SOCIAL JUSTICE IRELAND

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Social Justice Matters Policy Brief

Healthcare in Ireland

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'Social Justice Matters Policy Brief' is a series designed to provide independent and in-depth analysis on important social policy issues and to present policy options that should be prioritised in the coming years. This series is part of *Social Justice Ireland's* ongoing contribution to the public policy debate to ensure it focuses on what matters most to people who are poor or vulnerable or in need. Our aim is to improve public policy in order to improve society and the lives of people.

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Executive Summary

The current global public health crisis is unprecedented and has been termed the worst in a century. Ireland remains the only western European country without universal coverage for primary care.

Covid-19 has exacerbated many issues in society, not least when it comes to healthcare. According to data from the National Treatment Purchase Fund there were 178,064 people waiting for 18 months or more for outpatient's treatment in March 2021. Almost three in every 10 of the 628,756 people awaiting treatment that month.

One of the most obvious concerns about the Irish Healthcare system is to do with access. Ireland's health system ranked 22nd out of 35 countries in 2018, but on the issue of accessibility, Ireland ranked worst.

According to the latest available data 2,112 children and young people were awaiting supports from the Child and Adolescent Mental Health Service (CAMHS). Of these one in ten were waiting for treatment for 12 months or more. The number of children and young people waiting between six and 12 months for treatment increased from one in four in September 2018 and 2019 to one in three in September 2020.

Before the onset of COVID-19 the Irish public hospital system was already operating under pressure from high population growth and ageing, and because of system cuts to bed capacity in the preceding decade.

Certain groups continue to experience health difficulties and need a particular policy focus, and inequalities still need to be addressed as disparities, such as in life-expectancy, continue to be great between socioeconomic groups.

Introduction

This policy brief looks at the Irish healthcare system, both before and during the pandemic.

Healthcare services are fundamental to wellbeing - important in themselves and important to economic success in a range of ways, including improving work participation and productivity. Securing healthcare services and infrastructure is one of the key policy areas that must be addressed if Government are to deliver on the Programme for Government commitment of 'A New Social Contract' (Government of Ireland, 2020).

People should be assured of the required treatment and care 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, where people attach importance to the health service. Our health system, and its workers, have been placed under tremendous pressure due to the COVID-19 pandemic since March 2020. The pandemic has highlighted shortcomings in our healthcare system and significant additional resources have had to be provided since.

This briefing outlines some of the major considerations *Social Justice Ireland* believes Government should bring to bear on decision-making about the future of our health service.

1.1 Healthcare for All

Access to Healthcare

The current global public health crisis is unprecedented and has been termed the worst in a century. Ireland remains the only western European country without universal coverage for primary care (OECD, 2019). One of the most obvious concerns about the Irish Healthcare system is to do with access. Ireland's health system ranked 22nd out of 35 countries in 2018 (Health Consumer Powerhouse, 2019), but on the issue of accessibility, Ireland ranked worst.

That report notes that even if a waiting-list target of 18 months were reached, it would still be the worst waiting time situation in Europe. Irish hospitals are working near full capacity. The occupancy rate for acute care beds is among the highest in OECD countries, and while having a high utilisation rate of hospital beds can be a sign of hospital efficiency, it can also mean that too many patients are treated at the secondary care level (OECD / European Union, 2020). By comparison with other OECD countries, the share of the Irish population delaying, or forgoing, care is comparatively high (above 30 per cent) (OECD, 2019b).

Even if a waiting-list target of 18 months were reached, it would still be the worst waiting time situation in Europe.

Ireland's complex two-tier system for access to public hospital care means that private patients have speedier access to both diagnostics and treatment, while those in the public system can spend lengthy periods waiting for a first appointment with a specialist and for treatment. Official statistics suggest that an enormous 628,756 people were waiting for an outpatient appointment in March 2020 while 35,634 people were waiting for treatment as an in-patient or day case (National Treatment Purchase Fund, 2021). The COVID-19 pandemic may have contributed to the numbers on the waiting lists in 2020. However, as Table 5 shows, there have been very high numbers on waiting lists over many years.

