National Women's Council in Ireland (NWCI)
Strategy on Health 2008-2010

Aim of strategy:
To achieve equal access to quality health care for all women in Ireland.

Introduction:
The health status and life expectancy of women in Ireland has improved dramatically in the last two decades. Alongside Ireland's economic development has come a significant improvement in health status.
Irish women live on average five years longer than Irish men. And both Irish men and women now live longer than the European average. Life expectancy for women is now 80 years of age, for men its 75.
However, while women live longer lives, they carry a disproportionately larger burden of ill health later in their lives, while women from lower socio-economic groups live shorter lives than those from higher socio-economic groups.
A broad range of factors outside of the health system determines women's health. These include income, wealth, educational achievement and opportunities, housing and employment status, access to recreation and transport, genetic, lifestyle and environmental factors.
Like every other country in the world, poorer Irish people experience poorer health. In Ireland women are overly represented in poverty statistics with more women experiencing and at risk of poverty than men. As poorer women have poorer health, they also have a greater need for health services.
Low income entitles 30% of the Irish population to a medical card. Medical card holders are entitled to "free" health care including access to GPs and prescribed medicines, as well as hospital care.
Combat Poverty's analysis of the 2005 EU SILC data estimates that 229,000 people at risk of poverty do not have medical cards, while 47,000 people in consistent poverty do not have medical cards. This is because the income thresholds for medical eligibility have not kept in line with inflation and social welfare rates.
Due to the way hospital services are organised in Ireland and the two-tier health system that exists, public patients have slower access to what can be essential or life saving diagnosis and health care than private patients.
Currently over half the population in Ireland has private health insurance which enables them access private health care in public or private hospitals quicker than public patients. The vast majority of medical card holders are public patients who are discriminated against in relation to access to specialist hospital services.
Susie Long personified the inequality in access to essential health care in Ireland. Despite numerous visits to her GP, Susie Long, a public patient had to wait seven months before she was diagnosed with stomach cancer. At that point her cancer was untreatable and Susie died a premature and perhaps unnecessary death within months of her diagnosis due to Ireland's unequal two-tier health system.
The NWCI advocates better health for all women, in particular women living in poverty or those who experience poorer health, however the focus of the

2008-2010 NWCI Health Strategy is to achieve equity of access to quality health care in Ireland.
NWCI believe that ensuring equitable access to health care is a crucial stepping-stone towards achieving better health for all women in Ireland.

Irish health policy:
Quality and Fairness, A Health System for You, 2001
Quality and Fairness, A Health System for You, is the blueprint for health policy and health service developments in Ireland. Although it was published seven years ago in 2001, it is still official statement of Irish health policy in Ireland. The commitments in Quality and Fairness include

- health care provided on the basis of need, not ability to pay
- an additional 3,000 hospital inpatient beds
- 5,600 extended care/community nursing units
- an end to waiting times of longer than three months for surgical and medical treatment by end of 2004
- a new model of primary care providing new multi disciplinary team based primary care service across the country
- increased staffing in the health services.

None of these commitments have been achieved.
There have been two major developments in the health services in the last seven years – the increased privatisation of health services and the establishment of the HSE – neither of which were outlined in the 2001 health strategy. (See health services section below for more detail)

The Primary Care Strategy, 2001
Within a week of the publication of the health strategy, a Primary Care Strategy was published. This detailed a plan for the development of state of the art primary care centres with multidisciplinary teams through out the country. Seven years later, apart from the ten pilot teams set up at the time of the launch, most areas of the country remain without primary care teams. While there has been a renewed interest in primary care since 2005 and there are commitments in Towards 2016 to have 300 teams in place by the end of 2008. Neither Budget 2008 nor the HSE's 2008 National Service Plan contains the required funding to ensure that these teams will be created by the end of 2008.
According to the HSE in May 2008, there are 60 teams in place and 90 teams will be up and running by the end of the year, 210 short of commitments made in Towards 2016 and the 2007 Programme for Government. However, according to the Irish Medical Organisation, none of the 60 teams in place are fully functioning ie they are short of many of the essential members of primary care teams, they do not work out of the same premises, the teams are much smaller than originally envisaged.

