

3.6 Healthcare

CORE POLICY OBJECTIVE: HEALTHCARE

To provide an adequate healthcare service focused on enabling people to attain the World Health Organisation’s definition of health as a *state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*

Healthcare is a social right that every person should enjoy. People should be assured that care in their times of vulnerability is guaranteed. The standard of care is dependent on the resources made available which in turn is dependent on the expectations of the society. The obligation to provide healthcare as a social right rests on all people. In a democratic society this obligation is transferred through the taxation and insurance systems to government and other bodies who assume/contract this responsibility

Health inequalities in Ireland

A very welcome insight into the extent of health inequalities in Ireland has been provided by the Public Health Alliance of the Island of Ireland (PHAI). This group, a north-south alliance of non-governmental organisations, statutory bodies, community and voluntary groups, advocacy bodies and individuals who are committed to work together for a healthier society by improving health and tackling health inequalities, have published a detailed report entitled “*Health in Ireland – An Unequal State*”. The report gathered together the baseline information on health inequalities in Ireland and its findings are worthy of serious attention. These included:

- Between 1989 and 1998 the death rates for all causes of death were over three times higher in the lowest occupational class than in the highest
- The death rates for all cancers among the lowest occupational class is over twice as high for the highest class, it is nearly three times higher for strokes, four times higher for lung cancer, six times for accidents
- Perinatal mortality is three times higher in poorer families than in richer families
- Women in the unemployed socio-economic group are more than twice as likely to give birth to low birth weight children as women in the higher professional group

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- The incidence of chronic physical illness has been found to be two and a half times higher for poor people than for the wealthy
 - Men in unskilled jobs were four times more likely to be admitted to hospital for schizophrenia than higher professional workers
 - The rate of hospitalisation for mental illness is more than 6 times higher for people in the lower socio-economic groups as compared with those in the higher groups
 - The incidence of male suicide is far higher in the lower socio-economic groups as compared with the higher groups
 - The 1998 and 2002 National Health and Lifestyle Surveys (SLAN) found that poorer people are more likely to smoke cigarettes, drink alcohol excessively, take less exercise, and eat less fruit and vegetables than richer people. Poorer people's lifestyle and behavioural choices are directly limited by their economic and social circumstances
 - On average 39 per cent of people surveyed in 2003 identified financial problems as the greatest factor in preventing them from improving their health.

The report also found that some groups experience particularly extreme health inequalities. These include:

- Members of the Traveller community live between 10 and 12 years less than the population as a whole
- The rate of sudden infant deaths among Travellers is 12 times higher than for the general population
- Research has found that many expectant mothers in direct provision suffer malnutrition, babies in these communities suffer ill-health because of diet, many adults experience hunger
- Homeless people experience high incidence of ill-health – a 1997 report found that 40 per cent of hostel dwellers had a serious psychiatric illness, 42 per cent had problems of alcohol dependency, 18 per cent had other physical problems
- The incidence of injecting drug use is almost entirely confined to people from the lower socio-economic groups.

The PHAI also compared the health of people in Ireland against that of the 15 other EU states (pre-enlargement) They found that Irish people compare badly with the experience of citizens in other EU countries. These findings included:

- Mortality rates in Ireland are worse than the EU average for a range of illnesses, particularly diseases of the circulatory system, breast cancer and death from smoking related illnesses
- Irish women have almost twice the rate of death from heart disease as the average European woman
- The incidences of mortality for Irish women for cancers of the breast, colon, larynx and oesophagus and for ischaemic heart disease are among the highest in the EU
- At the age of 65 Irish men have the lowest life expectancy in the EU.
(PHAI, 2004:3-4).

Poverty and health status

The link between poverty and ill health has been well established by international and national research such as that outlined above. The poor get sick more often and die younger than those in the higher socio-economic groups. Poverty directly affects the incidence of ill health; it limits access to affordable healthcare and reduces the opportunity for those living in poverty to adopt healthy lifestyles. Reflecting this, a 2006 study of the accessibility of health care found 18.9 per cent of Irish people indicated that cost had deterred them from visiting a GP and seeking medical advice (O'Reilly and Thompson, 2006). Healthcare exclusion is a major dimension of poverty and social exclusion.

