Health Policy

October 2022

Contents

1 Summary and Key Points

This policy outlines an approach to health policy in Ireland based on 6 core principles, in the context of recent crises, the acceptance of Sláintecare by most political parties as the best way forward, a spend of over €20 billion on health but with continued shortcomings and falling staff morale:

(a) a commitment to an evidence-based approach using the best available research

(b) A right to, and equal access to health on the basis of medical need

(c) Illness prevention and maintenance of health and wellbeing as integral

(d) Minimising waste and maximising value for money

(e) Patient-Centred Care delivered with compassion

(f) Adoption of best currently available information technology

Some key points from this policy include:

- Fully fund Sláintecare
- Development of a public information campaign similar to the BMJ's "Too Much Medicine" to influence patient demand on resources
- Acknowledging the lack of attention to problems which predominantly affect women and addressing them by providing more robust screening, improved choice in maternity care and a focus on endometriosis and eating disorders
- School nurses in every primary and secondary school in Ireland with an emphasis on educating children and preventative health.
- Harm reduction dealing with addiction instead of diverting resources from the prevention of the root causes of problems of substance abuse.
- Reform the HSE into a strong central authority and resource integrated care organisations with clear reporting structures in each geographical area.
- Include patients and local health professionals on the boards of every healthcare organisation, and give those boards flexibility once they meet minimum standards.
- A national eReferral programme to ensure that communication between professionals is standardised, systematic and meaningful.
- Invest in patient safety and patient safety organisations including HIQA

- Work to reduce the carbon and plastic footprint of healthcare through better procurement and resource use.
- Deliver emergency healthcare through paramedic first responders, community health drop in centres and minor injury clinics near where people live.
- Introduce social prescribing to supplement conventional care
- Keep hospitals in the centre of a collaborative network of care that makes sure as much care as possible is delivered to the patient at or near home.
- Build family homes in such a way that when a serious illness hits, patients can be cared for at home.
- Develop dementia villages to care for those with cognitive impairment
- Curtail the access of sales representative to healthcare staff, and instead spend 1% of healthcare turnover on staff education and training
- Develop and train more specialists and advanced practitioners in nursing and allied health professions. Investigate possibilities for physicians' assistants to help doctors deliver care. Increase consultant led care.
- Resource a bank of locum doctors to cover independent GP practices throughout the country
- Extend the right to register with a GP, currently restricted to those with a medical card, to cover all patients resident in Ireland
- Elevate the role of public health doctors to help protect our health
- Increase training places in all healthcare disciplines to ensure Ireland is self-sufficient in this area – resource other countries where necessary.

2 Policy

2.1 Introduction

Vision Statement

We believe in creating a world-class, patient-centred system of universal healthcare, accessed on the basis of health needs, supported by information technology, and executed in an equitable, economic, and ecological manner.

We value the person-environment relationship and the profound impact of our environments on the health and wellbeing of individuals, communities, and the nation.

We advocate a systematic approach to the promotion of lifelong mental and physical health, centred around personal empowerment, knowledge, and choice.

Policy Context

This policy is published at a time when the health services is recovering from a cyber-attack in May of 2021 and the unprecedented pressure brought by the Covid-19 pandemic.

The Sláintecare Report[1] was published by the Department of Health in 2017, as cross-party agreement on a single, long-term vision for health and social care and the direction of health policy in Ireland. We accept this vision, and we support its implementation in full, and without delay.

Ireland will spend €22.1 billion on Health and Social Services in 2022[2],. Despite this, over 225,000 people are waiting for more than one year for an outpatient appointment, with some 150,000 of these waiting over two years.[3] Morale within the health service is low and the talk among junior nursing, medical and allied health professional staff is about emigrating or changing career.

We do not believe that health, health policy or the health services should be used for political point scoring and we will acknowledge positive developments made by the current or previous Governments. We aim to develop and build on these models. We advocate for long-term, successful improvements to health which will accommodate surges in demand as discussed below.

1 Committee on the Future of Healthcare Sláintecare Report, May 2017, Available from URL: https://www.gov.ie/pdf/?file=https://assets.gov.ie/165/270718095030-1134389-Slaintecare-Report-May-2017.pdf#page=1 [cited 27/1/22]
2 Government of Ireland budget 2021, where your money goes, available from url: https://whereyourmoneygoes.gov.ie/en/ [cited 3/8/21]
3 National Treatment Purchase Fund, Waiting List Data, 2021, Available from URL: https://www.ntpf.ie/home/pdf//2021/12/nationalnumbers/out-patient/National01.pdf [cited 27/1/22]

Public policy in Ireland has failed to clearly define the levels of service that are guaranteed and accessible to all. The result is a system of unequal access both geographically and socially, with arbitrary barriers to access and preferential access for those with influence, powerful advocates or leverage through private health insurance. Through this policy document we seek to lead a public discussion on this issue.

Core Health Principles

We commit to an evidence-based approach to healthcare, and we expect the best available research findings (the evidence) to be used when decisions are being made about healthcare.
To be effective healthcare professionals should use research evidence along with clinical expertise and patient preference. We believe in evidence-based medicine and we expect the best available research findings (the evidence) to be used when decisions are being made about healthcare.

Every citizen has a Right to Health and equal access to health on the basis of medical need, and not the ability to pay.
We endorse the view of the World Health Organisation that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".[4]

Those who are disadvantaged or marginalised are often less able to access the opportunities and services available and there is extensive data to show that inequality, more than poverty, is an indicator of poor health outcomes for all strata of society. We are committed to equity of outcomes in health as well as to fairness in opportunities and access to health services for all medical conditions.

The 'right to health' principle reminds us that we must value diversity. People of different cultures, and religions, and beliefs may have different visions of health and differing expectations from healthcare services. People of various ethnic backgrounds and countries of origin may differ in their foundations for health, their vulnerability to disease and the acceptability of interventions to promote health. We recognise that health policy must welcome and support diversity and ensure that goods and services are offered in a culturally sensitive way. We also recognise that health services, and all public services, influence the life of the community and the country and that no discrimination or prejudice should exist in our health system.

A serious and practical example of this discrimination, faced by an increasing number of patients, is that many GP practices have closed their lists to new patients. This is particularly likely to affect migrants to Ireland, and can make referral to necessary services difficult or impossible for those affected.

4 World Health Organisation, Constitution of the WHO, 45th Ed., 2006, Available from URL: https://www.who.int/governance/eb/who_constitution_en.pdf [cited 9/3/22]

We see Illness Prevention and the Maintenance of Health and Well-being as an integral part of any health service development.

Delivery of healthcare services tends to dominate discussion of health policy in Ireland because of the pressing, and sometimes urgent, needs of those who are ill. However it is still true that prevention is better than cure or management of disease. The WHO defines health as “a state of complete physical, mental and social well-being, and not merely the absence of disease”. This definition underpins our policy on health as it emphasises a holistic and positive approach to health. Promoting the health of the population requires that we look beyond the delivery of healthcare services to the wider issues (determinants of health) that impact on health and quality of life.

Public policy in areas such as environment, poverty, employment, housing, education, gender equality and planning that empower people to maximise their health together with acceptance of personal responsibility for health is a key aim. Self-reliance and co-operation are founding principles of the Green Party/Comhaontas Glas. Although many of the things that are most important for health are beyond the control of the individual, all citizens have a responsibility to do what they can to protect their own health and the health of others. This is reflected in the overall thrust of this policy. Citizens have a duty to share the costs of ensuring that everyone has a fair chance to enjoy the best possible health.

A health service that minimises waste of resources maximises Value for Money so that we deliver for people without damaging the health of others.

The way that healthcare services are currently delivered generates significant waste. It has been estimated that of every $5 spent on healthcare in the USA $1 is wasted. If this was applied in Ireland, the cost would be in excess of €2.5 billion, based on what the taxpayer pays, but greater when private or insurance funding is taken into account. The waste is a result of unnecessary care, fraud and abuse, administrative inefficiency, medical mistakes and preventable conditions. Some healthcare organisations internationally and nationally have used lean methodologies to reduce this waste. This document outlines efficiency measures to incentivise less-wasteful healthcare and encourage significant savings.

We support all initiatives to incorporate lean technologies / processes into all aspects of the healthcare system. We also support a programme to measure the extent of waste in healthcare in Ireland and a fund to finance the implementation of efficient practices if they can be shown to deliver a potential savings of 2:1 or greater.

About €7.2% of GDP is spent on healthcare in Ireland annually. Increasing the proportion spent in primary care is shown to achieve an overall reduction in healthcare costs. If similar funding structures were introduced into Ireland - increasing the spend on primary care to 8% of total health spend - a savings of €2.6 Billion could be achieved in the Irish context. Those who commission health are responsible for ensuring that this money is well spent.

Delivering value for money is an increasingly popular topic in health policy as we face additional financial constraints, increased patient demands, an ageing population, and more expensive technologies. Information is central to ensuring that the healthcare we provide is of value to both those who pay for it, and those who use it.

Healthcare services are intensive users of energy, materials and chemicals and service providers should take account the environmental impact of the work they do and have programmes in place to ensure that their environmental impact is reasonable in the context of their contribution to health. It is particular important that we engage in sustainable and fair use of scarce resources because older people, and those of lower socio-economic background who tend to experience poorer health outcomes are also more susceptible to climate change.

The patient should be at the centre of their own care, and that such care should be delivered with Compassion

A ‘patient-centred’ approach to healthcare is consistent with our party’s founding principle that decision making should be made at the lowest possible level. Every effort should be made to ensure that patients and their carers are empowered to make decisions regarding their own health at all levels within the system, and that information systems and care pathways should be redesigned to facilitate the open and transparent transfer of information to those making such decisions.

Structural changes to make healthcare more patient-centred include:; legislating for public participation and accountability through reporting;, involving local communities in decision making;, establishing a public body responsible for promoting public participation; and establishing an independent patient representative organisation which has the powers to seek redress for patients.

We believe that health care should take into consideration a person’s full range of needs, and that it should be delivered in an environment that promotes healing and care. Health is central to empowering people and communities to achieve what is important to them, allowing them to live more fulfilled lives.

The Adoption of the best currently available Information Technology is vital to the health of our people.

The importance of using the best currently available information technology systems in the provision of properly functioning, modern healthcare cannot be understated, particularly in a situation where a sizeable number of health care users are suffering from chronic illnesses, and practitioners may be unaware of their medical history and other treatments that may have been used in the past.

Risk management in aviation, banking and other high risk systems has been improved dramatically by the adoption of information technology. Healthcare, being a high risk system where the patient is the one at risk should be considered in the same light.

2.2 Policy Details

(a) A healthier people on a healthy planet

Encouraging healthier and more sustainable lifestyles

We believe that Health policy must be based on the principle that sustainable human health and wellbeing is dependent on a healthy ecology. A future where we fail to minimise the effects of climate change will be a future of worsening disease and pandemics, which we will need to face as a global community. As part of efforts to protect human health in a sustainable way, we support strengthening measures to protect our air, water and soil from contamination and degradation, and our biodiversity from destruction.

We support an expanded role for the Environmental Health Services (working closely with the Environmental Protection Agency) to deal more comprehensively with the impact of the environment on health, including issues of radiation exposure, noise and planning.

We believe in promoting health rather than simply treating disease. This can be achieved by promoting healthy eating education in schools and elsewhere and promoting a healthy infrastructure and environment as outlined in the extensive environmental measures, in all Green Party/Comhaontas Glas policies and campaigns. (See 'Health in all Policies' above)

Healthy Agriculture for a Healthy People

We recognise the obvious link between nutrition and health, but also the impact of the environment on food production and of food production on the environment. We see food and agricultural policies as inextricably linked to health policy.

We support much tighter controls on the advertising of fast food, sweets, carbonated drinks and alcohol and a prohibition on providing toys and gifts as incentives to purchase food[5]. We support planning restrictions on outlets selling high calorie 'junk-food' and beverages within or adjacent to primary and secondary schools, hospitals and sporting facilities. Food provided in hospitals, care facilities and other public organisations should reflect healthy eating principles. [6] [7]

We also support a requirement for restaurants and fast food outlets to provide information to customers on the nutritional content of their food.

There is evidence to suggest that highly processed foods are particularly likely to be consumed by people on low-incomes[8]. This issue around consumption, nutrition, and the cost to public health services of diseases associated with poor diet (including diabetes, heart problems, mobility and

5 Tirado's 'Hand to Mouth if they want to understand why, when you're poor, you eat junk food, smoke, and engage in other unhealthy behaviours', Available: http://talkpoverty.org/2014/10/15/reflections-on-hand-to-mouth/

6 World Health Organisation: WHO urges governments to promote healthy food in public facilities, January 2021: https://www.who.int/news/item/12-01-2021-who-urges-governments-to-promote-healthy-food-in-public-facilities [cited 25/8/21]

7 Nova Scotia Health Authority, Healthy Eating - WRW Available from URL: http://www.cdha.nshealth.ca/wellness-and-respectful-workplace-1 [cited 26/9/21]

8 Baraldi LG, Martinez Steele E, Canella DS, et al Consumption of ultra-processed foods and associated sociodemographic factors in the USA between 2007 and 2012: evidence from a nationally representative cross-sectional study BMJ Open 2018;8:e020574. doi: 10.1136/bmjopen-2017-020574

many other health impairments), and the relationship with socio-economic status requires much more investigation and is something that we strongly support further research in an Irish context. We recognise that antimicrobial resistance is a serious threat to human health and while the reasons for it are complex that the use of antimicrobials in agriculture, particularly intensive farming, is a significant contributor to the problem.[9] There is also a continued risk to human health from zoonosis.[10] We see the solution to this as a reduced reliance on such agricultural methods, and a reduced consumption of animal products.

Threats to the environment (climate change, soil quality, water quality, air quality/emissions, biodiversity) which impact on agriculture also indirectly affect human health by reducing yield and nutritional quality, and driving populations into using less nutritionally complete processed foods.

The Air That We breath

It is an established fact that air pollution contributes to respiratory, cardiac and neurological disease, and that poor air quality amounts to about 0.8 million (1.2%) premature deaths and 6.4 million (0.5%) years of life lost (YLL).[11] [12]The lockdowns associated with the recent COVID-19 pandemic, and the resultant reduction in motor traffic led to a reduction in admission to hospital for asthmatics. **[13]** A London coroner in 2020 ruled that excessive air pollution was to blame for the death of girl with asthma.[14]

We will strive to introduce policies which tackle air pollution and ensure that we live in homes surrounded by clean breathable air both in urban and rural areas as a significant health promotion intervention.

