Equity of Access to Health Services

Some relevant issues in an Irish context

A Background Paper prepared
for the Working Group on the
National Anti-Poverty
Strategy (NAPS) and Health

THE INSTITUTE OF
PUBLIC HEALTH IN IRELAND

EQUITY OF
ACCESS TO HEALTH SERVICES

SOME RELEVANT ISSUES IN AN IRISH CONTEXT

Prepared by

Anna May Harkin, MA, Dip Psych

May 2001

Published by The Institute of Public Health in Ireland

ISBN 0-9540010-5-2

For further copies of this paper please contact:

The Institute of Public Health
6 Kildare Street
Dublin 2

Tel: 00 353 1 662 9287
Fax: 00 353 1 662 9286
Email: iph@RCPI.ie
Also contactable at Belfast: 00 44 28 9079 3050

CONTENTS

Summary

This paper, prepared as background material for the Sub-group on Equity of Access to Health Services of the Working Group on the National Anti-Poverty Strategy (NAPS) and Health, seeks to provide an overview of some of the issues relevant to equity of access to health and personal social services in an Irish context. The paper first addresses the question of the contribution of health services to health status. Drawing on the work of Davey Smith, it proposes that, while many factors other than health services affect health, improvements in recent years in treatment following the onset of disease, mean that equity in access to services has increasing potential to reduce health inequalities.

The definition suggested of equity in relation to health care is that of Whitehead in her elaboration on WHO's work:

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

The paper acknowledges the persistence of inequities despite increased investment and some improvements in service provision in recent years. The paper is structured round inequities related to a) legislative/regulatory issues, b) organisation and operational matters and c) competing demands for finite resources.

There is a short section at the end listing some of the initiatives in place which should over time result in improved responsiveness of the health care system to the needs of people who are poor or socially excluded. The author states that while the principle of equity is one of the key principles underpinning the National Health Strategy and while many of the initiatives listed have the intention and capacity to improve the health of those most in need, what is lacking is a coherent implementation and monitoring framework for embedding equity across the system.

1. Introduction

In keeping with the commitments (1) in the Programme for Prosperity and Fairness (PPF) to develop National Anti-Poverty Strategy (NAPS) targets and a NAPS framework for the health sector, a Working Group (WG) on NAPS and Health was established by the Department of Health and Children in Autumn 2000. The WG decided to progress its work by focusing on three main themes: a) Equity of Access to Health Services b) Impact of Public Policy on Health and c) Research/information issues and by establishing three corresponding Sub-groups. This paper has been prepared as background information for the Sub-group on Equity of Access to Health Services. For the purposes of the PPF commitments health services mean the health and personal social services which are the responsibility of the Department of Health and Children.

The paper seeks to outline some of the issues relevant to equity of access to services. It is not intended as a statement of what has been achieved to date on this issue (though there is a summary of some initiatives in place at the end of the paper) nor is it intended to propose what should be done (as this is a matter for the consultative process). Nor is the role of the paper to address the links between poverty and health as this is part of the subject matter of a separate paper developed by the Institute of Public Health (2). This paper is intended to stimulate thinking and discussion. It aims to look at systemic and cross cutting issues and processes which might affect several interest groups rather than looking at issues on a care group/interest group basis.

2. Contribution of Health Services to Health Status

An examination of issues of equity of access to services in the context of setting targets to reduce poverty and inequalities in health raises the question of the extent to which health services influence health status and inequalities in this. Health is influenced by many factors including genetic endowment, early life experiences, material conditions such as income and housing, education, psycho-social factors such as social support networks, health-related behaviour and biological risk factors, and medical care. As the National Health Strategy *Shaping a Healthier Future* (3) states "health promotion provides the obvious starting point for any refocusing of the health services towards improving health status and the quality of life." This entails a multi-sectoral approach since many of the factors which affect health lie outside the direct remit of the health sector per se. The continued salience of these factors in the 20th century was highlighted by McKeown (4) in the mid-1970s. The importance of a broader multi-sectoral approach to reducing poverty and inequalities in health is reflected in the NAPS and Health Working Group's decision to establish a special sub-group on the impact of public policy on health.

While recognising that "many of the determinants of health lie outside the purview and influence of clinical care", Health 21 – The Health for All Policy for the WHO European Region (5) states as follows in relation to the contribution of health services to population health: "Health services make a highly significant contribution to population health. They use a considerable amount of economic resources and count among each country's major employers. They also foster a feeling of security in individuals and a climate of confidence in society, factors which are important for the development of the economy and more generally for society as a whole." Health services are defined as including those structures and personnel that work for health promotion, disease prevention, treatment and rehabilitation, using resources specifically identified and allocated for these purposes. In reviewing health services in the WHO European Region, Health 21 also states that “generally an over emphasis on care itself, particularly curative care, continues to dominate, while health promotion, disease prevention and rehabilitation efforts receive far less attention than they should”.

Meanwhile researchers have been attempting to assess the contribution of health care or sometimes the narrower area of medical care, to health. For example, estimates of the degree to which medical care has influenced mortality trends have been made by John Bunker (6) using the most rigorous available data – from randomised trials where possible – as the source of evidence on effectiveness. Grouping effective clinical preventative services, (including screening for and treatment of hypertension; immunisation for diphtheria, polio and tetanus and screening for cervical cancer) and clinical therapies (including appendectomy; insulin for type 1 diabetes; treatment of kidney failure and ischaemic heart disease) he estimated that in the USA medical care had contributed about a fifth to the 30 years of increased life expectancy seen during the 20th century. While improvements in quality of life and reductions in morbidity have been more difficult to identify and evaluate, a meaningful contribution from medical care is also claimed for this domain.

McCarthy (7), writing in an English context, has made the point that medical care may have a differential effectiveness in relation to social position: “Historically some public health interventions, for example immunisation, would have helped the health of working class people more because of their higher disease rates. On the other hand, apart from problems of access (e.g. the inverse care law), treatments for major diseases (e.g. for cancer, kidney disease) may be on average less effective for lower socio-economic groups because they more frequently have other conditions (such as obesity, smoking) that contribute to poorer outcomes”.

Writing in a recent issue of the journal Health Economics Davey Smith (8) argues along the following lines. The potential contribution of medical care to reducing mortality has certainly increased over recent decades. The major causes of premature death in both men (CHD) and women (breast cancer) were little influenced by treatment after disease onset when McKeown was writing in the mid –1970s; now the introduction of treatments which produce substantial increases in life expectancy following disease development have contributed importantly to the declining levels of mortality from these conditions (9,10). The inequitable delivery of health care for these, and other, conditions could contribute importantly to socio-economic differentials and the widening mortality gap seen between socio-economic groups. Realising the potential population health gain due to medical care requires that effective treatments are delivered properly – care should be available, targeted at those in need, providers should maintain high standards of care, and patients should adhere to treatment. Davey Smith argues that improving these fragile steps in the chain of care delivery are appropriate interventions for reducing socio-economic inequalities in health.

3. Equity of Access to Health Services

The National Health Strategy – Shaping a Healthier Future (11) is underpinned by three principles, one of which is equity. As defined in the National Health Strategy the principle of equity means that services are accessible on the basis of need rather than on geographical location or ability to pay. The Strategy elaborates on the principle as follows :

> "The achievement of an equitable health service has a number of dimensions. Access to health care should be determined by actual need for services rather than ability to pay or geographic location. Formal entitlement to services is not enough; those needing services must have them available within a reasonable period. Furthermore, the pursuit of equity must extend beyond the question of access to treatment and care, and must examine variations in the health status of different groups in society and how these might be addressed."

