

Evolution Of Health Services And Health Policy In Ireland

Brian Harvey

Evolution Of Health Services and Health Policy In Ireland

AUTHOR

Brian Harvey is an independent social research consultant, based in Dublin, specialising in issues of social policy, poverty, equality, community development and European integration. He works for voluntary organisations, community groups, civil society and non-governmental organisations as well as government agencies, trusts and foundations in both parts of Ireland, Britain and continental Europe.

Published by
Combat Poverty Agency
Bridgewater Centre
Islandbridge, Dublin 8

© 2007

ISBN: 978-1-905485-36-9

While every effort has been made to ensure that the information contained in this book is accurate, no legal responsibility is accepted by the author or Combat Poverty for any errors or omissions. The views expressed in this publication are the author's own and not necessarily those of Combat Poverty Agency.

TABLE OF CONTENTS

Context and overview	4
Organisation of the health services	5
Role of voluntary and community organisations	7
Health policy	9
Poverty and health	11
Issues in Irish health policy	13
Relationship between the state and the voluntary and community sector	15
Conclusions and future	17
Further information	18
Combat Poverty Agency's Building Healthy Communities programme	18
Useful websites	18
Bibliography	19

Context and overview

Health services in Ireland began in the 18th century in the voluntary, philanthropic and private sector. Doctors, concerned citizens and philanthropists, motivated by the condition of the sick poor, founded the first hospitals in the 1720s, funding them through legacies, donations and public subscriptions.

In the early 19th century, there was a substantial growth in hospital and related services run by Catholic religious orders and lay organisations. In the mid-19th century, the British government introduced the workhouse or poor law system, which provided infirmaries, dispensaries and medical officers to care for the very poor. However, standards were set intentionally low to prevent malingering.

In 1922, the Free State government turned the workhouses into county homes for a wide range of poor people with medical and social needs. Generally, though, health services were not a financial priority in the early years of the state. Instead, public health services were delivered through the local government system until 1970 and funded through lotteries (the hospital sweepstakes). The most significant achievement of the early state was the drive to eliminate tuberculosis (TB) in the late 1940s. The Department of Health was established in 1947.

By contrast, in Britain, the 1942 Beveridge report (*Report on social insurance and allied services*) proposed a universal scheme of social insurance and a National Health Service for all citizens, free at the point of use. Impressed by these developments, the Irish government published a white paper, *Outline of proposals for the improvement of the health services* (1947), proposing a similar health system in Ireland. In a second white

paper, *Social security* (1949), the government proposed a system of universal social insurance. Between them, these white papers set the Republic on course for a welfare state and a universal, national health service. These years thus marked an important turning point in the development of health and social policy in the Irish state.

However, the health proposals foundered on ferocious opposition from the medical profession, the Catholic Church and the Department of Finance. The social insurance proposal also failed, with subsequent governments taking the view that Ireland could not afford a welfare state as extensive as that in Great Britain and Northern Ireland. Instead, in both welfare and health policy, successive governments opted for incremental improvements when and as the country could afford them.

The pattern of a two-tier health service became firmly established. When the medical card system (the General Medical Scheme or GMS) was introduced in 1970, it was on the understanding that coverage would be limited to not more than 40% of the population. (In practice, it has often been much less than that and closer to 30%). For most people, the result was a complex system of subsidised services, state and private health insurance, with payment at most points of use. A state-sponsored health insurance scheme, Voluntary Health Insurance, was introduced in 1957.¹

1 For the history of health services in Ireland, see Barrington, Ruth: *Health, medicine and politics in Ireland, 1900-70*. Dublin, Institute of Public Administration, 2000; and O'Connell, Seamus: "The 1949 white paper and its impact on social welfare policy" in: Lavan, Ann (Ed): *Fifty years of social welfare policy*. Dublin, the Department of Social Community & Family Affairs, 1999.

Organisation of the health services

There have been two organisational upheavals in the Irish health service. The first happened in 1970 when health services were removed from the local authority system and re-organised as eight regional health boards under the the Department of Health. These eight regional health boards had a broadly similar organisational structure, with three programme areas (hospital services, special or psychiatric hospitals and community care), each under a manager. The health 'boards' consisted of local authority councillors, representatives of the senior medical professions and people nominated by the Minister for Health who met each month.

In the 1990s, the Eastern Health Board was sub-divided into three smaller boards (northern, south-western and east coast), resulting in a total of 11 regional health boards by the end of the century. Meantime, about 40 semi-state agencies concerned with health had emerged, with specialised functions ranging from advice to regulation, research to health promotion.

