June
2011

ISSN: 1649-4954

SOCIAL JUSTICE IRELAND

Policy Briefing

# Healthcare

Healthcare is a social right that every person should enjoy. People should be assured that care in their times of vulnerability is guaranteed.

To ensure everyone in Ireland can access healthcare in the most appropriate manner when needed requires that Primary Care Teams (PCTs) be in place in all parts of the country.

It also requires that these PCTs be fully operational and working in an integrated manner and that they be adequately funded.

Community based health and social services must become more:

- **Accessible** and **acceptable** to the community they serve;
- **Responsive to the needs** of the local community and its particular set of requirements;
- Developed to a position of **dominance** in relation to acute hospital services and be accepted as the **primary** health and social care option to be accessed by the community;
- Supportive of local people in their efforts to **build caring communities**.

These goals can be achieved in a reasonably short time period.

For this to happen however, in the overall context of health service delivery, there will be a need to:

- Integrate the acute hospital care system
- Integrate the community-based service system
- Integrate both hospital and community systems to ensure that there is a consistent and seamless approach to service delivery where the person is at the centre of the service.
- Develop and enhance a social care model of service focused on supporting local communities in improving the overall health and well-being of the population.

Every country in the world is now party to at least one human rights treaty that addresses health-related rights.

This includes the right to health as well as other rights that relate to conditions necessary for health.

Article 25 of the United Nations Universal Charter on Human Rights states: *"Everyone has the right to a standard of living adequate for the **health** and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."*

The standard of care provided is dependent on the resources made available which in turn is dependent on the expectations of the society.

For years Ireland has struggled to deliver a fair and equitable healthcare system in which people could have trust.

*Social Justice Ireland* welcomes the new Government's commitment to produce a one-tier healthcare system.

Budget 2012 is a good opportunity to progress this process.

## Inside this issue:



**Social Justice Ireland**
**Arena House**
**Arena Road**
**Sandyford**
**Dublin 18**

**Phone: 01 2130724**
**www.socialjustice.ie**

***Policy Briefing*** *is a regular publication issued by Social Justice Ireland. It addresses a wide range of current policy issues from the perspective of those who are poor and/or socially excluded. Comments, observations and suggestions on this briefing are welcome.*

# Health Inequalities in Ireland

A very welcome insight into the extent of health inequalities in Ireland has been provided by the Public Health Alliance of the Island of Ireland (PHAI). This group, a north-south alliance of non-governmental organisations, statutory bodies, community and voluntary groups, advocacy bodies and individuals who are committed to work together for a healthier society by improving health and tackling health inequalities, has published two detailed reports in recent years:

*Health in Ireland – An Unequal State* (2004); and

*Health Inequalities on the island of Ireland: the facts, the causes, the remedies* (2007).

These reports gather together the baseline information on health inequalities in Ireland and their findings are worthy of serious attention. These include:

- Between 1989 and 1998 the death rates for all causes of death were over three times higher in the lowest occupational class than in the highest
- The death rates for all cancers among the lowest occupational class is over twice as high as for the highest class; it is nearly three times higher for strokes, four times higher for lung cancer, six times for accidents
- Perinatal mortality is three times higher in poorer families than in richer families
- Women in the unemployed socio-economic group are more than twice as likely to give birth to low birth weight children as women in the higher professional group
- The incidence of chronic physical illness has been found to be two and a half times higher for poor people than for the wealthy
- Men in unskilled jobs were four times more likely to be admitted to hospital for schizophrenia than higher professional workers
- The rate of hospitalisation for mental illness is more than 6 times higher for people in the lower socio -economic groups as compared with those in the higher groups
- The incidence of male suicide is far higher in the lower socio-economic groups as compared with the higher groups
- The 1998 and 2002 National Health and Lifestyle Surveys (SLAN) found that poorer people are more likely to smoke cigarettes, drink alcohol excessively, take less exercise, and eat less fruit and vegetables than richer people. Poorer people's lifestyle and behavioural choices are directly limited by their economic and social circumstances
- On average 39 per cent of people surveyed in 2003 identified financial problems as the greatest factor in preventing them from improving their health. This is likely to have increased significantly since

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

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

These findings have been confirmed by subsequent studies.

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

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

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

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

Furthermore, they noted that "research has also established that the greatest determinant of health is the level of income equality in society. Societies with more equal distribution of income across the population have higher average life expectancies and better health outcomes than less equal societies" (PHAI, 2007 p8).

