Ireland's Future
Todhchaí na hÉireann

An Opportunity for a World Class, All Island National Health Service

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Health care is one of the most significant sectors for any country and is high on the list of priorities when Irish unity is discussed. Concerns from voters in the North often centre around the paid-for element of the HSE, while citizens in the South state they worry about the cost of integrating the two systems. However, there is now much greater clarity and evidence around these and other issues that might have previously caused concern.

The context of healthcare across the island is important. Citizens north and south face similar challenges, with people from the poorest communities on the island of Ireland likely to die up to seven years earlier than those in the most affluent areas. This gap is more pronounced in the North.

- In the South, average life expectancy for men in the most deprived areas is 5 years less than for men in the most affluent areas, while for women the gap is 4.5 years.
- In NI average life expectancy for men in deprived areas is 7.1 years less than for men in the most affluent areas, while for women the gap is 4.4 years.
- The gap in the number of years people can expect to live free of a disability between NI's least and most deprived areas is 14.5 years for men and 13.9 years for women, and the gap has widened in recent years.
- In the South, 43% of people aged 65+ in the lowest income group have a long-term health related limitation on activity, compared with 16% of those in the most affluent group.

While the statistics above are broad and far from exhaustive, and more work undoubtedly needs to be completed, it is already clear that citizens North and South would benefit from an integrated, island-wide health system, that is affordable, with services that can be funded and delivered so that they are free at the point of need.

In this section, we provide evidence-based information that directly addresses these key concerns, as well as highlighting the benefits and challenges in building an integrated all-island health system.

1. How is healthcare currently operated on the island of Ireland?

The island of Ireland geographically is small, just 486 km long and 275 km wide, and has a population of just under 7 million, which remains below population levels of the mid-nineteenth century.

Outside the Dublin and Belfast metropolitan areas, the island has one of the lowest population densities in Europe. Yet in this small territory there are two separate healthcare systems in operation with very little co-operation between them. One system, in the south, covers three quarters of the island, where approximately half the population hold a private insurance–based system. The other, in the north, is governed by protocols drawn up in a Britain which unlike Ireland, is highly urbanised and densely populated.

2. Do both health systems work well?

Both systems are sub-optimal. The National Health Service in Northern Ireland is in practice an under-funded regional health service. Devolution within the UK has led to very different per capita budgeting decisions, delivery structures and crucially health outcomes in England, Wales, Scotland and Northern Ireland.

Northern Ireland has significantly longer waiting lists when compared to other regions within the UK National Health Service. Its morbidity and life expectancy metrics are also bottom of the NHS league table.

Health policy in the south has, since the 1990's focused on re-shaping healthcare infrastructure and improving health outcomes for citizens. There has been a cross-party commitment to bear down on the legacy of vested interests which had during the early decades of the new state's development held back the construction of a comprehensive publicly-funded free at the point of need system.

3. How has peace and political progress assisted the southern system to improve over recent decades?

The pace of catch-up by the south has been quite impressive given where it had to start from and the effect of partition in constraining its development. It had to contend with political instability and conflict in the north throughout the latter part of the 20th century, meaning that potential resources were invested in other areas and foreign investment was deterred.

It is not co-incidental that the south of Ireland enjoyed 10 years of the fastest rate of economic growth in the world, after China, following the Good Friday Agreement in 1998. The promise of the dissolution of the physical border in Ireland as a barrier to collaboration and trade was enough to unbridle the south's atrophied growth potential, reversing more than a century of net emigration, attracting new investment and generating the increased tax revenues which enabled the government to invest in new infrastructure and system change. This all had a net benefit result on the health system in the south of Ireland.

4. When did co-operation in healthcare between North and South begin and what are the commonalities?

In healthcare, threads of co-operation between the systems North and South began to be spun in the 2000s – yielding significant gains for local populations in the north-west with the development of cancer services in Altnagelvin, in Fermanagh with the construction of a new hospital in Enniskillen and across border areas with the EU-funded CAWT (Co-operative and Working Together) initiative.

The two systems, north and south, contrary to common belief have much in common and are based on the same underpinning values. There is considerable existing alignment in terms of the training of healthcare professionals, the move towards evidence-based practice, the regulation of health care professionals, and care quality standards - much of this has been driven by EU-wide work in recent decades.

Some key legislative frameworks e.g. the Midwives Act Ireland 1918 predate partition and have ensured a broadly similar role in both jurisdictions.

