8.

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 wellbeing and not merely the absence of disease or infirmity.*

Healthcare services are fundamental to wellbeing and thus are important in themselves and are also important as a factor in economic success in a range of ways, including improving work participation and productivity. Provision of decent services is one of the key policy areas that must be addressed urgently as part of the Core Policy Framework we set out in Chapter 2 under the heading of Enhancing Social Protection. This is one of five priority areas identified by *Social Justice Ireland* which must be addressed in order to realise the vision for Ireland articulated there.

Healthcare is a social right that every person should enjoy. People should be assured that care is guaranteed in their times of illness or vulnerability. The standard of care is dependent to a great degree on the resources made available, which in turn are dependent on the expectations of 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 that assume or contract this responsibility. These are very important issues in Ireland today as our health services come under increasing financial pressure and fundamental changes are envisaged. This chapter outlines some of the major considerations *Social Justice Ireland* believes Government should bring to bear on such decision-making.

Poverty and Health

Health is not just about healthcare. The link between poverty and ill-health has been well established by international and national research. A World Health Organization Commission that reported in 2008 on the social determinants of health found that health is influenced by factors such as poverty, food security, social exclusion and discrimination, poor housing, unhealthy early childhood conditions, poor educational status and low occupational status.

A more recent report by the World Health Organization into 53 European countries highlights how people have not shared equally in Europe's social, economic and health development and that in fact health inequalities are not diminishing but are increasing in many countries (WHO, Regional Office for Europe, 2013). In Ireland, studies conducted by the Irish Public Health Alliance (IPHA) detail striking differences in life expectancy and premature death between people in different socio-economic groups. The Pfizer Health Index showed that those from a lower socio-economic background are more likely to be affected by a wide range of medical conditions (including heart disease, cancer, depression and arthritis) than middle class people (ABC1) (Pfizer, 2012).

Analysis of Census 2011 data by the CSO confirms the relationship between social class and health. While 95 per cent of people in the top social class enjoyed good or very good health, this proportion fell across the social groups to below 75 per cent in social class 7 (CSO, 2012).

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. In summary, poor people get sick more often and die younger than those in the higher socio-economic groups. The crisis of recent years has reduced access to healthcare for many people across the EU (Eurofound 2014). This is attributed to reduced availability of healthcare services and reduced coverage as well as to reduced access due to households' increased need for certain services and reduced disposable income. A study by Eurofound (European Foundation for the Improvement of Living and Working Conditions) showed that regarding chronic diseases the health status of Europeans deteriorated during the economic crisis and that the gap between the self-reported health of low-income earners and that of the highest income earners is increasing (Eurofound, 2012).

A number of recent studies provide evidence that is of great concern relative to inequality and health in Ireland especially for children:

- A survey measuring the response of Irish households to the economic downturn showed that a large majority reduced their spending and that more than half cut back spending on groceries (CSO 2013).
- Research funded by the Department of Social Protection in 2012 found that 10 per cent of the population in Ireland was living in food poverty; the rate of food poverty increased to 18 per cent for households with three or more children and 23 percent for lone parent families (Carney & Maitre, 2012).
- The latest report from a study that has tracked a large cohort of Irish children from birth highlights a widening health and social gap by the time they are just 5 years old. Children from the highest social class (professional/ managerial) are more likely than those from the lowest socio-economic group to report that their

children are very healthy and have no problems. The socio-economic background of the child is also shown to be associated with being overweight or obese (Growing Up in Ireland, 2013).

- The position of Ireland in an international study (published in the Lancet in 2015) across 34 countries is of particular concern; this study, carried out between 2002 and 2004 has shown widening health inequalities among adolescents (aged 11 to 15). The study confirms that adolescents from the most impoverished socioeconomic groups are more likely to suffer from poor health due to diminished physical activity and larger body mass indices. In relation to the amount of physical activity taken by poorer adolescents, Ireland was ranked worst of 34 countries for socioeconomic inequalities. It ranked second worst for body mass index, meaning the difference in size between poor adolescents and their better-off peers is greater in Ireland than almost anywhere else (Cullen 2015).

These findings are of particular concern in respect of the future health and life-chances of disadvantaged children.

Life Expectancy

According to Eurostat's figures for 2012, Irish males had life expectancies at birth of 78.7 years while Irish females were expected to live 4.5 years longer, reaching 83.2 years (See Table 8.1). These figures have gradually but consistently improved in recent years and there has been an increase of almost 3 years since 2003 (Department of Health 2014). This improvement is largely attributed to better survival from conditions such as heart disease and cancer affecting older age groups (Department of Health 2014).

Ireland's life expectancy performance is slightly above the European average. It must be acknowledged, however, that the EU average is decreased by low life expectancies, especially among men, in such countries as Bulgaria, Latvia and Lithuania (see Table 8.1). Relative to the older member states of the EU, the Irish figures are somewhat less impressive. Furthermore, life expectancy at birth for both men and women in Ireland is lower in the most deprived geographical areas than in the most affluent (CSO, 2010). For example, life expectancy at birth of men living in the most deprived areas was 73.7 years (in 2006/07) compared with 78 years for those living in the most affluent areas. For women the corresponding figures were 80 and 82.7 years (CSO, 2010).

Ireland's life expectancy figures should be considered in the context of many of the findings of reports on health inequalities referred to above and the poverty figures discussed earlier (see Chapter 3). Ireland's poverty problem has serious implications for health, because of the link between poverty and ill health. Thus, those in lower socio-economic groups have a higher percentage of both acute and chronic illnesses.

Table 8.1 - Life Expectancy at Birth by sex, 2012

	Males	Females	Gender difference
EU (28 countries)	**77.5**	**83.1**	**5.6**
Belgium	77.8	83.1	5.3
Bulgaria	70.9	77.9	7
Czech Republic	75.1	81.2	6.1
Denmark	78.1	82.1	4
Germany	78.6	83.3	4.7
Estonia	71.4	81.5	10.1
Ireland	**78.7**	**83.2**	**4.5**
Greece	78	83.4	5.4
Spain	79.5	85.5	6
France	78.7	85.4	6.7
Croatia	73.9	80.6	6.7
Italy	79.8	84.8	5
Cyprus	78.9	83.4	4.5
Latvia	68.9	78.9	10
Lithuania	68.4	79.6	11.2
Luxembourg	79.1	83.8	4.7
Hungary	71.6	78.7	7.1
Malta	78.6	83	4.4
Netherlands	79.3	83	3.7
Austria	78.4	83.6	5.2
Poland	72.7	81.1	8.4
Portugal	77.3	83.6	6.3
Romania	71	78.1	7.1
Slovenia	77.1	83.3	6.2
Slovakia	72.5	79.9	7.4
Finland	77.7	83.7	6
Sweden	79.9	83.6	3.7
United Kingdom	79.1	82.8	3.7

Source: Eurostat 2014, tsp00025

Access to Healthcare: Medical Cards, Health Insurance and Waiting Lists

In a report from 2012, international experts noted that Ireland is the only EU health system that does not offer universal coverage of primary care (World Health Organisation & European Observatory on Health Systems and Policies, 2012). People without medical or GP visit cards (approximately 60 per cent of the population) must pay the full cost of almost all primary care services and outpatient prescriptions. Thus Ireland is considered to have a very under developed system of primary care and 60 per cent of the population have to pay €40-60 for each GP visit, and up to €144 a month for prescription drugs (Burke *et al* 2014). The international report, already mentioned, also noted that gaps in population and cost coverage distinguish Ireland from other EU countries as does an element of discretion and lack of clarity about the scope of some services, especially community care services, in which there are service and regional differences (World Health Organisation & European Observatory on Health Systems and Policies, 2012). Our complex system involving a two-tier approach to access to public hospital care means that private patients have speedier access to both diagnostics and treatment (Burke et al 2014).

