Giving Health Inequality a Voice

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Executive Summary

EAPN Ireland sees at first-hand how the social determinants of health, poverty and ill-health intersect to create health inequalities. This report was commissioned to make those links apparent through listening to people in communities and proposing recommendations to improve the health outcomes of those we work for and represent by strengthening how our national health strategies address health inequalities.

The project is funded by the Irish Human Rights and Equality Commission and builds on the work of the Community Platform on the right to health. It involved five focus groups in late 2019 in Knocknaheeny in Cork City, Donegal, Longford, Fettercairn in Tallaght and in Dublin's north inner city. In total more than 50 participants took part in the focus groups.

EAPN Ireland believes that everyone has the right to health but is concerned at the lack of an explicit right to healthcare in Ireland. The UN Covenant on Economic, Social and Cultural Rights (ICESCR) recognises the right to health and defines it in relation to availability, access to, acceptability and quality of health facilities, goods and services. However, in Ireland the state is failing in its duty to provide adequate healthcare for many disadvantaged and marginalised individuals and groups, with the result that they experience worse health outcomes, including lower life expectancy.

While we welcome the focus on outcomes and the impact of policies on people and communities in the new Programme for Government, we note that neither health inequalities nor the need to address the social determinants of health are mentioned anywhere in this Programme.

Health Ireland

The Healthy Ireland Framework for Improved Health and Wellbeing 2013- 2025 states that health and wellbeing are not evenly distributed across Irish society and says that a broad focus

is needed to address the social determinants of health. Goal Two of the framework is reducing health inequalities. EAPN Ireland believes that placing the eradication of health inequalities within a behavioural lifestyle strategy is aspirational but not practical for vulnerable and disadvantaged groups as it does not address the root cause of their predicament, structural disadvantage, which results from distribution choices and explicit resource restriction in the public health system. We agree that behaviour change programmes have a part to play in improving population health but are convinced that it is unrealistic to expect people living precarious disadvantaged lives to engage with these initiatives.

— EAPN Ireland asks that *Healthy Ireland* recognises the limited ability of vulnerable groups to opt into engaging with its programmes and initiatives and develop more user sensitive, proactive and effective ways of engaging with these disadvantaged communities.

Sláintecare

While EAPN Ireland supports the ambition, scale and breadth of the Sláintecare reforms to deliver the Right Care, in the Right Place by the Right Team at low or no cost, we are concerned that reducing health inequalities is not in itself a central goal.[1] We acknowledge the complexity of the challenges, in particular the unwinding of private health care from public health care settings, but wish to see a more explicit and cohesive approach to addressing the social determinants of health and the negative role they play in the lives of citizens who experience health inequalities. We note the various projects across the four workstreams which aim to reduce cost and improve access but recommend a deeper focus and alignment of effort to combat how difficult circumstances and lack of access to resources affect vulnerable users of the public health service. We are also deeply concerned at the significant delay in Sláintecare Project 2.4 (to review the current framework and develop a policy proposal and

roadmap for universal eligibility) which was one of only two projects which experienced a major delay in 2019. This delay in implementing the entitlement element of the Sláintecare reforms is very disappointing for EAPN Ireland as this is a critical enabler to reduce health inequalities. It does not bode well that this core element of the Sláintecare transformation did not progress in 2019 given how inequality of access is embedded in our current health system, where the complex nature of eligibility for services and schemes blocks access and affordability.

— To reduce the future burden on the health system EAPN requests a more cohesive approach across all Government Departments to streamline and align all actions/ deliverables on the social determinants of health to improve effectiveness, efficiency and transparency.

— EAPN Ireland requests the establishment of a monitoring index containing both health inequality indicators and all measures which address health inequalities, particularly in both Healthy Ireland and Sláintecare - and all other relevant strategies. We propose that the maintenance of this index should be the remit of an independent research institute or body.

Recommendations from Communities

Through its work with disadvantaged communities across Ireland the European Anti-Poverty Network (EAPN) Ireland knows that service users are best placed to advise on what supports make a positive difference to their lives and meet their needs. This is why we decided to capture the voice of disadvantaged people, in five focus groups held across Ireland in late 2019, to hear their stories of accessing health services. The gaps, failings and deficits of current health policy and service provision were laid bare in these personal accounts. The experiences, observations and most importantly the suggestions from the focus groups form the basis for

the recommendations in this report which we offer in a spirit of collaboration.

These recommendations come directly from the people who attended the five EAPN Ireland focus groups held in Cork City, Donegal, Longford, Dublin County and Dublin's north inner city in late 2019. Participants came from a cross section of the disadvantaged communities living in these locations including low income families, lone parent households, migrants, Traveller and Roma and people living with addictions. Specific themes emerged in these meetings, in particular how inadequate income and poor access to resources impact negatively on people's lives and health status.

The recommendations below are informed directly by the lived experience and daily lives of the participants. EAPN Ireland is deeply grateful for the honesty and openness of those who shared their stories. They willingly contributed so that future health policy and services can be more effective in reducing the deep inequalities in both access to health and in outcomes health.

All focus group participants had an intuitive understanding of the links between the **social determinants of health** and health status and outcome. Participants wanted health and social care professionals to both understand how the social determinants of health impact negatively on the health status of communities and to show this understanding in their approach and practice. They recommended that:

— Training on the social determinants of health should be mandatory for all health and social care staff in both acute and community settings. Health and social care managers need to have the autonomy and responsibility to ensure that their staff undergo training to deepen their ability to engage respectfully and appropriately with people from different cultural and social backgrounds.

Participants raised concerns over **long waiting times** as a serious barrier to accessing healthcare as well as the additional barriers created by the **cost or inadequate provision of transport.**

The corrosive impact of poor **mental health** on individuals, families and communities was a priority issue for participants. People were unanimous that experiencing poor mental health often stemmed from their daily struggles dealing with the social determinants of health - housing, low or no income, poor educational opportunities and attainment, living in deprived areas with no amenities, uncertain legal status et al. The interconnectedness between poverty, the negative effects of living in poor living conditions and neglected deprived communities and the lack of adequate mental health services was clearly articulated. There was a majority view that not having timely access to health services resulted in people experiencing poorer mental health and higher levels of stress. The participants made the following recommendations.

— The HSE should collaborate with community leaders and groups in areas with severe social problems to find solutions which improve the physical and mental wellbeing of residents.

— The provision of 24/7 access to community-based wrap around mental health services.

— Responsive integrated referral management should be put in place- including Social Prescribing and referral to specific community and voluntary services - to optimise patient outcomes and avoid acute admissions.

— Person-centred support should be provided for people, prior to planned mental health appointments, to encourage attendance.

— The HSE should employ people who have experience of mental health conditions, to work in support roles in the community.

— A one stop phone line for mental health services be rolled out to all regions.

— The rotation of mental health doctors should be limited, as consistency is key to forming trust and a positive patient doctor relationship.

There was a detailed discussion in relation the **General Practitioners** and recommended to following.

— GP training should have a stronger component of authentic communication and listening skills as these attributes were identified as core attributes of effective GPs.

— GPs need to be better informed of what other interventions and services are available in their community (both statutory and voluntary).

— GPs need to have a proactive approach to collaborating with local community and voluntary service providers and refer patients if appropriate.

— GPs must be open to investing time in agreeing structured ways to develop relationships and links with local non statutory service providers and organisations.

— GPs must stop charging medical card holders for needed blood tests in contravention of national policy.

Low referral rates from health professionals to community-based health services and supports was accepted as a disappointing reality for many community organisations. The importance of **more collaboration and joint working** was highlighted with a consensus view that more proactive referrals to local services, in particular by GPs and Public Health Nurses, would result in better health and wellbeing outcomes for patients. Participants were clear that they wanted health care staff to have a deeper knowledge of what services and supports community organisations in their catchment area offer. Minority ethnic participants spoke of the need

for the health and social care services to reflect their communities, saying that the best way to achieve this is to employ staff from these communities and marginalised groups.

— Social prescribing should be rolled out and used as a priority service across the HSE and by all GPs contracted under the Medical Card Scheme. Resources must be allocated in all Regional Integrated Care Areas using the learning from the Sláintecare Integrated Fund projects to increase the use of this model.

— All health and social care professionals working in primary and community care service settings should undertake a compulsory community development training module

— HSE should employ people from specific ethnic groups to work as paid advocates in their communities.

— Language and other supports for groups in resettlement programmes should continue as long as needed, with people employed from these communities to act as peer educators who can help people link into services and supports.

— Statutory staff must have dedicated time factored into their work plan to allow time for developing relationships, build joint working processes and knowledge of community groups.

— Both statutory and community sectors must accept that assumptions, attitudes and behaviours must change on both sides to collaborate effectively.

— Formal processes are needed to ensure authentic community representation is factored into the design and delivery of health and social care services.

— Structures must be designed, and maintained, which enable and facilitate both the knowledge of community groups and their feedback, to be fed into how local services are designed.

— Sensitive, respectful restorative space must be prioritised to build community capacity to engage productively with statutory health services, particularly in very deprived areas.

EAPN Ireland notes that the new Programme for Government views enhanced governance and accountability as key components of the Sláintecare reforms. This correlates very closely with how the focus groups felt that issues of **discriminate and attitudes** needed to be addressed and the strong call for HSE managers to be visible to services users and for them to be **accountable** for the attitudes and behaviours of those staff working for them.

— Cultural and ethnicity training to be provided so that all health and social care staff are aware of specific cultural differences in the Traveller and all ethnic minority communities.

— HSE managers must be both visible and held accountable for the level and quality of services their staff provide. Training must be provided to resource managers to enable them to deliver on this responsibility.

— Managers should visibly intervene when poor behaviour is witnessed or reported, with swift and transparent action taken in the event of a breach of good practice.

— The HSE should employ staff from minority ethnic groups and from marginalised groups to specific roles within relevant services.

— Behaviours and attitudes of staff who deal with service users with different ethnicities, cultures and religions must be tolerant, respectful and show courtesy and dignity.

— Complaints procedures must be clearly explained and displayed prominently in HSE settings.

The focus group participants raised a number of issues and made recommendations related to **medication and equipment.**

— GPs should ensure that the medication they prescribe is covered under the Medical Card Scheme to avoid unnecessary stress and embarrassment for patients.

— Instructions on medication must be written in clear English to take into account language and literacy problems.

— Pharmacists should be incentivised to collaborate proactively with local organisations to improve service user understanding. Pharmacists should publicise local groups which support specific groups (those with low literacy, foreign nationals) to understand their medication and instructions.

— To ensure consistency and patient wellbeing for long-term mental health services users who attend out-patient appointments, all prescribing should be done by a consultant, and not by Senior House Officers, who rotate on a six-monthly basis.

A range of **administrative and structural barriers** to accessing healthcare were highlighted and the participants proposed the following to address some of these.

— Primary Care Reimbursement Service to improve the quality and responsiveness of their customer care service particularly in difficult and complex cases.

— Prioritise the roll out of the Single Assessment Tool across all regions.

— Take service user residence into account when scheduling appointments for tests and treatment, particularly for those outside Dublin who must travel.

— Improve communication on how to access equipment and simplify procurement to reduce the number of suppliers patients must interact with.

— Allow GPs to issue repeat prescriptions for people with chronic conditions, avoiding the need to attend specialist out-patient clinics - EAPN Ireland is aware of the ongoing modernisations in areas of eHealth, medicines management and multidisciplinary working.

— Improve access to nutritional advice in primary care settings, particularly in GP practices where possible.

— Review conditions covered under the Long-Term Illness Scheme.

Finally, a number of issues related to **dental services** were raised with the recommendations to:

— Improve capacity in the Dental Treatment Service Scheme to reduce waiting time for treatment.

— Provide weekend access to emergency dental services.

1 Government of Ireland. (2017). Committee on the Future of Healthcare Sláintecare Report. Available at: https://tinyurl.com/y3mr7ajo [Accessed 11th November 2019].

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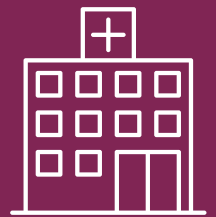
1.1 Rationale for this report

Now more than ever the protection and wellbeing of vulnerable groups must be central to how the health services are designed and delivered.

Across the globe the Covid19 pandemic is throwing health inequalities into sharp relief where people with less means and resources struggle to access health care and experience worse health outcomes, with some paying the ultimate fatal price. In Ireland those in precarious situations - the unemployed, people with disabilities, homeless people, those with addictions, ethnic minorities (particularly Travellers and Roma) and migrants (documented and undocumented) who cannot access social protection schemes, are very vulnerable. Many people with precarious work have lost their poorly paid jobs with minimal protection and benefits.

