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EUROPEAN SOCIAL CHARTER

12th National Report on the implementation of
the European Social Charter

submitted by

THE GOVERNMENT OF IRELAND

Complementary information on Articles 3§4, 11§3, 13§1,
13§4; 14§1 (Conclusions 2013)

Report registered by the Secretariat on

12 December 2014

CYCLE 2015

2014 Ireland (12th) Report under the Revised Charter –

Health, Social Security and Social Protection

Article 3 – The right to safe and healthy working conditions

With a view to ensuring the effective exercise of the right to safe and healthy working conditions, the Parties undertake, in consultation with employers' and workers' organisations:

- 1. to formulate, implement and periodically review a coherent national policy on occupational safety, occupational health and the working environment. The primary aim of this policy shall be to improve occupational safety and health and to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, particularly by minimising the causes of hazards inherent in the working environment;*
- 2. to issue safety and health regulations;*
- 3. to provide for the enforcement of such regulations by measures of supervision;*
- 4. to promote the progressive development of occupational health services for all workers with essentially preventive and advisory functions.*

Article 3 - Right to safe and healthy working conditions

Paragraph 4 - Occupational health services

The Committee notes that the report submitted by Ireland does not provide any information on Article 3§4 of the Charter.

The Committee refers to its previous conclusion (Conclusions 2009) where it deferred its conclusion pending receipt of information on:

- the impact of the Health and Safety Authority's Workplace Health and Well-being Strategy on the development of health services in small and micro enterprises;
- the proportion of enterprises equipped with medical services or sharing them;
- whether the public authorities envisage encouraging the full development of occupational health services by other means than statutory requirements or the aforementioned Strategy.

Conclusion

The Committee concludes that the situation in Ireland is not in conformity with Article 3§4 of the Charter on the ground that it has not been established that the public authorities promote the progressive institution of occupational health services.

Response

There is no statutory requirement in Ireland on employers to provide access to occupational health services and there are no statutory plans to establish such services.

Larger organisations in both the public and private sectors may provide some occupational health services for employees. These services are provided on a full or part time basis depending on the number of employees and the employment sector. The services provided would include rehabilitation, absence management and health promotion.

Small and micro enterprises rarely provide occupational health services because of the cost. The 2008 Workplace Health and Wellbeing Strategy, produced by the Health and Safety Authority, recommended the development of a service delivery model that would support small and micro enterprises in implementing workplace health prevention, promotion and rehabilitation programmes including access to occupational health services. Appendix 1 contains an outline of the Occupational Health and Employee Assistance Services provided by the Health Service Executive which is Ireland's biggest employer.

Since the Sixth Report, there has been no progress made in developing occupational health services for small and micro enterprises.

It is not possible to give an accurate estimate of the number of companies and the proportion of employees that still do not have access to occupational health services in 2013, but it is highly likely that the majority do not.

There is no plan in place by the government, its agencies or private enterprise to improve the provision of such services for small and micro enterprise.

Article 11 – The right to protection of health

With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed inter alia:

- 1. to remove as far as possible the causes of ill-health;*
- 2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;*
- 3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.*

Article 11 - Right to protection of health

Paragraph 3 - Prevention of diseases and accidents

Ireland has submitted no information on Article 11§3 in its report.

The Committee refers to its previous conclusion (Conclusions 2009) where it held that the situation was not in conformity with the Charter on the ground that it had not been established that adequate measures were in place to prevent the risks arising from asbestos and that adequate measures were in place to prevent and reduce accidents.

The Committee reiterates its previous finding of non-conformity.

Conclusion

The Committee concludes that the situation in Ireland is not in conformity with Article 11§3 of the Charter on the grounds that:

- it has not been established that adequate measures are in place to prevent the risks arising from asbestos
- it has not been established that adequate measures are in place to prevent and reduce accidents.

Response

ASBESTOS

The placing on the market, supply and use of asbestos fibres of all types, and of products containing asbestos fibres, is now prohibited under the EU Registration, Evaluation, Authorisation and Restriction of Chemicals (REACH) Regulation. The restriction on asbestos fibres and products containing these fibres that applies in Ireland is contained in Annex XVII of the REACH Regulation.

