Health

The Health of the Nation

Everyone agrees that 'health' will be one of the major issues in the coming General Election. In reality, however, it is not health but health services that will be the focus of debate. But the state of the nation's health ought to merit some serious attention, and some promises of action, by those who would aspire to form the next government.

Ireland may be one of the wealthiest countries in Europe but it is not one of the healthiest. While there have been improvements in life expectancy for both men and women in the past decade, the rate of mortality for a range of illnesses is significantly worse than is the case in the best-performing EU countries. Studies in Ireland on some of the lifestyle factors that influence health status – smoking, harmful alcohol consumption, amount and regularity of exercise, incidence of obesity – do not provide a reassuring picture. While the incidence of smoking in the overall population has fallen, it remains high among teenagers and young people (around a third of whom smoke); the Irish incidence of binge drinking is the worst in Europe; 39 per cent of the adult population is overweight and 18 per cent obese, and it has been estimated that as many as 300,000 Irish children are overweight or obese.[1] There are even concerns that if the present trends in health endangering behaviours continue, today's children will have a shorter life expectancy than their parents.

Unhealthy divisions

There are, furthermore, significant social class differences in mortality rates and health status. Premature deaths, accidents, heart disease, some cancers, for instance, are more common in the lowest income groups of the population, which also have the highest incidence of low birth-weight babies and perinatal and infant mortality. Little wonder that nearly every Irish study that looks at social class health inequalities resorts to employing the phrase: 'Poor people are sick more often and die younger'.

It is widely recognised that responding to health inequalities requires addressing not just the high incidence of health endangering behaviours, such as smoking, among people who are poor. It also requires responding to poverty itself, and its related problems of poor housing, poor diet, educational deprivation, and stress. What is not generally appreciated is that addressing inequality would improve the health not only of poorer people but of the population generally: international studies show that inequality in itself poses a threat to the overall health status of a country's population. Among developed countries, it is those with the highest levels of inequality which have the worst health profiles and lower life expectancy, and conversely it is those which are least unequal that are the healthiest. If Irish society as a whole is to become more healthy, it must become less unequal.

Is there a Black Hole?

It is frequently alleged that there is a 'black hole' in the Irish health care system, into which a substantial part of the increased health expenditure of recent years has vanished, with the result, it is claimed, that all the extra spending has brought no improvements in services. A more accurate and fair representation of what has happened would be to say that, while we cannot be sure that all of the money spent has been used efficiently, extra spending has brought some improvements in services and enabled the upgrading of buildings and facilities – but not to anywhere near meeting the scale of need.

Spending on health

At first sight, the increase in Irish health expenditure is impressive. Current expenditure on health has risen three-fold since 1997, and for 2007 is budgeted at 13.4 billion, with capital expenditure projected at 4.3 billion. However, Irish health spending needs to be seen in the context of at least three important factors: the need to make up for the deficits which arose during a prolonged period, from the late 1980s onwards, when public expenditure on health was severely curtailed; the need to provide for a growing population (which increased by 8 per cent in the period 2002 to 2006 alone and which includes a increasing proportion of people over 65, the age group most susceptible to acute and long-term illness); and the need to be able to provide treatments now possible as a result of medical advances. When, as frequently happens, Irish public spending on health is represented as comparing favourably with the EU average, the importance of these factors in putting the Irish performance into perspective is usually ignored. What needs to be taken into account also is the fact that Irish health expenditure figures include the costs of social support services, which in many other countries come under a separate budget.

Scale of improvements needed

Every analysis of the Irish health care whether by official sources or by independent bodies, lays out clearly how each part of the system – whether it be primary care, acute hospital services, rehabilitation, continuing care, therapies and social supports – needs additional investment to provide improved and expanded services. In addition, there is need for changes in the way professionals work together, and better co-ordination between sectors. For example, it is widely accepted, including by the Government itself, that primary care in Ireland is underdeveloped and in most parts of the country is not in a position to provide the medical procedures that should be feasible at this level. Neither is it currently able to provide local communities with access to a full range of services, such as social work, counselling, health education, social supports, in an integrated manner.

In the context of the debate about whether the system is characterised by wastefulness, it is instructive to consider the findings of an independent review of one part of it – namely, mental health care. The Review Group on the Mental Health Services, whose report was published in early 2006, noted how some areas provided better and more coordinated services than did others with similar levels of funding.[2] The Review Group was clear about the importance of monitoring expenditure and ensuring efficiency. But this was far from being its key finding: its overall conclusion was that the system lacked the capacity to meet appropriately the needs of patients and their families through a range of services. It put forward a long list of recommendations which it calculated would necessitate 1,800 additional posts to implement and would require that non-capital investment would be €151 million greater than that in 2005.

It is likely that independent reviews of other parts of the system would reach similar conclusions – that while there is every need for mechanisms to avoid waste and ensure efficiency, the underlying capacity problems of Irish health care can only be dealt with by a continuous commitment of substantial funding. This was, in effect, acknowledged by the Government itself in the 2001 Health Strategy, published six months before the last General Election.[3] It outlined a programme of reform, involving substantial additional funding, over a ten-year period. Half-way through that timescale, the failure to provide the kind of sustained investment its implementation required means that many of the deficiencies identified remain and that Ireland has merely postponed facing up to the costs which addressing them will involve.