Through its work with member organisations working in disadvantaged communities across Ireland the European Anti-Poverty Network (EAPN) Ireland knows that service users are best placed to advise on what supports make a positive difference to their lives and meet their needs. This is why we decided to capture the voice of disadvantaged people, in five focus groups held across Ireland, to hear their stories of accessing health services. The gaps, failings and deficits of current health policy and service provision were laid bare in these personal accounts. The experiences, observations and most importantly the suggestions from the focus groups are the basis for recommendations in this report. They are made with the intention to improve how health inequalities are currently being addressed in Irish national strategies.

The focus groups were held in November and December 2019, in Knocknaheeny in Cork City, Donegal, Longford, Fettercairn in Tallaght and in Dublin's north inner city. In total more than 50 participants took part in the focus groups.

EAPN Ireland offers this report as a timely contribution to influence how current health policy

and strategies can be strengthened to reduce health inequalities, where access to quality health and social services is equitable and not dictated by income and where the right to health is enshrined and protected in law. This report also builds the work EAPN Ireland has undertaken as a member of the Community Platform on the right to health and its six principles for an inclusive health policy.

The purpose of this report is three-fold:
1. to show how deeply the social, economic and environmental determinants of health affect both people's experience of accessing health services and their health outcomes

2. to highlight how current national health strategies do not adequately address the challenge of health inequalities

3. to contribute recommendations to strengthen how national policy strategies tackle health inequalities and the right to health

Section 1 of the report offers a short overview of current health and social care policy and services showing how the social determinants of health - in particular socio-economic status and lack of resources - and inequalities of access to public health services impact on health status and outcome. Other reports are cited which demonstrate how the entwined nature of public and private healthcare provision reinforce the depth and breadth of health inequalities in Ireland. The section concludes with a brief critique of the two main health strategies in how they address health inequalities, namely Healthy Ireland and Sláintecare.

In section 2 the stories, insights, observations and concerns from the five focus groups are used to illustrate the deficits and gaps in the public health system. Recommendations to address health inequalities and strengthen the right to health are provided in a spirit of collaborative and constructive engagement. EAPN Ireland is appreciative of the good will and interest of relevant health policy makers and stakeholders who had agreed, pre

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Covid 19, to participate in a roundtable event where these recommendations were to be explored and discussed further in a solution focused dialogue to address health inequalities.

1.2 The right to health

EAPN Ireland believes that everyone has the right to health. This right relates to both the right of individuals to obtain a certain standard of health and health care, and the State obligation to ensure a certain standard of public health with the community generally.

EAPN Ireland is concerned at the lack of explicit right to healthcare in Ireland. There is no fundamental right to health in the constitution. Article 45.4.1 of the Irish Constitution states

> *The State pledges itself to safeguard with especial care the economic interests of the weaker sections of the community, and, where necessary, to contribute to the support of the infirm, the widow, the orphan, and the aged* [2]

But as this article sits under the Directive Principles of Social Policy it is not binding and is only used for general guidance only. As yet the right to health and social care services is not defined in Irish legislation. Without legislation access to health will continue to be discretionary and unequal.

Like many other nations Ireland brought the European Convention on Human Rights into law in 2003. Previous to this date the UN Covenant on Economic, Social and Cultural Rights (ICESCR) was ratified in 1989. This covenant recognises the right to health defined in relation to availability, access to, acceptability and quality of health facilities, goods and services. Article 12 provides the most comprehensive article on the right to health in international human rights law. It recognises "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

In the 22nd session, (in its General Comment no 14) the UN Committee on Economic Social and Cultural Rights provided detailed guidance to States regarding their obligations to respect, protect and fulfil the right to health. The Committee also noted that the right includes the following interrelated and essential features: [3]

— **Availability**. States should ensure the provision of enough functioning public health and individual health care facilities throughout their territory, as well as safe water and sanitation facilities, trained and fairly-paid medical professionals, and essential medicines.

— **Accessibility**. Access to health involves four key elements: non-discrimination, physical accessibility, economic accessibility, and information accessibility. Health facilities and services should be accessible to everyone, especially the most vulnerable, without discrimination on any prohibited ground. The facilities and services, as well as underlying determinants of health such as water and sanitation amenities, must be within safe physical reach. Health care facilities, goods and services must be affordable for all, with any payment based on the principle of equity so that poorer households are not disproportionately burdened with health-related expenses. States must ensure that every person has the right to seek, receive and impart information on health, in balance with the confidentiality of medical information.

— **Acceptability.** Health facilities should be respectful of medical ethics and the culture of individuals and communities, as well as attentive to gender and life-cycle requirements.

— **Quality.** Health facilities should be scientifically and medically appropriate and of good quality. Among other things, this requires the provision of necessary medicines and equipment, skilled

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medical professionals, and adequate water and sanitation.

In 2015, during its examination of Ireland's progress in protecting, respecting and fulfilling rights contained in ICESCR, the Committee expressed concern at the overall deteriorating healthcare services and at the negative impact on the access of disadvantaged and marginalised individuals and groups to adequate healthcare, in particular:

a. The widening disparity between people with and those without private health insurance in accessing medical services,

b. The delay in providing universal health services and community-based health services;

c. The lack of oversight of healthcare services; and

d. The poor health state of Travellers and Roma, particularly their life expectancy and infant mortality which are respectively 15 years less and more than three times higher than the general population.

The shortcomings and deficits listed by the ICESCR in 2015 have not been eliminated. Health inequalities continue to have a very steep social gradient where those with less means depend on the oversubscribed public health system where demand outstrips supply.

1.3 Overview of the Irish public health system

Ireland remains unique in the EU in not providing universal access to primary care. Ireland's acceptance of the high level of duplicate private health insurance coverage has resulted in a distinct two-tier health care system where those who can afford it buy private health insurance and avail of fast tracked access to diagnosis and treatment, while those on limited incomes make do with an oversubscribed, under resourced public health system characterised by long waiting lists and

slower access to needed care, not always provided by consultants. In Ireland access to health services is predicated on income. This results in health inequalities in Ireland having a serious social gradient with those in the lower socio-economic groups experiencing worse health outcomes, morbidity and life expectancy. [4]

While EAPN Ireland fully supports the vision of the all-party Sláintecare reform blueprint to deliver universal access in a one tier system we are very aware that the right care in the right place at the right time is not the reality for people currently trying to access the public health system in Ireland. Equal access to equal care for equal need is not a reality for people in the Irish public health system. Life expectancy is poorer for people with low incomes, for those living in deprived areas and for Travellers in particular, than for the general population.

> "
> The differences in life expectancy between people living in the most disadvantaged areas compared to those living in the most affluent is stark.
> "

1.4 Inequality in life expectancy and death rates

Data from difference sources shows that life expectancy for specific groups in Ireland is lower than for the general population, particularly for Travellers. The differences in life expectancy between people living in the most disadvantaged areas compared to those living in the most affluent is stark. There are clear differences in life expectancy

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related to social class. Figures 1 and 2 below show how social class and occupation impact on life expectancy and death rates.

Census 2016 shows that people in the most deprived areas have the worst life expectancy, with life expectancy for men in the most well off areas living five years longer than those in the poorest (84.4 years and 79.4 years respectively), while for women the gap in years lost due to location was four. [5]

Differences in life expectancy in years from least deprived to most deprived areas

	Males	Females
All	82.0	85.5
First Quintile (least deprived)	84.4	87.7
Second Quintile	83.2	86.5
Third Quintile	82.2	85.7
Fourth Quintile	81.9	84.9
Fifth Quintile (most deprived)	79.4	83.2

Table 1. Source CSO Mortality Differentials in Ireland 2016-2017

While this is an improvement on the 2010 statistics, glaring differences in life expectancy persist related to occupation. The difference in life expectancy at birth for men in the professional social class group was 6.1 years higher than for their unskilled counterparts while for women the difference in life expectancy was 5 years.

The gap in death rates for different occupations is also evident. Figure 2 shows that for every 100,000 deaths in the population 494 were professional workers, while the death rate was 796 for unskilled workers out of every 100,000 deaths.

Standardised death rates per 100,000 of population

Social Class	Persons	Males	Females
Professional workers	494	478	451
Managerial & technical	482	501	470
Non-manual	511	590	497
Skilled manual	676	627	673
Semi-skilled	661	677	637
Unskilled	796	804	751
Others including unknown	841	906	803

Table 2. Source CSO Mortality Differentials in Ireland 2016- 2017 [6]

1.5 Cost of healthcare a barrier to access

Two recent reports show the correlation between inability to pay and lack of access to needed health care.

The ESRI analysis of the EU SILC 2013 data found that 4% of the population had an unmet health need with 59% citing the cost of care as the reason they did not access the care they needed, while long waiting lists were blamed by those with medical cards. This research found that women, lower income groups and people with poorer health status were most likely to have an unmet need for health care. [7]

In 2019 research by the Trinity Centre for Health Policy and Management found that there was an increase in the level of unaffordable private healthcare spend, from 15% in the period 2009 to 2010 up to 18.8% in 2015 to 2016 period.[8] Analysing data from the Irish Household Budget Survey this study found that households on the lowest incomes were disproportionately affected by this increase in

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private health expenditure. It found that those with the least means selected to pay for private access to outpatient consultations. Given the unacceptably long waiting times in the public system this is not an unexpected finding. Other results included:

— Over 16% of the spend for medical card holders went on GP visits, in patient and out-patient consultations, which are free to this cohort in the public system

— Spend on private health insurance increased the most in the lowest income quintile in both waves of the survey

The below table summarises their findings:

	2009–2010	2015–2016
Proportion of households experiencing unaffordable out of pocket payments		
Medical Card	63.8%	72.5%
GP card	2.7%	5.8%
No cover	33.5%	21.7%
Proportion of households experiencing unaffordable private health insurance expenditure		
Medical Card	57.2%	62.3%
GP card	3.2%	9.7%
No cover	39.6%	28%

Table 3 Source Private health expenditure in Ireland: Assessing the affordability of private financing of health care

These findings clearly show that those on the lowest incomes chose to incur unaffordable expenditure to access timely diagnosis and treatment via private health insurance, even though they could not afford to and already had free access to the public health system as medical card holders. That 62.3% of households with free access to the public system spent their limited income on buying unaffordable access to private care demonstrates how intolerable this inequity is for this needy cohort.

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1.6 Health inequalities - the link to poverty and low income

Analysis of the 2017 SILC data found that almost a third of households which needed medical treatment found the cost difficult to afford, with 27.4% reporting dental costs as problematic while 35% found the cost of medication caused hardship.
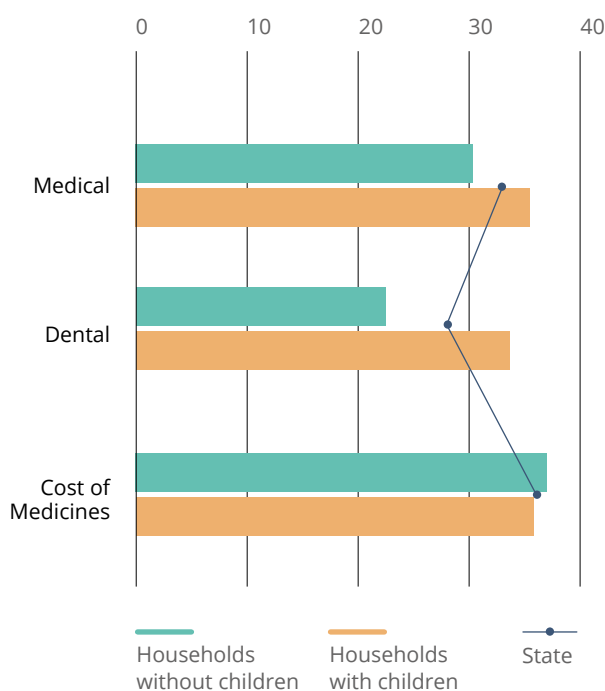
Figure 1. Households who experienced a financial burden from health expenses. Source CSO SILC 2017 [9]

Data from the same source shows that 89% of people in consistent poverty had medical cards, while 71% of those at risk of poverty had either a medical card or a GP Visit Card.
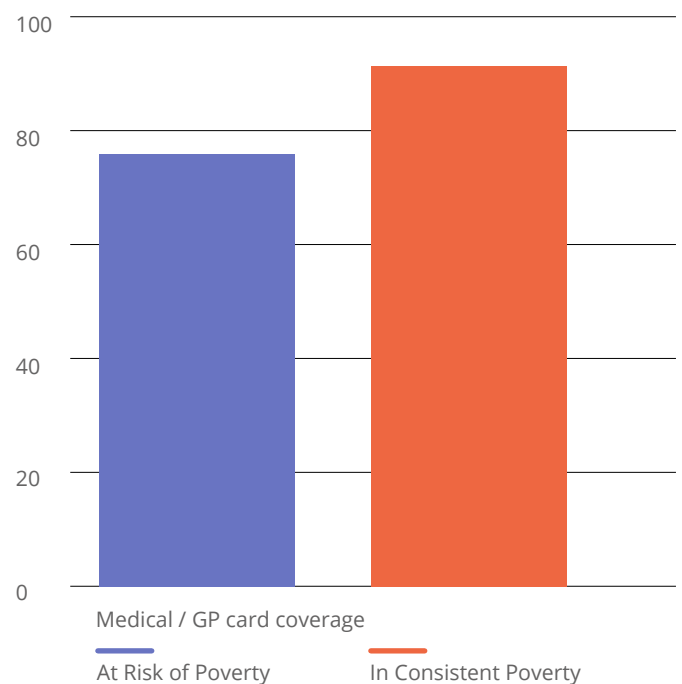
Figure 2 Medical card and poverty status. Source CSO SILC 2017 [10]

1.7 Health Inequalities - a structural problem

Recent reports have highlighted how the hybrid structure of the Irish health system results in poorer access and outcomes for those forced to rely on the public health system. A welcome focus has emerged on the needs of the 'twilight' group of people who have incomes above the medical card eligibility, without private health insurance who experience hardship when they pay for needed heath care.