Life expectancy and infant mortality

In 2007 Irish males had life expectancies of 76.8 years while Irish females are expected to live 4.8 years longer reaching 81.6 years (see table 3.6.1). The story behind these figures incorporates many of the findings of the PHAI report and the earlier poverty figures. Ireland's poverty problem has serious implications for health in light of the fact that there is a clear link between poverty and ill health. This relationship has been well supported by international research. Thus, those in lower socio-economic groups have a higher percentage of both acute and chronic illnesses.

Table 3.6.1: EU-27 life expectancy at birth by sex in 2007, in years.

Country	Males	Females	Difference
France	77.5	84.4	6.9
Spain	77.7	84.1	6.4
Italy	78.4	83.8	5.4
Belgium	77.3	83.3	6.1
Sweden	78.9	83.0	4.1
Austria	77.3	82.9	5.5
Finland	75.8	82.9	7.0
Luxembourg	77.6	82.7	5.1
Netherlands	78.0	82.3	4.3
Slovenia	75.0	82.3	7.3
Germany	76.9	82.3	5.4
Greece	77.0	82.0	5.0
Malta	77.2	81.8	4.5
Cyprus	77.0	81.7	4.7
United Kingdom	77.6	81.7	4.1
IRELAND	76.8	81.6	4.8
Portugal	75.2	81.6	6.4
Denmark	76.0	80.5	4.5
Czech Republic	73.7	79.9	6.2
Poland	71.0	79.7	8.8
Estonia	67.4	78.5	11.1
Slovakia	70.5	78.1	7.6
Hungary	69.2	77.3	8.2
Lithuania	64.9	77.2	12.3
Latvia	65.8	76.5	10.7
Bulgaria	69.2	76.3	7.1
Romania	69.2	76.1	7.0
EU 27	75.8	82.0	6.2

Source: CSO 2009:54

Health expenditure

Healthcare must be seen as a social right for all people. For this to be upheld governments need to provide funding to ensure this occurs. In table 3.6.2 we see that Ireland spends 7.5 per cent of GDP on health; well below the EU-27 average of 8.6 per cent. Less is spent on public and private health as a proportion of GDP

than the majority of other EU-27 countries. In Gross National Income (GNI) terms this expenditure translates into a figure of 8.6 per cent.⁶² In comparison France spends 11.1 per cent, Germany spends 10.4 per cent and Portugal 10 per cent. Ireland has the eleventh lowest expenditure on health (measured as a percentage of GDP) according to EU-27 data, although this ranking position has been increasing over time. Healthcare costs tend to be higher in countries which have a higher old age dependency ratio. This is not yet so significant an issue for Ireland as the old age dependency ratio is extremely low (10.8 per cent are aged 65 yrs and over) compared to a much higher EU average. However, this level of funding must be seen as inadequate in light of the fact that waiting lists, bed closures, shortage of staff and long-term care requirements are issues in the health service today. Clearly, there are significant efficiencies to be gained in a restructuring of the Irish health system, and in particularly the HSE. However, as the population ages and demand for facilities increases funding as a percentage of national income will have to rise.⁶³

Table 3.6.2: EU-25 health expenditure as a percentage of GDP, 2007

Country	%	Country	%
France	11.1	Finland	7.6
Germany	10.4	Hungary	7.6
Portugal	10.0	Ireland (% of GDP)	7.5
Austria	9.9	Luxembourg	7.2
Greece	9.9	Slovakia	7.0
Belgium	9.5	Bulgaria	6.9
Denmark	9.5	Czech Republic	6.8
Netherlands	9.3	Cyprus	6.3
Italy	9.0	Lithuania	6.2
Sweden	8.9	Poland	6.2
Ireland (% of GNI)	8.6	Latvia	6.0
Slovenia	8.4	Romania	5.7
United Kingdom	8.4	Estonia	5.0
Malta	8.3		
Spain	8.1	EU 27	8.6

Source: CSO (2009:53)

⁶² GNI is similar to the concept of GNP and has a similar value.

