

Preface

The Adelaide Hospital Society exists to advance healthcare, seeking to ensure that healthcare is available to all based upon health needs and not on financial means. The Society believes in **Just Caring** which embraces both our ethic of care and our ethic of justice.

To be cared for by others, to need caring, is a permanent part of the human condition. To contribute to the development of a caring society is a responsibility of every citizen. Each person is dependent upon others to a greater or lesser extent throughout his/her life. Dependency is part of the human condition. It is a key part of responsible State action to ensure that social solidarity is developed in Irish society to ensure equal treatment and equal access to healthcare for every citizen. Caring is not a commodity to be bought and sold on the market in a civilised society.

The Adelaide Hospital Society is deeply committed to an ethic of justice. Proper healthcare is a human right and indeed such healthcare may be seen to underpin other human rights such as the right to life. It is manifest that many social groups and individuals do not receive proper healthcare in Irish society and thereby suffer a grave injustice. It is the responsibility of the State and all citizens to seek to address injustice and promote a more just and caring healthcare service.

This Policy Paper is a contribution directed towards evoking appropriate political and social responses in respect of Just Caring.

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Executive Summary

Purpose of Paper

This Policy Paper is focused upon equity and access in healthcare and, in particular, upon what may be proposed to address the current inequities and unequal access experienced in Irish healthcare. The Health Strategy, 2001 set 'fair access' as one of the four major goals of the Strategy. It is now clear that the Health Strategy proposals to achieve this are a failure. This key aspect of the Health Strategy urgently needs to be reviewed and a determined political effort made to address how it is to be achieved.

Policy Orientation: social solidarity

The key element in the optimum context for public policy aimed at redressing inequity and unfair access must be a public consensus about social solidarity in healthcare: this means social and political acceptance of the value that all citizens must receive equal care and treatment upon the basis of their healthcare needs rather than their financial means.

Policy Recommendations

1. Appoint a Minister for Population Health with Cabinet rank and reform the existing Department of Health and Children into a new Department of Population Health.
2. Appoint an Independent Expert Inquiry to report to the Oireachtas on health inequalities.
3. The Department of Finance should lead 'cross cutting' public expenditure reviews of the effectiveness of health and other public service expenditure in relation to the achievement of population health targets.
4. 'Design in' community and voluntary participation in healthy public policies and service delivery through using the provisions of the Health Act, 2004.
5. The ultimate goal of health reform should be the provision of a free comprehensive primary care service to the entire population. This should be achieved in planned stages. Immediately, medical card income guidelines should be raised above the poverty line for all households and there should be provision for free access to primary care for all children from 2007.
6. An objective system of assessment for access to publicly funded hospitals according to medical priority is essential. There is an urgent need for 3000 beds to provide appropriate hospital capacity in the Republic.
7. An urgent public debate is needed in respect of the public and private ownership of Irish hospitals.



Just Caring: Equity & Access in Healthcare

1. Introduction

1.1 This Policy Paper sets out some clear and positive recommendations to address health inequities as well as the lack of access to health services suffered by so many Irish citizens. These recommendations are set within a critique of the economic and social model being pursued by Irish society in respect of the health outcomes such a model produces. The policy recommendations, however, address inequities and lack of access in respect of:

- primary care
and
- acute hospital services

and how to build an effective infrastructure for

- population health.

The purpose of the Adelaide Hospital Society is to advance healthcare according to a clear set of values. We seek to ensure that healthcare is available to all based upon health needs and not on financial means. It is hoped that this Adelaide Policy Paper will be a significant contribution to achieving this.

1.2 'Policies that will make a difference ...' The purpose of this Policy Paper is to address the unfair, unnecessary and avoidable inequity of the Irish healthcare system. It is time to move from diagnosis to prescription in order to change the stark health inequities in Irish society. It is important at the outset to distinguish between the terms 'health inequalities' and 'health inequities'. 'Health inequality' refers to the difference in the prevalence or incidence of health problems between individual people of higher and lower socio-economic status and to any health differences arising from natural or other factors such as geography or age. 'Health inequity' refers to avoidable disadvantages experienced by citizens in attaining their full health potential in regard to such aspects as unequal access to available care for equal need, unequal utilisation of care for equal need, and unequal quality of care.

1.3 This Policy Paper is focused upon equity and access in healthcare and, in particular, what may be proposed to address the current inequities and unequal access experienced in Irish healthcare. The relationships between health, poverty and social exclusion have become more clearly established in both research and the policy literature (see *Health, Poverty and Social Inclusion in Europe Literature review on concepts, relations and solutions* by Ingrid Stegeman and Caroline Costongs, EuroHealthNet Brussels, September 2003). This Policy Paper concentrates on key policy changes that are required to make a difference now and in the period ahead. The focus is upon 'downstream' and 'midstream' interventions. 'Upstream' interventions and policies are those that target social disadvantage and thereby address the root causes of inequalities in health. They are matters for society as a whole and for Government policy in relation to the distribution of income and wealth in society; 'midstream' interventions involve public health and health promotion and seek to change everyday behaviour and habits which have a negative impact on health, particularly amongst poorer socio-economic groups; while 'downstream' interventions involve the health system directly as it provides medical services to people (see *Reducing Inequalities in Health A European Perspective* eds. J. MacKenbach and M. Bakker, Routledge, 2002).

1.4 The Adelaide Hospital Society organised a Public Conference on *Equity and Access in Healthcare* on 11th October 2003 and this Policy Paper draws upon the contributions made by a wide range of speakers, including Professor Richard Wilkinson, Professor of Social Epidemiology at the University of Nottingham Medical School and author of the landmark study *Unhealthy Societies: the afflictions of inequality* published in 1996. At the Conference the then Chairman of the Society, Mr Richard Greene, called for a 'common platform' to ensure inequities in healthcare are addressed – a platform that could be shared and promoted by many interested organisations in order to achieve change. This Policy Paper is a contribution towards the construction of such a 'common platform'. An excellent overview report on health inequalities has been published by the Public Health Alliance Ireland entitled *Health in Ireland – An Unequal State* in 2004 and it brings together baseline information on health inequalities in Ireland. It might be read in conjunction with this Policy Paper. A draft Discussion Paper on 'Equity and Access in Healthcare', prepared by the Health Policy Committee of the Society, was used as a background paper for an Adelaide Policy Seminar composed of experts and leading healthcare practitioners held on 4 November 2004. Professor David Hunter, Professor of Health Policy and Management at the University of Durham, provided a specialist contribution at this Seminar in relation to developments in the United Kingdom. Policy recommendations are required to address what is inequitable about the health inequalities evident in the Irish population. This paper briefly summarises the evidence from research and the current policy framework in Ireland in Section 2 and in the Appendices. In Sections 5 to 6, the Adelaide Hospital Society proposes key recommendations which amount to a prescription for change towards equity and access for all in Irish healthcare.

2. Background, Context and Research Findings

2.1 In 2001 *Quality and Fairness A Health System for You* (hereafter the **Health Strategy, 2001**) stated:

"Equity will be central to developing policies (i) to reduce the difference in health status currently running across the social spectrum in Ireland and (ii) to ensure equitable access to services based on need" (page 18).

As we approach halfway in the 7-10 year period for the *Health Strategy* little or no real progress has been made to translate this goal of equity into effective actions, much less to achieve it.

2.2 The main focus of public debate in the wake of the *Health Strategy* and subsequent reports has been upon the proposed structural reforms of the health system itself. Indeed the *Health Service Reform Programme* announced by the Government in June 2003 has, in effect, pushed equity down the reform agenda because of public controversy and debate about structural reforms including the new Health Services Executive. Therefore, it is imperative to bring forward clear and definite proposals which are designed to address the most serious defect of our health services: that as a society we provide healthcare according to financial means and social class rather than upon the basis of medical need.

2.3 **What does equity in healthcare mean?** Equity in health implies that every citizen should have a fair opportunity to attain his/her full health potential and that none should be disadvantaged from achieving this potential if it can be avoided. Equity includes

- equal access to available care for equal need
- equal utilisation of care for equal need
- equal quality of care for all

(see M. Whitehead 'The Concepts and Principles of Equity in Health' *International Journal of Health Sciences*, Vol 22 No 3, 1992, pp429-445).

The National Economic and Social Forum (NESF) in an important report *Equity of Access to Hospital Care* (Report No 25, 2002) stated:

"Equity in access to healthcare should mean access on the basis of medical need or capacity to benefit from care, and should not be affected by other factors such as ability to pay or where one lives."

2.4 It is not proposed to rehearse and analyse the detail in relation to the mounting evidence of inequity and unfair access in Irish healthcare. The various studies and reports are noted in the Select Bibliography and in the text. A brief summary is provided in the following paragraphs. Those interested in the detail are encouraged to read the literature and to study the methodologies used to obtain the evidence presented.

2.5 **What is the evidence for inequity and unfair access in relation to Irish healthcare?**

"... the primary determinants of disease are economic and social and, therefore, its remedies must also be economic and social" (G. Rose *The Strategy of Preventive Medicine*, 1992).

Research has now established that the greatest determinant of ill-health in society is the level of income inequality in society. Egalitarian societies have higher average life expectancies and better health outcomes than less egalitarian societies (see R. Wilkinson *Unhealthy Societies The Affliction of Inequality* (London, 1996) and R. Wilkinson 'Putting the Picture Together: Prosperity, Redistribution, Health and Welfare' in *Social Determinants of Health* eds. M Marmot and R. Wilkinson (Oxford, 1999)).

According to the UN's 2002 World Development Report, the level of income inequality in Ireland is second only to the USA among OECD countries. Ireland is consistently among a group of countries with relative income poverty rates considerably above the European Union average (though not as high as the USA). This has not changed during the recent years of economic prosperity; indeed our relative income poverty rates have generally risen over those years (see T. Callan, M. Keeney, B. Nolan, B. Maitre *Why is Relative Income Poverty So High in Ireland* Policy Research Series No 53, September 2004). Death rates caused by alcohol, violence or accidents tend to be strongly related to income distribution and to reflect the effects of increasing income inequality in society. In brief, social exclusion and low social status are major sources of stress, which is chronic in relatively less well off socio-economic groups. A survey of Tallaght's people, for example, revealed very high levels of stress: 59% of primary or principal carers surveyed had experienced stress in the year prior to the survey and, of those, 35% consulted their general practitioner because of their stress and 19% of them had received prescribed medication (see *People Living in Tallaght and their Health A Community Based Cross-Sectional Survey*, Report prepared for The Adelaide Hospital Society by the Department of Community Health and General Practice, Trinity College, Dublin, 2002). Chronic stress affects the endocrine and immune systems and leads to greater vulnerability to illness. Close-knit, egalitarian and inclusive societies are comparatively much healthier. Therefore, economic and social policies, such as taxation policy, should be used to promote an egalitarian and inclusive society and in the longer term this will result in a much healthier society.