In Ireland out-of-pocket spending on medical expenses as a share of household consumption is above the European (EU28) average and it increased by over 2 percentage points between 2007 and 2012 (OECD 2014). Out-of-pocket expenses – such as prescription charges - in healthcare tend to operate as a much bigger barrier for poorer people who may defer visits or treatment as a result. A study by the Centre for Health Policy and Management, TCD, shows that while the numbers of people covered by medical cards, drug payment, long term illness and high tech drugs schemes went up from 2005 on, the costs of the schemes went down from 2009 on – partly driven by better deals with the pharmaceutical industry. However, in the case of the drugs payment scheme this is also driven by declining numbers using the scheme due to hefty increases on the reimbursement threshold;[51] as the study concludes this was in effect a direct transfer of costs from the State onto patients (Burke et al 2014).

According to the Health Insurance Authority, in September 2014 there were 2,018,000 people insured with inpatient health insurance plans (2014). This represents an increase in the number of insured people of 1,000 over the latest quarter, but a decrease of 29,000 over the past twelve months. Overall this figure has been declining since the end of 2008 when 2.3 million were insured. The percentage of the population with inpatient health insurance plans stands at 43.8% down from the 2008 peak of 50.9% (Health Insurance Authority 2014). A report on 37 European

[51] In 2008 the State paid out over €311million under the Drugs Payment Scheme whereas by 2012 this had more than halved to €127million (Burke et al 2014)

countries queries if Ireland's very high reliance on healthcare insurance can be regarded as an extreme case of dissatisfaction with the public health system (Health Consumer Powerhouse, 2015). One puzzling part of this situation from a funding point of view is that, notwithstanding the fact that so many people are insured, private health insurance contributes relatively little to Ireland's overall spending on healthcare – between 7-10 percent of current public revenue (Normand 2015).

Statistics published on the Department of Health web site suggest that in April 2014, 1,800,182 people had a medical card (Department of Health, 2014); the number projected to have one at 31 December 2014 is 1,782,395 (Health Service Executive 2014). This represents a significant decrease on the position in 2013 when 1,849,380 people (40.3 per cent of the population) had a medical card. Some 125,166 people had a GP Visit card in April 2014 and a large increase in this number is now envisaged as a result of Government's decision to issue them to those under 6's and those over 70 years ((Department of Health, 2014; Health Service Executive 2014).

The number of people benefitting from Discretionary Medical Cards fell by just under 24,000 or over 30 per cent between 2011 and 2013 – that is, from 74,281 people benefitting at the end of 2011 to 50,294 in December 2013 (Health Service Executive, 2012; Health Service Executive, 2013). Many people suffered unnecessary stress as a result of a review of discretionary medical cards that took place in 2014, although this policy was discontinued and revised guidelines on their operation are awaited. However, there are still reports in the media of difficulties and delays in accessing medical cards for adults and children with serious long-term illnesses.

Social Justice Ireland believes that healthcare is a social right that every person should enjoy and that people should be assured that care is guaranteed in their times of illness or vulnerability. Thus full medical card coverage is necessary for all people in Ireland who are vulnerable. Timely access to quality healthcare services can also prevent higher healthcare costs in the long run (Eurofound 2014).

Between January and October 2014 there was an overall increase of 5,539 (1.7 per cent) in the number of emergency (or unscheduled) admissions to hospitals compared to the same period in 2013 (Health Service Executive 2014). Particular problems with overcrowding in emergency departments are being highlighted in the media in early 2015. For example, figures from the INMO (Irish Nurses and Midwives Organisation) suggested that there were just over 600 people on trolleys on 6th January 2015 and the figure on 23 January remained relatively high (at 388 people) (Irish Nurses and Midwives Organisation, 2014). By contrast, in 2006, a former health Minister was forced to declare a national emergency when the number of patients on trolleys hit 495, well below the levels that were reached in January 2015 (Cullen, Irish Times, 2015). Behind these figures there is unnecessary human suffering as many patients, often older patients, are left waiting on trolleys

or chairs for hours or even days before they are admitted to hospital, to say nothing about the risk to patient safety which is much greater in cramped conditions.

This situation is exacerbated by problems accessing support in the community as well as access to nursing homes – in October 2014, 2,135 people were waiting on funding to allow them to avail of a residential bed through the Nursing Home Support Scheme (Fair Deal) with an average waiting time of 15 weeks (Health Service Executive, 2014). In November the figure was reduced somewhat but was still 1,898 people (Health Service Executive 2014).

In addition to the issue of emergency admissions, the length of waiting lists is a cause of major concern in the Irish healthcare system. Overall, towards the end of 2012 and through 2013 and 2014, there has been a decrease in inpatient activity and a levelling off of day cases despite increased demand (Burke *et al* 2014).

According to monthly trends published by the Department of Health, there have been very significant increases during 2014 in the numbers waiting for elective procedures (in-patient and day-case) both for adults (waiting more than 8 months) and children (waiting more than 20 weeks) (Department of Health, 2014, Figure 3.2). This continues a trend in recent years: in October 2012 the number of adults waiting more than 8 months was under 3,000; in September 2013 it was approximately 5,000, and by September 2014 it was approaching 10,000 (Department of Health 2013; 2014).

There have also been increases (from Jan 2014 to September 2014) in the numbers on the outpatient waiting list and in those waiting longer than 52 weeks for an outpatient appointment (Department of Health, 2014). There are extremely long wait times for an initial appointment with a specialist. According to a study by the Centre for Health Policy and Management, TCD, in November 2013, there were 384,632 people waiting for public outpatient appointments, of these 846 were waiting over four years, 3,138 were waiting between three and four years, 12,861 were waiting between two and three years, while 39,425 people were waiting between one and two years (Burke *et al* 2014).

The above statistics illustrate how many of those dependent on the public system may spend very lengthy periods waiting for a first appointment with a specialist and also for treatment. These waiting times are totally unacceptable and demonstrate the lack of fairness within our current system in which people with private health insurance do not have to wait. The 2001 health strategy, *Quality and Fairness*, set a target of a maximum wait of three months for treatment following referral from an out-patient department. A subsequent Government target was that no one would wait over one year for a first specialist appointment by December 2013. The most recently announced target is that no one will wait longer for treatment or an

outpatient appointment than 18 months by mid-2015 and no longer than 15 months by end 2015 (Department of Health Priorities published in January 2015). These are extremely unambitious targets.

In a survey of 36 countries from a consumer perspective, the Euro Health Consumer Index, Ireland was ranked 22nd, down from 14th the previous year (Health Consumer Powerhouse, 2015). The report expresses doubts about Irish official statistics on waiting times and, for the latest report (relating to 2014), the authors took account of feedback from patient organisation, which accounts for the drop in the ranking. By contrast, the health system in the Netherlands topped this ranking (with the authors concluding that their system 'does not seem to have any weak spots') and is the only country that has consistently been among the top three in the total ranking of any European index published by the Health Consumer Powerhouse since 2005 (Health Consumer Powerhouse, 2015). As can be seen from Table 8.2 below, the Netherlands also tops the European table in terms of health spending as a proportion of GDP. It may also be worth noting that the Netherlands has an overall tax to GDP ratio that is considerably higher than Ireland's: at 39 per cent in 2012 , the level in the Netherlands is similar to the EU-28 average rate (of 39.4) but over 10 percentage points above the Irish level (of 28.7 per cent) (Eurostat 2014).