9 OECD, [Website] Anti-microbial resistance is a global challenge for food systems and public health, http://www.oecd.org/agriculture/topics/antimicrobial-resistance-and-agriculture/ [cited 5/4/21]
10 AG Safety & Health, Zoonotic Disease and Agriculture, MAY 17, 2019, https://ag-safety.extension.org/zoonotic-disease-and-agriculture/ [cited 5/4/21]
11 Aaron J. Cohen, H. Ross Anderson, Bart Ostro, Kiran Dev Pandey, Michal Krzyzanowski, Nino Künzli, Kersten Gutschmidt, Arden Pope, Isabelle Romieu, Jonathan M. Samet & Kirk Smith (2005) The Global Burden of Disease Due to Outdoor Air Pollution, Journal of Toxicology and Environmental Health, Part A, 68:13-14, 1301-1307, DOI: 10.1080/15287390590936166
12 Carrington D, Air Pollution is slashing years of the lives of Billions, The Guardian, London, 2021, Sept 1st, Availbale from URL: https://www.theguardian.com/environment/2021/sep/01/air-pollution-is-slashing-years-off-the-lives-of-billions-report-finds [cited 26/9/21]
13 Quintine, Kelly, Sheridan, Kenny O'Dwyer, Impact of COVID-19 LockdownRestrictions: Ambient NO2 and Asthma Hosital Admissions, Ir Med J 2021 (114):7:413, Available from URL: http://imj.ie/impact-of-covid-19-lockdown-restrictions-ambient-no2-and-asthma-hospital-admissions/ [cited 8/9/21 as reported in McCárthaigh, Irish Independent,23 August 2021 https://www.independent.ie/irish-news/health/lockdown-fall-in-noxious-traffic-fumes-linked-to-fewer-asthmapatients-in-hospital-40777601.html
14 MSN News: Coroner traces London girl's asthma death to air pollution, dw.com 12/17/2020 available from URL: https://www.msn.com/en-us/news/world/coroner-traces-london-girls-asthma-death-to-air-pollution/ar-BB1c0URn [cited 8/9/21]

Healthy Lifestyles

We applaud the 'Healthy Ireland' Framework 2013-2025 [15] and would welcome development of this framework incorporating the ideas mentioned in this document.

Health education and health promotion should become central to the practice of health workers, who should take part in health advocacy in all areas of local and national policy where health is at issue. Additionally closer working relationships should be developed between health workers, the voluntary sector, communities, families and individuals.

"First, Do No Harm"

We propose to introduce legislation to the following effect:

1. Make the recycling of non-contaminated medical containers mandatory for medications dispensed in Ireland
2. Invest in greater research into the safe recycling of pharmaceutical devices/containers
3. Offer financial incentives to both patients, community pharmacies and hospitals to comply with this legislation.

We would also propose that further initiatives be promoted through the National Healthcare Sustainability Office (NHSO) [*please refer to section 2.2(b) of this document*]

Sustainable Homes and Communities

Enabling Environments, food and nutrition security, equity and access

We support the design of our communities around principles which allow all of our citizens to live healthy lives incorporating the three elements of successful urban development: early, far-reaching citizen outreach involvement; a long-term ecological perspective; and an ability to improve continuously. An example of such a city is Freiburg in Germany.[16]

Defective or poorly designed, built or maintained homes also have implications for our health and the health of our population. Appropriate investment in ensuring people have healthy, well insulated homes can return dividends in reducing healthcare costs by improved health and reduced hospital admissions.[17]

The Party supports further research in improving the insulation of homes as it represents a preventative health measure that will significantly reduce healthcare usage and carbon usage. [18].

Please refer to our housing policy at https://www.greenparty.ie/policies/housing-homelessness/ for further details.

15 Department of Health, Healthy Ireland 2013, available from http://health.gov.ie/blog/publications/healthy-ireland-a-framework-for-improved-health-and-wellbeing-2013-2025/

16 Derek Scally, Irish Times, What's it like to live in a truly green city? Ask these Germans, Sat March 27th, 2021 https://www.irishtimes.com/life-and-style/travel/europe/what-s-it-like-to-live-in-a-truly-green-city-ask-these-germans-1.4519906

17 Rodgers SE, Bailey R, Johnson R, et al. Health impact, and economic value, of meeting housing quality standards: a retrospective longitudinal data linkage study. Southampton (UK): NIHR Journals Library; 2018 Jun. (Public Health Research, No. 6.8.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK508015/doi: 10.3310/phr06080

18 Clinch JP & Healy JD, Cost-benefit analysis of domestic energy efficiency, Energy Policy 2001, 29:113-124

Personal Health

Public Information on Health Care Services

We would commission a public information campaign similar to the British Medical Journals 'Too Much Medicine', which aims to highlight the threat posed by over-diagnosis to human health and the waste of resources involved in unnecessary care.[19]

We oppose direct or indirect marketing of health care services and supports a prohibition on the growing practice of active marketing of cosmetic surgery and other complex interventions directly to the public.

We oppose any change to EU legislation, which would permit direct marketing to the public of prescription drugs and drugs currently available only from pharmacies.

Screening for Disease

We support the application of well-established criteria to the development and evaluation of screening programmes[20] and advocate for an integrated and independent public health service to provide impartial advice on the value of screening programmes and the relative priority of programmes.

Childbirth

We support safe and comprehensive maternity care which supports the personal choice around where a person gives birth and who accompanies them.

We support the development of publicly-funded health care services of the highest quality for parents who wish to birth either in a maternity hospital or at home. We would fund the provision of high quality midwifery services and access to supported professionals.

We would provide antenatal and postnatal support for new parents, including education on breastfeeding and ongoing community support to help mothers who wish to, to breastfeed successfully for as long as possible, as well as outlining the risks associated with giving infants breastmilk substitutes. We would further provide access to dietetic, physiotherapy and other services in the community health centres should also be available in a manner that promotes the dignity of all service users.

We support the provision of a national maternal milk bank to provide nourishment for premature babies while also supporting mothers who have difficulty establishing breastfeeding. We see breastfeeding as a right for both the mother and her infant in terms of health and we are committed to supporting this.

We support the World Health Organisation (WHO) position in actively promoting breastfeeding as the best source of nourishment for infants and young children, having

19 British Medical Journal, Too Much Medicine [website] available from URL: http://www.bmj.com/too-much-medicine
20 Wilson and Junger; Principles and Practice of Screening for Disease, World Health Organization, 1968

published the International Code of Marketing of Breast-milk Substitutes in 1981 and stood by it since.[21]

We note HIQA reports into neonatal deaths and other issues in various maternity hospitals in the state. We support a collaborative development of standardised governance structures by the State and hospitals such as that outlined in the National Maternity Strategy.[22]

Family planning & Reproductive Rights

We believe that cost should not be a barrier to family planning decisions. We therefore propose that all forms of contraception should be offered free of charge through pharmacies, to people of all genders, and that any related GP visits should also be free.

Gender and Healthcare

Acknowledging the lack of attention to treatments which predominantly affect women

The Irish state has a poor history with regard to conditions which have predominantly affected women. We have the lowest number of consultant obstetricians or gynaecologists per capita in Europe.[23] This has meant that we have long waiting lists for gynaecological services and a lack of choice in maternal care. There are geographic inequalities in the lack of availability of services which has contributed to differences in outcome in addition to a lack of choice.

Current shortcomings exist in addition to the historical maltreatment of women in mother and baby homes, Magdalen laundries, as well as specific scandals such as Anti-D blood products, hysterectomies in Our Lady Of Lourdes Hospital Drogheda, Symphysiotomy, CervicalCheck and the long abortion ban.

We call for a gold standard of excellence when it comes to our public health screening services, particularly in relation to women's healthcare with a quality control framework in place to ensure accuracy and accountability, as well as accessibility to all women.

We call for the establishment of a centre of excellence for the diagnosis and treatment of conditions such as endometriosis which have in the past been subject to long delays for women trying to access care. We support the Endometriosis Association of Ireland in their call for the HSE[24]:

21 WHO https://www.who.int/news-room/facts-in-pictures/detail/breastfeeding
22 Creating a Better Future Together: The National Maternity Strategy 2016-2026. https://assets.gov.ie/18835/ac61fd2b66164349a1547110d4b0003f.pdf
23 World Health Organisation, Regional Office for Europe, European Health Information Gateway, Obstetricians and Gynaecologists per 100, 000 2021,, Available from URL: https://gateway.euro.who.int/en/indicators/hlthres_130-obstetricians-and-gynaecologists-per-100-000/visualizations/#id=28115 [cited 20/4/21]
24 Endometriosis Association of Ireland Election Manifesto 2020, available from URL: https://www.endometriosis.ie/eaige2020/ [cited 12/10/21]

- To reduce the delay in diagnosis of those with endometriosis and adenomyosis in Ireland. It is currently an average of 9 years, with those presenting with pain symptoms below 25 facing a longer delay than those over 25.

- To advance the education of the general public and those in the medical or similar professions concerning the causes, effects and treatment of endometriosis and adenomyosis.

- To provide one accredited multidisciplinary centre of care for endometriosis and adenomyosis that focuses on current best practice and uses dedicated services.

- To secure funding to support the study, research into and discussion on all matters relating to causes, alleviation and cure of endometriosis and related conditions, and with particular regard to improving the quality of life of those affected by endometriosis.

Men - shorter life expectancies

We acknowledge the disparity in life expectancy, morbidity and mortality between men and women and support any initiatives to encourage men to take more responsibility for their own health, in line with preventative measures discussed elsewhere in this document. Health promotion directed specifically at men should be included in any programme tackling disease where there is a higher incidence of the disease, or poorer outcomes in the male population.

In terms of men's mental health, depression and suicide are serious threats, particularly in isolated or younger men. Other countries have successfully implemented programmes to highlight and to develop initiatives that address these issues, including self-awareness and support programmes, and we support research into and the introduction of appropriate equivalent or modified programmes in Ireland.

Alternative Pathways to Trans Healthcare

We acknowledge the rights of people of all gender identities to access appropriate healthcare and therapies in a timely manner. Please see the Green Party/Comhaontas Glas Gender Recognition Policy on www.greenparty.ie for further details.

Children's health

Children with additional needs

We recognise that the approach to the care of children with additional needs to be transformed to improve their access to health care. Noting the high level of dissatisfaction among carers of people with autism, we call on the Department of Health to fund the

Autism Action Plan [25] as outlined in the HSE's Report for the Review of the Irish Health Service for Individuals with Autism Spectrum Disorders[26]

Health in Schools

We believe that much more can be done in schools to prevent illness by caring for children and educating children about health. We are in favour of school nurses being appointed to every school in Ireland, both at primary and secondary level, based on enrolment numbers and adjusted for demographic and social needs.

In addition, we propose to introduce a broader focus on health awareness in schools, including eliciting through quizzes, discussions and workshops, what constitutes a healthy diet, how to prepare basic nutritional dishes, what factory farming means, and how reducing meat consumption can benefit health.

We recognise that not all children enjoy team sports, and that cultural or health differences may make team sports unsuitable for some children. We support measures that allow all children to choose an exercise programme that best suits them.

Education empowers people to ask questions and find ways to maximise their health. We support the view that education can play a central role in our health education, as clearly outlined in a 2008 review by the Institute of Public Health in Ireland (Health Impacts of Education).[27]

We favour the use of fit-for-purpose, energy efficient and soundproof school buildings for all pupils. Where rapid or changing demographics require additional short-term modular construction it should be constructed to the highest standards of insulation, ventilation and ergonomics and should be used in a sustainable manner. We also believe that classroom seating must be based on sound ergonomic principles.[28]

We believe that retrofitting existing buildings, including older school buildings should always be considered in preference to demolition and green field building of new structures as this is found to be more ecological.[29] This also has benefits for the health of children in terms of working with the infrastructure which has over time developed around such existing buildings.

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25 As I am.ie, Every Child Counts, A Report into Autistic Children's Access to Healthcare in Ireland, May 2021, available from URL: https://asiam.ie/advocacy/our-work-policy-and-campaigns/health/every-child-counts-report/ [cited 13/9/21]
26 Health Service Executive, Report of the Review of the Irish Health Services for Individuals with Autism Spectrum Disorders, 2019. Available from URL: https://assets.gov.ie/10708/33f312f0421443bc967f4a5f7554b0dd.pdf [cited 13/9/21]
27 Institute of Public Health in Ireland, Health Impacts of Education: A Review, 2008, Available from URL: http://www.publichealth.ie/files/file/Health%20Impacts%20of%20Education.pdf
28 Department of Education and Skills, Loose Furniture for Post Primary Schools Specifications and Standards, 2001, https://www.education.ie/en/Schools-Colleges/Services/Furniture-Equipment/pbu_loose_furniture.pdf
29 Melton, Retrofitting (usually) greener than new buildings, 2012 https://www2.buildinggreen.com/article/retrofits-usually-greener-new-construction-study-says

Vaccination

Effective expansion & implementation of immunisation programmes is a key measure in protecting health & quality of the primary health care system. The extension of the provision of the HPV vaccine, regardless of gender, is one key component of the provision of a comprehensive immunisation strategy.

While we acknowledge that not all healthcare comes from a syringe, appropriately approved and tested vaccines are an important and acknowledged tool in the prevention of infectious diseases. All healthcare interventions have the potential for adverse effects, but the risk benefit should be considered. We must recognise and look after those who are affected by these effects. The introduction of a national immunisation register will assist in providing necessary information on the immunisation status of individuals & the prevalence of preventable diseases within the nation.

We need further education and engagement with the public on how vaccinations are a key component to ensuring the collective public health. Supports for ensuring access to immunisation, particularly in disadvantaged areas of society require promotion.

School Dinners

By caring for the nation's children and providing healthy, nutritionally-balanced school meals, the State would make an important investment in the future. The effective provision of school dinners has long-term consequences, not just in terms of the social and economic benefits and the health of the individual, but in fostering the ethos of a caring and just society where the State acts for the common good. Please refer to WeSchool Dinners Policy (https://www.greenparty.ie/wp-content/uploads/2015/04/Green-Party-School-Dinner-Policy-2015-1.pdf) for more information.

