NWCI NEWS

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NATIONAL WOMEN'S COUNCIL OF IRELAND

National Women's Council of Ireland
Comhairle Náisiúnta na mBan in Éirinn

NWCI Women's Health Campaign 2009
Financing the Irish Health System to Achieve Equality for All

The National Women's Council of Ireland dedicated the first Member's meeting of the year to the crucial issue of financing the Irish health system and its reform. Our members took the opportunity to think about our health system, the difficulties for patients in accessing its current three-tiered structure and to discuss which would be the best model for a new public health system, from a feminist perspective. To assist in our deliberations Dr. Steve Thomas, a lecturer at the Centre of Health Policy and Management, TCD was invited to speak to members on the options for achieving a one-tier universal health system, which has equality of access and quality care as its central goals.

The health spokespersons of the Green Party, Fine Gael, Labour, and Sinn Fein, spoke on their respective Party's position on financing the Irish Health System. A spokesperson from Government was also invited to participate, but declined. Participants heard each Party's perspectives on what they believed were the failings of the existing health system and their proposals to change the way the Irish health system is currently financed through taxation, private health insurance and individual out of pocket fees. Members discussed the merits of each of the models presented and added a few ideas of their own. Elaine Houlihan, Health Projects Officer with the Combat Poverty Agency, provided feedback and observations, on the day's proceedings. The comments confirm the NWCI view that access to good quality public health services is a social right for all women, regardless of age, where you live, family status, ethnic or cultural background, socio-economic status, sexuality, ability or disability.

This newsletter has been compiled with the aim of capturing information and issues discussed at our Member's Meeting on the 19th February 2009. It has been designed to put the spotlight on Women, their health and their experiences in accessing health care services in Ireland. It aims to share information about work being done by our members and colleagues around the country to improve women's health and wellbeing. It contains summaries of each of the speaker's presentations, spelling out the obstacles in moving from the current system to a universal health system. Feedback from participants at our February Members meeting is also included for information. We hope it captures the mood of the discussions on the day, which was most definitely one of change. Also included are articles from our members to provide you with a snapshot of other equality focused and women-led health campaigns currently underway.

The NWCI women's Health Campaign hopes to build on the consensus achieved at the meeting by encouraging everyone to work together to change our health system to ensure that the currently stated goals of equity of access, fairness and quality are achieved for the whole population.

Editorial

This newsletter marks an important moment for the National Women's Council of Ireland – this is the beginning of a campaign which we feel has the potential to haul our health system out of the dysfunction in which it has for far too long been mired.

What you'll find in these pages is anger, anger at a system that looks after those who can afford to pay while utterly failing to provide for those who cannot, anger at the endless waste of precious resources, anger at the ineptitude of those charged with making the health system work. But what you will also find is a passionate search for solutions, because the NWCI is determined to harness the anger of its members and turn it into a movement for change.

The newsletter records a Members meeting our health worker, Joanne Vance, organised in February in Dublin, with key speaker Dr Steve Thomas of Trinity College. The meeting brought together members of some of the 155 member groups within the NWCI and politicians. We invited all the main parties to send a spokesperson – all of them did so except Fianna Fail. You can read their contributions – all said that they agree with the NWCI's vision of a one tier health system which is equally accessible to all of us. You can make up your own mind as to who means it - we intend to hold all of them to what they told us, and to insist that the Minister for Health, Mary Harney, listen to the women of Ireland on this crucial issue of equality.

As the new director of the NWCI, I am excited and impressed by this campaign, and by the work Joanne and our intern, Georgina Buffini have put into it. I urge you to read the newsletter – it is packed with fresh ideas – and then make your way to one of the Right to Health Workshops which we, along with the Women's Human Rights Alliance, are organising around the country in the coming months.

Susan McKay
Director, NWCI

Welcome to the June issue of the National Women's Council of Ireland's e-newsletter:

Contents:

Introduction - Member's Meeting Update

Women Voice their Opinions on the Current Health System and Their Hopes for the Future

The aim of the NWCI Women's Health Strategy is to achieve a one-tier universal health system, which will provide equal access to quality healthcare for all women. The focus of the campaign for 2009 is to address the inequalities in the system. The following is a summary of comments made by those in attendance on the information delivered by the key note speakers at our meeting on the 19th February. 53 participants representing NWCI members and other interested individuals and organisations attended the event.

Members were first struck by the fact that all speakers were in agreement that a single-tiered health system would work best for all. They recognised that although there was common thinking, amongst the political parties present that a universal health system was most desirable in terms of equity and fairness, there were very different ways of going about it. No-one doubted that change was needed and suggested that co-operative thinking and a shared policy platform, endorsed by all Parties, would be right at this time. It was acknowledged that proper research was needed, before any premature decisions are made, because the current system is so fragmented.

The Health Service and Funding – What Do You Think?

Participants stated that there was a lack of public awareness about how the health service works; the actual cost of the present system, the various sources of funding including voluntary private health insurance and out of pocket fees and a lack of transparency about how money is spent. They agreed with speakers on the importance of ring-fencing money for certain services, especially mental health.

They were candid about not having previously thought about what it costs to subsidise private health care in Ireland, through the National Treatment Purchase Fund (NTPF) Scheme, private bed allocations in public hospitals, tax breaks to developers etc. They expressed fears and concerns about the increasing privatisation of the health service and stated that Health Care is an integral part of building society and should not be seen as a source of private funds. Members were also interested in how All-Island co-operation could work to improve health care provision.

Based on the whole day's feedback, it is clear that NWCI members desired a one tier integrated and adequately resourced health system, strongly focused on Primary Care, which would be community oriented and underpinned by a population based, social determinants of health model.

Workshop Feedback

Members were asked to write both their positive and negative experiences of the Health Service currently. As expected there were more critical comments than complimentary views expressed. Their views are summarised below.

What's Right With It?

Participants stated that the best thing about the current health system is the fact that front line health practitioners are willing to work and care for people well, despite infrastructure and political failings. *"Once you get into the system you are well cared for".* Others noted the importance of medical cards for people on low incomes, and the fact that Cancer Services are now developing along the right path continues to play a positive role in women's health. The HSE strategy to ensure Health Service Users participation within the health service was also seen as significant.

What's Wrong With It?

Participants made a range of comments on the flaws in the current health system. First and formost women expressed grave concerns about the lack of governance and accountability; barriers to access and equity; gaps in health policy, planning and delivery and finally the cost of health care.

Governance and Accountability Issues

Several participants stated that the system created a culture of "buck passing" with nobody taking responsibility for problems in the service. Vested interests were named as the "medics, private companies, politicians and HSE, too few people with all the power". They suggested that improvements in governance was dependent on

the introduction of patient centred electronic information systems, similar to those used in Northern Ireland, which would support the tracking and monitoring of waiting lists, as referred to by Dr. O'Reilly in his presentation. Mechanisms for Health Service Users input/participation in designing the health system would also improve accountability.

Lack of Access and Equity

The unfair nature of a three-tier, fragmented and unfriendly system, especially for the more vulnerable and socially excluded people, was a recurring theme. Members proposed that a system that respected the basic Human Right to Health and abolished the system of up-front fees at point of delivery, particularly in Primary Care, would deliver much more to patients and to high risk groups.

Health Policy, Planning and Delivery

The following responses indicate that NWCI members are aware that there has been an ongoing process of reform in the health service, but to say that they are unimpressed with the achievements to date, would be mild. Women were angry about a disfunctional and ineffective system where "*women are literally dying while waiting for consultation".* The comments below provide clear indication of women's lack of faith in the current Government *Health Strategy, Equality and Fairness A System For You*

- Too much policy not enough implementation
- The Health System doesn't start in the community
- The (three-tiered) HSE reforms have not worked; no primary care, no health
- Prevention- Local health centres are currently under used
- No clear strategy being implemented – contradictory models being promoted
- Nurses moving on to other areas of training and not being replaced
- I think it depends on where you live (no regional/ national plan).

Members comments on the Cost of Health Care highlight how women experience health services differently, based on their financial situation. They provide a picture of the on going problems in the health service that is badly in need of reform.

- Too expensive even with expensive health insurance
- Too costly for lack of service – no preventative medicine
- Unless you have health insurance it is hard to get into the system
- Cuts prevailing in front line services, non replacement of therapists etc.
- Medical cards not easy to get (income under €180.00 per week)

Participants then looked at potential solutions for the financing and reorganisation of the health system. Please see page 14.

NWCI Member's Vision for the Public Health Service

NWCI Member's Vision for the Irish Public Health Service

The member's meeting was part of the research and information gathering phase of the NWCI's Women's Health Campaign. We initially sought member's views through a health related questionnaire, which was sent to 159 member organizations by email, to gauge member's views on their health priorities and interests in relation to women's health. We used these opportunities to ask members **what sort of health system do you and your members want?** Interestingly, both processes brought out very similar results, a summary of which is listed below, in order of strength:

- Affordable, accessible, integrated, local, equitable, culturally sensitive and appropriate. Good outcomes for all socio-economic groups (no more single GP practices), single door, same journey, primary care units; integrated health promotion system tied in with Primary Care Teams and schools.
- An equitable, accountable state run health system based on fairness, equity, accessibility, and quality, would provide a public service for all based on need, not ability to pay. SHI (Social Health Insurance) or tax based system, free at point of delivery.
- A Health service that places a human rights based approach into all aspects of the system, using the five principles, ensuring that legislation and policies compare with international human rights law, ratifying relevant UN conventions
- Adequate integrated community based mental health services – properly funded.
- Inclusive, inter-cultural, social determinants of health model used, social and economic factors have a strong impact on health.
- A women friendly Health service that takes account of the needs of the user in a holistic way, which can ensure prevention, education and complementary therapies within a public health care package.
- Greater recognition of the major life challenges for women and a health approach on how to manage the many roles as parent and carer, partner, worker and the role that many women provide in rural areas.
- Government's Active encouragement of women, especially minority ethnic women, Travellers, and disabled women at all levels of planning and decision making on women's health issues, including domestic violence and sexual violence.
- Reverse privatization and co-location.