Health expenditure

Healthcare is a social right for everyone and a move to a rights based approach is a key action under the heading of Governance Reform in the Core Policy Framework set out in Chapter 2 - one of five priority areas identified by *Social Justice Ireland* which must be addressed in order to realise its vision for Ireland. For this right to be upheld, governments must provide the funding needed to ensure that the relevant services and care are available when required.

Comparative statistics are available for total expenditure on health (i.e. public plus private) across the EU. Changes in the ratio of health spending to GDP are the result of the combined effects of growth/reductions in both GDP and health expenditure. Table 8.2 shows that, at 8.1 per cent, Ireland's spending on healthcare as a percentage of GDP, was similar to the EU average in 2012 (the latest comparable data available). In Gross National Income (GNI) terms this expenditure translates into a figure of 9.9 per cent (in 2012).

Table 8.2 - EU 27 Expenditure on Health as a percentage of GDP, 2010- 2012

Country	2010	2011	2012
Netherlands	12.1	11.9	12.4
France	11.7	11.6	11.7
Austria	11.6	11.3	11.5
Germany	11.5	11.3	11.3
Denmark	11.1	10.9	11.2
Belgium	10.5	10.5	10.8
Ireland (% of GNI)	**11.1**	**10.8**	**9.9**
Spain	9.6	9.3	9.6
Sweden	9.5	9.5	9.6
Portugal	10.8	10.2	9.4
United Kingdom	9.6	9.4	9.4
Greece	9.4	9.0	9.3
Italy	9.4	9.2	9.2
Finland	9.0	9.0	9.1
Malta	8.5	8.7	9.1
Slovenia	8.9	8.9	8.8
EU			**8.7 (EU28)**
Ireland (% of GDP)	**9.3**	**8.8**	**8.1**
Hungary	8.0	7.9	7.8
Slovakia	9.0	7.9	7.8
Czech Republic	7.4	7.5	7.7
Bulgaria	7.6	7.3	7.4
Cyprus	7.4	7.4	7.3
Luxembourg	7.2	6.7	6.9
Croatia	7.8	6.8	6.8
Poland	7.0	6.8	6.7
Lithuania	7.0	6.7	6.7
Latvia	6.5	6.0	6.0
Estonia	6.3	5.8	5.9
Romania	5.9	5.6	5.1

Source: Ireland: CSO: 2015; EU: OECD 2014, Table 6.2.1. Includes public and private spending.

Ireland's public spending on healthcare has reduced in recent years as Table 8.3 shows – using the latest data published by the CSO. However, healthcare costs tend to be higher in countries that have larger populations of older people. This is not yet a significant issue for Ireland as, at 17.3 (Department of Health 2014), the old age dependency ratio[52] is low compared to the much higher EU average.

Table 8.3 Ireland: Public expenditure on health care, 2002-2013

Year	Total (€m)	% of GNI	% of GDP	Per capita at constant 2012 prices (€)
2002	7,933	7.3	6.1	2,645
2003	8,853	7.4	6.3	2,755
2004	9,653	7.2	6.2	2,773
2005b	11,160	7.6	6.6	3,026
2006	12,248	7.6	6.7	3,092
2007	13,736	8.0	7.0	3,223
2008	14,588	9.0	7.8	3,193
2009	15,073	10.7	9.0	3,269
2010	14,452	10.3	8.8	3,249
2011	13,728	9.8	8.0	3,044
2012	13,787	9.7	8.0	3,007
2013	13,492	9.1	7.7	2,973

CSO, 2014 (2002/2004); CSO 2015 (2004-2013). b=break in series

The decline in expenditure that took place between 2009 and 2012 was particularly rapid in the opinion of international experts (WHO & European Observatory on Health Systems and Policies, 2012).

In 2012, health spending has started to increase again in real terms. But in the view of the OECD, this is at a very modest rate (OECD 2014). In Ireland, 68 per cent of health spending was funded by public sources in 2012, which is slightly less than the average of 72% in OECD countries (OECD 2014) – but is considerably less than the Netherlands, the U.K and most Nordic countries which have levels of public financing exceeding 80 per cent (OECD 2014) and they also tend to have higher levels of overall tax revenue than Ireland (that is, taxation as a ratio of GDP) (Eurostat 2014, Graph 3). In fact the trend in Ireland's public expenditure on health has been consistently downwards in recent years (as a percentage of total expenditure on health) – the

[52] The old age dependency Ratio refers to the number of persons aged 65 years and over as a percentage of those aged 15-64 years.

percentage in 2005 was 76 per cent (OECD Stat Extracts). This means that the rate has dropped by 8 percentage points between 2005 and 2012. See Table 8.4.

Table 8.4 Public expenditure on health as a percentage of total expenditure on health

	2005	2006	2007	2008	2009	2010	2011	2012
Ireland	76.0	75.4	75.7	75.4	72.6	69.6	67.0	68

Source: OECD online database (2005-2011); 2012: OECD 2014.

Approximately €4 billion was cut from the Irish healthcare system between 2008 and 2014 (Health Service Executive 2013); there were over 12,000 fewer Health Service Executive staff in December 2013 than there were at the height of public health sector employment in 2007 (Burke *et al* 2014). The Department of Health reports that there has been a 16 per cent reduction in total public health expenditure between 2009 and 2014 (Department of Health, 2014). Capital expenditure was 42 per cent lower in 2013 than in 2008 (Department of Health, 2014).

These changes took place during a period of rapidly rising unemployment and consequently growth in the numbers of people qualifying for medical cards, and of population ageing. A study by the Centre for Health Policy and Management, TCD, concludes that, from 2013 on, the health system has been under increasing pressure and has had no choice but to do 'less with less' (Burke et al 2014, p.7). Given that the Health Service Executive cannot control emergency admissions to hospitals, what could be expected this to result in is reduced access to medical cards, day and inpatient hospital treatment, as well as social care in the home. While these strictures may result in short-term savings, they may work out more expensive in the longer term if they result in hospital admissions that could have been avoided (Burke *et al* 2014) – to say nothing of the cost in human suffering.

The amount allocated in Budget 2015 for the health services was €13,079 billion, and involved a modest increase (€635m). However, according to the Health Service Executive National Service Plan for 2015, this only allows net costs to increase by €115million when account is taken of the 2014 projected net expenditure deficit (the deficit being €510million). Simultaneously there is a minimum savings target of €130million set by the Department of Health for 2015 and an increased income collection target of €10million (Health Service Executive 2014). This comes after seven consecutive years of budget cuts resulting, as stated already, in a 16 per cent reduction in total public health expenditure between 2009 and 2014 according to the Department of Health (2014).

Budget 2015 also envisaged a move to multi-annual planning, with the health budget now envisaged to be developed over a two-year period, something that *Social Justice Ireland* has welcomed.

Successive budget cuts in recent years have also occurred while simultaneously a major system transformation was being pursued (including major organizational change such as the abolition of the HSE, the establishment of separate Directorates and a reconfiguration toward a universal primary care system). International evidence from the World Health Organization and others suggests that significant year-on-year variations in the level of statutory funding available for health services is disruptive to the sustained delivery of services of a given quality and desired level of access (World Health Organization & European Observatory on Health Systems and Policies, 2012). These international experts who reviewed the Irish healthcare system in 2012 concluded that continuing budgetary cuts and consequent adjustments raise 'serious concerns whether this can be achieved without damaging access to necessary services for certain groups' (World Health Organization & European Observatory on Health Systems and Policies, 2012, p.47). Barriers to access to healthcare are highlighted, especially among those just above the threshold for a medical or GP visit card (World Health Organisation & European Observatory on Health Systems and Policies, 2012).

