IRELAND

1. Situation and key trends

GDP growth of 4.7% in 2005 ensured that the economy continues to grow appreciably above average EU rates (1.6%). Forecasts for 2006 estimate an increase in GDP growth of 5.3%, although there are concerns that there is an over-reliance on the construction sector. Employment rates continue to grow and, if current trends are sustained, IE is likely to achieve all quantitative Lisbon targets on employment. The overall employment rate in 2005 stood at 67.6 %, the male employment rate was 76.9% and female employment 58.3%. Employment amongst those aged 15-24 (48.7%) and employment amongst those aged 55-64 (51.6%) are both above EU averages.

IE unemployment remains low and stable at 4.4% (2005). While overall activity rates (70.8%) now exceed the EU averages (70.2% in 2005), there are continuing constraints, notably in relation to care services, which limit the capacity of some categories – e.g. families with children (particularly lone parents) - to participate in the labour market.

At 20% in 2004, the at-risk-of-poverty rate remained substantially above the EU average (16% in 2004). At-risk-of-poverty rates are particularly high amongst older people living alone and lone parents, though more recent national data from 2005 indicate that at-risk-of-poverty rates for these categories have been significantly reduced, reflecting the impact and focus of the Irish social security system on people on the lowest incomes.

Life expectancy at birth (75.8 and 80.7 for males and females in 2003) is about the EU average. It has increased by about three years for men and two years for women over the last decade (72.9 and 78.4 in 1995). It has risen consistently since 1970 (68.54 and 73.19). Healthy life expectancy (63.4 for males and 65.4 for females) is slightly below the EU15 average (64.5 and 66 respectively) but it has not changed much for men since 1995 and it shows a small reduction for women (67.6 in 1999). The infant mortality rate (4.9 in 2004) is about the EU average and shows a large reduction since 1960 (29.3) though it decreased more slowly in the last decade (6.4 in 1995). Perinatal mortality is however rather high (9.2 in 2001).

The current old-age dependency ratio (16.5 in 2005) is considerably below the EU average, but is projected to increase significantly to reach 45.3 by 2050.

Gross social protection expenditure amounted to some 17% of GDP in 2004, which is substantially below the EU average (27.3%). The very significant growth in GDP, however, means that the very significant real increases in benefit rates and child income support introduced in recent years is somewhat masked. Further explanatory factors for the lower levels of social protection expenditure in IE include the lower proportion of pensioners and the reliance on private pension provision to supplement flat-rate State pensions; and lower spending on unemployment benefits in the light of sustained low unemployment figures.

2. Overall strategic approach

The Irish National Strategy Report can generally be said to contain a coherent strategic approach which builds upon the achievements of the earlier National Anti-Poverty Strategy and the National Plan against Poverty and Social Exclusion 2003-05. Mirroring the outcome

of the negotiations on a new Social Partnership Agreement, *Towards 2016*, it adopts a lifecycle approach which makes for a cogent analysis of the issues being addressed in tackling social exclusion.

The four priorities identified - child poverty, access to quality employment, integration of immigrants, and access to quality services – are appropriate and consistent with EU priorities and in most cases clear, ambitious but achievable targets are included, again drawing to a considerable extent from *Towards 2016*.. A notable weakness, however, is the absence of any explicit targets in relation to poverty reduction. It is important to note that IE will shortly complete a separate new National Action Plan for Social Inclusion in parallel with, and complementary to, the forthcoming National Development Plan 2007-13. While a certain caution towards the setting of poverty reduction targets (even in relation to the national consistent poverty measure) can be discerned in the Strategy Report, it is expected that this new Plan will clearly address this issue. At a wider level, the streamlining of Action Plans on Poverty and the NDP must be viewed as a positive step, since it should facilitate greater coherence in policy development and more effective mainstreaming of poverty and social exclusion issues across all policy domains.