It is the nature of these inequalities and the fact that they are so interconnected with the social, economic and political environment of Ireland that places this issue as central to the agenda of *Social Justice Ireland*. Our annual *Socio-Economic Review* addresses each of these issues and many, though not all, are covered in this *Policy Briefing*. The 2011 *Socio-Economic Review*, 'A New and Fairer Ireland', is available on our website.

# Poverty and Health Status

The link between poverty and ill health has been well established by international and national research such as that outlined on page 2. Essentially, the poor get sick more often and die younger than those in the higher socio-economic groups. Poverty directly affects the incidence of ill health; it limits access to affordable healthcare and reduces the opportunity for those living in poverty to adopt healthy lifestyles.

Earlier this year we published a *Policy Briefing* on poverty and income distribution which explored the nature and consequences of poverty in some detail. However, table 1 summarises the key trends over recent years.

As the Irish economy boomed in the late 1990s many fell behind and the numbers living in poverty (below 60% of median income - approximately €222 per week for an adult in 2011 terms) increased. In recent years as social welfare payments increased poverty decreased once again reaching 14% in 2008. However, as table 1 indicates many still live on a low-income according to the most up-to-date data available from the CSO which is for 2009. In that year almost 630,000 people lived below the poverty line.

Aside from the aforementioned impacts of such national income divisions (see p2) two further studies reflect the implication of these poverty levels.

- A 2006 study of the accessibility of healthcare in Ireland found 18.9 per cent of Irish people indicated that cost had deterred them from visiting a GP and seeking medical advice. Clearly, healthcare exclusion is a major dimension of poverty and social exclusion.
- Irish males have a life expectancy of 76.8 years while Irish females are expected to live 4.8 years longer reaching 81.6 years. While these figures are similar to the EU-27 average they are 2-3 years below the levels achieved in countries such as Spain, France and Italy.

**Table 1: The numbers of people in poverty in Ireland, 1994, 2004 & 2009**

| | % of persons in poverty | Population of Ireland | Numbers living in poverty |
|---|---|---|---|
| 1994 | 15.6 | 3,585,900 | 559,400 |
| 2004 | 19.4 | 4,045,200 | 784,769 |
| 2009 | 14.1 | 4,459,300 | 628,761 |

# Ireland's Health Expenditure in an EU Context

Healthcare must be seen as a social right for all people. For this right to be upheld governments need to provide the required funding to ensure the relevant services and care are provided as required.

In table 2 we see that Ireland spends 7.6 per cent of GDP on health; well below the EU-27 average of 9.3 per cent. Less is spent on public and private health as a proportion of GDP than the majority of other EU-27 countries. In Gross National Income (GNI) terms this expenditure translates into a figure of 8.8 per cent (GNI is similar to the concept of Gross National Product [GNP] and has a similar value).

In comparison France spends 11 per cent, Germany spends 10.4 per cent and Portugal 10 per cent. Ireland has the twelfth lowest expenditure on health (measured as a percentage of GDP) according to EU-27 data, although this ranking position has been improving over time.

Healthcare costs tend to be higher in countries which have a higher old age dependency ratio. This is not yet so significant an issue for Ireland as the old age dependency ratio is extremely low (11.1 per cent are aged 65 yrs and over) compared to a much higher EU average.

However, this level of funding must be seen as inadequate in light of the fact that waiting lists, bed closures, shortage of staff and long-term care requirements continue to be issues in the health service today. Clearly, there are significant efficiencies to be gained in a restructuring of the Irish health system. However, as the population ages and demand for facilities increases, funding as a percentage of national income will have to rise posing challenges for both health policy and taxation policy in the medium to long-term.

**Table 2: EU-27 health expenditure as a percentage of GDP, 2007**

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

**Source:** CSO (2010) *Measuring Ireland's Progress*

# Primary Care - the cornerstone of the health system

Primary Care has been recognised as one of the cornerstones of the health system. Despite and indeed as a consequence of shrinkage in public finances, it is crucial that the health services, as far as possible, have a clearly defined model of care consistent with the provision of services in community based settings.