The legislation prohibits the use, reuse, sale, supply, further adaptation etc. of materials containing asbestos fibres. The restriction conditions for asbestos fibres can be found in entry no. 6 of Annex XVII of the REACH Regulation, amended by Regulation (EC) No. 552/2009. The Health and Safety Authority is the lead Competent and Enforcement Authority for REACH in Ireland. Enforcement of REACH is facilitated under the Chemicals Acts 2008 and 2010. Further information on the REACH regulation can found on the REACH

webpages of the HSA website www.hsa.ie.

The Chemicals (Asbestos Articles) Regulations 2011 (“CAA”) (S.I. No. 248 of 2011), which came into operation on 31 May, 2011, specify how the Health and Safety Authority may issue a certificate to exempt an asbestos-containing article, or category of such articles, from the prohibition on the placing on the market of an asbestos-containing article provided for by Article 67 and Annex XVII of the EU REACH Regulation 1907/2006. The purpose of the CAA Regulations is to give effect to provisions laid down in the second subparagraph of paragraph 2 of Entry 6 (6.2.2) of Annex XVII to the REACH Regulation (see Regulation 552/2009). Under 6.2.2, Member States are allowed to decide whether or not to allow the placing on the market of second hand articles (i.e. articles installed or in service before 1st January 2005) containing asbestos fibres at a national level.

See more at:

http://www.hsa.ie/eng/Your_Industry/Chemicals/Asbestos/Legislation/#sthash.pbL1EKEu.dpuf

In addition, there is other relevant legislation which regulates the use and further restriction of asbestos and asbestos containing materials in Ireland. The Safety, Health and Welfare at Work (Exposure to Asbestos) Regulations, 2006 (S.I. No. 386 of 2006), amended by S.I. No. 589/2010, aim to protect the health and safety of all employees who may be exposed to dust from asbestos containing materials, during the course of their work activities. The regulations apply to all work activities and workplaces where there is a risk of people inhaling asbestos dust.

See more at:

http://www.hsa.ie/eng/Your_Industry/Chemicals/Asbestos/Legislation/#sthash.pbL1EKEu.VYVJqlgK.dpuf

Health and safety requirements for asbestos

Health and safety legislation govern the removal and disposal of asbestos¹ and the methodology adopted for the removal and disposal of asbestos in each case is specific to the risks identified and dependant on the type of asbestos. The Health & Safety Authority (HSA) is the appropriate body to contact with regard to the handling of asbestos. Significant information relating to the handling of waste asbestos containing materials is available from the HSA and queries concerning working with asbestos should be directed to the Health & Safety Authority (HSA).

In 2013, the HSA published comprehensive guidelines on ‘Asbestos-Containing Materials (ACMs) in Workplaces’. Section 17 of the Guidelines describes the management and disposal of ACMs and Appendix 2 addresses the management of asbestos-containing materials, including specific guidance on asbestos cement. This publication is available here: **[http://www.hsa.ie/eng/Publications and Forms/Publications/Chemical and Hazardous](http://www.hsa.ie/eng/Publications_and_Forms/Publications/Chemical_and_Hazardous)**

¹ http://www.hsa.ie/eng/Your_Industry/Chemicals/Asbestos/Legislation/

**Substances/Asbestos-containing Materials ACMs in Workplaces -
Practical Guidelines on ACM Management and Abatement.html**

Steps taken to detect the presence of asbestos in residential and public buildings

The Health and Safety Authority has responsibility for the regulation of health and safety in workplaces. In relation to privately owned residential properties, there are new responsibilities for homeowners where they plan to undertake construction related work. Duties on homeowners are contained in the Safety, Health and Welfare at Work (Construction) Regulations 2013 (S.I. No. 291 of 2013). These regulations require that the homeowner appoints project supervisors where there may be a particular risk such as asbestos. Further information can be found in the following HSA guidance document.

http://www.hsa.ie/eng/Publications_and_Forms/Publications/Construction/homeowners_guidance.pdf

Asbestos Waste

The primary responsibility for the management of any waste, including costs for removal or disposal, lies with the holder of the waste, i.e. the natural or legal person in possession of the waste, or the producer of the waste.

The provisions of the EU Waste Framework Directive (2008/98/EC) have been transposed into Irish law through the *Waste Management Act 1996 & S.I. No. 126 of 2011 (EU Waste Directive) Regulations*. The legislation places a duty of care on the producers of waste to ensure that the waste does not present a risk to human health or the environment.

In particular, regulation 32 of S.I. No. 126 of 2011 requires that;

(1) A person holding, treating or otherwise in control of waste shall ensure that waste management is carried out without endangering human health, without harming the environment and, in particular—

- (a) without risk to water, air, soil, plants or animals,
- (b) without causing a nuisance through noise or odours, and
- (c) without adversely affecting the countryside or places of special interest.