The Strategy also states that achieving equity in the health care system will involve not only ensuring fairness, but also being seen to be fair and that important steps to ensure greater equity are:

- Implementing uniform rules for eligibility and charges for services across the country
- Measures to reduce waiting-times for those availing of public services
- Giving special attention to certain disadvantaged groups

Whitehead (12) using an approach adapted from the WHO Health for All Targets for 2000, states that equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that none should be disadvantaged from achieving this potential, if it can be avoided. Based on this definition, the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level and quality of health but rather to reduce or eliminate those which result from factors that are considered to be both avoidable and unfair. Equity is therefore concerned with creating equal opportunities for health, and with bringing health differentials down to the lowest level possible. Specifically in relation to health care Whitehead states that equity is defined as:

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

4. Persistence of inequities in access despite increased investment and improvements in services.

The years since the publication of the National Health Strategy and in particular the latter years have seen a major increase in investment in the health services to the stage where this year (2001) current and capital spending is to reach more than £5 billion. Much of this additional investment has been, and is being devoted to areas of the service which cater for the health and personal social service needs of disadvantaged groups e.g. persons with disability (in particular to date those with intellectual disability), children in need of care and protection and older people. There has also been considerably increased investment in the public hospital system on which those in lower socio-economic groups are dependent and to which the whole population has access (with modest charges for non-medical card holders).

This increased investment has resulted in considerable improvements in the levels of services available whether measured in terms of acute hospital activity or in terms of services for groups such as persons with disability, older people, persons with mental illness, Travellers, children in need of care and protection and drug users. Numbers in many of these groups have been increasing e.g. the whole population which has access to acute hospitals, the number of older people, increased survival of persons with disability, increased numbers of drug users coming forward for treatment.

Despite the improvements mentioned above there are still inequities in access to services and there is certainly a strong public perception that these persist. There is evidence – some based on research and statistics and some anecdotal – to support this contention. It is proposed in the remainder of this paper to outline some of the issues surrounding these inequities. One logical way of organising the paper would be to examine inequities at each stage of the health care continuum from prevention through primary and secondary care through rehabilitation and long-term care.

However its was considered that this approach could lead to considerable duplication and repetition, as some similar systemic and cross-cutting issues can arise at each stage. For this reason it has been decided to present the issues under three broad headings:

- Issues related to the legislative/regulatory framework
- Issues related to organisational and operational matters
- Issues flowing primarily from resource constraints

It is acknowledged at the outset that these are not mutually exclusive categories. The choice of a particular legislative/regulatory framework may reflect resource constraints and so may some operational arrangements. A legislative/regulatory framework once in place may be hampered in achieving its intended benefits by inadequate operational arrangements and/or by resource constraints.

5. Inequities related to the legislative/regulatory framework

5.1 Access to acute public hospitals

One of the most frequently expressed concerns about equity is in relation to access of public patients to acute hospital services. The growth in the proportion of the population with private health insurance – currently estimated at just under 45% – is in part, at least, a reflection of this concern. A recent survey (13) conducted by the Economic and Social Research Institute (ESRI) for the Department of Health and Children found that 98.6% of the insured gave "being sure of getting in to hospital quickly when you need treatment" as a very important or quite important reason for them having such insurance. (Issues related to quality of care had also increased in importance since a similar survey in the early 1990s). Data on waiting lists and waiting times for some procedures bear witness to the reality underlying such concern. Though the number of people on waiting lists for elective procedures represent just over 3% of total hospital discharges, for any given individual the possibility of such a wait can constitute a threat to security and for those with adequate resources, it appears, a risk not worth taking.

Apart from the official waiting list data there is reliable anecdotal evidence (e.g. from the St. Vincent De Paul Society) that in some instances people who have been told they will have to wait months or years when seeking admission as a public patient have been offered much faster and sometimes immediate access to the same hospital when they have indicated that they will opt for treatment as a private patient. It is this latter type of situation which is perceived as one of the most inequitable in the system, however explicable it may be at operational level in terms of the designation of beds as public or private and the maintenance of the separate waiting lists for public and private patients introduced on foot of the 1991 Health (Amendment) Act (arrangements which were introduced precisely because of concerns about equity of access). It is also relevant to mention that this type of public/private inequity can arise not just for hospital in-patient services but also for diagnostic services and for out-patient referral.

It is of interest to note that a recent Irish Independent/IMS Poll (14) found that, in a situation where people were faced hypothetically with an illness requiring hospitalisation, 64% said they would have more confidence in the private system compared to 23% having more confidence in the public system. (8% saw no difference between the two and 6% said they didn't know).

Under the eligibility arrangements for care in public hospitals introduced on foot of the 1991 Health (Amendment) Act, hospital beds must be designated as public or private (with a small number of beds, generally intensive care beds, being non-designated). The designation process requires the agreement of the Minister. Approximately 20% of overnight beds and 32% of day beds in acute public hospitals are designated as private. Public patients must be accommodated in public beds and private patients in private beds except in cases of emergency when a patient can be accommodated in any available bed.

Some findings from the ESRI survey (15) mentioned above in relation to the operation of the eligibility arrangements for care in public hospitals are of interest. The study found no evidence that elective admission of private patients to public beds was taking place though it noted some inadequacies in the monitoring system. Crossover in use of public and private beds by public and private patients takes place in both directions. The main factor identified by hospital management as leading to private patients being accommodated in public beds was admission through Accident & Emergency (A&E). The present system does not provide for hospital management to validate that all admissions of private patients to public beds are taking place through A&E. Consultant certification that an emergency is required in such cases, originally envisaged in the Regulations, is not built into the monitoring system. The way financial incentives facing management and individual consultants are structured may also be a factor. The fully insured patient is financially unaffected by where the care is received or in what type of bed. Hospital consultants currently receive payment (from the VHI) for treating patients in public hospitals who opt for private status, whether they are accommodated in public or private beds. The hospital, on the other hand, receives payment only where a private bed is occupied. The ESRI study concluded that changes in the structure of incentives facing hospitals, consultants and insurers could significantly alter the nature of the regulation required to promote equity of access.

5.2 Access to Primary Care Services

While most media attention focuses on access to acute hospitals (possibly because people are seeking to access these at a point when they are sicker and more vulnerable), most people's first point of contact with health services is at primary care level and many more people use these services on an annual basis than avail of acute hospital services. Under the 1970 Health Act, access without charge to primary care is limited to those (currently about 31% of the population) who, in the opinion of the Chief Executive Officer of the relevant health board, are unable without undue hardship to provide general practitioner medical and surgical care for themselves and their dependants. The issue of equity of access to primary care can be approached on two levels: a) on the broader question of whether there should be universal access without user charges to this type of care and b) on the narrower question of whether, from a hardship point of view, the current income guidelines for access without charge are adequate.

In relation to the first of these, it can be argued that if the emphasis of a health care system is on prevention and on treatment of people at the earliest stages of ill health, then there should be no financial disincentive to appropriate uptake of primary care. Given that the gradient in health status is continuous across socio-economic groups (rather than simply better among the wealthiest than among the poorest), Murphy (16) has argued that it is nonsensical to introduce a cut-off point anywhere in the income distribution and to say that care is deserved by one group and not the other.

Research on the effect of user charges on appropriate usage of services is a relevant consideration here. Analysts appear to differ on this and there is the added difficulty of applying findings from one country to those with different health systems. Creese writing in 1997 (17) as a health economist with the World Health Organisation has stated that "the higher the proportion of user payments in the total mix of financing for health, the greater the relative share of the financing burden falling on poor people. Poorer people are both sicker and more sensitive to health care prices than wealthier people. … As an instrument of health policy, user fees have proved to be blunt and of limited success and to have potentially serious side effects in terms of equity. They should be prescribed only after alternative interventions have been considered". Reggler (18), a GP practising in the UK, disagrees with Creese's analysis and says that it is based predominantly on evidence from countries in the second and third worlds. He states that "for GPs in Britain user fees will not only reduce total demand, but also particularly reduce inappropriate demand, allowing general practitioners to provide a better service for their needier patients"[1]. A paper prepared in 2000 by the Society of Actuaries in Ireland (19) on the financing of primary care has recommended that primary care be funded mainly from income-related payments (i.e. general taxation or social insurance) and a system of co-payments per treatment introduced with lower co-payments for low income groups. The objective of the co-payments is to give an incentive to eliminate unnecessary treatment or drugs. Alongside this the Society recommended a capitation system of paying doctors, with additional payments to encourage them to treat patients in so far as possible themselves rather than referring them to hospital or to other primary care providers. The recommendations also included provision for competition among providers. Nolan (20) writing in 1993 states as follows "from an equity perspective, financing public health care via taxation (or social insurance) means that, in broad terms, those on higher incomes pay a larger share than others. With user fees, by contrast the sick pay a larger share than others, and this remains true even when "the poor" are exempted".