The second major reorganisation of the health services followed the publication of the *Prospectus* report in 2003. This reorganisation was designed to make the health services more unified, efficient and streamlined and, some say, less vulnerable to local and parochial pressures. *Prospectus* proposed:

- Abolishing the 11 health boards and replacing them with a single national health service organisation called the Health Service Executive (HSE);
- Making the Department of Health (now called the Department of Health and Children) responsible for deciding policy and the Health Service Executive responsible for executing policy, administering and managing;
- Abolishing or merging most of the 43 semi-state health agencies and bringing them into the department;
- Removing the system of local accountability and making the Minister for Health and Children theoretically responsible for health services through the Dáil. (In practice, parliamentary questions about services are referred to the parliamentary division of the HSE for answer).

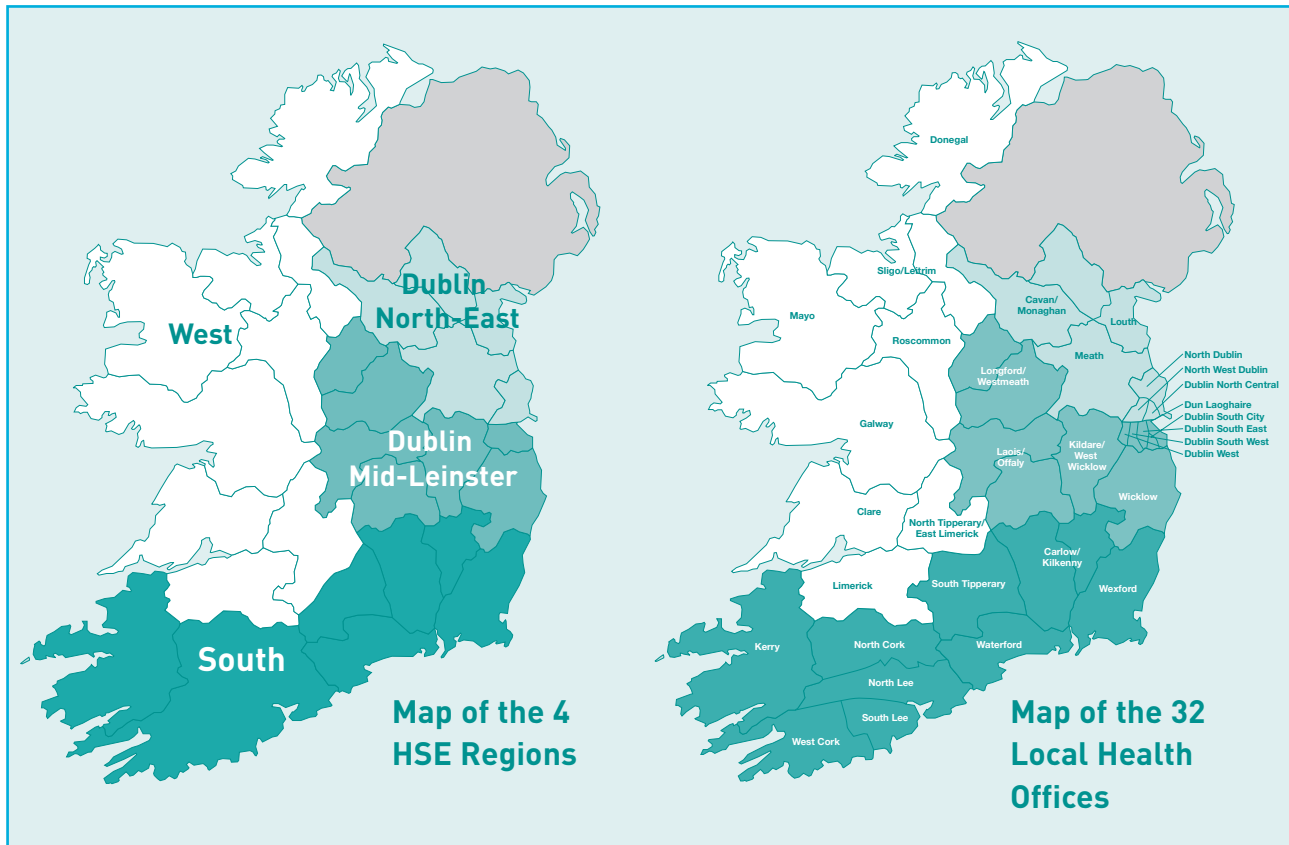
The new system marked a substantial shift from a decentralised, almost federal system to a national, unified, command system run on a much more technocratic basis.

Following approval by the Oireachtas of the Health Act, 2004, the Health Service Executive came into being on 1 January 2005. It operates through four regions and 32 Local Health Offices (LHOs) and publishes an annual *Service plan* explaining how it plans to deliver its services each year.

So far, the full recommendations of the *Prospectus* report have not been put into effect and there has been a remarkable continuity of personnel, policies and approaches, with former health board staff receiving assurances that their

positions would be guaranteed. The semi-state health agencies remain in place. Of these, the most relevant to voluntary and community organisations are Breastcheck, the Health Research Board, the Mental Health Commission and the National Council for Ageing and Older People.