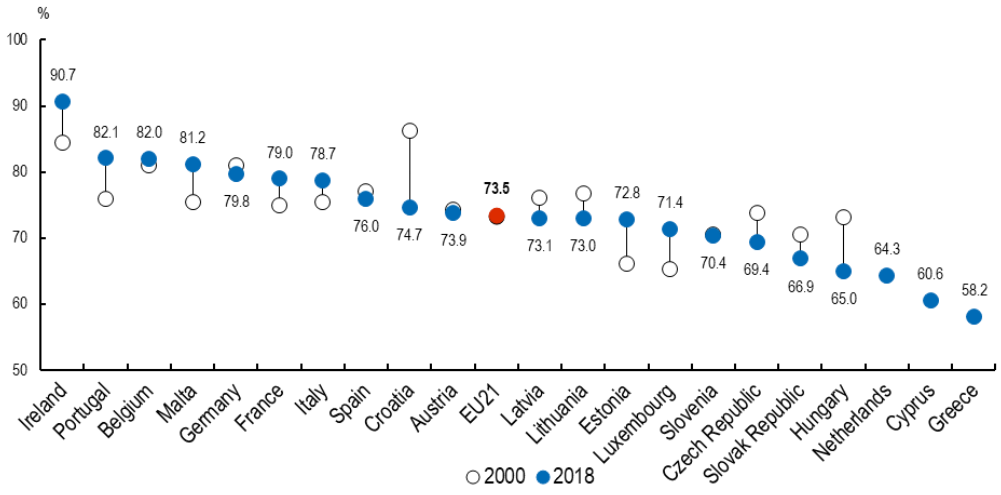
Those waiting for outpatient appointments in March 2021 numbered almost 630,000 an increase of 16,180 on November last year. Both the 2020 and March 2021 figures represent very large increases over the figure for the end of 2014. Those waiting for 18+ months numbered 178,064 in March 2021 (up from 156,955 in November 2020). The number waiting for in-patient appointments (35,634) in March 2021 was less than half the number of the previous November (when it was just above 72,000).

Occupancy and Acute (Hospital) Beds

Even though Ireland spends more per capita on health than the EU average (health spending is about one-fifth higher) (OECD, 2019), the number of beds per 1,000 population is considerably less than the EU average. In 2018, bed occupancy rates for curative (acute) care averaged 73 per cent across EU Member States, but they were 91 per cent in Ireland (OECD/European Union,

2020). See Chart 1.

Chart 1: Occupancy Rate of Curative (acute) Care Beds, 2000 and 2018 (or nearest year)



Source: OECD/European Union (2020) from OECD Health Statistics 2020 Eurostat Database. Note: The EU average is unweighted

This may signal over-reliance on the hospital or acute care sector. In fact, the OECD (2019) has highlighted how in Ireland many hospital admissions could be avoided (especially for chronic conditions like Asthma and COPD) if there were improvements in primary care.

Mental Health

According to the latest available data, the HSE Management Data Report for September 2020, 2,112 children and young people were awaiting supports from the Child and Adolescent Mental Health Service (CAMHS). Of these one in ten were waiting for treatment for 12 months or more. This is a slight proportionate decrease on the same period in 2019 when 11 per cent were waiting in excess of 12 months or more, and on September 2018 when the proportion was 13 per cent.

The largest proportionate change is in those waiting between six and 12 months, increasing from one in four in September 2018 and 2019 to one in three in September 2020. The proportion waiting six months or less decreased by six percentage points in the last number of years, from 64 per cent in September 2018 and 2019 to 58 per cent in September 2020.

A mental health crisis is likely to be a prevailing legacy from Covid-19, not just because of the immediate stress; but also the impact of the illness on those who contract it and their wider circle; the impact on healthcare workers and other frontline staff; and the impact on those who live in vulnerable households, including households with domestic abuse (Kelly, 2020).

1.2 Policies and Reforms

Poverty, Health and Life-Expectancy

Health is not just about healthcare. The link between poverty and ill-health is 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 like poverty, food security, social exclusion and discrimination, poor housing, unhealthy early childhood conditions, poor educational status, and low occupational status. In 2019 an OECD report again underlines that large inequalities in life expectancy exist by socio-economic status including education level, income or occupational group (OECD, 2019).

Health is influenced by factors like poverty, food security, social exclusion and discrimination, poor housing, unhealthy early childhood conditions, poor educational status, and low occupational status.

According to this report, on average across OECD countries, people without high-school diploma can expect to live about 6 years less than those with third-level education. People with low incomes are less likely to see a doctor while access to preventative services is systematically concentrated amongst the better-off.

Life expectancy is another area where there are differences between socio-economic groups. Overall, Ireland shows an increasing life expectancy since the 1990s (Department of Health, 2019). Life expectancy at birth stands at 84.1 years for women in 2018 (marginally above the EU-27 average of 83.6) and at 80.5 years for men (again, above the EU-27 average of 78.2 years) (Eurostat online database demo_mlexpec). The gap between male and female life expectancy has narrowed in the past decade - male life expectancy had been 5.3 years below female life-expectancy in 1997 (Department of Health, 2019). These are positive developments.

However, life expectancy differs based on socio-economic background (Central Statistics Office, 2019). For example, life expectancy at birth of males living in the most deprived areas in the State was 79.4 years in 2016/2017 compared with 84.4 years for those living in the most affluent areas. The corresponding figures for females were 83.2 and 87.7 years, respectively. The differential between female and male life expectancy was greatest in the most deprived areas.

Healthcare Model

The number of children with special needs at primary level in Ireland increased Problems with the Irish healthcare system are often apparent through difficulties of access though that is not the whole story. There are barriers in access to primary care, delays in Accident & Emergency Department admissions, and

waiting times for access to hospital care in the public system. International experts note that Ireland is the only EU health system that does not offer universal coverage of primary care and 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, 2014).