---

[1] Reggler's view was expressed in a short letter to the BMJ and there is no indication that it is representative of the views of GPs in general.

Within a narrower frame of reference, perceptions of inequity have arisen in recent years in relation to the level of the income guidelines for medical cards. These guidelines are determined each year by the Health Board Chief Executive Officers (who additionally have discretion under legislation to award cards to persons who exceed the guidelines). The frame of reference here is narrower than that outlined in the previous paragraphs in that the concern is mainly with those who are just above the current income guidelines. The elderly and large families are viewed as those most disadvantaged in this regard in a system where those without such eligibility must pay for GP services. Income guidelines for older people aged 70 years and over have been relaxed progressively over the past few years and, on foot of the 2001 Budget, all such persons are being granted entitlement. A recent study (21) of women's health issues in the Cherry Orchard and Ballyfermot areas cited the cost of health services and the current income eligibility threshold for medical cards as major deterrents for those needing to access health care. Under a PPF commitment (22), medical card eligibility is currently being reviewed with a particular emphasis on families with children and barriers to take-up including information deficits.

It is likely that the fact that certain preventive services e.g. cervical smear tests, are not available without charge through GPs, even for persons with a medical card, is a deterrent to the use of such services by women on low incomes. (There is a commitment to have both cervical and breast screening available to all eligible women at recommended intervals when the National Cervical Screening Programme and the National Breast Screening Programme, currently both in their first phase, are extended nation-wide).

There are a number of other inequities at primary care level which might be said to be in part, at least, a by-product of lack of clarity in the legislative and regulatory framework of the health care system itself or in some cases of the absence of legislative guidelines. These are outlined in the paragraphs below.

As the National Health Strategy – *Shaping a Healthier Future* notes there are a number of services for which no eligibility criteria, or rules governing charges, are set down in legislation, in many cases because these services have developed since the last major overhaul of the Health Act in 1970. These include services which now play a very important role in providing appropriate care in the community to people who might otherwise need residential care; for example, community paramedical services, home helps, meals on wheels and day care centres. This can lead to considerable differences from area to area in relation to the extent to which these services are provided, who is entitled to them and what charges, if any, can be made. This situation can give rise to inequities based on geographic location.

Murphy (23), for example, has drawn attention to the inadequacies in paramedical services at primary care level.

> "A most frustrating aspect for general practitioners in caring for GMS patients is the lack of access to other primary care colleagues (such as physiotherapists and psychologists) and essential services such as ultrasound or mammography. Acknowledgement of the gains in access to these services since the development of the GP Units is appropriate. Nevertheless the fact that 50% of all GMS spending goes on drugs <u>alone</u> speaks volumes. The range of services provided by the GMS Scheme at present is <u>not</u> comprehensive and is focused almost entirely on the delivery of drugs".

It is relevant to state that while historically the inadequacies in availability of paramedical services relate to legislative issues among other things, more recently recruitment difficulties are also a factor.

Another potential source of inequity arises in relation to the legislative framework for dental services. The 1970 Act (sections 66.2 and 67.2) provides for the provision of dental services to pupils attending national (as distinct from primary) school. With the extension of the school dental services to the 14-16 year age group, this provision could have implications for the legislative basis for eligibility for these services of the increasing numbers of returning emigrants, immigrants, refugees and asylum seekers (as well, of course, as Irish children who have attended private schools or the small number being educated at home). Access to dental services is particularly important in view of the findings of the 1990 adult dental survey (24) that the percentage edentulous (without teeth) was higher in the lower socio-economic groups compared to those more advantaged.

5.3 Long-stay charges

The current legislation governing long term care (25) gives rise to anomalies and inequities as regards the charges which can be made and the basis on which they can be made and there is need to provide a clearer basis for contributions towards the cost of long term maintenance.

6. Inequities related to organisational and operational matters

6.1 Geographic distribution of services

Inequity in access to services can also arise from the way in which services are organised and operated, including their geographic distribution. For example, research (26) is highlighting considerable variation in the geographic distribution of GP services nationally and within urban areas, with some disadvantaged areas in the latter and some rural areas being particularly under-served. Access to pharmacy services is also an issue in some areas.

The Report of the Cardiovascular Health Strategy Group (CHSG) – Building Healthier Hearts (27) found evidence of regional variation in service provision. Summarising these findings the 1999 Annual Report of the Chief Medical Officer (28) states: "The CHSG discovered substantial regional variation in the provision of diagnostic, therapeutic and rehabilitation services for CHD (coronary heart disease). These variations cannot be explained solely by regional variations in disease prevalence, but must reflect variations in professional referral patterns and/or regional inequities in access to these procedures. Such variations are clearly unacceptable".

The CHSG also found that some cardiac procedures such as arteriography, PTCA and CABG are substantially lower in women than in men. The Report states that some of the lower provision in women, particularly in younger are groups, reflects lower levels of need compared with men. It states that in older age groups there may be a higher threshold for referral of women for coronary arteriography.

83% of those surveyed in research conducted in 1999 by the National Women's Council (29) among individuals and affiliate groups with a specific interest in women's health indicated that there were no family planning services aimed specifically at young people in their area. The most frequently requested features of a young people's family planning service were outreach and education in schools, followed closely by confidentiality and non-judgemental support, ease of access and affordability. An ESRI survey (30) carried out in 1994 found perceived differences in the availability of family planning services in different parts of the country and by women from different social backgrounds. As late as 1998 there was evidence from health boards' own reviews of their services that provision at that time fell short of demand, especially in remote areas. Regional assessment services for people with physical and sensory disability and child and adolescent psychiatric services are two other examples of services which are not currently well distributed throughout the regions.

Geography and population density are currently being highlighted as issues in relation to equity of access. There is an increasing number of reports in the medical literature that the best health outcomes for some illnesses are being achieved by multi-disciplinary teams in centres of excellence which can only be supported and maintained at appropriate skill levels by population bases of a given size. With increasing medical sub-specialisation and the training needs of Non-Consultant Hospital Doctors, it is becoming increasingly difficult to provide the full range of services in more peripheral hospitals. The issue of centres of excellence can generate a perception of inequality in terms of service availability. The organisation of breast cancer diagnostic and treatment services is a recent high profile example in Ireland but the point is also applicable to many other types of service. While tele-medicine holds the potential to improve access to consultation, diagnosis and monitoring/care for some medical conditions for people in remote locations, it is unlikely to be a remedy in all cases in the foreseeable future. As well as transport (dealt with below) and telemedicine, it is also important to provide as much of the service as possible in more peripheral centres e.g. the initial diagnostic work up/treatment in the main centre, with follow-up/subsequent treatments closer to the patient's home. This is working quite well, for example, in the Western Health Board area with oncology where patients have their initial treatment in Galway but subsequent rounds of chemotherapy in Castlebar or Ballinasloe by an oncology nurse under the supervision of the oncologist.

Breen (31) conducted a one week census of all nine ambulance services in the country. He looked at the response times (the period from mobilisation of the vehicle to its arrival at the scene of the emergency) for all 3,357 calls logged during a week. Nationally 60% of all calls had an ambulance at the scene within eight minutes. For rural centres however, at 26 minutes, 32% of patients were still waiting for an ambulance. Murphy (32) has drawn attention to the fact that this has significant implications for the management of acute conditions such as heart attack or cardiac arrest and states that it strongly suggests that rural areas must be provided with alternative sources of emergency care. The Donegal Prehospital Emergency Care Project is studying the effectiveness of equipping GPs with defibrillators and providing them with the expertise and resources to conduct prehospital thrombolysis (33). Murphy makes the point that such initiatives must be supported and replicated throughout the country, if rural patients are to have equal access to acute treatment modalities.