Community based health and social services must become more:

- **Accessible** and **acceptable** to the community they serve
- **Responsive to the needs** of the local community and its particular set of requirements
- Developed to a position of **dominance** in relation to acute hospital services and be accepted as the **primary** health and social care option to be accessed by the community
- Supportive to local communities in an effort to help **build values supportive of social development.**

This model of care can, if supported appropriately, help realise these goals in a reasonably short time period.

In the overall context of health service delivery, there will be a need to:

- Integrate the acute hospital care system
- Integrate the community-based service system
- Integrate both hospital and community systems to ensure that there is a consistent and seamless approach to service delivery where the person is at the centre of the service.
- Develop and enhance a social care model of service focused on supporting local communities in improving the overall health and wellbeing of the population.

**It is crucial that the health services have a clearly defined model of care consistent with the provision of services in community based settings.**

Currently the HSE is undergoing a process of transforming all primary community and continuing care services into Primary Care Teams and health & social care networks on a geographic model basis. Primary Care Teams must be the *building blocks* of local community-based public health care provision.

Local communities will need to see the benefit of such a change in approach to health service delivery through:

- Improved access to services including more professionals working in the community and available for extended working hours.
- Improvement in quality of services
- Accessibility to a greater range of health and social care services within the community including services currently only provided in acute hospital settings e.g. diagnostics.
- Defined care pathways between the acute hospital and primary care services
- Increased involvement in the planning of primary care services by the local community
- Increased emphasis on prevention, rehabilitation, and maintenance as well as the traditional focus on diagnosis and treatment.
- Utilising local needs assessments to support decision making.

# What is a Primary Care Team?

A Primary Care Team (PCT) is a team of health and social care professionals (catering for a population of 7,000-10,000 people) who work closely together to meet the needs of people living in a community.

These needs relate to both health and personal social care services. A fully functioning Primary Care Team would be a "one stop shop" where the person could access the appropriate service to meet the majority of his or her health and social care needs.

These professionals include GPs and their Practice Nurses, Community Nursing i.e. Public Health Nurses and Community RGN's, Physiotherapists, Occupational Therapists and Home Care Service staff. These provide the first point of contact when individuals need to access the health system. When fully developed, it is planned that there will be 518 PCTs covering the whole country.

PCTs should also closely interlink with other community based service providers ensuring that health and social care needs are provided to as many people as possible within the PCT setting. These include Speech & Language Therapists, Dieticians, Community Mental Health Nursing, Consultant Psychiatrists, Area Medical Officers, etc.

PCTs and the professionals working within them need also to have ongoing and significant contact, communication and inter linkages with other service providers in the geographic area including Housing Officers with Local Authorities, Probation Officers, Gardai and in particular Community Liaison Officers, Community Welfare Officers, principals of local schools, agency staff working to support school-going children and others providing services in areas such as social housing and disability.

There should also be a defined relationship with voluntary agencies and local groups who support various care group activities such as older people, day care services children, etc.

The overall focus should be to develop and enhance a social care model of service dedicated to supporting local communities in improving the overall health and social wellbeing of the population.

PCT's should provide a single point of contact for the person into the health and social care system. They should facilitate navigation *in, around and through* the system and processes. In this way they can ensure that primary care really is the cornerstone of the health system in practice.

# Developing Primary Care Teams (PCTs) in Ireland in 2011

Currently the development of Primary Care Teams is ongoing throughout the country. Some of the existing teams, particularly those that commenced in 2006/2007, are at a significantly developed level and have capability for managing complex care needs in the community in a coordinated manner. The challenge is to build in a sustainable approach to the ongoing development of all PCT's and to ensure a consistency in their approach to service provision with a focus on key outcomes. Therefore, a sustainable, performance-driven approach to management of PCT's needs to be significantly developed.

This needs to be approached through a review of the existing management structure as well as developing a focus on categorisation of PCT's in relation to their ever improving capacity to deliver services and to improve processes and performance etc. It should also be noted that development should always be in conjunction with expertise already in existence in the community.

Such a categorisation is set out below with regards to the various stages of development of PCT's.

**Primary Care Team: Category 1:**

Category 1 PCT's would have core membership of all the General Practitioner (GP) practices in the geographic area and also the key HSE professionals of Public Health Nursing, Physiotherapy, Occupational Therapy and Home Care Services.

A PCT local working group would be meeting on an agreed and regular basis.

It would have developed a work plan based on priorities identified following an assessment of health and social care needs for the particular area.