The corrosive effect of the growing income inequality evident in Irish society on the quality and duration of life is evidenced by both comparisons with other EU countries and in the current figures for alcohol and drug abuse, violence and the disregard generally for human life and well-being; the latter is graphically illustrated by road deaths and injuries. For example, alcohol-related problems cost the Republic over €2.6 billion in 2003 (Dr Joe Barry, *Irish Medical Times*, 10 December 2004). Therefore, closing the income inequality gap in Irish society is a key 'upstream' policy if it is desired to reduce the differences in health status across the social spectrum (see E. Van Doorslaer and A.M. Jones 'Income-Related inequality in health and healthcare in the European Union', *Health Economics*, Vol 13, 2004, pp605-608 and E. Van Doorslaer and X. Koolman 'Explaining the differences in income-related health inequalities across European countries', *Health Economics*, Vol 13, 2004, pp609-628 which shows that significant inequalities in health (utility) favouring the higher income groups persist in all European countries).

In recent years, key reports have documented the major avoidable, unnecessary, and unfair inequities in the distribution of healthcare resources which exist in Ireland. The degree of systematic inequity was highlighted in the first *Annual Report of the Chief Medical Officer (CMO)*, Dr James Kiely, in 1999. Dr Kiely drew attention to the pervasiveness and magnitude of occupational class health inequalities in Irish society. These profound inequalities have been further documented by the Institute of Public Health in Ireland Report *Inequalities in Mortality 1989-1998* published in 2001. From these reports, in simple terms, we learn that the poorer social groups suffer more illness and die younger than the better-off social groups; in both jurisdictions on the island the all-cause mortality rate in the lowest occupational class is 100%-200% higher than the rate in the highest occupational class. Socio-economic inequality is associated with poor health. The Irish experience in regard to health inequalities is significantly inferior to that of European Union member state averages. Yet we are now a well-off member of the EU.

2.6 Another key report *Inequalities in Health in Ireland – Hard Facts* published by The Department of Community Health and General Practice, Trinity College, Dublin in 2001 found, for example, that:

- unskilled manual male workers are **twice** as likely to die prematurely as higher professional men
- unskilled manual male workers are **eight** times more likely to die as a result of accidents than higher professional men
- there are strong links between socio-economic status and the incidence of psychiatric conditions – unskilled manual workers are almost **four** times as likely to be admitted to hospital for the first time for schizophrenia than higher professional workers
- unemployed women are more than **twice** as likely to give birth to low birth-weight babies as women in the higher professional socio-economic group.

2.7 The stark social consequences of such health inequalities have been documented by the Society of St Vincent de Paul (SVdP) in their publication *Health Inequalities and Poverty*, based on their experiences in seeking to assist the less well off social groups in Irish society. The Society poses a key question and gave a shocking answer:

"The question *in whose interest do the health services operate?* must be answered unequivocally – the Society knows that it is not in the interests of the poor and vulnerable."

2.8 As a result of detailed Reports, we now know that people in the lowest social income groups suffer worse health for all conditions than richer social groups and there is considerable evidence for geographic health 'black spots', which have increased mortality and morbidity associated with socio-economic deprivation. We know also that the less well off in Irish society have poorer access to health services: too many people cannot receive medical care when they need it, either because they cannot afford to access primary care or because they must wait as public patients for treatment in hospital. There is evidence that when public patients do at last obtain their hospital treatment, too much of their care is delivered by junior doctors in a consultant-led service. Private patients enjoy a consultant-provided service.

2.9 The NESF Report *Equity of Access to Hospital Care* considered "that structural change may be necessary to the current public-private mix in our system of hospital care to ensure that patients are dealt with on an equitable footing". The uniquely Irish 'two-tier' system of access and care remains grossly unfair: financial means determine access to medical care rather than access solely upon medical need. The Society of St Vincent de Paul has documented actual cases where finance determined such access.

The *Commission on Health Funding* Report in 1989 proposed a common waiting list for all patients based on medical need. It is clear that little progress has been made. The *Health Strategy, 2001* set 'fair access' as one of the four major goals of the strategy. It admits that the public-private mix "raises serious challenges, which must be addressed in the context of equity of access for public patients". It is already clear that the Strategy proposals in this regard are a failure: the proposed elimination of waiting lists by 2004 has not occurred and the measures proposed to achieve 'fair access' have either not been taken or will not result in 'fair access'. This goal of the Health Strategy urgently needs to be reviewed and a determined political effort made to address how it is to be achieved. The *Health Strategy* made no reference to the time spent waiting for first consultant appointment after referral by a GP or to the inequity between public and private patients in the waiting times for initial specialist appointments which also needs to be addressed in such a review.

Box 1: Summary of Health Inequalities

Until the early 1990s, little work had been published on socio-economic differences in health in Ireland. However, a large number of reports in recent years have addressed the issue and identified a number of concerns.

- The Institute of Public Health in Ireland has highlighted the pervasiveness and magnitude of occupational class mortality. Its report, *Inequalities in Mortality. A report on All-Ireland Mortality Data*, based on data for the ten-year period 1989-1998, has shown that the all-cause mortality rate in the lowest occupational groups was 100-200 per cent higher than the rate in the highest occupational group. These occupational class gradients in mortality were present for all major causes of mortality: cancers, circulatory diseases, respiratory diseases, injuries and poisonings.
- The Institute's report also highlighted the existence of gender differences in mortality. The all-cause mortality rate for men was 54 per cent higher than for females in the ten-year study period. This gender gradient in mortality was present for cancers, circulatory diseases, respiratory diseases, injuries and poisonings.
- Examination of routine health information systems over the past 20 years has demonstrated a higher mortality rate in unskilled manual men compared to higher professional men. Over this time period, unskilled manual men were also eight times more likely to die from accidents than were higher-professional men.
- Such occupational class mortality is evident from birth. Perinatal and infant mortality rates are higher in families where the father is an unskilled manual worker or is unemployed.
- Five years' (1991-1996) data from the National Psychiatric In-Patient Reporting System provided evidence of an increasing socio-economic gradient in incidence of all psychiatric conditions from professional to unskilled manual groups.
- Travellers have significant disadvantages in health status. Travellers of all ages have much higher mortality rates than people in the general population. Traveller women live on average 12 years less than women in the general population. Traveller men live on average 10 years less than men in the general population. In addition, Travellers experience higher rates of stillbirth, infant mortality and perinatal mortality.
- The health status of the adult homeless population is less than the population average. Homeless adults suffer from a substantially greater burden of ill-health including depression, hypertension, hepatitis, alcoholism and illicit drug use. Also, they experience huge difficulty in accessing the health services they require.
- The incidences of specific conditions, for example coronary heart disease and lung cancer, are higher in geographic areas that experience higher levels of socio-economic deprivation.
- Health behaviours also show a social class gradient. Adults and children in the lower socio-economic groups have significantly less healthy lifestyles (higher levels of smoking, higher body mass index and less healthy eating habits) than those in higher socio-economic groups.
- The prison population suffers from a disproportionately large rate of psychiatric and drug-related problems. All mental health indicators are much worse for prisoners than for the general population and are particularly high for female prisoners. Almost one quarter of this population suffer from a long-standing disability or illness that limits their activity.

Source: *Better Health for Everyone A Population Health Approach for Ireland* (Annual Report of CMO, 2001)

The lack of 'fair access' means people are dying unnecessarily. For example, we know that the mortality rate for the lowest occupational class for heart diseases is about 120% higher than for the highest occupational class. Access is one key factor to be considered in addressing this variation; there are substantial variations in the provision of diagnostic, therapeutic and rehabilitative services for coronary heart disease with the less well off having least access to such services.

- 2.10 In a pioneering paper, Richard Layte and Brian Nolan have examined 'Equity in the Utilisation of Health Care in Ireland' (see *The Economic and Social Review* Vol. 35 No 2 Summer/Autumn 2004). This paper analysed the extent of equity of health service delivery across income distribution in Ireland – that is the extent to which there is equal treatment for equal need irrespective of income. It sets out the complexities behind both the concept of 'equity' and the measurement of utilisation of services. It was found that almost all services, apart from dental and optical services, are used more by those at the lower end of the income distribution, but that this group also have the greatest need for healthcare. The comparison of health need to healthcare delivery across income distribution without standardising for confounding factors suggests that those in higher income groups receive more healthcare for a given health status, indicating inequity. Considerably more research is required to map equity or inequity in healthcare and to translate the findings into public policies which can be implemented.

2.11 European Union Policy Responses to Poverty and Health Inequalities

'Socio-economic factors are to be considered in all actions aimed at lifestyle-related health determinants ...'
EU Public Health Programme

The recent EU competence in public health is a most welcome development [Article 152 Maastricht]. The EU Public Health Programme 2003-2008 recognises the importance of tackling health inequalities and that joint approaches across sectors are required, in particular with regard to:

- Health policy (targeting of health services, public health, risk factors, determinants)
- Social policy (social inclusion, social care, living conditions)
- Employment policy (secure jobs, working conditions)
- Co-ordinated approaches across communities

(see M. Huebel 'The EU Context: Policy Responses to Poverty and Health Inequalities' in *Building Healthy Communities Putting Poverty and Social Inclusion at the Centre of Health Policy and Practice*, Combat Poverty Conference, 21 May 2003)

Of particular value is the programme of the European Commission in developing health indicators for the EU; we need comparable information on health and health-related behaviour of the population, on diseases and health systems.

Further information: www.europa.eu.int/comm/health/index_en.htm

3. Current Policy: the failure of implementation

- 3.1 Appendix 1 seeks to summarise and bring together stated Government policy as set out in *Health Strategy, 2001*, the *National Anti-Poverty Strategy, and Sustaining Progress 2003-2005*, the current national social partnership agreement.

It is important to record in detail the policies concerning 'equity' and 'access' in the *Health Strategy, 2001* as there is little point in calling for policies which are already in place: the point will be obviously to seek **implementation**. "... what is lacking is a coherent implementation and monitoring framework for embedding equity across the system" (Anna May Harkin *Equity of Access to Health Services some Relevant Issues in an Irish Context*, The Institute of Public Health in Ireland, May 2001, p2).

4. The 'Upstream' Context for Health Outcomes

- 4.1 It is valuable to categorise policy prescriptions to address equity and access in healthcare in relation to whether they are 'upstream', 'midstream' or 'downstream' proposals. Determined action is required in each category but the actors who must act are different according to whether the proposals are addressing the root causes of inequality in society ('upstream'), the general area of public health and promotion ('midstream') or more directly how healthcare services are provided ('downstream').

- 4.2 "Europe has a long history of developing social protection systems which are rooted in the egalitarian tradition. Healthcare is no exception and most European Union member states have long achieved fairly universal coverage for their populations for a rather comprehensive package of healthcare services" (E. Van Doorslaer, A.M. Jones 'Income-related inequality in health and healthcare in the European Union', *Health Economics*, Vol 13, 2003, p605).