The same can largely be said of training for health and social care professionals. Universities north and south offer programmes to train doctors, nurses, midwives, social workers and allied health professionals. Students from the south frequently choose to complete elective placements in the north (or GB) and vice versa.

Current challenges around how points are calculated under the Central Applications Office (CAO) system make it more difficult for northern students to gain places in degree programmes in the south however some pilot work is underway aiming to address this.

With regard to mutual recognition of qualifications, there is already significant movement of doctors, nurses, midwives, and allied health professionals (AHPs) across the island of Ireland and between Ireland and Britain. Much of the training for key health and social care professionals has been guided by EU frameworks so currently there is significant alignment.

It is clear however that the planning and preparing for an all island health service in the eventuality of a united Ireland is not taking place to any meaningful extent but since the

turn of the century there have been some examples of cross-border, border area, or all-island health initiatives.

Although the Covid-19 pandemic exposed severe weaknesses in having two health systems on the island, it appears that cross border understanding and co-operation has increased significantly due to factors such as the pandemic, Brexit, and the work of the Irish Government's Shared Island initiative. This includes:

- Paediatric cardiac services
- North west cancer network
- Emergency services - border counties residents go to nearest hospital in an emergency
- Rescue helicopter
- Ambulance cooperation
- CAWT work on improving outcomes and reducing cross-border barriers to accessing care for citizens in border areas
- Specialist services & cross-referral. Advantages for families and service users from the north in not having to take a ferry/plane to GB
- Cross charging systems in place when emergency care is provided in the other jurisdiction

With regard to public health, policies in both jurisdictions are already well-aligned. For example in 2004, the south became the first jurisdiction in the world to ban smoking in all indoor workplaces, with the north following in 2007. It makes no sense to have a smoking ban in place in Dundalk but no such ban in Newry. These issues are quite often a matter of common sense.

Health experts are increasingly focused not just on the manifestations of ill health such as heart disease, cancer, mental ill health, nor even on the immediate causes such as smoking, obesity, addiction but on the deeper underlying causes such as poverty, social injustice, poor attachment, ACEs and trauma.

In recent years disease prevention, the promotion of wellbeing and increasing healthy lifespan has been a focus for both the Stormont Assembly and the Oireachtas, as it has been worldwide. This commonality of focus between both jurisdictions means that alignment in terms of priorities should not present major challenges.

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5. Have political differences presented any difficulties in sharing healthcare across the island?

As with other areas of shared working between the two states on the island, at times co-operation has been fraught with difficulty and political controversy. Accessing healthcare resources on either side of the border, even if it is only a short distance away, has been regarded in some instances as anathema, despite increasing difficulties in funding for NHS services located in Britain.

While the case for heart surgeries to be done in Dublin and a cancer network to be established in the north west, could not in the end be resisted, other areas of clinical collaboration continue to be eschewed despite the obvious benefits to citizens, north and south. Unionist political parties in particular have acted as barriers to cross border collaboration.

Brexit has also presented problems regarding the sharing of healthcare across the island. According to a circular1 issued by the Department of Health in the North, EU citizens who were normally resident in the North or already registered with a GP and holding a HSC number as at 30 June 2021 will continue to access publicly-funded health care services in the North.

However other EU citizens, including those from the South, lost this right on 1 July 2021. This has far-reaching impacts, particularly for those living in border regions, and can only be fully addressed within an all-Ireland context.

6. What health reform initiatives have recently been implemented or are currently in planning for the North?

In the North the Compton (2011), Donaldson (2014) and Bengoa (2016) reviews all focused on the six county, Northern Ireland landscape as a stand-alone self-contained territory, largely ignoring the populations and resources in the contiguous hinterlands across the border.

And in constructing their analyses to rationalise the closure of acute hospitals outside of the Belfast/Portadown axis they have drawn on British-based metrics which are the product of very different landscapes of concentrated populations, transport networks and agglomeration economies. The result has been to peripheralise border communities, even those in population centres such as Newry with large hinterlands to the south.

1 HSS (MD) 45/2021 9 July 2021 https://bit.ly/36qgRF2

This approach means that the service-reach of Daisy Hill Hospital in Newry is only measured against half its actual territorial hinterland i.e. those communities to its south have been ignored with the relocation of many of its acute services to Portadown rationalised on that basis.

This is a very practical example of how partition is failing citizens from an access to healthcare perspective in a border population centre such as Newry. In a new, united Ireland, this issue simply does not exist as resources would be pooled and citizens' needs would come before narrow political agendas that exist in a divided island.