The work plan would include the objectives as set out by the PCT and would set out how these objectives would be enabled and by whom.

A Category 1 PCT would set out and plan activities in relation to public information sessions, health awareness activities and strategic alliances to be formed or developed with local community based service providers, with a view to facilitating community participation in the PCT process. These for example could feature and focus on the area of health prevention and health awareness in the local community.

The work plan would also feature specific dates for clinical meetings including all GP practices and key HSE professionals and would have a model in place by which such clinical meetings would agree on the clients to be discussed, the focus of the clinical meeting with regards to the development of specific care plans for complex cases etc.

**Primary Care Team: Category 2:**

Having completed and worked through the process outlined in Category 1, a Category 2 PCT would have developed a greater potential and ability to define responsibilities and be clearer on accountability in the delivery of services.

The PCTs would have commenced undertaking responsibilities outlined under the various clinical care programmes.

These PCT's would have identified from within the team, key leaders to deal with aspects of service delivery i.e. a professional who would develop and ensure a preventative programme was developed, interlinking with health promotion and other community and voluntary based providers in the area and to establish and strengthen this portion of the work plan.

Other key leaders would be involved in specific care planning for a number of complex care cases i.e. perhaps one Public Health Nurse would be taking responsibility for coordinating the care plan of a particular number of older people living alone with complex care needs or vulnerable in the community.

These PCTs would also have access to a suite of key information regarding performance which would be used for comparison purposes and also for ensuring that programmes of care were effective in relation to service delivery.

Category 2 PCTs would be developing a greater appreciation of the need to measure outcomes and interlink these with the use of the available resources i.e. the delivery of Home Care Services to mental health patients.

**Primary Care Team: Category 3:**

Following on from developing capacity as outlined in Category 2, Category 3 would see PCTs with a more sophisticated and highly developed work-plan.

This work-plan would embed the requirements of the clinical programmes, and the PCT would be in a position to deliver on it as planned.

The PCT would be functioning at a high level and would be focussing on the outcomes of the assessment of need to address identified gaps.

The PCT would be able to find resolution to many of the issues which would arise on a day to day basis e.g. have the ability to coordinate service delivery in a specific manner to particularly vulnerable clients and families.

PCT will have a developed relationship with the local community based on a two way consultation process and therefore will be more responsive to the needs.

**Primary Care Team: Category 4:**

Category 4 will be the fully developed PCTs, where the provision of service through a team process has been fulfilled, both in terms of culture and leadership. The person / local community will be the complete focus of service provision by the team. The local health and social care needs of the community will be predominant in the mindset of the team members and in the manner in which they deal with their workload.

The team will be able to self manage to a large degree, and will be focussed on better outputs, key deliverables and have a capacity and comprehension with regards to resource allocation and management within the teams and across the social care network to which they belong.

**Information Technology Required**

It must be acknowledged that to progress through the categories, the Primary Care Teams will need the support of Information Technology where key information related to patients and the community can be maintained and accessed on an ongoing basis. This IT process must be interlinked with the acute hospital system so that information on the patient is available and the Primary Care Team members can make informed decision about, and with, the patient. IT and administrative support must be seen as a significant requirement to deliver key outcomes in relation to the productivity of the team as well as providing information which will support decision making and access to the required services across the service.

# Mental Health: overview and areas of concern

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

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

Commitments in the 2011 *Programme for Government* offer hope that progress in this area will be made over the next few years. We welcome these commitments to better funding the sector and working to reduce the stigma of mental health and improve access to facilities and services for assisting those with mental health problems. *Social Justice Ireland* urges Government to continue to support progress in this area.

We also welcome the appointment of a Minister of State with responsibility in this area and trust it is an indication of the Government's serious commitment to addressing the needs that are clearly identifiable in this area of policy.

***Areas of concern in mental health***

There is a need for effective outreach and follow-up programmes for people who have been in in-patients institutions upon their discharge into the wider community. A stronger emphasis on the development of community services for all levels of mental health is urgently required and *Social Justice Ireland* hopes the new Government will honour its commitment to deliver this. While there has been some improvement in recent years, there is an issue with the lack of appropriate mental healthcare for all who need it, especially vulnerable groups such as children, homeless, prisoners, Travellers, asylum seekers, refugees and other minority/vulnerable groups. People in these and related categories have a right to a specialist service to provide for their often-complex needs.