It is relevant to note that 40% of Society of St Vincent de Paul Conferences assist with transport for medical appointments or hospital visits (34). Achieving greater equity may therefore mean more focus on issues such as transport, greater flexibility in methods of service delivery and (where the patient has family responsibilities) social supports. Physical access to services isn't an issue just for people living in remote locations. The question might be asked, for example, how a person without a car is to get from say Leixlip to Tallaght Hospital. For some types of services greater use of outreach and mobile units may improve equity. These have already been introduced for services such as drug treatment, Traveller health services and the National Breast Screening Programme – Breastcheck. The recent study of women's health issues in the Cherry Orchard and Ballyfermot areas cited earlier, showed a demand for such an approach e.g. in the area of cervical screening. These issues can be, and require to be, addressed through innovative and flexible approaches.

Difficulties of access for those dependent on public transport (and increasingly also in the current traffic situation for those with private transport) can arise from services being scattered in different locations. Such difficulties can be exacerbated for the elderly and less able bodied and for parents (most frequently mothers) of young children and can act as a disincentive to uptake of services.

It may be of interest to note that considerable geographic variations in service access and use have been found in the UK as detailed in the White Paper – *The New NHS – Modern, Dependable* (35*).*

6.2 Integration of Services

An important issue affecting timely access to appropriate services, particularly for people requiring multiple supports is the degree of co-operation and integration at the policy and operational level, not just within the health sector but between that sector and other related sectors such as housing and education. For example, rural women at a recent conference (36) organised jointly by the health boards and the National Women's Council felt their family resource projects should be used more for delivery of information and of some services and that such co-ordination would benefit both the providers and the resource centres. Lack of co-ordination between sectors can result in some cases in those in need of services (frequently those in disadvantaged groups) "falling between stools" and in others cases in unnecessary duplication of services and inefficient use of resources. Integration and co-ordination is an issue which will require ongoing development and monitoring in the context of equity of access.

The absence of individual care plans, developed in consultation with patients/clients and their relatives/carers, could be said to constitute an inequity in access from the point of view of quality of care. The development of individual care plans for groups such as people with mental illness, with intellectual disability or autism, with physical or sensory disability, drug users, children in need of care and protection and older people, provides a focus around which services can be integrated in a patient-centred way. While such individual care plans are a growing feature in a range of services, there is still considerable variation in the extent of their provision.

6.3 Validation of Waiting Lists

In addition to the regulatory issues mentioned earlier and the financial constraints to which reference is made later, organisational and operational issues also influence equity of access to acute hospital services. Validation of waiting lists is one relevant issue here. The key objective of the Waiting List Initiative in acute hospitals is that no adult should have to wait more than 12 months for a procedure and no child longer than 6 months in the target specialties. In December 2000, 10,337 adults were waiting 12 months and over in the target specialties (compared to a December 1999 figure of 14,833). There were 2,146 children waiting 6 months or over in the target specialties (compared to a December 1999 figure of 2,719). In all, 27,857 people (adults and children) were waiting more than 3 months for acute hospital care compared to a December 1999 figure of 36, 855 (37).

A number of agencies report noticeable reductions in individual specialties following a detailed validation of their waiting lists. This issue clearly requires ongoing attention so that an accurate and up-to-date picture of waiting lists can be maintained. The active management of waiting lists by consultants with referral protocols agreed with GPs and prioritising of need has an important part to play in the process.

6.4 Staffing arrangements

Staffing arrangements are another organisational/operational feature which can affect access to services in the community and in hospitals. A crucial difficulty is personnel capacity both within the community and hospital sectors. For the first time ever in Ireland difficulties are arising in the recruitment of all types of staff, from highly paid hospital consultants to home care workers. These difficulties are most exacerbated in those deprived areas of most need.

Even without the current recruitment difficulties, an issue had arisen in relation to availability of "out–of-hours" services. There are a number of initiatives in place e.g. Dubdoc, Caredoc (in Carlow) and Tallaght GP project which are addressing the issue of out-of-hours GP services but difficulties in access persist in many areas. This inadequacy in the system can deter people from seeking necessary care or lead to inappropriate self–referral to hospital accident and emergency departments, making access more difficult for those genuinely in need of the hospital service. There are also difficulties in accessing other community care services out-of-hours (and even within-hours because of the recruitment difficulties already referred to) which can impact negatively on the support available to vulnerable groups being cared for in the community (e.g. people who are mentally ill).

The lack of availability of senior clinical decision makers outside "nine to five" can lead to decisions to admit patients unnecessarily to hospital (thereby reducing bed access for others). It can also raise questions about the quality of care available.

Continuity of care is usually considered a desirable feature of treatment and follow-up. To the public this generally means being seen by the same consultant preferably, or at least by the same non-consultant hospital doctor (NCHD). Such experience is generally perceived as unlikely (or certainly not guaranteed) if one is a public patient. It is interesting that in the ESRI study (38) referred to earlier, 96% of those with private health insurance rated "being sure of getting consultant care" as a very important or quite important reason for having such insurance.

At operational level there is lack of clarity as to who is responsible for provision of dental services to residents of longstay institutions who no longer hold a medical card.

6.5 Access to Information/Education

Equity of access to services also embraces equity of access to information about services and indeed to the health education services which can help people maintain and improve their health and reduce their need to access treatment services. There is evidence (39) that people in lower socio-economic groups generally, compared to those better off, present for health services at a later stage in their illness. While information and health education may be only one factor affecting this, it is one amenable to health service intervention.

In relation to health education services/programmes for young people, the timing and appropriate targeting of these is important to efforts to reduce inequalities in health, particularly in the light of the research evidence that many life style related risk factors such as smoking are more prevalent in economically disadvantaged groups. There is need for vigilance, to ensure, for example, that school health education programmes such as the Social and Personal Health Education (SPHE) programme are in place to address the life-skills needs of young people who leave school early and not just of those who come from more socio-economically advantaged backgrounds. Some UK research (40) indicates that health promotion payment claims by GPs in London show "a remarkably close inverse correlation with Jarman scores" (area deprivation index).

It is of interest that in a recent study of the readability of health information leaflets published in Ireland, Hough (41) found that the majority of the 30 leaflets tested had a readability level equivalent to Junior Certificate level or above. This represents a reading level of 15 -16 while the recommended level for the general population is 9-11. Hough concluded that in the light of the Adult Literacy Survey (Dept of Education 1997), current written health information may be inaccessible to a sizable proportion of the population. A national study of women's health carried out in 1994 by the ESRI (42) on behalf of the National Maternity Hospital highlighted problematic gaps in basic health information available to women. The study also found that the information deficit was most prevalent among disadvantaged women, unemployed women and those with lower educational qualifications. Information deficits and demands to remedy them were also an important theme coming through in the consultative process which preceded the development of the National Plan for Women's Health 1997–1999 (43). This Plan refers to the need expressed by women in the consultation process for the dissemination of information about health and health services in an appropriate and accessible format.

> "Difficulties in accessing information which was appropriate, relevant and timely was identified by women as the factor which caused the greatest disadvantage in accessing health care. This inability to access information was identified as limiting their decision making powers and reducing their options when considering health issues. This problem permeated all levels of the service". (Quote from the consultative process for the Plan for Women's Health).

Information technology has the potential to assist considerably in this area provided that access to computors and relevant training in their use is well disseminated among all sections of the community.

It should be mentioned that barriers to access for some disadvantaged groups are not confined to literacy problems but may also relate to cultural attitudes to preventive services.

There is also a case to be made that the system is not pro-actively helpful to those people or their carers who might benefit from multiple supports. There is certainly anecdotal evidence that some people have to make numerous visits and phone calls to find out what is available, what their entitlements are to available services and how they might access them. This can be a particular deterrent to those who are less articulate, less familiar with the vagaries of the administrative system or who are already burdened with an illness or disability and/or with caring responsibilities. There may be a case here for some type of client advocacy function within the system itself and/or for appointment of co-ordinators of supports to carers.

Even when initiatives are introduced aimed at improving services they may not benefit those most in need unless there is a concerted effort to ensure that this happens. Mc Auliffe (44) reports one such example. Research into the "reach" of the 1992 Department of Health's Charter of Rights for Hospital Patients indicated that after two years, only 26% of patients in the Health Board surveyed had heard of the Charter, and only 10% of these could recall any of the rights mentioned. Socio-economic status influenced whether patients were aware of the Charter, with non-medical card holders twice as likely to have heard of it.