(2) A person who contravenes paragraph (1) shall be guilty of an offence.

(3) The Agency and the local authorities shall, in carrying out their respective functions under the Act of 1996, take the necessary enforcement measures to ensure that waste management is carried out in accordance with paragraph (1).

With regards the control of hazardous waste, Regulation 33 (1) of S.I. No. 126 of 2011 requires that it shall be the duty of waste producers and waste holders to ensure that the

production, collection and transportation of hazardous waste, as well as its storage and treatment, are carried out in conditions providing protection for the environment and human health.

In addition, in the case of hazardous waste, a holder of waste is required, without delay, to inform both the Local Authority concerned and the Environmental Protection Agency of any loss, spillage, accident or other development concerning that waste which causes or is likely to cause environmental pollution. Enforcement actions against illegal waste activity are a matter for the Local Authorities and the Office of Environmental Enforcement (OEE) within the EPA.

Section 32 of the Waste Management Act 1996 (as amended), also imposes a general duty of care on holders of waste.

Subsection (1) states that a person shall not—

- (a) cause or facilitate the abandonment, dumping or unauthorised management or treatment of waste, or
- (b) hold, transport, recover or dispose of waste, or treat waste, in a manner that causes or is likely to cause environmental pollution.

Section 32 also provides that it shall be the responsibility of the original waste producer or other waste holder to carry out the treatment of waste himself or herself or have the treatment handled by a dealer or an establishment or undertaking which carries out waste treatment operations or arranged by a private or public waste collector.

Furthermore Section 32 provides that the EPA, the local authorities and Dublin City Council shall take the necessary measures to ensure that, within their territory or area of responsibility, the establishments or undertakings which collect or transport waste on a professional basis deliver the waste collected and transported to appropriate treatment installations.

Waste technical requirements

Waste management, including the disposal of waste asbestos containing materials comes under the remit of the provisions of the Waste Management Act 1996 (as amended) and S.I. No. 126 of 2011 (EU Waste Directive) Regulations as referred to above.

Classification

Asbestos waste is classified as hazardous waste under European waste legislation, and a specific code applies to waste construction materials containing asbestos (EWC 17-06-05*).

Treatment/Disposal

Within the State, waste asbestos containing materials can only be disposed of at a waste facility licensed by the EPA. Currently however, there is no facility currently operational for the acceptance of asbestos for disposal in Ireland. Prior to any demolition work or remediation of materials containing asbestos, a hazardous waste transfer station licensed by the EPA should be contracted with a view to arranging to have the asbestos waste transferred for treatment/disposal at an appropriate facility abroad. Additional general information on asbestos, including information on disposal and hazardous waste transfer facilities can be obtained from the Environmental Protection Agency's website <http://www.epa.ie/waste/hazardous/asbestos/>

Transport

Asbestos waste must only be surrendered to a waste collection permit holder authorised under the Waste Management (Collection Permit) Regulations 2007, to collect this type of waste. Offaly County Council was appointed as the National Waste Collection Permit Office (NWCPO) and has been in operation from the 1st February 2012. NWCPO's role is to accept and process all new and review Waste Collection Permit applications for all Waste Management Regions in the Republic of Ireland. NWCPO also carry out additions and amendments to existing Waste Collection Permits. For further details, please refer to their website: <http://www.nwcpo.ie/>

As a hazardous waste, the movement of asbestos waste within the State is also subject to a notification procedure, and the European Communities (Shipments of Waste exclusively within Ireland) Regulations 2011 designate the National Transfrontier Shipment Office (NTFSO) in Dublin City Council as the sole competent authority for the administration of hazardous waste movements within Ireland. The NTFSO has set up an electronic tracking system in accordance with the provisions of these Regulations, and establishments or undertakings which produce collect or transport hazardous waste on a professional basis and consignees of waste containing asbestos are obliged to comply with the requirements of the NTFSO concerning the completion and use of waste transfer documents. Furthermore, the Regulations oblige a waste producer or waste holder to take appropriate steps to obtain documentary evidence that any consignment of hazardous waste which is moved on his or her behalf by a carrier is received by the relevant consignee.

