

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 to a great degree on the resources made available which in turn are 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. These are very important considerations at this particular moment as a new Government proposes fundamental changes in Ireland's healthcare system. In the following pages we outline some of the major considerations *Social Justice Ireland* believes Government should bring to bear on its decision-making on these issues.

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, has published two detailed reports in recent years: *Health in Ireland – An Unequal State* (2004) and *Health Inequalities on the island of Ireland: the facts, the causes, the remedies* (2007). These reports gather together the baseline information on health inequalities in Ireland and their findings are worthy of serious attention. These include:

- 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
- 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 reports 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.⁶³
- The rate of sudden infant deaths among Travellers is 12 times higher than for the general population.
- Research has found that many expectant mothers among asylum seekers in direct provision suffer malnutrition, babies in these communities suffer ill-health because of diet, many adults experience hunger.

⁶³ For much greater detail on age-specific mortality rates among Travellers and a range of other Traveller health statistics cf. *All Ireland Traveller Health Study: Our Geels*, September 2010, published by the All Ireland Traveller Health Study Team, School of Public Health, Physiotherapy and Population Science, University College Dublin.

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- 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, and 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).

In their 2007 study the PHAI summarised what the international research literature highlights as the most important influences on health and the causes of health inequalities. These are the economic, social and political environments in which people live including:

- Level of income;
- Early life experience;
- Access to education and employment;
- Food and nutrition;
- Work opportunities;
- Housing and environmental conditions;
- Levels of stress and social support.

Furthermore, they noted that “research has also established that the greatest determinant of health is the level of income equality in society. Societies with more equal distribution of income across the population have higher average life expectancies and better health outcomes than less equal societies” (PHAI, 2007:8).

It is the nature of these inequalities and the fact that they are so interconnected with the social, economic and political environment of Ireland that places this issue as central to the agenda of *Social Justice Ireland*. Throughout the various part of this *Socio-Economic Review* we address each of these issues.

Poverty and healthcare exclusion

The link between poverty and ill health has been well established by international and national research. 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 2008 Irish males had life expectancies of 76.8 years while Irish females were expected to live 4.8 years longer reaching 81.6 years. Based on these figures, Ireland's life expectancy performance is similar to the European average; the EU average, however, is dragged down by low life expectancies among men in Estonia, Latvia and Lithuania among others (see table 3.6.1). Relative to the older member states of the EU, the Irish figures are less impressive. The story behind Ireland's life expectancy figures incorporates many of the findings of the PHAI reports and the earlier poverty figures (see Section 3.1). 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, a relationship that 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 2008, in years.

Country	Males	Females	Difference
Spain	78.9	85.0	6.2
France	77.5	84.3	6.8
Italy	78.8	84.1	5.3
Belgium	77.5	83.5	6.1
Sweden	79.1	83.2	4.1
Finland	76.3	83.0	6.7
Austria	77.6	83.0	5.3
Luxembourg	77.6	82.7	5.1
Greece	77.5	82.5	4.9
Germany	77.2	82.4	5.2
Malta	76.7	82.3	5.6
Netherlands	78.3	82.3	4.0
Slovenia	75.4	82.3	6.8
Portugal	75.5	81.7	6.3
Cyprus	77.0	81.7	4.7
United Kingdom	77.6	81.7	4.1
IRELAND	76.8	81.6	4.8
Denmark	76.3	80.7	4.4
Czech Republic	74.0	80.1	6.2
Poland	71.3	80.0	8.7
Estonia	68.6	79.2	10.6
Slovakia	70.9	78.7	7.9
Latvia	67.2	77.9	10.7
Hungary	69.8	77.8	8.0
Lithuania	66.3	77.6	11.3
Bulgaria	69.5	76.6	7.1
Romania	69.2	76.1	7.0
EU 27	76.1	82.2	6.1

Source: CSO 2010:53

Health expenditure

Healthcare is a social right for all people. For this right to be upheld governments need to provide the required funding to ensure the relevant services and care are provided as required. In table 3.6.2 we see that Ireland spends 7.6 per cent of GDP on health; this is well below the EU-27 average of 9.3 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 8.8 per cent.⁶⁴ In comparison France spends 11 per cent; Germany spends 10.4 per cent and Austria 10.1 per cent. Ireland has the twelfth lowest expenditure on health (measured as a percentage of GDP) according to EU-27 data, although this ranking position has been improving 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 (11.1 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 continue to be issues in the health service today. Clearly, there are significant efficiencies to be gained in a restructuring of the Irish health system, and in particular the HSE. However, as the population ages and demand for facilities increases funding as a percentage of national income will have to rise.⁶⁵