6.6 Special access problems for some groups

The way in which services are organised can pose particular access problems for some groups e.g. people with disabilities. These problems can relate to the built environment in which services are delivered as well as to staff knowledge of, and attitudes towards, the needs of these groups. Sometimes the problems are very easily remedied as, for example, in the not unknown situation where the name of a deaf person is called out in the waiting room when it is their turn to see the doctor. While there has been increasing recognition of these issues in recent years and the implementation of some staff awareness programmes and programmes to make buildings accessible, this is an area requiring ongoing work into the future. It is of relevance to a variety of groups including Travellers, gays and lesbians, immigrants, refugees and asylum seekers.

There are a number of community-based services where the attitudes of the local community can be a significant factor affecting access. Chief among these are services for drug users and for people who are mentally ill. Proposals regarding the location of such services frequently meet with strong opposition from the community. For example, such resistance has been a very significant factor hindering the development of treatment and allied support services for drug users in the Dublin area.

Research (45) in relation to homeless people has identified a clear need for multi–disciplinary primary care teams which incorporate outreach for this group and also for additional mainstream social services to support those homeless people who obtain accommodation, to prevent relapse into homelessness.

Refugees and asylum seekers, as a group relatively recent to Irish society, require particular attention in terms of equity of access. While their eligibility for health services may be not be an issue, they face some special barriers to access in terms of culture and language. Because of experiences in their country of origin or in transit they may need psychological support services. There is evidence that uptake of screening is low and they may need reassurance that availing of such services is in their own interest (and not just about protecting the rest of society) and will not adversely affect their application for refugee or asylum seeker status.

Prisoners are a group with both physical and psychological health needs, particularly related to the high prevalence of drug use among them. A Trinity College Dublin study (46,47) documented a considerable level of unmet need in this population. The high throughput and high recidivism rates provide many opportunities for service interventions. A report prepared for the Minister for Justice, Equality and Law Reform by the Department of Health Promotion, NUI, Galway (48) found that almost a quarter of prisoners (compared to 7% of males in the SLAN survey) reported that they had a long-standing disability or illness that limited their activity. This figure did not include asymptomatic illnesses or infections such as Hepatitis C or HIV disease. All mental health indicators were much worse for prisoners than for the general population and particularly high for female prisoners. While prisoners in closed institutions expressed most dissatisfaction with the health service, there were significant differences in this across the closed institutions, ranging from 13% to 79%. Lack of access to services, perceived poor communication skills on the part of doctors and inadequate diagnosis and treatment of specialised problems such as mental illnesses and drug addiction were the main reasons reported by prisoners for their dissatisfaction. The Report made a number a recommendations including the introduction of an adequately funded comprehensive primary care health service across the prison system.

6.7 Participation – by patients, carers, community and voluntary organisations and the public generally.

Socially excluded groups have increasingly come to express the view that for the services to meet their needs it is necessary that they have more participation in needs assessment, planning, delivery, monitoring and evaluation of the services. While there are some examples of such involvement e.g. the Traveller Primary Care Workers, the Regional Co-ordinating Committees for Disability (which are involved in service planning and more recently in monitoring), the Women's Regional Health Advisory Committees, the Local Drug Task Forces, the delivery of a more equitable health service and the perception of such delivery is likely to entail more widespread participation. In this regard the following quotation from Whitehead (49) – an international authority on health equity – is pertinent:

> "Within the health care system, an equitable approach requires the genuine decentralisation of power and decision-making matched by the participation of people in every stage of the policy making process."

In an Irish context the recent White Paper – Supporting Voluntary Activity (50) has given formal recognition to the role of the community and voluntary sector in contributing to the creation of a vibrant, participative democracy and civil society. It has as one of its principles "a shared commitment by both the State and the Sector to ensure the involvement of consumers and people who avail of services in the planning, delivery, management and evaluation of policy and programmes. This applies at all levels; national, regional and local".

It should be stated that the demands for greater participation come not just from disadvantaged groups but also from the public in general – women, for example, who comprise half of the population. This broader type of participation is considered more democratic. It is likely that the most appropriate "reach" of participation will vary depending on the issue in question.

6. 8 Patient Responsiveness in general

Attention has been drawn by the Society of St Vincent De Paul (SVP) (51) to the negative experience of some public patients in the acute hospital system, for example, "people left waiting for long times in A & E and out-patients, being arrogantly treated by some health personnel and discharged early with insufficient community support". The SVP (52) also highlights the way lack of support and resources for Community Care impacts daily in the lives of the vulnerable and disadvantaged e.g. "the serious lack of psychiatric services for those discharged from hospital into the community and inadequacies in terms of supports for carers and respite care particularly for those who cannot afford the services of a paid carer".

Some findings from the WHO World Health Report 2000 (53) are also of interest though it must be stated that this report and particularly its league table of health systems' performance has been the subject of some criticism. The Report ranks countries on the basis of the overall performance of their health system. This was measured by relating achievement of health system goals (in terms of a) health and its distribution, b) responsiveness and its distribution and c) fairness in financing) to health expenditure. Ireland ranked 19th among 190 countries in terms of overall performance. It ranked 6-7th in terms of fairness of financing but did less well on measures of health and responsiveness. In terms of health, measured as disability-adjusted life expectancy (DALE) at birth, Ireland ranked 27th of 190 countries and for distribution of health measured by equality of child survival, Ireland ranked 13th overall and 7th in the EU. On health system responsiveness (the issue under consideration in these paragraphs) Ireland ranked 25th (just ahead of the UK at 27th) and 11th in the EU. Responsiveness was measured in terms of respect for persons (dignity, autonomy and confidentiality) and client orientation (prompt attention, quality of basic amenities, access to social support networks during care, choice of providers).

In her discussion paper on Performance Measurement in the Health Sector, Butler (54) reviewed some performance–type measures currently in use in Ireland and internationally. Her findings “suggest that the dimension of performance identified in other health systems but neglected in the Irish system, at least at national and regional level, is patient orientation/satisfaction”.

7. Inequities arising from competing demands for finite (and historically constrained) resources

In addition to the above examples of sources of inequity there are other situations which can be perceived as inequitable and which may be viewed as arising, not primarily from the legislative/regulatory framework or the organisation or operation of services but as the fallout from competing demands on finite resources. These would relate, for example, to the services and supports available for people with special needs and their carers e.g. persons with intellectual disability, with autism, with physical and/or sensory disability, people with mental illness, older people particularly those with Alzheimers disease, homeless people, drug users and children in need of care and protection. While waiting times and shortfalls in services currently being experienced by these groups can in many cases be attributed in part, at least, to financial constraints in the past (as well as in many cases to increases in the numbers in need of services), considerable investment in some of these areas has been made in recent years and there is ongoing commitment to this in the National Development Plan (NDP) (55). However, efforts to expedite improvements in the situation are now hampered in some cases by capacity constraints in the building industry and by staff shortages in the health sector itself. Historical financial constraints are also an issue in relation to inequities in speed of access to acute hospitals, as the extent of the difference in waiting times for some procedures between public and private patients reflects, in part at least, inadequacies in bed numbers which in turn are the result of financial cutbacks in the late 1980s. This issue is currently being addressed in the context of the Review of Bed Capacity to which a commitment was given in the Programme for Prosperity and Fairness (56). On a broader front, the fact that resources are finite (even in the wealthiest societies) suggests a need for more open societal debate on priorities in relation to health and health care.