There is clearly a need to reassess all public policies in Ireland in respect of whether and how effectively they are addressing the root causes of health inequalities in Irish society. As Dr James Kiely, Chief Medical Officer, stated in his 1999 Annual Report

"All policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities, and should be formulated in such a way that by favouring the less well off they will, whenever possible, reduce such inequalities."

To put in place such a routine system of public policy health equity evaluation will require that as a nation we create and develop a public consensus that all our citizens are entitled, as equal citizens, to universal and accessible healthcare upon an equitable basis. It will be necessary to change the paradigm which has developed in Ireland with our exceptional 'two tier' health system (from an EU perspective); the new paradigm of equity requires a new public culture of **social solidarity** as reflected in the European social model – the 'Berlin' model – rather than the 'Boston' model of emphasising private care and individual responsibility. The new paradigm will be built upon an emphasis upon the values inherent in social solidarity that healthcare is a social investment and a collective responsibility. It is not a 'commodity' to be rationed according to the income means of 'consumers'. The value and principle of social solidarity need to be vigorously reasserted in Ireland.

Box 2: Social Solidarity

The key element in the optimum context for public policy aimed at redressing inequity and unfair access must be a public consensus about social solidarity in healthcare; this means social and political acceptance of the value that all citizens must receive equal care and treatment upon the basis of their healthcare needs rather than their financial means.

This key element poses a real challenge for all political parties, for healthcare organisations, both statutory and voluntary, and for many other agencies, particularly those in the social partnership pillars as they negotiate future national agreements. It will require a real national debate on key questions such as:

- (i) Why is 'poverty' bad not only for the poor but for the better off social groups also? A greater public awareness of the ill-effects on Irish society generally, because of impoverished economic progress and unbalanced social development, of other people's poverty and consequent ill-health, is more likely to lead to healthier and more equitable public policies and the provision of resources they require.

- (ii) Why do we have such difficulty implementing the *Health Strategy 2001* and the equity policy goals it contains?

This may lead to a wider social consensus around social justice, an essential precondition to the implementation of more equitable policies.

- (iii) Why is primary care and public health so underdeveloped in respect of our health system?

Health promotion, prevention of illness and accessible primary care for all citizens depends upon a strong public consensus that (a) health is a national priority because of social justice and social solidarity and (b) the best health outcomes depend upon empowering citizens to take action in relation to their lifestyles and to enable them to adjust the risks to their health.

Given Ireland's state of economic and social development, it is clear that it has the collective resources to provide sufficient capacity to meet all the appropriate and reasonable health needs of all its people. It is not beyond us, as a nation, to achieve this in terms of both financial and organisational capacity if we have the commitment and the will to do so. Leadership is, however, required to change the paradigm so that particular interest groups with a vested interest in the current arrangements are led to place more premium on securing better health outcomes for all citizens than on protecting financial or other interests.

- 4.3 As egalitarian societies have higher average life expectancies and better health outcomes, then public policies should seek to build a more egalitarian society in Ireland (see par 2.5 above). Closing the widening income gap in Irish society is a key long-term 'upstream' policy approach if as a nation we desire to reduce the differences in health status across the social spectrum.

- 4.4 There are clear indications in our morbidity and mortality statistics that the present economic and social model being followed in Irish society is incompatible with the achievement of the optimum health outcomes. Healthcare organisations, such as the Adelaide Hospital Society, can do no more than point this out and encourage Government and the social partners to give greater attention to key 'quality of life' indicators in framing economic and social policies.

5. Policy Recommendations: 'Midstream'

- 5.1 *Policy Recommendations to develop effective population policies and an effective population health infrastructure*

What is population health? It is an approach to health that aims to improve the health of the entire population or sub-groups within the population. It involves the development of policies aimed at reducing health inequalities among population groups. It avoids relatively narrow biologically and individually focussed definitions of health and illness to embrace the social determinants of health and health inequalities which the Annual Report of the Chief Medical Officer 1999 states "are the most pressing issues facing us in the health field". The "external determinants of health include social cohesion and community networks, education, employment, food production, housing, water and sanitation, transport, and health services. Of the external factors, socio-economic status and, in particular, poverty are among the most powerful influences affecting good health. There is a clear social class gradient for the major causes of mortality, with those at the lowest socio-economic level suffering most" (*Better Health for Everyone* p.12). Population Health has emerged as a major element in the current health reform process with key units being proposed for the restructured Department of Health and Children and the Health Services Executive.

- 5.2 It is imperative to develop a population health infrastructure as a central part of the Irish health system. Such an infrastructure will require very high level political, administrative and financial support with effective links between the policy oriented Population Health Division of the Department of Health and Children and the delivery oriented Population Health Units of the Health Services Executive. The Annual Report of the Chief Medical Officer in 2001 stated (page 19):

"The development of the proposed Population Health Division within the DOHC and its equivalent within the health boards will give sharp focus within the health system to promoting ... cross-cutting intersectoral issues, with the ultimate objective of reducing health inequalities".

5.3 Policy Recommendation 1:

Appoint a Minister for Population Health with Cabinet Rank and reform the Department of Health and Children into a new Department for Population Health

In order to give “sharp focus” to the developing Population Health infrastructure there is a need for a new Government Minister for Population Health with Cabinet rank with a ring-fenced financial budget to focus upon the wider determinants of health and to ensure intersectoral approaches are maximised. There is a new opportunity now to designate the current Department of Health and Children as the Department for Population Health as a key part of the reform of the Department underway as the HSE takes over responsibility for the delivery of health services. The new focus of the Department for Population Health ought to be to ensure attention to the broad social determinants of health across the whole range of Government responsibilities. An emphatic political response is required at Government level if a population health strategy is to be effective: ‘joined up’ government is particularly difficult as is evidenced by the experiences to date with the 10 ‘Special Initiatives’ in *Sustaining Progress* 2003-2005.

The 10 ‘Special Initiatives’ in *Sustaining Progress* 2003-2005 which involve cross-cutting issues and policy areas such as ‘Housing and Accommodation’; ‘Care – Children, People with Disabilities and Older People’; ‘Alcohol/Drug Misuse’; and ‘Ending Child Poverty’ indicate that barely a start has been made in respect of intersectoral approaches on the determinants of health among certain disadvantaged population groups.

In relation to these 10 ‘Special Initiatives’, the Government and the social partners identified a number of areas in national policy that require to be the subject of a sustained focus of effort in order to yield results. The learning in respect of these initiatives will require to be built upon. In respect of ‘Population Health’ approaches, it will be essential to develop from these initial approaches to encompass more effectively a range of statutory and voluntary organisations at national, regional and local level. As the Chief Medical Officer noted in 2001, it will require: “significant political commitment at national level, the support of government departments and the full involvement of the health system, including the voluntary sector ... intersectoral initiatives will require leadership, commitment, resources and accountability mechanisms. These measures will be required at national, regional and local levels. There is a need to strengthen and widen the partnership approach that encompasses the statutory and non-statutory sectors. Sustained partnership-building measures need to be identified and supported.” (*Better Health for Everyone* p24)

Underpinning a Population Health approach is the clear need for an intersectoral approach to public health. Our departmental and statutory agency structures are notoriously weak in respect of ‘joined up’ policymaking and implementation; as the Chief Medical Officer states, they “... may not easily accommodate interdepartmental collaboration. Even within departments, the divisional structures tend to favour vertical rather than horizontal communication.” (Annual Report, 2001 p23). The *Health Strategy* recommended a Cabinet Sub-Committee and its support structures as the most effective way of ensuring intersectoral co-operation. It does not appear that this has been either sufficient or sustained in recent years to ensure the required health outcomes.

5.4 Policy Recommendation 2:

Appoint an Independent Expert Inquiry to report to the Oireachtas on Health Inequalities

Important results would arise if the Government appointed an Independent Expert Inquiry to the Oireachtas in relation to Health Inequalities and how they might be more effectively addressed in public policies. An Expert Inquiry, made up of experts from bodies such as The Institute of Public Health, Economic and Social Research Institute and third-level institutions, could present to the Oireachtas for consideration the evidence on inequalities in health including the need for more research and data collection and thus raise political and public awareness and help point to effective policy responses in Oireachtas hearings based upon the Reports of the Expert Inquiry.

Public understanding of the causes of health inequalities

It is important that research is conducted into how people think about social inequalities in health as these perceptions will shape their responses to any proposed policy initiatives. What kind of causal attributions do they use; who or whom do they blame for ill health? (see Jennie Popay ‘Beyond Beer, Fags, Egg and Chips? Exploring Lay Understanding of Social Inequalities in Health’, Adelaide Hospital Society Conference, 13 October 2003).

Evidence suggests that all social groups tend to neglect structural causes of health and illness giving primacy to individual responsibility for health; that is, people will give more prominence to individual lifestyle factors than to wider structural factors including unemployment, low income, poor housing, unsafe roads and pollution. Indeed there may be a reluctance amongst people living in disadvantaged areas to accept the notion of inequalities in health between areas and social groups.

The importance of psychosocial pathways linking material and health disadvantage in seeking to bring about change is becoming evident but requires a great deal more research. This is particularly relevant to community-based strategies seeking health improvement.

An Expert Inquiry would be analogous in some respects to the UK Department of Health’s *Report of the Independent Inquiry into Inequalities in Health* (HMSO, London 1998). This evidence-based process would help underpin the Minister for Population Health’s task and the work of the emerging Population Health infrastructure.

5.5 Policy Recommendation 3:

The Department of Finance should lead ‘cross-cutting’ public expenditure reviews of the effectiveness of health and other public service expenditure in relation to the achievement of population health targets

For too long there has been a sterile debate about ‘how much’ the Irish health services are costing and whether the increases in health expenditure have been effective in relation to health services. The Department of Finance needs to take a much more developmental role in relation to public expenditure both in respect of sustained multi-annual funding and of ‘cross-cutting’ approaches to effective policy implementation. For example, in respect of health inequalities the Departments of State need to be able to demonstrate how their spending plans over time help in achieving the over-arching goals of reducing health inequalities as set out in national policy. Health Impact Assessment will be an effective tool in this regard as are cross-cutting spending reviews such as those conducted by the Treasury in the UK.

There is increasing awareness that systematic assessments of health effects are needed to inform the development of policies that may impact on health. Health Impact Assessment (HIA) has been developed as a way to systematically evaluate how policy decisions may affect people’s health so as to enable decision making that will promote a favourable and equitable health trend. The HIA process is set out in *Better Health for Everyone* Annual Report of the Chief Medical Officer, 2001 Appendix 2 (see also *Health Impact Assessment An Introductory Paper*, The Institute of Public Health in Ireland, 2001). The national *Health Strategy*, 2001 underlined the significance of HIA as a means of dealing with intersectoral policies which impact on health:

“Health Impact Assessment will be introduced as part of the public policy development process
The health impact assessment process identifies the factors which have a potential impact on health and it has the potential to bring greater transparency to the decision-making process by clarifying the nature of trade-offs in policy.