7. What health reform initiatives have recently been implemented or are currently in planning for the South?

In May 2017, the Oireachtas committee on the Future of Healthcare published the Sláintecare report2, which has led to arguably the greatest overhaul of the HSE since its creation. Among the recommendations were commitments to:

- Resource and develop a universal child health and wellbeing service
- Remove inpatient charges for public hospital care
- Reduce prescription charges for medical card holders
- Remove the Emergency Department charge
- Ensure universal primary care
- Disentangle public and private health care financing in acute hospitals and remove the ability of private insurance to fund private care in public hospitals

The Sláintecare report commits to the provision of health cards for every citizen, guaranteeing access to primary care free of charge, as currently in place in the North.

Sláintecare has been on the political and health agendas for the past five years. It's primary objective is very noble and worthwhile, that is to abolish the state's two-tier health system, replacing instead with a universal healthcare model, much like the NHS is intended to be.

It is also intended to improve the experience of users and staff, reduce waiting lists, lower healthcare costs and achieve overall better healthcare outcomes.

2 https://www.gov.ie/pdf/?file=https://assets.gov.ie/165/270718095030-1134389-Slaintecare-Report-May-2017.pdf

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This initiative is supported by every political party in the state.

A notable part of the initiative is to establish six autonomous, regional health areas across the state, each area with its own responsibilities in budgeting, planning and healthcare delivery. In the context of a new and united Ireland this could increase to seven or eight areas and a new all island configuration could be established meaning Donegal could be paired with Derry instead of Galway and Monaghan could be paired with Armagh instead of north Dublin.

The Sláintecare model is in fact, the perfect foundation on which to build a world class, outstanding health service for the people of Ireland. Its glaring downfall is the fact that it leaves out the northern six counties. It makes no sense whatsoever to leave out the north but is yet another example of how partition is failing the citizens of Ireland, particularly those in border areas.

While some funding has been delayed, the expectation remains that this will be in place by 2030. If achieved, this will remove arguably the biggest perceived concern about an all-Ireland health system.

8. Do the aforementioned health reform initiatives take a shared island approach?

Over the last two decades in the face of healthcare challenges facing governments across the advanced industrialized world - ageing populations; atomization of families and communities; competition for skilled people from other sectors - increased demand for services; rising levels of obesity, heart disease and diabetes; citizen demands to enjoy better quality lives and the emergence of new expensive treatments, policy makers in the two jurisdictions have been engaged in a process of reviewing the working of the respective healthcare systems.

It is evident that a fundamental weakness of the aforementioned reviews North and South is that they have been separate exercises with no cross-referencing or consideration of the impacts of their proposals across the partition boundary in the other jurisdiction – nor has any serious consideration been given to the potential to solve problems by sharing expertise, buildings and equipment across the island.

This, in the face of a process of infrastructure re-configuration in the south which led in the early 2000s to the closure of acute facilities in Dundalk and Monaghan.

As the likelihood of a referendum on Irish unity grows, policy-makers in both jurisdictions should move beyond a mindset that sees the partition boundary as the "edge" and the communities there as living in a frontier zone.

Facilities in border towns in both jurisdictions have been hollowed out over time and resources, and the jobs and buildings that they have supported, instead have been concentrated in centres and areas that don't always reflect the needs of communities and citizens.

The result today is that there are large areas either empty of or at risk of losing accessible provision, particularly of acute healthcare services in a partition "cordon sanitaire".

It is no accident that the larger towns and rural communities in border areas have some of the highest levels of poverty, unemployment and ill health on the island.

These settlements were badly damaged by partition. Even when it doesn't appear apparent, the evidence is now very stark that partition was and is their greatest burden.

Having no plan for an all island health service means these border communities will continue to suffer the same disadvantage and inequality.

9. What did we learn from Covid 19 with reference to two healthcare models on the island of Ireland?

If the pandemic has revealed anything it is that our healthcare systems north and south, lacked headroom to cope with a crisis. Health reviews obsessed about making cuts in employee numbers, closing wards and reducing beds under the auspices of efficiencies – and those who championed this were shocked in 2020 and 2021 when ambulances were queued on hospital forecourts.

What the pandemic also exposed is the lack of hospital capacity across the island and whilst this was be the case across the globe, the reality is that resources, expertise, facilities, ideas and equipment should have been shared across Ireland from the outset to ensure as few people as possible got ill or died.

Policy-makers north and south should have met regularly, shared information, and in public, informed and reassured citizens that their needs were being attended to.

The policy of the north being grouped with regions in Britain was folly and almost ridiculous. Social distancing rules were different north and south, bars and restaurants could open at different times north and south, vaccination programmes were different north and south.