Comparison is frequently made between expenditure on health care in Ireland compared to that in other EU countries. The most comprehensive and comparable data are those collected by the OECD. Tables 1 and 2 in the Appendix show data for the years 1979-1998. Table 1 shows that per capita public expenditure in Ireland has been increasing over the period (with the exception of some years in the mid 1980s), but up to 1998, the latest year for which an EU average is available, spending was still below the EU average. Table 2 relates to total expenditure on health care as a percentage of gross domestic product (GDP). This table shows that from 1994 to 1998, total health expenditure as a percentage of gross domestic product (GDP) was decreasing, reflecting the fact that economic growth outstripped public investment in health care. In the last four years (1997-2001) however, public expenditure on health care in Ireland has doubled and total expenditure on health care as a percentage of GDP is now increasing. Comparable data for the years 1999-2001 for other EU countries are not yet available (and therefore are not shown in the tables). However it is likely that, despite the increasing trend, the percentage for Ireland remains below the EU average.

8. Summary of some initiatives in place in Ireland

The main focus of this paper is on highlighting issues relevant to inequities in access to services in the Irish health care system. It may be useful at this point to make reference to some of the general initiatives in place to address them. In recent years a considerable number of such initiatives have been (and are continuing to be) undertaken which should over time result in improved responsiveness of the health care system to the needs of people who are poor or socially excluded. Without any attempt to be exhaustive, a summary of these is provided in the following paragraphs. While the principle of equity is one of the key principles underpinning the National Health Strategy and while many of the initiatives listed have the intention and capacity to improve the health of those most in need, it could be argued that what is lacking is a coherent implementation and monitoring framework for embedding equity across the system.

The National Development Plan (NDP)

The £2 billion investment in infrastructure over the period 2000-2006 as envisaged in the National Development Plan (NDP) will improve the capacity of the public health care system and the environment in which services are delivered across a range of service areas relevant to disadvantaged groups. The opportunity of the National Development Plan is being taken to improve the proportion of capital funding being allocated to non-acute/community care services. From a position where 70% of such funding has been going to acute hospitals in recent years it is planned to equalise funding between the two sectors over the period of the NDP. A start has already been made to this process in 2001.

National Strategies

Implementation of strategies such as the National Children's Strategy, the Health Promotion Strategy 2000-2005, the Report of the Cardiovascular Health Strategy

Group, the ongoing implementation of the Cancer Strategy, the Report of the Maternity and Infant Care Scheme Review Group, The Plan for Women's Health, the recommendations of the Task Force on Suicide, the upcoming Plan for Travellers' Health, the National Drugs Strategy and National Youth Homeless Strategy as well as the Government commitment to address, over the period 2000-2003, identified need in the area of intellectual disability and autism, all have strong elements aimed at reducing inequalities in health including inequities in access to health services. The National Health Strategy – *Shaping a Healthier Future* has equity as one of its underlying principles and it is envisaged that the new National Health Strategy, currently being developed, will have a strong emphasis on this issue also.

Hospital Care

The second phase of the Review of Bed Capacity is now at an advanced stage. The first phase of the review resulted in a £32 million initiative to alleviate identified pressures, particularly over the winter period. This resulted in the provision of more Accident and Emergency consultants, more anaesthetists and the purchase of over 700 contract beds in private nursing homes as well as additional supports for older people.

Most health agencies now have a structured system for managing waiting lists and bed management. All health boards also have a waiting list co-ordinator or equivalent person to liaise between their hospitals and to report back to the Department of Health and Children. A number of agencies report noticeable reductions in individual specialties following a detailed validation of their waiting lists. This issue clearly requires ongoing attention so that an accurate and up-to-date picture of waiting lists can be maintained. A Department/Health Board working group has examined this issue and prepared its report. Recommendations are expected to issue shortly relating to standardised criteria and protocols for managing waiting lists. One example illustrating the value of validation was reported recently in the Journal for Health Gain (57). At the start of the study 240 patients were awaiting hip replacements and 98 awaiting knee replacement at Croom Hospital in Limerick. A validation process which involved detailed assessments of the patients reduced the waiting lists by 20% and 12% respectively.

The National Teaching Hospital Accreditation Scheme launched in February 2000 is aimed at achieving excellence in quality of care. Initially the latter programme will focus on the eight major teaching hospitals in Dublin, Cork and Galway but it is intended to expand the programme later to other hospitals and agencies, including private hospitals.

The reform of the law in relation to the involuntary detention of patients in psychiatric hospitals and the establishment of the Mental Health Commission to promote, encourage and foster the maintenance of high standards and good practices in the delivery of mental health services, are aimed at improving the health and well being of this vulnerable group.

Services in the community

There is a choice of doctor scheme at primary care level which is free of charge to about one third of the population and with relatively instant access (subject to the limitations mentioned earlier in sections 5.2, 6.1 and 6.4).

There is a commitment in the Programme for Prosperity and Fairness (58) to develop multi–purpose primary care centres from which a range of services would be delivered and where there would be greater flexibility in the times at which some services, e.g. GP services, would be available.

In some health boards, initiatives such as the Primary Health Care Project for Travellers and the Community Mothers Scheme are enabling those affected by services to have more participation in their planning and delivery.

In child care, the report Best Health for Children is being implemented and there are ongoing developments in the area of high support/special care, pre-school services, foster care and the Social Services Inspectorate. Springboard Family Support initiatives and teenage parenting support projects are focused on vulnerable children, many of whom are from areas of socio-economic deprivation. A comprehensive immunisation programme, free of charge to everyone, is in place to eradicate infectious diseases.

The Integrated Services Project, the Local Drugs Task Forces as well as health board participants in the more recent County Development Board process are seeking to address the issue of better service integration at an inter-sectoral level. Within the health services themselves a greater focus is being placed on this issue e.g GP/ hospital committees, clinical directorates and care groups. The need for a better integrated and more patient-focused service was one of the main reasons for the reconfiguration of health service structures in the eastern region.

Social Inclusion Networks in operation in some boards are focusing on team working, responsiveness and improving service delivery. The three eastern area boards have developed a policy in line with the White Paper on Supporting Voluntary Activity.

Personnel issues

Developments in relation to greater flexibility in working hours and skill mix among health care workers, being pursued in the context of the National Partnership Forum (59) and the Report of the Medical Manpower Forum (60) are also intended to improve the capacity and responsiveness of the system.

Eligibility issues

Income guidelines for medical cards for older people aged 70 years and over have been relaxed progressively over the past few years and on foot of the 2001 Budget all such persons are being granted entitlement. Under a PPF commitment (61) medical card eligibility is currently being reviewed with a particular emphasis on families with children and barriers to take–up including information deficits. The Drug Payment Scheme has been revamped to ensure that no individual or family has to pay more than £42 in any month for prescribed drugs and medicines.

The Dental Treatment Services Scheme (DTTS) has been extended progressively over the last number of years to medical card holders in all age groups. Likewise an agreement has been in place since July 1999 between health boards and the Association of Optometrists of Ireland for the provision of sight testing and spectacles for adult medical card holders and their adult dependants.

Other Cross–cutting Issues

Health board and other health agency annual Service Plans detail a range of initiatives e.g. ongoing feedback mechanisms for patients and carers, more use of evidence-based protocols and guidelines and the gradual introduction of performance indicators which should act both as a spur to standards and a means of accounting for performance.

In relation to physical and other aspects of access a project undertaken by the NEHB, the (then) EHB and the Irish Society for Quality in Health Care is of interest (62). The project involved the development of an assessment standard and an assessment tool for access assessment of services for people with disabilities. The standard comprises eight distinct areas: management processes; referral processes; assessment services; communication; information; physical environment; health and safety and service delivery and user involvement. The assessment tool includes a series of questions relating to each of the eight areas of the standard and is aimed at fostering reflective practice for continual improvement. The assessment follows a logical sequential journey, following how people arrive at, enter, move around in, use and leave services. Proposals are currently being prepared for the advancement of the implementation of this work. The use of such instruments or at least some aspects of them would have relevance to access issues for a variety of groups such as people with disabilities, Travellers, gays and lesbians, immigrants, refugees and asylum seekers.

The Freedom of Information Act, the Office of the Ombudsman as well as the Equality Authority can reinforce positive trends in responsiveness as can organisations such as the Irish Patients'Association and the Irish Society for Quality in Health Care.

Many of the initiatives mentioned above are national ones while a number are in place only in one or some areas and/or are at a pilot stage. The intention has been to give a flavour of the range of initiatives involved.