The Department of Health and Children will develop the ‘procedures, methods and tools by which a policy programme or project may be judged as to its potential effects on the health of the population and the distribution of those effects within the population’ (WHO, Regional Office for Europe, 1999) and will have a key role in supporting other departments and agencies in carrying out health impact assessment.” (*Health Strategy* page 61)

5.6 Policy Recommendation 4:

‘Design in’ Community and Voluntary Participation in Healthy Public Policies and Service Delivery through using the provisions of the Health Act, 2004

A radical new approach is required to release the potential of the very extensive community and voluntary healthcare sector in tackling health inequalities and securing equity and access to comprehensive health services. Such an approach involves the Department of Health and Children and the Health Services Executive specifically 'designing in' the contribution of the community and voluntary healthcare sector to policy formation and service delivery in partnership with statutory and other agencies. The sector must move from the margins to the centre if full public and patient participation is to be secured in order to address equity and access issues.

The Health Act, 2004, which establishes the Health Services Executive (HSE) states that in performing its functions and using "the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public" the HSE "shall have regard to services provided by voluntary and other bodies that are similar or ancillary to the services" which it is authorised to provide (Section 7, Health Act, 2004)

This is a clear legislative mandate for the HSE to capitalise upon the vast resources available to it in the extensive community and voluntary healthcare sector (O'Ferrall, 2000 and 2003). There is a current *Directory of Community and Voluntary Healthcare Organisations* published in 2004 by The Wheel. In addition, an electronic database for such healthcare organisations is maintained by The Wheel. These organisations are represented by the Health Spoke of The Wheel, which facilitates addressing common issues and building effective relationships with statutory agencies such as the HSE. Therefore, there is in place the consultative structures for the HSE to have full regard to the healthcare services provided by these agencies.

The Health Act, 2004 provides a statutory basis for 'designing in' the community and voluntary healthcare sector. Under Section 15, the Board of the HSE may establish committees "to provide assistance and advice to it in relation to the performance of its functions" composed of those who have special knowledge and experience. There is a clear need for an HSE Committee in respect of the community and voluntary healthcare sector. In addition in Part 8 of the Health Act, 2004 public representation and user participation is provided for in addition to the National Health Consultative Forum convened by the Minister. Section 43 allows the HSE to "take such steps as it considers appropriate to consult with local communities or other groups about health and personal social services". In parallel to the Regional Health Forums for local government there is a need for the HSE to establish Regional Community and Voluntary Healthcare Forums to provide public and patient participation in our health service provision and development. The *Community Participation Guidelines* published by The Health Boards Executive in 2002 provide a good basis to develop HSE structures for the participation of the community and, in particular, voluntary and community organisations in decisions about the delivery of health and personal social services. Such participation was a clear commitment of the *National Health Strategy 2001*. The aim should be to move the level of such public and patient participation in health up the ladder from mere consultation to actual involvement in determining priorities, assessing local needs and decision-making.

The achievement of equity and access in Irish healthcare depends in great part upon the HSE's imagination and ability to mobilise public commitment and support for the optimum promotion and protection of the health and welfare of all people. Community and voluntary organisations have a unique potential for such involvement at three levels:

- (1) for patients and their own care
- (2) for patients and the public about the range and quality of health services
- (3) in setting priorities and planning and organising service developments.

The value of greater public participation in healthcare has been increasingly apparent in healthcare studies (Chambers, Drinkwater, Boath, 2003) and may be set out as follows:

Benefits to public health

- Reduction in health inequalities
- Improved health
- Greater understanding of the links between health and the circumstances in which people live their lives
- More healthy environmental, social and economic policies

Benefits to communities and to society as a whole

- Improved social cohesion
- A healthier democracy – reducing the democratic deficit
- A health service better able to meet the needs of citizens
- More attention to cross-cutting policy issues and closer co-operation between agencies with a role to play in health improvement

Benefits to our health service

- Restoration of public confidence
- Improved outcomes for individual patients
- More appropriate use of health services
- Potential for greater cost effectiveness
- Contribution to problem resolution
- Sharing with the public responsibilities for healthcare

Benefits to people

- Better outcomes of treatment and care
- An enhanced sense of self-esteem and capacity to control their own lives
- A more satisfying experience of using health services
- More accessible, sensitive and responsive health services
- Improved healthcare organisations, a greater sense of ownership of the HSE and health service

Citizens need to be seen as partners in planning, providing and evaluating health services and in addressing health inequalities and in promoting openness and accountability. The Chief Medical Officer defines 'community participation' as "a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change". He goes on to state:

"The development of community involvement will require that human resource policy within the health system fully enables the health system to realise its potential involvement. Appropriate skills development and training will be needed by staff to facilitate community involvement in an integrated fashion within the health services. In addition to this, change management processes at all levels within the health system will have to facilitate and enable the realisation of the objectives of community involvement."

(Better Health for Everyone, pp40-41)

A key approach in developing people's capacities to address health inequalities and to secure more equal health outcomes is that of community development and community work. Such approaches require substantial investment based upon a social model of health inherent in community and voluntary participation and empowerment (see *Community Work Approaches to Address Health Inequalities Strategy Guide 7* published by the Community Workers Co-operative, Galway, 2004).

The White Paper *Supporting Voluntary Activity* published in 2000 set out how the Government would establish Voluntary Activity Units in all Departments having significant engagement with the community and voluntary sector. The DOHC has nominated a Voluntary Activity Unit, which has begun to engage in the issues with The Health Spoke of The Wheel. The commitment given by the Department of Health and Children in 2004 to the Health Spoke to establish a Voluntary Activity Unit with designated staff as part of the restructuring of the DOHC is a most welcome building block in 'designing in' the community and voluntary healthcare sector.

There is a commitment in *Sustaining Progress 2003-2005* that the learning from community participation in the context of the initiatives taken under the **Primary Care Strategy** will be used to inform models of participation appropriate to the wider **Health Strategy, 2001**. The former Minister for Health and Children, Mr Micheál Martin, TD, noted the fact that the UK *Cross Cutting Review on Tackling Health Inequalities* a joint Treasury and Department of Health Report – in its key findings on successful interventions, highlighted the importance of local community involvement in action if interventions are to have a long-lasting and sustainable impact:

I believe that such an approach is not only important in helping us to develop more responsive and quality conscious health services, but also has a role to play in creating the type of health supporting communities where people are sufficiently engaged in their society to care about what is going on and to feel empowered to try to influence it. (Minister's Address to Building Healthy Communities, Combat Poverty Conference, 21 May 2003).

The experience internationally bears out the role of civil society organisations as key stakeholders in attempts to achieve health equity and the importance of strengthening their capacity to influence relevant government policy and practice (see S. Nathan et. al. 'Closing the gap: building the capacity of non-government organisations as advocates for health equity' in *Health Promotion International* Vol 17 No 1 2002 pp69-78).

6. Policy Recommendations 'Downstream':

The ultimate goal of health reform should be the provision of a free comprehensive primary care service to the entire population.

6.1 Policy Recommendation 5:

The policy should be set that a free comprehensive primary care service will be developed in planned stages. Immediately medical card income guidelines should be raised above the poverty line for all households and there should be provision for free access to primary care for all children from 2007

This policy goal should be set because:

- primary care is the first point of contact that people have with health and personal social services
- primary care is the appropriate setting to meet 90-95 per cent of all health and personal social services needs
- effective primary care has the potential to prevent the development of conditions which require secondary care and it can also facilitate earlier hospital discharge.

As *Primary Care A New Direction* published as part of *Health Strategy 2001* states

"Primary care needs to become the central focus of the health system. The development of a properly integrated primary care service can lead to better outcomes, better health status and better cost-effectiveness. Primary care should, therefore, be readily available to all people regardless of who they are, where they live or what health and social problems they have" (page 7).

Access is not available even to a General Practitioner for many people much less to the comprehensive model of primary care as proposed in the *Health Strategy 2001*. The current very limited implementation of the *Primary Care Strategy* involving 10 implementation projects and a total extra funding of €8.4m in 2002 and 2003 was far too limited either in terms of the reform of primary care required or the scale of public investment needed to build the capacity required especially in socio-economic deprived areas. The current spatial distribution of GP practices and services indicates a huge concentration in better off areas of Dublin (Dr Joe Barry 'Inequalities in Irish Healthcare – the hard facts at local level' Address to Adelaide Hospital Society Conference, 11 October 2003).

To understand this lack of access the complex details of current eligibility for health services, including the medical card system, must be set out in a context of where poverty is defined in Irish society.

The *Health Strategy, 2001* promised new legislation to provide for clear statutory provisions on entitlements to health and personal social services. It admitted that the system of eligibility for services is complex and that criteria are not always clear-cut and that "there may be inconsistencies in eligibility for certain services between different health board areas" (*Health Strategy, 2001*). The objective according to the *Health Strategy, 2001* is "to move away from the rather theoretical model of 'eligibility' to a system of entitlement to services within a reasonable time frame".

There is an inappropriate 'Poor Law' heritage involved in the current system of eligibility for health services whereby the determination of eligibility category to which a person is assigned remains a matter for staff of the health services. The determination of "full eligibility" based on hardship grounds as set out in Section 45 of the Health Act, 1970, illustrates the 'Poor Law' mentality. The *Health Strategy 2001* commitment to introduce new legislation to provide for clear statutory provisions on **entitlements** to health services generally has not been delivered.

No such legislation or review has been published. The decline in the numbers covered by medical cards has been marked in Ireland. Medical card holders are entitled to a range of health services free of charge. These include doctors, drugs and hospital services. To qualify people have to have means below a certain limit.

It is important to set the issue of medical cards in the context of poverty in respect of weekly incomes.

Appendix 2: Medical Cards and the 'poverty line' sets out a summary of the key details

Twenty years ago in 1984, 37% of the population had medical cards. By 2003 this had dropped to about 31% of the population (see Table in Maev Ann Wren *Unhealthy State Anatomy of a Sick Society*, Dublin 2003, p375). The percentage of the population with private health insurance has risen from about 31% in 1984 to about 47% in 2003.

The figures given in *Health Statistics, 2002* for persons aged 18 and over classified by type of medical cover based on 2001 data show that:

25.9% have medical card cover only
46.1% have private health insurance only
2.1% have both
25.9% have neither

(Table D2 *Health Statistics 2002*, Department of Health and Children, p108)

These are alarming figures for the population with no medical cover: 43.5% of 18-24 age group and 33.7% of 25-35 age group have no medical cover. Figures show that between 1997 and 2003 the number of people with a medical card fell by 94,242. In 2003 alone, the number of people on medical cards fell by 10,602. Only in 2002, with the granting of cards to the over 70s, was there an annual rise in the number of medical card holders (*Irish Medical Times* Vol 38, No 18, 30 April 2004).