The Institute of Public Health in Ireland is a north-south body founded by the two respective departments of health to examine common north-south health issues and has already developed work on issues of health inequality, for example in the area of mortality.



Reproduced with kind permission of the Health Service Executive

Landmarks in the development of health services

- 1947** White paper *Outline of proposals for the improvement of the health services*, Department of Health
- 1949** White paper *Social security*, Government of Ireland
- 1953** Health Act, section 65, funding for voluntary and community organisations
- 1970** Health Act, establishing eight health boards
- 2004** Health Act, establishing the Health Service Executive (2005)

Role of voluntary and community organisations

Social and health policy in the early days of the Free State can only be described as austere. The philanthropic health service providers, which had grown up in the previous two centuries, had by now exhausted their endowments and were experiencing great difficulty in attracting resources. By 1970, most had closed, amalgamated or been absorbed into the local government system. Those which remain are called ‘public voluntary hospitals’, although for those who use their services, they are indistinguishable from other hospitals managed directly by the state.²

Small voluntary and community organisations concerned with social distress and poor housing emerged from the 19th century onward, often with a strong religious motivation. By far the largest and most enduring of these was the Society of St Vincent de Paul. From the 1930s, the Archbishop of Dublin, John Charles McQuaid, led a radical expansion of voluntary-funded social services in the city, many of which addressed issues of ill-health or their consequences (e.g. the Catholic Social Service Conference).

2 For a discussion on the evolution of the roles of the voluntary hospitals, see O’Ferrall, Fergus: *Citizenship and public service – voluntary and statutory relationships in Irish healthcare*. Dublin & Dundalk, Adelaide Hospital Society with Dundalgon Press, 2000.

In Britain, voluntary and community organisations played a large role in the delivery of the health and social services which were put in place following the Beveridge report and expanded enormously in the post-war years. However, with the failure of the white paper *Social security*, there was no welfare state in the Republic – nor, by implication, was a voluntary and community sector needed to deliver services. The legacy of these events is still evident today, for the density of voluntary and community organisations in the Republic is only about half that of Northern Ireland.³

The first recognition of a role for voluntary and community organisations came with Section 65 of the Health Act, 1953, which allowed the health services (known as the health boards from 1970) to provide funding to voluntary organisations for health and related purposes. ‘Section 65 funding’, as it became known, became the largest source of funding for voluntary and community organisations in the state and health boards took a broad social view of the type of services that these organisations should provide. By 2001, the value of Section 65 funding to voluntary and community organisations was about €486 million.⁴

The Health Act, 2004, changed the name from section 65 grants to section 39 grants, with applications going through the 32 Local Health Offices. However, the Act did not give voluntary and community organisations a role in decision-making.

3 Acheson, Nick; Harvey, Brian; Kearney, James & Williamson, Arthur: *Two paths, one purpose – voluntary action in Ireland, north and south*. Dublin, Institute of Public Administration, 2004.

4 For a description of these developments, see Curry, John: *Irish social services*. Dublin, Institute of Public Administration, 2003 (4th edition).

Nowadays, a range of voluntary and community organisations address issues of poverty and ill-health, either directly or indirectly. Many disability organisations work directly with the health services - both individually and through national umbrella bodies such as the Disability Federation of Ireland. The past decades have also seen the formation of small voluntary organisations concerned with specific diagnostic disorders (such as motor neurone disease, muscular dystrophy and Huntingdon's disease). Health issue groups are now a distinct part of the voluntary and community sector. The Wheel, a national organisation which brings together voluntary organisations, has a dedicated health 'spoke'.

Health policy

There are few health policy documents from the early days of the Free State and the Republic and those which were published tended to focus on organisational concerns. Not until the 1990s were framework health policy strategies drawn up, accompanied by strategies for particular aspects of the health services.

The first of these national strategies was *Shaping a healthier future* (1994), followed by the current strategy *Quality and fairness - a health system for you* (2001). These are broad documents, setting down general principles and the most favoured lines for the development of services. These national strategies are flanked by a series of specialised strategies, including *The years ahead* (1988, the policy for older people), *A plan for women's health* (1997) and strategies for Traveller health, cancer and alcohol, among others.

Policies for improved health may also be found in generic national policy development documents, principally those developed by the National Economic and Social Council (NESC) and the National Economic and Social Forum (NESF). In addition, specific commitments to improve health services may be found in the national social partnership agreements introduced since 1987. The current agreement, *Toward 2016*, includes commitments to improve health outcomes for children, people of working age and older people.

In addition, Irish health policy is influenced by developments at an international level. The United Nations Organisation, through the World Health Organisation, has played an important role in encouraging its members to set standards for health care and disease prevention and to improve life expectancies. The European Union has a commissioner and directorate general responsible for health and runs a funding programme in public health, focusing on information exchange and the prevention of communicable diseases. A number of European networks concerned with health issues lobby the European Union for more enlightened policies in the area of public health.