⁶³ This issue is also analysed in section 3.2 of this review.

Primary care

Primary Care has been recognised as one of the cornerstones of the health system. This was given recognition by the publication of a strategy *Primary Care – A New Direction* (2001). Between 90 and 95 per cent of the population are treated by the primary care system. The model of a primary care team presented in the document must be viewed in its most flexible form so that it can respond to the local needs assessment. The principle underlining this model should be a social model of health. This is in keeping with the World Health Organisation's definition on health. Universal access is needed to ensure that a social model of health as outlined in the document becomes a reality. For the development of *Primary Care – A New Direction* there is a clear need for the allocation of more resources. This would need an increase in the percentage of the healthcare budget being allocated for primary care.

The General Medical Service (GMS) system was first introduced in 1972 and it gave a commitment that 40 per cent of the population would be covered by this system. By 1977 some 39 per cent of the population were eligible for medical cards on income grounds. By 2007 this figure had decreased to approximately 29.5 per cent of the population. For families just over the eligibility level a visit to the GP and a prescription could cost some 25 per cent of their total weekly income. The implications of this for many individuals and families are that they cannot afford to access appropriate care at the time needed. This reduction must be viewed in the light of failed government commitments contained in, for example, the Department of Health and Children's document *Quality and Fairness – A Health System for You* (2001). Accessibility is one of the factors in ensuring equity. Among other things equity is about outcomes. To achieve parity in outcomes requires recognition of the social determinants of health. The World Health Organisation (WHO) makes the following observation:

Community participation is a programmatic necessity. Without the close involvement of the community, and its families and individuals in health promotion, disease prevention and care of the sick, there is little likelihood that health services will have a durable impact on the health of the community.

The importance of paying attention to local people's own perspective on their health and to understand the impact of the conditions of their lives on their health is essential to community development and to community orientated approaches to primary care. There needs to be a community development approach to ensure

that the community can define its own health needs, work out how these needs can best be met collectively and decide on a course of action to achieve the outcomes in partnership with service providers. This will ensure greater control over the social, political, economic and environmental factors that determine the health status of any community.

The Government's own Primary Care Strategy acknowledges the need for "community involvement" as a key factor in addressing health issues and recognises the need for partnership in both the planning and evaluation of all services. Community participation is an "essential component of a more responsive and appropriate care system which is truly people-centred" (Chief Medical Officers Report).

Primary care teams

Ireland's healthcare system has struggled to provide an effective and efficient response to the health needs of its population. Despite a huge increase in investment in recent years great problems persist. One key initiative that would make a substantial positive impact on reducing these problems would be the development of primary care teams across the country.

Primary care teams draw the health professionals in an area together into a team that provides a one-stop shop where people can go locally rather than heading directly to the accident and emergency unit in the nearest hospital. Up to 80 per cent of those who go to accident and emergency units should not be there.

The National Social Partnership Agreement *Towards 2016* contains a commitment to engage in ongoing investment to ensure integrated, accessible services for people within their own community with a target of 300 primary care teams by end-2008, 400 by 2009 and 500 by 2011. However, progress towards this target has been unacceptably slow. *Social Justice Ireland* strongly supports the immediate implementation of this commitment and its potential to have a very positive impact on Ireland's healthcare services.

However, we strongly urge Government and the HSE to ensure that these centres are progressed on the basis of local needs assessment including fair coverage of both rural and urban areas. We also urge Government and the HSE to take the necessary action to ensure that development of the 200 primary care teams for these centres is initiated as soon as possible. Furthermore, we urge all involved to ensure that the target of 500 teams is reached by the target date of end-2011.