While the World Health Organisation states that universal healthcare is the best way to improve

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global health, Ireland has remained an outlier in continuing its complex system of health financing founded on the mix of public/ private provision.[11] Access, entitlement and eligibility to the various elements of the public health system, and in particular to the various schemes is complex and difficult to navigate.

Health service users struggle with complicated mean testing systems which are time consuming to apply for (and to process) and which exclude many whose incomes are above social welfare payment rates. Signposting within the HSE, given its complexity, multiple settings and locations is unsatisfactory to many service users and HSE staff themselves acknowledge the difficulties inherent in the different schemes and services.

The de Buitléir report published in 2019 sets out an explicit road map to remove private health care from publicly funded hospitals. This report is of central importance to the effective delivery of the Sláintecare reforms. It lays bare the interwoven nature of how private care is delivered in public hospitals alongside the provision of care to public patients, thus diverting resources from those waiting for treatment in the public system. This report flags the inequities which result from the differing payment models for GPs, consultants and hospitals where payment is a flat rate in the public system, while a fee per service model is used for private patients. This dual approach to fee payment results in perverse incentives and fosters inequalities of access and outcome, with public patients in effect competing against private service users to gain access to treatment. EAPN Ireland welcomes the commitment to remove the delivery of private care from public hospital settings and agrees with the EU Commission's 2020 Country Specific Recommendations for Ireland which state that this is an "essential" step to achieve the Sláintecare reforms.[12] This document also critiques the reform progress to date noting that the implementation remains "vague" and that a monitoring framework would improve delivery. It recommends in Country

Specific Recommendation 1 that Ireland

> *"Improve accessibility of the health system and strengthen its resilience, including by responding to health workforce's needs and ensuring universal coverage to primary care."*

Other recent reports concur with the structural barriers which impede progress to universal health care. A 2018 report from the European Social Policy Network noted the structural disincentives which reinforce unequal access and outcomes. [13] Also in 2018 a TASC and FEPS report again drew attention to Ireland's unique position in Europe in not having universal access to primary care.[14] This report critiques the two-tier system and points to the large gap of 21.5% between higher and lower income groups in the self-reporting of their health status. This report also highlights the precarious position of the 'twilight' group whose low incomes prevents them from being able to afford the high costs of out of pocket health expenses.

A follow up TASC report in 2019 used a case study approach to analyse access to autism, lung cancer and brain tumours.[15] That report found clear inequities of access to diagnosis and treatment and long wait times for autism services and no clear pathways to diagnosis for brain tumour patients. The report also referenced the National Cancer Registry's report which found a higher overall prevalence of cancer in more deprived populations and that disadvantaged people were more likely to have other health conditions.[16]

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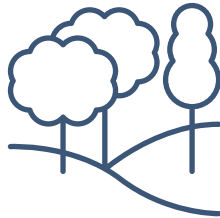
1.8 Health inequalities - the role of geography

Geographic variations in availability and access to health resources play a huge role in people's access to health services. Historically the approach to budget allocation has not been based on the level and prevalence of local resulting in different outcomes dependent on the so-called 'postcode' lottery where access differs according to budget and location not need.

The ESRI report from July 2019[17] shows clear inequalities in supply of all health and social care services, particularly in the wider Dublin region and eastern seaboard area. This report argues that

population health care need must dictate resource planning and allocation otherwise health inequalities will persist.

EAPN Ireland welcomes the announcement in July 2019 of the six new integrated regional areas (with a single budget for both community/primary and acute sectors) which will use population health data to deliver improved planning and delivery of health service based on need (see Appendices 2 and 3). The timely delivery and resourcing of this structural reform will be an important enabler in reducing health inequalities as real need will be demonstrated and resources can be allocated to where they are most needed.

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1.9 Poor capacity and long waiting times cause inequalities

Historic underinvestment in primary care, plus the reduction in services due to austerity measures, has resulted in limited capacity in the public system's primary and community care services. This contributes to deepening health inequalities as those who cannot afford to buy fast tracked access to private diagnosis and treatment must endure long waiting times to access the care they need. These delays in access are of particular concern, as many interventions are time sensitive with patients needing more expensive and complex treatment later if they do not receive timely interventions. This is particularly the case in terms of the treatment of children, where delays in accessing time sensitive treatment can lead to sub-optimal outcomes, long term damage and the need for ongoing rehabilitative treatment.

The below snapshot of service provision from the various Community Healthcare Organisations show how the regions differ in terms of waiting times for critical primary care interventions and services.[18]

Only one CHO, out of the 9 countrywide, hit its target for delivering structured type 2 diabetes education programmes. Six CHOs had a red rating for the performance of this service.

Access to the Dental Treatment Services Scheme fell by 16% in the period 2013 to 2016.[19] This is the public dental scheme which is used by people who cannot afford to pay for private dental treatment. The 2017 SILC data found that the cost of dental treatment was a financial burden for 32.5% of households with children. [20] This rationing of access to public health dentistry continues. In the period June to September 2019, the latest period for which data is available from the HSE, 11% of the total number of orthodontic patients were waiting for treatment for over four years, while only 46% were seen for assessment within 6 months.

Orthodontics: % seen for assessment within 6 months
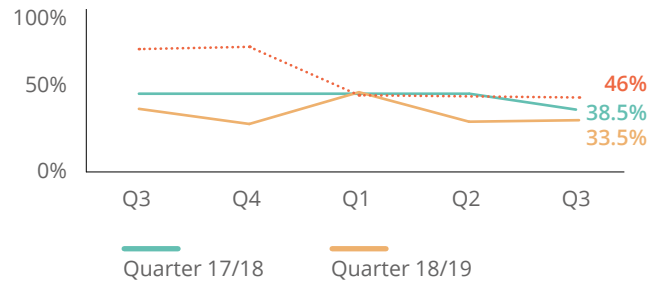
Orthodontics: treatment waiting list > four years
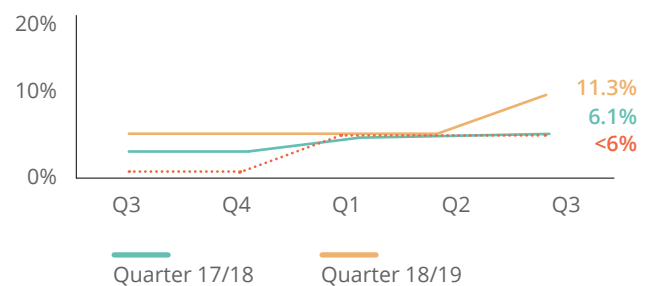
Figure 3. Source: HSE July to September 2019 Performance Profile Report

The most recent HSE report on ophthalmic services, dating from 2017, shows that the numbers treated in the HSE funded optical treatment scheme fell from 769,700 in 2015 to 699,900 in 2017. This report notes that the waiting times are very high and that the service is very under-resourced resulting in a "reduced, non-standard range of services being provided".[21]

The provision of public mental health services has been a long-term cause for concern, with the most recent HSE statistical report available for the period July to September 2019 showing that 70.5% of adults seeking access to mental health services had been seen within twelve weeks, the HSE target is 75%. Three Community Health Organisations did not reach their targets with CHO 9 seeing 57.4%, CHO 7 seeing 58.2% and CHO 4 seeing 59.8% of patients within twelve weeks. [22]

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Adult Mental Health - % offered an appointment and seen within 12 weeks
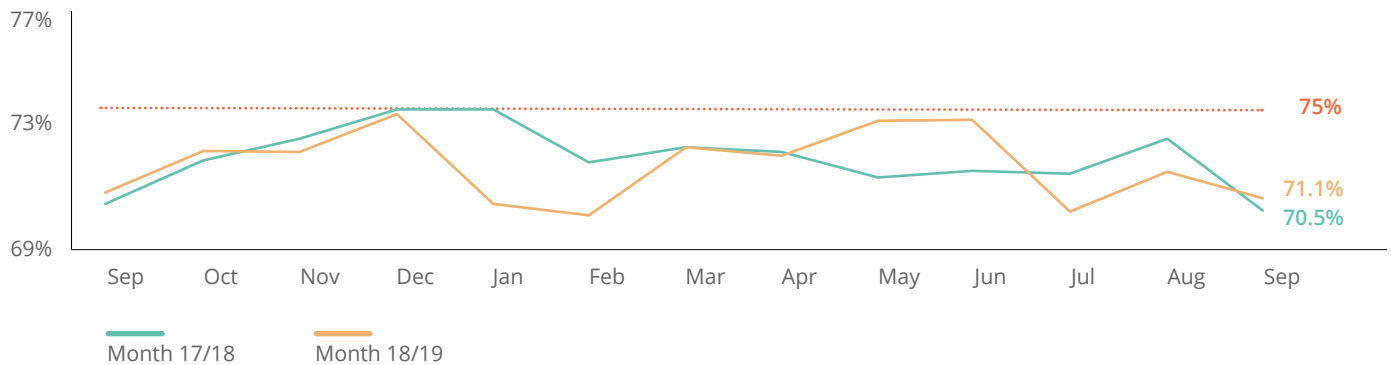
Figure 4. Source: HSE July to September July to September Performance Report

By the end of 2019, there were 7,000 children and teens waiting to see a psychologist, an increase of 20% in one year. In the period 2012 to 2018 there was a 24% increase in referrals to the Child and Adolescent Mental Health Teams, with 2,327 waiting at the end of 2019.

In December 2019 there were 19,000 children waiting for speech and language therapy in the public health system, with 2,000 waiting more than a year and 300 waiting more than two years. North Dublin had the highest volume of children waiting at 2,400, while there were none waiting in Dublin South East, and ten waiting in Dún Laoghaire.[23] These figures reveal the ongoing variation based on geography not need with people living in different parts of the same city experiencing very different waiting times. These delays cause severe difficulties for children who must struggle with difficulties which affect all aspects of their lives, not least their ability to participate in school, while families who can afford the cost of private therapist care receive timely treatment and have better outcomes.

The numbers waiting for treatment in public hospitals puts the divide between those who can afford private care in sharp relief with those who cannot. In January 2020 there was a total of 556,770 people on waiting lists for treatment in public hospitals, with 107,040 waiting over eighteen months.[24] These numbers have been increasing

relentlessly year on year. In March 2018 the total numbers waiting were 504,111, with 77,547 waiting over 18 months.[25] In December 2019 there were 215,000 children on public waiting lists (hospital and community services) with over one in four waiting over a year for treatment. The breakdown of these figures show discrepancies in waiting numbers and times which varies significantly region to region and hospital to hospital depending on their specific budget allocation.[26]

The ongoing problem of long public waiting lists as a major cause of health inequalities of access and outcome has been noted by the OECD, the European Observatory on Health Policies and Systems and also the European Commission. In its 2020 Irish Country Report the European Commission states that substantial investment is needed to achieve the Sláintecare mission of universal access to healthcare.[27] The Health at a Glance 2019 report identifies high bed occupancy rate (at 95% much higher than the EU average of 77%) and high levels of hospitalisation for conditions which should be treatable in community settings as the major causes of long waiting times for elective surgery alongside legacy low investment in capacity in the public system.[28]

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2 http://www.irishstatutebook.ie/eli/cons/en/html#part14

3 United Nations, 2000. Committee on Economic, Social and Cultural Rights Twenty-second session General Comment No 14. Geneva. Available at: https://tinyurl.com/y7ub5s3f [Accessed 12th March 2020].