Several trends are evident in Irish health policy. The 1980s saw a new focus on prevention, health promotion and self responsibility (*Health - the wider dimensions*, 1986), coupled with a determination by the government to reduce institutional and hospital-based care. There was a sharp fall in the amount of time people spent in hospital, several hospitals were closed, beds were decommissioned and there was a strong push to move the care of psychiatric patients into the community (*Planning for the future*, 1985). In recent times, health policy has emphasised prevention (e.g. Breastcheck), healthy living (e.g. smoking, obesity), more active lifestyles and community-based services (e.g. 'care packages' for older people).

Many people's first contact with the health service is through the primary care services, mainly the local doctor who is called a General Practitioner (GP). About 1,600 practices nationwide

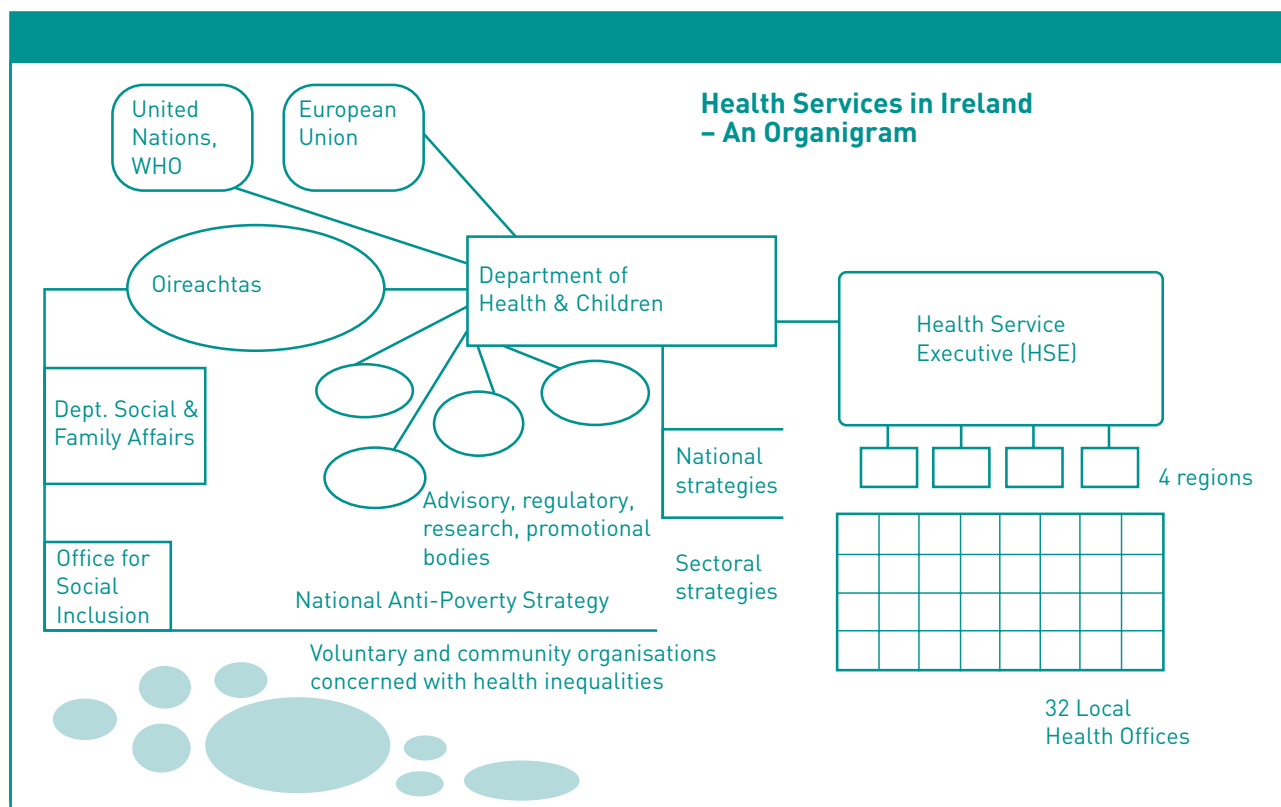
provide primary care services. In 2001, the government published a fresh policy for the development of primary care services (*Primary care – a new direction*, 2001). This proposed wider availability of GP services through teams and GP co-operatives and the establishment of multi-disciplinary primary care teams (GPs, nurses, health care assistants, therapists, social workers etc). Although medical card holders receive free primary health care, the remaining two-thirds of the population must pay at the point of use. In the rest of the European Union, by contrast, the norm is for primary care to be free at the point of use.