In relation to the most basic level of health care, the State pays GPs for the care of about 27% of the population on the very lowest incomes and has paid for the care of all over 70 year olds since 2001. For many others the cost of general practitioner care is a major barrier to access, compounded by the cost of medication. One visit to a family doctor costs one-third of the weekly income of an individual earning just above the threshold for a medical card (*Wren Unhealthy State* p204).

When the *Health Strategy 2001* was launched the Minister stated that he planned to extend medical card eligibility to 200,000 extra people from 2003. In November 2004 the Minister for Health and Children announced changes for 2005 in respect of medical cards. A further €60million was allocated to provide

- an estimated 20,000 medical cards to provide full cover; the general income guideline for current medical cards is being increased by 7.5% in 2005 compared with 2004
- an estimated 200,000 'GP visit only' medical cards for those whose income is 25% over the income guidelines for full medical card
- in respect of the means test the income allowance for each of the first two children will be increased by 20% and the allowance for the third and subsequent children will be increased by 30%.

Box 3: Suffering lack of Access

Letter to Irish Times: 26th August 2004

Medical Card Injustice

Madam, nearly 200,000 fewer Irish citizens qualify for a medical card on the basis of income than in 1997, once the 90,000 plus medical cards given to over-70s irrespective of income (many of whom did not need them) are discounted.

Our Government informs its citizens that this fall in medical card numbers reflects the growing prosperity of the nation. The evidence of my own eyes and ears daily contradicts this blithe dismissal of reality.

Yesterday (and not unusually) I saw the reality. A single mother, a patient of mine, has recently returned to the workplace full time. She has had a medical card with me since I started practice in 1995. She is obliged to work shifts and, as a result, pays for childcare for her son. The boy has a serious neurological condition and has required many surgical procedures. In addition his hearing is impaired.

For her labours she earns the princely sum of €340 a week before deductions and before childcare. She sought my help, being €70 a week over the income limit for a medical card.

My powerlessness to help her casts shame on us all as a civilised society and a wealthy nation.

Yours etc

Dr Ronald Boland
Blackpool, Cork

Prior to this announcement, 1,151,106 people were covered by medical cards, of whom 111,065 were over 70 year olds qualifying on age, not income, grounds out of a total population of 4.01m. That means that 1,040,041 people qualified on income grounds. In 1997, 1,252,385 people were covered on income grounds (Parliamentary Questions cited in *The Village* 12 November 2004).

The provision of medical cards to the over 70 age group in 2001 resulted in an inequitable agreement to pay dual rates to GPs. Doctors receive €480 annually for treating better off over 70 year olds and between €99 and €178 annually for treating 70 year olds who qualify on income grounds. The annual cost of the over 70s medical card was €153m (*Irish Medical Times* 12 November 2004).

One estimate of the cost of the provision of universal free GP care at the 2004 average cost per medical card patient is €717million p.a., which could be financed in a number of ways by way of general taxation or social insurance. (Maev-Ann Wren *Village* 6-12 November 2004).

In October 2004, the Comhairle Social Policy Report *The Medical Card Affording Health on a Low Income* identified the main problems with the medical card system as follows:

- Entitlement to a medical card is not clear and consistent
- The income guidelines are too low and are not linked to objectively established criteria
- The discretion available to health boards is not sufficiently publicised
- There is very little information available on how this discretion is exercised or on the numbers who have availed of it
- There is no independent appeals system.

In fact the nineteenth century 'poor law' heritage of our Irish health services means that health boards (and politicians who benefit from clientalism) exercise 'hardship' or 'deserving' tests which allocate medical cards in a way totally inappropriate for citizens in a modern republic.

Box 4: Medical Cards and 'Poverty Line'

A comparison of the medical card income guidelines with the income poverty line for householders illustrates the stark reality of the lack of access for the poorer income groups in Irish society. In 2004 a single person under 66 years was required to be below a weekly income of €142.50 to qualify for a medical card while the poverty line income figure in 2003 for such a person was €180.30. A couple with three children under 16 needed to be below €284.50 weekly income to qualify for a medical card while their poverty line income was €477.80. (see Appendix 2: Medical cards and the 'poverty line').

Associated with these financial barriers to accessing primary care is the geographical distribution of primary care services. Studies have shown that in areas of greatest concentration of lower socio-economic population groups, there are three times fewer GPs than in middle- and upper-class areas. The location of practices does not accord with the location of need. The fee-based economic incentives for GPs are so structured as to ensure that the less well off areas are under-provided.

It is urgent to reform medical cover and the fee-based structure of primary care. Pending the introduction of a comprehensive free primary care service, medical card income thresholds should be maintained above the poverty line (see Appendix 2: Medical Cards at the 'poverty line' pp-below) for all households and should provide for free access to primary care for all children. These ought to be but the first building blocks towards a free comprehensive primary care service for the whole population. The Government should appoint salaried general practitioners to provide the medical personnel for the new Primary Care Teams described in the *Primary Care Strategy* which needs to be rolled out rapidly throughout the country. This development needs to be urgently advanced as essential to a properly funded system of primary care. A comprehensive primary care system, without financial barriers to access, has the potential to revolutionise Irish healthcare. Comprehensive primary care is the cornerstone of an equitable health service.

6.2 Policy Recommendation 6:

An objective system of assessment for access to publicly funded hospitals according to medical priority is essential. Combined with this there is an urgent need for 3000 beds to provide appropriate hospital capacity in the Republic.

It is inequitable that patients in medically similar circumstances do not have equal access to services. In regard to waiting lists there must be an objective system of assessment for access to publicly funded hospital services. As

the Commission on Health Funding (1989) stated

This would relate to all planned admissions, whether to public or private accommodation, and would result in a common waiting-list from which cases would be taken in order of medically established priority rather than the type of accommodation sought. (1989: 239)

Waiting lists are **not** inevitable. France and Germany are examples of countries where waiting lists occur much more rarely than in Ireland. There is recognised in Ireland a serious lack of acute hospital bed capacity amounting to 3000 beds and it is imperative that investment is made to achieve the required capacity. In the meantime, whatever capacity exists should be shared equitably amongst all patients.

The *Health Strategy* adopted the following specific targets for waiting times:

- by the end of 2002, no adult will wait longer than twelve months and no child will wait longer than six months to commence treatment following referral from an out-patient department;
- by the end of 2003, no adult will wait longer than six months and no child will wait longer than three months to commence treatment following referral from an out-patient department; and
- by the end of 2004, no public patients will wait longer than three months for treatment following referral from an out-patient department.

The Capacity Problem in Irish Hospitals

In 2002, the Department of Health and Children published a key report entitled *Acute Hospital Bed Capacity National Review*. This found that the number of acute hospital beds per capita in Ireland is one of the lowest among EU and OECD countries at 3.1 beds per 1,000 population. Germany, for example, has over 7 beds per 1000 population. Inpatient hospital activity increased by 57% between 1980 and 2000 with a very big increase in day case activity by 2000. The average length of stay (ALOS) reduced from 9.7 days in 1980 to 6.6 days in 2002.

The figures cited above illustrate the **capacity** problem which is at the heart of the dysfunctional hospital system in Ireland: bed occupancy levels "are unacceptably high in the major hospitals: twenty-three hospitals have occupancy levels greater than an internationally recognised measure of full occupancy of 85%. Among these hospitals the average occupancy level is 95%; the range of occupancy levels is from 85% to 123%" (*Acute Hospital Bed Capacity* page 10).

The population in 1981 was 3,443,405 whereas the population in 2004 is 4,063,000 (est) and growing, so a greatly reduced hospital capacity has to serve nearly a further one half million people and an increasingly aging element in the total population. The *Acute Hospital Bed Capacity* stated in 2002:

"demographic projections for Ireland suggest that by 2011 the population aged 65+ will have increased by 20% from 421,600 to 503,900. By 2026 people aged 65+ will have almost doubled in number to an estimated 767,300 and will constitute 16.4% of the population. This is a factor of major significance in planning for the provision of acute hospital services."

It also pointed out that demand for healthcare is increasingly related to better education, increased expectations, economic prosperity and technological advances in healthcare permitting earlier and improved diagnosis and treatment. The National Review wisely noted that acute hospital care is just one component of the healthcare system and is dependent upon primary care, community services and specialist care services. It might have added that all of these other components remain highly deficient in Ireland, adding to the problems of lack of access to health services in Ireland.

The *Health Strategy* stated that acute hospital capacity will be increased by over 25% in acute hospital bed capacity and targeted more firmly towards acute public patients. The *Health Strategy* stated that 3000 new beds will be added to the health system over the next ten years, of which 650 would be provided in 2002. Not all these beds would be in the publicly funded hospital sector. In 2002, 200 beds in private hospitals would be contracted for public use. Beyond 2002, the document does not indicate when the remaining 2,350 planned beds will come on stream nor does it give any breakdown of how many of the remaining beds will be provided in the public sector and contracted from the private sector respectively.

Since the publication of the *Health Strategy* in 2001, funding has been provided to open an additional 900 hospital beds including the 700 beds provided under the bed capacity initiative in 2002 and 200 beds provided for as part of commissioning new units in September 2004; 300 further new beds are to be opened in 2005, and some further beds in respect of new acute medical units (see Parliamentary Questions reported in *Irish Medical Times* 10 December 2004).

Waiting Lists

The number of people on waiting lists (day cases and in-patients) at the end of December 2003 was 27,318. This includes 16,184 on the inpatient waiting lists and 11,134 on the day case waiting lists. As of December 31 2003, of the 12,054 patients on the speciality target list of the hospitals, 1,257 were waiting 2 years or more; 2,080 were waiting 12-24 months; 4,472 were waiting 6-12 months; and 4,245 were waiting 3-6 months.

The National Treatment Purchase Fund

The National Treatment Purchase Fund (NTPF) was established in 2002 to reduce waiting lists as quickly as possible. There is no doubt that this has ameliorated the situation for many who had waited too long for treatment. The NTPF has indicated that in:

January 2003 39% of patients waited over 12 months
16% of patients waited over 24 months

January 2004 20% of patients waited over 12 months
2.5% of patients are waiting over 24 months.

In May 2004 the Minister for Health and Children transferred the responsibility of publishing waiting list figures to the NTPF. The National Waiting List figure indicated in May 2004 by NTPF, after a validation process on the 27,318 patients on the list, was an estimated 22,818.

The NTPF reported in March 2005 that 27,000 patients had been treated under the NTPF since it was set up. From 2002 to February 2005, €63 million had been spent on buying surgical procedures in private hospitals for these 27,000 patients. In 2005, NTPF plans to spend a further €64 million to provide treatment for 16,000 patients (see 'Record of Treatment Fund Defended', *The Irish Times*, 24 March 2005).

The failure of the *Health Strategy*, 2001 to achieve the specific targets for waiting times underlines the necessity for adequate public hospital capacity to ensure both equity and access. The NTPF does not represent anything more than a temporary amelioration for those waiting longest for treatment; it ignores the complexity of particular cases, for example, of those waiting under the target times.