9. Conclusion

In addressing the issue of equity of access to services and the persisting inequities outlined in earlier sections, the Sub–group on Equity of Access to Health Services and the NAPS/Health consultative process generally will need to take account of developments such as those mentioned in the previous section. This is to ensure that what emerges from the NAPS/Health process adds value rather than duplicates. Account will also need to be taken of information on the characteristics of successful interventions where the experience is applicable and transferable to an Irish context.

In the context of the brief of the Sub-group on Equity of Access it may be useful to conclude with a quotation from Davey Smith (63):

> "We consider that health services now have a substantial impact on population health, whether measured as quality of life or survival. This is likely to increase in the future. Therefore, adequate provision of health services to all social groups is a factor which will, increasingly, come to influence inequalities in health".

References

1. **Government of Ireland.** *Programme for Prosperity and Fairness.* Dublin, Stationary Office; 2000. p 79 paragraph 3.1. p 96 paragraph 3.10.26.
2. **Burke S.** *Setting Health Targets for the National Anti-Poverty Strategy:A Background Research Paper.* Dublin, Institute of Public Health in Ireland; 2001.
3. **Department of Health.** *Shaping a Healthier Future – A Strategy for Effective Health Care in the 1990s.* Dublin, Stationary Office; 1994. p 17.
4. **Mc Keown T.** *The Role of Medicine.* London, Nuffield Provincial Hospital Trust; 1976.
5. **European Regional Office of the World Health Organisation.** *Health 21 – The Health for All Policy for the WHO European Region.* Copenhagen, WHO; 1998. p 89.
6. **Bunker J P.** *Medicine matters after all.* Journal of the Royal College of Physicians London 1995; 29:105-112.
7. **McCarthy M.** *Causes and Contributions of Public Health.* Discussion Papers for Meeting of the Issues Panel for Equity in Health. London, King's Fund; 2001.
8. **Davey Smith G, Frankel S and Shah E.** *Rationing for Health Equity: is it necessary?* Health Economics 2000; 9:575 –579.
9. **Tunstall-Pedoe H, Vanuzzo D, Hobbs M et al.** *Estimation of contribution of changes in coronary care to improving survival, event rates, and coronary heart disease mortality across the WHO MONICA Project populations.* Lancet 2000; 355:688-700.
10. **Peto R, Boreham J, Clarke M et al.** *UK and USA breast cancer deaths down 25% in year 2000 at ages 20-69 years.* Lancet 2000; 355:1822.
11. **Department of Health.** *Shaping a Healthier Future – A Strategy for Effective Health care in the 1990s.* Dublin, Stationary Office; 1994. p 10.

12. **Whitehead M.** *The Concepts and Principles of Equity and Health.* International Journal of Health Services 1992; 22(3):429-445.
13. **Nolan B and Wiley M.** *Private Practice in Irish Public Hospitals.* Dublin, Economic and Social Research Institute; 2000. p 95-108.
14. **Irish Independent (Review Section).** Irish Independent / IMS Poll. Dublin, 30 December 2000. p 3.
15. **Nolan B and Wiley M.** op. cit. p 109-129.
16. **Murphy A.** *Equity and Access in Irish Primary Care.* Presentation to the Southern Health Board conference on Inequalities in Health, 20 May 2000. Galway, Department of General Practice, NUI.
17. **Creese A.** *User fees – they don't reduce costs, and they increase inequity.* British Medical Journal 1997; 315:202-203.
18. **Reggler J.** *User fees would both yield money and encourage more responsible use of NHS.* British Medical Journal 1998; 316:70.
19. **The Society of Actuaries in Ireland.** *The Financing of Primary Health Care.* Dublin, February 2000.
20. **Nolan B.** *Charging for Public Health Services in Ireland: Why and How?* Dublin, Economic and Social Research Institute; 1993.
21. **The Cherry Orchard Concerned and Active Citizens Group.** *The Cost of Keeping on their Feet.* Dublin, The Vincentian Partnership for Justice; 1998.
22. **Government of Ireland.** *Programme for Prosperity and Fairness.* Dublin, Stationary Office; 2000. p 79 paragraph 3.1. p 96 paragraph 3.10.26.
23. **Murphy A.** op.cit.
24. **O'Mullane D and Whelton H.** *Oral Health of Irish Adults 1989-1990.* Dublin, Stationary Office; 1992. p 15.
25. **Department of Health.** Institutional Assistance Regulations, 1965; Health (Charges for In-Patient Services) (Amendment) Regulations, 1976 and Health (Charges for In-Patient Services) (Amendment) Regulations, 1987. Dublin, Stationary Office .

26. **Sinclair H, Bradley F, Murphy AW, Kelly A.** *The Inverse Care Law: A Rubicon yet to be crossed?* Paper presented at the Association of University Departments of General Practice 26th Annual Scientific Meeting 16-18 July 1997, Trinity College Dublin. Also work in progress at SAHRU, Dept of Community Health, Trinity College Dublin.
27. **Department of Health and Children.** *Building Healthier Hearts – The Report of the Cardiovascular Health Strategy Group.* 1999. p 35.
28. **Department of Health and Children.** Annual Report of the Chief Medical Officer. Dublin, Stationary Office; 1999. p 41-42.
29. **The National Women's Council of Ireland.** *Survey on Women's Health Issues.* Dublin, 1999.
30. **Wiley M and Merriman B.** *Women and Health Care in Ireland.* Dublin, Economic and Social Research Institute; 1996.
31. **Breen N, Woods J, Bury G, Murphy AW and Brazier H.** *A National Census of Ambulance Response Times to emergency calls in Ireland.* JAEM 2000; 17:392-5.
32. **Murphy A.** op. cit.
33. **North Western Health Board.** *Donegal Pre–hospital Emergency Care Project.* Manorhamilton, Co Leitrim, North Western Health Board; 1999.
34. **Society of St. Vincent de Paul.** *Social Policy Manifesto 2000.* p10.
35. **Department of Health and Social Services.** White Paper entitled *The New NHS – Modern, Dependable.* London, HMSO; 1997. p 15.
36. **National Women's Council in association with the health boards.** Report of a Conference entitled *Working Together Creatively for Women's Health – New Challenges and Opportunities* 28-29 November, 2000. Dublin, The National Women's Council.
37. **Department of Health and Children.** Information supplied by the Secondary Care Division. Dublin; March 2001.
38. **Nolan B and Wiley M.** op. cit. p 98.
39. **Coleman MP, Babb P, Damiecki P et al.** *Cancer survival trends in England and Wales, 1971-1995; Deprivation and NHS region***.** London, The Stationary Office; 1999.

40. **Bardsley M, Bevan P, Gill M and Jacobson B.** *Health in the capital: A city-wide perspective.* London, 'The Health of Londoners' Project; 1997.
41. **Hough, EM.** *Readability of Health Information Leaflets – Are they appropriate for adults with reading difficulties?* The Journal of Health Gain Vol 4; Issue 4; Autumn 2000.
42. **Wiley M and Merriman B.** op. cit.
43. **Department of Health and Children.** *National Plan for Women's Health 1997-1999.* Dublin, Stationary Office; 1997.
44. **Mc Auliffe E.** *Towards Patient-centred Care: consumer involvement in health care. P.286-305.* In Mc Auliffe, E and Joyce, C (eds) A Healthier Future: Managing Health Care in Ireland. Dublin, Institute of Public Administration; 1998.
45. **Holohan T.** *Health and homelessness in Dublin.* Irish Medical Journal 2000; 93:41-43.
46. **Allwright S, Barry J et al.** *Hepatitis B, Hepatitis C and HIV in Irish Prisoners: Prevalence and Risk.* Report prepared for the Minister for Justice, Equality and Law Reform by the Department of Community Health and General Practice, Trinity College Dublin. Dublin, The Stationery Office; 1999.
47. **Long J, Allwright S et al.** *Hepatitis B, Hepatitis C and HIV in Irish Prisoners, Part 11: Prevalence and Risk in Committal Prisoners 1999.* Report prepared for the Minister for Justice, Equality and Law Reform by the Department of Community Health and General Practice, Trinity College Dublin. Dublin, The Stationary Office; 1999.
48. **Centre for Health Promotion Studies.** *General Healthcare Study of the Irish Prisoner Population.* Report prepared for the Minister for Justice, Equality and Law Reform by the Centre for Health Promotion Studies, Department of Health Promotion, NUI, Galway. Dublin, The Stationary Office; July 2000.
49. **Whitehead M.** art. cit.
50. **Dept. of Social, Community and Family Affairs.** *White Paper on Supporting Voluntary Activity.* Dublin, Stationary Office; 2000.