Equity

The 2001 Health Strategy, and indeed its 1994 predecessor, stated that equity was to be a core value underlying Irish health care provision. Equity implies that care should be provided on the basis of need, not income. In reality, the health system is structured toward inequity: speed of access to care, and the type of care received, often depend on whether one is a public or a private patient. The implications of this are all the more serious given that it is those most likely to be reliant on public care who are also most likely to have the poorest health.

Acute hospital services

The most frequently cited, but by no means the only, example of inequity in the system occurs in acute hospital care. Surveys of patients' experiences of waiting for outpatient, day care and inpatient hospital services have consistently shown that public patients can wait significantly longer for treatment than private patients. The Patient Treatment Register (as the waiting list for public hospital services is now called) shows that in December 2006 there were 15,096 adults and 2,300 children waiting for surgical procedures and 4,425 adults and 402 children awaiting a medical admission; around 30 per cent of both adults and children had been waiting for longer than a year.[4] These statistics do not adequately reflect the full scale of delay in accessing services since they include only people who have been waiting for more than three months. Neither do they reveal the extent to which patients have been waiting for a first appointment at an outpatient clinic in a public hospital.

The lack of equity in hospital care is evident also in the quality of care received: private patients have their medical care delivered by consultants; public patients receive 'consultant led' treatment, with their care provided mainly by doctors who are still in training, whose working hours are unacceptably long and who may be inexperienced, and inadequately supervised.

Key elements facilitating the present inequity in hospital care are the 'common contract' for hospital consultants, and the allocation of beds in public hospitals for the treatment of private patients. These features of the system provide the means, as well as giving important financial incentives, to allow consultants accord priority to private patients. It is obvious that reform of the consultants' contract and a significant increase in the number of consultants are fundamental changes needed if some reduction in the level of inequity in the system is to be achieved. However, more radical reform is required if the promise that the system would be based on equity is to be fulfilled. More than thirty years ago, Irish society found it possible to eliminate the distinctions in the way public and private patients accessed GP care; it is now time to start a process towards achieving the

same goal in the delivery of hospital care. A 2006 report, commissioned by the Adelaide Hospital Society, has shown that a system of social health insurance that would provide for equity of access *is* a realistic option for Ireland.[5]

Medical card eligibility

Issues of equity also arise in relation to entitlement to medical cards. Apart from those over seventy, who automatically qualify on the grounds of age, eligibility for a medical card is determined on the basis of a strict means test. Individuals and families whose incomes are modest but still too high for entitlement to a medical card may face health-related costs that constitute a disproportionate share of their income. The Health Strategy 2001 promised that 'significant improvements' would be made in regard to the entitlement criteria, thereby increasing the number of people eligible. However, it was not until late 2005 that eligibility was extended and meanwhile the percentage of the population with a medical card had fallen to the lowest level recorded since the system was introduced in the early 1970s.

In November 2004, the Government announced the introduction of a new form of entitlement – the GP-only medical card. While this meets one element of the costs of medical care for lower income people, it excludes significant other benefits of a full medical card – for example, coverage of the cost of prescriptions, public hospital charges, and other health related services. The introduction of the GP-only card was not among the proposals in the Health Strategy, and was not preceded by any published analysis of why this was considered an appropriate means of addressing the expense and anxiety faced by those on low incomes who failed to qualify for the full medical card.

Conclusion

Improving the public's health will not be achieved by the actions and services of the health system alone. Indeed, it might be suggested that the first item on the 'to do' list of the next Minister for Health should be to write 'to do' lists for his or her fellow Ministers who have responsibility for the distribution of those resources – income, housing, education, transport, opportunities for play, recreation, and sport – that have such an important influence on the nation's capacity to maintain good health and on the level of inequality in health status between different social groups.

Addressing these wider questions does not, of course, diminish the role which the health services themselves must play. Both the public and politicians have to be honest in facing up to the scale of the challenge of building a better health service – given the legacy of a long period of under-investment and the rise in population, especially in older age groups.

In recent years, there has been increasing reliance on the private sector to provide the additional services required, with this being promoted as being a quicker means of achieving progress. But the implications of this trend in terms of reinforcing unfairness in an already inequitable system have not been fully acknowledged by those who support this approach. The question also arises: do we as a society wish to turn away from a long tradition where health care was provided not just out of public funds but through the voluntary work of religious orders and non-profit bodies to one where increasingly profit-making is the ultimate motive of involvement in health care provision. A 'better' health system can only be one which truly has fairness at its core and is based on a recognition that health care is a service, not a commercial product.

In light of how deeply entrenched are the shortfalls and the inequitable features of the present system, and of the many vested interests involved, the task of developing an adequate and fair system will be a long and difficult one. However, the election of a new Dáil provides an opportune time for Irish society and its elected representatives to make a commitment towards achieving significant progress in this area.

In the past, Irish people commonly used the phrase: 'Your health is your wealth'; perhaps prosperous Ireland needs to remind itself of this truth and shape its policies accordingly.

Notes

1. *Obesity: The Policy Challenges – Report of the National Taskforce on Obesity 2005*, Dublin: Department of Health and Children.
2. *A Vision for Change: Report of the Expert Group on Mental Health Policy* (2006) Dublin: Stationery Office.
3. Department of Health and Children (2001) *Quality and Fairness: A Health System for You – Health Strategy*, Dublin: Stationery Office.
4. National Treatment Purchase Fund, *A Report on the Patient Treatment Register*, Dublin, December 2006.
5. Stephen Thomas, Charles Normand and Samantha Smith, *Social Health Insurance: Options for Ireland*, Dublin: Adelaide Hospital Society, 2006.