NWCI Submission to the Health Service Capacity Review

September 2017

National Women's Council of Ireland

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The National Women's Council of Ireland (NWCI) welcomes this opportunity to input into the Health Service Capacity Review (thereafter 'Capacity Review'). Our submission focuses on issues relating to the health needs of women in the Capacity Review. The first part of this submission outlines why attention to women's health needs is important in the context of the Capacity Review. The second part responds to the questions posed in the consultation paper.

Recommendations

1. The Capacity Review in all its work, from reviewing current capacity, to determining future demand to 2030 and considering how proposed healthcare reforms will impact on future capacity should ensure that **gender inequities in current care** are considered and ameliorated in future service design and delivery.
2. Develop and implement a **Women's Health Action Plan** (commitment in *National Strategy for Women and Girls 2017-20*) to ensure future health service capacity responds to women's health needs.
3. To aid the current Capacity Review and future service planning, invest in **data and research** to bridge knowledge gaps, including:
    - Collection and publication of disaggregated data (by sex and complemented by grounds of age, disability, ethnicity) to address gender inequities and inequities among women.
    - Fund research investigating women's needs in particular health services, e.g. to make women's mental health needs visible and to document the health needs of particular groups of women, e.g. Traveller women.
4. Expand current capacity to address **current unmet needs within health services**, including for those who cannot access public services due to eligibility criteria, in mental health services and maternity services.
5. Develop and invest in **supports for family carers** who are the mainstay of health and social care supports in the community.
6. Make capital investment in the **structures and staffing to create a universal health and social care system**.

PART1: Reflecting women's health needs in the Capacity Review

Introduction to NWCI and our work on women's health

Founded in 1973, NWCI is the leading national women's membership organisation. We represent and derive our mandate from our membership, which includes over 180 organisations from a diversity of backgrounds, sectors and locations across Ireland. We also have a growing number of individual members who support the campaign for women's equality in Ireland. Our mission is to lead and to be a catalyst for change in the achievement of equality for women. Our vision is of an Ireland and of a world where women can achieve their full potential and there is full equality for women.

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NWCI has been working on women's health for over 40 years. NWCI receive AGM motions from our vast and diverse membership on many issues relating to health, including maternity services, mental health, reproductive health, cancer services, women and smoking, female genital mutilation, osteoporosis, Traveller women's health and violence against women. In our health policy work we seek to draw attention to the various barriers to women accessing health services, highlight women's experiences and identify gaps in provision. We have a unique role in communicating the health concerns of a diversity of women in Ireland through ongoing consultation with our membership base and other organisations. As an example, NWCI supported the HSE and the Department of Health in consultations on the National Maternity Strategy in 2015 with hard-to-reach groups of women.

Reflecting the health needs of women in the Capacity Review

The health status and life expectancy of women in Ireland has improved dramatically in the last two decades. Irish women live on average four years longer than Irish men. However, while women live longer lives, they carry a disproportionately larger burden of ill health later in their lives, while women from lower socio-economic groups live shorter lives than those from higher socio-economic groups. As in every country in the world, poorer Irish people experience poorer health. In Ireland women are overly represented in poverty statistics with more women experiencing and at risk of poverty than men. As poorer women have poorer health, they also have a greater need for health services.

Women are more likely to be poor, to parent alone, to be the main provider of unpaid care work, to be in precarious employment, to earn low wages and to be at risk of domestic or sexual violence.

Women, as a result of gendered divisions in society, experience particular inequalities in accessing healthcare, as well as having specific health concerns (such as reproductive and

maternal health) and a higher incidence of negative experiences (gender-based violence, eating disorders, depression, etc.) which affect their wellbeing. Efforts to improve the health of women and girls have primarily focused on maternal health and reproductive services. Yet, women – who tend to live longer and with more chronic disease – require a broadened remit for women's health, encompassing not only reproductive health but mental health and chronic diseases (the leading cause of death and disability for women). The wide span of health services required by women should be reflected in the Capacity Review.

The World Health Organisation recognizes that the social construction of gender identity and unbalanced power relations between women and men affect the health seeking behaviour and health outcomes of women and men in different age and social groups. Sex and gender is relevant in various health areas (mental health, cancer, cardiovascular disease, etc.) and gender inequalities cut across other forms of inequality such as poverty, economic and educational disadvantage, disability, age, ethnicity and sexual orientation. In order for women to attain the optimum level of health over their lifetime health systems need to plan for women's biological differences and gender roles.