For more details please see Underpinning Principles for Any Social Health Insurance Model on page 17.

Next steps for the Campaign - What can the NWCI and its member organizations do to support change?

The following suggestions and priorities were proposed on how NWCI should engage with the political process. There was a strong feeling amongst members that if we had gender balanced government of at least 40% women, changing the health system to a Universal one tiered health system, would be less challenging.

- NWCI Members need to shout about the immediate cuts and how they will impact on women
- Meet with the Health Spokespersons again and encourage Political Parties to work together to gain a Universal one-tiered health system
- NWCI to call on government to hold a referendum on health system - People need to vote on health issues
- We need women involved at all levels of health decision making and health planning
- Clear simple positions for us to take to constituencies, politicians and publics
- More collaboration with Dr. Steve Thomas's and his Trinity team asking to access his team's research and work up a gender analysis to finance the health system
- More clarity on the different models of health care in other countries, such as France and Belgium.

Engagement with the Political Process

Caoimhghin O Caolain, Sinn Féin Spokesperson on Health
End of Healthcare Apartheid in Ireland

One of the tragedies of the Celtic Tiger era was that the Government did not use the prosperity of those years to transform our health services on the basis of equality and excellence. Yes, spending on health was greatly increased. But much of this was to catch up and repair the damage caused by the cuts of the 1980s. In 2004 the OECD reported that Irish public spending on health was one of the lowest of any developed country, in spite of massive increases in health expenditure since the late 1990s.

We are now facing a devastating recession with health services that are still organised on the basis of an inequitable and inefficient, two-tier, public-private system. If this does not change then recession will greatly increase that inequity and inefficiency. Those with wealth will be looked after by the private system which the Government has built up while the majority dependent on the public health system will face longer waiting times, fewer hospital beds, staff cuts, closure of local hospitals and reduction of services in the community.

The recession will compound this. More people are becoming entitled to the medical card with diminishing State resources to fund them. The current system will become unsustainable.

Sinn Féin has a different vision. We believe that healthcare is a fundamental human right. We need to ensure that everyone has equal access to health services that are both equitable and efficient. We also need to ensure that factors which lead to poor health for many people, including social and economic inequality, are tackled effectively.

Studies in Ireland and worldwide have shown that those with less wealth are far more likely to suffer illness and premature death than more privileged sections of society. Therefore Sinn Féin views health not just as an absence of illness but, in line with the World Health Organisation, as a "state of complete physical, mental and social well-being" and the enjoyment of health "is one of the fundamental rights of every human being without distinction".

We translate our vision for the health services into three key proposals:

- A new universal public health system for Ireland that provides care to all free at the point of delivery, on the basis of need alone, and funded from general, fair and progressive taxation
- Fundamental re-orientation of the health system to adopt a central focus on prevention, health promotion and primary care (including mental health care), and on ultimately eliminating the underlying social and structural causes of ill-health and premature death, such as poverty and inequality
- Immediate establishment of a Health Funding Commission to report on the projected costs of the transition to an all-Ireland system of universal provision, taking into account all current health spending, including health insurance.

How would we begin the process of change? Real savings need to be identified. We need to distinguish real savings from thoughtless and savage cutbacks that diminish front-line services and end up costing far more in the long run, both in terms of people's health and demands on State funds.

Our two-tier health system is wasting money. The Irish tax payer is subsidising private health companies to the tune of hundreds of millions of euros. The National Treatment Purchase Fund (NTPF) is directly subsidising private healthcare, at a cost of €92 million. Not only does the NTPF cost more per patient than public hospitals, it also gives hospital consultants perverse incentives to keep patients on public waiting lists until they are transferred to private practice.

More wastage is evident in the treatment of private patients in public beds. The Irish Nurses Organisation has stated that private patients are being subsidised by the tax payer to the tune of €113 million per year in public hospitals[1]. Over half of the hospital beds in the Dublin Maternity Hospitals are private for-profit beds. It would be

[1] Irish Times 12 December 2008

more efficient to reinvest the €100 million spent on the NTPF in public hospital services.

We would end all subsidies of private practice in public hospitals and charge practitioners for the use of public equipment and staff, making savings of €113 million[2].

Irish hospital consultants earn €250,000 per annum on the basis of a 33-hour week. The cap of 25% of the time spent by consultants in private practice is not monitored. We would propose a "clock-in" system for hospital consultants to ensure they spend their 33-hour week in public hospitals.

The state's promotion of private healthcare through tax exemptions for private for-profit hospitals, such as the co-location scheme, have allowed investors to avoid large tax bills on their rental income. Tax exemptions should go and the co-location scheme should be scrapped. The savings should go back into the public hospital system.

In 2006, the drugs bill exceeded €1.84 billion or approximately 15% of total healthcare expenditure in this State. The cost of drugs is far higher in Ireland than in most other European countries.

I want to pay tribute to all who are campaigning for decent healthcare, especially those healthcare workers who have dared to speak out. All those working in our public health services deserve our gratitude. The vast majority of them provide excellent care, in spite of the huge difficulties they face because of the inequities and the inefficiencies fostered by successive governments.

Sinn Féin would like to be part of an all-party agreement on health to create of a single-tier, universal healthcare system, free at the point of delivery, with equal access for all based on need and state funded. We need a wider coalition for equality and excellence in our health services, to build up our public health system and harness the commitment and dedication of health services workers, communities, and patients groups and everyone in our society concerned with building better and fairer health services.

We have a positive message, there can be healthcare justice. We can have equality and excellence. We look forward to continuing this important dialogue and working together to achieve this aim.

Go raibh maith agaibh.

[2] INU, Irish Times 18 December

Jan O'Sullivan T.D.
Labour Party Spokesperson on Health

The Labour Party has been advocating a single-tier Health Service financed through Universal Health Insurance since the publication of our substantive policy document 'Our Good Health' in 2002.

The current 3-tier system is abhorrent to the principles on which the Party is founded, particularly those of equality and solidarity. We believe that people should have access to Healthcare on the basis of need not ability to pay and, along with education and housing, health is one of the areas where the society and the state has an obligation to provide security for all its citizens.

The single-tier system proposed by the Labour Party represents a levelling up rather than a levelling down so that freedom of choice and prompt treatment will be available for all. It will include free primary care and hospital treatment. The model we proposed in 2002 was based on people having a choice of insurer with the state taking responsibility for paying for those with lower incomes while those above a certain income threshold would pay their own insurance while approximately 20% of the population in the middle would get assistance with payment on a sliding scale.

The model presented by the Labour Party is set in the context of promoting a healthy society rather than developing an illness industry. We believe that all aspects of a person's life contribute to their health and people should have as much control over their own treatment as possible. We also believe that there has to be a strong commitment to primary care and that community based centres of wellness should be the focal point for an integrated service that would keep as many people as possible out of acute hospitals. Those who care in the community and the home must be valued and supported.

Mental Health is as important as Physical Health and needs to be part of an integrated service and appropriately funded.

Many things have changed since 2002 but we remain strongly committed to Universal Health

Insurance. We are reviewing our policy to take account of the changes including the establishment of the HSE and the growing privatisation under Minister Harney to which Labour is opposed. We want to restore the 'not for profit' ethos that previously pertained in the Health Service in Ireland. If we retain the model of multiple insurers they must be strictly regulated, there must be a mechanism in place to encourage 'not for profit' insurers and the VHI must not be privatised.

The Social Insurance model which has been explored in detail by the Adelaide Hospital Society is a valid alternative which has low administrative costs and which is successful in many EU countries.

A change of system is urgent both for reasons of equality and efficiency. The Labour Party costed its proposals in 2002, including the cost of the extra beds and Health professionals that would be needed to build up the capacity of the service. At that time we estimated that spending on Health would have to go up from £5 billion per annum to £7 billion.

Current public spending on Health is €16 billion with an estimated €4 billion more in private spending. This, more than anything else, shows that putting extra money into a bad system brings very poor results. Allowing for inflation and converting pounds to euros, we are still spending a lot more now than what we estimated could deliver an excellent and equal service. It shows the urgent needs for fundamental change.

The overall structure which the Labour Party would put in place would restore political responsibility to the Minister for Health, reducing the power and the management layers of the HSE. We would decentralise decision-making, where appropriate as close to the patient as possible and set up a Health Service Ombudsman.

There is broad agreement amongst most political parties; many health professionals and representative bodies and a growing number of citizens, that Ireland must change its hybrid, unequal and highly inefficient Health system. The more debate there is on this vital issue in advance of the next General Election the better so that we can establish a system in which people will have faith.