Social Justice Ireland believes that, overall, the cutbacks over seven years (resulting in measures like high prescription charges, increased thresholds for the Drug Repayment Scheme and other measures) are most adversely affecting people on low-incomes. Very long waiting times are impacting on poorer people without private health insurance. This is not compatible with a health-service designed to included safety, high-quality and equity. Furthermore, *Social Justice Ireland* is seriously concerned that there is no evidence that funding has been provided to address the ageing of the population that will result in a steady increase in older people and people with disabilities accessing services. For example, those over 65 are increasing in number annually by approximately 20,000. Those over 80 years, who have the greatest healthcare needs, are growing by some 4% annually. This ageing of the population is the most dramatic anticipated change in the future structure of the Irish population (Department of Health 2014). See below for more discussion of population ageing and its consequences.

One would have to conclude that overall the thrust of recent policy is disjointed, lacks coherence and involves levels of expenditure reduction within a short space of time that are not compatible with a well-managed system.

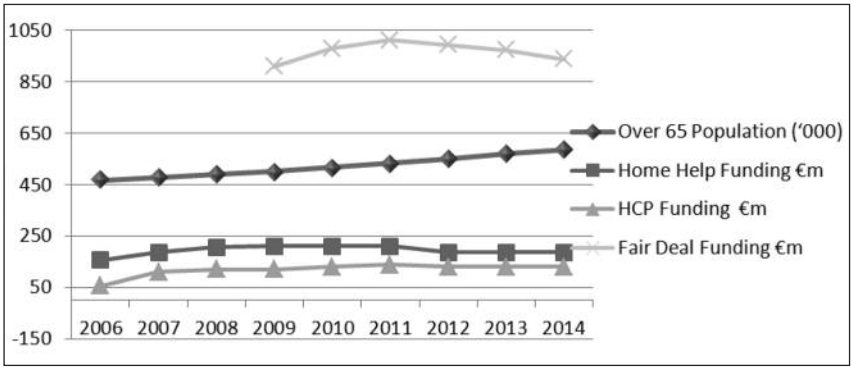
Current capacity on community services is insufficient to meet growing demands associated with demographic pressure and which are reflected in the inappropriate levels of admission to and delayed discharges from acute hospitals referenced above. The acute hospital system, which is already under some considerable pressure, will be unable to operate effectively unless there is a greater shift towards primary and community services as a principal means of meeting home support and continuing care needs and enabling people to live in the community for as long as possible.

The short-comings in resourcing of community services can be illustrated in figure 8.1 below.

Social Care: Fair Deal, Home Helps, Home Care Packages

A review of the funding across the Social Care services of Fair Deal, Home Help and Home Care Packages relative to the over65 population from the period 2006-2014 indicates that while the population continues to grow year on year, the allocated funding for each service was reduced in 2011 (see Figure 8.1 below). It is acknowledged that pay savings and productivity measures arising from national agreements and associated measures have contributed to control of staffing costs in the public system, but the benefits in this regard are not sufficient to offset the growth in demand.

Figure 8.1 Fair Deal and Home Care Funding: 65+ population, 2006-2014 - €m.



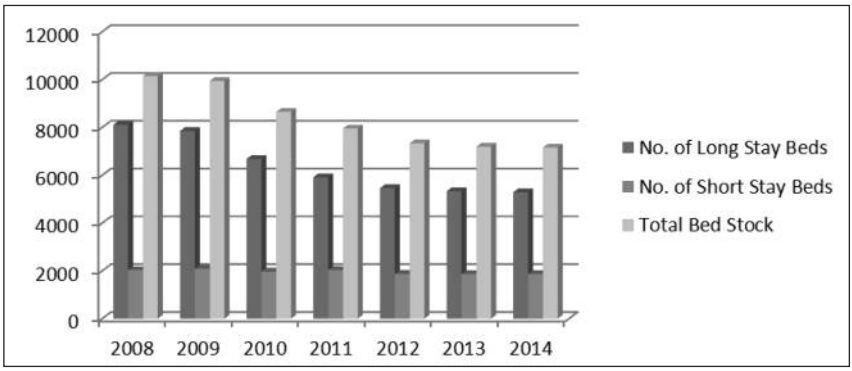
Source: Health Service Executive Reports – Various years

Key points in relation to Figure 8.1:

- **Home Help:** the level of Home Help service has reduced from a high of 12.64m hours delivered to 55,000 people in 2008 to a current level of 10.3m hours delivered to 47,000 people, a reduction of 14% being supported by the service. The funding level was reduced from a high of €211m to €185m over this period.
- **Home CarePackages:** While the numbers being supported by HCPs have increased year on year to the current position of 13,199, the average value of each HCP has fallen as the funding available has remained relatively static since 2008.
- **Fair Deal:** Since the inception of NHSS, the number of clients supported in long-stay residential care has remained relatively static despite the increase in population of older people.

Public Residential care beds are key resources in the continuum of care, as short-stay beds serve as an intermediate care provision across hospital and community, providing respite, assessment and step-down care. The long-stay residential care is the resource which provides for residents with highly complex requirements that may not be able to be supported in private beds.

Figure 8.2 Public Residential Long-stay & Short-stay beds, 2008-2014



Source: Health Service Executive Reports – various years

Key points in relation to Figure 2:

- Despite the steady growth in population, the public bed stock capacity has reduced significantly from a high of over 10,000 beds in 2008 to a current capacity of 7,157 beds in 2014, which represents a 29% bed stock reduction since 2008 inclusive of:

  - a reduction in short-stay from a high of over 2,000 to the current capacity of 1,868 (11% reduction);
  - a reduction in long-stay beds from over 8,000 to the current capacity of 5,289 (35% reduction);
  - In addition to the funding issues, HIQA requirements in relation to the standards of long-stay accommodation has deemed certain facilities or parts of facilities to be unsuitable or required reduced occupancy levels in others. This is a continuing issue for the sustainability of current levels of public bed provision. There has been some major and minor capital provision to address this issue, but not on a scale which would allow for the planned improvement or replacement of all facilities in need of upgrading.

The above information underlines the reduction that has been a feature of the available resource across these key areas of service provision at a time of increasing

population of older people. What is of interest is that the provision of community based service, albeit at lower capacity over the past 5-6 years, has 'stretched' the service provision in order to match the needs as far as possible. Also, a key indicator of value is that the NHSS (Nursing Homes Support Scheme) at this point supports 3.9% of the population aged over-65 in residential care. In planning norms identified in the mid-2000s, the key target figure was 4%.

However, it is clear that there is a link between the diminished levels of services as outlined above and the ongoing increasing activity experienced by the Acute Services in terms of presentations of older people and subsequent delayed discharge numbers while the current configuration of services are in place. We will return to some of the issues highlighted in this section below when we discuss the situation relating to older people.