Framework national health strategies

- *Shaping a healthier future*, 1994
- *Quality and fairness – a health service for you*, 2001

Some sectoral health strategies

- *Planning for the future*, 1985 (psychiatric services)
- *The years ahead*, 1988 (older people)
- *Cancer services in Ireland – a national strategy*, 1996
- *A national breast-feeding policy for Ireland*, 1996
- *A plan for women’s health*, 1997
- *Building healthier hearts*, 1999
- *National health promotion strategy*, 2000
- *Primary care – a new direction*, 2001
- *Report of the national advisory committee on palliative care*, 2001
- *Traveller health national strategy*, 2002
- *Obesity – the policy challenges*, 2005
- *Reach out – national suicide prevention strategy 2005-2014*, 2005
- *A vision for change*, 2006 (mental health)
- *A strategy for cancer control*, 2006
- *Working together to reduce the harms caused by alcohol misuse*, 2006



Poverty and health

The links between poverty and ill-health have long been established. Indeed, they prompted the setting up of the first hospitals in the 18th century. In modern times, research has shown how poorer socio-economic groups have higher rates of infant mortality, live less healthy lives, are more vulnerable to illness and die younger. Some groups have been shown to be at exceptionally high, life-threatening risk of poor health, notably Travellers and homeless people.

Poverty and socio-economic class

Comparing people in the lowest and highest socio-economic groups, those in the lowest socio-economic group are:

- Three times more vulnerable to perinatal mortality;
- Three times as likely to have circulatory diseases;
- Twice as likely to die of cancer;
- Twice as likely to give birth to low weight babies;
- Two and a half times more likely to have a chronic physical illness;
- Six times more likely to be admitted to hospital for mental illness;
- Eight times more likely to die from accidents.

The life expectancy of Traveller men is ten years less than that of the settled community; for Traveller women, it is twelve years less. Infant mortality for Traveller children is three times the national average.⁵

The first National Anti-Poverty Strategy, *Sharing in progress* (1997), considered poverty primarily in income, geographical and educational terms. The revised strategy, *Building an inclusive society* (2002), gave commitments to narrow the gaps in health outcomes between rich and poor, specifically to reduce gaps in premature mortality and low birth weight between the highest and lowest socio-economic groups and to reduce the gap in life expectancy between Travellers and the whole population.

The present government strategy against poverty is the *National action plan for social inclusion, 2007-2016*. This gives government commitments to work for the reduction of poverty generally, for groups across the lifecycle (children, people of working age, older people) (this is called the lifecycle approach) and for specific groups (people with disabilities). In the area of health policy, the plan emphasises the delivery of Community Mental Health Teams for children, adolescents and adults. The plan promises a focus on cancer inequities, with the development of indicators by geographic area and levels of deprivation. There will be an ethnic identifier to facilitate the planning of health services for minority ethnic groups, while a national intercultural strategy will address the unique health and

5 For more information on health, poverty and social inequality, see Public Health Alliance Ireland: Health in Ireland - an unequal state, available at www.publichealthalliance.org

support needs of minority groups such as refugees, migrants and Travellers.

Government commitments to greater health equality

- *Quality and fairness - a health system for you* (Department of Health & Children, 2001).
- *Building an inclusive society* (Department of Social, Community & Family Affairs, 2002).
- *National action plan for social inclusion 2007 – 2016* (Government Publications, The Stationery Office, 2007).

Issues in Irish health policy

Health policy and performance have been important, high-visibility political issues in Ireland for a number of years. There has been sharp criticism of the health service for long waiting times in accident and emergency, lengthy waiting lists for individual operations and the services' costs, structures and bureaucracy (see the Prospectus report).

Services are uneven, with huge variations in what is available in different parts of the country (e.g. palliative care). The rationalisation of services in larger units has provoked strong reactions from local

communities who fear they will be left with inferior services and longer, life-threatening distances to travel (e.g. the Monaghan hospital controversy). The government, for its part, argues that investment in health services is now at record levels and that the gaps in services, waiting times and delivery are being progressively bridged.⁶

Not only has the operational performance been criticised, but so also have the outcomes of the health service.

6 For recent discussion on current health issues, see Quin, Suzanne: "Health policy" in: Quin, Suzanne; Kennedy, Patricia; Matthews, Anne & Kiely, Gabriel: *Contemporary Irish social policy*, Dublin, University College Dublin, 2005. See also Wren, Maeve-Ann: *Unhealthy state - anatomy of a sick society*. New Island, Dublin, 2003.

Some Irish and European health statistics

	Ireland	Europe	
Infant mortality rate per 1,000 births	5.1	4.3	
Life expectancy – women	79.6	81.6	Years
Life expectancy – men	74.6	75.5	Years
Ischaemic heart disease	230	140	Deaths per 100,000 people
Circulatory diseases – women	258	207	Standardised death rate ⁷
Circulatory diseases – men	422	386	Standardised death rate
Cancers – men	249	182	Standardised death rate
Hospital beds per 100,000 people	485	631	
Acute beds per 100,000 people	300	410	
Doctors per 100,000 people	200	330	
GPs per 100,000 people	60	90	

Sources

- ✦ European Commission: *The social situation in the European Union, 2004*. Luxembourg, Office for Official Publications of the European Communities, 2004.
- ✦ European Commission and Eurostat: *Europe in figures - Eurostat yearbook, 2005*. Luxembourg, Office for Official Publications of the European Communities, 2005.
- ✦ Wren, Maeve-Ann: *Unhealthy state - anatomy of a sick society*. Dublin, New Island, 2003.