The linkages with the National Reform Programme will be addressed within the context of the Steering Group, chaired by the Secretary-General of the Department of the Taoiseach (Prime Minister) and representing the Government and the Social Partners, charged with overseeing the implementation of *Towards 2016*. This Group will periodically review progress in implementing key strategies including the NSSPI, the NAP/Inclusion 2006-08, the National Development Programme 2007-13 and the National Reform Programme.

3. Social inclusion

3.1 Key trends

The economic background in Ireland remains positive with strong GDP growth and a vibrant labour market predicted to continue over the coming years. There are concerns however that growth is excessively linked to domestic consumption and notably to the construction sector, and there is some concern too at the relatively high levels of inflation currently being experienced. Of particular significance is the net migration experienced in recent years with population growth, largely fuelled by immigration, of 8.1% being recorded between 2002 and 2006. This presents a new set of challenges to be faced in terms of integration and service provision.

While the latest figures for the national 'consistent poverty' measure show positive results, down from 8.8% (2003) to 6.8% in 2004, it is not possible to measure trends over the longer term owing to methodological issues associated with the change from the ECHP to the EU-SILC.

IE argues that the high levels of people at risk of poverty (20% in 2004) is attributable primarily to an increase in the median income driven by a significant shift from one to two income households (itself a consequence of increased female workforce participation). While the impact of rapid economic growth and associated household structural changes over the past decade does tend to mask the very significant investment in welfare benefits over the same period, the underlying high proportion at risk of poverty also reflects the structure of the Irish welfare system (based on flat-rate benefits) and points to a continued level of inequality in Irish society which must be a matter for concern. Expenditure on public social expenditure

in Ireland (15.5% in 2004) is considerably below the EU average (23.4%). Families with children (particularly lone parents), older people living alone and people with disabilities are particularly vulnerable to being at risk of poverty. It is notable also that there is an increasing prevalence of people in employment who are at risk of poverty, reflecting primarily those who are engaged in low-paid and/or part-time work.

3.2 Key challenges and priorities

The strategic approach can be viewed as a further development of the strategy followed in Ireland to date in the National Anti-Poverty Strategy and the previous NAP/inclusion and sets out the intention to continue reform of the social welfare system, to address access to the labour market, enhance employability and improve access to better quality education, health and other services. The strategic framework adopted mirrors that contained in the recently concluded social partnership agreement – *Towards 2016. T*he major innovation in *Towards 2016* in relation to social policy is its adoption of a life cycle approach. This divides up the population into three groups: children, people of working age and older people, (although it continues to identify people with disabilities as a separate category) and includes a set of policy goals in relation to each group, together with priority actions.

IE places a strong emphasis on the provision of enhanced services and reiterates commitments to continued investment in welfare provision.

As regards active social inclusion, the Strategy again reflects the tenor of *Towards 2016* which seeks to be more explicit than in the past in identifying the complementary relationship between social policy and economic policy. This can be seen as reflecting also the greater visibility of flexicurity as a policy driver insofar as the Strategy identifies the importance of effective interaction between social protection and growth and employment. (The creation of the new Office of the Minister for Children is also a significant development in terms of structures designed to facilitate effective implementation of the lifecycle approach.) Overcoming educational disadvantage is also taken up as one of the challenges ahead for Ireland.

As regards policy co-ordination and the involvement of all actors, there are further welcome developments in the IE approach. *Towards 2016* provides for instance that a 'streamlined national social inclusion report' will be prepared annually by the Office for Social Inclusion, with the purpose of monitoring and reviewing progress at each stage of the life cycle. This development is welcomed and should help to ensure that social inclusion issues receive due weight in policy development and implementation.

The challenges identified in the 2006 Joint Report related firstly to the need to sustain investment in service provision, notably in relation to childcare and elder care; and IE can be regarded as having responded positively in this area (e.g. through the Childcare Investment Programme). The second area related to the need to address the high proportion at risk of poverty and the high level of income inequalities. While significant investment in income supports has been sustained in recent Budgets, including the 2006 Budget, the absence of an explicit commitment to setting poverty reduction targets gives some cause for concern. As noted earlier, the finalisation of a new NAP/inclusion will provide a clearer picture of IE's intentions in this regard.