An open and transparent debate on funding of healthcare services is needed. Ireland must decide what services are expected and how these should be funded and prioritized. In terms of government's overall expenditure, healthcare accounted for 27 per cent in 2011 and 24 per cent in 2015, the second largest area of expenditure (after social protection) (Department of Expenditure & Reform, 2011; 2014). Despite expenditure of 8 per cent of GDP on healthcare (in 2012), and a relatively young population, there are recurring problems illustrated above and in the rest of this Chapter in areas that include access to specialists, waiting lists, access to accident and emergency care, mental health services, long-term care and community care. However, this debate must acknowledge the enormous financial expenditure on healthcare. Public healthcare expenditure grew rapidly over the decade 2000 to 2010, from €5.334bn to €14.165bn. This was an increase of 160 per cent over a period in which inflation increased by 33 per cent. The difference is attributed in part to improved and expanded services, as well as to organisational changes (such as home-helps, for example, becoming salaried members of staff within the HSE). Medical inflation was inevitably also an issue. International experts have noted that, despite increased investment during the previous decade, when the financial crisis occurred in 2008 Ireland still had poorly developed primary and community care services (WHO & European Observatory on Health Systems and Policies, 2012).

Clearly significant efficiencies are possible within healthcare system – not least due to improvements in technologies. Experts in this area conclude that good versions of universal health care are affordable where services are provided efficiently (Norman 2015). Obtaining value for money is essential. However, these efforts should be targeted at areas in which efficiencies can be delivered without compromising the quality of the service and without disproportionately disadvantaging poorer people. *Social Justice Ireland* continues to argue that there is a need to be specific about the efficiencies that are needed and how they are to be delivered.

As well as a debate on the overall budget for healthcare, there should be discussion and transparency on the allocation to each of the services. Currently nearly 60% per cent of the budget is allocated to Primary, Community and Continuing Care, which includes the medical card services schemes (Department of Health, 2014 figure 6.2). *Social Justice Ireland* recommends an increase in this percentage and greater clarity about the budget lines.

The model of healthcare

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

- is accessible and acceptable to the communities they serve;
- is responsive to the particular needs and requirements of local communities;
- is supportive of local communities in their efforts to build social cohesion; and
- accepts primary care as the key component of the model of care, affording it priority over acute services as the place where health and social care options are accessed by the community;
- provides adequate resources across the full continuum of care, including primary care, social care as well as specialist acute hospital service to fully meet the needs of our ageing population.

There are a number of key areas requiring action if the basic model of care that is to underpin the health services is not to be undermined. There areas include:

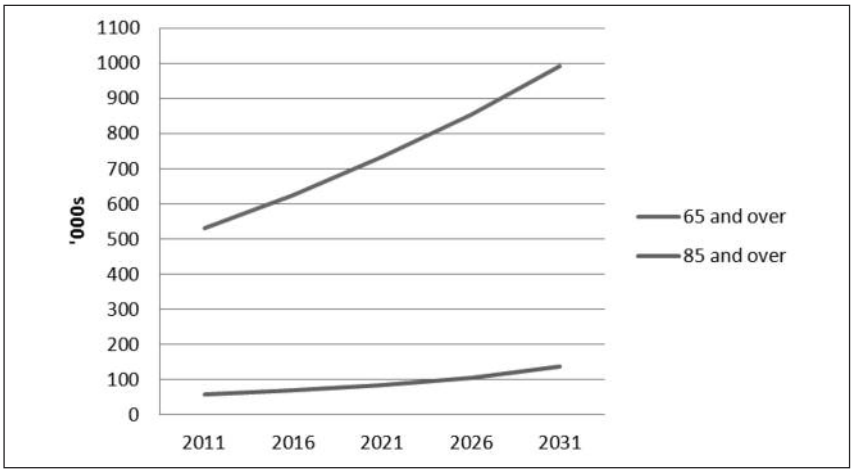
Older people's services
Primary care, primary care teams and primary care networks
Children and family services
Disability, and
Mental health

Older people's services

Although Ireland's population is young in comparison to those of other European countries, it is still ageing. Between 2006 and 2011, those over 65 years of age increased by 14.4 per cent and those aged over 85 years increased by 22 per cent (CSO, 2012). The most dramatic anticipated change in the future structure of the Irish population is the increase in the numbers of older people. See Figure 8.3. Some facts recently published by the Department of Health (2014) relative to population ageing:

- Those over 65 are increasing in number annually by approximately 20,000 per year;
- By 2026 the number of those over 85 years will have almost doubled;
- While there were approximately 530,000 people aged 65 and over in 2011, there will be nearly 1 million by 2031 – an increase of 86.4 per cent;
- There were 58,000 people aged 85 or over in 2011 and this number will increase to some 136,000 people by 2031, and this represents an increase of 132.8 per cent;
- The old age dependency ratio (the ratio of those aged 65 years and over to those aged 15-64) was 17.3 in 2011 and it is projected to rise to 30 by 2031.

Figure 8.3 Projected Population, 2011 to 2031; ages 65+ and 85+ ('000s)



Source: Department of Health 2014, Table 1.4. Actual figure for 2011

Statistics from the 2011 Census (CSO, 2012) demonstrate a strong link between disability and increased age:

- The disability rate is less than 10 per cent for those in their 20s;
- The rates is 20 per cent by the age of 60, and from age 70 on the rates increase more sharply
- The percentage of the population aged 85 and over who have a disability is 72.3 per cent – the rate is higher (at 75.1 per cent) for females aged 85 or over
- There were 56,087 disabled persons who lived alone and were 65 years or over.

Thus very striking increases in the numbers of older people are now projected, particularly of those who are over 85. While there is some evidence that the care needs of older people will not overwhelm the health system and that the changes will happen gradually and slowly (Normand 2015), there is also evidence to the contrary which suggests that the current experience of challenges within the acute hospital system around trolley waits, delayed discharges, increased waiting lists for elective surgery as well as significant HIQA reports indicating a system under pressure provides strong evidence that the reducing budgets since 2008, allied to the increasing ageing population and related demands, are indeed overwhelming the system. This level of population ageing will be associated with higher levels of disability and long-term ill-health and this requires planning and investment which will provide a resource not just for demographic growth from 2015 onwards but the deficits which have grown from 2008 onwards to achieve a stabilised healthcare system across hospital and community services. It requires health promotion measures and action to facilitate the full participation of people with disabilities – including older disabled people - in social life. It also requires a comprehensive approach to care services that would include integrated services across the areas of GP care, public health nursing, home care supports, acute hospital care, rehabilitation and long-term care.

The 2015 HSE National Service Plan envisages an approach to delayed hospital discharges that involves an allocation of an additional €25million (Health Service Executive 2014). This is to be used on, amongst other things, increased provision of long stay places under the Nursing Homes Support Scheme (€10million), increased provision of short-stay beds intended to provide transitional and rehabilitation services in the Dublin area (€8million), and additional Home Care Packages (400 additional packages benefiting 600 people in course of the year, cost €5 million). However, the Service Plan acknowledges that this allocation has 'limited potential' to deal with the increased demand due to rising levels of chronic disease and dependency on health and other social services associated with people living longer than even a decade ago (Health Service Executive 2014 p.6). Thus the level of funding allocated to address population ageing is not adequate.

For example, the HSE Service Plan for 2015 envisages making 300 new places available under the Nursing Home Support Scheme (NHSS or 'Fair Deal' scheme) and a reduction in waiting times to eleven weeks from January 2015 (Health Service Executive, 2014). These are not ambitious targets, given that there were almost 2,000 people waiting for funding approval under the scheme in November 2014 (Health Service Executive 2014). This appears to represent a huge increase in those waiting to access the scheme – as there were fewer than 500 people on the placement list in December 2013 (Health Service Executive, 2013). The number of people projected to be funded by the scheme in 2015 is 22,016 (Health Service Executive, 2014) but this is some 1,000 fewer places from the total at end Dec 2013 (23,007) (Health

Service Executive (2014). The National Service Plan for 2015 acknowledges the risk that there is insufficient capacity to meet current and additional requirements. This approach risks leading to more older people remaining in inappropriate care facilities such as acute hospitals, an outcome in the best interests of neither the individual nor the health services. This is not an appropriate response when the number of people aged over 85 is increasing rapidly as many of them rely on public services to continue to live with dignity. It is crucial that funding be released in a timely manner when a person is deemed in need of a 'Fair Deal' bed and that sufficient capital investment is provided to ensure that enough residential care beds are available to meet the growing demand for them.