7 The standardised death rate is defined as the death rate in a population of standard age distribution.

The Euro Health Consumer Index for 2006 ranked Ireland 25th out of the 25 member states. What was especially interesting was that, instead of using traditional measurements of outcomes like those listed above, the index used criteria such as patient rights and information, waiting times for treatment, outcomes, levels of provision and availability of medicines.

In general, policy-makers, health professionals and the non-governmental community agree on the *objectives* of policies articulated in national health policy documents. The main arguments are around implementation and the allocation of resources. In particular, there is criticism of the relatively higher levels of investment in the big hospitals, plant and institutions, compared to community-based services which get only 16%. It is also argued that certain sectors fare relatively poorly, notably mental health, disability and psychiatric services.

The main area of political disagreement around the development of health services concerns the public-private mixture, the two-tier system which became entrenched in policy after the failure of the two white papers in 1947-9. Successive governments have argued that resources should be concentrated on the most needy (in effect, GMS medical card holders), while those who can better afford to pay for health services should do so. Despite our improved economic performance, the government's view is that a national health service, free at the point of use, is neither affordable nor practical.

Critics focus on the inequity of the two-tier system which means, they say, that medical card holders must wait for long times for procedures while people who can afford health insurance can 'jump the queue' and get a much faster service. They point to the national health systems of continental European countries, where waiting times are short or insignificant, outcomes better and access is equal for all citizens. The Health Act, 2006, made provision for the further extension of private hospital facilities, leading to the allegation of 'creeping Americanisation' of the system. Critics said this would have disastrous consequences, namely lack of access by poor people to a deteriorating public health service and even poorer health for those on low or fixed incomes.

Relationship between the state and the voluntary and community sector

The relationship between the Irish state and the non-governmental, non-profit, voluntary and community sector has been a problematic one. Although the government promised to define that role in 1976, it did not publish a white paper on the subject until 2000. Even then, there was much criticism that the white paper, *Supporting voluntary activity*, was neither properly nor wholeheartedly implemented.

These general difficulties have been echoed in the health sector. The difficulties between the state and the voluntary and community sector were especially evident in the long-running battle between the state and the Adelaide hospital in the 1990s around issues of control, independence, accountability and voluntary management. The relationship between smaller voluntary organisations and the state was largely defined through Section 65 grants, which were repeatedly criticised for their inconsistency, inadequacy, uncertainty, lack of criteria, political patronage, high entry barriers and opaque procedures.

Relationships between the health service and voluntary and community groups began to be formalised in the 1990s following the introduction of service level agreements. These agreements were first suggested in the Department of Health's *Enhancing the partnership* (1997). In exchange for a grant, each provider would state exactly what

services it would provide, to what standard and what systems of quality control, monitoring and accountability it would use. The idea was to set down a system of mutual obligations and responsibilities and to establish a more predictable relationship and negotiating environment for both the health service and the voluntary sector provider. In the event, some health boards applied service level agreements, but others were slow to do so and this unevenness is still reflected in the HSE system. Another feature of the agreements compared to the original proposal is that the list of obligations on the voluntary and community organisation has lengthened, while the list of obligations on the state side has changed little.

There was and is a lack of agreement within the health services as to what should be the respective roles of the voluntary and community sector on the one hand and the state on the other. In other words, there was no shared understanding of 'who should do what'. In some parts of the country, particular services such as those for older people were delivered by voluntary groups, in others by health boards and in yet others by a mixture of the two. This might not matter except that the services became very uneven: well provided in some places but not provided at all in others. Moreover, some groups, especially those working in the area of specific diagnostic disorders, found it difficult to get funding or support at all. Few health policy documents have attempted to grapple with what should be the appropriate relationship between the state and the sector. A notable exception is *The years ahead* (1988).

At the heart of the problem may be the lack of access by voluntary and community organisations to the decision-

making system within the health service. Generally, opportunities for voluntary and community organisations to have a dialogue with the health service over policy and the planning of services have been limited to once-off consultations, although some health boards formed advisory committees which included non-governmental organisations (for example, in the disability field). Overall, though, opportunities for voluntary and community groups to have a formal 'voice' within the health service have been limited, marking Ireland as different from the countries of continental Europe.

