of the HNA will be co-defined with the population of interest.

A population can be identified as (19):

- People in a defined geographical area such as a whole population at a local, regional, or national level.
- People in particular settings such as schools, prisons, or residential care facilities.
- People with a shared social experience or health determinant such as ethnicity or homelessness.
- People with a defined medical condition such as diabetes, lung cancer etc.

The 6P HNA Framework can be used to carry out a HNA for all of these different population types, using the same basic steps and tailoring each step to the population of interest. Clearly defining the population of interest for the HNA is important to support decision-making regarding what is in- and outside of the agreed scope of the HNA.

PARTNERSHIP

Engaging with stakeholders for Partnership in HNA

There are various stakeholder engagement models and approaches described internationally. In Ireland, the HSE People's Needs Defining Change Health Services Change Guide summarises the different levels of communication and engagement that may be undertaken with stakeholders (20 p.19). (Figure 4) For HNAs, a collaborative partnership approach should be taken, representing the highest level of engagement with stakeholders. Engagement should also be informed by consideration of the health literacy among the population of interest.

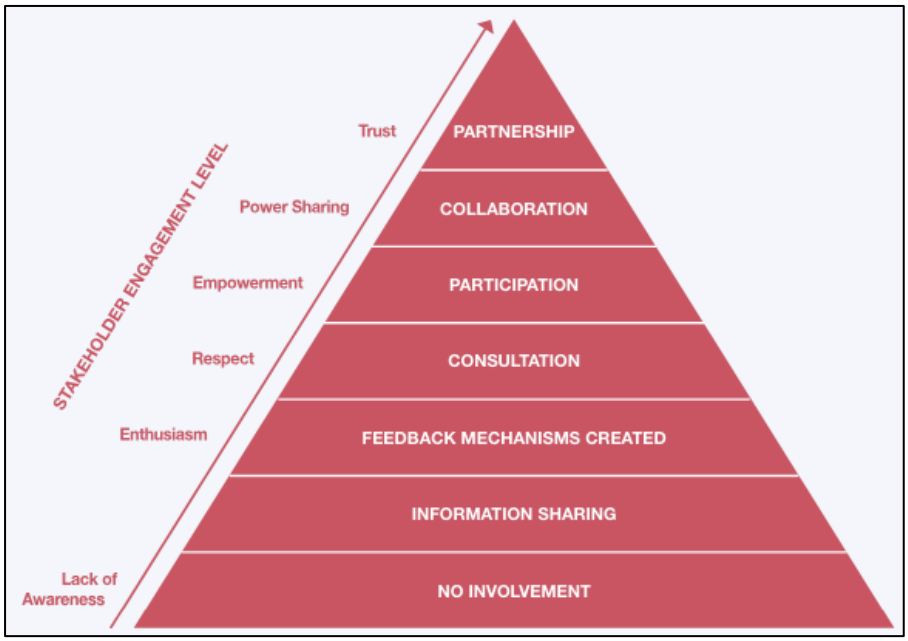

Figure 4. Levels of Stakeholder Communication and Engagement.

Source: HSE People's Needs Defining Change Health Services Change Guide (2018) (20 p.19).

Principles of engagement are also important to consider in the approach. In Ireland, the Department of Rural and Community Development Guide for Inclusive Community Engagement in Local Planning and Decision Making proposes nine principles for inclusive community engagement. These principles note that engagement processes should be genuine, purposeful, planned, clear, inclusive, collaborative, accountable, accessible and fit-for-purpose (21).

Why is Partnership important in a HNA?

In the 6P HNA Framework, Partnership is at the centre to highlight its relevance and importance for all HNA steps. As mentioned under the Prepare step, identification of key partners is an important early consideration in preparation for a HNA. This is because establishing these relationships early in the process of a HNA creates a stronger sense of partnership and joint ownership of the process, early insights into the needs and preferences of the population, and a greater likelihood of success in implementing agreed actions.

Who are the key partners in a HNA?

Key stakeholders may include healthcare professionals in primary, secondary and community care, healthcare organisations, patient representative groups, local and national government, third sector organisations, communities and any other key group likely to have an interest.

Overall, the key stakeholder group in relation to partnership is the population of interest for the HNA. For example, if the subject of the HNA is a population with a specific health condition, people with this condition are the population of interest and together with their carers and family members, are the key stakeholder group. If the subject of the HNA is a specific geographic region, communities and members of the public in a given region are the population of interest and will be the key stakeholders for such HNAs.