3.3 Policy measures

The following four priority areas are selected: child poverty; access to quality work and learning opportunities (activation measures); integration of immigrants; and access to quality services. While by definition, identifying priority areas means that some other worthy issues are overlooked, it is perhaps regrettable that the approach adopted has the perceived effect of diminishing the priority accorded to vulnerable groups, such as Travellers, in earlier NAPs/inclusion. In general, however, the areas identified are all in need of significant attention and fit well with EU priorities.

Notwithstanding the absence of explicit child poverty reduction targets, the Report identifies a wide range of targets that will impact on child poverty in the areas of income support, childcare, tackling early school leaving, addressing educational disadvantage (notably through the implementation of the 'Delivering Equality of Opportunity in Schools' programme), and improving health outcomes. A review of child income supports is to be completed within a year. This is a critical area, given the emphasis on improving access to employment opportunities, since there is evidence to suggest that disincentives to employment within the welfare system have re-emerged as a serious issue. The key targets identified are by and large quantitative, time-limited and demonstrate an integrated approach to addressing child poverty.

The second objective focuses on increasing employment participation and access to education among marginalised groups, notably lone parents, people with disabilities, older workers and the unemployed through the removal of barriers to employment on one hand and the implementation of a new case active management service for all social welfare customers on the other. If it is to succeed, this approach will demand a more flexible response in the area of training and education provision if the needs of the target groups are to be adequately addressed (e.g. in terms of affordable and accessible childcare and the removal of rigidities in the scheduling of training). The targets set relate primarily to literacy, employment rates and investment in the Back to Education Initiative and are relatively clear and time-limited. No targets are included however in respect of the adoption of a case management approach for all social welfare customers. In 2006, substantial investments were made in employment and training supports for the unemployed and the economically inactive and programmes aimed at facilitating access to learning opportunities for low skilled disadvantaged workers

The third objective – integration of immigrants – is clearly an area of increasing relevance in IE, given the scale of inward migration in recent years. The approach outlined is wide-ranging covering service provision, active integration and anti-racist initiatives, but there is an absence of clear targets (other than to increase the number of language support teachers in schools) with continuing data shortages being advanced as the key explanatory factor. While the NSSPI does indicate that this issue is being addressed as part of the data strategy of the Office for Social Inclusion, it is important that data deficits are not allowed to become a barrier in themselves to effective early actions to address the needs of migrants and to ensure their integration into society.

The final objective relates to access to quality services and the approach outlined represents a substantial development on earlier Plans. An impressive range of policy domains - income support, health, long term care services, transport, accessible ICT, housing and accommodation, improving local environments, and investing in local infrastructure – is covered and clear targets relating to housing, health and transport are included

The approach taken to gender issues is mixed. A gender perspective is systematically included within the discussion of each policy objective, an approach which demonstrates an increased awareness of the particular issues facing men and women. This does not however translate

into gender-specific targets. The adoption of the life cycle approach, mirroring that set out in the *Towards 2016* Agreement can be characterised as 'gender-blind' with the result that the visibility of gender mainstreaming is diminished considerably.

While budgetary allocations are provided in respect of some specific actions (e.g. the National Childcare Investment Programme), and current (2006) expenditure levels are broadly outlined, the Report indicates that future proposed resource allocations will be contingent on the completion of the National Development Plan 2007-13 and on the annual budgetary process. No reference is made in the report on the possible future role of the ESF in supporting actions planned under the Strategy.

3.4 Governance

IE continues to demonstrate a clear commitment to wide-ranging consultation in the preparation of its inclusion strategy. An extensive consultation process was undertaken, including a public call for submissions, regional public consultations, a meeting of the Social Inclusion Forum and consultation with the local authorities. (There is a commitment now to establish Social Exclusion Units in half of all local authorities by end-2008, a welcome – albeit limited – development which will help to embed social exclusion-related activities more concretely within local communities.) Other seminars were run by the Combat Poverty Agency and by various community and voluntary organisations. The direct involvement of stakeholders is more limited in the areas of implementation, monitoring and evaluation although the social partners will have an oversight role through their participation in the Steering Group for the Social Partnership Agreement.