Taking just one area in particular, *The years ahead* recommended in 1988 that consultative committees be set up between health boards and voluntary and community organisations working with older people. Ten years later, an examination of the implementation of *The years ahead* found that almost no progress had been made on the recommendation. The most recent finding (2006) is that only 15% of groups working with older people are formally consulted by the health services; 71% are either never or infrequently consulted. Given the high proportion of older people at risk of poverty, this has important implications for social exclusion.

Since then, the government has given commitments to new forms of consultation, both at national and local level. When the national health strategy *Quality and fairness – a health system for all* (2001) was devised, the Minister for Health appointed a National Health Strategy Consultative Forum comprising health professionals, consumers and management and this began a series of annual meetings. Section 41 of the Health Act, 2004 formalised the National Health Strategy Consultative Forum. Following this, the Minister

appointed 350 forum members drawn from health service management, service providers, voluntary and professional bodies, patient and client groups, trade unions and government departments.

Section 43 of the Health Act 2004 allows the Health Service Executive to consult with local communities or other groups about health and personal social services. This may include panels of people who use health services, carers, service providers or others.

The national policy on primary care, *Primary care - a new direction* (2001) specifically calls for⁸:

- Mechanisms for active community involvement in primary care teams to be established;
- Involvement of local community and voluntary groups in the planning and delivery of primary care services to be encouraged;
- Consumer panels to be convened at regular intervals;
- User participation in service planning and delivery to be encouraged at local level by primary care teams;
- Consumers to have an input into needs assessments.

The primary care policy specifically states that: "A greater input from the community and voluntary sector will enhance the advocacy role of primary care teams in ensuring that local and national social and environmental health issues, which influence health, are identified and acknowledged".

8 See Action Plan for implementation No. 19 in *Primary care - a new direction*, 2001.

Conclusions and future

Health services in Ireland date back over 300 years. Health policy was not a priority for the Irish state until the late 1940s, but it is now a top national issue. The problem of health inequality has only recently been recognised as an issue but is now embodied in framework health policy documents and in the national anti-poverty strategy. Overall, we can make the following observations:

- Policy-makers, government and non-governmental organisations generally agree on health policy objectives.
- The role of non-governmental, voluntary and community organisations remains unsatisfactory and unresolved, especially their lack of access to decision-making and dialogue on policy issues.
- Although there is a government commitment to address health inequality, there is political disagreement about the mix of public and private health provision and how fair and equal access and outcomes can be achieved.
- It is yet to be seen how the new organisational arrangements (the Health Service Executive) set down in 2003-5 will work. As figures quoted in this paper show, there is still a considerable gap between the performance and outcomes of the Irish health system and the health systems of continental Europe.

For the future, the key questions appear to be:

- Will the national health strategy in general and the national anti-poverty strategy in particular succeed in closing the gaps in health inequalities?
- Will Irish health standards and outcomes rise to continental European norms?
- Will the current two-tier system become more entrenched and more 'Americanised' or will there be a move to universal equal provision?
- Will non-governmental organisations find a 'voice' in health policy?
- Will the voluntary and community sector concerned with health inequality grow in size, cohesion and confidence?

Further information

- › Institute of Public Administration:
Yearbook & Diary.

Published annually in December, this provides details of the Health Service Executive, the Department of Health and Children, health agencies, and national voluntary and community organisations.

Available from the Institute for Public Administration, Research Publishing Membership and Finance, Vergemount, Clonskea, Dublin 6, www.ipa.ie

- › *Irish Medical Times*, 24-6 Upper Ormond Quay, Dublin 7, tel 01-817 6300.

Combat Poverty Agency's Building Healthy Communities programme

This programme supports 10 projects working in geographical and sectoral communities to address poverty and health inequalities. Combat Poverty has a range of information on health, poverty and inequality and a regular publication *Action on Poverty Today*, www.combatpoverty.ie

Useful websites

- › Cáirde (formed to address health inequalities among members of minority ethnic communities):
www.cairde.ie
- › Community Development and Health Network:
www.cdhn.org
- › Department of Health & Children:
www.dohc.ie
- › Department of Health, Social Services and Public Safety, Belfast:
www.dhsspsni.gov.uk
- › European Commission, Directorate General for Health:
http://europa.eu.dgs/health_consumer/index_en.htm
- › Euro Health Consumer Index:
www.healthpowerhouse.com
- › European Public Health Association:
www.eupha.org
- › Health Service Executive:
www.hse.ie
- › Health spoke of the Wheel:
www.wheel.ie
- › Institute of Public Health in Ireland:
www.publichealth.ie
- › Office for Social Inclusion:
www.socialinclusion.ie
- › Public Health Alliance of Ireland:
www.publichealthallianceireland.org
- › Women's Health Council:
www.whc.ie
- › World Health Organisation:
www.who.int

Bibliography

Acheson, Nick; Harvey, Brian; Kearney, James & Williamson, Arthur: *Two paths, one purpose – voluntary action in Ireland, north and south*. Dublin, Institute of Public Administration, 2004.