The partnership role of stakeholders in a HNA includes, but is not limited to:

- Identifying the topic of the HNA
- Shaping the aims, objectives and scope of the HNA
- Painting a picture of the local health needs, resources, and assets – the Picture step of the framework
- Prioritising needs and recommendations
- Implementation and evaluation

Community Partnerships

The spirit of community partnership is *'nothing about us, without us'*. (22 p.1) Community focussed partnership is a collaborative approach that equitably involves all partners in the process and recognises the unique strengths that each brings. Engaging community populations is vital to ensure their voice and particular needs are heard, acknowledging that people themselves have the best insights, wisdom and knowledge to identify their assets and their needs. As noted by UNICEF, effective community engagement should (22):

- Be systematic and integrated to ensure sustainability
- Involve two-way communication and participatory spaces which are central to building trust
- Ensure inclusion of the voices of the marginalised and vulnerable
- Empower communities by acknowledging and valuing community assets and networks
- Work with communities to strengthen existing capacity which will help foster autonomy
- Ensure engagement and partnership approaches are context specific and iterative to respond to the concerns and needs of communities.

Cross-sectoral Partnerships

Cross-sectoral partnerships encompass partnerships between various sectors across the public, private and philanthropic domains. While the sectors involved in collaboration will depend on the aim, objectives, scope and population of the HNA, such partnerships have many common advantages, including:

- Resource sharing, financial, staffing, expertise
- Data sharing
- Relationship building
- Co-ordinated and aligned implementation strategies, particularly in relation to the wider determinants of health, which will support achieving the best outcomes, particularly in relation to health equity (23)

PICTURE

The development of a comprehensive picture of the population of interest is a key step in any HNA. This is achieved by collating and presenting quantitative and qualitative data. With regard to quantitative data, there are a variety of data sources available in Ireland to support building a picture of different populations of interest. Examples and mapping of quantitative data sources available in Ireland to support HNA, across various population types, will be provided as part of the HNA Toolkit.

Qualitative methods can be used to seek contributions from the population of interest to determine their views and perspectives on their needs and knowledge of individual and community resources (24).

A picture of the target population will typically include:

Population (Demographic) Profiles

Demographic profiles are usually based on Census data and provide a quantitative view of the demographic, socioeconomic status and geographical structure of a population.

Population Health Profiles

A Health Profile provides quantitative data on health status, health experiences, morbidity estimates, health inequalities and health related behaviours of the population of interest.

Population Profiles and Population Health Profiles for the population of interest may already be published and available for the HNA. Alternatively, consideration may be given to the creation of a profile for the population of interest, with agreed parameters.

Information on Wider Determinants of Health

An accurate picture of a population or community health needs involves consideration of the wider determinants of health when collecting data. This includes, but is not limited to, factors such as poverty level, educational attainment, health literacy, access to fresh food and green spaces, crime levels, educational opportunities, housing. (Appendix:

Figure 5). Some of this information will be available from demographic profiles, health profiles and mapping of community assets.

Description of Community Assets

Including community assets in a HNA provides a more complete picture of the population of interest through identifying what assets are available and what may be needed. Community assets have been described by McLean (25, p.4), as "*the collective resources which individuals and communities have at their disposal, which protect against adverse health outcomes and promote health status*".

The authors of a recent scoping review of community assets classified these assets into seven overarching categories (14):

1. Community demographic characteristics; youth/elderly population, literacy rates
2. Capital assets: geographical location, natural resources
3. Economic and financial capital; community business, members income, housing, and land ownership
4. Community infrastructure; transport, sports clubs, libraries, community centres
5. Community social and educational facilities**;** NGOs and non-profit organisations, educational facilities, religious communities, community associations
6. Community health and social facilities; traditional medicine providers, health and social facilities and providers
7. Community's social and cultural values and resources; cultural diversity, religion, strong family bonds and values, strong community connections (11).

Description of Health and Social Care Resources

It is important to define and describe existing services and healthcare infrastructure as relevant to the agreed aim and objectives of the HNA. This may include:

- Location and distribution of relevant services.
- Provision of relevant services e.g. whether by public, private or non-governmental organisations, or other entities.

- Characteristics of specific locations and service types to highlight differences between locations and types of services that may affect equitable access to services.
- Service staffing levels and specialities.
- Integration between services, waiting lists, access to community and hospital care and diagnostic services that are likely to be priorities for the population of interest.