Dr. James Reilly
Fine Gael Health Spokesperson
FairCare-To Provide Health Insurance to All and End Two-Tier System

I want to take this opportunity to tell you how Fine Gael's FairCare Policy will deliver improved medical care for you and your loved ones. In mid 2008 our Party Leader Enda Kenny, established a Health Commission to develop a radical and patient focused solution that will give us the Health service that we deserve within a five year time frame. Our approach is built around the patient, rewarding performance from doctors and hospitals, and ensuring that there will no longer be a two tier health system.

Over the last 10 years the health service has become a shambles. Government has thrown money at every problem, without making any fundamental change to the way the health system works. We regularly have over 350 people on trolleys in A&E, waiting lists that go on for months, outpatient waiting lists that go on for years and cancelled operations across the country.

Our health service is a fiasco, Fine Gael proposes to fix these problems in three phases; and by addressing Primary Care, Hospital Care and the model of financing the health system; by introducing Universal Health Insurance.

We will begin by slashing waiting lists, for a fraction of the money spent on the National Treatment Purchase Fund (NTPF) every year. We will restore Ministerial accountability in the Health system by establishing a Special Delivery unit, which will set non negotiable targets for access and waiting lists. This rigorous performance management system is working well in Northern Ireland, where problems in achieving waiting lists are brought directly to the Minister for Health's attention.

Fine Gael will further reduce demand for hospital beds, by giving Primary Care the priority it deserves. We will develop a comprehensive network of new Primary Care centres where groups of GPs with other health care professionals will treat patients **free** out of modern purpose built premises with access to x-ray, ultrasound and endoscopy so that patients can be diagnosed in their communities by the doctors who know them best. The centres will also include rooms for visiting specialists and will

accommodate a robust community mental health service. The goal of every patient having a free GP package can be achieved within 5 years.

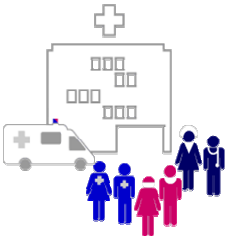
We believe that the capital costs of this programme can largely be borne by the private sector, if appropriate long term contracts are put in place. This can be achieved within 5 years, with the introduction of Universal Health Insurance.

Fine Gael will further reduce patient flows to hospital by introducing an annual National Body Test (NBT) to pick up illness early, address chronic illnesses early and to prevent the complications that land people in hospital.

There will be some who will say that we cannot afford major reforms at a time of recession. To them I say: as budgets come under more pressure we can't afford not to reform our €16 billion a year health system. It is also estimated that a further € 4 billion is going into the system in private contributions.

We will then introduce a "money-follows-the-patient" budgeting system so that hospitals are paid for how many patients they treat. Patients will no longer be seen as "costs" to the health service, but as sources of "income".

Finally, we will deliver compulsory Universal Health Insurance where every man, woman and child will be covered. This will eliminate the unfair and inefficient public/private divide. Fine Gael has looked in particular detail at the Dutch system of Universal Health Insurance as a model for Ireland's health service. The Netherlands spends only slightly more than us on health on a per capita basis, but has minimal waiting lists and is ranked number one in Europe for health.



Under Fine Gael's proposals, we will move towards the Dutch system, adapted to Irish circumstances, where everyone has mandatory private health insurance, either subsidised or fully financed by the State. Strict community rating and an obligation to cover, which means that insurance companies will not be able to discriminate against anybody on the basis of age, sex, medical history. This will be underpinned by a system of Risk Equalisation, which will compensate insurers for covering higher risk, higher cost patients. The insurance model will also address mental health.

Patients will be able to choose from a number of competing insurance companies, all offering the same basic insurance package, which will be set by the Government. Our proposals are based on the idea of **managed competition**, Heath-care providers compete for contracts with insurers on price and quality of care. These reforms will provide us with a Single-tier system where ***everyone has insurance.***

In conclusion, I want to welcome you to our special website, where Fine Gael's FairCare policy documents can be read in full. More detailed reports will be published over the next few months. I hope that you can explore the various aspects of FairCare which I believe will bring very valuable facets to our health service: access, transparency, accountability and fairness; and choice. http://www.faircare.ie/

Senator Deirdre De Burca
Green Party spokesperson on European Affairs, Health & Children and Defence

There are two realities facing us at the moment in relation to the health system:

- Most people in Ireland are despairing about the state of health services. People also recognise the positive experiences on individual level but overall the health care system, particularly hospitals, are not equitable and do not deliver the kind of services we should expect. Access to good quality health care is a basic human right but not all citizens have access to it
- Health care costs are spiralling. Other countries that have very good health care systems make a huge effort to curtail costs while using new technologies which are effective at prolonging life but are very costly. It is always a challenge for policy makers to ensure that costs do not spiral out of control which has implications for public spending. We have to make a link between the level of taxation we pay and the level of (universal) services we can expect from that.

The Green Party Health Care Policy has been boiled down to six main strategies to tackle these problems:

- Currently there is an ad hoc development of our health care system which is not informed by any specific clear vision or set of values

about how health services should be. Health education and promotion need to be prioritised as healthy citizens manage their own health better. The Green Party believes self-reliance and responsibility are very important principles. People should be educated to manage their health better (individuals and families) re: obesity etc., and there should be ring-fencing of funding for this. Funding is currently limited to 1% of the health budget but this gets moved/taken for other priorities which is a reflection of the fact that we do not acknowledge the importance of health promotion and education. We also need to measure the effectiveness of programmes. They need to have impact and clear objectives such as innovative ways of promoting health, e.g. community support programmes for young mothers and breast feeding etc.

- We should pay more attention to other related policy areas that have huge impact on health:
    - Environmental, social factors such as the ban on smoking and smokeless coal. Both policies had major impact and will continue to over time
    - We also need to examine other connected policy areas and to be consistent with health policies, for example, tackle issues on proper planning, housing estates and encourage walking
    - The whole area of community supports and families in underprivileged areas needs to be explored and encouraged. These supports are very important and have a huge impact on people.
- Alternative health care should be properly integrated into the health care system as it is still considered to be on the fringes of medicine. People recognise alternative methods to health care even though they still use mainstream medical services. Unfortunately insurance systems do not cover alternative treatments and they are largely not recognised by the conventional medical system, which needs to change. We need to integrate and regulate alternative treatments and people need to be able to access both.
- Primary health care (PHC) systems need to be developed properly and they need to be free at point of access. Research has shown that 90% of health care needs can be met at PHC stage, once they are properly developed. There should be availability of diagnostic and multi-disciplinary treatments, e.g. physiotherapists, dieticians, etc. as this would help take the pressure off the costly hospital system.
- We need to bring in much greater decentralisation of health care structures as the HSE has proven to be disastrous with its severe lack of accountability and transparency. The Green Party is in favour of decentralisation and greater public participation at local level. It is essential that local communities have the opportunity to have input into health related decision making in local areas which could get fed back up to government level.
- The Green Party supports a universal compulsory health care system that would cover access to PHC, hospital care and hospice care.

All of the above will have implications for taxation system and we need to be honest and realistic about this.

Financing the Health Care System in Ireland: Options for Achieving Policy Goals
Dr. Steve Thomas, TCD

Steve Thomas' presentation reviewed the nature of the health care financing system in Ireland, the main problems it faces and potential solutions, focusing on Social Health Insurance as an option.

What is the problem?

Despite the massive increase in health funding over the Celtic Tiger years, the health care system in Ireland is still characterised by inequities, inefficiencies and limited capacity. Access to good care is uneven and there are many inefficient subsidies from the public to the private sector. The population can be divided into three tiers: those with private insurance (who get faster access to higher quality acute care) those with medical cards (who get free access to GPs) and those with neither (who are not entitled to anything without paying extra for it). There is also a shortage of skilled professionals and modern health care infrastructure: Ireland has quite a low bed density as a result of historical underinvestment and a very low doctor to population ratio.

Assuming that doing nothing is no longer an option there are three main choices:

Develop Ireland's public system of finance: extending medical cards to more people is cheap, as the most expensive citizens are already covered (the poor and the old). Removing subsidies for private providers also makes sense. However, public financing is dependent upon general taxation which is being hit hard by current circumstances. Further people generally dislike paying taxes and hence the health system is always likely to be underfunded.

Extend current private insurance system: this risks being inequitable as private insurance is related to ability to pay. Also private insurance systems are notoriously expensive (see USA) as there are few incentives for cost control.

Adopt Universal Health Insurance: This is new to Ireland but would involve all people paying a regular contribution based on income, access to care being determined by clinical need and not ability to pay, contributions to the social insurance fund (or funds) being kept separate from general budget funds and the social insurance fund purchasing care on behalf of the insured persons (contracting with both public and private providers depending on who provides the best deal).

How to get social insurance right: Social Health Insurance (SHI) is a mechanism and not a policy it can be tailored to meet different policy objectives. Its main advantages are transparency which often proves popular with the public. For Ireland the TCD team suggest several principles: it is not worth doing if there is no improvement in health services; it must be designed to address equity and efficiency; there must be no subsidies for providers; all those paying no income tax (approx 1/3 of population) do not pay for SHI and there should be no ceilings on contributions for the rich.

SHI Options or Stages

The ideal would be to get to what the TCD team call the "Levelling up" option. This gives medical cards to all the population and effectively extends the benefits of private supplementary hospital insurance to all (including private/semi-private hospital beds and access to consultants). However an SHI system could also prioritise just PHC (medical cards for all) or just hospital care (better access to private beds and consultants) as an end in itself or a stepping stone to Levelling Up.