Barrington, Ruth: *Health, medicine and politics in Ireland, 1900-70*. Dublin, Institute of Public Administration, 2000.

Beveridge, William: *Report on social insurance and allied services*. London, HMSO, 1942.

Curry, John: *Irish social services*. Dublin, Institute of Public Administration, 2003 (4th edition).

Department of Health: *Outline of proposals for the improvement of the health services*. Dublin, the Stationery Office, 1947

Department of Health: *The psychiatric services - planning for the future*. Dublin, Stationery office, 1984.

Department of Health: *Health – the wider dimensions*. Dublin, author, 1986.

Department of Health: *The years ahead*. Dublin, Stationery Office, 1988.

Department of Health: *Shaping a healthier future*. Dublin, Stationery Office, 1994.

Department of Health: *A national breast-feeding policy for Ireland*. Dublin, author, 1996.

Department of Health: *Cancer services in Ireland – a national strategy*. Dublin, author, 1996.

Department of Health: *Enhancing the partnership*. Dublin, author, 1997.

Department of Health: *A plan for women's health*. Dublin, Stationery Office, 1997.

Department of Health & Children: *Building healthier hearts – introduction to the report of the Cardiovascular Health Strategy Group*. Dublin, author, 1999.

Department of Health & Children: *National health promotion strategy*. Dublin, author, 2000.

Department of Health & Children: *Primary care – a new direction*. Dublin, Stationery Office, 2001.

Department of Health & Children: *Quality and fairness - a health system for you*. Dublin, Stationery Office, 2001.

Department of Health & Children: *Report of the national advisory committee on palliative care*. Dublin, author, 2001.

Department of Health & Children: *Traveller health national strategy*. Dublin, author, 2002.

Department of Health & Children: *Obesity – the policy challenges – report of the National Task Force on Obesity*. Dublin, author, 2005.

Department of Health & Children: *Working together to reduce the harm caused by alcohol misuse*. Dublin, author, 2006, published as a special initiative under Sustaining progress.

Department of Social, Community & Family Affairs: *Building an inclusive society*. Dublin, author, 2002.

Department of Social, Community & Family Affairs: *Supporting voluntary activity*. Dublin, Stationery Office, 2000.

Department of Social Welfare: *Sharing in progress*. Dublin, author, 1997.

Department of the Taoiseach: *Toward 2016*. Dublin, Stationery Office, 2006.

European Commission: *Europe in figures - Eurostat yearbook* Luxembourg, Eurostat, 2005.

European Commission: *The social situation in Europe, 2004*. Luxembourg, Office of Official Publications of the European Union, 2005.

Government of Ireland: *Social security*. Dublin, the Stationery Office, 1949.

Government of Ireland: *A vision for change - report of the expert group on mental health policy*. Dublin, Stationery Office, 2006.

Health Service Executive, National Suicide Review Group & Department of Health & Children: *Reach out - national suicide prevention strategy 2005-2014*. Dublin, Health Service Executive, 2005.

National Cancer Forum: *A strategy for cancer control*. Dublin, Department of Health & Children, 2006.

O Cinneide, Seamus: "The 1949 white paper and its impact on social welfare policy" in: Lavan, Ann (Ed): *Fifty years of social welfare policy*. Dublin, the Department of Social Community & Family Affairs, 1999.

O'Ferrall, Fergus: *Citizenship and public service - voluntary and statutory relationships in Irish healthcare*. Dublin & Dundalk, Adelaide Hospital Society with Dundalgan Press, 2000.

Office for Social Inclusion: *National report for Ireland on strategies for social protection and social inclusion (NSSPSI), 2006-8*. Dublin, author, 2006.

Prospectus & Watson Wyatt: *Audit of the structure and functions of the Irish healthcare system*. Dublin, Department of Health, 2003 (known as the Prospectus report)

Public Health Alliance Ireland: *Health in Ireland - an unequal state*, available at www.publichealthalliance.org

Quin, Suzanne: "Health policy" in: Quin, Suzanne; Kennedy, Patricia; Matthews, Anne & Kiely, Gabriel: *Contemporary Irish social policy*. Dublin, University College Dublin, 2005.

Wren, Maev-Ann: *Unhealthy state - anatomy of a sick society*. New Island, Dublin, 2003.

This paper explains, for communities and anti-poverty groups, the evolution of health services and health policy in Ireland. It gives an overview of the health services, from their origins and development to current policies and contemporary issues. In addition, it examines the role of voluntary and community organisations in providing health services and their relationship with the state. The paper focuses on health inequalities and government policies to address them and suggests further sources of information.

design by www.reddog.ie



Bridgewater Centre, Conyngham Road, Islandbridge, Dublin 8

Tel: 01 670 6746 Fax: 01 670 6760 Email: info@combatpoverty.ie Website: www.combatpoverty.ie