Support for people to remain in their own homes is a key and appropriate policy objective and coincides with the wish of most older people. But this commitment does not appear to be supported in practice when we note the significant decrease in the provision of home help hours in recent years[53] especially at a time of population ageing. As Table 8.5 shows, there were approximately 8,300 fewer people in receipt of home help support in 2014 than there had been in 2008 (a decrease of approximately 14.5 per cent) and there was a decrease of 2.34million in the hours delivered (a decrease of some 18.5 per cent). Looking at the years after 2008 there was a steady decrease in the number of hours delivered and people receiving hours especially from 2011, and although there has been a slight increase in 2014, both the number of hours delivered and those served by the scheme are still considerably less than in 2008 or indeed in 2011. During the period 2008-2014, the number of people in receipt of Home Care Packages grew (by 4,200 people), representing an increase of some 47 per cent, but, as already mentioned, the funding for this scheme has remained static. The 2015 Health Service Executive National Service Plan envisages additional spending in this area (including on Home Care Packages for 600 people) but also acknowledges the risk that overall the amount allocated for older people is not sufficient to address increasing demand.

[53] HSE reports make it clear that older people are the main beneficiaries of Home Help services and Home Care Packages.

Table 8.5 - HSE Support to Older People in the Community, 2007 - 2013

	2007	2008	2009	2010	2011	2012	2013	2014
Home Help:								
People in receipt	54,736	55,366	53,971	54,000	50,986	44,387	46,454	47,061
Home Help:	12.35m	12.64m	11.97m	11.68m	11.09m	9.8m	9.73m	10.3m
Hours delivered Home Care Packages People in receipt	8,035	8,990	8,959	9,941	10,968	10,526	11,873	13,199

December Performance Reports, 2008, 2009, 2011, 2012; 2013;2014.
November Performance Report, 2010 and HSE Annual Report 2010.

Another issue that is relevant is the impending closure of public nursing home beds due to failure to meet the standards set by the Health Information and Quality Authority (HIQA). The Health Service Executive Director General has indicated that there is currently insufficient funding to bring accommodation standards in thirty large public nursing homes up to the levels required by HIQA. Closure of these units would have a number of consequences for their individual residents and also a knock-on effect on hospital overcrowding due to increasing the numbers of people needlessly occupying hospital beds for want of a suitable alternative.

Over the past six or so years, changes in public services (such as in home help hours and community nursing units, reductions in the Fuel Allowance, cuts in the Household Benefits Package, abolition of the Christmas bonus, and increases in prescription charges as well as decreased frontline staff and services within the healthcare sector) have all adversely affected older people, falling most heavily on poorer groups without the income to compensate and especially, of course, on poorer people with disabilities or illness. International experts have identified that in relation to public health spending alone, the reduction in Ireland's spending on over 65s will have fallen by approximately 32 per cent per head between 2009 and 2016 (World Health Organization & European Observatory on Health Systems and Policies, 2012).

Supports that enable people to live at home need to be part of a broader integrated approach that ensures appropriate access to, and discharge from, acute services when required. To achieve this, the specific deficits in infrastructure that exist across the country need to be addressed urgently. There should be an emphasis on replacement and/or refurbishment of facilities. If this is not done the inappropriate admission of older people to acute care facilities will continue, along with the consequent negative effects on acute services and unnecessary stress on older people

and their families. A related issue is the shortage of appropriately resourced and staffed geriatric rehabilitation units. The National Clinical Programme for Older People (2012) recommended that every hospital receiving acutely ill older adults have a dedicated specialist geriatric ward and a designated multi-disciplinary team, as well as access to onsite and off-site rehabilitation beds delivering a structured rehabilitation programme for older people. This document recognises that it is a fundamental right of an older person to receive an adequate period of rehabilitation before a decision with regard to long-term care is made. But implementation of these recommendations is lacking and there continues to be a shortage of appropriately resourced and staffed geriatric rehabilitation units in the country (O'Neill 2015).

The stated focus on the development of community based services to support older people in their own homes/communities for as long as possible is welcome. But an Expert Group described Ireland's under-resourced community health services as 'perhaps the greatest deficiency in the current provision of public health services in Ireland' (Ruane, 2012, p.48). A commitment to supporting people at home is only aspirational if funding is not provided for home help services, day care centres and home care packages – some of which have received serious and unwelcome cuts in recent Budgets at a time when they should, on the contrary, be the subject of investment to address population ageing.

Social Justice Ireland believes that on the capital side, an investment in the order of a total of €500 million over five years, (i.e. €100 million each year), is required to meet this growing need. This would enable some 12 to 15 community nursing facilities with about 50 beds each to be replaced or refurbished each year. In addition to supporting the needs of older people, this proposal would also stimulate economic activity and increase employment in many local communities during the construction periods.

Social Justice Ireland also believes that, on the revenue side, funding in excess of €100m is required at a minimum to bring core community services for HCPs, Home Help as well as residential care supports through the Fair Deal scheme to more sustainable levels. This funding will assist in stabilising the current system and allow for a progressive development towards an integrated model of service over a period of years based on an appropriate allocation for demographic growth each year.

Primary care

Primary care is one of the cornerstones of the health system something acknowledged in the strategy document *Primary Care – A New Direction* (2001). Its importance was recognised in subsequent strategies, *Future Health* (2012) and *Healthy Ireland* (2013). Between 90 and 95 per cent of the population is treated by the

primary care system. The model of a primary care needs to be flexible so that it can respond to the local needs assessment. Paying attention to local people's own perspective on their health and understanding the impact of the conditions of their lives on their health is essential to community development and to community orientated approaches to primary care. A community development approach is needed to ensure that the community can define its own health needs, work out collectively how these needs can best be met, and decide on a course of action to achieve this 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 principle underlining this model should be a social model of health, in-keeping with the World Health Organization's definition of health as a 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. Ireland's *Healthy Ireland* strategy describes health as 'a personal, social and economic good'.

Universal access is needed to ensure that a social model of health can become a reality. Government's commitment to introduce universal health insurance is currently postponed if not entirely shelved[54] and indeed the timeframe for its introduction always seemed ambitious. Delays and challenges are associated with government's approach to extending free GP care to all children under six. Another issue that has to be addressed in any planning for the future is how to deliver an integrated system of care, especially for people with complex or chronic conditions, if what is proposed is that primary and hospital care would be funded through the insurance system, but social care services, including long-term care, would not be. For the approach outlined in *Future Health* to be implemented there is a clear need for an increase in the proportion of the total healthcare budget being allocated to primary care and a more comprehensive and integrated approach to social care services to support people living at home.

Ireland's healthcare system has struggled to provide an efficient response to the health needs of its population. Despite a huge increase in investment in recent years great problems persist. The development of primary care teams (PCTs) across the country could have a substantial positive impact on reducing these problems.