People with a disability

Please refer to the Green Party Policy on Disability and Carers on www.greenparty.ie for further details.

Chronic Inherited Conditions

Patients with cystic fibrosis, or other lifelong conditions require lifelong care, including preventative treatments to ensure that they enjoy as much time as possible outside of acute care settings. In Ireland an estimated 1 in 19 people carry at least one of the gene mutations which cause cystic fibrosis[30] and individuals living with such conditions currently have a huge burden of care placed on them. We need specific measures to ensure that these people do not have to fight individually for services.

Encouraging patients with these conditions to interact with patient registries should ensure better care for all, but care needs to be taken to ensure that a patient's need for privacy and right to refuse interventions is accepted.

30 Cystic Fibrosis Ireland, [Webpage] About Us, Available from URL https://www.cfireland.ie/

Addictive Substances

As part of a holistic approach to individual health, we recognise that where people have unmet social or psychological needs that they might turn to substances or habits that are harmful to themselves, others or the planet. We favour supporting methods which deal with the causes of addiction and problem behaviour, and the implementation of harm reduction measures that do not divert resources away from the identification and prevention of the root causes of these problems.

We recognise also that some of these substances or habits in moderation may have a positive value to others in society. We favour actions that meet the needs of citizens rather than tackling problems with the criminal justice system. We recognise that the regulation of some of these practices might be appropriate to ensure that children are not impacted and that harm to those affected is minimised.

For drugs of addiction, please refer to the Green Party Policy on Drugs at www.greenparty.ie

Additionally, we support the following short-term harm reduction methods:

- A ban on advertising and sponsorship of sports activities and any activities involving young people by alcoholic beverage companies or Bookmakers.[31]
- Minimum pricing on alcohol in retail and licensed premises[32]
- Plain packaging for tobacco and similar products
- Measures to inform the public of risks with substances which are packaged and labelled for a different purpose, e.g. products sold as bath salts but used by some to 'get high'.

Eating disorders

We call for the implementation without delay of the HSE National Clinical Programme for Eating Disorders. [33] We note that 3 years after the publication of the model of care a large proportion of the allocated funds have not been spent and the appropriate healthcare professionals and hospital beds are not in place.[34]

31 O'Brien & Kipri, Alcohol industry sponsorship and hazardous drinking among sportspeople, Addiction, 2008; 103, 1961–1966 doi:10.1111/j.1360-0443.2008.02371.x
32 CJP Consultants Ltd, 'The Efficacy of Minimum Unit Pricing, Fiscal and other Pricing Public Policies for Alcohol' September 2013, available from URL http://health.gov.ie/wp-content/uploads/2014/03/ALCOHOL_CJP_2013.pdf
33 Health Service Executive, Eating Disorder Services: HSE Model of Care for Ireland, January 2018 Available from URL: https://www.hse.ie/eng/services/list/4/mental-health-services/national-clinical-programme-for-eating-disorders/ed-moc.pdf [cited 13/9/21]
34 Hosford P, €4m of €5.7m fund for eating disorder services remains unspent, Irish Examiner, 2021 April13th, Availbale from URL: https://www.pressreader.com/ireland/irish-examiner/20210413/281659667861085 [cited 13/9/21]

Promoting physical activity & Incentives for Healthy Living

Parks, Gardens and Activity Centres

We recognise the need for outdoor recreational space in all communities both urban and rural and their role in physical and mental health. The environmental and social effects of access to green space in a locality has been acknowledged as important. This is particularly important in our cities and large towns because of the urban heat island effect.

We favour enhanced coordination and communication between local health authorities and planning departments to ensure open-air amenities are available at a reasonable distance from all homes and workplaces. Obliging the provision of outdoor facilities such as playgrounds, spaces for exercise, or outdoor gym equipment would create the opportunity, space and resources for all ages to better engage in physical exercise.

Funding of Grassroots sports

Everyone should have access to a range of recreational and sporting opportunities, to promote healthy lifestyles and community involvement. Grassroots sports activities are central to this aim and we support a robust and fair funding model to ensure that these sports are accessible to all.

We would review VAT rates on sports equipment and clothing to make both more affordable and accessible, and allow a tax-efficient salary sacrifice (deducted from salary before deduction of taxes - similar to the current bike-to-work scheme) of up to €100 annually (for each family member) for payment of membership of gyms and swimming clubs, and active sporting memberships of GAA, soccer, rugby clubs and similar organisations.

Projects that involve the active restoring and protecting of our natural landscapes and biodiversity outdoors should be prioritised, as should the development of safe/stand-alone cycle lanes.

These initiatives should be funded, in-part, by an increase in VAT on foods with high sugar / salt content and drinks containing high levels of caffeine or cornstarch derivatives. We contend that such a VAT increase could raise between €3-4 hundred million over a 5 year period but as this is intended to encourage behaviour change rather than act as a revenue generating exercise we anticipate this revenue falling as people choose healthier options. This is in addition to the existing sugar sweetened drinks tax.[35]

We are committed to putting ‘play ‘at the heart of the school curriculum and support allocating time in the school curriculum, and money to promote more physical exercise amongst all sections of the community, young and old, for the long-term health and social benefits of society.

35 The Revenue Commissioners, Sugar Sweetened Drinks Tax (SSDT) Updated 16th June 2021 [webpage] available from URL: https://www.revenue.ie/en/companies-and-charities/excise-and-licences/sugar-sweetened-drinks-tax/index.aspx [cited 14/9/21]

Anecdotal evidence that a culture of litigation is leading to a ban on 'running' or 'climbing' in school should be investigated for validity.

Individual Physical Exercise

The Irish Heart Foundation's 'Slí na Sláinte'[36] physical activity programme is a simple initiative to encourage people of all ages and abilities to walk more. We would support the development of this programme in local authority areas.

We also call for the funding and development of "Couch to 5k" schemes such as those managed by the NHS in Britain.[37]

We call on local authorities to provide for public swimming areas in rivers, canals and sea coasts throughout the country.

Sharing Sporting and Play Facilities

We would welcome the provision of local authority-run community sports centres and sports grounds where suitable school sports facilities are limited. These could include, playing fields large enough for football, hockey etc. or running and long-jump tracks, which schools in the locality could share.

(b) Structure of a Green Health System

Governance

In line with Strategic Action 1 of Sláintecare,[38] we agree that the HSE will be reformed into a strong central authority with responsibility for national planning, strategy and standard setting. This will be complemented by regional integrated care organisations that will operate with appropriate operational autonomy within defined geographic areas and with clear reporting structures.

As part of the parties core principles and commitment to local democracy we recognise a need to explore structures to reconnect healthcare services to local communities and their elected representatives. The regional integrated care organisations, which will combine hospital and community care groups would be responsible for finding solutions to local needs, be able to direct funding into the most cost effective providers, and enable transfer of service provision at the lowest level of complexity.

Budgets Managed on the basis of services

We believe healthcare should be a collaborative process with the patient at the centre, and that the distinction between hospital (secondary and tertiary) and community (primary) care should be reduced to facilitate this.

36 The Irish Heart Foundation, Slí na Sláinte, available from URL http://www.irishheart.ie/sli
37 NHS, Exercise: Couch to 5K, https://www.nhs.uk/live-well/exercise/?tabname=couch-to-5k
38 Strategic Action 1, from Dept of Health, Sláintecare Implementation Strategy and Next Steps, 2019, available from URL: https://www.hse.ie/eng/about/who/cspd/ncps/acute-medicine/resources/slaintecare-implementation-strategy-final.pdf [cited 15/9/21]

Clinical governance of hospital services must support responsible management allowing for coherent teams of health care practitioners working together for the patient. This could be achieved by organising budgets and recruitment on the basis of particular services provided by hospitals and hospitals groups. Management of staff in a particular discipline should take place through heads of services, for example head of surgery or medicine in a hospital having responsibility for linked services through their hospital and group.

Patient Representation in all decision making

In order to make healthcare more patient-centred, we support legislating for public participation, accountability and decision making by local communities. We support the establishment and funding of an independent patients' representative organisation as a public body responsible for promoting this participation. This organisation would have powers to seek redress for patients[39] and would be similar to initiatives in the NHS in Scotland.[40]

The health service often appears to provide services which are based on what is easy to provide, rather than on what patients want or need.

Boards of hospitals, hospital groups and local community care commissioners should include patient representatives and local primary care professionals as members, to advocate directly for patients. Local people should decide what and how services are provided and these services should have complete flexibility to meet local needs as long as they meet minimum standards.

We take the view that the policy making process should be informed by evidence, but that informed decisions should be made at the lowest possible level. Policies should address issues that are critical to the well-being of vulnerable population groups and be based on evidence of what works. Technical expertise in these areas must be balanced with public and community participation in agreeing priorities and developing and implementing policies. We also support the development of local and regional consultative processes that give people a role in making decisions about their health.

All healthcare services should be delivered on the basis of providing clear information to allow patients make informed choices and give informed consent. All healthcare providers should maintain records of consultations and treatments and should be subject to a complaints procedure and a mechanism for dealing with adverse outcomes should be implemented for all healthcare providers. Also the role of prescribing or recommending medicines and remedies should, to the greatest possible degree, be performed independently of those who sell the remedy.

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39 Appendix 8, from Prospectus/Watson Wyatt, Audit of Structures & Functions in the Health System, Govt, Publications, Dublin , 2003, Available from URL: https://www.lenus.ie/handle/10147/42913 [cited 15/9/21]
40 NHS Scotland, Better Together, Scotland's Patient Experience Programme, 2008, available from URL: https://patientperspective.org/wp-content/uploads/2014/10/Scottish-Government-Building-on-the-Experiences-of-NHS-Boards.pdf [cited 15/9/21]

Learning from Experience – Monitoring, reporting and listening by means of Robust Data Systems

As outlined in our core principles above, we believe that the adoption of the best currently available information technology is vital to the health of our people. To achieve this we support the implementation of the eHealth Strategy[41] and believe that patients should have access to their summary-care records and be able to make comments where information is incomplete or inaccurate. This will require up-skilling on the part of clinicians, a change of culture within our health service and investment in infrastructure.

We believe that patients own their individual health and to the greatest extent practical full information should be provided to patients as a matter of course, except where the individual waives that right or where it is clearly documented why a delay in information release is in the patient's interest. Healthcare delivery systems should take all reasonable measures to protect the confidentiality of healthcare records and comply with data protection legislation.

Community health professionals, including general practitioners and community pharmacies should be supported in following the progress of patients within the hospital system, and feeding information into that process to inform hospital-based professionals and assist them in empowering the patient to make critical decisions about treatments. This should include input into multidisciplinary team meetings around difficult decisions related to complex interventions and appropriate management of care towards the end of life. We support the development of a national eReferral[42] programme to ensure that patient referrals between practitioners are done in a standardised, systematic way electronically.

We believe that information technology solutions used in the Irish healthcare system should be, in as far as practicable, based on *open-source*[43] software, suitable for practitioner coding. Open-source software has many advantages for providers and patients, including interoperability, speed of problem resolution, flexibility and more frequent updates.

Allowing healthcare practitioners to code their own solutions was an integral part of the improvements brought about in the US Veterans Health system, as the practitioners involved were able to design an ICT infrastructure tailored to their needs. We would support the development of a model similar to the NHS 'Hack Day[44]' when software

41 HSE/Dept of Health, eHealth Strategy for Ireland, 2013, Available from URL; https://www.ehealthireland.ie/knowledge-information-plan/ehealth-strategy-for-ireland.pdf [cited 22/9/21]
42 Alice Hm Chen, M.D., M.P.H., Elizabeth J. Murphy, M.D., D.Phil., and Hal F. Yee, Jr., M.D., Ph.D., eReferral — A New Model for Integrated Care, N Engl J Med 2013; 368:2450-2453June 27, 2013DOI: 10.1056/NEJMp1215594
43 Open source software is software whose source code is available for modification or enhancement by anyone. 'Source code' is the part of software that most computer users don't ever see; it's the code computer programmers can manipulate to change how a program or application works.
Open Source.com: *What is Open Source?* Available from URL: http://opensource.com/resources/what-open-source
44 NHS Hack Day [Website] Available from URL: https://nhshackday.com/about/ [cited 26/9/21]

developers are involved in designing solutions to technology problems within the healthcare setting.

In healthcare, interoperability is the ability of different information technology systems and software applications to communicate, exchange data, and use the information that has been exchanged.[45] Data exchange schema and standards should permit data to be shared across clinicians, lab, hospital, pharmacy and patient, regardless of the application or application vendor.

Promotion and protection of health can be seen as a continuous quality improvement process. To achieve continuous improvement, we need to agree on goals, identify the status quo and forecast how changes in policy and practice can bring about improvements that we can see and measure. Health information that is meaningful and collected in a standardised way should also be published in a timely manner. The WHO's 'Framework and Standards for Country Health Information Systems'[46]- although developed primarily for developing countries and global agencies - provides a useful framework for review of Ireland's health information systems. Whenever possible health measurements should be performed by standardised, internationally accepted methods to permit meaningful comparison (for example Europeristat[47]), over time with other countries.

The NHS report 'An Organisation with a Memory' suggests that reporting systems are vital in providing sound, representative information on which to base analysis and recommendations. Experience from non-healthcare settings such as aviation show that when systematic approaches are used, including recording and reporting adverse events and 'near misses' whether harm occurs or not, safety, performance and cost-effectiveness are improved.[48]

Organisations providing health services should monitor any inequality in the delivery of services by keeping records - with patient consent - on the provision of services and the outcomes for people in different groups. It should take seriously and investigate comments and complaints that relate to unequal or unfair treatment on the basis of gender, sexual orientation, ethnic or cultural background, faith, disability including learning difficulties, or age.