Costs and Financing

SHI systems tend to cost more than taxation-based systems. Costing Levelling up model reveals that it would increase spending by around 2 billion or 1.4% of GDP (a measure of economic activity). Nevertheless, there may well be efficiency gains with contracting. Further additional costs would be for additional services. Most of the burden of this would fall on the rich. The unemployed would pay nothing, while those on low incomes would pay around 20 per month extra for free GP care, drugs and good access to acute care.

Moving Forward

There needs to be clarity on objectives for the health sector. The recession might help focus us on what needs to be done and bring consensus. SHI would bring transparency and could be associated with increases in funds as internationally populations are more willing to give to an earmarked fund than to general taxation. BUT we need capacity expansion: more beds and more doctors in particular. Furthermore, we need to be strategic, as change will always bring winners and losers and those who manage reform must be prepared to tackle vested interests**. Due by the end of 2009: the study will review SHI financing options and consider what organizational structures will be needed.**

"More budget cuts. One gown per room. Who wants to wear it first?"

Potential Solutions

Potential Solutions: A New Health Funding Model for Ireland

In his presentation Dr. Steve Thomas highlighted four financial options, which could be developed to provide a new model for health care in Ireland. Some of these models were discussed in more detail by the Health Spokespersons from the three main opposition parties. Participants were given the opportunity to debate these options in their workshops. Their comments are presented below:

1. **Do Nothing Option**

   Participants felt that this was not an option as change was most definitely required. It is essential to move away from the current system and to use this current national funding crisis to develop new thinking and a shared consensus on the best model for Ireland.

2. **Develop Current Mainly Public System of Finance and Delivery**

   This means that the system would be funded directly by taxation and it would be delivered through public services. This system would remove any subsidies or tax breaks to private health insurance or private health service delivery. *(Sinn Fein spokesperson Caoimhghlin O'Caolain discussed this model in his presentation).*

   Participants were in agreement that public funds raised through taxation should be used to support the public health service and not for the purpose of subsidising the private health care market. Participants were not in favour of selling/giving public land for private gain.

3. **Extend Current Private Insurance System to the Whole Population**

   This model is being proposed by Fine Gael and is based on the current Dutch system extending private health insurance to the whole population. They hope it will address the current problem where a sizeable part of the population is effectively uninsured, with no Medical card or voluntary private health insurance. The Netherlands had a publicly funded system before moving towards a system of managed competition - "money follows the patient" model. Government regulates the system to ensure that everyone is covered and every one has access to health services, based on need.

   Participants felt that they needed more information on how the government subsidy works, the role of the health insurance companies, and the role of the state and private health provider in delivering health care. They expressed concern that any health system would become answerable to insurance companies, citing difficulties faced by banks, Irish Life, BUPA Ireland. They stated a preference for a needs-driven rather than profit-driven health service.

On the Positive side this model is:

- Not dependent on public taxation
- Could be more competitive, and would keep prices down.

Challenges/negatives:

- Concern that the Dutch system is being adapted without due consultation with other successful systems i.e. Belgium, France
- System dependent on good health care infrastructure, bed capacity, primary care, number of doctors etc. Ireland still has to catch up with the Netherlands
- Can the insurance companies be trusted not to operate as a cartel? Strong monitoring on the part of the State is required – can the State be trusted to fulfil this role?
- Dutch System needs good regulation by government – Ireland does not do regulation well – look at the banks!
- Somebody or some groups will loose out if insurance companies don't want them – will it be equitable?

Universal Social Health Insurance

This is the preferred model as put forward by Dr Steve Thomas TCD Centre of Health Policy Management. The Health System is funded through a specific health insurance contribution (compulsory) made by citizens, and scaled progressively according to income. Unemployed people are covered as their contribution is made by the state. It can be designed to give universal, equal accessible services to all. **Participants were keen to learn more about this model.**

Positives

- One tier access for everybody based on need, not ability to pay
- Transparency - money collected goes into a specific fund for health
- Takes the tax breaks out of the system and all the perverse incentives.

Challenges

- If the scheme is based on income it would work for the PRSI worker but what about:
  - Non PRSI workers / self employed. How would you ensure that they paid their share? This would need to be fair and transparent
  - What about women working inside the home, would they be included as individual citizens even if they were not making employment contributions or claiming benefits or credits?
- Need to make sure there is an emphasis on primary care by first putting investment and proper infrastructure in place.
- Will everyone be eligible for the scheme, migrant women in the home, asylum seekers, homeless people etc.

Which model would best ensure equality for all women?

Participants felt that they need more in depth information on all the financing models before they could state a preference. However they stated that it was extremely important for the NWCI to hold a strong critical voice at this time. Decisions on the best approach to take should be based on clear principles for health and well being, such as those outlined in this newsletter. Over the next few months we will continue to facilitate discussions with our members and other interested groups to establish a clear NWCI policy position on the future direction of the Health service, including the best policy option for financing the health services, based on our expressed goal to achieve equality for all.

Underpinning Principles for any Social Health Insurance Model

Under-pinning Principles for any Social Health Insurance Model

In his presentation, Dr. Steve Thomas explained that Social Health Insurance is a mechanism to raise finance to support the health system. It is not a policy in itself, and there is no point in doing it if the system and the services are not going to improve as a result. Every health system needs a clear vision of what sort of health system is wanted and we need to develop rules and principles to govern it.

NWCI aspires to a vision of women's health in Ireland where all women are enabled to reach and maintain optimal levels of health across their live cycles.

Workshop participants agreed that the key to developing a NWCI position on the financing of the health service would be to establish key rules and principles to inform policies and practice within the Health Service. Interestingly, the following principles mirror those identified in the NWCI research publication entitled ***Women's Health: Meeting International Standards*** (2006) which situated women's health within a human rights context:

- Recognise the social determinants of health (and women's health)
- Culturally appropriate accessible provision - women are a diverse health population with particular health needs
- Embrace the principles of equality and human rights, to achieve equal access
- Encourage participation by all groups of women in decision making at all levels
- Transparent, integrated and adequately resourced public health system
- Emphasis on primary care, health promotion and alternative health care models across the life cycle
- Promote social inclusion -targeting those who are most disadvantaged and those suffering most from the economic downturn
- All island perspective – Good Friday Agreement (principal of equivalence)
- Adopt gender mainstreaming strategies to improve health service policy, planning and provision.

Is the Health System a Feminist Issue?

How government funds the health system - Is it important? Is it a feminist issue?

These are some of the reasons given by members as to why the NWCI should be addressing this issue:

- "Yes, it is a feminist issue. All issues in Ireland affect women due to a gender imbalanced government and decision making. We pay tax PRSI but women are not equally represented in decision making."
- "More women in politics! Women who support the issues of concern to women!!"
- "Health affects everyone - with the universal health system, women would have better access and security."
- "Yes! Women are often main bearers of responsibility for family and community health; women are not getting the service they need."
- "Representation/participation needed at all levels in health service to inform policy. Especially minority ethnic women."
- "The government has no human rights impact assessment for plans, proposals, policies, programmes and especially budgets."
- "How funding is delivered is crucial not only for reasons of equity but also to quality and best practice."
- "Women experience or are at risk of poverty in greater numbers. Poverty pre-determines poorer health. We need to be involved."
- "The majority of services being restructured are in women's health, i.e. smear tests to 60, mammograms to 65, vaccinations for cervical cancer prevention for young girls. Does a woman's health not matter past 60 up?"
- "A good quality health service means women can undertake health prevention/awareness at home and in the community."
- "For sick women there is a lot of frustration, long waits, mixed up files, incorrect information."
- "Recognition of the importance of all paid work, especially essential services mostly done by women - clerical officers, catering, cleaning, porter, makes for a better health service."

Feedback from Member's Questionnaire

Introduction

As part of the research and information gathering phase of the NWCI's Women's Health Campaign, a health related questionnaire was sent out to 159 member organizations by email on 19th January, to gauge member's views on their health priorities and interests in relation to women's health and the public health system. A second call or appeal to members was made in March. This was followed a final round of telephone calls during the last week of March. In total 56 out of a possible 159 responses were received, representing a 35% response rate. Respondents were also asked to indicate their organisation's level of activity in relation to women's Health. The survey results confirm that women's health is a priority for at least 75% of our membership, with 14% of respondents stating that it was a core part and a further 59% stating that health was an element of their organisation's work. In addition 21% of respondents stated that the issue of women's health was of general interest to their organisation. The profile of the member organisations that completed the questionnaire is broadly representative of the membership. Please see Chart One:

Chart 1: Profile of Organisations (56 Respondents Total)