For the Capacity Review to be comprehensive and successful for women in Ireland, the analysis of current capacity and future health service needs must take account of women's health needs. This requires the integration of the social determinants of women's health (including caring responsibilities, longer lives with chronic diseases and low incomes) into health service development to effectively address the health impact of sustained inequality on women.

Inequity in access to public services further exacerbates women's health inequalities. The higher proportion of women in low/unpaid work and undertaking the majority of unpaid care means women are particularly disadvantaged by the two-tier health service in which those with lower incomes wait longer for services and have worse outcomes. Women from deprived areas and marginalised social groups, including members of the Travelling Community (with a life expectancy a decade less than the wider population), homeless women and those living in Direct Provision, are likely to experience multiple disadvantages within the health service. Over the period of the recession underfunding of the public service and reductions in funding for organisations supporting women (e.g. domestic violence services) have further reduced women's access to essential health services.

Women's health in Ireland	
Age-related disability	Although women have a higher life expectancy than men, women spend many more years than men living with age related ill-health and disability. While women live longer on average, the gap between male and female life expectancy in Ireland has narrowed over the last decade, from 5.5 years in 1994 to 4.2 years in 2014. [1]
Unpaid care work	Women undertake the majority of unpaid care work, which has a negative impact on their mental and physical health, leading to exhaustion, depression, headache, injury and greater vulnerability to illness generally.[2]
Low-income work	Women are concentrated in low income work – over 50% of women earn €20,000 or less, while women are only half as likely as men to be earning €50,000 or more.[3] Women are also more vulnerable to a dramatic rise in precarious work and a steady erosion of job security.[4]
Chronic disease	Women make up a greater proportion of deaths from cardiovascular disease, yet rates of hospitalisation from men with heart disease and heart attacks are nearly double that of women.[5] Women experiencing a heart attack are more likely than men to be misdiagnosed and less likely than men to be referred to a specialist.[6]
Mental health	Depression and anxiety are three times more prevalent amongst women.[7] The 2016 Healthy Ireland Survey[8] recorded higher levels of positive mental health among men than women. More women than men attempt suicide and self-harm. Men are three times more likely to die by suicide than women.
Health behaviours	By 2012, smoking rates for men had declined over the previous two years to 22.58% but increased for women to 20.87%.[9] Lung cancer is the main cause of death from cancer for women in Ireland and lung cancer is nearly twice as prevalent amongst women from disadvantaged communities.[10]
Health inequity	Life expectancy for women living in the most deprived areas is 80 years, compared to 82.7 years for those living in the most affluent areas. Age/sex-adjusted mortality risk among cancer patients is between 19% and 54% higher among patients from the most deprived areas, with the greatest inequality for breast cancer.[11]
Traveller women	Traveller women have a life expectancy 10 years lower than the general population. Female Travellers experience significantly higher rates of heart disease and stroke than male Travellers (489 females / 337 males compared to every 100 in the general population).[12]

Applying a gender sensitive approach to the Capacity Review

The Irish Government has made firm commitments both nationally and internationally to incorporate a gender perspective into the planning, delivery, implementation and monitoring of health care, including in the *National Strategy for Women and Girls 2017-20*. Gender mainstreaming is an internationally recognised approach which includes assessment of gender inequalities and a gender sensitive approach to health care policy, planning and service delivery. NWCI and the HSE have been working in partnership since 2010 to integrate a gender dimension into Irish health services. The Framework for integrating gender equality into HSE policy, planning and service delivery[13] was developed by NWCI and the HSE in 2012. This sets out a strategic and operational plan for uncovering and tackling

gender inequalities and gender differences in health and addressing the complex interaction between gender and other social determinants of health. The Framework should be used to integrate a gender perspective into the current Capacity Review.