The Strategy envisages a more streamlined approach in the future to the monitoring and evaluation of social inclusion issues. The role of the Office for Social Inclusion has been enhanced under *Towards 2016* and the Office is now charged with monitoring progress on the implementation of the NSSPI, the forthcoming NAP/Inclusion and the social inclusion elements of the new National Development Plan. A single annual Social Inclusion Report will be published, commencing in June 2007. Given that a key message emerging from the consultation process centred on the need to address the 'implementation gap' in existing legislation, policy programmes and task force recommendations, it is to be hoped that the more streamlined monitoring process will in turn underpin a more rigorous implementation of commitments and the achievement of targets. In this regard, also, the recent overhaul of the poverty proofing process, now known as Poverty Impact Assessment, is a positive step.

4. Pensions

Pensioner incomes in Ireland are among the lowest in the EU-25, relative to the overall population (65% of those aged 0-64), and persons aged 65+ are more at risk of being in poverty than those aged 0-64 . In 2004, 33% were at risk of poverty (men 30%, women 36%), meaning that poverty rates of older people in Ireland remain amongst the highest in EU-25, in spite of the fact that State pensions have been increasing at a faster rate than either prices and earnings.

The 2006 Sustainability Report assessed Ireland as a medium-risk Member State as regards the sustainability of public finances, notably due to the high cost of ageing and despite the current strong budgetary position. According to the AWG 2005 projections, public spending on first-pillar pensions (including public service pensions) is set to rise from 4.6% of GDP in 2004 to 11.1% in 2050. The rise is relatively continuous and stable over the whole period. Theoretical pension replacement rates are expected to stay stable until 2050 (78% total net

and 67% total gross – of which 31% from public pensions; currently only about 50% of the employed population is covered by occupational schemes).

Ireland has made progress in making provision for increasing the adequacy of pensions, and further steps have been announced recently by the Government which will have a particular impact on the poorest older pensioners, the majority of whom are women. Nevertheless, as set out in the 2006 Joint Report, extended coverage of supplementary pension provisions is important to ensure the effectiveness of the income replacement function of pension systems. Evidence suggests that despite Government initiatives, levels of supplementary pension coverage are at best static. Although Ireland has made good progress in increasing its older workforce, early retirement is still common, in particular for reasons of illness or disability. Further strengthening of incentives to work longer would contribute to ensuring future adequacy and sustainability. The Irish Government's commitment to allow a pension to be drawn, whilst continuing to work, could help improve flexibility in retirement.

The Irish Government is committed to accumulating a considerable reserve fund in order to partially pay for future liabilities, and thus make a significant contribution to financial sustainability, in the face of significant projected pensions expenditures in the future. Recent returns of the reserve fund (19.5% in 2005) are impressive and have taken the value of the fund to 11% of GDP. The commitment to monitoring the adequacy of contribution rates through regular actuarial reviews should help to react to any signs of adjustments being needed, and thus help to keep the system on a sustainable footing. A pensions green paper is expected in early 2007 setting out further possible steps for pension reform. A consultation process will follow the publication of the green paper and the Government will respond to these consultations by producing a framework for long-term pensions policy.