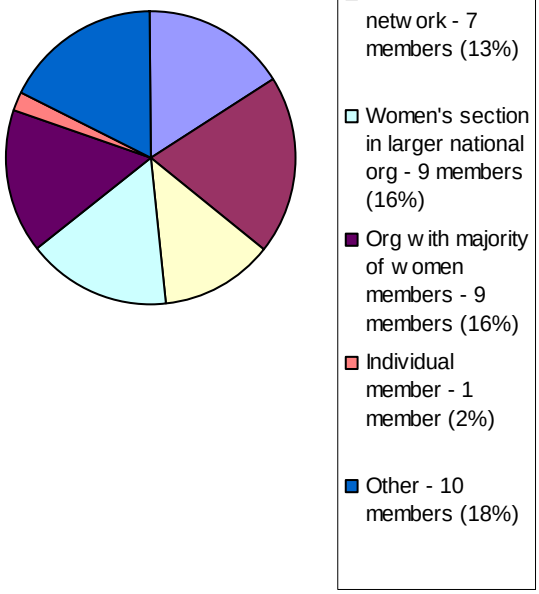
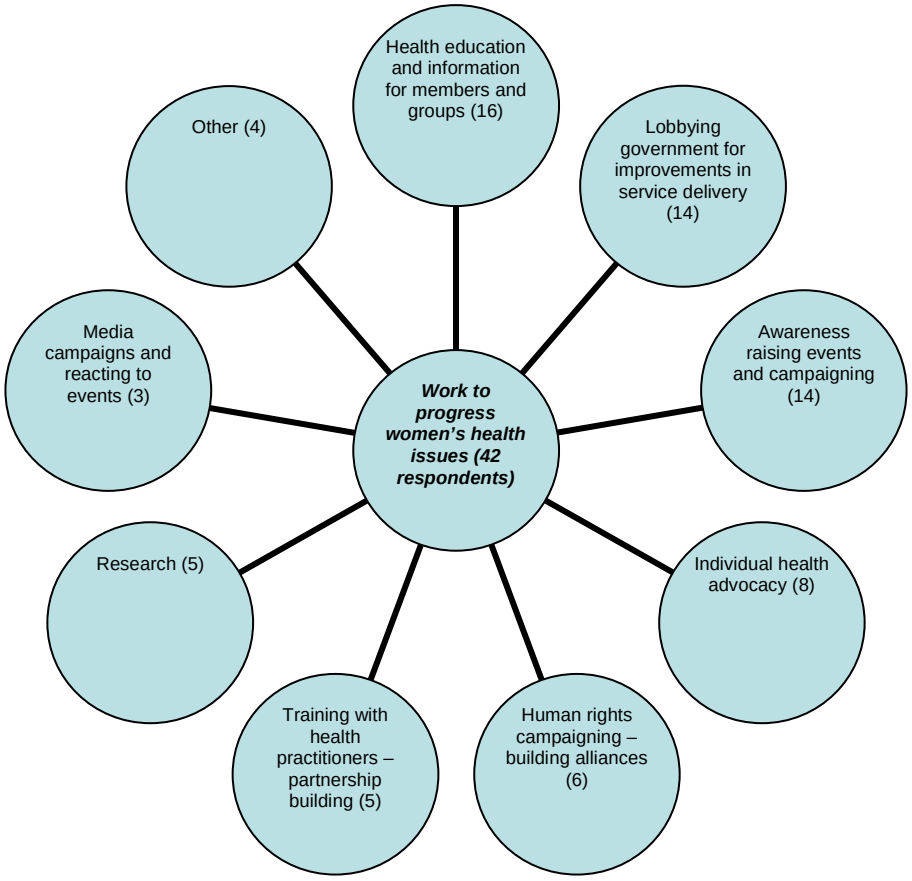
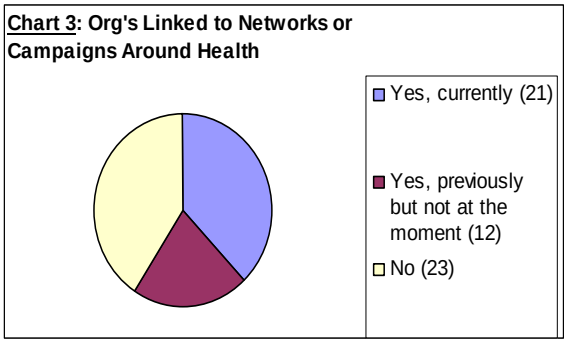


Chart 2: Members described a range of ways their respective organisations work to progress women's health issues. The majority of respondents gave more than one example of how they worked to achieve their goals. It demonstrates the variety of ways members are involved at local, regional and national levels.





There have been a wide range of women's health campaigns including cancer services, sexual and reproductive health and violence against women. Other organizations were campaigning for better access to quality services locally and nationally. A few examples were given of alliance based campaigns. These were the Women's Human Rights Alliance, the Mental Health Coalition and the Cross Border Women's Network. Please see Health Campaigns in Focus on page 25.

Table 1:

The three most important issues for member organisations	Totals	Rank
Breast, cervical and ovarian Cancer care	**45**	**1**
Health practitioners lack of understanding of women's health	**36**	**2**
Affordability of health care	**28**	**3**
Other *	**28**	**3**
Other community based services	20	
Privatisation of the health service	20	
Lack of women friendly policies	20	
Sexual and Reproductive health	18	
Maternity Services	16	
GP visits	11	
Waiting lists	9	
Public health Nurses	8	
Access to Accident & Emergency	7	
Changes in HSE structures	7	
HPV vaccine	2	

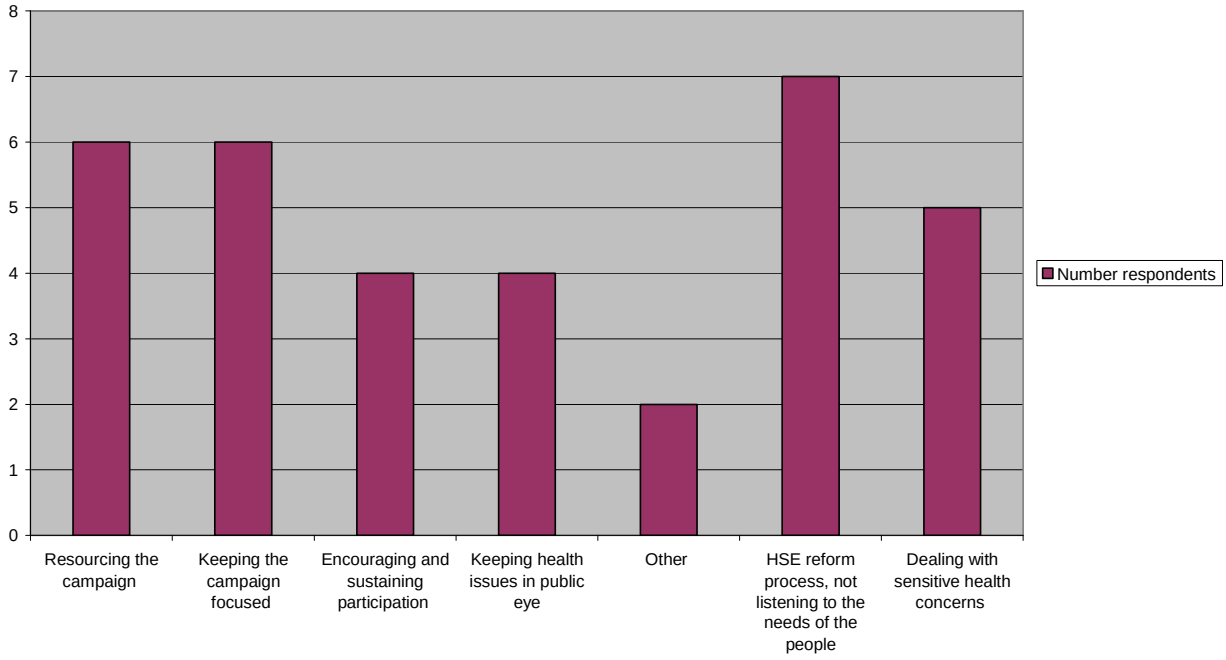
*Within the Other category, members stated that mental health issues and eligibility to services/health discrimination were key priorities.

Table 2:

What Actions, Programmes or Politices would Improve the Public Health System	Totals	Rank
Greater representation of women's concerns at all levels of health services planning and decision-making	**242**	**1**
A women friendly service that takes account of the needs of the user in a holistic way (physical, emotional, family)	**225**	**2**
One tier public health system	**200**	**3**
Change in the underpinning values of the health service to incorporate equity, dignity and respect	197	
Recognition by service providers of the impact of caring responsibilities on women's health	172	
Comprehensive education on health matters (Health promotion)	167	
Other	6	

Respondents who expressed an interest in being involved in an NWCI Women's Health Campaign	
Dublin and Wicklow	21
Kerry	3
Cork	3
Limerick	3
Galway	2
Mayo	1
Carlow	1
Tipperary	1
Monaghan	1
Donegal	1
Belfast	1
Total	**38**

Chart 4: Campaign Challenges



Health Campaigns in Focus

AMNESTY INTERNATIONAL

Amnesty International Ireland will shortly be launching its groundbreaking new mental health campaign.

What's particularly special about this campaign is that its agenda has been set by rights holders – that is, people with direct experience of using mental health services. So we know it will address the serious problems they know to exist in Ireland's mental health services.

AI has been campaigning in the area of mental health since 2003 and has a committed determination to ensure the human rights of people so often stigmatised and marginalised by society are respected.

Under international human rights law, everyone has a right to the highest attainable standard of mental health and mental health services.

Ireland recognised this right when it ratified the International Covenant on Economic, Social and Cultural Rights, in 1990. But this right is far from a reality for the majority of people using services today.

The Government mental health policy, *A Vision for Change*, was launched in 2006. And although the Women's Health Council had recommended in its 2005 report that a gender approach must be adopted in order to understand and treat mental health problems effectively, this directive was largely ignored. Instead the report was criticised for omitting to include a gender element in its recommended policy.

Despite this gap, AI and other campaigners welcomed the policy because it did promise some positive changes, including an overhaul in how services are provided to enable the move from institutional care to care in the community. It also recognised the crucial importance of having service users centrally involved in planning and decision-making. It is also cross-departmental, importantly, including recommendations around housing, education, for example, in addition to health.