Government commitments to addressing women's health

In tandem with adopting a gender perspective in the Capacity Review, NWCI calls on the Department of Health and HSE to progress the development of a Women's Health Action Plan (WHAP)[14], as committed to in the *National Strategy for Women and Girls 2017-20.*

NWCI believes that the differentiated health needs of women are not being addressed in a strategic or targeted way by our health services. The different experience of health between women and men remains absent from general health policy and service development and is most often confined to women only-illnesses. Yet, the need for a gendered approach is evidenced in continued sex and gender differences in life expectancy and mortality, health inequalities between different sub-populations of women, a substantial body of evidence supporting a gender specific approach to engage more effectively with women and men and the imperative to build on progress achieved to date. Ignoring gender as a structuring factor in healthcare is contrary to Ireland's international human rights commitments, to EU policy direction and to the Public Sector Duty which mandates attention to gender equality in service design and delivery.

In 2016, the Government launched the *National Men's Health Action Plan 2017-2021* to respond to men's particular health needs. At present, there is no overarching women's health strategy, with the current focus on women's health centred on specific healthcare areas, primarily via the *National Maternity Strategy*. The only statutory body with a gender specific health focus, the Women's Health Council, was dissolved in 2009 and no women's health officers remain employed by the HSE.

The implementation of a comprehensive Women's Health Action Plan can assist the Department of Health and HSE to meet their statutory obligations under the Public Sector Duty to promote equality and human rights, including preventing gender discrimination in policies, plans and service provision. Further, the WHAP can support implementation of *Healthy Ireland* framework, particularly the reduction of health inequalities which is one of the overarching goals of the framework. Integrating a specific focus on women's health in future capacity development would make a significant contribution to this goal.

PART 2: CONSULTATION QUESTIONS

1. What changes in models of care and in the way we deliver care are (a) most urgent and (b) what implications will this have on capacity requirements?

Model of a single tier, universal health and social care system

The Capacity Review must assess future capacity needs in light of the activity to reform the public health system into a single-tier universal health and social care service via the cross-party Oireachtas *Sláintecare* model. NWCI recognises that *Sláintecare* requires further gender analysis to ensure that the model and its implementation fully address the healthcare needs of women.

Sláintecare will require the development of additional capacity across the public system (hospital beds, community and residential long-term care, full primary care teams, diagnostics in primary care, community mental health services and human resources across all settings, etc.). Implementation of *Sláintecare* will create a universal single tier service where patients are treated on the basis of health need rather than on ability to pay. The Capacity Review should seek to ensure the future system can achieve the targets set out in *Sláintecare*: no-one should wait more than 12 weeks for an inpatient procedure; 10 weeks for an outpatient appointment; and ten days for a diagnostic test.

As has been recognised for many years, the fundamental building blocks of a primary care-led universal system – community and continuing care – have significant gaps in their infrastructure. Currently, inequity in access to public services exacerbates women's health inequalities. As a higher proportion of women engage in low/unpaid work and undertake the majority of unpaid care, women are particularly disadvantaged by the two-tier health service in which those with lower incomes wait longer for services and therefore have worse health outcomes. The experiences of public patients having to wait longer than private patients for diagnosis and treatment, the poor conditions in Emergency departments and public wards, the disconnect between the down-grading of local hospitals without increased provision in primary and community care and cutbacks in home help and home care packages all impact on women's experience of healthcare.

Ireland currently operates a tax-based system that has always had user charges and in austerity the cost of care is being increasingly transferred onto individuals through inpatient day charges, Emergency attendance charges, prescription charges, as well as reduced eligibility for schemes such as the drugs repayment scheme. As a result, during the austerity period we have witnessed the shrinking of the semblance of universal coverage. Cuts in

funding have further restricted access to health services through the closure of hospital beds, longer waiting lists and reductions in frontline staff.

Through the *Sláintecare* model the vast majority of all aspects of healthcare will be provided in the community through population health, primary or social care. As outlined in the *Sláintecare* report (May 2017), significant and ongoing investment, in the region of €2.8bn over a ten year period, will be required in order to build up the necessary capacity, provide all residents with entitlements to primary and social care, and reduce the relatively high out-of-pocket costs experienced by users of the health system. A transitional fund of €3bn will support investment across the health system in areas such as infrastructure, e-health and training. Priorities for capacity expansion include: health and wellbeing and other measures central to providing integrated care; adequate resourcing of child health and wellbeing services; reduction and removal of charges; expansion of primary care, social care, mental healthcare, dentistry, and public hospital activity; and expansion of public hospital activity, including through removal of private care from public hospitals.