The amount of asbestos which was notified, via the Waste Regulation Management System, as moving within the State during 2012 and 2013 was as follows:

2012 – 5,422 tonnes

2013 – 6,057 tonnes

Where asbestos waste is being transported, the Health and Safety Authority has a regulatory role in relation to the transport of asbestos containing waste by road in Ireland. The European Communities (Carriage of Dangerous Goods by Road and Use of Transportable Pressure Equipment) Regulations 2011 (S.I. No. 349 of 2011) as amended by S.I. No. 289 of 2013,

apply to the carriage of dangerous goods by road in tanks, bulk and packages, including the related packing, loading, filling and unloading of the dangerous goods. The 2011 and 2013 regulations give effect to the 2013 European Agreement Concerning the International Carriage of Dangerous Goods by Road (ADR). There are some exemptions for asbestos. See HSA information note:

http://www.hsa.ie/eng/Your_Industry/ADR_-_Carriage_of_Dangerous_Goods_by_Road/Information/Asbestos_by_road.pdf

The Transfrontier shipment of asbestos waste is also subject to control procedures under EU and national legislation, Waste Management (Shipments of Waste) Regulations, 2007. Further details on the rules applicable to the transport of hazardous waste such as asbestos can be found here:

[http://www.dublincity.ie/WaterWasteEnvironment/Waste/National TFS Office/Documents/FAQSWTF2011.pdf](http://www.dublincity.ie/WaterWasteEnvironment/Waste/National_TFS_Office/Documents/FAQSWTF2011.pdf)

ACCIDENTS

The Health and Safety Authority (HSA) was established in 1989 under the Safety, Health and Welfare at Work Act, 1989 and reports to the Minister for Jobs, Enterprise and Innovation.

The Mission of the Authority is to protect people from death, injury and ill-health arising from all work activities and chemicals.

The Authority has a number of major roles. These are:

- The national statutory body with responsibility for ensuring that approximately 1.8 million workers (employed and self-employed) and those affected by work activity are protected from work related injury and ill-health. This is effected by enforcing occupational health and safety law, promoting accident prevention, and providing information and advice across all sectors, including retail, healthcare, manufacturing, fishing, entertainment, mining, construction, agriculture and food services.
- The lead National Competent Authority for a number of chemicals regulations including the EU REACH (Registration, Evaluation, Authorisation and Restriction of Chemicals) Regulation and the Seveso II Directive. The responsibility in this area is to protect human health (general public, consumers and workers) and the environment, to enhance competitiveness and innovation and ensure free movement of chemicals in the EU market.
- A key agency involved in market surveillance and ensuring the safety of products used in workplaces and consumer applications. The Authority has a remit to protect 4.5 million citizens from unsafe products and articles and to enable the international movement and trade of goods manufactured in Ireland. In this regard it has a role in respect of EU Directives or Regulations relating to personal protective equipment, machinery, transportable pressure equipment and lifts, gas appliances, REACH, classification, labelling and packaging, and detergents
- Together with the roles outlined above, the Authority has responsibilities in the areas of transport of dangerous goods by road, control of major accident hazards, chemical weapons, and offshore installations.

The Authority works with key duty holders to ensure that they meet their legal obligations in relation to workplace health and safety and chemicals. It motivates and informs through providing a combination of promotion, information, inspection and enforcement.

The Authority's Strategic Priorities are to:

1. Enable enterprises to comply with their legal obligations in a practical and reasonable manner.
2. Achieve a high standard of compliance with safety, health and welfare and chemical laws.
3. Support the Minister in the development of a well-functioning, robust and proportionate regulatory framework.
4. Engage and work with people and organisations nationally and internationally to achieve our vision.
5. Be a high performing organisation delivering value to the Irish taxpayer.

There are a wide range of activities that fall under the remit of the Authority, including:

- Promotion of good standards of health and safety at work;
- Inspection of all places of work and monitoring of compliance with health and safety laws;
- Investigation of serious accidents, causes of ill health and complaints;
- Undertaking and sponsoring research on health and safety at work;
- Developing and publishing codes of practice, guidance and information documents;
- Providing an information service during office hours;
- Developing new laws and standards on health and safety at work.

The Health and Safety Authority has overall responsibility for the administration and enforcement of health and safety at work in Ireland. It monitors compliance with legislation at the workplace and can take enforcement action (up to and including prosecutions). In this regard, the Authority has a very broad mandate as set out in over two hundred Acts, Regulations and international conventions. A significant portion of these Acts and Regulations were initiated as a result of transposing European Directives. A full list of legislation administered and enforced, in whole or part, by the Health and Safety Authority is available at http://www.hsa.ie/eng/Legislation/List_of_Legislation/january_2014.pdf

The HSA is the national centre for information and advice to employers, employees and self-employed on all aspects of workplace health and safety. It also promotes education, training and research in the field of health and safety. It consults widely with employers, employees and their respective organisations, and it works with various advisory committees and task forces focusing on specific occupations or hazards, to help develop sound policies and good workplace practices.