## Suicide

A related problem to mental health is suicide. For many years the topic of suicide was one rarely discussed in Irish society and as a consequence the healthcare and policy implications of its existence were limited – thankfully this has begun to change. Table 3 shows that the number of suicides in Ireland has climbed over the last decade and the current recession has accelerated this increase. The table also shows that suicide is predominantly a male phenomenon with 80 per cent of suicide victims being male. When assessed by age group the data from the National Office of Suicide Prevention suggest that young people, and in particular young males, are the groups most at risk. Among this age-group in the population, suicide is one of the largest killers. Of course the statistics in table 3 only tell one part of the story. Behind each of these victims are families, communities and individuals devastated by these tragedies. *Social Justice Ireland* believes that further attention and resources need to be given to addressing and researching Ireland's suicide problem. As a society we need to become more aware of this issue and more aware of methods to prevent it.

**Table 3: Suicides in Ireland 2003-2009**

| | Males | Females | Total |
|---|---|---|---|
| **Year** | **Rate** | **Rate** | **No** |
| **2003** | 19.5 | 5.5 | 497 |
| **2004** | 20.2 | 4.3 | 493 |
| **2005** | 18.5 | 4.8 | 481 |
| **2006** | 17.9 | 3.8 | 460 |
| **2007** | 16.7 | 4.4 | 458 |
| **2008** | 15.0 | 3.8 | 424 |
| **2009** | 19.0 | 4.7 | 527 |

**Source:** National Office of Suicide Prevention
**Note:** Rate is per 100,000 of the population

## Older People/Mental Health

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

Significant investment has been made to develop services for older people. We welcomed the announcements of the introduction of "*A Fair Deal – The Nursing Home Care Support Scheme 2008*". This initiative has been activated but underfunded. It remains critical that sufficient capital investment is provided to ensure that the additional numbers of residential care beds are made available to meet the growing demand as identified. Furthermore, the focus on the development of community based services to support older people remaining in their own homes and communities for as long as possible is welcome. Improved funding is also required for home help services, day care centres and home care packages - areas that have received serious and unwelcome cuts in recent Budgets and we continue to advocate for these cuts to be reversed and these services enhanced. There is a real danger that one outcome of these cuts would see the service being nothing more than a B&B facility which would be a travesty of what was intended and, more importantly, of what is required.

# Key Priorities on Healthcare

**CORE POLICY OBJECTIVE**

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

- Recognise the considerable health inequalities present within the Irish healthcare system and provide sufficient resources to tackle them.
- Give far greater priority to community care and restructure the healthcare budget accordingly. Overall, government should ensure that at least 35 per cent of the non-capital healthcare budget is allocated to community care. In moving towards this target increased allocation should not go to the GMS or the drug subsidy scheme.
- Resource and implement the commitment to provide 500 primary care teams.
- Increase the percentage of the health budget allocated to health promotion and education in partnership with all relevant stakeholders.
- Address the serious problems with the annual budget for health. In particular ensure that government provides an adequate budget each year to cover the expenditure required and that the Department of Finance, the Department of Health, the Department of Children and the HSE co-ordinate on what exactly is to be delivered and how it is to be funded. A transparent and honest approach to the annual budget is required.
- Provide the childcare services with the additional resources necessary to effectively implement the Child Care Act.
- Provide additional respite care for elderly people and people with disabilities and ensure this is not compromised by the funding provided for the Fair Deal.
- Promote equality of access and outcomes to services within the Irish healthcare system.
- Ensure that structural and systematic reform of the health system reflects the key principles of the Health Strategy aimed at achieving high performance, person centred, quality of care and value for money in the health service.
- Develop and resource mental health services, and recognise that they will be a key factor in determining the health status of the population.
- Continue to facilitate and fund a campaign to give greater attention to the issue of suicide in Irish society. In particular, focus resources on educating young people in this context.
- Monitor and evaluate the National Health Reform Programme to ensure equity, people-centeredness, quality and accountability for all.
- Enhance the process of planning and investment so that the healthcare system can cope with the increase and diversity in population over the next few decades.
- Take a population health approach which is more beneficial and cost-effective in the longer term.

## Medical Cards: Reform Needed

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

The eligibility thresholds for full medical cards have not been raised but the numbers have grown because many newly unemployed people have seen their income slip below the threshold. The eligibility threshold for 'doctor-only' cards was raised in mid-2006 to a level 50 per cent above the standard medical card thresholds. As of December 2007 there were 75,542 doctor-only cards.