Where capacity is adequate to meet the demands for services with a single-tier system it will also be essential that patients can move effectively through the service, i.e. through patient sign-posting to the correct service and level of service. The HSE is currently engaged in a Signposting project and the interaction between this project and the Capacity Review should be exploited.

2. How can current capacity be more effectively used?

a. Health intelligence & data collection to monitor current healthcare use and plan services

Current capacity can be more effectively used through health intelligence, based on data analysed by gender, age, socio-economic and ethnic categories. Health systems tend to be unresponsive to the particular health needs of women in part due to a lack of sex disaggregated data and gender analysis.[15] Collection and use of such data in service planning can tackle structural inequalities and improve the capacity and quality of health services for women. There is a wide range of health data available in Ireland, however, not all data are broken down by sex and gender, and where this does occur the data is not always analysed as a basis for service improvements.

Data should also be disaggregated to provide information on health service use and outcomes for different groups of women e.g. Traveller and Roma women, women with disabilities. Recognition must be given to the health impact of multiple discriminations experienced by particular groups of women, including older women, women with disabilities, women from ethnic minorities and those living in poverty amongst others. For these groups the experience of basic gender inequality is compounded.

b. Unmet need within current capacity

In addition to assessing current capacity and health care use, the Capacity Review should take account of unmet need within current capacity. The Irish health system has been characterised by a number of weaknesses which point to inadequate capacity – health outcomes, equity of access, rationing of care, underfunding (particularly of primary care), lack of quality indicators and waiting times. *Sláintecare* recognises that the current costs to access healthcare are likely to suppress necessary use of services; therefore the current volume of care (capacity) is not an adequate gauge for the true demand.

Women have significant unmet need for care within current capacity. A review of expressed unmet need for healthcare in 2013 using the Irish sample of the EU-Statistics on Income and Living Conditions survey (EU-SILC) found that almost four per cent of survey respondents reported an unmet need for medical care. Overall, women, lower income groups, those with poorer health status and those without a medical card or private insurance were more likely to report an unmet healthcare need. The majority of those reporting an unmet need noted that their unmet healthcare need was due to affordability issues (59 per cent) or waiting lists (25 per cent).[16] The authors of the review estimate that unmet need due to cost is likely to reflect the high out-of-pocket cost for primary care; while unmet need due to waiting lists reflects the relatively long waits for hospital care in the public system.

Below we outline particular areas where women in particular experience unmet need within current capacity.

Unmet need amongst those who cannot prove entitlement

There is unmet needs for people living in Ireland – including people who are undocumented – who cannot access health services due to lack of clarity about entitlement to public services.

Many Roma in Ireland do not have access to medical cards, resulting in lack of access to GP care. This is related to a lack of access to social protection and an inability to prove their means when applying for a medical card. Roma women report inability to access GPs; concerns about using emergency or maternity services in case they are billed for treatment; and receiving conflicting reports in relation to payment for maternity services and a lack of knowledge of the Maternity and Infant Care Scheme. To increase healthcare uptake and ensure adequate capacity for Traveller and Roma women, NWCI recommends the funding of a new National Traveller Health Action Plan and funding of primary healthcare projects with the Roma community to increase access to information on healthcare and uptake of services, as committed to in the *National Traveller and Roma Inclusion Strategy 2017-20.*[17]

High healthcare costs leading to suppression of necessary healthcare use

Women in low-paid employment or women with full-time caring responsibilities may limit use of necessary health services due to the high out-of-pocket charges to receive care in Ireland (particularly GP care for non-medical card holders). During austerity, the effect of the crisis on health budgets and staffing was to increase out-of-pocket payments and rationing via public waiting lists. These new charges have amounted to at least €100 per person per year across the whole population[18], although it was the sickest and the oldest individuals who paid the most.

Services for women experiencing mental health difficulties

As outlined in *Sláintecare,* community mental health services remain under-resourced, and overly reliant on medication rather than psychological and counselling services. While mental health difficulties affect women and men in equal measure, they experience different kinds of problems and are affected by them in different ways. Yet, current mental health policy and service provision is predominantly gender-blind, failing to recognise gender differentials in presentation and treatment for illness. This has led to an absence of services designed to meet women's mental health needs. Evidence providing a comprehensive profile of women's mental health needs, including qualitative research focusing on the different experiences of women and girls, is urgently required to ensure that the current review *of A Vision for Change*, which will provide the basis for mental health service delivery for the next decade, adequately incorporates women's needs. In developing capacity within community mental health teams there should be a particular focus on vulnerable women (including asylum seekers, homeless women and women with intellectual disabilities) who require specialist services for their complex needs.