But three years into the policy progress is painfully slow while funds under *A Vision for Change* have simply not materialised.

In the 2006 and 2007 Budgets the HSE was allocated an additional €51 million to develop this policy but the whereabouts of much of it remains a mystery. Millions were diverted into spending gaps in other areas of the HSE.

In Budget 2008 and 2009 there was no allocation of additional funding at all. Because of a lack of facilities 247 children were placed in adult psychiatric facilities in 2008.

Specialist mental health services, such as for people with eating disorders or brain injuries, are largely unavailable outside of Dublin.

Important areas of policy have been sidelined, such as advocacy and peer support. Governmental departments outside of health have not pulled their weight.

In September of last year the Mental Health Commission report, *The Economics of Mental Health Care in Ireland*, estimated the direct annual cost of poor mental health in Ireland at a staggering €3 billion, or 2% of GNP. In this economic climate, surely we should be increasing, not decreasing, investment in all the mental health services set out in *A Vision for Change*.

The right to health is not a stand-alone right; it embraces a wide range of socio-economic duties on Government to promote conditions in which people can lead a healthy life such as food and nutrition, housing, safe and healthy working conditions, and a healthy environment. All Government Departments must live up to *A Vision for Change*.

As part of our campaign we will be working on a number of objectives to ensure that government recognises its responsibility to prioritise the improvement of mental health services and related supports.

But to achieve this Amnesty International Ireland needs your help. Hundreds of people take action every month as part of our Mental Health Lobbying Network, demanding that their elected representatives honour their commitments on mental health and calling for all Departments to take action.

With your support we can end the practice of putting children in adult psychiatric wards. We can get a real implementation plan for mental health services and other associated areas. We can force the Government to roll out the Community Mental Health teams programme.

But it won't happen unless you make it happen. Get involved, email mentalhealth@amnesty.ie - put human rights at the heart of mental health policy in Ireland.

WHY WE'RE FIGHTING CERVICAL CANCER WITH ONE HAND TIED BEHIND OUR BACKS
A perspective from the Dublin Well Woman Centre, May 2009

Every year in Ireland, more than 200 women are diagnosed with cervical cancer, and between 70 and 80 women die.

Since 2006, we have had two vaccines available in Ireland that have the potential, over time, to significantly reduce our high instances of cervical cancer. The vaccines work by fighting against some of the sub-strains of the Human Papilloma Virus (HPV), the sexually-transmitted infection that causes over 99% of cervical cancer.

On the face of it, having a vaccine that reduces the risk of getting cervical cancer by over 70% is a wonderful development. Most European countries, as well as many of the U.S. states, have already introduced Government-delivered vaccination programmes to get the vaccine to young girls before they become sexually active (when the vaccine gives the best protection).

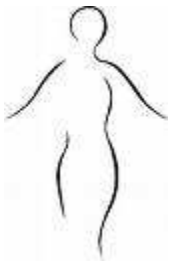
Last August the Minister for Health announced plans to introduce a HPV vaccination programme for 12 year-old girls and said that its introduction 'could significantly reduce overall cervical cancer rates'. We were delighted by her announcement; despite the fact that the intended programme focused solely on 12-year olds (expert advice to the Minister had recommended that the vaccine be given to 12–15 year old girls).

In a stunning reversal of policy, and reinforcing the lack of serious commitment to decent sexual and reproductive policies and services in Ireland, the Minister in November 2008 announced that the HPV vaccination programme was being cancelled for budgetary reasons. Even given a tightening public purse, this decision is short-sighted and Well Woman has since been campaigning to have it reversed.

Whatever short-term budget savings may be made by not proceeding with the vaccination programme, the reality is that unnecessary deaths will arise among the cohort of girls who were to be targeted. Furthermore, because money is being pulled at the prevention stage, it can be expected that exchequer costs will be incurred in treating women who will inevitably develop cervical cancer. To this end, the 'cost savings' – both in terms of lives and money – is questionable.

So how do we fight cervical cancer?

Since Autumn 2008 we have had a National Cervical Screening Programme called CervicalCheck and it makes it possible for all women aged between 25 and 60 to have regular smear tests, free of charge, either from their own GP or a Well Woman clinic.



Cervical cancer is a very slow-developing cancer, and smear tests aim to detect cells in a woman's cervix (the neck of the womb) *before* they turn into cancer. This means that as soon as changes are detected on a smear sample, the woman can be monitored and get the appropriate follow-up, either more frequent smear tests, or referral on into a hospital-based gynae clinic for further testing and treatment.

Having a national, population-based screening programme for cervical cancer is real progress in the battle against this cancer. Being able to access the test free-of-charge should make a huge difference, as research has shown that as many as 1 in 5 women in the target age group has never had a smear test.

Cost may have been a barrier in the past, but there is also a huge information gap in terms of

making women aware of the need for regular smear tests. In Well Woman, we have three Dublin clinics, each of them in a different part of the city, and each seeing a different demographic group. This means that we can compare and contrast test results between the three clinics.

When we look at smear test results from our Coolock clinic we can see that in every age category, from 20 years on up to 49, medical card patients are much more likely to have an abnormal smear test result, compared with women attending our Ballsbridge or City Centre clinics. This is a clear demonstration of the link between low economic status and poor health:

- Cervical cancer is more prevalent in areas of social deprivation
- HPV is more prevalent in women who are smokers
- It is also more prevalent across groups who first experience sexual intercourse at an early age
- Poorer immunity, resulting from poor diet, is also a possible contributing factor to low resistance to HPV.

Well Woman wants to see the National Cervical Screening Programme start a number of targeted communication initiatives in areas of high social deprivation, to emphasise the importance of smear testing. We hope any restrictions to their funding will not impact on this important area of their work.

In February 2009, we started our own (limited) vaccine programme for 12-year old girls from our Coolock clinic because of the higher numbers of abnormal smear tests in women in that area. What we are doing has a very political goal – to demonstrate to the Minister that high demand exists for the HPV vaccine, and that parents want to access it for their daughters.

However, our small initiative is NOT a substitute for a national, Government-delivered vaccination programme. Making the vaccine available publically, combined with regular smear testing, has the potential to really turn the corner on the appalling reality of nearly 80 deaths each year.

NOTE: The HPV vaccine is a complementary tool in the battle against cervical cancer, and is not a substitute for regular smear test

Alison Begas
Chief Executive, Dublin Well Woman Centre

Breast Cancer Advocacy: Getting key messages to all women

Europa Donna Ireland, The Irish Breast Cancer Campaign (EDI), is an independent non-profit, volunteer run, breast cancer patient advocacy organization, one of 42 countries affiliated to EUROPA DONNA - the European Breast Cancer Coalition.

Our mission is to bring the voice of the woman with experience of breast cancer:

- to raising awareness of the need for **screening** and access for all women to best quality **specialist centres** and
- to campaign for evidence-based, best practice health policy changes to ensure this happens.

In particular, Europa Donna Ireland wants women of all ages in Ireland to know what they can and should expect in terms of risk, diagnosis, treatment, recovery and support in order to improve early detection rates and survival rates for breast cancer.

In Ireland, 6 women are diagnosed with breast cancer every day and every week twelve women die from it making breast cancer the most common cancer and leading cause of cancer death among women in Ireland. Incidence is increasing by 2% every year and our mortality rates are 15% higher than the EU average and 30% higher than in USA.

But the good news is that population screening for breast cancer works and starts to show results when it is offered with high quality specialist breast disease services. Mammographic screening can detect breast tumours up to four years before a woman would notice the symptom herself. By the end of 2009, BreastCheck will have a presence in every county in Ireland.

Over the last few years EDI has been campaigning strongly for specialist breast centres in Ireland and the national cancer control strategy received a major boost in 2007 with the appointment of Professor Tom Keane as Interim Director to establish Ireland's specialist cancer centres. The fact that breast cancer services have been prioritised means that we are well on the

way to having the 8 specialist breast centres in place by the end of this year. For the first time, we now have the opportunity to make substantial gains in reducing the number of deaths among women due to breast cancer in Ireland.

Not surprisingly, it is the voices of women that have been instrumental in pushing for change including the voices of women, sadly no longer with us, who fell victim to outmoded practices and failure to benefit from the best that medical science has to offer.

While we are on the right road, changes of this magnitude take time. But the direction is clear and unequivocal and the momentum must not be lost despite the economic downturn.

Your risk of breast cancer doesn't stop at 65 and yet there are still many challenges. BreastCheck stops at age 64 for women, despite the evidence that risk continues and **increases** for women as they age. Three quarters of breast cancers are found in women over 50 and while the cumulative risk of a woman developing breast cancer before the age of 50 is one in 48, before the age of 65 it is 1 in 16, and by 75 it is 1 in 11. Clearly, the implications are that screening must continue for women into their 70's and women have to make their voices heard and insist on staying in the screening programme.

The fact that the risk of developing many cancers is related to lifestyle behaviours such as obesity, physical activity, alcohol consumption, smoking, diet and nutrition suggests that there is considerable scope for cancer prevention through lifestyle changes and this is no less true for breast cancer. Europa Donna's **Breast Health Day – 15th October** focuses on what women can do to reduce their risk of getting breast cancer.

Primarily because the evidence suggests that disadvantaged women are less likely to access the screening and treatment benefits associated with earlier detection and increased survival, EDI has partnered with DESSA – Disability Equality Specialist Support Agency, to access networks, project workers and community education approaches to get important messages about breast cancer to women in key target groups and in disadvantaged / deprived areas. Already a successful collaboration with NWCI has yielded interesting possibilities.