NESF

The concerns of the National Economic and Social Forum as set out in April 2002 in respect of this aspect of the Health Strategy in its key Report No 25 **Equity of Access to Hospital Care** are vital continuing concerns:

“Firstly, the Strategy only addresses one – very important – element of the time spent waiting on the pathway to care. Part of the problem facing public patients is lengthy waits for first consultant appointment after referral by a GP, but this issue is not recognised or addressed by the Strategy. At the very least those implementing the Strategy must be in a position to ensure that the waiting list targets are not met through ‘wait shifting’ – i.e. reducing waits between out-patient consultation and treatment by increasing waits between GP referral and out-patient consultation. This will require systematic measuring and monitoring of waiting at all points on the pathway to treatment. However, beyond this immediate issue the inequity between public and private patients in the waiting times they face for initial specialist appointments must itself be addressed.

Secondly, the commitment to timely access for public patients requires that policy commitments in this area must be underpinned by legislation. As noted above, the Strategy provides that public entitlements for those with and without medical cards will be clarified and codified in legislation, in terms of entitlement rather than eligibility. In our view it is essential, however, that this legislation should also guarantee rights to treatment within a reasonable period ...

In short, and in line with the recommendation of the UN Committee on Economic, Social and Cultural Rights, the objective should be that everybody has the opportunity for maximum health gain and enhancement through public policies, supportive environments, and access to appropriate services when needed.

Thirdly, as we have discussed above, the Strategy signals that public hospitals must give greater priority to timely access (i.e. within the targets set by the Strategy) for public patients, and achievement of this priority may sometimes require delaying private admissions. The Forum fully supports this approach. However, we are concerned that no specific commitment is made to ensure that all admissions to public hospitals – whether public or private – should be prioritised in accordance with medical need, and not that of ability to pay. In other words, we believe that at a minimum, access to public hospitals should be on the basis of a common waiting list, otherwise the underlying inequality in the system will continue.

Fourthly, one peculiarity in the Irish case, for example, is that the Government is turning to private suppliers to provide capacity for public patients, while dedicating some 20 per cent of existing public capacity to private patients. Greater use of private suppliers should not, however, be such as to undermine the primacy of the State's role in the provision of public health ... It would be essential, of course, that there should be uniformity in standards and that the same standards should apply both in the private as well as in the public sectors.

Fifthly, the Forum would emphasise the importance of adopting a fully-fledged partnership approach in the implementation of the Strategy, between providers, administrators and patients, and the involvement of the Social Partners. Facilitating and encouraging participation and involvement by the local community and voluntary groups are particularly important in this regard.

Finally, a broader but fundamental question about the Strategy's treatment of equity of access must be raised. If all the targets set out in the Strategy are achieved and maintained, the question remains does that constitute full equity of access to acute hospital care in Ireland? Equity of access has indeed been widely equated with shorter public waiting times, and the new Health Strategy carries this through to its logical conclusion. (It may not, however, do full justice to the concept.) Success in terms of the Strategy's targets would entail shorter waiting times for public patients – sometimes very much shorter – than at present, but public patients might well still have to wait longer for essential treatment than private patients and not necessarily be treated in the same way when in hospital.

This is currently seen by many as a result of the structure of the Irish public hospital system, with its unusual intermingling of public and private, which the Strategy essentially leaves unchanged. The Forum regards the current public-private mix as a significant issue in relation to equity and believes that there is a requirement to examine, taking into account the actions in the Strategy and the Report on Review of Bed Capacity in particular, structural change which may be necessary to ensure that patients are dealt with on an equitable footing, and that incentives to providers are clearly aligned with that perspective.”

Policy Recommendation 7:

An urgent public debate is needed in respect of the public and private ownership of Irish hospitals

A key challenge in current Irish health policy is to determine the extent to which our hospital services should be **public**, in the sense of being organised on a not-for-profit basis, or whether policy should encourage a **private** for-profit hospital sector. Current Government policy appears to favour the development of a private for-profit hospital sector but it is unclear how this relates to stated Government policy in the *Health Strategy* published in 2001 in relation to equity of access. There has been a recent boom in the building of private hospitals (see *Cheering Up the Patient Opportunities for Private Sector Investment in the Irish Healthcare Sector*—Goodbody Stockbrokers April 2005).

Different models of hospital services are possible including (i) State owned and managed (e.g. Connolly Memorial Hospital, Blanchardstown), (ii) voluntary not-for-profit (e.g. Adelaide & Meath Hospital, Tallaght), (iii) privately owned for-profit (e.g. Blackrock Clinic).

Hospital services in the European Union are provided under each of these models but countries like Holland rely heavily upon not-for-profit forms of governance. The Adelaide Hospital Society calls for a public debate and clarification of national policy in respect of whether a common provision of hospital services is to be provided by public hospitals or by a mix of public and private hospitals. Creeping “privatisation” of healthcare is not in the national interest because of the likely conflict in policy objectives and in particular those of equity and access. The current public-private mix in our public hospitals whereby 20% of the beds are designated ‘private’ is itself very problematic as has been noted. It is the State's responsibility to plan the national hospital network in the public interest.

There is a key principle at stake: the right of every citizen to have access to a common ‘basket’ of hospital services based upon medical need not financial means. Government is responsible for the vindication of that right for **all** citizens. It may well be that Government tax reliefs and indirect subsidisation of private for-profit hospitals (i.e. through favourable location on public hospital sites or through purchasing care for public patients on waiting lists) makes, good public expenditure and economic sense. However, the case has not been proven nor has Government set out clearly in policy such a case. There is a strong case for investing in and developing a network of public hospitals in Ireland committed to equal treatment and equal access for all citizens. Given the current confusion in Government policy, this case needs to be freshly articulated.

Irish healthcare has advanced in the past mainly through public voluntary teaching hospitals. These have the additional costs of education and research. Public hospitals alone provide accident and emergency services and will take every kind of patient no matter what their condition. Private hospitals for profit must make a return on investment for their investors and so will undertake hospital care that is ‘profitable’. It is possible to have public hospitals governed on a non-profit basis run as competitively and as efficiently as for-profit hospitals as international experience in USA and other countries demonstrates. It depends upon the funding arrangements which each State makes for healthcare: social insurance funds, for example, can ensure efficiency and competitiveness without a ‘profit’ being taken out of healthcare. Any ‘surplus’ on a hospital's activity may be re-employed in the development of its services. Any purchasing of hospital care from private for-profit providers should only be undertaken when it is clearly established that this is the optimum use of public funds and that it is also the highest quality avenue to vindicate the citizen's right to patient care. An urgent public debate should be followed by clarification of public policy in relation to Irish hospitals and their future development.

7. Conclusion

Summary of Recommendations: A Prescription for Change

7.1 Political will is essential to achieve change. Public support is vital if politicians are to have the will and courage to implement policies that bring change, combat vested interests and end fatalism and even apathy. It is to be hoped that many people and organisations will be able to voice strongly their support for the 'Prescription for Change' set out in this Policy Paper and thus help to create the necessary public support and political will. We see this 'Prescription for Change' as a dynamic one which will be developed as it is implemented so that the citizens of Ireland can come to believe that equity in, and access to, healthcare is indeed both possible and necessary for every citizen.

7.2 Summary of Recommendations: A Prescription for Change

Policy Orientation: Social Solidarity

The key element in the optimum context for public policy aimed at addressing inequity and unfair access must be a public consensus about social solidarity in healthcare: this means social and political acceptance of the value that all citizens must receive equal care and treatment upon the basis of their healthcare needs rather than their financial means.

1. Appoint a Minister for Population Health with Cabinet rank and reform the existing Department of Health and Children into a new Department of Population Health.
2. Appoint an Independent Expert Inquiry to report to the Oireachtas on health inequalities.
3. The Department of Finance should lead 'cross cutting' public expenditure reviews of the effectiveness of health and other public service expenditure in relation to the achievement of population health targets
4. 'Design in' community and voluntary participation in healthy public policies and service delivery through using the provisions of the Health Act, 2004.
5. The ultimate goal of health reform should be the provision of a free comprehensive primary care service to the entire population. This should be achieved in planned stages. Immediately, medical card income guidelines should be raised above the poverty line for all households and there should be provision for free access to primary care for all children from 2007.
6. An objective system of assessment for access to publicly funded hospitals according to medical priority is essential. There is an urgent need for 3000 beds to provide appropriate hospital capacity in the Republic.
7. An urgent public debate is needed in respect of the public and private ownership of Irish hospitals.

Appendix 1: Current Policy Overview

- 1 A central principle of current health policy as set out in the *Health Strategy 2001* is that of "equity and fairness". The concepts of 'health gain' and 'social gain' are stated to be key to the *Health Strategy* which adopts the definition of 'health' used by the World Health Organisation:

'a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity ... a resource for everyday life, not the objective or living; it is a positive concept emphasising social and physical resources as well as physical and mental capacity' (page 19).

The *Health Strategy, 2001* is based on a presentation of all the determinants of health, stating "to develop an effective health system, the determinants of health, that is the social, economic, environmental and cultural factors which influence health, must be taken into account" (page 15). The *Health Strategy* "recognises the value of investment in health, the benefits to be gained in, for example, overall economic development; and the potential to contribute to societal well-being by focusing on people's ability and willingness to work together for mutual benefit" (page 16).

- 2 Specifically the *Health Strategy, 2001* states in respect of 'equity' reiterating WHO:

"Everyone should have a fair opportunity to attain full health potential and, more pragmatically, no-one should be disadvantaged from achieving this potential, if it can be avoided. Inequity refers to differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust" (page 17).

The Strategy states

"People from the lower socio-economic groups suffer a disproportionate burden of ill health. The equity principle recognises that social, environmental and economic factors including deprivation, education, housing and nutrition affect both an individual's health status and his or her ability to access services. The equity principle underpins the National Development Plan and the need to address health inequalities in more radical ways than in the past was highlighted in the 1999 Report of the Chief Medical Officer.

Access to healthcare should be fair. The system must respond to people's needs rather than have access dependent on geographic location or ability to pay. A perceived lack of fairness and of equal treatment are central to many of the complaints made of the existing system. Improving equity of access will improve health by ensuring that people know what services they are entitled to and how to get those services and that there are no barriers, financial or otherwise, to receiving the services they need" (page 18)

- 3 In summary the *Health Strategy, 2001* stated

"equity means that:

- health inequalities are targeted
- people are treated fairly according to need" (page 17).