5. Health and long-term care

5.1. Health care

Description of the system: A National Health Service (NHS) provides care to all residents some of whom (medical card holders) are entitled to free care (primary, secondary, dental, ophthalmic, aural, maternal and infant care, medicines) based on income and age (70+). Non-medical card holders are subject to charges for consultations, inpatient, outpatient and emergency care and are not covered for dental, ophthalmic and aural care. The NHS is a mix of public and private provision. Primary health care (PHC) is delivered in health centres on the one hand, and in the private premises of general practitioners (GPs), pharmacists, dentists and optometrists, on the other. A GP referral gives access to specialist and hospital care which are available in hospitals' outpatient and inpatient departments. Public sector specialists also conduct private practice for outpatients. Most hospitals are publicly owned but private care can be provided in public hospitals. GPs are paid on a capitation basis for medical card patients and a fee-for-service for all others, whereas specialists' pay is salary based in hospitals and fee-for-service in the private sector. The NHS is mainly financed through general taxation. Private health insurance (duplicate, complementary and supplementary), mostly community-rated and run by the Voluntary Health Insurance Board (80% of market), covers 43.8% of the population. Highlighting health inequalities and barriers to access as serious challenges, authorities have goals to improve general health and reduce health inequalities through health promotion and to provide more easily accessible and equitable services that are better organised and integrated with social services, whilst enhancing system responsiveness and performance.

Accessibility: Data show that individual financial costs of care are rather high (private health care expenditure was 21.5% of total health care expenditure in 2004). To tackle this (over and above medical cards and an annual cap on hospital charges for all), authorities are extending free GP services to those around a threshold income. Moreover, they are introducing new legislation changing income guidelines and bringing further funding into the sector to increase the numbers of medical and free GP visit card holders. However, data show that GP numbers (3.1 per 100 000 inhabitants in 2004) are well below all other EU countries (e.g. 80.8 in England), which is clearly an obstacle to achieving appropriate and accessible PHC. The Irish authorities' response to this is the planned training of more GPs and expanding GP geographical coverage (including GP out-of-hours cooperatives), with 300 PHC teams expected by 2008. To address acute care shortages authorities are allocating funding to open new acute hospital beds and to contract with private facilities. The report highlights that appropriate long-term care outside the acute care setting can free additional beds. Emergency, renal and organ transplantation services will also receive additional funding. To reduce waiting times, the Irish authorities have set up the National Treatment Purchase Fund that collects data and pays for those waiting too long to be treated in private hospitals. A strong concern expressed in the report relates to substantial health inequalities: mortality was 3.5 higher in the lowest occupational class, chronic physical illness 2.5 times higher among the poor, infant mortality 3 times higher in poorer families, and travellers live 10-12 years less than the general population. Indicators are being defined for vulnerable groups and by socio-economic status (see further).

Quality: To improve quality the authorities are implementing quality standards together with a regulation and inspection regime. Legislation will establish the Health Information and Quality Authority (HIQA) and, to provide quality assurance, authorities will run a continuous accreditation system conducted by the Accreditation Board and a staff registration system. A national health information strategy is currently being implemented to develop standardised data sets and comparable indicators (on health status, health determinants, sector activity and financing) which authorities hope will support the planning and evaluation of services. In order to support the information system more emphasis will be placed on ICT. Authorities have allocated additional funding to the health research board to pursue research and evidence-based decision making. The HIQA will evaluate health technology. A customer charter and a complaints framework are planned, patients will be offered a choice of provider wherever possible, and an electronic health care record is planned. According to the report various fora (e.g. national consultative forum, regional health forums) are to provide opportunities for users, providers and staff to give feedback and be involved in decision making. To improve coordination between services and reduce fragmentation of management and delivery of care, the Health Service Executive was created, merging 11 previously separate and specialised agencies. ICT will support the links between services.

Long-term sustainability: Total health expenditure (7.2% of GDP and 2619 per capita PPP$ in 2004) is slightly below the EU average in GDP terms. It varied little throughout the decade, probably due to high GDP growth. Per capita expenditure increased rapidly between 1998-2002 (showing real rates of growth of between 9.8 and 11.2%). The share of public expenditure (78.5% of total expenditure in 2004) is around the EU average having increased in the last decade. The 2006 EPC/EC age-related projections foresee an increase in public expenditure of 2.0 percentage points of GDP by 2050. In this context, extra resources can be used to improve access and increase promotion and prevention activities whilst still achieving efficiency gains. The Irish authorities emphasise the need to enhance the use of PHC and daycase surgery while improving DRGs definition and DRG payment as a means of controlling costs and enhancing efficiency. They expect that the new organisational structure