4 The 2017 study by Maev Ann Wren and Sheelagh Connolly "Unmet healthcare needs in Ireland: Analysis using the EU-SILC" found that 59% said that the reason they did not access required health care was because of the cost.

5 CSO. (2019). Mortality Differentials in Ireland 2016-2017. Dublin. Available at :https://tinyurl.com/y67grm4u [Accessed 12th March 2020].

6 CSO. (2017). Mortality Differentials in Ireland 2016-2017. Dublin. Available at: https://tinyurl.com/y67grm4u [Accessed 12th March 2020].

7 ESRI Research Bulletin. Sheelah Connolly and Maev-Ann Wren. Unmet Healthcare Needs in Ireland. Dublin. ESRI. Available at: https://tinyurl.com/y39qql9z [Accessed 13th March].

8 Johnston, B., Burke, S., Barry, S., Normand, C., Ní Fhallúin, M., Thomas, S 2019. Private health expenditure in Ireland: Assessing the affordability of private financing of health care. ScienceDirect, Volume 123, Issue 10, October 2019, Pages 963-969. Available at: https://doi.org/10.1016/j.healthpol.2019.08.002. This study defined households which spend over 40% of their budget (or capacity to pay) on catastrophic health spend as being pushed into poverty or having an unaffordable need.

9 CSO. (2017). Survey on Income and Living Conditions (SILC) 2018. Available at https://tinyurl.com/y386ovgo [Accessed on 16th March 2020].

10 CSO. (2017). Survey on Income and Living Conditions (SILC) 2018. Available at: https://tinyurl.com/y386ovgo [Accessed on 16th March 2020].

11 WHO and European Observatory on Health Systems and Policies. (2014). Health system responses to financial pressures in Ireland (Studies Series 33). Denmark. Available at: https://tinyurl.com/y5v-vprh8 [Accessed 25th February 2020].

12 European Commission. (2020). COUNCIL RECOMMENDATION on the 2020 National Reform Programme of Ireland and delivering a Council opinion on the 2020 Stability Programme of Ireland. Brussels. Available at:https://tinyurl.com/yyd5j2hn [Accessed 6th May 2020].

13 Buffel, Veerle & Nicaise, Ides. (2018). ESPN Thematic Report on Inequalities in access to healthcare Belgium. Available at: https://tinyurl.com/yx9zb3dq [Accessed on 14th February].

14 Forster,T., Kentikelenis, A., Bambra, C. (2018). Health Inequalities in Europe: Setting the Stage for Progressive Policy Action. Dublin. TASC FEPS. Available at: https://tinyurl.com/yxvvhys4 [Accessed 15th February 2020].

15 Doyle, K., Forster, T., Kentikelenis, A., Legido-Quigley, H.,Torrecilla, M. (2019). Reducing Health Inequalities: The Role of Civil Society. Dublin. TASC FEPS. Available at: https://tinyurl.com/y2o7jjjr [Accessed 16th February 2020].

16 Walsh PM, McDevitt J, Deady S, O'Brien K & Comber H (2016) Cancer inequalities in Ireland by deprivation, urban/rural status and age: a report by the National Cancer Registry. National Cancer Registry, Cork, Ireland. Available at: https://tinyurl.com/y39ojn2w [Accessed 16th February 2020].

17 Smith, S., Walsh, B., Wren M A., Barron, S., Morgenroth, E., Eighan, J., and Lyon, S. (2019). Geographic Profile of Healthcare Needs and Non-Acute Healthcare Supply in Ireland. Dublin. ESRI. Available at: https://doi.org/10.26504/rs90 [Accessed 10th February 2020]. Data on ten public health services were studied, using 2014 data: GPs, Community Nurses, Public Occupational Therapists, Speech & Language Therapists, Podiatrists, Counsellors & Psychologists, Social Workers, Public Home Care Hours and both and private physiotherapists and nursing home beds.

18 CHOs are community healthcare services outside acute hospitals, such as primary care, social care, mental health, and other health and well-being services. These services are delivered through the HSE and its funded agencies to people in local communities, as close as possible to their homes.

19 https://www.cso.ie/en/statistics/health/hsefundeddentaltreatments/ The numbers treated fell from 1,227,000 to 1,025,600.

20 https://www.cso.ie/en/releasesandpublications/ep/psilc/surveyonincomeandlivingconditionssilc2017/healthmodule/

21 HSE. (2017) Primary Care Eye Services Review Group Report. Dublin. Available at: https://tinyurl.com/y6sgjpd5 [Accessed 9th February].

22 https://www.hse.ie/eng/services/publications/performancereports/july-to-september-quarterly-report.pdf

23 https://www.rte.ie/news/ireland/2019/1206/1097362-children-waiting-lists/

24 https://www.ntpf.ie/home/pdf//2020/01/nationalnumbers/out-patient/National01.pdf

25 https://www.ntpf.ie/home/pdf/2018/03/nationalnumbers/out-patient/National01.pdf

26 https://www.rte.ie/news/ireland/2019/1206/1097362-children-waiting-lists/

27 European Commission. (2019). COMMISSION STAFF WORKING DOCUMENT. Country Report Ireland 2019. Brussels. https://ec.europa.eu/info/sites/info/files/file_import/2019-european-semester-country-report-ireland_en.pdf

28 https://www.slideshare.net/OECD_ELS/health-at-a-glance-2019-chartset

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02

Social Determinants of Health - their role in health inequalities

2.1 Is Healthy Ireland reducing health inequalities?

2.2 Are health inequalities addressed in Sláintecare?

2.3 Co-creation and a health inequalities index to improve
citizen outcomes in Healthy Ireland and Sláintecare

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There is now a compelling body of research which shows that the social determinants of health have a very strong causal effect on health outcomes and status. The seminal report by the World Health Organisation's Commission on the Social Determinants of Health framed the challenge of health inequality through the lens of ethics and social justice. Three principles of action were recommended:

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.

2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.

3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.[29]

This section of the report looks at how the two parallel, but not interconnecting, health strategies - the Healthy Ireland Framework for Improved Health and Wellbeing 2013 - 2025 and Sláintecare, seek to address health inequalities in Ireland. The former is a citizen facing strategy which seeks to engage with individuals and communities to take personal responsibility for their health status and to empower them to make behaviour and lifestyle changes to improve their health. The latter is the ambitious ten year blue print for transformation of the Irish health system which aims to deliver universal single tier health care. Its objectives are:

— Promote the health of our population to prevent illness

— Create a system where care is provided on the basis of need, not ability to pay

— Move the system from long waiting times to a timely service

— Bring the majority of care into the community

— Create an integrated system of care, with healthcare professionals working closely together

— Drive accountability and performance in the health service

— Deliver a health service that has the capacity and ability to plan for, and manage, changing needs

2.1 Is Healthy Ireland reducing health inequalities?

EAPN Ireland is very aware that Goal Two of the Healthy Ireland Framework for Improved Health and Wellbeing 2013 - 2025 is to reduce health inequalities. This strategy acknowledges that "health and wellbeing are not evenly distributed across Irish society" and that

This goal requires not only interventions to target particular health risks, but also a broad focus on addressing the wider social determinants of health – the circumstances in which people are born, grow, live, work and age - to create economic, social, cultural and physical environments that foster healthy living. [30]

Health inequalities are clearly defined in this framework (p.7) as the

differences in health status or in the distribution of health determinants between different population groups due to the conditions in which people are born, grow, live, work, and age

The framework goes on to state that decreasing health inequalities will deliver positives for society and that socially targeted interventions are needed which tackle the specific needs of at-risk groups. The importance of reporting relevant data at geographic levels to facilitate population health planning is also noted.

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The emphasis in Healthy Ireland is on the delivery of outputs; projects, initiatives and programmes which are dependent on a willingness and ability by the population to engage in activities which achieve positive behaviour and lifestyle changes. There is an abundance of actions being delivered countrywide which seek to engage individuals and communities in behaviour change to improve their health and wellbeing. These outputs are delivered in a variety of ways and platforms across different sectors. Each HSE Community Healthcare Organisation has its own Healthy Ireland implementation plan, while there are also regional and county level plans.

Despite the plethora of projects and programmes in this framework, EAPN Ireland remains convinced - through its decades of direct working with people experiencing different types of disadvantage - that engaging in initiatives focusing on behaviour and lifestyle change to improve health outcomes and status is not, and cannot be, a priority for vulnerable groups.

Approaches targeting behaviour change, where people take personal responsibility for their wellbeing, works for some people. It is unrealistic, however, to expect this approach to be effective for the majority of households living precarious disadvantaged lives. Placing the eradication of health inequalities within a behavioural lifestyle strategy, namely the Healthy Ireland Framework, is aspirational but unrealistic for low income groups as it does not address the root cause of their predicament, structural disadvantage, which results from distribution choices and explicit resource restriction in the public health system.

The lives of people experiencing disadvantage are very often consumed with the struggle to deal with the barriers they experience in accessing basic resources. If a household or individual does not have adequate income, housing, are struggling with access to health or education, have literacy issues, are find themselves in a challenging legal status, their motivation and capacity to engage with a lifestyle changing programme is limited or non-existent. They simply do not have the space, energy or motivation to opt into self-actualising actions which depend on personal responsibility.

EAPN Ireland considers that Healthy Ireland cannot deliver on its goal to reduce health inequalities by providing behaviour and lifestyle change interventions alone as people experiencing health inequalities are largely outside the reach of these actions and cannot engage with these activities.

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— EAPN Ireland asks that Healthy Ireland recognises the limited ability of vulnerable groups to opt into engaging with its programmes and initiatives and develop more user sensitive, proactive and effective ways of engaging with these disadvantaged communities.

EAPN Ireland is concerned that Healthy Ireland has not demonstrated to date actual and concrete improvements in the reduction of health inequalities. There is a lack of explicit reporting year on year within the framework on how, where and by how much health inequalities data has changed. While the yearly Healthy Ireland survey does capture changes on some areas[31] there is a lack of systematic and granular reporting within the different socio-economic groups.

We note that the **Healthy Ireland Outcomes Framework**[32] was published in 2018 to monitor and drive the achievement of Healthy Ireland's targets and performance indicators. We acknowledge its four high level outcomes and three sets of indicators (in the areas of health status, health outcomes and social determinants). The document's approach of "focusing on actual results or progress achieved, rather than inputs and outputs" (p.2) is very welcome.

Social Determinants

Environmental Factors

— Air Quality Index
— Water Quality
— Radon

Socio-Economic Factors

— Long-term unemployment
— Jobless Households
— Education: Retention
— Education: Attainment
— Literacy and Numeracy
— Consistent Poverty Rate
— Inequality of Income
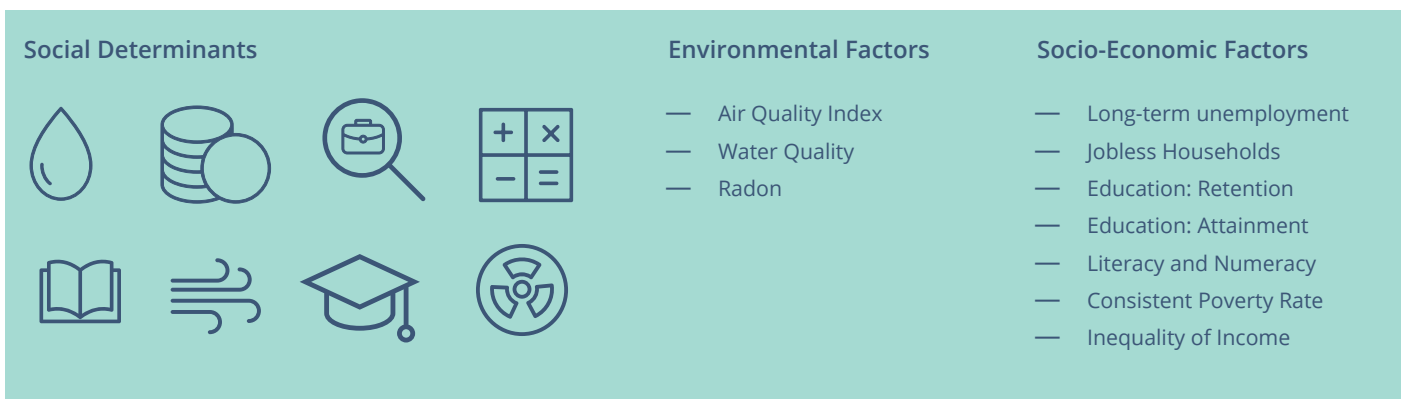
Figure 5 HI Outcomes Framework Social Determinant Indicator source HI Outcome Framework Document 2018

Recommendation

— While the above table of indicators in the Outcomes Framework is relevant to the measurement of progress in the social determinants area of the Outcomes Framework EAPN Ireland suggests that they should be widened to include for example housing and environment.