To provide the best value in quality healthcare, now and in the future, we must measure and record performance throughout the system. We support introducing a research database to anonymously record patient treatments, like the Clinical Practice Research

45 HIMSS Dictionary of Healthcare Information Technology Terms, Acronyms and Organizations, 2nd Edition, 2010, Appendix B, p190, original source: Wikipedia. See http://www.himss.org/library/interoperability-standards/what-is-interoperability

46 World Health Organisation, Health Metrics network, Framework and Standards for Country Health Information Systems, Second edition, available from URL: www.who.int/healthmetrics/documents/hmn_framework200803.pdf

47 Europeristat, Better statistics for better health for women and their babies [website] available from URL: http://www.europeristat.com/ [cited 6/8/2015]

48 Donaldson L, An Organisation with a memory, 2000, available from http://www.aagbi.org/sites/default/files/An%20organisation%20with%20a%20memory.pdf [cited 5/8/15]

Datalink in Britain.[49] This database should be accompanied by clear legislation and regulations with stiff penalties for infringing medical privacy.[50]

We believe that the healthcare delivery service should consider health service and biomedical research as intrinsic to its mission and that the highest priority for publicly funded health research should be the promotion and protection of health and disease prevention, and the development of new or improved diagnostic systems and treatments. We have signed up to the AllTrials[51] campaign for open access to records from medical trials. By signing up to the AllTrials campaign we are making a solid commitment to evidence-based decision making in health care, and the provision of full information on treatments to patients.

All healthcare, whether intended to promote wellbeing or treat illness, should be provided equally to all regardless of economic, social or cultural status. All organisations providing health services should monitor and address any inequality in the delivery of service. This should apply to economic, as well as other differentials including gender, sexual orientation, ethnic or cultural background, faith, disability, emotional, behavioural or intellectual difficulty, or age.

The healthcare delivery system should regularly review its performance to ensure that appropriate healthcare services are available to, and accessed by groups that may have specific constraints on access to services, such as those with disabilities, members of the travelling community and recent migrants. A formal process for regular review of services, in consultation with stakeholders, is needed to identify barriers to access. The outcome of these reviews should include plans to deal with problems of access and should be published.

Separation of Church and State

While recognising the historical role which charities and organisations based around communities of different faiths have had in the past in building healthcare infrastructure, we acknowledge that there are potential conflicts between the ethics of these organisations and the services that are needed. We also assert that the healthcare as a public good should be provided by the state primarily, and not by charitable organisations.

Specifically, we call for the National Maternity Hospital to be placed under full public ownership, as part of a broader plan to completely separate church and state in healthcare.

49 NHS?National Institute for Health Research, Clinical Practice Research Datalink, Available from URL http://www.cprd.com/intro.asp
50 Ben Goldacre, The NHS plan to share our medical data can save lives – but must be done right, February 2014, Available from URL: http://www.theguardian.com/society/2014/feb/21/nhs-plan-share-medical-data-save-lives
51 The Alltrials initiative http:// www.alltrials.net

Quality and Risk

Risk Management in community and hospital services should be developed in communication with patients. Surveillance systems and audit of outcomes (including healthcare-associated infection) are important measures and should employ uniform methods and standards for collecting and analysing information and be published. The obligation to collect and publish relevant information must be an obligation on both private healthcare providers and the public health service.

We will improve quality and reduce risk by:

- Enhancing the patient safety role of HIQA and better supporting this organisation.
- Investing in patient safety to ensure that cost-effective approaches to reducing adverse events in medicine are put in place, including a medication safety infrastructure. Ensuring that hospitals are incentivised to have a patient safety officer and a medication safety pharmacist in place, where the cost/benefit of such roles can be shown.
- Funding research and education organisations which exist to promote patient safety among healthcare professionals and the public, including the Irish Patients Association[52], the Irish Medication Safety Network[53] and others.
- Legislating for mediation as a first resort for disputes involving malpractice in the health services.
- Emphasising patient empowerment in all clinical decisions and ensuring that a robust advocacy system is in place for patients or families unable to communicate their wishes.

Ecological Impact of our Healthcare System

Given the relationship between poor environment and poor health, we believe that the health sector can and should play a leading role in mitigating climate change. Acute care is energy and resource intensive and procurement, resource use, transportation and other policies and practices play a large role in health services' heavy carbon footprint. We must work with existing facilities to reduce healthcare consumption to what is needed, where it is needed for a carbon efficient approach.

Healthcare is essential for sustaining and improving human wellbeing. However, the delivery of that care currently has a carbon and consumption footprint that contributes to environment-related threats to human health. Depending on which indicator is

52 Irish Patients Association, see https://www.irishpatients.ie
53 IMSN, see http://www.imsn.ie

considered, this impact ranges between 1% and 5% of total global impacts, and are more than 5% in some countries.[54]

We would review the HSE 2017-2019 Sustainability Strategy for Health[55], and ensure that strategy is broadened to include all aspects of healthcare delivery, and to match the UK's NHS in putting in place a programme to reach net zero emissions from the HSE and all it's operations by the year 2040.[56]

We would staff the national Healthcare Sustainability Office[57] and move it from being a part of the HSE Estates, ensuring that we have the capacity to measure the carbon and waste product footprint of all operations within the HSE, making those operations accountable, and providing budgets to reduce these footprints.

We support the WHO's 7 steps for reducing waste in healthcare systems[58], including better planning for carbon-neutral living - which also benefits health, due to a reduced reliance on motorised transport and increased walking and cycling, which has the knock-on effect of preventing obesity, reducing road traffic injuries, improving air quality, reducing noise pollution and improving social interaction,[59] and has been included in other Green Party/Comhaontas Glas Policies.

Ensuring the sustainability of our healthcare services requires effective planning for demands likely to be placed on healthcare services by climate change. Climate change may impact on health services both through surges in demand for services related to increased frequency of extreme climate events and through changes in the baseline rates of diseases related to rising temperatures.

Antimicrobial Use

A specific area of threat to the sustainability of healthcare services relates to the unnecessary use of medicines, such as antibiotics and other antimicrobial agents. The consumption of antibiotics in human and animal healthcare and food production has driven an alarming evolution of antibiotic resistant bacteria in recent decades.[60] We support the monitoring and control of antibiotics and antibiotic-resistant bacteria by way of laboratory-

54 Lenzen, M, Malik, A, Li, M, Fry J, Weisz H, Pichler PP, et al. The environmental footprint of health care: a global assessment, Lancet Planet Health 2020; 4: e271–79, Available from URL: https://doi.org/10.1016/S2542-5196(20)30121-2. [cited 20/9/21]
55 HSE, National Healthcare Sustainability Office, Sustainability Strategy for Health, 2017-2019.
56 Greener NHS, Delivering a Net Zero NHS, October 2020, Available from URL: https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/
57 NHSO, https://www.hse.ie/eng/about/who/healthbusinessservices/national-health-sustainability-office/climate-change-and-health/
58 Healthy Hospitals Healthy Planet. Addressing climate change in health care settings, WHO 2009, available from URL: http://www.who.int/globalchange/publications/healthcare_settings/en/index.html
59 Institute of Public Health in Ireland, Climate Change and Health : A platform for action, 2010, available from http://www.publichealth.ie/files/file/Climate_change_and_health.pdf
60 Stef L.A.M. Bronzwaer, corresponding author* Otto Cars,† Udo Buchholz,* Sigvard Mölstad,‡ Wim Goettsch,* Irene K. Veldhuijzen,* Jacob L. Kool,* Marc J.W. Sprenger,* John E. Degener,§ and participants in the European Antimicrobial Resistance Surveillance System, The Relationship between Antimicrobial Use and Antimicrobial Resistance in Europe, Emerg Infect Dis. 2002 Mar; 8(3): 278–282. doi: 10.3201/eid0803.010192

based surveillance and antibiotic stewardship in hospitals, the community and veterinary practice. We are opposed to the use of antibiotics as growth promoters in animal husbandry and supports the monitoring of veterinary prescription of therapeutic antibiotics to ensure that their use in animal husbandry is minimised.

Integrated healthcare based around the patient in their own home

We contend that healthcare provision is a human right and should be delivered in an equitable way to all citizens and that health services should be based upon the needs of our population.

Our health service should have the patient at the centre of all care, and this care should be delivered as close to the patient's home and family as possible - which given the spatial distribution of the population, is likely to involve some mobile or electronic service delivery.

Ireland's relatively small, and broadly-dispersed, population demographic requires a unique approach that cannot be modelled directly on the UK National Health Service. This demographic, coupled with Ireland's deep cultural understanding of care in the community give us some unique advantages and should be nurtured as core features of any health care system.

Health professionals should act as advisers and enablers to the public in helping them achieve optimal health rather than acting as gatekeepers and commissioners of that health.

We envisage paramedical services, delivered by ambulance staff arranged in regions based on practical response times rather than political boundaries. These first responders should refer suitable medical problems to community pharmacies, community health drop-in centres, general practices, hospitals or other services as appropriate.

We also support the introduction of a 24 hour triage and health concerns telephone and website service which helps to direct patients into appropriate streams of care.

Community Health Drop-In Centres & Minor Injury Clinics

Community health drop-in centres and minor injury clinics with extended opening hours, similar to the 'polyclinics' found in European countries should be provided regionally, based on the distribution of the population.

Funding and expertise should move from centralised facilities toward community healthcare, but only as such facilities come on line. These community health centres should be the focal points for self-help and community-based initiatives and should provide a wide range of services including primary healthcare, health education and health promotion programmes. A variety of specialist services, in particular midwifery, obstetrics, family planning, counselling and psychiatry, should also be available. The midwifery and obstetric service should be such that the option of home delivery becomes a real

alternative to hospital care. To provide the widest possible range of services and interventions, staff should be organised into multi-disciplinary teams and the public should have direct access to specialist and general nurses, dieticians, physiotherapy, occupational therapy, speech & language and other health and social care services. Community health centres should also provide walk-in facilities for patients with minor injuries and illnesses.

We also support access to day-programmes and drop-in services in an informal setting for young people. This should help young people to develop positive relationships with childcare workers, who can support them as they develop into adults and possibly parents. Such drop-in services should be integrated with existing support services to allow for a varied-level of response tailored to the needs of the young person.

Primary care teams should be supported in delivering the highest level of care in the community. Support should include direct access to specialist advice and support – both telephone and electronic - through primary-care support teams associated with hospitals. Supports should also include direct access to an appropriate range of diagnostic investigations and interpretations. Access to investigations and the transfer of laboratory samples by patients should be planned to avail of local transport networks, making transfers more efficient and reducing wasteful journeys by the patient.

We believe that out-of-hours services should be as close as possible to the user, but also immediately adjacent, to hospitals in order to reduce the dependence on Emergency Departments. These community health centres should be responsible - in collaboration with telephone triage services - for providing cover outside of the hours of standard general practice.

General Practice & Primary Care

The emphasis in building primary care in the community should switch from the construction of primary-care buildings to the development of efficient teams of healthcare professionals and robust referral pathways, and contracts between the state and General Practitioners should reflect this.

GPs need a clear incentive to take responsibility for a wider range of primary-care services. They should also be incentivised to expand the expertise they offer by employing a broader range of health professionals, including nursing and allied health professionals, such as physiotherapists, occupational therapists, dieticians, and pharmacists. This should enable more collaborative arrangements and more appropriate care for patients.

Primary-care teams should be encouraged to collect relevant information to support local auditing of processes and outcomes and consideration should be given to a forum where the community is updated on team performance, which is set against standard criteria.

We call for the introduction of a right to register with a GP, within reasonable distance of their home, for everyone who is ordinarily resident in Ireland. Currently this right exists

only for medical card holders. GP practices are free to accept or reject non-medical card holders, and this can and does leave vulnerable patients without access to a GP and dependent on out-of-hours locum services. We consider that access to medical care is a right, and the most basic part of that right is access to a GP.

This right would be implemented in the same way as currently operates for medical card holders. Once a person has been rejected by three GP practices, they would be able to contact the HSE to be allocated directly to a GP practice. Allocation would take account of current workload for the practices in the local area, so that new patients are shared fairly between practices."

Preventative services in the Community

We recognise the important role of rural general practice in looking after patients in their own homes, and support measures to incentivise healthcare practitioners to care for those unable to travel to a GP's practice or health centre.

In order to maintain equity for this patient group, we support the reinstatement of the distance codes - reduced under the FEMPI acts - that reimburse GPs who look after medical card patients in their own homes, and the standardisation of the granting of rural practice allowances. Both of these measures would help rural gps serve clients in remote locations without having to bear the bulk of the associated costs.

Social Prescribing

Social prescribing, also sometimes known as community referral, is a means of enabling health professionals to refer people to a range of local, non-clinical services. The referrals generally, but not exclusively, come from professionals working in primary care settings, for example, GPs or practice nurses.[61]

General Practitioners with Special Interest

We support the work of the Irish College of General Practitioners (ICGP) and the development of accredited training and recognition of 'General Practitioners with a Special Interest' (GPwSI)[62]. Such a qualification could be achieved through an intercalated year within general practice training or with post-graduate course/recognition.

Minor Procedures

We would preferentially direct funding towards programmes which, improve local health services, patient access, and offer shared-care - such as referral from outpatients to general practice for minor surgery. We would reform the system of payment by the PCRS of 'Special Type Consultation' fees in order that they cover the full cost of materials

61 The Kings Fund, What is Social Prescribing, https://www.kingsfund.org.uk/publications/social-prescribing
62 Royal College of General Practitioners in the UK, GP with a Special Interest (GPwSI) accreditation available from URL: http://www.rcgp.org.uk/clinical-and-research/clinical-resources/gp-with-a-special-interest-gpwsi-accreditation.aspx

needed for minor surgical procedures and that. GPs would not be out of pocket for providing such services.

Allied Health Professionals in Community Practice

Independent physiotherapy, dietetics and other allied health professionals (AHP) should be an integral part of multidisciplinary teams in acute and community care and should be accessible to all patients, without need for referral.

Where referral pathways exist they should be such that patients can be fast-tracked to receive the necessary medical diagnosis or treatment if they present first at such services.

Community Pharmacy

Schemes for the reimbursement of medications need simplifying and should be provided by a community pharmacy on a single transparent system. The medical card scheme, long-term illness scheme, hi-tech medicines scheme, hardship medication schemes should be amalgamated into a single medication reimbursement scheme, with a sliding scale system of co-payments depending on patient status and class of medication.

We believe in the continual development of quality individualistic care by pharmacists in the community, therefore we are opposed to initiatives that commoditise the service such as the current payment system which encourages the consolidation of pharmacies in order to avail of bulk purchasing power. Reimbursement prices should be paid electronically and based on actual invoiced cost in order to reduce the incentive to consolidate multiple pharmacies.