To compare statistics and data for people in Derry with Leicester or Blackburn instead of Letterkenny, yet again illustrates in a very practical fashion, the bizarre continuation of having two healthcare systems on our small island.

Major lessons should be learned to ensure the same mistakes are not made again.

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10. In advance of Irish unity what should be done?

A successful healthcare model in a shared, new and united Ireland lies in everyone across the island having equality of access to the best healthcare available. To achieve that we must identify the needs of our citizens and match those against the existing infrastructure of facilities and healthcare professionals on the island.

We must also identify the gaps and the resourcing shortfall and agree a plan to secure those resources – and ignore the partition boundary in the way that Covid-19, or in fact any disease human or animal ignores lines on maps drawn through towns, villages, along roads, and through the hearts of communities.

When it came to protecting farm animals from disease, an all-island phyto-sanitary framework was put in place, a policy so important that the EU Protocol was built around it. If this can be done for farm animals why not for people?

How can two different vaccination schedules, different rules on social distancing, the ring fencing of supplies of PPE and vaccines for the exclusive use of one population or the other, be defensible?

Surely until the whole island has human phyto-sanitary security no part of it has?

11. How might a health budget be spent in a new and united Ireland?

Both jurisdictions spend similar amounts per citizen on healthcare.3 The Heenan report (2021)4 highlights the similar level of spend: "While Northern Ireland's health spending per person has been slightly higher than in the south, currently the two are almost identical, with the south spending €4,204 per person in 2021 and Northern Ireland spending the equivalent of €4,182."

Therefore the finance question needs to be less about affordability and more focused on how money is spent.

There are currently significant differences in finance routes within the two healthcare systems. One of the key principles of healthcare as experienced by citizens in the North is that services are free at the point of use, whereas in the south citizens pay for GP visits, emergency department attendances and prescriptions.

The South is an outlier among EU countries in terms of charging for GP access, and this would need to be reviewed regardless of work towards a shared system.

Resolving this single issue is likely to remove a key barrier in terms of the perceptions of citizens in the North about the Southern system.

More widely, the North operates a straightforward taxation based model, whereas the Southern system is a mix of public and insurance funding.

The insurance companies active in the southern system include VHI which is wholly owned by the Irish Government and all health insurers in the south are regulated and monitored by the Central Bank of Ireland. Around 46% of people in the south have some level of health insurance5. The average premium paid is around €1200.

In reality however, many citizens in the north also hold private health insurance, or pay for key consultations for themselves or their loved ones - often because waiting lists are so long. According to the private healthcare sector, 10% of all healthcare provided in the North is private.6

3 https://www.thejournal.ie/all-island-healthcare-shared-island-5385981-Mar2021/

4 https://www.ria.ie/sites/default/files/heenan_arins.pdf

5 https://www.hia.ie/sites/default/files/Market%20Figures%20Dec%202020.pdf

6 https://www.belfasttelegraph.co.uk/opinion/news-analysis/mark-regan-theres-huge-health-inequality-between-northern-ireland-and-england-31454876.html

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The South is also struggling with waiting lists and they operate a mixed system, with medical card holders receiving healthcare that is free at the point of use (similar to the NHS/HSC) while those on higher incomes pay for health insurance.

A third group, the 'twilight zone' citizens, are of particular concern. These individuals cannot afford private healthcare, and yet their incomes are higher than the current threshold for the medical card scheme.

The Sláintecare strategy aims to close this gap, aiming to ensure that medical card coverage is extended.

Summary

An all island approach to healthcare is a medical imperative.

For too long both the HSE and the NHS have operated sub-optimally on the island of Ireland. When the two systems work together they can work well. The example of the congenital heart disease network is a clear example and this was built on a Swedish model. What else can we learn from similar sized countries?

The patients and the medical professionals in Ireland have so much in common. It makes no sense to continue doing things separately. Every area of healthcare would be improved if there was an all island approach.

Waiting lists would undoubtedly shorten but the waiting list system itself, is a system that is designed to fail. A new Irish National Health Service provides an opportunity for significant root and branch reform, in a way that would be necessary given the current state of healthcare.