Developing PCTs and primary care networks is intended as the basic building block of local public health care provision. The Primary Care Team (PCT) is intended to be a team of health professionals that includes GPs and Practice Nurses, community

[54] As of January 2015, a costing analysis is to be completed and the Minister for Health is preparing a 'roadmap' for next steps. Furthermore, current changes to the rules on community rating which incentivise people at younger ages to buy insurance directly contradict the plan to move to a single tier universal insurance system for everyone within the next few years (Normand 2015).

nurses (i.e. public health nurses and community RGNs), physiotherapists, occupational therapists and home-care staff. PCTs are expected to link in with other community-based disciplines to ensure that health and social needs are addressed. These include speech and language therapists, dieticians, area medical officers, community welfare officers, addiction counsellors, community mental health nurses, consultant psychiatrists and others.

It was envisaged that 530 Primary Care Teams supported by 134 Health and Social Care Networks would cover the country by 2011. According to the HSE, there were 486 PCTs in place by the end of 2012 (Department of Health, 2012) but some of these have now been merged, and, at the end of December 2013, 419 Primary Care Teams were operating (Department of Health, 2014). Thirty-four primary care centres have opened and the development of a further 48 are underway (Department of Health, 2014). The Health Service Executive Service Plan for 2015 envisages establishment of new organisational structures including nine Community Healthcare Organisations and 90 Primary Care Networks intended, inter alia, to support Primary Care Teams. The work done on existing teams is very welcome but much more is needed to ensure they command the confidence and trust of local communities. Greater transparency about their planning and roll-out is also needed.

The recent establishment of seven Directorates to run the health system is of concern because this approach may obstruct the delivery of an integrated healthcare system for service users at local level. There are real concerns that the new approach will increase rather than reduce costs and bureaucracy. Instead of an integrated system based on primary care teams at local level, seven 'silos' could emerge, competing for resources and producing a splintered system that is not effective, sustainable or viable in the long term.

Social Justice Ireland believes that reform of the healthcare system is necessary but is seriously concerned that the proposed new structure will see each Directorate establish its own bureaucracy at national, regional and local levels. An important first step to address these concerns would be the publication of a comprehensive plan for the implementation of the new community healthcare organisations and the 90 primary care networks envisaged. This plan should clearly outline how the Primary Care Teams and networks will link with mental health and social care services and how collectively these community services will be integrated with acute hospital services as well as other important services at local government, education and wider community level. It will also be necessary that this work be linked to the new GP contract which it is intended will focus on chronic disease management, prevention and community involvement.

Children and family services

There is a need to focus on health and social care provision for children and families in tandem with the development of primary care team services. The 2006 Concluding Observations of the UN Committee on the Rights of the Child noted the lack of a comprehensive legal framework and the absence of statutory guidelines safeguarding the quality of, and access to, health care services, particularly for children in vulnerable situations (Children's Rights Alliance, 2014). The Committee also raised concerns about the practice of treating children with mental health issues in adult in-patient facilities.

Social Justice Ireland welcomed the announcement of free GP care for under-fives several years ago. However, implementation of this scheme (now to apply to under 6's) is still awaited and it will require negotiation with providers and legislative changes. Policy in this area appears fragmented and lacking transparency as the withdrawal of discretionary medical cards from some children with high levels of medical need during 2014 shows, and - although this policy has officially been reversed - there are still media reports of difficulties for families in this situation. A universal approach to primary care of under 6's should not be accompanied by a harder line being taken to children with high levels of medical need.

Many community and voluntary services are being provided in facilities badly in need of refurbishment or rebuilding. Despite poor infrastructure, these services are the heart of local communities, providing vital services that are locally 'owned'. There is a great need to support this activity and, in particular, to meet its infrastructural requirements. *A Vision for Change* (revised as per Census 2011 data) recommended the establishment of 107 specialist Child and Adolescent Mental Health teams, but by the end of 2012 there were 63 teams operating and staffing was at just 38 per cent of what had been recommended (Children's Rights Alliance, 2014).

Social Justice Ireland has welcomed the extra €6million allocation for therapy services in the Children and Young People programme provided in Budget 2015, and believes that a total of €250 million is required over a five year period to address the infrastructural deficit in Children and Family Services. This amounts to €27 million per area for each of the nine Children Services Committee areas and a national investment of €7 million in Residential and Special Care.

As well as the issue of child protection, current key issues include waiting times for treatment (see above), policy on early childhood care and education, child poverty, youth homelessness, addressing disability issues among young people and the issue of young carers.

Disability

A total of 595,335 persons, accounting for 13 per cent of the population, had a disability in April 2011 (CSO 2012). Disability policy remains largely as set out in the National Disability Strategy from 2004 and its Implementation Plan published in 2013. There are many areas within the disability sector in need of further development and core funding and an ambitious implementation process needs to be pursued now.[55]

People with disabilities have been cumulatively affected by a range of policies introduced in successive Budgets in recent years. These include cuts to disability allowance, changes in medical card eligibility criteria and increased prescription charges, cuts in respite services, cuts to home help and personal assistant hours and other community-based supports such as the Housing Adaptation Grants Scheme as well as the non-replacement of front-line staff providing services to people with disabilities. A modest additional allocation provided for in the Health Service Executive Plan, 2015, while welcome, is not sufficient for 'additional new service developments' (Health Service Executive 2014). The cumulative effect of the changes made in recent years makes it more difficult for some people to continue to live in their communities. Furthermore, people with disabilities experience higher everyday costs of living because of their disabilities and one study suggests that the estimated long-term cost of disability is about one third of an average weekly income (cited in Watson and Nolan 2011). As Chapter 3 discusses, they are one of the groups in Irish society at greatest risk of poverty.

The Value for Money (VFM) & Policy Review of Disability Services in Ireland 2012 recommends a complete and radical transformation of disability services in Ireland. The HSE Service Plans in 2014 and 2015 indicates some progress in putting in place the structures and processes necessary to implement the type of comprehensive change programme envisaged by Government. However, *Social Justice Ireland* is concerned that the pace of change is too slow and that additional targeted resources will need to be provided to ensure a comprehensive and lasting system of change initiative is delivered to the benefit of service users and local communities. *Social Justice Ireland* welcomes the establishment of a high level Steering Group to oversee the change programme, reporting to the Minister. However, given the scale of infrastructural development required to move away from communal settings, towards a community based, person-centred model of service, a dedicated reform fund will need to be put in place to support the transition to a new model of service. People with disability will need to be supported, not only by the health service, but by the Department of the Environment through Local Authorities in terms of

[55] Other disability related issues are addressed throughout this review.

housing need and through the Department of Social Protection in terms of income supports as well as by the Department of Education in terms education and training requirements. A dedicated reform fund supported by government departments would assist in achieving the type of radical change required.

Mental health

The Expert Group on Mental Health Policy 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. In 2009, the Mental Health Commission expressed concern about the slow pace of implementation and consequent impacts on the quality of mental health services available to those with mental health issues (2009).

A study on the impact of the recession on men's health, especially mental health, showed that employment status was the most important predicator of psychological distress, with 30.4 per cent of those unemployed reporting mental health problems (The Institute for Public Health, 2011).

According to a study from Eurofound, between 2008 and 2012, there was almost no increase in the transfer of either budget or staff from hospitals to the community resulting in the under-provision of community services and the overmedication and increased hospitalisation of people with mental health problems (Eurofound, 2014). Readmission rates were also found to have increased.

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.* This 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 estimate increased to 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 coming years.

Social Justice Ireland welcomed the allocations in Budgets 2014 and 2015 for mental health services, but there have been delays in spending previous allocations due it appears mainly to recruitment difficulties. According to the HSE's divisional plan for mental health for 2015, staffing levels are still at approximately 75% of what was recommended in *A Vision for Change* (HSE 2015). The mental health services are going through a significant change process at a time when demands on services are growing, as the HSE has noted, in line with population increases and the effects of the economic crisis (2014). It is vital that ongoing reductions in inpatient beds are matched by adequate and effective alternative provision in the community.