Services of interest may include:

- Hospitals
- Primary care teams, GPs
- Specialist and allied health and social care services
- Specialist imaging or diagnostic services

Qualitative Input from Stakeholders

A comprehensive picture of health needs is unlikely to be possible based on quantitative data alone. Following review of the available quantitative datasets, consideration should be given to what additional information will need to be collected from stakeholders, including patients, staff and communities. This information may be collected in multiple different ways such as surveys, interviews and focus groups. Consideration should be given to the health literacy and accessibility needs of different groups to ensure all voices are heard.

PRIORITISE

Information obtained in developing the population health Picture, including information on the population of interest, available health services and community assets, combined with the views of key stakeholders, is then synthesised and triangulated, usually in stakeholder workshops, to agree priorities to be addressed, and rank these priorities for action.

Four criteria are used in selecting issues for action (7):

- **Impact** - which health conditions and determinant factors will have the biggest impact in terms of size and severity, on the health of the population of interest?
- **Changeability** – are these conditions or factors capable of change and will this change result in an improvement?
- **Acceptability** - what are the most acceptable changes needed to achieve the maximum impact?
- **Resource feasibility** - are there adequate resources to make these changes?

There are many prioritisation frameworks which can be used in partnership with the target population, and all other main stakeholders, to achieve consensus on the priority areas for action to meet the gap between services and needs, with a focus on equity at all times. The prioritisation approach selected may depend on the HNA aim, objectives, scope and population of interest. As part of the HNA Toolkit, further resources will be shared to support the Prioritisation step, outlining approaches and criteria that can be used to support prioritisation of issues identified as part of a HNA, for action.

PLAN

Once priorities are agreed with stakeholder partners, then plans for implementation, monitoring and evaluation, are collaboratively produced with relevant stakeholders. Those with responsibility for implementing the prioritised service changes should take the lead role in creating the implementation plan. Specific recommended actions should be identified within the implementation plan. Resources to support ongoing implementation, monitoring and evaluation should be agreed to ensure sustainability over time.

The implementation plan should include:

- Robust and transparent governance structures, preferably embedded within a service planning cycle and integrated within current governance arrangements
- Aims and objectives of the plan
- Agreed priority areas, associated actions, expected outcomes
- Agreed responsibilities for recommended actions
- Agreed implementation timelines
- Agreed evaluation methods (what, why and how) including:
    - Indicators to monitor and measure progress
    - Targets/outcomes for success

Consideration will be needed regarding data sources for agreed indicators and targets/outcomes e.g. secondary data sources or de novo data collection.

Key learning from the process and outcomes should be captured and shared across the system as a resource to reduce duplication of effort and inform future actions, highlighting and building on what has worked well and providing an opportunity to learn from challenges.

Conclusion

Health Needs Assessments (HNAs) support a population-based approach to planning, prioritising and resourcing health services. HNAs provide a structured collaborative approach to understanding the needs of the population, identifying priorities, and informing processes to ensure the provision of equitable and accessible services that will have greatest impact on the health of the population and that are achievable within the resource envelope of the system.

This document provides a summary framework for conducting a HNA at national, regional or local level that is both generic and flexible for use across different populations. It is a first step in the creation of a suite of HNA resources as part of a HNA Toolkit to support those involved in planning and prioritisation of services based on population needs in the HSE Health Regions, in line with the Sláintecare vision of providing the right care in the right place at the right time for all. These resources will be developed over 2024 to build on this document and support each of the six steps of the 6P HNA Framework.