EAPN Ireland notes the commitment to set up a cross-sectoral governance structure to oversee the development and use of the Outcomes Framework. We applaud the stated intention to:

— Explore how best to use the Outcomes Framework to underpin Health and Wellbeing Impact Assessments of relevant intersectoral policy areas

— Support evaluation and monitoring of impacts of Government policies and programmes on the Healthy Ireland outcomes.

— Identify and select policy areas with reference

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to the wider social policy agenda and Project Ireland 2040

— Target areas of policy with the greatest impact on quality of life and which seek to address health inequalities

— Report annually to Government

Recommendation

— EAPN Ireland believes that the engagement of the community and voluntary sector in the cross-sectoral governance of the Healthy Ireland Outcomes Framework will be critical to the achievement of the above commitments to reduce health inequalities. The sector should be encouraged and resourced to participate in the cross-sectoral governance, monitoring and delivery of the framework's indicators.

2.2 Are health inequalities addressed in Sláintecare?

EAPN Ireland recognises the ambition, scale and breadth of the reforms needed to deliver Sláintecare's vision of the Right Care, in the Right Place by the Right Team at low or no cost.[33]

We understand that Sláintecare is a systems wide blueprint for deep structural, architectural and fiscal reform of the current two-tier health system and note that the various projects relevant to reducing health inequalities are situated across the four workstreams. We acknowledge the achievements secured in 2019, the first full year of implementation of the strategy and note that 112 out of the 138 projects within the four workstreams (see Appendix 1 for further detail workstreams) were on track by year end.

Unfortunately, **Project 2.4 to review the current framework and develop a policy proposal and roadmap for universal eligibility was one of only two projects which encountered a significant challenge.** This delay in implementing the

entitlement element of the Sláintecare reforms is very disappointing for EAPN Ireland as it is a critical enabler to reduce health inequalities. The European Commission also noted that capacity and organisational issues were prioritised to date in the Sláintecare implementation, it notes that the plans to achieve universal coverage "remain less detailed" and have been scheduled for later years in the reform timeline.[34]

EAPN Ireland understands that the Department of Health is committed to setting up the Eligibility and Entitlement workstream as a priority reform programme for 2020 but is concerned that this central plank of the delivery of a single tier system is likely to encounter resistance. It does not bode well that this core element of the Sláintecare transformation did not progress in 2019 given how inequality of access is embedded in our current system, where the complex nature of eligibility for services and schemes hinder access and affordability.

We also understand that the cost of providing economic supports and resourcing the health system to respond to the pandemic will result in long term disruption of planned Sláintecare reforms. However, the Covid 19 crisis has demonstrated how swiftly the planned introduction of improvements to health care configuration and delivery can happen when urgently required. Telemedicine - where GPs and other health care professionals communicate remotely with their patients - and ePrescribing which removes the need for patients to frequently visit GP surgeries to renew prescriptions are two such innovations which were implemented speedily during the early weeks of the pandemic to benefit service users, showing how flexible stakeholders can be when necessary. We hope that the introduction of these pandemic related measures are the beginning of a more agile approach to improving the equality of access to services and interventions.

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2.3 Co-creation and a health inequalities index to improve citizen outcomes in Healthy Ireland and Sláintecare

EAPN Ireland sees that both Healthy Ireland and Sláintecare acknowledge the role of the social determinants of health on health inequalities, but is concerned that there is insufficient focus on this critical intersection. We ask that a more cohesive approach is adopted across all Government Departments to streamline and align all action on the social determinants of health.

Recommendations

— To reduce the future burden on the health system EAPN requests a major policy commitment to focus on and agree definitive action on the social determinants of health. This will require all party cohesion and a long-term commitment to resourcing.

— To improve effectiveness and efficiency EAPN requests a renewed alignment of both strategies with other relevant strategies, as appropriate, such as Sharing the Vision - a Mental Health Policy for Everyone, the Roadmap for Social Inclusion 2020 – 2025, Project Ireland 2040 and the Inclusion Health Framework (which drives improvements in health outcomes for specifically vulnerable groups).

EAPN Ireland is committed to co-creation as a way of working - engaging with service users and their communities in equal partnership from the earliest phase of service design and development. We believe that listening to and taking on board what service users say is the most effective way to reduce health inequalities through improving services. We do not believe that superficial consultation for the sake of compliance with strategic rhetoric achieves real engagement and improved services. We know that authentic community engagement takes time, training, commitment, understanding and dedicated resources.

Recommendation

— EAPN Ireland requests that co-creation is embedded as a core principle in how health and social care interventions, projects, programmes and services are designed and delivered, and that the Citizen and Staff Engagement Programme (4.1) in Sláintecare is modified to reflect this. EAPN Ireland views both national and local autonomous community development organisations and structures as important stakeholders, alongside the community and voluntary sector in co-creation processes.

We conclude this section by noting that Ireland does not have a single monitoring matrix where both health inequality indicators and the measures to address them across all relevant Government strategies are captured, monitored and measured. This overarching matrix, updated in real time, is necessary so that all stakeholders can easily access progress towards delivery. We propose that the maintenance of this index should be the remit of an independent research institute or body.

Recommendation

— EAPN Ireland requests the establishment of a monitoring index containing both health inequality indicators and the measures which address health inequalities, particularly in both Healthy Ireland and Sláintecare - and all other relevant strategies.

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29 CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization. Available at: https://www.who.int/social_determinants/thecommission/finalreport/en/ Accessed 9th February 2020].

30 Government of Ireland. (2013). Healthy Ireland A Framework for Improved Health and Wellbeing 2013 – 2025. Dublin. Available at https://www.drugsandalcohol.ie/19628/1/Healthy_Ireland_Framework.pdf [Accessed 28th January 2020].

31 Topics in the yearly Healthy Ireland survey include smoking, alcohol, diet and nutrition, general health, oral health and health service usage.

32 Department of Health, (2018). Healthy Ireland Outcomes Framework. Dublin. Available at: https://assets.gov.ie/7626/cb95e0dbb01e-4a9fb7ce7affd609507e.pdf [Accessed 20th January 2020].

33 Government of Ireland. (2017). Committee on the Future of Healthcare Sláintecare Report. Available at: https://assets.gov.ie/22609/e68786c13e1b4d7daca89b495c506bb8.pdf [Accessed 11th November 2019].

34 European Commission. (2020). COMMISSION STAFF WORKING DOCUMENT. Country Report Ireland 2020. Brussels. Available at: https://ec.europa.eu/info/sites/info/files/2020-european_semester_country-report-ireland_en.pdf [Accessed 12th June 2020].

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3.1 Social Determinants of Health and the link to health inequalities

3.2 Long waiting times

3.3 Cost and inadequate provision of transport services

3.4 Mental health

3.5 GPs

3.5.1 GPs charging medical card holders for blood tests

3.6 Collaboration and joint working

3.7 Discrimination, respect and accountability

3.8 Medication and equipment

3.9 Administrative and structural barriers

3.10 Dental services

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The following recommendations come directly from the people who attended the five EAPN Ireland focus groups held in Cork, Donegal, Longford, county Dublin and Dublin's north inner city. Participants came from a cross section of the disadvantaged communities living in these locations including low income families, lone parent households, migrants, Traveller and Roma and people living with addictions. Specific themes emerged in these meetings, in particular how inadequate income and poor access to resources impact negatively on people's lives and health status.

The recommendations below are informed directly by the lived experience and daily lives of the participants. EAPN Ireland is deeply grateful for the honesty and openness of those who shared their stories. They did this so that future health policy can be more effective in reducing the deep inequalities in both access to health and in outcomes in health status.

3.1 Social Determinants of Health and the link to health inequalities

All participants had an intuitive understanding of the links between the social determinants of health and health status and outcome. In every focus group observations such as these were made:

Poverty is an issue - sometimes parents can't make appointments as they can't get, or afford a bus etc. They then get a letter saying their appointment is cancelled

The chances of health are seriously impacted if you live in a disadvantaged community

The health services need to think more broadly about health and be more holistic

Unemployment creates stress, this is linked to bad health as well as not having enough money

More and more people are depending on foodbanks, they have become more accepted

and a part of the system. Many also depend on the St Vincent de Paul Society

Accommodation is another big issue which affects a person's health

Transport is a big issue

It's a big challenge to afford health care if you are living in poverty or a lone parent managing childcare and everything

If someone can't afford or access food they will be sick more often

A two-fold desire was expressed; that health and social care professionals truly understand how the social determinants of health impact negatively on the health status of communities and also that they demonstrate this understanding in their approach and practise. It was noted that not all health staff were operating from a place of knowledge and belief in how difficult it is for people to struggle with inadequate access to adequate incomes, education, housing, work, participation. The need for health and social care staff to understand how corrosive and damaging it is for people not to able to access resources was very clearly expressed. Many participants felt that some health staff neither had respect for, or prioritised showing respect to, those who were struggling with disadvantage.

The prevalence of Post-Traumatic Stress Disorder, especially for some people in recovery from severely traumatising life events such as chronic addictions, mental health problems, domestic violence, racism and the challenges of living in unsafe communities was observed as an increasing issue. People also noted the aggressive behaviour of a minority of service users with addiction problems which resulted in unacceptable behaviour against health staff at times. These events were regretted. Uncertainty persisted, however, as to whether or not health staff understood the reality of how difficult it is to combat addiction while living in a severely disadvantaged situation.

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Health literacy was also noted as a barrier to access to health particularly in relation to taking medicine and using equipment. The important role of community pharmacists in reducing the frustration caused by language barriers for those seeking prescriptions was noted with positive commentary on the various initiatives at local level where pharmacies and community organisations work together for better understanding and outcomes.

Recommendation

— Training on the social determinants of health should be mandatory for all health and social care staff in both acute and community settings. Health and social care managers need to have the autonomy and responsibility to ensure that their staff undergo training to deepen their ability to engage respectfully and appropriately with people from different cultural and social backgrounds.

3.2 Long waiting times

Waiting times were mentioned as a serious barrier to access to healthcare. Poor access to both primary care and acute hospital-based health services was a priority issue for focus group participants. The stress caused by not being able to get timely access to specialist care when needed was the most cited concern raised in the discussions:

> *Not been able to access services for physical needs causes mental stress*

One participant highlighted an experience where a heart condition was not diagnosed on time. The heart condition was diagnosed by the patient, but at the time she was being treated for ear problems and had grommets inserted. She was referred to a heart specialist but missed appointments due to ill health caused by her ear problems, her appointment was rescheduled for six months later. It took two years to be finally seen by a cardiologist at which point her condition had deteriorated to a chronic level.

People commented negatively on the total length of time it takes to be seen by the required specialist, which begins with the wait to be assessed, then followed by the wait to see the actual specialist to whom they have been referred. A woman noted:

> *You need an appointment to get an assessment, and then you have to wait for the assessment to access the service*

People shared how annoying and frustrating it was to be written to for confirmation that they were still on a waiting list. While list cleansing is common practice within health systems to improve efficiencies, receiving a letter enquiring if they still want to stay on a list acted as a reminder for people of their inability to fast track their healthcare needs by having private health insurance:

> *There are waiting lists for everything, including mental health services. Those on waiting lists get a letter or message to enquire if they still want to be on the waiting list*

People are very aware that their lack of income means that they are enduring long waiting times because they cannot afford private health insurance which secures quicker access. It was also noted that the lack of consultants causes delays, which is worsened when a clinician leaves and there are delays in replacing them, which is common practice:

> *One person has been waiting for a consultant for over 3 years - if you have an appointment for a consultant and they leave, you are back on the waiting list*

Participants understood that diagnosis, intervention and treatment for certain health conditions is often time sensitive, with negative consequences arising if access is delayed or denied due to lack of resources. A participant working in an early years care and education setting stated that she liaised frequently with health and social care professionals (primary care, A&E staff, physiotherapists and Speech and Language therapists) who all have long

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patient waiting lists. In her workplace she witnesses small children not thriving and reaching their developmental milestones due to a lack of timely medical intervention to address their problems.