Repeat prescriptions for chronic and preventative illnesses should be managed in community pharmacy in collaboration, and with the oversight of the local general practice, which should be subject to audit.

Public Health Nursing

Along with patient empowerment, a comprehensive public health nursing service can support the aims of preventative healthcare. We support the aims and findings of the North/South report on public health nursing[63] and would support a detailed review of this document to ensure that it is put into practice.

63 Nursing for Public Health: Realising the Vision 2005, http://health.gov.ie/wp-content/uploads/2014/03/Nursing-for-Public-Health-Realising-the-Vision.pdf
https://www.lenus.ie/bitstream/handle/10147/46393/1318.pdf?sequence=1&isAllowed=y.

Mental Health

We are looking at radical new ways for the delivery of mental health care. Central to our policy will be removal of the current emphasis on "illness" and "disorder" and the dominance of the biomedical model.

The policy group is exploring a whole range of alternative treatment settings and therapeutic approaches.

The current party policy on Mental Health is available from https://www.greenparty.ie/policies/health-disability/

Acute Hospital Services

Hospital care within the publicly funded health care system must be based on the principle that adequate basic healthcare services and human dignity for all - bed capacity, basic comforts, relief of distress and competent general medical and surgical care for common conditions - takes priority over increasing sub-specialisation and use of the latest technology.

Hospitals need to consider how to develop and sustain caring and healing recuperation in the face of high-patient throughput, and the possible stress brought on by high-technology interventions.

The community health centres mentioned earlier in the policy should deal with minor illnesses and injuries, freeing up accident and emergency departments to focus solely on emergencies. There should also be adequate night and weekend cover from consultants and diagnostic facilities in all hospitals dealing with emergency admissions.

Hospitals should be focused on services for patients needing inpatient care as part of a collaborative network, including primary care centres and community health centres, where evidence-based pathways facilitate the moving of patients and staff to where they are most needed.

The 2010 Report of the National Acute Medicine Programme[64] outlines a framework for hospitals ranging from small local hospitals, classified as ‘Model One’ up to national referral hospitals, classified as ‘Model Four.’ In this framework ‘Model Two’ hospitals take referrals directly from primary care and telephone triage and where appropriate these hospitals take planned admission of patients - including through special streams for those with a diagnosed chronic condition. Separate streams exist for those with inherited illness or lifelong illnesses, based on effective planning built around projections of the expected incidence of these illnesses in different regions of the country. In the framework ‘Model Three’ referral hospitals have full emergency departments and take referrals from primary

64 Health Services Executive, Report of the National Acute Medicine Programme, 2010, http://www.hse.ie/eng/about/Who/clinical/natclinprog/acutemedicineprogramme/report.pdf

care and telephone triage. These hospitals focus on more complex procedures, and more acute cases.

The Framework report on the future of small hospitals[65] and the Higgins report on hospital groups[66] should be adopted along with the provisions of the Hanly report on medical staffing[67], including forming a collaborative system based on co-operative models rather than as standalone competing hospitals.

Clearing waiting Lists

The current two-tier system of healthcare encourages the creation of waiting list as a perverse incentive creating a need for patients to purchase health insurance in order to aceess treatment. After the cancellation of elective services during the Covid-19 pandemic, waiting lists for adult inpatient/day case surgery stand at almost 70,000 people, while 570,000 adults and 90,000 children wait for an outpatient appointment. [68]

Sláintecare will tackle the causes of these waiting lists. However, the sheer numbers waiting for treatment at this point mean that actions need to be taken in the short term to increase outpatient and inpatient capacity in our hospitals. We are in favour of requiring community and hospital healthcare groups to allocate resources on a group-wide basis and to utilise theatre space in a manner which is efficient for the group as a whole. We also support measures outlined below to ensure that patients can receive treatment abroad or in Northern Ireland where it available

Long Term Care

We consider the home to be the best location for people to receive care. Where this is not possible, settings where they are surrounded by their own family and community or in which they can be most comfortable should be considered. Sheltered accommodation may be appropriate for some people, and a smaller proportion may need institutional care, either on for respite or on a longer-term basis. We support the proper resourcing of carers and homecare services in order to keep as many people out of institutional care as possible.

All family homes, especially new builds should be built in such a way that is very easy to convert a part of the home for a relative to move in and supports should be provided for the family who makes that choice that will be beneficial for all.

65 HSE/Department of Health, Securing the Future of Smaller Hospitals – A Framework Report, 2013, available from URL: http://health.gov.ie/wp-content/uploads/2014/03/SecuringSmallerHospitals.pdf
66 Higgins, The Establishment of Hospital Groups as a transition to Independent Hospital Trusts A report to the Minister for Health, February 2013, http://health.gov.ie/wp-content/uploads/2014/03/IndHospTrusts.pdf
67 Hanly, Report of the National Task Force on Medical Staffing, June 2003, http://health.gov.ie/wp-content/uploads/2014/03/Report-of-the-National-Task-Force-on-Medical-Staffing-Hanly-report.pdf
68 National Treatment Purchase Fund, National Waiting List Data [Website], available from URL: https://www.ntpf.ie/home/nwld.htm [cited 26/9/21]

Nursing Home Support

We support an urgent review of the Nursing Home Support ('Fair Deal')[69] scheme, and the upgrading, renovation and retrofitting of existing facilities ahead of bed closures. We advocate changing the 'Fair Deal' scheme away from a fixed annual allocation to one that is demand-led.

We support an increase in nursing home beds to ensure that pressure is taken off acute hospitals and that all patients can access suitable long term care without long delays. We are committed to ensuring that the people looking after our vulnerable elderly are vetted, well-paid, and qualified for the work that they are doing. To avoid future abuse of patients, regular unannounced checks on staff and facilities should be carried out and such checks should be made in a professional, accountable and transparent manner.

Cognitive Impairment

We support investigating the development of 'Dementia Villages' such as those in the Netherlands, where patients with cognitive impairment are cared for in settings which are in line with their childhood and young adult memories. These environments are associated with a more pleasant experience for such patients, a reduction in challenging behaviour, and less reliance on the need for pharmacological treatment for agitation.[70]

Chronic health conditions

We support expansion of pilot programmes, which have been demonstrated to be effective such as the 'hospital in the home' and 'respiratory outreach'[71] programmes for patients with chronic obstructive pulmonary disease. We would fund the programmes similar to the ICGP 'Heartwatch' [72] for patients with cardiac disease, diabetes, and other conditions which would not be based on medical card eligibility, or ability to pay.

End of Life

Palliative Care

We believe that palliative care should be further expanded. All services - hospital, hospice, community hospitals, health clinics and care homes - should promote the knowledge and understanding of the process of dying and universal palliative care training should be required for all clinical, care and ancillary staff, appropriate to each staff member's role.

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69 Health Service Executive, https://www2.hse.ie/services/fair-deal-scheme/about-the-fair-deal-scheme.html [cited 26/9/21]

70 Alzheimers.Net, Dementia Care: What in the World is a Dementia Village? August 7, 2013 available from URL: http://www.alzheimers.net/2013-08-07/dementia-village/

71 Dunican et al, Factors that predict Failure in home management of an acute exacerbation of COPD *Thorax* 2011;**66**:358-359 doi:10.1136/thx.2009.125385

72 Irish College of General Practitioners, Heartwatch, Available from URL: https://www.icgp.ie/go/research/heartwatch [cited 27/9/21]

Assisted Dying

Please refer to the Green Party/Comhaontas Glas, Assisted Dying Policy on www.greenparty.ie

Dental Health

We support measures to prevent dental health problems including measures to reduce the consumption of high-sugar content foods and drinks, the promotion of good oral hygiene, and fast, equitable access to approved dentists and mouth hygienists for preventative and remedial treatment. Essential dentistry, including regular check-ups are part of basic health care and should be provided free of charge. Appropriate co-payments on a sliding-scale could be used to encourage responsibility for other treatments.

We acknowledge the continuing concerns of many people regarding health risks associated with fluoridation of water and that many expert organisations consider that fluoridation of water can reduce the incidence of tooth decay. Therefore, we support targeted public programmes to improve education and practice related to oral hygiene and improve access to dental care.

Occupational Health

We support strengthening the statutory requirements on workplaces to provide occupational health services, including training and equipment appropriate to relevant hazards. The criteria for such provision should be made as clear and as simple as possible, and enforcement through health and safety inspectors should be strengthened. Also companies should be encouraged to provide basic self-help medical training to all workers and to protect the time required for staff to attend health and safety training.

We consider 'wellness at work' as an important part of mental and physical health. We also support recent measures to offer staff statutory sick pay.[73]

Organ Donation

We support a public information and consultation process around the introduction of an opt-out system of organ donation, which would result in all suitable organs from deceased people being automatically considered for transplantation unless the donor has specifically made it clear that they do not want this to happen.

Medications & Medical Devices

All patients would obtain their medications from community pharmacies on a single scheme and to prevent medication costs becoming a barrier for treatment, a co-payment would be payable depending on the patient's medical condition or the status of the

73 Citizens Information, Sick Leave and Sick Pay, https://www.citizensinformation.ie/en/employment/employment_rights_and_conditions/leave_and_holidays/sick_leave.html# [cited 29/9/21]

medication. To achieve this, we support reducing the payment threshold for the drug payment scheme over a 4 year period With our proposed healthcare model patients on the Long Term Illness scheme[74] would be provided with full medical cards and be liable to pay the medication co-payments discussed above.

Regulating the prescribing and distribution of drugs and medicines

Procurement groups should be set up regionally to negotiate and agree on prices for medications. These groups will be affiliated with local hospital and primary care groups and will use EU procurement best practices to ensure that optimum prices and products are obtained. Contracts should be regional and not national as this reduces the risk of monopolies and stock shortages. Similar to the work currently carried out by the National Centre for Pharmacoeconomics and the HSE Drugs Management Programme, the aforementioned procurement groups should also identify 'preferred medication' where there is a difference in the cost, but not the efficacy of the medication. These procurement groups should be run in conjunction with hospital Pharmacy & Therapeutics (P&T) Committees, which should be composed of doctors, healthcare professionals, pharmacists, patient group representatives, economists, and a legally trained chairperson. These groups and P&T committees should be supported by robust evidence-based medicine research carried out by properly staffed medicines information services. The pricing arm of such committees should then decide on a fair price for the health organisation or hospital to pay the manufacturer for the drug.

Regulating the Marketing of Medications and Medical Devices

We recognise the role of the pharmaceutical and medical device manufacturers in our economy, and the need for rapid access to innovative solutions to health problems. However, we also note reports from some sources claiming that large sums of money are spent on marketing.[75] The access of sales representatives to healthcare staff needs to be severely curtailed as research shows that even small gifts are shown to influence prescribers.[76]

Allopathic Medicine

We support conventional healthcare based on biological, psychological and social science as the principal model for healthcare delivery in Ireland.

Other disciplines of health and healthcare (alternative/complementary health care) are now widely practiced in Ireland. We support the integration of alternative/complementary healthcare into publicly funded healthcare systems where clinical evidence of its effectiveness can be demonstrated and regulation of the relevant practitioners exists.

74 lti scheme, quoted from: https://www.ipha.ie/about-the-industry/supply-and-reimbursement/ [4/8/21]
75 Swanson A, Big pharmaceutical companies are spending far more on marketing than research, Washington Post 2015
76 Roehr B. Pharma gifts associated with higher number and cost of prescriptions written BMJ 2017; 359 :j4979 doi:10.1136/bmj.j4979 [cited 4/10/21]

Referral of patients between conventional healthcare providers and registered alternative healthcare providers should be facilitated. Pilot projects of shared-care between conventional and registered alternative health care providers should be evaluated within the publicly funded healthcare system.

(c) Staffing a Green Health System

Over 127,000 people are employed by the HSE and funded health services in the Republic of Ireland[77] [78]and many more are employed in related industries and services[79]. While technology has an important role to play in health, appropriately applied knowledge and care personally delivered by health staff is essential to ensure citizens receive the best care possible. Professional staff, support staff, families and carers need to be empowered to work collaboratively and to place the patient at the centre of all activities. With this in mind, we outline below our proposals in relation to career structure, recruitment, regulation and retention of skilled and unskilled staff within the system.

Planning needs to take place to ensure in order that statutory leave, such as parental and maternity leave can be managed appropriately with posts being replaced where there has been an established need for the role.

Recognition that healthcare is a public good but that health services staff need to be able to provide care in a way that does not impact on their own physical and mental well-being is essential. A work-life balance that takes into account the emotionally challenging aspects of working in an environment which is highly complex, potentially emotionally challenging, and historically under resourced, in addition to the need for such professionals to engage in life-long learning, is necessary.

We note that the HSE staff engagement survey in 2018 was completed by only 15% of staff members and that these are a self-selected sample.[80] While the results are an improvement on the 2016 survey, we look forward with interest to the 2021 survey,

We support the work of the HSE National Staff Engagement Forum. We note that the proper and prompt implementation of Sláintecare will lead in many ways to an improvement in staff morale

Flexibility is required as staff numbers in all areas are adjusted to ensure equity of access and healthcare provision. The objective of competent general care for all and collaboration between the professional bodies, the proposed integrated public health service, the Department of Health and Children, the health service delivery agencies and patient and

77 Government of Ireland, Health in Ireland: Key Trends 2018, available from URL: https://assets.gov.ie/9441/e5c5417ee4c544b384c262f99da77122.pdf [cited 8/6/21]
78 Health Services Executive, National Reports – Workforce Reports: March 2021, available from URL: https://www.hse.ie/eng/staff/resources/our-workforce/workforce-reporting/health-service-employment-report-mar-2021.pdf [cited 8/6/21]
79 Health Services Executive, Human Resources, Available from URL: https://www.hse.ie/eng/about/who/hr/
80 IPSOS, HSE National Staff Survey 2018, https://www.hse.ie/eng/staff/staff-engagement/resources/your-opinion-counts-staff-survey-2018.pdf

community groups should inform the skills profile of new staff and the type of training provided. New and replacement posts should be planned for over a five to ten year term and in order to achieve key health service priorities and infrastructure.

National and local processes should be evidence-based and transparent, and prioritise patient and family-centred care, as close as possible to the patients home. Also the use of high-cost technology interventions should be carefully managed and only used where value for money can be established.