Finally, to complement these initiatives, the national agreement also commits to continue to develop out-of-hours GP services in line with the recommendations of the GP out-of-hours service review

Medical Cards

The introduction of 30,000 new medical cards and 200,000 'doctor visit only' cards in Budget 2005 was a small step in the right direction. However, a great deal more needs to be done before the 1996 level of provision is regained. In 1996 1,252,384 people on low incomes were covered by full medical cards. After Budget 2005 1,069,934 people were similarly covered. Today there are approximately 1,400,000 people with medical cards.

The eligibility thresholds for full medical cards have not been raised but the numbers have grown because many newly unemployed people have seen their income slip below the threshold. The eligibility threshold for 'doctor-only' cards was raised in mid-2006 to a level 50 per cent above the standard medical card thresholds. As of December 2007 there were 75,542 doctor-only cards.⁶⁴ The process of applying for a medical card is difficult and there is a long time-delay before applications are approved which is not acceptable.

What is required is full medical card coverage for all people in Ireland who are vulnerable. Currently, the income threshold for accessing a medical card is far below the poverty line. This in effect creates an employment trap as parents are often afraid to take up a job and, consequently, lose their medical card even though their income remains low. The 'doctor visit only' cards are an improvement on the previous situation only if they are upgraded to full medical cards in due course. At present they will create new problems as many people will now find themselves in the most unenviable situation of knowing what is wrong with them but not having the resources to purchase the medicines they need to be treated.

Mental health

The National Health Strategy entitled *Quality and Fairness* (2001) identifies mental health as an area to be developed. The Expert Group on Mental Health Policy invited written submissions and held consultation days with all relevant stakeholders. We welcomed the publication of the report *Vision for Change - Report of the Expert Group on Mental Health Policy*. To date, little has been implemented to achieve this vision.

⁶⁴ Dail speech by Minister for Health and Children, December 19th 2007.

There is an urgent need to address this whole area in the light of the World Health Report (2001) *Mental Health: New Understanding, New Hope* where it is estimated that, in 1990, mental and neurological disorders accounted for 10 per cent of the total Disability-Adjusted Life Years (DALYs) lost due to all diseases and injuries. This was 12 per cent in 2000. By 2020, it is projected that these disorders will have increased to 15 per cent. This has serious implications for services in all countries in the coming years.

In recent years there have been some positive policy developments in this area. We welcome the *Towards 2016's* commitment to deliver one child and adolescent community mental health team per 100,000 of the population by 2008 and two per 100,000 of the population by 2013. However, this commitment has not yet been honoured.

Areas of concern

There is a need for effective outreach and follow-up programmes for people who have been in-patients in institutions upon their discharge into the wider community. These should provide:

- Sheltered housing (high, medium and low supported housing)
- Monitoring of medication
- Retraining and rehabilitation
- Assistance with integration into community

A stronger emphasis on the development of community services for all levels of mental health is urgently required. People with an intellectual disability who require a mental health service frequently find they do not have a psychiatric service available to them. Furthermore, there is a lack of appropriate mental healthcare for all who need it, especially vulnerable groups including children, the homeless, prisoners, Travellers, asylum seekers and refugees and other minority or vulnerable groups. People in these and related categories have a right to a specialist service to provide for their often-complex needs. A great deal remains to be done before this right could be acknowledged as being recognised and honoured in the healthcare system.

When the social determinants of health (housing, income, childcare support, education etc.) are not met the connection between those who are disadvantaged and ill health is well documented. This is also true where mental health issues are concerned.

Suicide

A related problem to mental health is suicide. For many years the topic of suicide was one rarely discussed in Irish society and as a consequence the healthcare and policy implications of its existence were limited. Data show that the numbers of suicide in Ireland has climbed over the last decade. In 1993 327 suicides were recorded and by 2007, the latest year for which data is available, the number of suicides had increased to 460. Over time Ireland's suicide rate has risen from 6.3 suicides per 100,000 people in 1980 to 10.8 suicides per 100,000 people in 2007 (OECD, 2005 and CSO, 2008:88).