A mother with a young son with special needs described her negative experience of trying to get access to health services for him:

> So many problems getting a diagnosis in the public system so I went private to get it. But when I brought the diagnosis back to the public system they wouldn't accept it. So he is still not recognised as having autism.

3.3 Cost and inadequate provision of transport services

The high cost of transport and inadequate services were identified as barriers to accessing health services. The cost of travel was a priority concern surfaced by those living in dispersed rural locations:

> It can cost from €10 to €20 to get to a GP

> If there is a choice to be made to heat a home or put a dinner on the table or spend the money on a taxi or bus to a hospital appointment you know what they will choose.. it will be the food or the heat

An example was given of how inadequate local transport is:

> I live in a town thirty miles outside of Letterkenny, the last bus out of town is 4 pm so that's it

3.4 Mental health

The corrosive impact of poor mental health on individuals, families and communities was a priority issue raised in the focus groups. People were unanimous that experiencing poor mental health often stemmed from their daily struggles dealing with the social determinants of health - housing, low or no income, poor educational

opportunities and attainment, living in deprived areas with no amenities, uncertain legal status et al. The interconnectedness between poverty, the negative effects of living in poor living conditions and neglected deprived communities and the lack of adequate mental health services was clearly articulated.

EAPN Ireland welcomes the launch in June 2020 of **Sharing the Vision the Mental Health Policy for Everyone** with its focus on early intervention, social inclusion and explicit time-bound implementation targets, but knows that protected funding will be required to achieve better access and outcomes for those in need.

The theme of Post-Traumatic Stress Disorder and its prevalence in some communities also surfaced as a challenge, and a partnership approach to tackling the problem was agreed to be effective where community leaders play a central and useful role.

Recommendation

— The HSE should collaborate with community leaders and groups in areas with severe social problems to find solutions which improve physical and mental wellbeing of residents.

Responsive and fast access to community mental health services was viewed as central to health and wellbeing. The fact that stress manifests itself in both physical and mental symptoms was widely understood. There was a majority view that not having timely access to health services resulted in people experiencing poorer mental health and higher levels of stress:

> When people have a letter with the appointment, and then get a letter postponing it - it is very stressful for people who get depressed waiting

These views were confirmed by the Mental Health Commission report launched in February 2020 which confirms unequivocally that the lack of access to tailored mental health supports and services in the community is leading to poor outcomes.[35]

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This report showed how the lack of specialist services such as crisis housing, high support hostels and specialist rehabilitation places is resulting in people accessing mental health services through Accident and Emergency when they are in a crisis situation. It was noted by the CEO of the Mental Health Commission that is it totally inappropriate for a person in a mental health crisis to enter the health system through this channel.[36]

Investment in community based mental health services was viewed as essential and seen as good value for money as people understood that early intervention is more effective than costly crisis treatment when people's ability to function has broken down.

While GPs are usually the first point of contact with the health services for a person in a mental health crisis, some participants found that their GPS had been unable to direct them onto a suitable pathway for optimal care due to an absence of available resources. A woman commented:

I had a breakdown and my environment was part of the cause. I explained that to my GP but there was nothing there for me

Another person spoke of being diagnosed as having a mental health problem:

It was recognised that I had PTSD but I was not referred to a service and left waiting

Others spoke of being prescribed medication when what they wanted to do was talk.

One woman spoke of having hesitated for some time about going to the GP as she felt very low, only to notice that he was writing up someone else's notes during her consultation.

Traveller mental health was also mentioned in the focus groups and the factors causing stress, sometimes leading to suicide, were discussed. Low literacy and the inability to provide for their families were identified as factors affecting Traveller men

in particular. The need to ensure that health and social care staff genuinely understand the challenges facing the Traveller community was emphasised.

The geographic catchment structure of community mental health services was raised as a problem as it can mean long distances to travel for some patients, particularly for rural dwellers, due to poor or non-existent transport links.

Participants were unanimous in their wish for better access to counselling and talk therapy in primary care settings. They wanted 24/7 access to wrap around mental health services in their communities. They were explicit that there is a higher need for this level of access in disadvantaged communities. Better, more proactive referral processes to mental health services was requested.

The benefits of the Social Prescribing model were highlighted, where services users are linked into the most appropriate local services, both statutory and community and voluntary, to improve their wellbeing and address their health issues.

Mental Health Recommendations

Participants were unanimous in their wish for better access to counselling and talk therapy in primary care settings. They were explicit that there is a higher need for this level of access in disadvantaged communities. They request:

— 24/7 access to community-based wrap around mental health services

— Responsive integrated referral management - including Social Prescribing and to specific community and voluntary services - to optimise patient outcomes and avoid acute admissions

— Providing person-centred support for people, prior to planned mental health appointments, to encourage attendance

— HSE employing people who have experience of mental health conditions, to work in support roles in the community

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— Rolling out the one stop phone line for mental health services to all regions

— Limiting rotation of mental health doctors as consistency is key to forming trust and a positive patient doctor relationship

3.5 GPs

As GPs are usually the first point of contact, and gateway into the health services for most people, this service attracted a high volume of commentary and observations. While people's experiences with their GP are by their nature highly individual some common themes emerged.

There was a general acceptance that many GPs were operating above their capacity. Given the numbers coming to retirement it is evident that this will continue to create more gaps and delays in service provision. The Irish College of General Practitioners' has estimated that at least 2,500 GPs will be needed over the next seven years to meet demand.[37] Sustained high level of pressure on GP services was widely accepted and people understood that this high level of demand created bottle necks and delays in access.

It was noted by participants that as GPs are sole traders and not HSE employees they have a degree of choice over who their patients will be. Some people reported that GPs often have rushed consultations due to oversubscribed surgeries and did not have the time to spend communicating effectively and respectfully with people who don't speak English, are homeless, have addiction problems and complex health conditions.

EAPN Ireland is very mindful of the dedicated GPs working in severe pressure in disadvantaged areas. Like many stakeholders we are concerned at the decreasing numbers of GPs working in the General Medical Card Scheme which results in less access, particularly in deprived communities.

People's experience of accessing GPs varied greatly

dependent on their local population profile. For some access was not a difficulty while for others a wait of weeks for non-urgent appointments was the norm. A reluctance to put some patients onto the Long-Term Illness Scheme was noted by a small number of participants, while a higher number of people expressed a degree of impatience waiting for their GP to refer them to a specialist.

The issue of some people being offered anti-depressants by GPs also surfaced, usually in the context of frustration being expressed when needs, or those of their children, were not being met, due to long waiting times or insufficient service levels.

On a positive note a community worker in the Dublin region praised the dedicated Roma GP clinic in her vicinity without which it would be more difficult for this cohort to access health services.

In summary participants agreed that the GPs who show respect, courtesy and dignity in how they treat patients were very valued and appreciated.

3.5.1 GPs charging medical card holders for blood tests

The ongoing issue of some GPs charging medical card patients for required blood tests, in direct contravention of national policy, surfaced in the focus groups. This practice causes hardship for those on low incomes, who have been issued with a medical card due to their income level. Despite the Minister for Health restating in the Oireachtas that these patients should not be charged[38] the practice has not been totally eradicated, nor dealt with conclusively in the newly negotiated GP contract. EAPN Ireland is mindful that Sláintecare Workstream 2, project 2.3.01 commits to progressing priority objectives for GP contractual reform, but remains concerned that there are vulnerable patients who still experience hardship and non-compliance by some members of a powerful stakeholder group. Anomalies in approach at individual GP level to charging for blood tests included:

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One medical card holder stated she had to pay €30 each time she got her bloods done in her GP's surgery, however if she travels to the Mullingar Primary Care centre the procedure is free.

A woman shared that her GP in Longford had a notice in his surgery stating that there was a charge of €20 for bloods for medical card holders.

A show of hands in one focus group showed that out of ten people, four did not pay for blood tests while six said they did, all were medical card holders. A medical card holder in Donegal reported being charged €45 for blood tests.

The fact that medical card holders forced to pay for required blood tests can make a complaint and initiate a refund process is not widely known by either patients or HSE staff in local health offices. This refusal to protect the incomes of the least well off is disappointing given that the practice is clearly out of step with the Sláintecare principles of decreasing costs for vulnerable health service users.

GP recommendations

— GP training should have a stronger component of authentic communication and listening skills as these attributes were identified as core attributes of effective GPs.

— GPs need to be better informed of what other interventions and services are available in their community (both statutory and voluntary).

— GPS need to have a proactive approach to collaborating with local community and voluntary service providers and refer patients if appropriate.

— GPS must be open to investing time in agreeing structured ways to develop relationships and links with local non statutory service providers and organisations.

— GPs must stop charging medical card holders for needed blood tests in contravention of national policy.

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3.6 Collaboration and joint working

Low referral rates from health professionals to community-based health services and supports was accepted as a disappointing reality for many community organisations. There was a consensus view that more proactive referrals to local services, in particular by GPs and Public Health Nurses, would result in better health and wellbeing outcomes for patients.

Participants were clear that they wanted health care staff to have a deeper knowledge of what services and supports community organisations in their catchment area offer. They understood that both pressure of work and staff needing to prioritise direct contact time with patients took precedence over referrals. Some people did question whether or not health professionals valued the contribution of community projects.

A community development health worker described her personal experience

> As the coordinator of a health project I could attend the Primary Care team meetings but this stopped as the meetings became more medically focused and my attendance was dropped. The new relationships I had developed in the primary care project got dropped too.

Another experienced worker in a community health project commented:

> Many people only want to access medical professionals, community expertise is not always recognised. It comes down to attitudes and behaviour of medical people (GPs). There is often no value placed on local community expertise and knowledge. They want letters after a name

A community worker noted that at times there are difficulties encouraging health staff to participate in community organised workshops. Another acknowledged that some disadvantaged communities, hardened by their experience

of trying to secure resources, view workers collaborating with statutory services as 'selling out'. This attitude was not the majority view with most participants interested in focusing on building better relationships and finding ways to improve communication between both sectors.

Minority ethnic participants spoke of the need for the health and social care services to reflect their communities, saying that the best way to achieve this is to employ staff from these communities and marginalised groups. The Syrian Resettlement Programme in Donegal was given as a good example of this where they had a dedicated resource for a year only. They felt that it would have made sense to employ one of their community.

Positive engagement between the HSE and community organisations

An authentic commitment to community participation in the design and delivery of health services can be seen in Donegal. In 2008 the HSE Social Inclusion Office set up the process where Community Health Forum representative sit on the Primary Care Business Teams. Any community groups with an interest in health and the wider social determinants of health participates in the 15 Community Health Forums in the county. Two representatives from these Forums sit on each of the 17 Primary Care Business Teams where they feed in community priorities and issues and are part of the decision making.

Social Prescribing is becoming increasingly popular as a community intervention which links GPs and other health and social care professionals with local community-based organisations and interventions which increase health and wellbeing, particularly for those suffering loneliness, anxiety and depression. The Sláintecare Integration Fund funds seven social prescribing projects across the country with the full commitment of participating GPs with the DeepEnd group of GPs serving the most deprived communities have recruited a Social Prescribing Link

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Worker in Dublin South City to provide this person-centred service.

Social Prescribing supporting health and wellbeing locally

Social Prescribing in Donegal began as a pilot project funded by the Primary Health Care Team and the Community Health Network. GPs employed a part time co-ordinator to link their referrals into local projects and activities to improve their health and wellbeing. The service is now based in the Derryveagh Community Health Network where the co-ordinator links people referred through health and social care professionals into appropriate activities and groups.[39] All local health and social care professionals (GPs, Mental Health Nurses, Public Health Nurses, Practice Nurses and Dieticians) refer people to the Donegal Community Health Network Social Prescribing Project.

Collaboration and Joint Working recommendations

There was agreement that community knowledge and experience must be valued by health and social care professionals and that staff should make more effort to be aware of what initiatives and services are provided by the voluntary and community sector in their catchment area. Likewise, it was accepted that community groups and organisations had a responsibility to reach out to the statutory services to communicate their services. Social prescribing was unanimously thought to be an excellent and efficient model.

— Social prescribing should be rolled out and used as a priority service across the HSE and by all GPs contracted under the Medical Card Scheme. Resources must be allocated in all Regional Integrated Care Areas using the learning from the Sláintecare Integrated Fund projects to increase the use of this model.