References

1. Irish Department of Health. Sláintecare Implementation Strategy and Action Plan 2021-2023. Dublin: Stationary Office, 2021.
2. Health Service Executive: Organisational Reform: HSE Health Regions Implementation Plan: 2023
3. Cambridge Dictionary. Framework [Internet] [accessed 1st May 2024] Available from: https://dictionary.cambridge.org/dictionary/english/framework
4. Collins Dictionary. Framework [Internet] [accessed 1st May 2024] Available from: https://www.collinsdictionary.com/dictionary/english/framework
5. Merrian-Webster Dictionary. Framework [Internet] [accessed 1st May 2024] Available from: https://www.merriam-webster.com/dictionary/framework
6. Higginson IJ, Hart S, Koffman J, Selman L, Harding R. Needs Assessments in Palliative Care: An Appraisal of Definitions and Approaches Used. J Pain Symptom Manage. 2007;33(5):500–5.
7. Cavanagh S, Chadwick K. Health Needs Assessment: A Practical Guide. National Institute for Health and Clinical Excellence; 2005.
8. Kawachi I, Lang I, Ricciardi W. Oxford handbook of public health practice 4e. Oxford University Press; 2020.
9. Wright J, Williams R, Wilkinson JR. Development and importance of health needs assessment. BMJ. 1998 Apr;316(7140):1310–3.
10. World Health Organization. Promoting Health in All Policies and intersectional action capacities [Internet] Geneva: World Health Organization [accessed 18th April 2024] Available from: https://www.who.int/activities/promoting-health-in-all-policies-and-intersectoral-action-capacities
11. Bradshaw J. A taxonomy of social need. In: McLachlan G,ed.Problems and progress in medical care.7th series. London: Oxford University Press, 1972.
12. Bindra R, Currie C. UK Faculty of Public. Health Health Knowledge. [cited 2023 Mar 19]. The uses of epidemiology and other methods in defining health service needs and in policy development. 2016.
13. Stevens A and James Rafter J (Eds.) Health Care Needs Assessment. The epidemiologically based needs assessment reviews. Second series. Oxford and New York: Radcliffe Medical Press. 1997. IBSN: 1 85775 199 X.
14. Ravaghi H, Guisset AL, Elfeky S, Nasir N, Khani S, Ahmadnezhad E, et al. A scoping review of community health needs and assets assessment: concepts, rationale, tools and uses. BMC Health Serv Res. 2023;23(1):1–20
15. Mate K. Institute for Healthcare Improvement. 2022 [cited 2023 Mar 19]. Why Asking "What Matters To You?" Matters. Available from: https://www.ihi.org/insights/why-asking-what-matters-you-matters
16. Marmot, M. Fair Society, Healthy Lives. The Marmot Review; UCL Institute of Health Equity: London, UK, 2010.

17. Gulliford M, Jessop E, editors. Healthcare Public Health: Improving health services through population science. Oxford University Press; 2020.
18. van der Ven LGL, van Baar JM, Wispelweij RS, Jambroes M. How to involve 'hard to reach' population groups in research projects. Eur J Public Health. 2022 Oct 1;32(Supplement_3):ckac129.476.
19. Hooper J, Longworth P. Health needs assessment workbook. Health Development Agency; 2002.
20. Health Service Executive – Organisation Development and Design (2018, reprinted 2023). People's Needs Defining Change – Health Services Change Guide. Kells, Co Meath, Ireland: Health Service Executive. 2023 p.19.
21. Irish Department of Rural and Community Development. A guide for inclusive community engagement in local planning and decision making. Dublin: Stationary Office, 2023.
22. UNICEF: Community Engagement Partnering with communities so they can lead the change process [Internet] New York: UNICEF; 2024 [accessed 18th April 2024] Available from: https://www.sbcguidance.org/understand/community-engagement
23. Health Research & Educational Trust. (2016, June). Engaging patients and communities in the community health needs assessment process. Chicago,IL: Health Research & Educational Trust, 2016.
24. Hayes C. Population Health Management: A Position Paper. Health Service Executive; 2022.
25. McLean J. Asset based approaches for health improvement: redressing the balance. UK: Glasgow Centre for Population Health. 2011.page 4
26. Buck D, Bayliss A, Dougall D, Robertson R. A vision for Population Health. Towards a Healthier Future. King's Fund; 2018. p. 17.
27. Buckle N. Spending Review 2022 Towards Population-Based Funding for Health: Model Proposal. 2023;
28. Marmot Michael, Allen Jessica, Boyce Tammy, Goldblatt Peter, Morrison Joana. Marmot Review 10 Years On - Institute for Health Equity. Report. 2020.
29. Whitehead M, Dahlgren G. What can be done about inequalities in health? Lancet. 1991;338(8774):1059–63.
30. Barton H, Grant M. A health map for the local human habitat. J R Soc Promot Health. 2006;126(6):252–3.
31. Arcaya MC, Arcaya AL, Subramanian S V. Inequalities in health: definitions, concepts, and theories. Rev Panam Salud Publica. 2015;38(4):261–71.
32. Solar O, Irwan A. A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice). Geneva; 2010.
33. Health Services Executive. Health Services Healthy Ireland Implementation Plan 2023 - 2027 : 2023.

Appendix: Definitions

Population Health is an approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional, or national population, while reducing health inequalities and ensuring health equity. Actions to improve population health involve working with communities and partner agencies and include (26):

- Preventative actions to reduce the occurrence of ill health.
- Action to deliver appropriate health and care services.
- Action on the wider determinants of health.

Population Based Planning (PBP) is a population-based approach to planning which aims to improve the health and wellbeing of the entire population by considering all determinants of health. It moves toward a holistic assessment of needs, equitable funding, and prioritisation of health and social care services. This approach seeks to address root causes of health inequities and support integrated care (2).