Significant efficiencies are possible within healthcare system – not least due to improvements in technologies. Experts in the area of health economics conclude that good versions of universal healthcare are affordable where services are provided efficiently (Normand, 2015). Obtaining value for money is essential, but efficiencies must be delivered without compromising the quality of the service and without disproportionately disadvantaging poorer people. As well as a debate on the overall budget for healthcare, there should be transparency on the allocation to each of the services. Approximately 55.2 per cent of the budget was allocated to Primary, Community and Continuing Care (in 2019), which includes the medical card services schemes (Department of Health, 2019, figure 6.2). *Social Justice Ireland* recommends an increase in this percentage and greater clarity about the budget lines. Ireland must decide what services are required, how these should be funded and prioritized (geographically and in other respects). Reform will require investment before savings can be made.

Primary Care

Countries with a strong primary care sector have better health outcomes, greater equity, lower mortality rates and lower overall costs of healthcare (Department of Health, 2016). The development of primary care teams (PCTs) and primary care networks across the country was intended to have a substantial impact on reducing problems within healthcare provision, and to shift from over-reliance on acute hospital services to a more community based model. The Primary Care Team is intended to be a team of health professionals that includes GPs and Practice Nurses, community nurses (i.e. public health nurses and community RGNs), physiotherapists, occupational therapists and home-care staff.

It was envisaged that 530 Primary Care Teams supported by 134 Health and Social Care Networks would cover the country (each to cater for 3,000-7,000 people). Community Healthcare Networks (CHNs) were subsequently envisaged as the fundamental unit of organisation for the delivery of community healthcare delivering services to an average population of 50,000 people (HSE, 2020). The allocation in Budget 2021, noted already, and the promised allocation for Budget 2022 will go a considerable distance towards ensuring the full roll-out of the CHNs.

The work done on existing centres and networks is welcome and *Social Justice Ireland* has acknowledged the commitment in Budget 2021 and Budget 2022 to community care and to development of Community Healthcare Networks. However, much more is needed to ensure that they are properly operational, staffed and integrated within the entire system. Without this they are unlikely to command the confidence and trust of local communities. *Social Justice Ireland* has called for the roll out of the full complement of CHNs intended, amongst other things, to support primary care teams. Greater transparency about their

planning and roll-out is also needed. A comprehensive plan for their implementation should be published. 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. *Social Justice Ireland* believes that an investment of €250 million over a five-year period is needed to support the infrastructural development of the PCTs and CHNs.

Mental Health

The estimated prevalence of mental health disorders is relatively high in Ireland compared with other European countries yet spending on mental health is relatively low (OECD, 2018).

By December 2018 there was a total of 1,687 staff in the General Adult Community Mental Health Service, which (according to the HSE) represents 74.8 per cent of the clinical staffing levels recommended in the 2006 policy roadmap A Vision for Change (HSE, 2018). Thus, unfortunately, the pace of implementation has been extremely slow. This is confirmed by the Mental Health Commission, which highlight how 'the current system is ad hoc, sporadic, lacks integration, and much of the mental health interventions are still linked to institutional care instead of community' (2020:3).

In 2019, the Inspector of Mental Health highlighted the continued lack of development of mental health rehabilitation services (rehabilitation in this context meaning an approach to recovery from mental illness that maximizes quality of life and social inclusion). One example relates to recommendations from A Vision for Change (2006) to develop 48 rehabilitation teams, whereas there were then (in 2019) only 23 poorly staffed teams (Finnerty, 2019). That report also considers it to be 'imperative' that funding is made available to implement a Model of Care for the provision of rehabilitation mental health services, rather than simply providing highly supported residential care.

Funding has been allocated in recent budgets for mental health services. *Social Justice Ireland* welcomed these allocations. However, progress in implementation has continued to be slow related partly to recruitment difficulties.

1.3 Policy Priorities for Healthcare

A number of the factors highlighted throughout this review will have implications for the future of our healthcare system, notably the projected increases in population and the ageing of our population. As an ESRI report concluded, two decades of rapid population growth, a decade of cutbacks in public provision of care and a consequent build-up of unmet need and demand for care, will require additional expenditure, capital investment and expanded staffing and will have major implications for capacity planning, workforce planning and training (Wren et al., 2017).

Social Justice Ireland believes that if the challenges we have highlighted throughout this paper are to be effectively addressed, Government's key policy priorities should be to:

Ensure that announced budgetary allocations are valid, realistic and transparent and that they take existing commitments into account.
Complete the roll-out of the Community Health Networks across the country and thus increase the availability and quality of Primary Care and Social Care services.
Ensure medical card-coverage for all people who are vulnerable.
Act effectively to end the current hospital waiting list crisis.
Create a statutory entitlement to Home Care Services. This will require increased funding, but will save the State money long-term, as home support allows people to remain living in their own homes, rather than entering residential nursing care.
Properly resource and develop mental health services, and facilitate campaigns giving greater attention to the issue of suicide.
Work towards full universal healthcare for all. Ensure new system structures are fit for purpose and publish detailed evidence of how new decisions taken will meet healthcare goals.
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 that structural and systematic reform of the health system reflects key principles aimed at achieving high performance, person-centred quality of care and value for money in the health service.

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