— All health and social care professionals working in primary and community care service settings should undertake a compulsory community development training module.

— HSE should employ people from specific ethnic groups to work as paid advocates in their communities.

— Language and other supports for groups in resettlement programmes should continue as long as needed, with people employed from these communities to act as peer educators who can help people link into services and supports.

— Statutory staff must have dedicated time factored into their work plan to allow time for developing relationships, build joint working processes and knowledge of community groups.

— Both statutory and community sectors must accept that assumptions, attitudes and behaviours must change on both sides to collaborate effectively.

— Formal processes are needed to ensure authentic community representation is factored into the design and delivery of health and social care services.

— Structures must be designed, and maintained, which enable and facilitate both the knowledge of community groups and their feedback, to be fed into how local services are designed.

— Sensitive, respectful restorative space must be prioritised to build community capacity to engage productively with statutory health services, particularly in very deprived areas.

3.7 Discrimination, respect and accountability

An absence of respect shown by some health and social care professionals was highlighted with incidents shared where behaviour was dismissive and rude, and in some cases discriminatory. Discrimination was agreed as the main challenge facing the Traveller community in their engagement

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with health professionals. This view was repeated by those working with the Roma community where the lack of access to health and housing services is viewed as a major challenges, particularly as they have to work for 52 weeks before being able to access Housing Assistance Payment or to get on a Local Authority social housing list. It was also experienced in relation to people's socio-economic background. There was a view, held by a sizable minority in the focus groups, that deeply held prejudices and institutionalised discrimination can influence how health staff treat specific cohorts of service users. Some examples of poor attitude included:

A woman living in the midlands could not get onto a GP list. After six months and six refusal letters she concluded that the reason was her Traveller ethnicity. She noted that Traveller family names are well known and she thought that this leads, in some cases, to people being treated differently by health and social staff.

A patient visited a Dublin rapid injury clinic with an injured hand. He returned to the clinic the following day as he needed a letter for the Department of Employment and Social Protection for a disability payment. He was refused this letter, with GDPR compliance being cited as the reason. An argument developed with clinicians and admin staff and he left without the required documentation. His INTREO officer, in the Department of Employment and Social Protection complained to the clinic about how he had been treated and the letter arrived after this intervention.

A man shared that when he looked at his file in a major Dublin public hospital he saw written "never worked a day in his life". He found that disappointing and upsetting, he wondered how the clinicians treating him knew his work history.

Stories were shared by those in recovery for drug addiction where a lack of trust between GPs and their patients was evident, to the extent that

GPs at times refused normal pain medication to these patients, instructing them instead to attend a consultant to receive this basic prescription. Examples of some GPs using methadone as the core approach to treating drug users, even though there is a physical ailment to be addressed, were provided.

The impact of a heavy work load was thought to contribute at times to sub-standard treatment of service users. One person noted:

> Health professionals don't enter this area because they are not interested in people. They are often dealing with stress in work due to being over worked and dealing with burnout. This may lead to lack of empathy. We need to understand this

Discrimination and respect recommendations

— Cultural and ethnicity training must be provided so that all health and social care staff are aware of specific cultural differences in the Traveller and all ethnic minority communities.

— HSE managers of services must be directly responsible for both the delivery of culture and ethnicity training and for staff behaviour on completion of the training.

— Managers should visibly intervene when poor behaviour is witnessed or reported, with swift and transparent action taken in the event of a breach of good practice.

— The HSE should employ staff from minority ethnic groups and from marginalised groups to specific roles within relevant services.

People were very clear that they wanted health and social care management to be accountable and accessible at local level. They wanted local level managers to be both visible and accountable for the level and quality of the services that their staff were providing. People wanted inadequate and poor service, manner, behaviour and attitude to be tackled openly by managers, and understand that training maybe required to both enable and support

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staff to carry out this function. There were many comments at how distant and difficult to contact HSE managers can be. People stated that holding staff to account for poor behaviour and attitude was complicated.

Accountability recommendations

— Mangers must be held accountable for unacceptable and poor staff behaviour.

— Managers must be trained and empowered to step in and tackle poor performance.

— Behaviours and attitudes of staff who deal with service users with different ethnicities, cultures and religions must be tolerant, respectful and show courtesy and dignity.

— Complaints procedures must be clearly explained and displayed prominently in HSE settings.

3.8 Medication and equipment

Inadequate support and explanation of medication and equipment was identified as an issue which can cause confusion and frustration. A woman diagnosed with diabetes spoke of being handed equipment by a practice nurse and sent home without an adequate explanation on how to use it. She brought the equipment into her workplace, as a colleague had the same condition, and was shown how to use it. This same person received no advice on nutrition. She felt disappointed that not enough care had been taken to ensure that she understood how to use the equipment and to manage her diet.

Careful prescribing was noted as an important element of the GP patient relationship. Some participants stated that they did not always receive adequate explanations of how to take medication, while others had been prescribed medication which was not covered under the General Medical Scheme which caused stress and embarrassment when they had to pay for it in the pharmacy.

A woman, speaking English as a second language, told her story of looking for over the counter medication (Calpol), but the pharmacist insisted that they go to their GP to get a prescription. Someone from a community group intervened and tried to help. They highlighted the existence of a community support to the Pharmacist in question who had been unaware of this group providing help to non-English speakers. They now publicise this group's contact details in their pharmacy.

Medication and equipment recommendations

— GPs should ensure that the medication they prescribe is covered under the Medical Card Scheme to avoid unnecessary stress and embarrassment for patients.

— Instructions on medication must be written in clear English to take into account language and literacy problems.

— Pharmacists should be incentivised to collaborate proactively with local organisations to improve service user understanding. Pharmacists should publicise local groups which support specific groups (those with low literacy, foreign nationals) to understand their medication and instructions.

— To ensure consistency and patient wellbeing for long-term mental health services users who attend out-patient appointments, all prescribing should be done by a consultant, and not by Senior House Officers, who rotate on a six-monthly basis.

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3.9 Administrative and structural barriers

EAPN Ireland looks forward to improved, more seamless, patient experiences and outcomes which should flow from the better alignment of services, data and budgets within the six Regional Integrated Community Areas.[40] However, current structural shortcomings continue to have negative impacts on service users. These include:

— Applying for a medical card continues to pose problems for some who encounter administrative issues with the Primary Care Reimbursement Board:

Before I could get a Medical Card I needed to gather evidence for 6 months. There were two offices involved, one saying yes because of my son's assessment and the other saying no because of a means test.

— More effective sharing of patient information would reduce multiple assessments by different health and social care professionals. The welcomed roll out of the Single Assessment Tool, delayed for technical and procurement reasons for over two years, will be an effective enabler of speedier service provision, however this will take time to bed in across the regions and will not be used in all specialisms.

— Last minute notification for critical treatments and or tests, for example chemotherapy, can cause problems for those who must arrange childcare, travel, time off work etc. Some patients travelling from outside Dublin to attend national screening programmes and or hospital treatments are sometimes allocated early appointments which cause difficulties if they are using public transport. An example was given of a woman, with young children, given a 7.50 am appointment in a Dublin Breast clinic who needed to travel from the Midlands.

— A rigidity in access protocols to emergency services can cause frustrations particularly in times of stress. An example was shared by a service user who brought his child, who was having an anaphylactic allergy reaction, to a primary care centre, to be told that he must ring for an appointment. He stepped outside the door, rang for an appointment then re-entered the clinic to receive treatment for his child.

— Configuration and boundaries in HSE community-based services can lead to difficulties where service users do not receive access to all the services they need at the same time, but are treated in a linear way which does not take into account their multi morbidity. The outcomes of not receiving treatment when needed is particularly serious in the diagnosis and treatment of children. One participant who works in an early years care and education setting noted that young children have better outcomes when they engage with Early Intervention Teams and also Community Teams simultaneously. It was noted that some services are designed so that users have to choose which one they need even if this means they then forego access to other needed supports:

You can't be on both the Early Intervention Team list and the Community Team list at the same time so you have to choose even though it might mean not being able to access the supports that one provides.

— Referring patients to acute settings outside their living area causes difficulties for parents dependent on public transport. An example was given of people living in Clondalkin being referred to Tallaght or Blanchardstown for hospital services which creates travel and access issues.

Administrative recommendations

— Primary Care Reimbursement Service to improve the quality and responsiveness of their customer care service particularly in difficult and complex cases.

— Prioritise the roll out of the Single Assessment

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Tool across all regions.

— Take service user residence into account when scheduling appointments for tests and treatment, particularly for those outside Dublin who must travel.

— Improve communication on how to access equipment and simplify procurement to reduce the number of suppliers patients must interact with.

— Allow GPs to issue repeat prescriptions for people with chronic conditions, avoiding the need to attend specialist out-patient clinics - EAPN Ireland is aware of the ongoing modernisations in areas of eHealth, medicines management and multidisciplinary working.

— Improve access to nutritional advice in primary care settings, particularly in GP practices where possible.

— Review conditions covered under the Long-Term Illness Scheme.

3.10 Dental services

Difficulties gaining access to dental services available in the Dental Treatment Service Scheme, for both adults and children, was another priority issue for focus group participants. The limited nature of treatment and long waiting times were noted by participants:

> If you have money you can have a great set of teeth....if you have a medical card then the approach of the dentist is rip it out, rather than treat it. Those in poorer areas can't get the same treatment

> Dental services for children are not easily available - there are only one to two treatments free and then you have to pay

Waiting times to access a dentist in the public system was criticised. Lack of access to emergency dental

treatment at weekends was also cited negatively. A participant spoke of the pain endured by his wife which resulted in them going to a private dentist for treatment which cost €250. She now needs further treatment but the waiting time in the public scheme is six months, and she is in constant pain.

Dental recommendations

— Improve capacity in the Dental Treatment Service Scheme to reduce waiting time for treatment.

— Provide weekend access to emergency dental services.

35 Mental Health Commission. (2020). Access to Acute Mental Health Beds in Ireland a Discussion Paper. Dublin. Available at: https://www.mhcirl.ie/File/Acutebeds_report_Feb2020.pdf [Accessed 19th February 2020].

36 https://www.rte.ie/radio/radioplayer/html5/#/radio1/21715152 accessed February 19th 2020

37 https://www.icgp.ie/go/about/media_press_area/press_re-leases_statements/archive?spId=CEDC3295-13EF-4FCE-911C097D8282A7A6 accessed February 20th 2020

38 https://www.oireachtas.ie/en/debates/question/2019-02-05/347/

39 http://www.donegalchn.org/donegal-social-prescribing/

40 https://www.gov.ie/en/press-release/95394a-minister-for-health-confirms-restructuring-of-health-services-and-de/

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EAPN Ireland sees at first-hand how the social determinants of health, poverty and ill health all intersect to create health inequalities. This report was commissioned to make those links apparent and to propose recommendations to improve the health outcomes of those we work for and represent.

We appreciate that the Sláintecare reforms are driven by an evidence and partnership approach which has a dedicated engagement programme for citizens and health service users. We also understand that despite the depth and scale of ambition to reform the Irish health system that the elimination of health inequalities is not a central objective, in itself, of this long-term reform blueprint for the Irish health system.

We acknowledge that the Healthy Ireland Framework 2019-2025 has a role to play in increasing health outcomes and wellbeing. However, we remain concerned at this strategy's lack of ability to reach the most marginalised and disadvantaged groups and communities. We know that there are too many people whose experience of health inequalities are exacerbated by the social determinants of health and these must be addressed through an integrated policy response.

To conclude, EAPN Ireland wants to see authentic consultation with communities and service users both embedded in the culture and values of the health system and reflected in the behaviour and attitudes of all health and social care service providers. The below graphic shows the enablers needed to make this a reality.

EAPN Ireland hopes that the recommendations offered in this report contribute positively to a reduction in the health inequalities which affect our most disadvantaged.