- 4 The *Health Strategy, 2001* summarised the evidence for inequalities in health status as follows:

Inequalities in health can exist for a variety of reasons, including geographical location, gender, age, ethnicity, hereditary factors and socio-economic status. Poverty, unemployment, education, access to health services and environmental factors including housing and water quality, all play important roles in determining the health of individuals. Disparities in health status within the population lead to consideration of the links between socio-economic factors and health. There are clear occupational class gradients in mortality:

- The Institute of Public Health (2001) has demonstrated that there was more than a three-fold difference in the age-standardised death rates between men in the lowest and the highest socio-economic groupings during the period 1989-1998. The strong impact of occupational class was evident for nearly all of the major causes of death. When the lowest occupation class is compared with the highest occupational class there are major differences in mortality.
- A Trinity College Dublin study on health inequalities demonstrated significantly higher mortality in semi-skilled and unskilled manual workers (TCD, 2001). This study showed that low birth weight was more likely in the unskilled manual and unemployed socio-economic group.
- The ESRI (Nolan, 1994) has demonstrated that perinatal mortality and low birth weight are associated with socio-economic background.

- Health inequalities are also evident in non-fatal but chronic disabling conditions. Psychiatric admissions can be used as an indicator of mental health and are more likely to be seen in the lower socio-economic groups (TCD, 2001). A recent ESRI study demonstrated that health status varies across occupational groups (Nolan, 2001). Adults in the lowest socio-economic group were twice as likely to report a long-standing illness as those in the highest socio-economic group (Nolan, 1994).
 - One group at significant disadvantage in health status is the Traveller community. The Travellers' Health Status Study demonstrated that life expectancy at birth for Traveller men was 9.9 years less than for settled men and 11.9 years less for Traveller women than for settled women.
- Other lifestyle factors and geographic location may also have an underlying socio-economic link. For example:
- The findings of the National Health and Lifestyle Survey (SLÁN) provides evidence of significantly less healthy lifestyles amongst lower socio-economic groups than those in higher socio-economic groups. (pp31-32).
- 5 In relation to 'access' the *Health Strategy*, 2001 stated:
- 'While individuals may be eligible for service, this does not mean that they will receive the services when they need them or in a reasonable timeframe. The situation is most evident in the hospital system where public patients may have to wait considerably longer than private patients for certain elective (non-emergency) treatment. It also arises where some community-based services are available to public patients in one part of the country but less available in another.
- The Strategy **must address the 'two-tier' element of hospital treatment where public patients frequently do not have fair access to elective treatment** [emphasis added]. All patients should have such access within a reasonable period of time, irrespective of whether they are public or private patients. Public patients should also have reasonable access to the range of publicly funded services irrespective of where they happen to live' (page 48)
- 6 In relation to poverty and health the *Health Strategy*, 2001 stated:
- 'Health follows a social gradient: poor people get sick more often and die younger. Chapter 2 has outlined how much wider than health services or genetic endowment are the determinants of health. It has been suggested by the Combat Poverty Agency (CPA) that poverty can reduce the opportunity or the motivation to adopt healthy lifestyles. In addition, poverty can make it more difficult to access or afford adequate or appropriate health care. As acknowledged by the CPA (2001), tackling health inequalities is inextricably linked with poverty. In devising the actions to tackle health inequalities for the Health Strategy, the Department has worked closely with the group working to review the targets for health for the National Anti-Poverty Strategy. The Strategy must also reflect the inter-departmental working required to tackle the link between poverty and other determinants of health, outside of health service provision' (page 56)
- 7 The *Health Strategy*, 2001 based on the preceding analysis set out above chose as one of four national goals 'fair access' which embraces these objectives:
- Eligibility for health and personal social services is clearly defined
 - Scope of eligibility framework is broadened
 - Equitable access for all categories of patients in the health system is assured (page 59).
- 8 The three other national goals are:
- Better health for everyone
 - Responsive and appropriate care delivery
 - High performance.
- Aspects of equity and access are also treated in the *Health Strategy* under 'Better health for everyone' which has as an objective that 'health inequalities are reduced'; the Strategy states:
- 'As outlined in Chapter 2, the most powerful influences affecting health and the promotion of health are socio-economic factors, in particular poverty. Every major health problem has a significant social gradient, with those at the lowest socio-economic level suffering most ill-health. This is supported by the findings of the first National Health and Lifestyle Survey (SLÁN). There is a need to build on the initiatives set out in the National Health Promotion Strategy, with a special focus on those identified as at risk in order to minimise the gap in socio-economic variations. This objective is about ensuring that disadvantaged groups get the help and support they need to ensure that everyone in society has an equal chance to achieve his or her full potential' (page 61).

- 9 In respect of reducing health inequalities the *Health Strategy, 2001* stated that 'a programme of actions will be implemented to achieve National Anti-Poverty Strategy and health targets for the reduction of health inequalities' and detailed the background as follows on pages 66-68:
- 'In 1997, the National Anti-Poverty Strategy (NAPS) was published. Under NAPS, all government policy is 'poverty proofed' to test if it reduces poverty or has an adverse impact on poorer people. Considerable progress has been made in reducing the level of poverty in Ireland over the intervening years. A commitment to review the NAPS and to set new targets in the areas of health and accommodation/housing was given in the Programme for Prosperity and Fairness.
- The Report of the Working Group on NAPS and Health identifies and maps the links between poverty and ill-health and provides the most appropriate framework for concerted action in addressing health inequalities.
- National Anti-Poverty Strategy: Health Targets**
- In NAPS targets have been chosen in relation to health status, equity of access and public policy in order to deliver improvement before 2007:
- | | |
|-------------------------|--|
| Health Status | <p>Reduce the gap between the lowest and highest socio-economic group by at least 10 per cent for circulatory diseases, cancers, injuries and poisonings by 2007</p> <p>Reduce the gap in life expectancy between the Traveller Community and the whole population by at least 10 per cent by 2007</p> <p>Monitor the life expectancy and health status of asylum seekers and refugees so that targets can be set for these groups. Monitor life expectancy and health status of Travellers so that targets can be reviewed and revised</p> <p>Reduce the gap in low birth weights between children from the lowest and highest socio-economic groups by 10 per cent from the current level by 2007.</p> |
| Equity of Access | <p>There should be equity of access to effective primary care services by 2007</p> <p>There should be equity of access to public acute hospitals by 2007</p> <p>There should be equitable access to available effective interventions for cardiovascular disease and cancer by 2007</p> <p>There should be increased equity of access to community supports for continuing care by 2007</p> <p>A comprehensive injury prevention strategy to reduce higher injury rates in people at risk should be developed by 2007.</p> |
| Public Policy | <p>It should be government policy for all relevant sectors to recognise and accept their responsibility for health by developing multisectoral working and the adoption of health impact assessment by 2007.</p> |
- The Report of the NAPS and Health Working Group envisages these targets being achieved through a series of actions related to the following:
- increased equity of access to primary health care services
 - increased equity of access to public hospital services
 - increased access to effective interventions for cardiovascular disease and cancers
 - increased equity of access to community supports
 - development of an injury prevention strategy
 - increasing the income threshold in the guidelines for the medical card, with a view to removing impediments to access to services and taking particular account of the needs of children
 - integrating an equality dimension into health and social service
 - development of a multisectoral approach to health and health impact assessment
- A key deliverable in relation to NAPS and health will be the putting in place of the indicator and research data needed to monitor and evaluate the NAPS health targets and to review existing targets and set new targets.

10 *The Health Strategy, 2001* set out initiatives to eliminate barriers in respect of disadvantaged groups:

'Personal and community health is the responsibility not only of government and other providers of health care but also of individuals and communities. Working in partnership with the consumer and community, the following actions will be undertaken to improve the health status of marginalised groups:

- Implementing existing policy on the prioritisation of health promoting activities for vulnerable groups (National Health Promotion Strategy 2000-2005)
- Identifying the barriers to the adoption of healthy lifestyles by those on low incomes and/or with low levels of education and developing effective intervention programmes to overcome those barriers
- Developing initiatives to assess the health information needs of local communities. Once those needs have been identified, information/education and preventive programmes can be developed and sustained locally with community support.

The Combat Poverty Programme 'Building Healthy Communities' seeks to fund innovation and capacity building in exploring the links between poverty and health and by encouraging community development responses. There are 13 projects in the Programme, an example of which is the Knocknaheeny/Hollyhill Project in Cork City. Such projects around the country were funded with small grants and in effect are pilot work in addressing health inequalities using community development approaches (see *Building Health Communities, Putting Poverty & Social Inclusion at the Centre of Health Policy & Practice*, proceedings of Combat Poverty Conference, 21 May 2003). The Programme is most welcome but with a funding budget of €180,000 for 2004 and individual grants not exceeding €15,000 it is far too limited given the scale of the need in respect of health and local populations.

A community development approach to health has an important role to play in involving people who experience poverty and social exclusion in changing their own situation and in shaping policy and practice. Combat Poverty Agency has defined community development as 'a process whereby those who are marginalised and excluded are enabled to gain in self-confidence, to join with others and to participate in actions to change their situation and tackle the problems that face their community'.

11 The 2001 Annual Report of the Chief Medical Office entitled *Better Health for Everyone A Population Health Approach for Ireland* is a very significant departure in Irish health policy, presented in the context of the *Health Strategy, 2001*. It elaborates on the concept of population health described in the *Health Strategy* and seeks to identify the changes required in this new approach.

What is population health? It is an approach to health that aims to improve the health of the entire population or sub-groups within the population. It involves the development of policies aimed at reducing health inequalities among population groups. It avoids relatively narrow biologically and individually focussed definitions of health and illness to embrace the social determinants of health and health inequalities which the Annual Report 1999 states "are the most pressing issues facing us in the health field". The "external determinants of health include social cohesion and community networks, education, employment, food production, housing, water and sanitation, transport and health services. Of the external factors, socio-economic status and, in particular, poverty are among the most powerful influences affecting good health. There is a clear social class gradient for the major causes of mortality, with those at the lowest socio-economic level suffering most" (*Better Health for Everyone* p.12). Population Health has emerged as a major element in the current health reform process with key units being proposed for the restructured Department of Health and Children and the Health Services Executive.

12 The *Health Strategy, 2001* set out the key elements in relation to Travellers' health: The Travellers' Health Strategy will provide a focused plan to improve the health of Travellers and will be implemented over the next seven years.