With the assistance of Lottery funding, EDI is keen to develop a network of informed advocates through its advocacy training programme, so if you are interested in the work we do, or for more information on our publications, and Breast Health Day.
www.europadonnaireland.ie or contact us at info@europadonnaireland.ie

Monaghan Alliance: Campaign for a Locally Based People-centred and Women-centred Health Service

It is a well documented fact that health outcomes for women are poorer than for men in many acute illnesses, the most studied having been that following heart attacks. Recent figures have also shown that while life expectancy has improved in Ireland for men, women have not seen an equal improvement. The reasons for this are multifactorial but access to healthcare plays a major role in all this data. There is great concern that reducing accessibility to acute hospital care in Monaghan will lead to adverse outcomes for all the local population, but most especially that of the women in the area. Increasing rates of heart disease in women has lead to increased numbers of women suffering heart attacks. It is well documented that with immediate treatment of a heart attack survival rates are high.

However, the closure of Monaghan General Hospital will lead to critical delays in receiving such treatment. Patients from the Monaghan area will now be faced with travelling to Cavan or Drogheda or even Northern Ireland to receive their care instead of the present situation, where they are taken to Monaghan Hospital and given the necessary care. International studies have proven beyond doubt that an increase in distance to acute hospital care leads to increased mortality.

The Closure of Acute Hospital services in Monaghan General Hospital: Its Impact on Women
The women of Monaghan have already suffered as a result of service closure in Monaghan Hospital. The transfer of maternity services to Cavan has created pressure on the maternity department there. This pressure has meant that women are pressurised into accepting early

discharge from hospital after their delivery with no extra home support being provided. The loss of Gynaecology services has had a major impact on women's health. Following a referral from their GP women are now faced with a 9 month wait before being seen in the gynaecology clinic. Many of these women are suffering from pain or heavy bleeding and thus have a reduced quality of life as a result.

Even more of concern has been the removal of the colposcopy service from Monaghan Hospital. Women with worrying abnormalities following smear tests were investigated and treated at this clinic. Failure by the HSE to provide the necessary support to the clinic has meant its closure and these women are faced, not only with a further time delay in being seen, but also the stress of having to travel to Dublin or Drogheda for their appointment.

When a Monaghan patient is brought to hospital in Cavan or Drogheda, it is the women who will suffer most due to the extra time and costs involved in travelling the extra distances to be with their loved ones. The HSE and Government have argued that patients must be offered the best care and no one will disagree with this. However to date all we have seen in Monaghan is the removal of services without any adequate replacement in other hospitals. This poorly planned reconfiguration of services has lead to deaths in Monaghan and deliveries of babies in ambulances on the side of the road. The women of Monaghan and their families deserve better and the Monaghan Alliance has been campaigning to get a change of policy from Government, which will be more patient-centred and women-centred.

Banúlacht
Women in Ireland in Global Solidarity

Women's health — a global perspective, Banulacht

Of the world's 876 million illiterate people over 15 years two-thirds are women; working women have less social protection and employment rights; a third of all women has been violently abused; over 500,000 women die each year in pregnancy and childbirth. Some 500,000 women—the majority in poor countries—die each year due to pregnancy-related causes. Gender-based violence is a global problem and one of the most widespread violations of human rights. UNIFEM, the women's fund at the United Nations, has described violence against women and girls as 'a problem of pandemic proportions that devastates lives, fractures communities and stalls development.' Violence against women is a major cause of death and disability among women between the ages of 15 and 24, higher than cancer, motor vehicle accidents, war and malaria.

Millions of women around the world experience discrimination in, or are prevented from, going to or staying on at school, attaining health care, or they are subject to harmful traditional practices, such as female genital cutting, child marriage or forced marriage. Gendered power differentials often mean that women and girls are not in a position to make their own decisions about sexual relations, childbearing, contraceptive use and reproduction.

Globally, the proportion of women and girls living with HIV continues to grow. In 1997, 41% of those living with HIV were women; by the end of 2003, this figure rose to almost 48%. In sub-Saharan Africa, 57% of the 23 million infected adults are women. The gendered impact of HIV/AIDS is acute, and the pandemic takes a brutal toll on women and girls. When women are economically dependent on men for their survival, a dependency compounded by their typically weaker position in terms of power in sexual relations, their ability to negotiate safe sex, whether within or outside marriage, is compromised. Thus, women's vulnerabilities—in terms of both greater physical susceptibility to infection, gendered power differentials and societal tolerance of different mores for male and female sexual behaviour—are both drivers of the epidemic and obstacles to accessing HIV/AIDS prevention information, treatment and care. Of the estimated 10 million young people between the ages of 15 and 24 worldwide living with the virus in 2003, 6.2 million were young women and 3.8 million were young men; and rates of HIV/AIDS infection among women are rapidly increasing. (Sources: UNAIDS, International Centre for Research on Women, WEDO, Oxfam, Trócaire).

Gender equality is key to improving maternal and child health and stemming the spread of HIV/AIDS and other diseases. Equally, women cannot achieve empowerment and equality

unless their health and reproductive rights are fully and legally realized. Women's health has been recognised as a human rights issue in a range of international human rights agreements, United Nations policy agendas and UN Security Council Resolutions, such as the Convention on the Elimination of All Forms of Discrimination Against Women, the Cairo Programme of Action, the Beijing Platform for Action and the Millennium Development Goals. These international agreements place strong obligations on governments to take action, including dedicating resources to ensure that women have access to adequate and affordable health care. But they go beyond the provision of health services, and oblige governments to take sustained and effective measures to bring about gender equality in the private and public spheres so that women's right to health can become a reality. For the Irish government, this means resourcing initiatives in Ireland, but also committing resources within its aid budget to support the work of women's organisations in the global South that are working for women's empowerment and human rights, including the right to health. In order to ensure that women's health in the broad sense outlined here remains a priority of Irish Aid's programmes in the South, it is critical that women's organisations in Ireland continue to lobby for the full implementation of women's human rights—in Ireland and globally.

Maeve Taylor
Policy and Training Project Leader Banúlacht

Cairde - Eligibility and Access to Health Services

In Cáirde's experience minority ethnic communities and individuals are not being adequately supported to achieve their full health potential. People from ethnic minorities encounter a range of difficulties in accessing public health services and in particular ethnic minority women are facing barriers in relation to maternity services. Unless these health inequalities are addressed, individuals will not be able to enjoy a decent quality of life.

A new area of concern has come to light as a result of the A&E charges, which were introduced by Government in last year's budget. We are all aware of the recent increase of A&E charges from €65 to €100. This is the charge for 'ordinarily residents' but did you know that there is a different charge of €250 for non-EU visitors?

People's eligibility for free or subsidised health services is mainly based on residency and their financial means. It is divided into two groups:

- medical card holders (category I or full eligibility)
- non-medical card holders (category II or limited eligibility).

People living in Ireland, who intend to continue to live here for at least a year are 'ordinarily resident'. They are not entitled to a medical card (Category I) if their income is over the threshold, in which case they are considered to be Category II and are thus entitled to a range of public health services that are free of charge or subsidised.

Cáirde is concerned that the process for establishing a person's eligibility to free or subsidised public healthcare is unclear, ad hoc, and open to discrimination against ethnic minorities accessing essential public services. It is important to ensure that the most vulnerable are not the ones who pay the most for their health. Unfortunately, in practice, this is often not the case.

How are the decisions made for individuals and what factors are taken into account when defining 'ordinarily resident', which entitles people to Category II eligibility to public health services? Current practices of establishing an individual's Category II eligibility differentiate from hospital to hospital and, in Cáirde's experience, eligibility can be established:

1) Within the hospital at the point of admission or
2) Ethnic minority patients will be directed to local HSE office to apply for a medical card or to seek clarification on their entitlement there.

The problem with eligibility being decided at the point of admission to hospital is that the person is sick and in need of a service. The decision as to which rate of payment is applicable is often made by personnel from the Patient Accounts section with little or no relevant training or expertise in the area. Another issue is that there is no appeal process for these decisions and if the hospital decides the person is not entitled to free or subsidised services they are forced to pay the bill.

It takes a few months to have the medical card application processed, and Cáirde would recommend that outstanding hospital charges for this period should be reduced or waived accordingly until it is decided if the patient is deemed to be 'ordinarily resident' with Category II entitlement. This does not happen in all of the hospitals. In some instances people are walking away from the service and the charge of €250 has been a barrier to access.

Minority Ethnic Women's Access to Maternity Services

Similarly, there is no coherent national policy on who is determining women's entitlement to free maternity care. In one Dublin maternity hospital, ethnic minority pregnant women, who cannot produce a medical card or the documents clarifying their immigration status, are required to pay a non-refundable fee of €1,212.00 on their first visit to the hospital. This requirement is putting pressure on women who are already in a very vulnerable situation. Women from minority ethnic groups, who are often in low paid employment or unemployed in low-income families, are forced to pay these charges while they are entitled to free maternity care because they are ordinarily (and legally!) resident in the state.

It is sad to see the creation of an unequal system in which people from minority ethnic groups are struggling to get access to correct information pertaining to their rights around, and eligibility to, public health services. It is our hope that we can achieve equal access to the hospital services through:

- Clear national policy guidelines, which are the same for all public hospitals in the state (including maternity hospitals), for both health service users and providers
- An assessment of patients, irrespective of their nationalities, for entitlement to free or subsidised public healthcare based on their ordinary residency, not on their country of origin/immigration status
- Decisions on ordinary residency and entitlement to Category II cover being made by trained personnel with due process and procedures in place for appeals on negative decisions.