51. **Monaghan J.** *Health Inequalities and Poverty – the SVP Perspective.* Paper delivered at the Society of St Vincent de Paul conference on Health Inequalities and Poverty, 23 November, 2000. Dublin.
52. **Idem.**
53. **World Health Organisation.** *The World Health Report 2000 – Health Systems : Improving Performance.* Geneva, WHO; 2000.
54. **Butler M.** *Performance Measurement in the Health Sector.* CMPR Discussion Paper No.14. Dublin, Institute of Public Administration; 2000. p 44.
55. **Government of Ireland.** *The National Development Plan 2000-2006.* Dublin, Stationary Office; 2000.
56. **Government of Ireland.** *Programme for Prosperity and Fairness.* Dublin, The Stationery Office, 2000. p 93 paragraph 3.10.4.
57. **Carey M and Masterson E.** Early results of a new method of prioritising Joint Replacement Waiting Lists. Health Science and Management Research Bulletin. Limerick. Mid Western Health Board, 2000; Vol.1, 3: 3-4.
58. **Government of Ireland.** *Programme for Prosperity and Fairness.* op.cit. p 97 paragraph 3.10.19.
59. **Ibid.** p 30 paragraph 1.4.3.
60. **Department of Health and Children.** *Report of the Forum on Medical Manpower.* January 2001.
61. **Government of Ireland.** *Programme for Prosperity and Fairness.* op. cit. p 94 paragraph 3.10.6.
62. **Fox M, Keane V et al.** *Access Assessment of Services for People with Disabilities* Journal of Health Gain Vol.4 ; Issue 4; 2000; 10-11.
63. **Davey Smith G, Frankel S and Shah E (2000).** art. cit.

APPENDIX

Tables on expenditure on health care in EU countries

Table 1: Public Expenditure on Health per capita (US$PPP) for EU Countries 1979-1998

Countries	**1979**	**1980**	**1981**	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**
Austria	401	455	490	517	545	574	623	678	721	770	833	889	931	1048	1143	1202	1348	1386	1338	1388
Belgium	435	482	551	645	662	701	724	744	831	965	1031	1107	1215	1348	1423	1455	1591	1697	1762	1866
Denmark	-	719	807	883	907	937	1008	1010	1071	1141	1165	1191	1258	1309	1415	1479	1558	1653	1674	1748
Finland	351	403	487	520	558	595	668	716	778	828	920	1045	1145	1103	1013	980	1074	1128	1134	1148
France	487	552	641	696	735	804	833	866	912	968	1068	1189	-	-	-	-	1539	1540	1529	1587
Germany	566	649	744	778	812	887	961	998	1054	1149	1136	1221	1250	1434	1424	1529	1701	1791	1788	1808
Greece	-	191	-	-	-	-	-	-	339	372	422	443	474	521	535	575	622	654	667	663
Ireland	302	371	398	409	415	427	448	445	449	451	470	571	656	761	803	878	958	968	1074	1088
Italy	389	472	500	541	578	598	643	658	757	842	898	1032	1135	1176	1120	1115	1089	1146	1193	1212
Luxembourg	491	559	637	668	674	732	796	649	1025	1115	1241	1383	1453	1610	1745	1785	1953	2024	1987	2044
Netherlands	451	507	569	616	644	672	697	714	767	796	894	963	1050	1189	1252	1282	1369	1311	1395	1458
Portugal	134	165	197	183	170	173	209	237	248	300	299	402	459	479	551	597	686	727	772	828
Spain	227	260	287	316	364	357	368	378	417	501	559	639	712	768	804	802	836	879	882	936
Sweden	673	785	872	942	991	1056	1059	1072	1143	1190	1274	1392	1289	1309	1292	1284	1382	1454	1442	1463
U.K.	346	397	448	463	523	550	574	613	664	700	751	812	851	994	1021	1057	1104	1180	1176	1224

Copyright OECD HEALTH DATA 2000

Table 2: Total Expenditure on Health as a % of Gross Domestic Product (GDP) for EU Countries 1979-1998

Countries	**1979**	**1980**	**1981**	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**
Austria	7.6	7.7	6.8	6.7	6.5	6.6	6.7	6.9	7.1	7.1	7.3	7.2	7.2	7.6	8.1	8.1	8.9	8.9	8.2	8.2
Belgium	6.8	6.4	6.9	7.1	7.3	7.2	7.2	7.4	7.5	7.5	7.4	7.4	7.8	7.9	8.1	7.9	8.2	8.6	8.6	8.8
Denmark	-	9.2	9.4	9.5	9.2	8.8	8.8	8.4	8.6	8.7	8.6	8.4	8.3	8.4	8.7	8.5	8.2	8.3	8.2	8.3
Finland	6.4	6.4	6.5	6.7	6.8	6.8	7.2	7.3	7.4	7.2	7.2	7.9	9.0	9.1	8.3	7.8	7.5	7.7	7.3	6.9
France	7.2	7.4	7.7	7.8	8.0	8.3	8.3	8.4	8.4	8.4	8.5	8.8	9.0	9.2	9.7	9.6	9.8	9.7	9.6	9.6
Germany	8.5	8.8	9.2	9.1	9.0	9.1	9.3	9.1	9.2	9.4	8.8	8.7	9.1	9.7	9.7	9.8	10.2	10.6	10.5	10.6
Greece	-	6.6	-	-	-	-	-	-	7.4	7.3	7.5	7.6	7.9	8.3	8.3	8.3	8.3	8.3	8.5	8.3
Ireland	7.9	8.7	8.3	8.1	8.2	7.8	7.9	7.7	7.4	7.0	6.6	7.0	7.4	7.8	7.8	7.7	7.4	7.2	7.0	6.4
Italy	6.0	7.0	6.9	7.0	7.1	6.9	7.1	7.0	7.4	7.6	7.7	8.1	8.4	8.5	8.6	8.4	8.0	8.1	8.4	8.4
Luxembourg	6.0	6.2	6.4	6.3	6.1	6.0	6.1	6.0	6.6	6.3	6.2	6.6	6.5	6.6	6.7	6.5	6.3	6.4	6.0	5.9
Netherlands	8.1	8.3	8.5	8.8	8.6	8.3	8.1	8.3	8.4	8.5	8.8	8.8	9.0	9.2	9.4	9.2	8.9	8.8	8.6	8.6
Portugal	5.0	5.8	8.2	6.1	5.8	5.9	6.3	6.9	6.7	7.0	6.4	6.4	7.0	7.2	7.5	7.5	7.7	7.7	7.6	7.8
Spain	5.5	5.6	5.8	5.9	5.9	5.7	5.7	5.6	5.7	6.3	6.5	6.9	7.0	7.4	7.6	7.4	7.0	7.1	7.0	7.1
Sweden	9.0	9.4	9.5	6.6	9.5	9.3	9.0	8.7	8.8	8.7	8.8	8.8	8.7	8.8	8.9	8.6	8.4	8.7	8.5	8.4
U.K.	5.3	5.7	6.0	5.8	6.0	6.0	5.9	5.9	6.0	5.9	5.9	6.0	6.4	6.9	6.9	7.0	7.0	7.0	6.7	6.7

Copyright OECD HEALTH DATA 2000

THE INSTITUTE OF
PUBLIC HEALTH IN IRELAND

Working for the health of the people of the island of Ireland

The Institute of Public Health
6 Kildare Street, Dublin 2

Tel: 00 353 1 662 9287
Fax: 00 353 1 662 9286
Email: iph@RCPI.ie
Also contactable at Belfast: 00 44 28 9079 3050

ISBN 0-9540010-5-2