A Vision for Change, 2005
The first mental health strategy for decades – A Vision for Change was launched in January 2005 with the political promise of €25 million per annum to implement it.

A Vision for Change proposes significant changes and improvements in mental health services, with a move away from inpatient institutional care and an increased reliance on community services. The policy states that assets acquired from the sale of mental health lands should be reinvested in developing community mental health services.
An extra €25 million was to be allocated annually to fund new developments outlined in A Vision for Change. However, just €27 million of the promised €50 million was spent on developing new services in 2006 and 2007, while the remainder was used to "shore up budgetary overspends" by the HSE. The HSE Service Plan for 2008 shows that no additional funds have been allocated in 2008 for the implementation of A Vision for Change. The Independent Monitoring Group set up to oversee A Vision for Change said there was "an unacceptable delay between allocation of resources and recruitment of staff" in 2007.
Chapter 17 of A Vision for Change states there are "substantial resources… tied up in institutions and the release of these could form a significant part of the investment required in funding the new model of care".
Research carried out by the Irish Psychiatric Association shows that "there is systematic shredding of assets… with both lands and buildings in mental health services either being given away or being sold for under the market cost without any benefit to mental health services…".

The HSE Transformation programme 2007-2010
The HSE Transformation Programme outlines 13 different Transformation Priorities, with an emphasis on providing services in primary, community and continuing care rather than in acute hospitals. Central to this is the building up of primary, community and continuing care so that local people can have their health needs met outside of the acute hospital.
The north east region is the pilot area for the Transformation Programme. There are five hospitals in the north east, many of which have been beset by scandals such as the Michael Neary case, cancer misdiagnosis and deaths of patients due to restricted services being operated within hospitals. Services in Monaghan, Drogheda and Navan hospitals are being "down graded" without any apparent increase in primary and community care provision. This combined with a number of health scandals in the region has resulted in an absence of confidence in the HSE Transformation programme and campaigns in each county to save their local hospital.
The recent OECD Review of Public Management Ireland, 'Towards an Integrated Public Service' is critical of what's happening in hospital location and planning in Ireland. Using the North East as a case study it broadly welcomes the approach being taken but it is critical of the absence of reforms in primary care while the downgrading of acute hospitals is already taking place alongside the sidetracking of primary care budgets to hospitals. It strongly recommends the transfer of staff from hospitals to a community setting, the establishment of primary care teams and adequate provision of nursing homes and step-down facilities in advance of "reconfiguring" hospital services.
The OECD Report is also critical of the shortage of GPs and nurse specialists; the "general lack of awareness and information among the medical

profession" in the north east of the Transformation programme; and also suggests that drawing on international evidence there could two not one "regional' hospital in the north east.
In relation to budgeting, it says "the reconfiguration project is taking place within existing budgetary allocations. The total cost of reform needs to be anticipated, and the necessary funds and resources made available to support the appropriate sequencing of reforms".

The National Women's Strategy 2007-2016

Objective 8 in the National Women's Strategy 2007-2016 commits to "improve the health status of women in Ireland through gender focused policies". Specifically it commits to

- incorporate a gender dimension into health policy planning at the earliest possible stage of development eg cardiovascular strategy
- ensure ongoing redevelopment of the health services structures includes representation of women at all decision making levels
- update women's health structures in light of recent health reform in collaboration with the HSE and the National Women's Health Council target
- put in place health policies and service that allow women full access (eg transport, childcare/elder care privacy)
- Put in place health policies and services to support carers such as respite, counselling, information, financial security).

Objective 8b commits to improve the physical health of women in Ireland through improving cancer screening and services for women.
In particular, it specifies the extension of Breastcheck and cervical screening nationally, the treatment of women with breast cancer at specialist centres and a study of older women with cancer. It also seeks to reduce the numbers of women dying from cardiovascular disease.

While these commitments are welcome, there is no detail on who is responsible for their implementation or how they will happen eg in the old health boards, there were Women's Health Committees and Officers. These no longer exist but no new structures for women's health have been put in place by the HSE.
Meanwhile despite promises since 2003 that breast cancer screening would be available nationally, some parts of the western seaboard still remain without Breastcheck.

The National Action Plan for Social Inclusion 2007-2016

There are no specific targets on women in the 2007-2016 National Action Plan for Social Inclusion despite an over representation of women living in poverty.