The Authority employs inspectors, professional specialists, administrators and clerical staff, and staff numbers at the end of 2013 were approximately 162. In 2013, expenditure for the Authority was approximately €23 million.

A Programme of Work is published by the Authority each year, in which the efforts required to achieve its strategic priorities are outlined. Progress in the delivery of the programme of work and strategy and, in particular, progress in delivering on key performance indicators, is monitored regularly by the Board of the Authority and the Executive Team and updates are reported to the Minister.

Overview of Workplace Injury, Illness and Fatality Statistics in Ireland for 2012 -2013

The latest published statistics are available for the years 2012-2013 and are outlined below:

Non-fatal injury

There were 6,598 non-fatal injuries reported to the Health and Safety Authority in 2013. Of these injuries 6,394 (97%) involved workers, while the 202 involved members of the public, including family members. There was insufficient information in the other two cases to enable categorisation. There was a small decrease in the number of injuries reported to the Authority in 2013 compared to 2012. While the number of people in employment increased in 2013, the rate of reported injuries as a proportion of those in employment declined marginally, from 3.6 per 1,000 employed to 3.4 per 1,000 employed.

The Health and Social Work sector submitted 22% of the non-fatal injury reports to the HSA and the manufacturing sector accounted for 16% of reports.

The estimates based on the Central Statistics Office (CSO) survey module on work related accidents and illnesses suggest that 17,786 people experienced work injuries requiring an absence from work of four or more days in 2012, an increase from the 16,843 reported in 2011. Expressed as a rate of those employed, there was an increase in such injuries from 9.1 to 9.6 per 1,000 workers between 2011 and 2012. However some of this difference may be due to changes in the questionnaire, and it remains to be seen whether this is the start of an underlying upward trend.

The highest rates of injury causing four or more days absence from work (i.e. 4+ days) in 2012 occurred in Construction, the Health and Social Work sector, and the Agricultural sector, with rates of 16.7, 15.9, and 14.2 per 1,000 workers respectively. Including less serious accidents (0+ days absence) the injury rates were highest in Agriculture and Health (both 29 per 1,000) and Accommodation and Food sector and Transport and Storage sector (27 per 1,000).

Consistent with previous years, female workers had lower injury rates than male workers in 2012. The time series data suggest that male injury rates have declined more steeply than female injury rates. For all injuries (0+ days absence) the male injury rate fell from 38 per 1,000 in 2007 to 23 per 1,000 in 2012. For women the rate fell from 19 per 1,000 to 15 per 1,000 during the same time period.

Non-Irish national workers comprised 14.6% of the Irish workforce in 2013 and 16% of nonfatal injuries notified to the Health and Safety Authority in 2012 involved non-Irish national workers. Manual handling related injuries continue to account for about one third of all non-fatal injuries reported to the Authority. Slip, trip and fall incidents were the second

most common accident trigger (18%). Incidents involving aggression, fright, shock or violence accounted for 5% of the non-fatal injury reports to the HSA, such events were most common in the Health sector where they accounted for 15% of reported incidents.

Work Related Illness

The rate of illness causing four or more (4+) days absence from work has increased from 10.6 cases per 1,000 workers in 2011 to 14.8 in 2012. This was the fourth year in a row in which an increase in the illness rate was recorded. A study underway as part of the Health and Safety Authority/Economic and Social Research Institute (ESRI) research programme, will investigate the factors underlying these trends.

The three sectors with the highest illness rates in 2012 (0+ days lost) were Agriculture, Forestry and Fishing (47 per 1,000 workers), Information/Communication (41 per 1,000 workers) and Education (37 per 1,000 workers). Two of these differ from the three sectors with the highest illness rates in 2011, which were- Agriculture, Public Administration and Defence and Administration and Support Services. Women experienced a higher illness rate than men in 2012, 29 per 1,000 workers compared to 25 per 1,000 workers. This continues a pattern which emerged in 2011. Illness rates were also somewhat higher among older workers. The rate was 29 per 1,000 workers for those aged 55 to 64 compared to a rate of 25 per 1,000 workers for those aged 25 to 34 years.