Nurses & Midwives

As we see 'care' as central to a functioning health services being the role of the nurse in all of our systems is paramount. We consider a more expansive utilisation of Clinical Nurse Specialists (CNS) and Advanced Nurse Practitioners (ANP), as part of a collaborative process with other advanced grades of professionals, as key to easing pressure in areas of our service.

We also recognise the important role of senior and experienced staff nurses, and support procedures that allow them to remain at the patient's side as much as possible. They should receive appropriate recognition for this invaluable service and have access to a appropriate level of continuing professional development and education.

The profession of medicine (Doctors)

General Practitioners

We recognise the central role of family doctors in providing ongoing support for the population in looking after their own health. We recognise the structural difficulties that have arisen in providing consistent and sustainable services in rural areas, but also in areas of high population growth and/or deprivation.

We recognise also the business pressures on General Practitioners and hope that the implementation of Sláintecare will remove the need for the supplementation of income relying on private patients. GPs are entitled to the same work-life balance as other salaried healthcare staff, while at the same time must be allowed maintain their independence. General Practice in Ireland has been experiencing a crisis which has continued for some time and has left many family doctors experiencing significant amounts of stress and lower morale.[81] We support 5 yearly review of the PCRS General Practice contract[82]

81 Irish College of General Practitioners, The Future of General Practice: ICGP Member Survey 2015, https://www.icgp.ie/speck/properties/asset/asset.cfm?type=LibraryAsset&id=E21D6E5F%2DD02B%2D6BC2%2DB065BD5083304AB4&property=asset&revision=tip&disposition=inline&app=icgp&filename=The%5FFuture%5Fof%5FIrish%5FGeneral%5FPractice%5F%2D%5FICGP%5FMember%5FSurvey%5F2015%2Epdf

82 HSE Terms of Agreement between the Department of Health, the HSE and the IMO regarding GP Contractual Reform and Service Development, 2019, https://www.hse.ie/eng/about/who/gmscontracts/2019agreement/agreement-2019.pdf

Funding to general practices should be delivered on a capitation basis and, given the relative low levels of doctor per capita in Ireland,[83] we need to increase the number of practice nurses, advance nurse practitioners and healthcare assistants to meet the increased demand for consultations that would be brought about by our proposed displacement of work from outpatients and day surgery. Accurate data is not available for current staffing levels in general practice but it is thought there are approximately 1,800 practice nurses and 3,500 administrative staff. We support revising the cap on staff subsidies to allow practices to invest in the personnel necessary for the expansion of services.

Currently rural GPs have no one to cover a leave of absence. We support the development of a bank of locum doctors to provide cover to rural doctors for annual leave, training and unexpected illness. This would lessen rural GPs reliance on agency staff, thereby reducing costs and the risk of burnout caused by overwork.

Consultants

Our hospital care needs to be led by specialist and generalist consultant staff. Increasing the number of fully trained hospital consultants is a key part of Sláintecare. Consultant led care, where the ratio of consultants to other doctors in our hospital approaches 1:1 ensures that patients see a doctor with a high level of expertise at an early point of their care,[84]

If we are to increase the number of consultants, as provided for in Sláintecare, bottlenecks exist in our training structures which need to be tackled, and working conditions need to be improved to attract Irish Medical graduates back to the country.

We support the conclusions of the McCraith Report 2014 with regard to better workforce planning for specialists, reconfiguring work schedules to ensure that the barriers of unattractiveness of working in some models of hospital is tackled, and improving supports for all consultants.[85]) We also agree that there is merit in establishing ways to overcome pay inequality for consultants which has been in place since 2012[86]

Non Consultant Hospital Doctors[87]

The health system is complex and to aid a fuller understanding of the totality of health we believe that rotations in general practice should be integrated into basic medical and

83 health at a glance, oecd health indicators 2013
84 Edwards N. Consultant led and delivered services BMJ 2012; 344 :e3229 doi:10.1136/bmj.e3229
85 Dept of Health, McCraith Report, Strategic Review of Medical Training and Career Structures Report on Medical Career Structures and Pathways following completion of Specialist Training, 2014, https://assets.gov.ie/67574/d3e6c1812ab34a9caefc4703cb576661.pdf
86 Irish Hospital Consultants Association (IHCA) Opening Statement
Meeting of the Oireachtas Joint Health Committee on the impacts of the Covid- 19 pandemic on cancer services, 2nd June 2021 https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/joint_committee_on_health/submissions/2021/2021-06-02_opening-statements-dr-gabrielle-colleran-vice-president-irish-hospital-consultants-association_en.pdf
87 Health Services Executive (HSE) National Doctors Training & Planning (NDTF) 9th Annual Assessment of NCHD Posts 2018-2019 https://www.hse.ie/eng/staff/leadership-education-development/met/ed/rep/report-on-contract-type-as-at-dec-31st-2014.pdf

surgical training. This would be done in collaboration with post-graduate training bodies and would mirror GP training, which requires trainees to spend a number of years in hospital posts. Ideally these placements should be in areas of economic disadvantage and rural areas, and support existing healthcare provision in these areas.

We support an increase in the number of doctors in the hospital system and believe that this will be helped by improving the quality of hospital training as outlined in the Hanly Report.[88] These measures include, but are not limited to: phasing out all non-training NCHD posts, safeguarding training time (protected time) for NCHDs and their trainers and ensuring that new posts are created as part of a cohesive care strategy and not created purely to meet short-term service needs. Additionally we would use data analytic techniques to determine the optimal numbers of healthcare practitioners in all units, based on patient outcome data.

Public Health Doctors

We see an important role for the discipline of public health as we face into the challenges posed by biodiversity loss and climate change on an ever more polluted planet. As the risk of pandemics increases, and the challenges of a more polluted planet become more apparent to us, we need a strong, well-resourced sector to prepare the healthcare response to these challenges.

Specialists in public health medicine have been the heroic in their efforts to lead the health response into containing the COVID-19 pandemic. The final recommendation of the Crowe Horwath review [89](2019) on the role of public health medicine in Ireland advised that serious consideration be given to affording specialists in public health medicine consultant status, equivalent to other medical specialists.

Public health has been severely understaffed and underfunded in comparison to similar western countries. We cannot afford to lose one public health specialist as their absolute numbers are so low.

Public health is a disproportionately female specialty compared with other specialties. A lens of historical sexism in parity of esteem cannot be ignored or tolerated.

We support parity of esteem for public health doctors by committing to providing pay equity by offering them consultant contracts for the primary aim of furthering a robust COVID-19 response. Immediate delivery of this commitment is essential to ensuring the biosecurity and health of the nation. The international market for public health specialists is now an even more highly competitive one. Failing to deliver on parity of esteem commitments risks collapsing a public health infrastructure which was stretched beyond capacity prior to the pandemic crisis. Ensuring parity of esteem is the only financially

88 Hanly Report of the National Task Force on Medical Staffing, 2003
https://assets.gov.ie/39348/634e7cea7b764923957698865ea66003.pdf
89 Crowe Horwath, on the Role, Training, and Career Structures of Public Health Physicians in Ireland, April 2018
https://assets.gov.ie/9446/56efd96dac314a9692b785706b5a5ecb.pdf

sound decision in the short, medium and long term. Investing in public health brings a return of 14:1, and this is unique from any other major health activity commissioned by the state.

As the public finances continue to deteriorate, targeted and prioritized investment must be made in priority areas to ensure the revitalization of the economy, the elimination of COVID-19 and further prevention of loss of life. Parity of esteem for public health specialists must be a key priority beyond any other upcoming public service pay commitments – this is simply an effective decision based on the marketplace competition for these specialist skills at this critical juncture. We make the strongest possible political commitment to address this issue immediately. Failure to address this issue risks not only attrition of the most key public sector staff in the face of the most profound national crisis since the Emergency, it compromises the integrity and likely longevity of government, and thus its ability to deal with the impending climate catastrophe

Physician Associates

Physician Associates are a healthcare professionals who, while not doctors, work to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision.[90] We would commission a study to find ways in which they can work in the Irish healthcare system to increase capacity in hospitals and primary care.

Health and Social Care Professionals

Independent physiotherapy, dietetics and other allied health professionals (AHP) should be an integral part of multidisciplinary teams in acute and community care and should be accessible to all patients, without need for referral.

Where referral pathways exist they should be such that patients can be fast-tracked to receive the necessary medical diagnosis or treatment if they present first at such services.

AHPs should also form an integral part of multidisciplinary teams in acute and community care. We support the use of chartered physiotherapists, physical therapists and advanced nurse practitioners to triage patients on waiting lists at a early stage and feed back to patients, their carers, relevant specialists and general practitioners with a view to fast tracking them to the appropriate place in the health system. This would include protocol-supported access to diagnostic testing.

We support increasing the funding for speech and language therapists / occupational therapists and believe the current waiting times for children with autism / special needs in accessing interventions are completely unacceptable.

90 NHS Health Education England, Physician associates, Available from URL: https://www.hee.nhs.uk/our-work/medical-associate-professions/physician-associates [cited 7/6/21]

The delays in registering new posts and obtaining Garda clearance are disappointing. We support initiatives to fast track posts in sensitive area such as these.

Pharmacists

As the stewards of the medication-use process and the final checking step between prescription and patient, pharmacists have an important role in preventing harm to patients from medications. Currently the regulation of pharmacies and pharmacists is focused on finance and discipline. We believe that the focus should shift towards quality and involve meaningful audits of how they have minimise harm to patients and reduce medication use where appropriate.

We do not believe that pharmacy support staff, such as pharmaceutical technicians, require full regulation, as their work is the responsibility of a supervising pharmacist. However, an ongoing system of continuing education and certification for such staff is appropriate, which could be monitored by the Pharmaceutical Society of Ireland.

We support the implementation of the 2011 Report on the Review of Hospital Pharmacy as agreed, without further delay, including the introduction of specialist level pharmacists, and the consideration of the introduction of pharmacist prescribing.[91]

Graduate entry level pharmacy degrees should be facilitated for those with appropriate primary degrees and experience, including pharmacy support staff. Under and post-graduate level training should involve placements in both hospital and community settings to help trainees gain a broader understanding of patient care. To ensure that cost is not a barrier to entry, postgraduate and integrated fifth year pharmacy undergraduate training should be appropriately funded by the Department of Health - meaning an appropriate number of students would pay no additional fees. Additionally, pharmacists undergoing pre-registration (internship) training should be paid at the salary scales agreed by the Department of Health.

Management & Administrative Grades

Non-medical staff, or staff who have moved from clinical to management roles in the health service have been vilified and blamed for many problems in the administration and management of the service over recent years. We recognise that these staff members play an important role in ensuring that trained medical staff are free to spend their time on direct patient care activities and that for many people their first contact with the health services will be through an administrative grade.

We support implementing an evidence-based approach to management and administrative work in our healthcare services. We also believe that administrative staff

91 Dept of Health/Health Services Executive/Hospital Pharmacists Association, Ireland/IMPACT Trade Union Report on the Review of Hospital Pharmacy, 2011, https://hpai.wildapricot.org/resources/Documents/Report%20on%20the%20Review%20of%20Hospital%20Pharmacy%202011%20with%202102%20JD%20included.pdf

should be able to change roles if it helps achieve more efficient healthcare delivery and that, where such grades are not required to be in direct patient contact, they should be allowed the flexibility to work in different geographical areas, so that peaks and troughs in workflow can be minimised. Administrative grades should also be offered the same training and development opportunities as clinical grades.

Highly trained information technology professionals are essential to the development of our health services. The eHealth strategy[92] and the extensive architecture of information technology within the health services, and the cyber-attack on the HSE in May 2021 as well suggest that there needs to be a robust plan to ensure that the numbers of appropriately trained staff are available to all hospitals and other areas of the health system to deal with the challenges.

Support Staff

Support staff without any formal training make up a large proportion of the healthcare workforce, and play a significant role in caring for patients, both as ward aids and, crucially, in helping healthcare settings comply with hygiene requirements in challenging circumstances. Such staff should be integrated into care teams and allowed development opportunities which reflect their important role in patient care.

Education and Training

For an effective health care system, the accreditation of medical schools, GP training schemes, and training schemes for other health care professionals should take place on the basis of projected demographics.

We should investigate the feasibility of developing appropriate postgraduate routes to training as a flexible short-term measure to manage staffing levels, and also to facilitate those who wish to change careers later in life. This investigation should include focus on all healthcare professions, and should be subject to close liaison between healthcare providers, the Department of Health and higher education authorities and institutions, as well as the representative bodies for each profession or grade, while focussing on road blocks to improving access.

We support increasing the number of training places in all healthcare professions, both undergraduate and postgraduate, to ensure that Ireland is self-sufficient in providing the number of staff needed for our healthcare system.

Recruitment of International Staff

The Green Party's founding principles on redistribution of the world's resources and world peace reflect an inclusive view of the world. We support international cooperation to

92 eHealth Ireland Strategy, 2014, https://www.ehealthireland.ie/knowledge-information-plan/ehealth-strategy-for-ireland.pdf

protect the health of our global family and acknowledges Ireland's obligation to ensure that our health and our health services are not sustained at the expense of the health of poorer people in other parts of the world.

Knowledge in healthcare is global in scope and the core skills and challenges are common to people of all nations. This means that healthcare staff can and will migrate to where they can get the best standard of living, and that patients too can obtain healthcare across borders.[93]

We recognise that Ireland has benefitted from the arrival of generations of doctors, nurses, other health professionals and non-professional staff from lower income countries, and in some cases this has been a "brain drain" to the health systems in those countries.[94]At the same time educational institutions and hospitals here have contributed to training professionals for countries internationally, some of whom have returned to work in the Irish system.

We recognise the advantages of medical migration for training and development of healthcare staff worldwide. Ireland should ensure that education and training capacity in Ireland is sufficient, but that when it falls short, that appropriate education and resources should be provided to source countries from whom we have received staff.

We should also offer appropriate development and training opportunities for international staff and provide for and support them when and if they wish to return to their countries of origin.

Healthcare is a worldwide market, and we recognise the right of those trained in Ireland to travel internationally. We would endeavour to keep these healthcare workers through establishing and maintaining professional networks and citizenship rights, for example extending the voting franchise or dedicated schemes to help with administrative barriers to returning to work in Ireland.