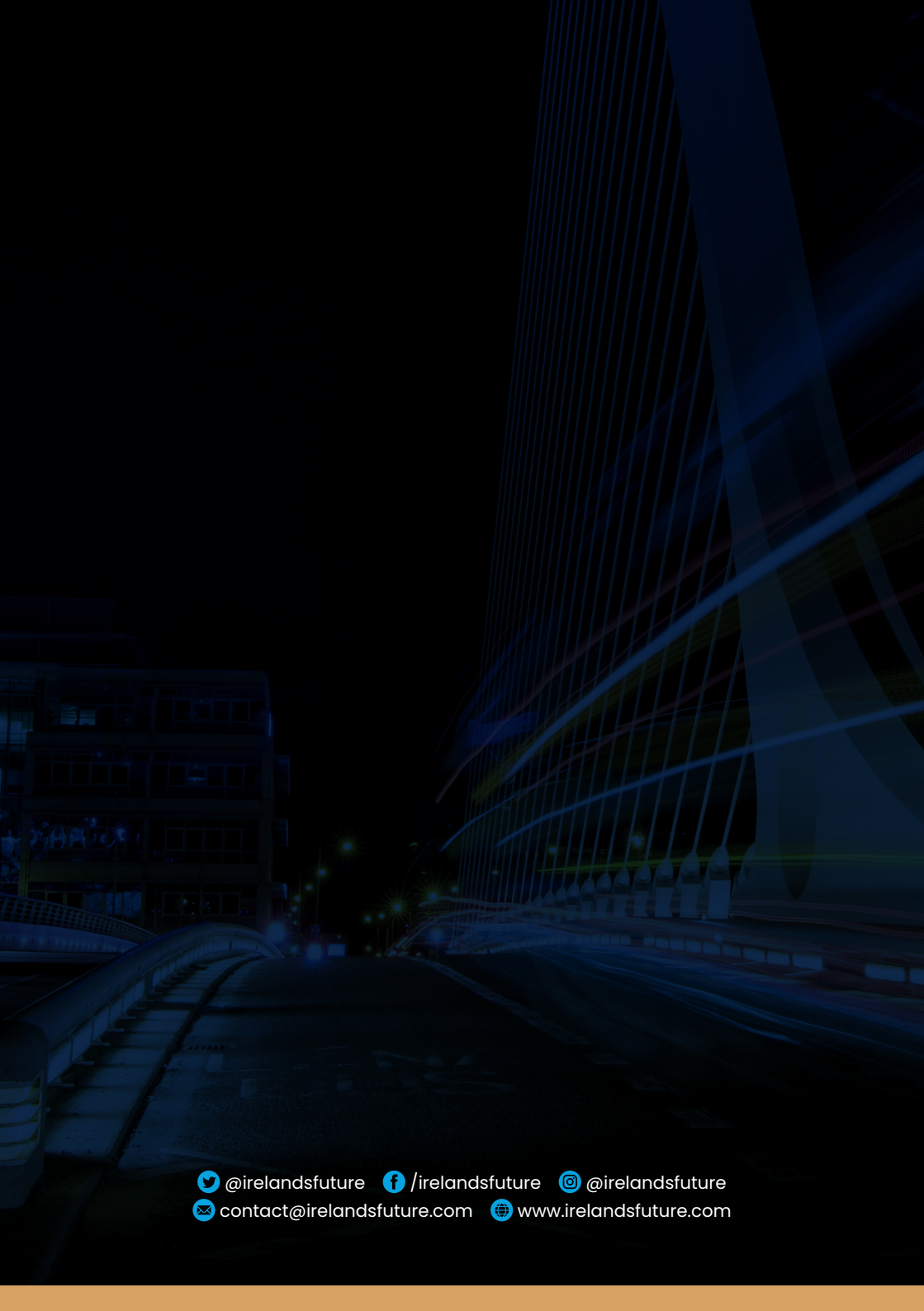
Professor Jim Dornan said,

"A starting point is that there should be memor-andum of understanding to say that there is no border in health. It is as simple as that. Nothing should be introduced healthcare wise, north or south, in the next decade without asking the question, should we be looking north, should we be looking south, how can have the best healthcare?

"It won't cost more money. I have always looked at Ireland from a health point of view as a Goldilocks sized country. NI is too small volume wise for a lot of health matters. Whereas if you take the whole of Ireland together…imagine if you take the whole of Ireland together, going to the pharmaceuticals and getting the best deal – and that is just to start. The reality is doing this all island will actually save money.

"Every decision taken in healthcare should be prefaced with the question, if we make this all island will this benefit our people, will this provide a better quality of living, will this be a more efficient use of our resources?

"Bill Clinton said 'it's the economy, stupid'. For us, 'it's health, stupid'. The common-sense approach would be a totally harmonised all island health service. There should be no borders in health".



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