The age and sex distribution of suicides provides an important insight into what groups in Irish society are most prone to suicide. Table 3.6.3 provides a breakdown for 2005 (the latest year for which a detailed breakdown is available) when there were 481 deaths by suicide and self-inflicted injury. It shows that suicide is predominantly a male phenomenon with almost 80 per cent of suicide victims being male. When assessed by age group the data suggest that young people, and in particular young males, are the groups most at risk. Young males aged between 15 and 34 account for over 36 per cent of all suicides in 2005. Among this age-group in the population, suicide is one of the largest killers.

Table 3.6.3: Suicides in Ireland in 2005, by age group and gender.

Age group	Male	Female	Total
10-14 years	2	1	3
15-24 years	82	20	102
25-34 years	92	23	115
35-44 years	76	13	89
45-54 years	66	19	85
55-64 years	43	12	55
65-74 years	19	7	26
75-84 years	2	3	5
85 years+	0	1	1
All ages	382	99	481

Source: CSO Report on Vital Statistics (2008:117)

The sustained high level of suicides in Ireland is a significant healthcare and societal problem. Of course the statistics in table 3.6.3 only tell one part of the story. Behind each of these victims are families and communities devastated by these tragedies. Likewise, behind each of the figures is a personal story which leads to victims taking

their own life. *Social Justice Ireland* believes that further attention and resources need to be given to addressing and researching Ireland's suicide problem. In that light, we welcome the establishment of the national office of suicide prevention and the directions laid out in the National Strategy for Action on Suicide Prevention (2005–2014). Resources are also required for the support systems that must be provided for such vulnerable groups. As a society we need to become more aware of this issue and more aware of methods to prevent it.

Older people

Mental health issues affect all groups in society. A particularly vulnerable group are older people with dementia as they often fall between two stools. i.e. mental health versus general medical care. Therefore there needs to be a co-ordinated service provided for this group. It is important that this service be needs based and service-user-led and should be in keeping with international human rights standards and best practice in line with the principles in the World Health Organisation's 2001 annual report.

Research and development in all areas of mental health is needed to ensure a quality service is delivered. Providing good mental health services should not be viewed as a cost but rather as an investment for the future. Public awareness needs to be raised to ensure a clearer understanding of mental illness so that the rights of those with mental illness are recognised.

We acknowledge the significant investment made to develop services for older people and the commitments made in *Towards 2016*. We welcomed the announcements of the introduction of "*A Fair Deal – The Nursing Home care Support Scheme 2008*". This initiative has been activated. It remains critical that sufficient capital investment is provided to ensure that the additional numbers of residential care beds are made available to meet the growing demand as identified. The focus on the development of community based services to support older people to remain in their own homes/communities for as long as this is possible is to be welcomed. Improved funding is also required for home help services, day care centers and home care packages.

Disability

The government's approach in Budget 2004 and subsequent Budgets to the funding of the Disability Services over a five-year period was a welcome initiative. This development has enabled a more co-ordinated and strategic approach to the planning and delivery of services. There are many areas within the Disability Sector

which are in need of further development and core funding and these need to be supported.⁶⁵

The health system reform process

It is a recognised fact that there was a need to restructure the health system as the last major re-organisation occurred some thirty years ago. The reform programme needs to be in keeping with the commitments and the vision of the National Health Strategy and Primary Care Strategy “a health system that supports and empowers you, your family and community to achieve your full health potential. A health system that is there when you need it, that is fair and that you can trust”. The reform process has identified the HSE (Health Services Executive) as the Executive Arm of the Health Service. Within this process there is a clear democratic deficit which has not been addressed to date. There is a need to recognise that community participation and involvement is key in the planning, delivery and evaluation of services to ensure that the vision of the Strategy is achieved. We welcome the establishment of a Service User Involvement Group. In this context, the commitment in *Towards 2016* to establish a new mechanism for consultation with the Community and Voluntary pillar has been honoured. This mechanism needs continued development to ensure an integrated health service is achieved.