Travellers' Health Strategy – key elements

- Establishment of active partnerships between Travellers, their representatives and health service personnel in the provision of health services
- Provision of awareness training for health personnel in relation to Traveller culture, including Traveller perspectives on health and illness
- Strengthening of Traveller health units comprising health board staff and Traveller representatives with responsibility for planning and implementing the Strategy in each health board
- Development of initiatives to increase Travellers' awareness of general medical services and to make services more accessible having regard to the Traveller communities
- Provision of designated public health nurses in each health board to work specifically with Traveller communities
- Replication of the successful 'Primary Health Care for Travellers Project' which established a model for Traveller participation in the development of health services
- Promotion of various 'peer led' initiatives to strengthen the links between Travellers and various health services
- Establishment of a permanent liaison mechanism between the Department of Health and Children and the Department of the Environment and Local Government, to collaborate in efforts to improve Travellers' living conditions on halting sites

13 In relation to 'Fair Access', the goal of the *Health Strategy* is "concerned with making sure that equal access for equal need is a core value for the delivery of publicly funded services. Access in terms of timing and geographic location is also embraced by this goal" (page 74). The objectives in achieving this goal are set out as follows:

1. **Eligibility for health and personal social service is clearly defined**
'the objective will be to move away from the rather theoretical model of "eligibility" to a system of entitlement to services within a reasonable time frame' (page 74)
2. **Scope of eligibility framework is broadened**
'the objectives of the various schemes are (i) to provide free medical care for those people who are on low incomes; (ii) to provide some monetary relief to those with chronic illness or disability; and (iii) to provide support at particular times for vulnerable groups such as children and older people. **The number of people covered by the medical card scheme will be increased significantly** [emphasis added]. Income guidelines will be extended to cover more people on low incomes and targeted increases will be implemented to ensure that more children are covered. In addition a number of other schemes, including the Maternity and Infant Care Scheme, will be extended' (page 74).
3. **Equitable access for all categories of patients in the health system is assured**
"A core objective of the Strategy is that all people should have access to high-quality services ... it is clear that there are significant inequalities in the system at present which must be addressed, such as unacceptably long waiting times for public patients for some elective hospital procedures" (page 74).

There is also evidence that people have difficulties in obtaining timely, appropriate and user-friendly information about entitlements and how to access services. A more proactive approach to ensuring that people understand their entitlements will be developed. Other issues affecting people's ability to access services, transport to services, opening times, waiting times for appointments and appropriate waiting facilities are also dealt with.

- All patients should have access to a high-quality service, within a reasonable period of time, irrespective of whether they are public or private patients.
- Public patients should also have access to the same range of publicly funded services irrespective of where they happen to live" (page 74).

14 The *Health Strategy, 2001* set out detailed proposals for ‘strengthening primary care’ and a ‘new model’ for delivering primary care services in *Primary Care A New Direction* published as part of the *Health Strategy*. It stated that ‘primary care’ must become “the central focus of the health system” as it is “the appropriate setting to meet 90-95 per cent of all health and personal social services needs” (page 95). The equity and access deficiencies in these proposals are identified in the Section 6 of this paper.

15 The *Health Strategy* sets out measures:

“... to ensure that all public patients can expect the high quality of service within a reasonable period of time. **This includes a ten-year programme for the largest ever concentrated increase in public acute hospital capacity** [emphasis added].

In relation to the reform of the acute hospital system the *Health Strategy* set out how a new ear-marked Treatment Purchase Fund would reduce waiting times for public patients: the “target is that by the end of 2004, all public patients will be scheduled to commence treatment within a maximum of three months of referral from an out-patients department” (page 104). Section 6 below details the numbers treated by the National Treatment Purchase Fund to date. In relation to ‘equity’ it stated that the proposed extra acute beds in public hospitals will be designated for use by public patients; that greater equity for public patients will be sought in a revised contract for hospital consultants; that the rules governing access to public beds will be clarified and that “action may be taken to suspend admission of private patients for elective treatment if the maximum target waiting time for public patients is exceeded” (pp 107-108).

16 Subsequent to the *Health Strategy, 2001* the Government and the social partners agreed *Sustaining Progress 2003-2005* which contains an important section on ‘Health and Addressing Health Inequalities’. It was jointly agreed that “within the general policy framework of the National Health Strategy *Quality and Fairness* and the associated NAPS objective to reduce the inequalities that exist, the very substantial resources now being invested in the health services be used effectively to achieve measurable health and social gain” (page 58). There are further key commitments in relation to

(i) Health Impact Assessment

Health Impact Assessment (HIA), a process which takes social determinants of health into account, will be developed so that relevant policies, strategies and legislation undergo a comprehensive process of health proofing so that their impact on the physical, mental and social well-being of the population is positive.

(ii) Health Promotion and Education

Health promotion and education activities will be further developed, in partnership with the community, targeting specific areas such as smoking, healthy eating, substance abuse, sexual health and other lifestyle changes. Workplace health promotion, mental health promotion and the area of men’s health have been identified as three areas for further strategic development.

(iii) Access to Primary Medical Care

Those recommendations of the CEO’s Report on the *Medical Card Scheme*, which address issues such as barriers to the uptake, information deficits and transparency in relation to income guidelines, will be implemented in the lifetime of this Agreement.

(iv) Eligibility

As part of the implementation process for the National Health Strategy, a review of all existing eligibility legislation is ongoing in the Department. Arising from this review, legislation will be drafted to clarify and simplify eligibility and entitlements to health services in line with the goals and objectives set out in the National Health Strategy.

As of may 2005 these commitments have not been met.

17 *Sustaining Progress 2003-2005* in relation to the challenge of delivering “a fair and inclusive society” admits that “the challenge going forward is to ensure real and significant progress in relation to implementation”

Sustaining Progress 2003-2005 has ongoing quarterly reviews and underwent “a particularly critical review” in 2004 when the terms of the pay agreement fell due for consideration

“This will provide an opportunity to take stock of the environment, or progress achieved in relation to the overall goals of the Agreement and to consider any opportunities arising to refocus and reprioritise action as improvements in the overall economic situation and the availability of resources might allow” (page 18).

So far as health inequity is concerned, this opportunity was not taken.

Appendix 2: Medical Cards and the ‘Poverty Line’

1 The General Medical Service (GMS) was first introduced in 1972 and there was then a commitment that **40 per cent** of the population would be covered by this system. By 2003 this figure has decreased to approximately **27 per cent** of the population eligible for medical cards on income grounds. This includes the over 70s who are now eligible for a medical card irrespective of income, so the figures are much lower for those covered originally.

The Revised Medical Card Income Guidelines from 1 January 2005 set out below should be compared with the ‘poverty line’ based on weekly incomes. Many studies, including those by ESRI, suggest **a line which is half average (mean) income, adjusted for family size and composition**. Alternatives set at 40 per cent and 60 per cent of average income are also used to relate to policy concerning State supports.

2 It is worth setting out the conclusions of the CORI Justice Commission in the Socio-Economic Review entitled *Priorities for Fairness*, published in April 2004 (pp19-20):

“Using information gathered in the *Living in Ireland Survey* for 2001, the ESRI established that the income per adult equivalent averaged over households (the average income per adult in Ireland during 2001) was €313.06 (2003:11). Consequently, the income poverty lines for a single adult derived from this average were:

40 per cent line – €125.22 a week	50 per cent line – €156.53 a week	60 per cent line – €187.84 a week
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Updating the more generally accepted poverty line (i.e. 50 per cent of average income) to 2004 levels, using actual and predicted increases in average industrial earnings (CSO, 2002 and 2003; and ESRI Medium-Term Review 2003:49), produces relative income poverty line of €180.30 for a single person. In 2004, any adult below this weekly income level will be counted as being in poverty.

The Table below applies this poverty line to a number of household types to show what income corresponds to each household’s poverty line. The figure of €180.30 is an income per adult equivalent figure. This means that it is the minimum income that one adult needs to receive to be outside of poverty. For each additional adult in the household this minimum income figure is increased by €119 (66 per cent of the poverty line figure) and for each child in the household the minimum income figure is increased by €59.50 (33 per cent of the poverty line). These adjustments are made in recognition of the fact that as households increase in size they require more income to keep themselves out of poverty. In all cases a household below the corresponding weekly income figure is classified as living in poverty.

One immediate implication of this analysis is that most social assistance rates paid to single people are €45.50 below the poverty line.

The Minimum Weekly Income Required to Avoid Poverty in 2003, by Household Types	
Household Containing:	Poverty Line:
1 adult	€180.30
1 adult + 1 child	€239.80
1 adult + 2 children	€299.30
1 adult + 3 children	€358.80
2 adults	€299.30
2 adults + 1 child	€358.80
2 adults + 2 children	€418.30
2 adults + 3 children	€477.80
3 adults	€418.30

About a quarter of Irish households are below the poverty line and one in every five people in Ireland is living in poverty using the 50 per cent poverty line: this translates into 304,549 households and 720,765 persons living in poverty in Ireland." (*Priorities For Fairness*, p20)

3 The category of eligibility to health services to which a person belongs determines what services should be paid for and what services will be free of charge. There are two categories of eligibility as follows:

Category One:

Persons who are unable, without undue hardship, to arrange general practitioner services for themselves and their dependants. Such persons have full eligibility for all health services, and are issued with medical cards by the health boards and Eastern Regional Health Authority (ERHA). The health boards and ERHA fix income guidelines to help in deciding on applications for medical cards. About 27% of the population are in this category.

Category Two:

Anyone ordinarily resident in Ireland, who does not qualify for full eligibility, has limited eligibility. About 65% of the population are in this category.

Services

The following is a list of the main services which are provided under each category:

Category One:

- general practitioner and pharmaceutical services;
- free maintenance and treatment in public wards of hospitals;
- free specialist out-patient services at public clinics;
- free dental, ophthalmic and aural services

Category Two:

- maintenance and treatment in public wards of hospitals subject to a specified charge. There is a charge of €40 (from 1 January 2003) per day for in-patient treatment services in a public ward, which is subject to a maximum of €400 in any period of 12 consecutive months.
- specialist out-patient services at public clinics free of charge; persons who attend the A&E Department are subject to a specified charge;
- assistance towards the cost of prescribed medicines;
- general practitioner maternity and infant care services;
- free drugs for certain long term illnesses

The following do not have to pay any charges

- Medical Card holders
- Children referred from child health clinics and school health examinations
- Children suffering from prescribed long-term illnesses (generally speaking those who qualify for free drugs and medicines for the particular illness)
- Children up to the age of 6 weeks
- Women receiving services in respect of motherhood
- People receiving services for infectious diseases

Medical Card Income Guidelines, 2002–2005

	From 1st Jan 2003	From 1st Jan 2004	From 1st Jan 2005
Single Person Living Alone			
• Under 66 years	€138.00	€142.50	€153.50
• 66-69 years	€151.00	€156.00	€168.00
Single Person Living with Family			
• Under 66 years	€123.00	€127.00	€136.50
• 66-69 years	€130.00	€134.00	€144.50
Married Couple			
• Under 66 years	€200.00	€206.50	€222.00
• 66-69 years	€224.00	€231.00	€248.50
• 70-79 years	€447.50	€462.00	€497.00
• 80 years and over	€471.00	€486.00	€522.50
Allowances			
• Allowance for each child under 16 years	€25.00	€26.00	€31.50
• Allowance for dependent child over 16 years with no income maintained by applicant	€26.00	€27.00	€35.50
• Allowance for house expenses (rent etc): in excess of	€25.00	€26.00	€26.00
• Allowance for cost of travelling to work: in excess of	€22.00	€23.00	€23.00

In January 1997 there were 1,252,385 medical card holders. In September 2004 there were 1,151,106 medical card holders; that is 101,279 less people. The figures include the over 70s who are automatically entitled to a medical card since 2002. (Department of Health and Children figures, see 'Huge Medical Card Drop' *Health Supplement, The Irish Times* 5th October 2004).

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