Population-Based Resource Allocation (PBRA) is a funding model for health and social care planning that seeks to distribute available healthcare resources according to population need, in order to promote efficiency and equity in both health outcomes and distribution of resources (27).

Determinants of Health

The link between poverty and ill-health is well established, with a myriad of evidence showing that more disadvantaged groups have relatively higher mortality rates, higher levels of ill health and fewer resources available to adopt healthier lifestyle choices compared to those in higher socioeconomic groups (28). Dahlgren and Whitehead proposed a model for the determinants of health that recognises there are complex, multi-layered influences and factors that have an impact on the health of individuals (29). These determinants can be health promoting, protective or health damaging. The model was updated by Grant and Barton to take into account the influences of both the built and

natural environment, and the wider global ecosystem including climate change and biodiversity (30). Health inequalities occur when a subgroup of the population suffers a disproportionate burden of ill health and premature death compared to the population as a whole (31). Health inequity refers to a specific type of health inequality that denotes an unjust difference in health; that is, there are systematic differences in health or healthcare provision that could be avoided by reasonable means (32).

Tackling health inequalities and health inequities requires action within all the layers of influence portrayed in Figure 5.

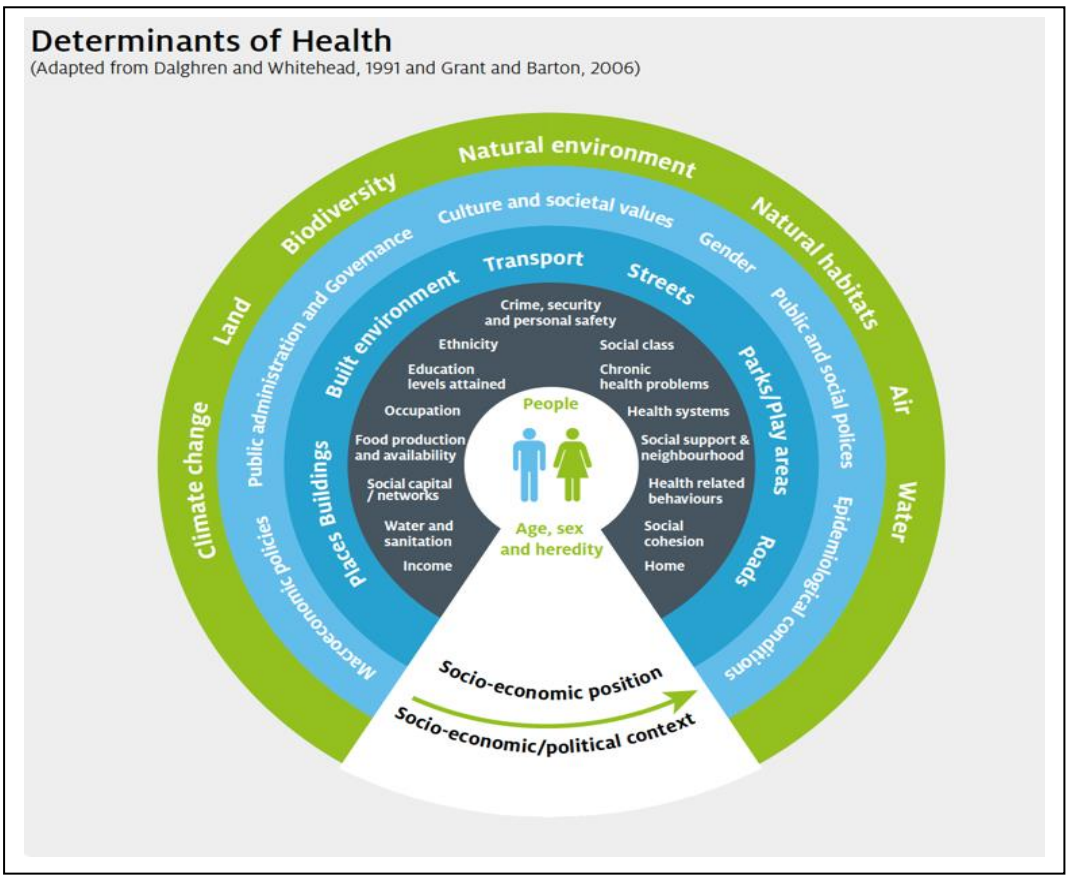

Figure 5 The Determinants of Health Diagram based on the work of Dahlgren and Whitehead and Grant and Barton. (29,30)
Source: Health Services Healthy Ireland Implementation Plan 2023-2027 (33).