Continuing Professional Development (CPD)

We also believe in state-funded CPDs for medical practitioners as an alternative to drug-industry-sponsored educational meetings[95].

We will set a target of 1% of overall budget for the HSE and individual hospitals and healthcare organisations to spend on the education and training of staff. Some of this should be disbursed to national representative organisations and to postgraduate training

93 Crisp P, Chen L, Global Supply of Health Professionals, N Engl J Med 2014; 370:950-957
DOI: 10.1056/NEJMra1111610 [cited 15/9/21]
94 Chen L, Boufford J, Fatal Flows – Doctors on the Move, N Engl J Med 2005; 353:1850-1852
DOI: 10.1056/NEJMe058188 [cited 15/9/21]
95 Royal College of Physicians in Ireland, Discussion Paper: Industry Support of Medical Education and Continuous Professional Development, March 2014 available from URL:
http://www.rcpi.ie/content/docs/000001/1732_5_media.pdf?1396431153

bodies for healthcare professionals to remove the influence of sponsorship by the industry on educational meetings and CPD provided for their members.

(d) Other specific policy measures

Healthcare for Special Populations

Care for the homeless

We believe that the provision of adequate housing is essential for good health and in particular for homeless people. (See the Green Party/Comhaontas Glas policy on housing and homelessness on www.greenparty.ie for further information)

Care of the Elderly

We consider the home to be the best location for older persons to receive care. Where this is not possible, settings where they are surrounded by their own family and community or in which they can be most comfortable should be considered. Sheltered accommodation may be appropriate for some people, and a smaller proportion may need institutional care, either on for respite or on a longer-term basis. We support the proper resourcing of carers and homecare services in order to keep as many people out of institutional care as possible.

We support an urgent review of the Nursing Home Support ('Fair Deal') scheme, and the upgrading, renovation and retrofitting of existing facilities ahead of bed closures.We advocates changing the 'Fair Deal' scheme away from a fixed annual allocation to one that is demand-led.

We support increased funding up to a level of €192 million by 2020 to allow provision of 7,000 nursing home beds as recommended by the Prospectus Report and noted in the ED task force report 2015. We are committed to ensuring that the people looking after our vulnerable elderly are vetted, well-paid, and qualified for the work that they are doing. To avoid future abuse of patients, regular unannounced checks on staff and facilities should be carried out and such checks should be made in a professional, accountable and transparent manner.

We support the 'Assisted Decision-making Bill[96] and believe it should be extended further to give the elderly, who are more likely to experience health problems, such as dementia,

People with a disability

We support the extension of the Assisted Decision-making Bill'[97] to those with disabilities in order to provide such individuals with greater autonomy over decisions pertaining to them.

96 Assisted Decision-making (capacity) Bill 2013 http://www.oireachtas.ie/documents/bills28/bills/2013/8313/b8313d.pdf
97 Assisted Decision-making (capacity) Bill 2013 http://www.oireachtas.ie/documents/bills28/bills/2013/8313/b8313d.pdf

We acknowledge that it is often more expensive to provide a person with a disability access to education, work, and healthcare but we consider it integral to the provision of dignity for all citizens and therefore deem it to be work the additional cost.

Creation of a Public Liability Insurance Scheme

We would create a public liability scheme similar to the Accident Compensation Corporation (ACC) in New Zealand. The ACC provides comprehensive, no-fault personal injury cover for all New Zealand residents and visitors to New Zealand. This scheme has been very successful in reducing insurance costs for various sectors including the medical/healthcare sector in New Zealand and we believe would do the same in Ireland.[98]

Irish Healthcare in an International Context

The Green Parties founding principles on redistribution of the world's resources and world peace reflect an inclusive view of the world. We support international cooperation to protect the health of our global family and acknowledges Ireland's obligation to ensure that our health and our health services are not sustained at the expense of the health of poorer people in other parts of the world

Health Tourism and Treatment Abroad

We recognise recognises the risks and opportunity to patients who travel abroad to access more affordable or inaccessible health treatments, sometimes known as 'health tourism' and care is needed to prevent exploitation of Irish patients abroad.

People with conditions for which treatment is not available in Ireland (or is not available within appropriate time-frame), either through the lack of specialist staff, or insufficient resources in a particular field should be able to access appropriate healthcare outside of the state[99]. We support the findings of the office of the Ombudsman in 2018[100] in that the Treatment Abroad Scheme be made more transparent for patients and their doctors. The decision should be made by the consultant reviewing the patient, based on a pre-referral check of services with the lead consultant nationally in that area, that a patient can avail of the scheme. We will also promote and expand the Cross Border Directive Healthcare Scheme[101],

North-South Cross border co-operation

We recognise the challenges to health experienced by citizens in the border counties, both within the Republic and Northern Ireland, and asserts the rights of patients to seek treatment at the setting most appropriate for them, in either jurisdiction. This might include

98 Accident Compensation Corporation, [Website] Welcome to ACC available from URL: http://www.acc.co.nz
99 HSE Treatment Abroad Scheme, [Web page] https://www2.hse.ie/services/treatment-abroad-scheme/treatment-abroad-scheme.html [cited 27/8/21]
100 Office of the Ombudsman, Treatment Abroad Scheme, January 2018, available from URL: https://www.ombudsman.ie/publications/reports/treatment-abroad-scheme/index.xml [cited 27/8/21]
101 HSE Cross Border Directive Healthcare Scheme, Available from URL: https://www2.hse.ie/services/cross-border-directive/about-the-cross-border-directive.html [cited 23/9/21]

care pathways that involve diagnosis and treatment in separate jurisdictions and will require improved information and transport links for patients. Costs of services may require a budgetary adjustment for cancer and other care programmes.

We also recognise the risks and opportunity to patients who travel abroad to access more affordable or inaccessible health treatments, and care is needed to prevent exploitation people who choose these options.

Where a case has been made, and suitable evidence exists that a therapy cannot be cost-effectively provided in Ireland, the patients local healthcare commissioning body should make arrangements to ensure that a patient can avail of such treatments abroad. The commissioning body should also ensure that such as scheme does not result in local patients being deprived of such services.

Blood Transfusion

We support the revision by the Irish Blood Transfusion Service of rules on blood donation, including removing the current restriction on the basis of sexual orientation and history of sexually transmitted infections, to ensure maximum safety, minimum discrimination, and consistency with rules in other countries, for example the UK, where Ireland sources blood from during times of domestic shortage."

2.3 Costing of a Green Healthcare System

We acknowledge that the type of healthcare people want will be costly, but we also believe that, with the right measures in place, we can deliver healthcare that is accessible to all and good value for money. This section addresses the following questions in health care finance:

- How should we fund healthcare?
- How are healthcare providers to be paid?
- How patients should pay for healthcare (and when they will not)
- Where else can we save money without cost to our health or to our environment?

Each of these three components affects the quality and cost of healthcare and need to be considered separately.

How is healthcare to be funded?

We believe in a single-tier health system based on need rather than the ability to pay and that the fairest and most progressive way to achieve this is by funding from the exchequer through the National Health Fund outlined in Sláintecare.

The Republic of Ireland spent an average of €4,386 on healthcare for each member of the population in 2019. Overall, €17.6 million was spent by the state, supplemented by €3.3

million from private health insurance, and out of pocket payments of €2.8 million in 2019 [102]

In 2021, the budget is to spend €22.1 billion on healthcare from a total of €89.6 billion[103], which will again be supplemented by private health insurance and out of pocket payments, some of which are partly reimbursed by tax rebates.

Sláintecare has been fully costed with the expansion of entitlements projected as between €385 and €465 million per year for the first six years of the plan.[104] and a €3 billion transitional fund to make up for a historical under investment in health, and to fund both changes in the infrastructure. This timetable has been delayed by Covid-19 and other factors, but investment continues through the budgetary process and the Programme for Government.[105]

Providing private and public care in our hospitals and primary care practices has resulted in an unfair system where those being paid for by health insurers receive a different level of service than those paid for by the state. Public patients are more likely to have to wait longer for appointments and tests and are likely to meet junior doctors, or specialist nurses rather than consultants. Doctors and hospitals are also incentivised to prioritise paying customers, for whom they are paid on a 'fee for service' basis ahead of those being paid for by the state, for whom they are paid by salary or capitation. This has clear implications on healthcare, and results in different outcomes for each patient group. We note a study where a large proportion of the Irish Public favour better public services over reduced personal taxation.[106]

We call for the development of a healthcare system that is fully-funded from a national health fund on the basis that:

(i) It is the most progressive – as those with the greatest ability to pay share more of the burden.

(ii) It is the most cost-effective - OECD data shows that countries with a social insurance model, or a private/social insurance hybrid pay significantly more per capita for their healthcare[107].

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102 CSO system of health accounts 2019 https://www.cso.ie/en/releasesandpublications/er/sha/systemofhealthaccounts2017/

103 Government of Ireland budget 2021, where your money goes, available from url: https://whereyourmoneygoes.gov.ie/en/ [cited 3/8/21]

104 Burke S et al, Sláintecare – A ten-year plan to achieve universal healthcare in Ireland, Health Policy, 2018, 122(12): 1278-1282 available from url: https://doi.org/10.1016/j.healthpol.2018.05.006 [cited 30/7/21]

105 programme for government: our shared future, 2020, available from url: https://www.gov.ie/en/publication/7e05d-programme-for-government-our-shared-future/

106 TASC, almost 70% of irish public agrees government should prioritise investing in public services over income tax cuts , 14th july 2015, http://www.tasc.ie/news/2015/07/14/almost-70-of-irish-public-agrees-government-should/

107 OECD(2014), "total expenditure on health per capita", health: key tables from oecd, no. 2. Doi: http://dx.doi.org/10.1787/hlthxp-cap-table-2014-1-en

(iii) Healthcare is not a perfect market commodity, and better healthcare results from collaboration and not competition[108].

(iv) The introduction of mandatory health insurance will be another burden on those on lower incomes who do not qualify for subsidisation[109].

(v) The two-tier nature of our current system leads to inefficient use of resources and causes significant hardship to patients.

(vi) Research has shown that the health service in the world with the best outcomes and the most cost-effective performance - American Veterans Health System[110]- is directly funded by general taxation.

How healthcare providers are to be paid:

We call for multi-annual budgeting, Activity Based Costing and Blended Capitation Schemes[111] to incentivise efficient targeted use of resources throughout our health system

2.3.1.1 Multi-Annual Budgeting

The health service is a demand-led service and experiences regular and often unpredictable surges in demand. The demands of budgeting within the current annual allocation of funding ends at what is often the busiest time of the year for healthcare services, frequently resulting in short term, cost-saving measures being introduced which are unsustainable in the long term. These short-term saving measures, such as the closure of wards and operating theatres, leads to more patients on trolleys, longer waiting times, poorer patient prognosis and ultimately more expensive care in the long run.

Multi-annual budgeting has been an objective of budgeting reform since November 2010[112], but its application in practice has been limited given the constraints of Ireland's legal framework which caters for an annual budgeting process. It reduces the need for short-term saving measures and is better suited to the long-term financial planning required for better healthcare.

108 chapt 3 market failure in healthcare: justifying the visible hand, from donaldson & gerard, economics of health care financing, the visible hand, 2nd edition, palgrave, london, 2005.
109 martin wall & fiach kelly, irish times, monday 29th june 2015, universal health insurance could cost up to €3,000 for adult, available from http://www.irishtimes.com/news/politics/universal-health-insurance-could-cost-up-to-3-000-for-adult-1.2265824
110 Phillip Longman, Best Care Anywhere, 3rd Edition, Bernett-Koehler, San Francisco, 2012.
111 Government of Alberta, Canada, Blended Capitation Clinical Alternative Relationship Plan (ARP) Model, [webpage] 2021, available from URL: https://www.alberta.ca/blended-capitation-clinical-alternative-relationship-plan-model.aspx [cited 25/11/21]
112 Joint Oireachtas Committee on Finance and the Public Service "Report on Macroeconomic Policy and Effective Fiscal and Economic Governance", November 2010

2.3.1.2 Activity Based Costing[113] and Full Economic Cost-Benefit Analysis

We believe that all financial units within the health services should provide activity-based costs and budgets, indicating exactly how resources were used, in order to receive funding for their activities. This should help to reduce waste. [114]

We are of the view that all requests for new funding - both capital and operational - should be subject to the guidelines above, and that a programme of reviewing existing programmes should be undertaken.

Hybrid Capitation Models

We call for the use of hybrid capitation payment arrangements such as weighted-capitation and blended-capitation to pay for healthcare services in hospital and the community.

Weighted capitation is a formula used to project future health costs. It starts with projections for a resident population, and then weights them as appropriate for the cost of care by age group for relative need over and above that accounted for by age, and takes into account unavoidable geographical variations in the cost of providing services. It is used to determine health authorities' target share of available resources. In blended capitation some ancillary services are fee-per item

These allow health services to use incentives to move care to those who need it most, and reward healthcare practitioners and providers who achieve the best outcomes for their patients.

Weighted capitation would apply to providers looking after patients in areas of deprivation or in sparsely-populated rural areas, and can be adjusted as part of long-term planning. It also allows for targeted schemes to deal with specific problems that might occur from time to time.

Blended capitation would apply to, for example, GP practices that achieve and maintain a reduction in hospital admissions for their cohort of nursing home patients

These incentives should be decided on a regional or local-level in response to health outcome targets which should be set by the Department of Health, in consultation with the public on a multi-annual basis.

113 See Health Services Executive, 2021 [website] available from URL: https://www.hse.ie/eng/about/who/finance/nationalfinance/activity-based-funding-healthcare-pricing-office/
114 Jalabadi et el, Activity Based Costing, Semin Plast Surg. 2018 Nov; 32(4): 182–186, https://dx.doi.org/10.1055%2Fs-0038-1672208

Tackling Waste in Healthcare

A core principle of this document is that we believe that a less wasteful model of healthcare can be found which can ensure that the valuable resources of the planet are maintained while reducing financial costs. Data from US systems puts this value at $1 in every $5 spent, but with the significant differences in structures, and a historical capital underspend it would be appropriate to make estimates without examining processes at a more granular level.