Maternity services

NWCI welcomed the publication of the *National Maternity Strategy* in January 2016 and in particular the focus on more midwife-led services in local communities to facilitate choice and continuity of care for women. This can only happen with considerable commitment to additional staffing resources; in particular the recruitment of additional midwives and staffing across multi-disciplinary teams and in a number of specialities. As recommended in the strategy, Government should commit to providing annual development funding to the HSE which will be ring-fenced to implement this Strategy.

c. Health system reliance on family caring capacity

The health and social care system relies on the services of unpaid family carers to support older people and people with chronic diseases living in the community. Women generally provide most family care in Ireland, looking after children and older family members. The impact of these caring responsibilities are often detrimental to women's participation in paid employment, with consequences in older age of risk of poverty, poorer access to health

and social care services and poor health.[19] The Irish health and social care system's heavy reliance on family caring is likely to continue within the period covered by this Review. In spite of their crucial role in supplementing the health and social care system, carers receive little social, practical or financial support from the health service. This is despite carers' widespread and documented experience of isolation, reduced social interaction, poor health and high levels of stress and psychological distress.[20]

Caring responsibilities are made more difficult due to the lack of capacity within the social care and long-term care elements of the health service. It is predicted (based on 2006 utilisation and some decline in disability rates) that demand for long-term residential care, formal and informal homecare would increase by almost 60% by 2020.[21] Since 2006 the number of long-term beds has fallen, as has the number of people in receipt of home help along with the number of home help hours provided. The number of home care packages provided has increased, although from a low base.

Currently, social care is primarily viewed as an individual responsibility subject to complex criteria and means-testing. Access to social care (for example, home-care packages, home help and meals on wheels) is subject to budget caps, depending on the resources available locally. In a society where we increasingly need to care for people with multiple morbidity living in the community the differences in entitlement to healthcare services (national eligibility based, although with significant capacity issues) and social care services (locally-allocated services) no longer appear appropriate, or fair. Whether a person needs medication or a home care package, there should be equal support for equal need. It is essential that social and long term care does not become a residual service, available only to those with the highest needs, with family carers required to stem significant gaps in capacity. In order to assist women in providing care to family members, support services (respite, counselling, access to equipment and financial support) must be developed to support carers. Further, additional capacity in care for older people, particularly in the community, must be developed to meet future demand.

3. What do you consider to be the priorities for capital investment over the next 15 years?

The priority must be to make capital investments which can secure a universal health and social care system. To achieve the integrated model of care in a universal system, where patients spend less time in hospital and receive a majority of their care through primary and community care services, investment must be made in increasing the volume of primary, community and long-term care services, including a primary care-centred chronic disease management system. However, given the current practices in the health system and the significant gaps in community-based services, there continues to be an unmet demand for approximately 1,200 acute public patient beds[22] which must also be addressed. If the health

system does not re-orientate to community services, the demand for public hospital beds would escalate to nearly 20,000 by 2020 (11,660 currently).[23]

Investment is required in:

- Women-centred health and social care services across primary, specialist, inpatient and outpatient facilities
- Primary care teams and centres to meet long-standing Government commitments to establish 530 teams nationally supported by 134 Health and Social Care Networks[24]
- Additional respite care, community and long-stay care facilities for older people, people with chronic diseases and people with disabilities
- Increased supports for carers, including aids and appliances, public allied health professionals and Public Health Nurses
- Capital investment in the structures and staffing to implement *Sláintecare*:
    - Primary care expansion – universal access to diagnostics in the community; extension of counselling in primary care to whole population; universal access to GP without charge; universal access to primary care services
    - Social care expansion – universal palliative care; universal homecare
    - Mental health expansion – staffing of CAMHs teams, adult mental health teams, old age psychiatric mental health teams, staff liaison posts and intellectual disability mental health services
    - Public hospital activity expansion – increased access to diagnostics in the community; reduced waiting list for first outpatient appointment and hospital treatment; expanded public hospital capacity.