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Figure 6 Enablers to reduce health inequalities

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Sláintecare Workstreams Graphic
and list of programmes relevant to reducing health inequalities

Sláintecare Executive Task force
Chair: Executive Director, Sláintecare

Workstream 1 Service Redesign & Supporting infrastructure	**Workstream 2** Safe Car, Co-ordinated Governance & Value for Money	**Workstream 3** Teams of the Future	**Workstream 4** Sharing Program
1.1 **Data, Research and** **Evaluation Programme**	**2.1** **Geoalignment and RICOs** **Structure Programme**	**3.1** **Workforce Planning** **Programme**	**4.1** **Citizen and Staff** **Engagement and** **Empowerment Programme**
1.2 **Population Based** **Planning Programme**	**2.2** **Corporate and Clinical** **Governance Programme**	**3.2** **Training Pipeline** **and New Ways of** **Training Programme**	**4.2** **Sláintecare Programme** **Implementation Office and** **Governance Programme**
1.3 **Service Redesign** **Framework Programme**	**2.3** **Public and Private** **Partners Programme**	**3.3** **Culture Change** **and New Ways of** **Working Programme**	**4.3** **Evaluation Framework** **and Reporting** **Progress Programme**
1.4 **Capital Planning** **Implementation** **Programme**	**2.4** **Eligibility / Entitlement** **Programme**	**3.4** **Innovation / Capacity** **Building Programme**	**4.4** **Integration Fund and** **Sláintecare Budget** **Management Programme**
1.5 **eHealth Programme**	**2.5** **Financing Reform** **Programme**	**3.5** **Future Intelligence /** **Influencers Programme**	**4.5** **Communications and** **Recognising Success** **Programme**

1.2   Population Based Planning

1.3   Service Redesign Framework Programme \
             (Model of Care, Access & Waiting Lists and Strategic Policies

2.4.01   Review the basis for existing hospital and medication charges

2.4.02   Eligibility and Entitlement Programme

4.1   Citizen and Staff Engagement Programme

🏠   Executive Summary   Ireland's public health system - a broken model   Social Determinants of Health - their role in health inequalities   Giving health inequalities a voice
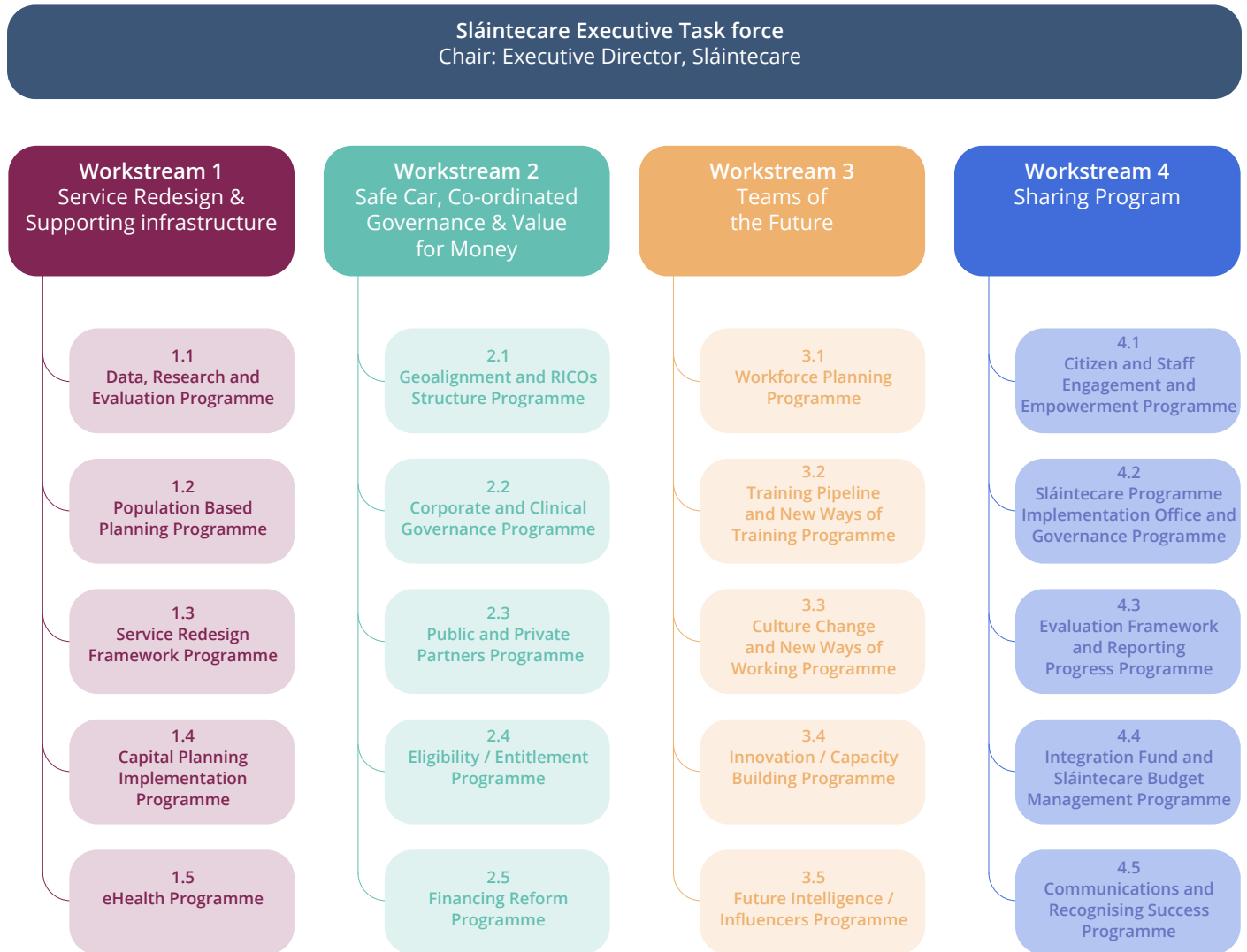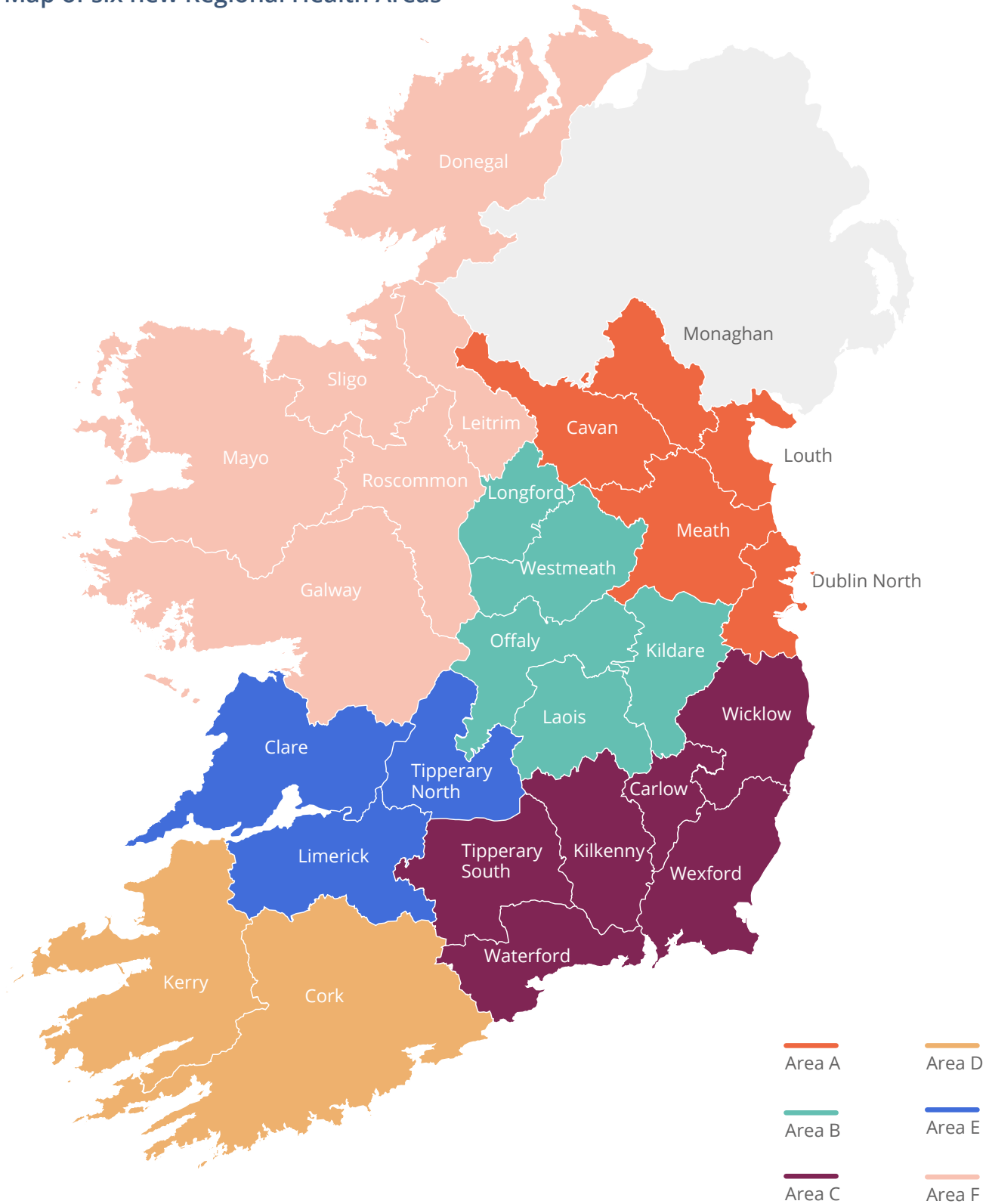
Conclusion   Appendices

Appendix 2

Map of six new Regional Health Areas

Area A
Area B
Area C
Area D
Area E
Area F

🏠 Executive Summary | Ireland's public health system - a broken model | Social Determinants of Health - their role in health inequalities | Giving health inequalities a voice

Conclusion | Appendices

Appendix 3

Details of the Counties, CHOs,[1] LHOs and Hospitals in each of the six new regional health areas

Geography	CHO Area covered	Counties/LHOs (Local Health Offices)	Hospitals (Model 4 hospitals in bold[2])	Population (Census 2016, rounded)
A	All of CHO 9 Part of CHO 8 (Meath, Louth) Part of CHO 1 (Cavan,[3] Monaghan)	Dublin North Central, North West Dublin, North Dublin, Meath, Louth, Cavan/ Monaghan	**Beaumont Hospital** Cappagh National Orthopaedic Hospital Cavan Monaghan Hospital Connolly Hospital Blanchardstown Louth County Hospital, Dundalk **Mater Misericordiae University Hospital** Our Lady's Hospital Navan Our Lady of Lourdes Hospital Drogheda Rotunda Hospital Dublin	1,080,000
B	All of CHO 7 Part of CHO 8 (Laois, Offaly, Longford, Westmeath)	Dublin South City, Dublin South West, Dublin West, Kildare/West Wicklow, Laois/ Offaly Longford/Westmeath	Coombe Women & Infants University Hospital Midland Regional Hospital Mullingar Midland Regional Hospital Portlaoise Midland Regional Hospital Tullamore Naas General Hospital **Tallaght University Hospital** St. James's Hospital St. Luke's Hospital, Rathgar	1,000,000
C	All of CHO 6 All of CHO 5	Dublin (South East), Dun Laoghaire, Wicklow, Wexford, Carlow/Kilkenny, Waterford, South Tipperary	Lourdes Orthopaedic Hospital Kilcreene National Maternity Hospital. Holles StreetRoyal Victoria Eye & Ear Hospital St. Columcille's Hospital St. Luke's General Hospital Kilkenny St. Michael's Hospital, Dun Laoghaire **St. Vincent's University Hospital** South Tipperary General Hospital **University Hospital Waterford** Wexford General Hospital	900,000
D	All of CHO 4	West Cork, Cork South Lee, Cork North Lee, North Cork, Kerry	Bantry General Hospital **Cork University Hospital** Cork University Maternity Hospital Mallow General Hospital Mercy University Hospital South Infirmary-Victoria University Hospital University Hospital Kerry	690,000
E	All of CHO 3	Limerick, Clare, North Tipperary/East Limerick	Croom Hospital Limerick Ennis Hospital Nenagh Hospital St. John's Hospital Limerick **University Hospital Limerick** University Maternity Hospital Limerick	390,000
F	All of CHO 2 Part of CHO 1 (Sligo, Leitrim,[3] Donegal)	Galway, Roscommon, Mayo, Sligo/Leitrim, Donegal	**Galway University Hospitals** Letterkenny University Hospital Mayo University Hospital Portiuncula University Hospital Roscommon University Hospital Sligo University Hospital	710,000

1 CHO: Community Healthcare Organisations

2 Model 4 hospital: This type of hospital provides regular acute and elective inpatient and ambulatory care, managing high acuitytypocedures and patients, cancer care and single national surgical specialities; and there is an Emergency Department.

3 West county Cavan: A small portion of west county Cavan continues to be aligned with Sligo/Leitrim for health services.

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