Table 3.6.2: EU-27 health expenditure as a percentage of GDP, 2007

Country	%	Country	%
France	11.0	Slovakia	7.7
Germany	10.4	IRELAND (% GDP)	7.6
Austria	10.1	Malta	7.5
Portugal	10.0	Hungary	7.4
Denmark	9.8	Bulgaria	7.3
Greece	9.6	Luxembourg	7.1
Belgium	9.4	Czech Republic	6.8
Sweden	9.1	Cyprus	6.6
Netherlands	8.9	Poland	6.4
IRELAND (% GNI)	8.8	Lithuania	6.2
Italy	8.7	Latvia	6.2
Spain	8.5	Estonia	5.4
United Kingdom	8.4	Romania	4.7
Finland	8.2	EU 27	9.3
Slovenia	7.8		

Source: CSO (2010:52)

⁶⁴ GNI is similar to the concept of GNP and has a similar value.

⁶⁵ This issue is also analysed in section 3.2 of this review.

The Model of Healthcare in Ireland

Community-based health and social services require a model of care that:

- Is accessible and acceptable to the community they serve;
- Is responsive to the local community and its particular set of needs and requirements;
- Is supportive of local communities in their efforts to build social cohesion;
- Accepts primary care as the key component of the model of care and gives it priority over acute services as the place where health and social care options are accessed by the community.

To achieve this, action is required in three key areas if the basic model of care that is to underpin the health services is not to be undermined. These areas are: **Older People's Services**

Primary Care and Primary Care Teams
Children and Family Services
Disability and Mental Health

and each is reviewed in turn below before we address related issues including medical cards and the health system reform process.

Older People's Services

If the health of older people is to be addressed appropriately then it is essential that there be support for older people to live at home by providing appropriate community-based services to meet their needs. This approach needs to be complemented by ensuring access to acute services is available in an appropriate manner when required. If this approach is to be followed then there is an urgent need to address the specific deficits in infrastructure that exist across the country. There should be an emphasis on replacement and/or refurbishment of facilities. If this is not done then we will see the inappropriate admission of older people to acute care facilities with the consequent negative impacts on acute services and unnecessary stress on older people.

Social Justice Ireland believes that what is required is a total investment of €500m over five years i.e. €100m each year is required.

Primary Care and Primary Care Teams

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. We address the issue of medical cards later in this section.

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 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).

The decision by the new Government to appoint a Minister of State with specific responsibility for Primary Care is welcome. Government must now follow-up on this appointment with tangible progress in the development and delivery of Primary Care over the next few years.

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. A very large proportion of those who go to accident and emergency units should not be there.

At the moment the HSE is developing Primary Care Teams and Social Care Networks as the basic 'building blocks' of local public health care provision. We understand a Primary Care Team (or "PCT") to be a team of health professionals (catering for a population of 7-10,000) who work closely together and with the local community to meet the needs of people living in that community. These professionals include GPs and Practice Nurses, community nursing i.e. public health nurses and community RGNs, physiotherapists, occupational therapists and home-care staff. They provide the first point of contact when individuals need to access the health system. When fully developed, it is expected that 519 primary care teams could cover the whole country. PCTs are also expected to link in with other community-based disciplines to ensure that health and social needs are addressed. These include: speech & language therapists, dieticians, area medical officers, community welfare officers, addiction counsellors, community mental health nursing, consultant psychiatrists, etc. PCTs provide a single point of contact between the person and the health system. They facilitate navigation 'in', 'around' and 'out' of the health system.

The former Government had committed to putting 500 of these primary care teams in place by 2012. Progress has been made but more is required if this essential development is to be secured. *Social Justice Ireland* believes that what is required is €250m over a five-year period to support infrastructural development in putting in place the 519 primary care teams that are required to cover the whole country. We hope the new Minister of State makes the delivery of this proposal a priority.

Children and Family Services

In tandem with the development of Primary Care Team services there is a need to focus on health and social care provision to children and families. The obligation on the State to develop and provide services and facilities to support vulnerable and at risk children has been well highlighted recently. The standard of care as monitored by HIQA and the challenges posed to provide care to young people with complex needs have proven difficult to address both in public and private provision.

In many communities there are community & voluntary services being operated out of very poor facilities in need of refurbishment/rebuilding. Despite poor infrastructure, these services are the heart of local communities and provide vital services that are locally 'owned'. There is a need to support this activity and in particular meet the infrastructural requirements which will in the main be by way of minor development at local level.

Social Justice Ireland believes that what is required is a total of €250m over a five-year period to address the infrastructural deficit in Children and Family Services. This amounts to €27m per area for each of the nine Children Services Committee areas and a national investment of €7m in Residential and Special Care.

Social Justice Ireland welcomes the appointment of a Minister for Children by the new Government. This is an area with a substantial agenda that could, however, be addressed effectively in a relatively short period of time if the political will to do so were present. As well as the Children's Rights Referendum and the issue of Child Safeguarding that have been highlighted by the new Government, we believe the key issues for the new Department are the second National Children's Strategy, policy on early childhood care and education, child poverty, youth homelessness, disability among young people and the issue of young carers.