There are serious problems with the annual budget for health. In 2010 this is an especially difficult situation as the healthcare budget has been reduced dramatically. Government provides an inadequate budget each year to cover the expenditure that is required. Likewise, it provides too little investment in infrastructure now to enable the new model of health to emerge in the future. It has a ‘pass the parcel’ approach to the annual budget in this context with no clarity between the Department of Finance, the Department of Health and Children and the HSE on what exactly is to be delivered and how it is to be funded. A transparent and honest approach to the annual budget is required. It is important that there is clarity about the cost of each scheme and how this cost is being funded. Efficiencies are required and getting value for money is essential. However these should be targeted at areas where efficiencies can be delivered without compromising the quality of the service. Consequently, we argue that there is a need to be specific about the efficiencies that are needed and how these efficiencies are to be delivered. Within this framework it is then possible to insist, with credibility, on getting delivery in these areas.

⁶⁵ Other Disability related issues are addressed throughout this review.

Future healthcare costs

A number of the factors highlighted elsewhere in this review will have implications for the future of our healthcare system. The projected increases in population by the CSO imply that there will be many more people living in Ireland in 10-15 years time, many of whom will be of different nationalities. In this context, we recognise the development of the *National Intercultural Health Strategy 2007-2012*. One clear implication of this will be additional demand for more healthcare and more healthcare facilities. In the context of our past mistakes it is important that Ireland begin to plan for this additional demand and begin to train staff and construct facilities to cope.

As we indicated in section 3.2, on taxation, the ageing of the population over the next four decades will be an additional challenge to the provision of healthcare. Again, planning and investment is required.

Policy Proposals on Healthcare

- **Recognise the considerable health inequalities present within the Irish healthcare system and provide sufficient resources to tackle them.**
 - **Give far greater priority to community care and restructure the healthcare budget accordingly. Overall, government should ensure that at least 35 per cent of the non-capital healthcare budget is allocated to community care. In the process care should be taken to ensure that the increased allocation does not go to the GMS or the drug subsidy scheme.**
 - **Develop and implement targets on health status within the *NAPinclusion*.**
 - **Increase the percentage of the health budget allocated to health promotion and education in partnership with all relevant stakeholders.**
 - **Address the serious problems with the annual budget for health. In particular ensure that government provides an adequate budget each year to cover the expenditure required and that the Department of Finance, the Department of Health and Children and the HSE co-**
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ordinate on what exactly is to be delivered and how it is to be funded. A transparent and honest approach to the annual budget is required.

- Provide the childcare services with the additional resources necessary to effectively implement the Child Care Act.
 - Develop nursing care of older people in their own community on the model of hospice care.
 - Establish monitoring procedures that will ensure the criteria for admission to continuing care for the elderly in receipt of state subvention for such services are administered in a manner, which is flexible and sensitive to the needs of the population.
 - Provide additional respite care for elderly people and people with disabilities and ensure this is not compromised by the funding provided for the Fair Deal..
 - Resource and implement the commitment in *Towards 2016* to provide 500 primary care teams by 2011; 400 of these were due to be in place by the end of 2009.
 - Promote equality of access and outcomes to services within the Irish healthcare system.
 - Ensure that structural and systematic reform of the health system reflects the key principles of the Health Strategy aimed at achieving high performance, person centred, quality of care and value for money in the health service.
 - Develop and resource mental health services, in particular by implementing the *Towards 2016* commitment and by recognising that this will play a key factor in the health status of the population.
 - Continue to facilitate and fund a campaign to give greater attention to the issue of suicide in Irish society. In particular, focus resources on educating young people.
 - Raise the eligibility threshold for the medical card.
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- **Implement the recommendations of the Health Service report on ‘The Medical Card Scheme’.**
- **Monitor and evaluate the National Health Reform Programme to ensure equity, people-centeredness, quality and accountability for all.**
- **Enhance the process of planning and investment so that the healthcare system can cope with the increase and diversity in population and the ageing of the population projected to happen over the next few decades.**
- **Work toward universal access to primary care.**