Transitional arrangements

Our current system relies significantly on out-of-pocket contributions by patients, either through premiums paid for health insurance, general practitioner's or other fees and cash paid for medications. GP fees are paid by 60% of the population and vary from €30 to €65. It is unclear if we receive value for money for this contribution as private healthcare makes up only about 20% of hospital beds

Currently, holders of medical cards attend a doctor twice as often as non-medical card holders[115], and it is accepted that the income generated from private patients is a significant subsidy to the system. Extending capitation-based care to all patients, even where a co-payment is included, represents a significant change to the funding structure of general practice and the new funding will have to factor in the loss of this subsidy.

Extension of the Public Scheme to the Full Population

The Green Party/Comhaontas Glas 2007 Health Policy[116] called for free GP visits for under sixes in order to remove cost as a barrier to healthcare for these children and its implementation by the 2011-2016 government marked an important first step on transferring of resources into general practice. We believe that eligibility should be extended on the basis of increasing the number of medical conditions entitled to free GP care on an annual basis over a number of years, as outlined in Sláintecare. A cumulative spend of €455 million over 10 years has been allowed for in Sláintecare for this extension of GP care.

Private Health Care sector within the new system

Within the system proposed in this policy document those who choose to access private health care would bear the entire cost of that choice. We support the phasing out of all tax incentives and public sector concessions of any kind for those who purchase or provide private healthcare services and private healthcare insurance. We think it is more appropriate that the resources directed to these areas through tax reliefs and incentives

115 central statistics office, health status and health service utilisation, q3 2010, available from http://www.cso.ie/en/media/csoie/releasespublications/documents/labourmarket/2010/healthstatusq32010.pdf
116 irish times, saturday january 27th 2007, green party outlines health policy available from http://www.irishtimes.com/news/green-party-outlines-health-policy-1.1291922

should be directed to sustaining and developing a universal-access publicly-funded system.

We believe that costs to the public healthcare delivery system arising from investigations or treatment commenced in the private sector should be borne entirely by the private healthcare provider involved in initiating the service.

We believe that private healthcare service providers, particularly those operating within a voluntary or not-for-profit model have made, and can continue to make, a contribution to healthcare services in Ireland. The private, for-profit sector may be able to provide some facilities and services to a publicly-funded healthcare system where they have quality-assured capacity and can provide such services in a cost-effective manner.

To the extent that private health care providers operate in Ireland they should be obliged to contribute health statistics and outcomes data to national health information systems.

We call for the phasing out of all tax relief on payments to private healthcare and private health insurance over a period of five years.[117] This approach will help an orderly wind down of such organisations and the transfer to funding from a single social insurance model.

Cost of medication & prescription charges

All medications should be prescribed by approved international non-proprietary names (generic name) in hospital and in the community unless there is a valid medication safety reason - as validated by the Health Products Regulatory Authority (HPRA) - not to do so. Reference pricing[118] should be extended and should include all therapeutic areas. The pricing should be based on procurement processes that are managed under the remit of the chief hospital pharmacist and in collaboration with community healthcare organisations Each of these organisations should be considered as accounting units and be expected to purchase medications using the tendering procedures outlined in EU public procurement directives, and in conjunction with the procurement groups and P &T committees mentioned above.

Managing Litigation Costs

In 2018 the state claims agency paid out in settlements and costs almost €300 million in clinical claims.

In 2018 the outstanding liability for clinical claims by the state was in excess of €2.2 billion. Since 2018 the figures have grown significantly.

117 Green Party/Comhaontas Glas, General election manifesto 2011, Available from http://vote.greenparty.ie/downloads/manifesto.pdf
118 The Health (pricing and supply of medical goods) Act 2013, available from URL http://www.irishstatutebook.ie/eli/2013/act/14/enacted/en/print.html

The cost arising from the claims in relation to cervical cancer screening alone , for which the HSE carries primary liability but in relation to which the private laboratories are currently indemnifying, could run into hundreds of millions of euros.

There is a risk that the current judicial system impacts on the ability to recruit appropriate personnel to high risk areas of medical practice with severe and serious implications for patient welfare.

At the same time the HSE urgently requires additional consultant another clinical staff and significant investments in capital to improve health outcomes.

The current situation is unsustainable, with the legal costs alone accounting for a significant proportion of the annual costs (approx. 30%).

The Green Party calls for the appointment of a Citizens Assembly to examine in detail solutions to address an outdated and inequitable situation.

The assembly should consider:

(i) making obligatory detailed pre trial procedures to facilitate early resolution of disputes through mediation.

(ii) Comprehensive legal protection for the carrying out of clinical audits whether anonymised or otherwise so that quality improvement is parameterized.

(iii) Consideration of enhanced medical benefits for persons suffering sub optimal medical outcomes based on no fault liability.

(iv) Special provision protecting from litigation population based screening services

(v) review of the appointment and or allocation to the personal injuries list of judges taken from the cohort of personal injury legal practitioners or where there is a close connection to persons engaged in the prosecution of personal injury claims.

Cost benefit of patient safety

Medical error costs include the cost of compensation, litigation and treatment costs, as well as the economic costs to victims of patient safety incidents. The cost of litigation and compensation has been covered above. A significant proportion of the remainder (85% in a US study[119]) is for the medical treatment of patients.

119 Andel C, Davidow SL, Hollander M, Moreno DA. The economics of health care quality and medical errors. J Health Care Finance. 2012 Fall;39(1):39-50. PMID: 23155743. Available from URL:

Table of Estimated Costs and Savings from This Policy

Measure	Cost (Savings) to Exchequer	Notes
Implementation of Sláintecare (estimated effect of medical inflation caused by the delays in implementation)	€300 million	Sláintecare has been fully costed, and will amount to €2.84 billion over 10 years. As the implementation is behind schedule, it can be expected that inflation will apply. While this has been less than 1% over the past few years, a higher rate is expected for 2021, and the cumulative inflation since 2017 may be in the region of 10%
Public Liability Insurance, similar to the New Zealand ACC	€3.7 Billion	The ACC spent NZ$6.25 billion (€3.7 billion) in 2020 for an approximately similar population with about half that figure received in premiums from the public.[120] Savings to counterbalance the shortfall between premiums and the cost of claims come from a reduction in costs to other parts of the economy, in particular in healthcare.
Improving Maternity Services	Cost Neutral	The estimated cost of maternity services in 2020 is in the region of €215 million, with expected legal claims for 2017 being €1.38 billion.[121] New Zealand shows the lowest maternal mortality in a list of countries studied by the commonwealth fund.[122] The New Zealand Government will spend NZ$200 million (€108million PPP In Ireland[123]) on maternity care in 2021[124] for an estimated 60,000 births, which is approximately the same as Ireland. However, with the average salary of a midwife in NZ at NZ$54,000 (€29,300) and Ireland at €57,663, adjusting by a factor of 2 gives very similar costs. This would suggest that the changes needed in maternity care in Ireland should be achievable with improvements in governance as outline elsewhere in this document and should be cost neutral on an overall scale.
Services for people with Endometriosis and related conditions		Healthcare costs associated with endometriosis are difficult to calculate. However, the opportunity costs of 7-10% of the female population aged 18-45 being lost to the economy is not insignificant. A US study estimated that Medicaid costs were

120 New Zealand Government, Financial Statements of the Government of New Zealand for the year ended 30 June 2020, available from URL: https://www.treasury.govt.nz/system/files/2020-11/fsgnz-2020.pdf [cited 26/1/22]
121 Whelan s, Hally and Gaughan, The True Cost to the State of Maternity Services in Ireland Ir Med J; Vol 114; No. 1; P241, available from URL: https://imj.ie/wp-content/uploads/2021/01/The-True-Cost-to-the-State-of-Maternity-Services-in-Ireland.pdf [cited 25/11/21]
122 Roosa Tikkanen et al., Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries (Commonwealth Fund, Nov. 2020). https://doi.org/10.26099/411v-9255
123 Calculated with https://startuptoolchain.com/calculators/ppp.html
124 https://www.health.govt.nz/about-ministry/what-we-do/budget-2021-vote-health

		approximately US$8,000 more than for other women[125].
Delivery of Transgender Healthcare		Providing necessary transgender healthcare, including include primary and preventive care as well as transitional therapy. has been shown to be cost effective in a study carried out by the Johns Hopkins Bloomberg School of Public Health The study estimated the cost for transitions at US $10,000–22,000 which is significantly less than that of potential negative endpoints from refusing therapy such as HIV, depression, suicidality, and drug abuse. [126]
Funding of the Autism Strategy	€2 million	This has already been secured in the 2020 budget
Patient Registries	€250,000	Without a full evaluation of each requirement with respect to the staff and software needed to manage registries, and given that many registries are run by patient representative organisations which rely on charitable donations and volunteer work by professionals, cost information can only be generally estimated. The US Agency for Healthcare Research and Quality estimate that the various registries in that jurisdiction could be combined for US$1 million.[127] [128] Much smaller scale changes in Ireland could be achieved for a fraction of that.
Increased funding for the treatment of eating disorders	€4 million (but with a saving of the equivalent in morbidity and mortality)	NHS Cost per eating disorder sufferer was estimated at £8, 850 per annum (in 2015). 400 people are currently either waiting for or receiving treatment for an eating disorder. [129] The cost of the additional morbidity and mortality from eating disorders has been estimated in the UK from the time off from work and education as £650 per annum for

125 Soliman et al., Health Care Utilization and Costs Associated with Endometriosis Among Women with Medicaid Insurance J Manag Care Spec Pharm 2019 May;25(5):566-572. available from URL: https://doi.org/10.18553/jmcp.2019.25.5.566

126 Padula, W.V., Heru, S. & Campbell, J.D. Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis. *J GEN INTERN MED* **31,** 394–401 (2016). https://doi.org/10.1007/s11606-015-3529-6

127 Gardner M & Jackson A, Developing a Patient Registry: A Practical Guide Medical Research Charities Group (MRCG) 2018, https://hrci.ie/wp-content/uploads/2019/10/Patient_Registry_Guide_7-18_LR__002__Modified_Acknowledgements.pdf [cited 21/1/22]

128 Research Report: Developing a Registry of Patient Registries: Options for the Agency for Healthcare Research and Quality. Content last reviewed January 2020. Effective Health Care Program, Agency for Healthcare Research and Quality, Rockville, MD. Availabe from URL: https://effectivehealthcare.ahrq.gov/products/registry-of-patient-registries-development/research

[129] Health Services Executive, Response to Parliamentary Question PQ Number: 2796/22 23rd February 2022

		under 20s, Stg£9,500 per annum for over 20s and £5,950 per annum for carers. [130]
Doubling of commitments to grass roots sports	€85 million	Based on current spend[131]
Additional Patient Safety Staff across 40 acute hospitals and 10 community healthcare areas	€5 million (savings in the treatment of patients, estimated at €10 million)	
Funding patient safety organisations	<€250,000	Allowing for three patient safety organisations to be funded, employing one administrative staff member, travel, subsistence and meeting expenses for 12 board members, and the preparation of printed material and a website annually, would cost less than €250,000 annually. Such funding would be based on grants which would require fully published and audited accounts.
Funding the NHSO	Cost Neutral	energy and sustainability savings from elsewhere in the health services exceeding all costs.
Social Prescribing	€1 million (returning €2.3 million)	The mean social return on investment for social prescribing in a UK study was £2.30 for every £1 invested. [132]
Treatment abroad	€13 million	Based on doubling the 2019 spend of €13 million to treat an additional 5,000 patients.[133]
Care at Home	€81.5 million	See family carers budget submission[134]
Nursing Home Support		The HSE reported that support to nursing homes under the fair deal scheme amounted to €969 million in 2018 and that residents

130BEAT, February 2015, The costs of eating disorders Social, health and economic impacts https://www.basw.co.uk/system/files/resources/basw_54403-3_0.pdf

131 Gasg D, €85 million Provides Timely Boost to Irish Sport Sector, November 2020 available from URL: https://www.sportireland.ie/news/eu85-million-provides-timely-boost-to-irish-sport-sector

132 Polley, M.,Bertotti, M., Kimberlee, R., Pilkington, K.,& Refsum, C. A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications, University of Westminster, June 2017, https://westminsterresearch.westminster.ac.uk/download/e18716e6c96cc93153baa8e757f8feb602fe99539fa281433535f89af85fb550/297582/review-of-evidence-assessing-impact-of-social-prescribing.pdf [cited 12/1/22]

133 RTE News, Significant Rise in HSE Patients Treated Abroad, Thur 2nd July 2020, Available from URL: https://www.rte.ie/news/health/2020/0702/1150941-treatment-abroad/ [cited 26/1/22]

134 FAMILY CARERS: **The Forgotten Frontline** Family Carers Ireland's Proposals for **Budget 2022** Available from URL: https://familycarers.ie/media/2306/family-carers-pre-budget-submission-budget-2022.pdf

		contributions amounted to a further €343 million. [135]
Dementia Villages	Cost Neutral	A dementia village being developed in the US by a private sector company is expected to cost US$70-90,000 per person. [136] Irish Nursing homes can cost up to €75,000 per annum[137]
Staff Training at 1% of Health Budget	€200 million	
Phasing out tax relief on private healthcare services	(€660 million)	No specific data is available from the revenue commissioners on the amount of money claimed in tax relief on payments to private healthcare or private health insurance. This figure is calculated based on 20% of tax that was potentially claimed on the €3.3 billion private healthcare spend in 2019.
Savings from tackling waste in healthcare	(€4 billion)	Applying this rate of saving to the Irish Healthcare budget would represent a saving of over €4 billion.

2.4 References

Please refer to footnotes throughout this document

135 Comptroller and Auditor General Special Report, The Nursing Homes Support Scheme (Fair Deal) Report number 110 May 2020, Available from URL: https://www.audit.gov.ie/en/find-report/publications/2020/special-report-110-the-nursing-homes-support-scheme-fair-deal-.pdf [cited 21/1/22]

136 Ferguson, Langley dementia village cost per patient estimated at $70,000 to $90,000 annually, Langley Advance Times Apr. 16, 2018 5:00 p.m. LOCAL NEWSHttps://www.langleyadvancetimes.com/news/langley-dementia-village-cost-per-patient-estimated-at-70000-to-90000-annually/

137 Retirement Services Ireland, Cost of Nursing Homes: Cost of Care in Nursing Homes & Care Centres, available from URL: https://retirementservices.ie/cost-care-nursing-homes/