Disability and Mental Health

We welcome the 2011 *Programme for Government* commitment to complete a consultation to establish "a realistic implementation plan for the National Disability Strategy". There are many areas within the Disability Sector which are in need of further development and core funding and these areas need to be supported.⁶⁶

⁶⁶ Other Disability related issues are addressed throughout this review.

Mental health

The National Health Strategy entitled *Quality and Fairness* (2001) identified 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 and subsequently published a report entitled *A Vision for Change - Report of the Expert Group on Mental Health Policy* (2006). This report offered many worthwhile pathways to adequately address mental health issues in Irish society. Unfortunately, to date little has been implemented to achieve this vision.

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.

Commitments in the 2011 *Programme for Government* offer hope that progress in this area will be made over the next few years. We welcome these commitments to better funding the sector and working to reduce the stigma of mental health and improve access to facilities and services for assisting those with mental health problems. *Social Justice Ireland* urges Government to continue to support progress in this area. We welcome the appointment of a Minister of State with responsibility in this area and trust it is an indication of the Government's serious commitment to addressing the needs that care clearly identifiable in this area of policy.

Areas of concern in mental health

There is a need for effective outreach and follow-up programmes for people who have been in in-patients 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 and *Social Justice Ireland* hopes the new Government will honour its *Programme for Government* commitment to deliver this.

While there has been some improvement in this area in recent years, people with an intellectual disability who require a mental health service frequently still find they do not have a psychiatric service available to them. Furthermore, while there has been some improvement in recent years, there is an issue with the lack of appropriate mental healthcare for all who need it, especially vulnerable groups including children, the homeless, prisoners, Travellers, asylum seekers, 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 mental health issue

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 number of suicides in Ireland has climbed over the last decade and the current recession has accelerated this increase. In 1993 327 suicides were recorded and by 2009, the latest year for which data is available, the number of suicides had increased to 527. Over time Ireland's suicide rate has risen from 6.3 suicides per 100,000 people in 1980 to 11.7 suicides per 100,000 people in 2007 (OECD, 2005 and National Office of Suicide Prevention, 2010:25).

Table 3.6.3 provides details on the levels and sex distribution of suicides in Ireland since 2003. It shows that suicide is predominantly a male phenomenon with 80 per cent of suicide victims being male. When assessed by age group the data from the National Office of Suicide Prevention suggest that young people, and in particular young males, are the groups most at risk. In the period 2003–2007 young males aged between 20–24 years had a suicide rate of 34.7 per 100,000 in the population; three times the national average. Among this age-group in the population, suicide is one of the largest killers (2010:25–26).

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 welcomed 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 and we welcome the commitments in the 2011 *Programme for Government* to provide this. As a society we need to become more aware of this issue and more aware of methods to prevent it.

Table 3.6.3: Suicides in Ireland 2003–2009

Year**	Overall		Males		Females	
	No.	Rate	No.	Rate	No.	Rate
2003	497	12.5	386	19.5	111	5.5
2004	493	12.2	406	20.2	87	4.3
2005	481	11.6	382	18.5	99	4.8
2006	460	10.8	379	17.9	81	3.8
2007	458	10.6	362	16.7	96	4.4
2008*	424	9.6	332	15.0	82	3.8
2009*	527	11.7	422	19.0	105	4.7

Source: National Office of Suicide Prevention (2010:25–26)

Notes: * Provisional figures

**Annual data is by year of occurrence (2003 to 2007) and by year of registration (2008 and 2009).

Rate is rate per 100,000 of the population.

Older people and Mental Health

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. 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 centres and home care packages - areas that have received serious and unwelcome cuts in recent Budgets and we continue to lobby for these cuts to be reversed and these services enhanced. There is a real danger that one outcome of these cuts is that the service would be nothing more than a 'Bed and Breakfast' facility that would be a travesty of what was intended and, more importantly, of what is required.

Medical Cards: Reform Needed

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 necessary level of provision is in place. 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 and the recession is increasing this number.

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.⁶⁷

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

⁶⁷ Dail speech by Minister for Health and Children, December 19th 2007.

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 create new problems as many people 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.

The health budget

There are serious problems with the annual budget for health. In 2011 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. Government has had 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. *Social Justice Ireland* continues to 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.

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 forecast by the CSO imply that there will be many more people living in Ireland in 10-15 years time. 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.

Key Priorities 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.**
- **Resource and implement the commitment to provide 500 primary care teams.**
- **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, the Department of Children and the HSE co-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.**
- **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.**
- **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, and recognise that they will be a key factor in determining 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 in this context.**
- **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.**