and various plans will improve governance and accountability. Public-private partnerships are seen as opportunities to bring extra funding (capital investment) into the sector. With regards to health workers, a skills' monitoring report was published which authorities hope will help in the the long-term planning of the work force. Further developments have been the introduction of a health care-assistant training programme and an increase in the numbers of trained therapists, paramedics and nurses. New midwifery and children's nursing places are also planned to open. Highlighting the need to improve general health and reduce health inequalities, the authorities are implementing various promotion strategies addressing risk factors and specific diseases (e.g. smoking, alcohol, diet, exercise, cancer, drugs, aids, obesity, breastfeeding, suicide, mental health). Health promotion is to be implemented in a comprehensive manner using health impact assessment in all sectors, legislation, environment, education, health sector (e.g. access, immunisation, screening), inclusion/ anti-poverty, income, employment, and supply side (drinking and food industry) policies. It is to be conducted in different settings (e.g. schools, workplace).

5.2. Long-term care

Description of the system: Services include, alongside PHC and hospital care: home nursing, home help and care attendants, day centres, grants to adapt homes, meals-on-wheels, nutrition advice, therapy and rehabilitation, day hospitals, public residential care and private nursing homes. Services are provided in partnership with users, families and carers and a range of statutory, non-statutory, voluntary and community groups. Access is based on needs. Care in public facilities is free or almost free while a means-tested subvention is given to patients to pay for private nursing home care. There are some financial schemes for carers such as the carer's allowance for low income carers and the respite care grant. Care in the community is considered the preferred option by authorities both for the individual and on economic grounds. The goal is to maintain people in dignity and independence at home in accordance with their wishes; to support family, neighbours and voluntary bodies; and to provide hospital and residential care once this is no longer appropriate. Healthy ageing (promotion and prevention at older ages) is also a stated aim.

Accessibility: The report argues that public supply may be insufficient and private care may impose large financial burdens on patients and their families. Hence, to ensure equal access, authorities want to run a national standardised needs assessment with appropriate levels of co-payments and provide additional funding to expand the home care package and contract private services. Home care grants have been piloted as an alternative to residential care.

Quality: To ensure quality the report suggests that the HIQA will set national quality and safety standards for public services and a regulatory framework will define the standards in private nursing homes. Inspections are to be carried out, nurses will have full training and attendants will receive informal training. The report indicates that the National Council on Ageing and Older People advises on issues relating to older people with particularly regards to health care. The report also describes a number of databases and indicators related to disability and those at particular risk such as the 65+ and 75+ (influenza vaccination rates, waiting lists for certain procedures, and rates of residential care and home care use) A survey and report on long-stay care is conducted annually. Authorities expect that multidisciplinary teams will ensure integrated care.

Long-term sustainability: The 2006 EPC/EC age-related projections show an increase in public expenditure of 0.6 percentage points of GDP by 2050. Several reports have been

looking at ways of financing long-term care. A combined system of taxation, co-payments and social insurance or pre-funding mechanisms is one possibility.

6. Challenges ahead

- To ensure that the investment in services is sustained, delivered in an integrated manner along with welfare reforms and that it leads increasingly to more accessible and more flexible delivery attuned to the needs of those groups at greatest risk of poverty and exclusion, in particular to break the cycle of deprivation.

- To continue to promote active inclusion to ensure that the range of issues, including the necessary adaptation of services, associated with the significant ongoing levels of migration are effectively addressed

- To ensure the ongoing adequacy of income support for pensioners, in order to avoid their exclusion in a context of rapidly rising general living standards and to achieve a significantly wider coverage of supplementary private schemes, while taking due account of the long-term sustainability of public finances;

- To implement the set of measures that tackle major barriers to access (e.g. financial burden of care and long waiting times) and ensure more equitable access notably through enhancing nationwide availability of PHC, acute care, emergency and long-term care services; improve care coordination and integrated care,

- To achieve efficiency gains in service delivery whilst improving the health of population and reduce substantial health inequalities.