Fatal injuries

There were 47 work-related fatalities reported to the Health and Safety Authority in 2013, compared to 48 fatalities in 2012 and 54 in 2011. Of these fatalities, 40 involved workers, giving a worker fatality rate of 2.1 workers per 100,000. This was lower than the 2012 rate (2.3) and the 2011 rate (2.6). The three-year rolling fatality rate has remained relatively stable since 2009 following a downward trend between 2006 and 2009.

The highest number of fatalities occurred in the Agriculture, Forestry and Fishing sector with 17 worker deaths recorded in 2013 with an additional 4 deaths of non-workers. This compares to 28 fatalities in the Agriculture, Fishing and Forestry sector in 2012. The fatality rate for workers in this sector for 2013 was 15.9 per 100,000 workers. This is considerably lower than the rate of 29.1 per 100,000 workers in 2012, 30.2 in 2011 and 30.5 in 2010. One reason behind this fall in the fatality rate is the significant rise in the number employed in the agricultural sector during 2013, this has the effect of increasing the denominator. The CSO cautions that this increase in the agricultural employment figures is uncertain and may be due to changes in the survey sample introduced post the 2011 Census (CSO, 2013). There were 11 fatalities in the Construction sector during 2013, one of which involved a non-worker. This translates into a fatality rate of 9.8 per 100,000 workers up from a rate of 6.9 recorded in 2012.

Similar to previous years, 22 of the fatalities in 2013 involved self-employed persons, including 15 farmers. The 65+ age group accounted for 8 of the fatalities (17%). Non-Irish nationals accounted for 20% of worker fatalities in 2013 (8 fatalities). The fatality rate for non-Irish national workers was 2.9 per 100,000 compared to the rate for Irish workers of 2.0 per 100,000 workers.

The latest European statistics on fatality rates refer to the year 2012. These figures, compiled by Eurostat, report a fatality rate of 2.7 per 100,000 workers for Ireland. This is the fifth

highest rate among the EU15 and is higher than the un-weighted average for the EU15 of 2 per 100,000 workers.

Further Information

More detailed analysis and background to these statistics is contained in a full report published by the Health and Safety Authority, and available at: http://www.hsa.ie/eng/Publications_and_Forms/Publications/Corporate/Stats_Report_2013_2012.pdf

EMERGENCY PLANNING

Emergency Planning in Ireland is structured around the “Lead Government Department” principle. There are currently 41 emergency types, each with a Lead Government Department (LGD). The Government Department that is responsible for an activity in normal conditions retains that responsibility during a major emergency. When an emergency occurs it is the responsibility of the relevant lead Government Department to chair the National Co-ordination Group (NCG) which deals with the relevant emergency.

The Department of Health is currently the LGD for two emergency types:

- Pandemic influenza & other public health emergencies
- Biological incidents (where incident is primarily a public health incident)

Infectious diseases falls under the emergency type - pandemic influenza and other public health emergencies which the Department of Health would be responsible for calling and chairing a meeting of the National Co-ordination Group should this be necessary to coordinate a ‘whole of Government’ response to issues arising from a health emergency relating to infectious diseases. The meeting would normally be chaired by the Minister and would include representatives from Government departments and state agencies.

Ireland is implementing EU Decision No 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious cross-border threats to health and repealing Decision No 2119/98/EC. This was agreed under the Irish Presidency, published in the Official Journal of the EU on 5 November 2013 and came into force the following day (6 November 2013).

The Decision provides a coherent framework for tackling all serious cross-border public health threats by:

- strengthening preparedness planning capacity at EU level by reinforcing co-ordination and sharing best practice and information on national preparedness activities;
- expanding the scope of the existing EU Early Warning and Response System to all serious threats to health;
- improving risk assessment for serious cross border threats that are not caused by communicable diseases but which are caused by threats of biological, chemical and environmental origin; and

- ensuring more effective coordination of national crisis responses in the event of a public health emergency.

It addresses 3 main areas: preparedness and response planning; risk monitoring and assessment; risk management and crisis communication. The Decision also includes provision for the Joint Procurement of medical countermeasures by EU member states.

The Network for the Surveillance and Control of Communicable Diseases was established by the European Parliament and Council Decision 2119/98/EC. The aim of the Network is to promote cooperation and coordination between the Member States, with the assistance of the European Commission, with a view to improving the prevention and control of communicable diseases in the Community. The Network includes an Early Warning and Response System (EWRS), which is formed by bringing into permanent communication with one another, through appropriate means, the Commission and the competent public health authorities in each Member State responsible for determining the measures which may be required to protect public health. Ireland is a participant in the EWRS.