Conclusion

NWCI welcomes the opportunity to input into the Health Service Capacity Review and hopes that women's health needs will form a core element of the deliberations and planning to ensure the health service can provide a quality and effective service to the public up to and beyond 2030.

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[1]Department of Health (2016) *Health in Ireland. Key Trends 2016*.
[2] See NWCI Pre-Budget Submission: September 2015 available at www.nwci.ie
[3] CSO (2014) *Women and Men in Ireland 2013*. http://www.cso.ie/en/releasesandpublications/ep/p-wamii/womenandmeninireland2013/
[4] CSO (2014) *Women and Men in Ireland 2013*.
[5] Women's Health Council (2002) *Women and Cardiovascular Health*. Department of Health. http://health.gov.ie/wp-content/uploads/2014/03/women_cardiovascular.pdf
[6] Women's Health Council (2002) *Women and Cardiovascular Health*. Department of Health.
[7] Research evidence from epidemiological studies from the UK, US, Europe, Australia and New Zealand shows that women are up to 40% more likely than men to develop mental ill health; women are around 75% more likely than men to report having recently suffered from depression and around 60% more likely to report an anxiety disorder. See Freeman, D and Freeman J (2013) *The Stressed Sex: Uncovering the Truth about Men, Women and Mental Health*. Oxford University Press.
[8] Ipsos MRBI (2017) *Healthy Ireland Survey 2016* http://health.gov.ie/wp-content/uploads/2016/10/Healthy-Ireland-Survey-2016-Summary-Findings.pdf
[9] www.hse.ie/eng/about/Who/TobaccoControl/Research
[10] Irish Cancer Society / NWCI: Women and Smoking - Time to Face the Crisis. Jan 2013.
[11] National Cancer Registry Ireland (2016) *Cancer inequalities in Ireland by deprivation, urban/rural status and age.* http://www.ncri.ie/sites/ncri/files/pubs/cancer-inequality-report-summary-2016.pdf
[12]All Ireland Traveller Health Study Team (2010) *Our Geels - All Ireland Traveller Health Study* 2010 http://health.gov.ie/blog/publications/all-ireland-traveller-health-study/
[13] NWCI and HSE (2012) *Equal but Different: A Framework for Integrating Gender Equality into HSE Policy, Planning and Service Delivery*. Available at www.nwci.ie
[14] Action 2.1: Strengthen the partnership work with the National Women's Council of Ireland in identifying and implementing key actions to address the particular physical and mental health needs of women and girls in order to advance the integration of their needs into existing and emerging health strategies, policies and programmes through an action plan for women's health. [Emphasis added.]
[15] Temmerman *et al.* (2015) 'Women's health priorities and interventions'. *British Medical Journal,* 351:Supp1.
[16] Connolly, S. and Wren, M.A. (2016) *Unmet healthcare needs in Ireland*. Dublin: ESRI
[17]*National Traveller and Roma Inclusion Strategy 2017-20*, Action 78: The Health Service Executive will develop primary healthcare projects for Roma based on the Traveller Primary Healthcare Project model and informed by the findings of the National Roma Needs Assessment for Roma in Ireland.
[18] Thomas, S., Burke, S. and Barry, S. (2014) 'The Irish health-care system and austerity: sharing the pain'. *The Lancet*, 383 (3), 1545-6.
[19] Temmerman *et al.* (2015) 'Women's health priorities and interventions'. *British Medical Journal,* 351:Supp1.
[20] See Conlon, C. (1999)*Women – the picture of health.* Dublin: Women's Health Council http://health.gov.ie/wp-content/uploads/2014/03/Women-The-Picture-of-Health-Report.pdf
[21] Irish Medical Organisation (2016) 'IMO Submission Budget 2017 2017 Budgetary Measures for the Future of Healthcare'. https://www.imo.ie/news-media/publications/IMO-Budget-Submission-2017-Final.pdf
[22] HSE 'Towards an Integrated Health Service or More of the Same? Background briefing based on Acute Bed Capacity Review. http://www.hse.ie/eng/services/publications/Hospitals/An_Integrated_Health_Service_-_Briefing_Document.pdf
[23] *Ibid*
[24] At the end of 2015, 484 primary care teams, at different stages of development, were in operation across the country. See: Children's Rights Alliance (2016) *Report Card 2016.* Dublin: Children's Rights Alliance.