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

## A Key Role for Prevention

The old adage 'prevention is better than cure' has a lot of relevance to a country's approach to healthcare. Resources allocated to increasing public health and public knowledge of health and disease/infection prevention issues, can result in significant long term savings for the healthcare budget.

The World Health Organisation (WHO) applies the principles of, and strategies for, health promotion to a variety of population groups, risk factors, diseases, and in various settings. Health promotion, and the associated efforts put into education, community development, policy, legislation and regulation, are equally valid for prevention of communicable and non-communicable diseases, injury and violence, and mental problems.

Prevention should be a central issue in promoting health. To this end it is important to note that health is linked to a range of other issues and services. These include the basic rights to water, food and nutrition, education and information. Ensuring each of these is in place would go some distance towards ensuring that every person's right to health was respected and promoted and that prevention was a central component of such an approach.

# Problems with healthcare budget

For many years the healthcare budget gave cause for concern. At times it required supplementary budgets to fund end of year deficits. The situation in 2011 is especially difficult as the healthcare budget has been reduced dramatically.

For several years Government has provided an inadequate budget to cover the expenditure that is required to honour the commitments made for the provision and development of services. Likewise, it provided too little investment in infrastructure to enable the new model of healthcare to emerge.

Over the years Government has had a 'pass the parcel' approach to the annual budget in this context with a lack of clarity between the Department of Finance, the Department of Health and Children and the HSE on what exactly is to be delivered and how it is to be funded. For example, on at least two separate occasions funding was provided in the Budget to increase the number of primary care teams substantially. On both occasions that funding was reallocated in the course of the year by the HSE with the agreement of the Department of Finance; the investment in primary care teams suffered as a result. This approach is not acceptable; a transparent and honest approach to the annual budget is required. It is important that there be clarity about the cost of each programme and how this cost is being funded.

Efficiencies are required and getting value for money is essential. However this should be done without compromising the quality of the service. *Social Justice Ireland* continues to argue that there is a need to be specific about the efficiencies that are needed and how these efficiencies are to be delivered. Within this framework it would then be possible to insist, with credibility, on getting delivery in these areas.

We welcome the new Government's commitment to clarity and transparency. We look forward to seeing clarity and transparency in Budget 2012.

# Carers and the Cost of Caring

There are more than 160,000 carers in Ireland.

The 2006 Census shows that 4.8% of the population aged over 15 provided some care for sick or disabled family members or friends on an unpaid basis.

The work of Ireland's carers receives minimal recognition in spite of the essential role their work plays in society.

This is a hidden army of people contributing to Ireland's healthcare process but they are under great stress as the current economic crisis puts families under ever-increasing pressure.

The Carers Association has calculated that these carers provide 3,724,434 hours of care which is valued at €2.5bn annually. A National Carers Strategy has been promised for more than half a decade.

We strongly urge Government to finalise and publish this strategy as a priority. This could then provide a framework for addressing the needs of carers.

**Social Justice Ireland**

We're on the web
***www.socialjustice.ie***

**Recent Publications from *Social Justice Ireland***

- A New and Fairer Ireland: Socio-Economic Review 2011
- Policy Briefing on Work, Jobs and Unemployment
- Policy Briefing on Poverty and Income Distribution
- Analysis and Critique of Budget 2011
- The Future of the Welfare State (2010)
- Building a Fairer Tax System: The Working Poor and the Cost of Refundable Tax Credits (2010)

*All of these are available on our website at www.socialjustice.ie. Printed copies can be purchased from the Social Justice Ireland offices.*

**Support *Social Justice Ireland***

If you wish to become a member of *Social Justice Ireland* or make a donation to support our work you may do so through our website at *www.socialjustice.ie* or by contacting our offices directly.

*Social Justice Ireland* is a research and advocacy organisation of individuals, groups and organisations throughout Ireland who are committed to working to build a just society where human rights are respected, human dignity is protected, human development is facilitated and the environment is respected and protected.

**Social Justice Ireland**

**Arena House**
**Arena Road**
**Sandyford**
**Dublin 18**
**Phone: 01 2130724**

**Email: secretary@socialjustice.ie**

**Web: www.socialjustice.ie**

**Charity number: CHY19486**