Policy on Prevention of Smoking

Government policy on smoking is for Ireland to be tobacco free by 2025. This policy aims to reduce and eventually eliminate tobacco-related harm in the population, including preventable deaths, disability and ill health caused by tobacco use. A more detailed analysis of current government policy on tobacco is provided below under the heading tobacco policy.

Tobacco Policy

Tobacco Free Ireland

Smoking is the greatest single cause of preventable illness and premature death in Ireland. Smoking is the leading preventable cause of lung cancer, as well as contributing to ischaemic heart disease, stroke and chronic obstructive pulmonary disease. Each year at least 5,200 people in Ireland die from diseases caused by tobacco².

Tobacco Free Ireland, the report of the Tobacco Policy Review Group, was launched in October 2013. It builds on existing tobacco control policies and legislation already in place, and sets a target for Ireland to be tobacco free by 2025. In practice, this will mean a smoking prevalence rate of less than five percent. The two key themes underpinning the *Tobacco Free Ireland* are protecting children and the denormalisation of smoking. *Tobacco Free Ireland* addresses a range of tobacco control issues and initiatives and contains over 60 recommendations. *Tobacco Free Ireland* is the first policy document to be published under the *Healthy Ireland* framework.

² Howell, F. R & Shelley, E. (2011). Mortality attributable to tobacco use in Ireland. The Faculty of Public Health Medicine RCPI Winter meeting; Dublin.

Under the auspices of the *Tobacco Free Ireland* policy, Ireland is working on a range of legislative measures, the aim of which is to further reduce the numbers of people, young and old, smoking in Ireland. These include:

- Public Health (Standardised Packaging of Tobacco) Bill 2014
- Protection of Children's Health (Tobacco Smoke in Mechanically Propelled Vehicles) Bill 2014
- Legislation for the introduction of a licensing system and other measures in relation to the sale of tobacco products and non-medicinal nicotine delivery systems (including e-cigarettes).

Smoking Prevalence in Ireland

The cumulative effect of Ireland's tobacco control legislation to date has been a decrease in the number of people smoking. In 2013, the National Tobacco Control Office reported that 21.5% of Irish adults smoked (22.9% men and 20.2% women). This represents a decline of 2.2% since 2010, and a decline of 7.5% since 2007 when the last comprehensive large scale study on smoking prevalence in Ireland was undertaken (SLAN study)³. Smoking rates are highest among young adults (18-34 years) reaching 27% in the 25-34 years age group.

The Irish Health Behaviour in School-aged Children Survey⁴ (2010) found that 27% of children reported that they had ever smoked tobacco - a 9% decrease from the 2006 Survey. In the survey, 12% of children aged 10-17 reported that they were current smokers, a reduction of 9.2% since 1998.

An EU Commission Report published in 2012 (DG SANCO 2008/C6/046)⁵ estimated the cost to the Irish Exchequer of smoking attributable diseases, including an estimate of the costs of absenteeism and incapacity, as €664m in 2009.

Tobacco Control Legislation

Tobacco control experts in Ireland and internationally recognise that no one element in isolation can be effective in reducing tobacco consumption and moving towards a tobacco free society. The aim of tobacco control legislation already in place in Ireland, including the Public Health (Tobacco) Acts 2002 and 2004, is to protect people from the dangers of tobacco consumption and from second hand smoke.

Tobacco control measures already in place in Ireland include:

- A ban on sale of tobacco products to individuals under 18 years of age (2001)
- Work-place smoking ban (2004)
- A ban on packets containing less than 20 cigarettes (2007)
- A ban on the sale of confectionaries that resemble cigarettes (2007)
- A ban on the point of sale display and advertising of tobacco products (2009)

³ A new large scale population study is planned under the *Healthy Ireland* framework, looking at the areas of tobacco, alcohol, diet and exercise. Work on the new survey began in September 2014, with first results expected in 2015.

⁴ Testing is underway on the latest Health Behaviour in School-aged Children Survey; first results are expected in 2015.