Health services in Ireland

Hardly a day goes by without some aspect of the health services hitting the headlines. The old and the sick queuing on trolleys in Emergency Departments; increasing numbers of deaths in hospitals due to hospital borne infections; the misdiagnosis of cancer patients in Portlaoise and Co Louth; the absence of regulation of private hospitals; the unfair, long waiting times for diagnosis and treatment for public patients; the restructuring of the HSE; the

outsourcing of more and more parts of the public health service; the shortage of doctors; the cutbacks in services and embargo on staff; the location of regional hospitals, the new children's hospitals and specialist cancer centres; the list just goes on and on..

There is a huge public discontent with how health services are organised and provided in Ireland. There is a divergence between the content of health policy documents and what is actually happening on the ground.

Yet there have been two predominant aspects of health service developments in the last six years. The first is the increased privatisation of health services, the second is the establishment of the Health Service Executive. Meanwhile the two tier unequal system of health care prevails without any plans to provide equal access to health care on the basis of need.

Privatisation of public health care

In 2002, generous tax breaks to encourage the construction of private hospitals and nursing homes were introduced. Currently two thirds of all nursing home beds are in the private sector, which is still not independently inspected. At the moment, private nursing homes are inspected by the HSE which also contracts the beds in these homes. In 2008, the Health Information and Quality Authority (HIQA) is due to take over the inspection of all nursing homes.

In June 2005, Mary Harney announced the co-location scheme. This is a plan to build private hospitals on the grounds of public hospitals, thereby freeing up 1,000 beds in the public hospital system. Critics of the scheme see it as a further copper fastening of the two-tier health system exacerbating existing inequalities in access to health care and diverting much needed money away from the public sector.

In December 2007, the HSE advertised for expressions of interest from developers for over 100 primary care centres. GPs and developers will build the facilities with the HSE taking up to half of the floor space for their services. Again, this is contrary to the Primary Care Strategy published in 2001, which envisaged a network of HSE built and owned multi disciplinary teams in public primary care centres across the country.

The Health Service Executive

In the aftermath of the 2001 health strategy, a range of reviews were commissioned on the staffing, funding and structures of the health boards and health services.

In 2003, an administrative reform programme was published and on 1 January 2005, the eleven old health boards, the voluntary hospitals and a raft of other health agencies came under the management of one unified health service – the Health Service Executive.

One of the main rationales for setting up a single executive in the form of the HSE was to remove the interference of local politicians and ensure consistency and standards across all health services. After the local elections in June 2004, politicians were not reappointed to health boards. But it took two and half year before the HIQA was established to ensure consistency in quality and patient safety across all services and regions.

Three and a half years on from the setting up of the HSE, there are complaints of greater bureaucracy than ever before, of confusion over where and how to find a specific health service or manager, of increased top down, centralised decision making from Dublin.

The two tier health system

The health strategy 'Quality and Fairness' had equity ('people treated fairly, according to need') as one of its core principles. The 2002 and 2007 Programmes for Government also promised equity of access. Yet in 2008, public patients still wait longer for diagnosis and treatment than private patients.

While this has been the case for decades, Susie Long brought this issue to public and political attention. Susie Long was a public patient who had to wait seven months for a colonoscopy before being diagnosed with stomach cancer. As a result she started her cancer treatment seven month later than if she had been a private patient. This resulted in her premature death.

When Susie Long died in October 2007, Mary Harney assured the nation that lessons would be learnt. Yet recent figures show that in some hospitals public patients wait up to 18 months for a colonoscopy while private patents wait just days for such a procedure. Other HSE figures show that public patients can be waiting up to eight years to get an outpatient appointment with a specialist.

The experiences of public patients having to wait longer than private patients for diagnosis and treatment, the poor conditions in Emergency departments and public wards, the disconnect between the "down grading" of local hospitals without increased provision in primary and community care, cutbacks in home helps and home care packages, the uncertainty on the location of new regional hospitals and cancer centres of excellence, the misdiagnosis of cancer cases – are all contributing to a crisis in confidence in the health services.

NWCI advocates that only when there is equitable access to hospital and specialist care and the provision of high quality services to meet the health needs of the population will the public's confidence in the health services be restored.