Areas of concern in mental health

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; and
- assistance with integration into community.

In the development of mental health teams there should be a particular focus on people with an intellectual disability and other vulnerable groups, including children, the homeless, prisoners, Travellers, asylum seekers, refugees and other minority 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 having been recognised and honoured in the healthcare system.

The connection between disadvantage and ill health when the social determinants of health (housing, income, childcare support, education etc.) are not met is well documented. This is also true in respect of mental health issues.

Older people and Mental Health

Mental health issues affect all groups in society and people of all ages. Dementia is not the only mental health issue to affect older people. It is not an inevitable part of ageing nor is it solely a disease of older age, but older people with dementia are a particularly vulnerable group whose average length of stay in long-stay residential care far exceeds that of others, for example (Cahill *et al* 2015). It is estimated that 47,000 people in Ireland have dementia (based on 2011 Census) and that number is projected to rise with the ageing of the population and could be as high as 132,000 by 2041 (Pierce, Cahill & O'Shea 2014).

A co-ordinated service needs to be provided for people with dementia. The uncoordinated and fragmented provision of specialist care units for people with dementia has recently been highlighted and offers an example of a lack of planning and coherence. It is generally agreed that the needs of people with dementia are unmet within long-term-care and that unmet needs are a source of reduced quality of life and increased disruptive behaviours: many symptoms are estimated to be caused, not by the dementia itself, but from the quality of care people with dementia receive in inappropriate settings (Cahill *et al* 2015). As a consequence, specialist care

units are required which offer care in relatively small household-type settings with specially trained staff and meaningful activities provided. However, a recent study found that, where they exist in Ireland, they account for only 11 per cent of the long term care facilities (54 units), and accommodate only 7 per cent of long term care residents[56] – this being the case when it is estimated that over 60 per cent of residents living in long-term care facilities have dementia in middle and high-income countries (Cahill *et al* 2015). A high proportion of the specialist units that do exist were also found to be caring for people in groups that are larger than the small group living arrangements that are recommended, and there were significant inequities regarding their location, with over 50 per cent of all specialist units in only four counties and long waiting lists for access to units in many areas.

A National Dementia Strategy was published at the end of December 2014 and funding has been promised for three priority areas over the next few years – intensive home care supports, GP education and training and dementia awareness. This is welcome. However, the strategy's publication is only a first step and there are many other areas that also require investment – day centres, respite services and other supports for carers, quality long-term care (at home and in care settings) and specialist care units, and evaluation and monitoring of all services.

Research and development in all areas of mental health are 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 in the future. Public awareness needs to continue to be raised to ensure a clearer understanding of mental illness so that the rights of those with mental illness are recognised.

Suicide – a mental health issue

Suicide is a problem related to mental health issues. For many years the topic was rarely discussed in Irish society and, as a consequence, the healthcare and policy implications of its existence were limited. There was a downward trend in the rate from 2003, which stopped in 2007, something partly attributed to the change in the economy by the National Office of Suicide Prevention (2011). There has been a subsequent reduction in 2010 followed by an increase in the rate in 2011 and a decrease in 2012.

Over time Ireland's suicide rate has risen significantly, from 6.4 suicides per 100,000 people in 1980 to a peak of 13.9 in 1998 and to 11.7 suicides per 100,000 people in 2008 (National Office of Suicide Prevention, 2011).

[56] By contrast, in the Netherlands for example, approximately 25% of all long-stay care is small-scale dementia specific, and this proportion is intended to be increased to 33% by 2015

As Table 8.6 shows, according to the latest figures available from the National Suicide Research Foundation, there were 507 recorded suicides in 2012, of which 413 were males and 94 were females. Table 8.6 shows that suicide is predominantly a male phenomenon, accounting for approximately 80 per cent of such deaths. Young males in particular, are the group most at risk, although the rate for men remains consistently high at all ages up to mid-sixties (National Office for Suicide Prevention, 2014).

Identification of overall trends in suicide rates is a complex process particularly using international comparisons. Statistics from Eurostat suggest that where overall rates of suicide are concerned, Ireland ranked 11th lowest in the EU (based on the 2010 rate). However, where younger age-groups are concerned (15-19), Ireland ranked fourth highest for deaths by suicide at 10.5 per 100,000 population (National Office of Suicide Prevention, 2014).

Table 8.6 Suicides in Ireland 2003-2012

	Overall		Males		Females	
Year	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	10.9	379	17.9	81	3.8
2007	458	10.6	362	16.7	96	4.4
2008	506	11.4	386	17.5	120	5.4
2009	552	12.4	443	20.0	109	4.9
2010	490	11	405	18.3	90	4.0
2011	554	12.1	458	20.2	96	4.1
2012	507	11.1	413	18.2	94	4.1
Rate is rate per 100,000 of the population.						

National Suicide Research Foundation (2015)

The sustained high level of suicides in Ireland is a significant healthcare and societal problem. Of course, the statistics 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 lives. *Social Justice Ireland* believes that further attention and resources need to be devoted to researching and addressing Ireland's suicide problem.

Future healthcare needs

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 more people living in Ireland in 10 to 15 years' time and many of them will be older people. One clear implication of this will be additional demand for healthcare services and facilities. In the context of our past mistakes it is important that Ireland begins to plan for this additional demand and begins to train staff and construct the needed facilities.

The system of Universal Health Insurance envisaged in the health reform strategy, 2012-2015, *Future Health,* was intended to facilitate access to healthcare based on need not income. Access to healthcare based on need, not income, is an important aim for Ireland's healthcare system. While steps toward a universal health service have been announced by way of the extension of free GP services to those aged under six and those aged over 70, the timescale for their implementation is less clear. The timeframe for the introduction of Universal Health Insurance has always seemed optimistic (given the level of change involved to an already very complex system) and its development appears to be currently on hold while a costing analysis is completed and while the Minister for Health prepares a 'roadmap' for next steps (as of January 2015).

We share the concerns of the Council for Justice and Peace of the Irish Episcopal Conference (2012) about a lack of focus on health outcomes in Irish public policy on health. We agree with it that the: 'public health strategy should ... not only spell out goals for public health but also set out the role that each major field of intervention is expected to perform in achieving those goals, the implications for resource allocation that arise from such roles, and the mechanisms that will be used to ensure that spending actually goes to the areas where it will achieve greatest benefit'.

Key policy priorities on healthcare

- Roll out the nine Community Healthcare Organisations and 90 Primary Care Networks intended, inter alia, to support Primary Care Teams as envisaged in the 2015 HSE Service Plan.
- Recognise the considerable health inequalities present within the Irish healthcare system, develop strategies and provide sufficient resources to tackle them.
- Give far greater priority to community care and restructure the healthcare budget accordingly so as to make the commitment to enable groups like older people to live in their own homes for as long as possible. Care should be taken

to ensure that the increased allocation does not go to the GMS or the drug subsidy scheme.

- Increase the proportion of the health budget allocated to health promotion and education in partnership with all relevant stakeholders, targeting, in particular, people who are economically disadvantaged in recognition of the health inequalities that exist.
- Provide the childcare services with the additional resources necessary to effectively implement the Child Care Act.
- Provide additional respite care and long stay care for older people and people with disabilities and proceed to develop and implement all aspects of the dementia strategy.
- Develop and resource mental health services, recognising 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 about suicide.
- 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 for the next few decades.
- Ensure any new healthcare structure is fit for purpose and publish detailed evidence of how the decisions taken will meet healthcare goals.