Cáirde is community development and health organization working to reduce health inequalities among ethnic minorities. Cáirde is committed to supporting the participation of communities to enhance their own health. Contact: Tonya Sanders - email: cdh@cairde.ie

PAVEE POINT
TRAVELLERS CENTRE

A Good model of Community Orientated Health: Travellers and Primary Health Care

Travellers experience poor health status and consistently greater health inequalities than the majority population in Ireland. Data from Census 2006 indicates that there is only 2.6 percent of the Traveller population presently aged over 65, compared to 11 percent nationally.[3] Traveller women live on average 12years less than their settled peers (HRB study 1987). The differential in infant mortality rates are approximately three times the national rate. Studies have also shown that Travellers experience considerable variations in morbidity when compared to 'settled' people particularly in relation to infectious disease control, accident prevention and ante-natal care.[4] Finally, as a distinct cultural group, Travellers have demonstrated different perceptions of health, disease, and care needs which impacts on primary and secondary prevention outcomes.

PHC in Ireland was piloted by Pavee Point with a training programme for Traveller women "New Opportunities for Women" funded by FÁS in 1991. The initial course was organised as a positive action measure for Traveller women recognising their exclusion from the education system and labour market. It was also targeted at Traveller women in recognition of their role as carers and the reality that Traveller women, like the majority of women, are responsible for their families' health and if you work with the mother it will have a positive impact on the health of the whole family and the community. The work is now funded by the HSE.

Primary Health Care for Traveller Projects (PHCTPs)

The 2002 National Traveller Health Strategy described Primary Health Care for Traveller Projects (PHCTPs) as the 'cornerstone' of the strategy. It makes it clear that by respecting and acknowledging the distinct culture and identity of Travellers, more equitable, sustainable and cost

[3] Census 2006 Volume 8
[4] Health Status Study, 1987

effective health care can be achieved. Primary health care in communities means enabling individuals and organisations to improve health through informed health care, self help and mutual aid. It means encouraging and supporting local initiatives for health. Crucially it is a flexible system which can be adapted to the health problems, the culture, the way of life and the stage of development reached by the community. Design and implementation of successful PHCTPs is determined through a process that values empowerment, partnership and advocacy, allowing partners to highlight inequity and negotiate solutions.

Outcomes So Far

The Pavee Point PHC project was recognised as a model of good practice by WHO in 1998 for "promoting all values of equity, solidarity, participation intersectoral approaches and partnership". It has been successfully replicated in up to 40 other locations around the country. The Traveller PHC projects nationally are currently undertaking a peer lead national Traveller health study in collaboration with UCD, "Our Geels", which will inform Traveller health policy in the future. (Website: paveepoint.ie)

Training in PHC care is essential and needs to be on-going feature of this work. The analysis and training in PHC uses a social determinants approach to health. It recognises that health is too important an issue to be left to the medical profession and that 90% of your health needs can be addressed outside of medical services. Training needs to be culturally appropriate , flexible and an on-going feature of the work of PHCPs. Training in community development is equally important as the training in health skills. The training is modular and flexible to reflect the individual and communities needs, and can be diverse, ranging from computer skills, literacy, first aid, research methodology, to community development, Traveller culture and ethnicity, gender, representation, human rights, anti-racism and discrimination. In 2004, in a survey of 367 Travellers in Community Care Area 6, 89% reported confidence in the visits by TCHWs.

The original PHC project is now running over 15 years and some of the work undertaken by TCHWs includes:

- Undertaking a baseline study on Traveller health needs
- Mapping Traveller accommodation provision and facilities and addressing environmental health issues
- Participating in policy fora and influencing health policy and services for Travellers
- Organisation of Well Woman and Breast Check clinics for Traveller women
- Audiology clinics and follow on speech and language clinics
- Production of culturally appropriate training materials including videos on child health and womens' reproductive heath, health education posters on a wide range of health matters including dental health, fire safety and nutrition. (some of these have been used with other marginalised groups and people with literacy difficulties)
- Providing training and information sessions on Travellers health to GPs, Nurses and hospitals
- Piloting data collection systems, including ethnic identifiers, to document Traveller access and experience of health services
- Identifying other emerging health needs and supporting the development of other programme initiatives such as violence against women, suicide awarenesss and prevention, mental health, drugs initiative, environmental health and anti racism training
- Addressing a range of health conferences and seminars at local, regional, national and international levels.

Primary health care plays a pivotal role in tackling and reducing morbidity in the community. The community is where most people receive most of their health care, most of the time. International evidence suggests that primary health care has an independent effect in reducing health inequalities and improving health status and that States with a well developed focus on primary health care in communities have healthier populations and reduced health care costs[5]. However PHC cannot be seen as the panacea for all Traveller health needs; it is only one of a broader range of initiatives that are required. We look forward to the evidence which will emerge from the All Ireland Traveller Health Study and are confident that the work that Traveller organisations and PHCPs have been investing in over the past 2 decades will be reflected in the findings.

[5] (Starfield 1994, Macinko et al 2003, Shi et al 2003).

Next Steps

Next steps for the Campaign - What can the NWCI and its member organizations do to support change?
The following suggestions and priorities were proposed on how NWCI should engage with the political process. There was a strong feeling amongst members that if we had gender balanced government of at least 40% women, changing the health system to a Universal one-tiered health system, would be less challenging.

- NWCI Members need to shout about the immediate cuts and how they will impact on women.
- Meet with the Health Spokespersons again and encourage Political Parties to work together to gain a Universal one-tiered health system.
- NWCI to call on government to hold a referendum on health system - People need to vote on health issues.
- We need women involved at all levels of health decision making and health planning.
- Clarity on the involvement of insurance companies in the provision of Social Health Insurance.
- Clear simple positions for us to take to constituencies, politicians and publics.
- More collaboration with Dr. Steve Thomas's and his Trinity team asking to access his team's research and work up a gender analysis to finance the health system.
- More clarity on the different models of health care in other countries.
- Spell out obstacles to move from present system to universal health system.

Details of our upcoming Women's Human Rights Alliance "Women's Right to Health" Workshops

The Women's Human Rights Alliance

The National Women's Council of Ireland (NWCI) has been a member of the Women's Human Rights Alliance (WHRA) since 2003. WHRA is coalition of local, regional and national nongovernmental organizations including Amnesty International, Banulacht, and the National Traveller Women's Forum, National Collective of Community Women's Networks, AKiDwA, Women's Aid, Cairde, Pavee Point, Immigrant Council of Ireland, and the Migrant Rights Centre etc.

WHRA has organised a series of regionally based workshops, to raise awareness about the International Convention on Economic, Social and Cultural Rights which recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." As part of the process we will be gathering the views of a diverse range of women about their experiences of health, well-being and health care in Ireland. This will inform the WHRA upcoming Shadow Report on Government's progress on its commitment to uphold the International Covenant on Economic, Social and Cultural Rights (ICESCR). The Shadow report is an alternative to the 'Official Version' which the Irish Government and all other States, who have signed the Covenant, prepare for International monitoring committee's consideration. It is anticipated that Government will produce its report by the end of 2009.

Please see schedule of meetings below:

County	Venue	Date	Time	Hosting Org	To Make a Booking
Cork City	Cork City Partnership Heron House, Rock Road, Blackpool Park Blackpool, Cork	Thursday 25th June	10.30am -1.00pm	NWCI	joannev@nwci.ie 01-8786401
Donegal	St Mary Parish Hall Stranolar-Ballybofey Co Donegal	Wednesday 17th June	10.30am -1.00pm	NWCI/Donegal Women's Network	donwomnet@eircom.net 074 9132023
Dublin City	Carmelite Centre, Angier Street D8	Thursday 18th June	1.30pm –4.00pm	NTWF	091 771509 / ntwf@iol.ie
Dublin City	Abbey Street, Dublin 1	Thursday 18th June	11.00am –1.30pm	AikDwA	01 8148582
Dublin South County	Aras Cronin Clondalkin	Tuesday 16th June	10.30am -1.00pm	NCCWN	Clondalkin Women's Network 01 4670748 info@cwn.ie
Eastern Region	Pavee Point, Nth Grt Charles St, Dublin 1	Tuesday 9th June	AM	Pavee Point	Caroline.mullen@pavee.ie 01 8780255
Galway City	Ballybane Enterprise Centre, Galway	Tuesday 23rd June	1.30pm –4.00pm	NTWF	091 771509 / ntwf@iol.ie
Mayo	Ballyhaunis	Tuesday 14th July	11.00am -1.30pm	AkiDwA	Info@akidwa.ie 01 8148582
Sligo		23rd/25th June TBC	11.00am -1.30 pm	AkiDwA	 01 8148582
Tipperary	Excel Tipperary Town	Thursday 11th June	1.30pm –4.00pm	NTWF	ntwf@iol.ie 091 771509
Tullamore	Tullamore Traveller Movement, Harbour Street, Tullamore	Monday 22nd June	1.30pm –4.00pm	NTWF	ntwf@iol.ie 091 771509
Waterford/ Wexford	Waterford Women's Centre	Tuesday 7th July	10.30am -1.00pm	NCCWN	nccwn@eircom.net 01 414 7872