⁵ http://ec.europa.eu/health/tobacco/docs/tobacco_liability_final_en.pdf

- A requirement for all tobacco products to be stored within a closed container which can only be accessed by the retailer (2009)
- A requirement for all retailers who wish to sell tobacco products to register with the National Tobacco Control Office (2009)
- A prohibition on self-service vending machines except in licensed premises or in registered clubs (2009)
- Combined text and photo warnings (graphic warnings) (2013)
- Social marketing and media campaigns, establishment of a National Smokers Quitline, social media and online cessation supports (on-going)
- Development of smoking cessation services (on-going)
- Nicotine Replacement Therapy available free to all medical card holders
- Increased excise duty on tobacco products (on-going)

Tobacco Pricing

In Budgets 2012, 2013 and 2014 the **excise duty on tobacco products was increased by 25 cent, 10 cent and 10 cent respectively**. Cigarette pricing controls in Ireland are part of a long-running and ambitious effort to decrease smoking prevalence. Evidence shows that pricing is a key tool in the efforts to control smoking and in particular preventing children and adolescents from taking up the habit. Cigarette prices in Ireland remain among the highest in the world (WHO MPOWER Report on the Global Tobacco Epidemic, 2011).

Policy on Prevention of Alcoholism

- 1) **For States that have accepted neither paragraph 1 nor paragraph 2, please describe the general public health policy and legal framework. Please specify the nature of, reasons for and extent of any reforms.**

Public Health (Alcohol) Bill

Alcohol related harm is a major public health concern. Alcohol is causing significant damage – to the individual drinker, the general population, the workplace and children in families.

Last October (2013), the Irish Government approved an extensive package of measures to deal with alcohol misuse, including the drafting of a Public Health (Alcohol) Bill. These measures were agreed on foot of the recommendations in the Steering Group Report on a National Substance Misuse Strategy. The recommendations in the Strategy are grouped under the five pillars of Supply Reduction (availability), Prevention, Treatment, Rehabilitation and Research.

The aim is to reduce alcohol consumption to the OECD average by 2020 (i.e. 9.1 litres of pure alcohol per capita) and to reduce the harms caused by the misuse of alcohol. In 2011 the average per-capita pure alcohol consumption for everyone over the age of 15 was 11.63 litres in Ireland.

The package of measures to be implemented will include provision for:

- minimum unit pricing for alcohol products;
- the regulation of advertising and marketing of alcohol;
- structural separation of alcohol from other products in mixed trading outlets;

- health labelling of alcohol products; and
- regulation of sports sponsorship.

Other Measures Agreed by Government

Public health messaging relating to alcohol will be based on grams of alcohol and weekly low-risk drinking guidelines should be 168 grams (17 standard drinks) and 112 grams (11 standard drinks) for men and women respectively.

The other measures (eg for the Health Service Executive (HSE), professional bodies etc) set out in the National Substance Misuse Strategy, were endorsed by Government and are to be progressed by the relevant departments and organisations.

Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the public health policy and the legal framework.

Work is continuing on the development of a framework for the necessary Department of Health legislation. It is hoped to publish a General Scheme of a Bill during the Autumn. The HSE has responsibility for implementing a number of recommendations in the National Substance Misuse Strategy and this is reflected in the HSE Service Plan for 2014. Letters have been issued to all Departments and Agencies identified as leads or participants requesting them to commence implementation of the recommendations.

A health impact assessment, in conjunction with Northern Ireland, was commissioned in 2013, as part of the process of developing a legislative basis for minimum unit pricing. The research studied the impact of different minimum prices on a range of areas such as health, crime and likely economic impact. The study should be finalised in the coming weeks.

Please supply any relevant statistics or other information on the percentage of smokers in the general population, trends in alcohol consumption and the rates of vaccination cover for infectious and epidemic diseases.

Trends in Alcohol Consumption

The Irish governments aim is to reduce alcohol consumption to the OECD average by 2020 (i.e. 9.1 litres of pure alcohol per capita) and to reduce the harms caused by the misuse of alcohol.

The average per-capita pure alcohol consumption for everyone over the age of 15 in Ireland was 11.63 litres in 2011, 11.60 litre in 2012 and 10.64 litres in 2013.

In 2013, the Health Research Board, on behalf of the Department of Health, conducted a survey which provides data personal consumption of, and expenditure on, alcohol among the population aged 18-75 years. Please see link to report attached.

http://www.hrb.ie/uploads/tx_hrbpublications/Alcohol_Consumption_in_Ireland_2013_web_version.pdf

Policy on Drug abuse prevention

Government policy in relation to drugs is set out in the National Drugs Strategy 2009-2016. The overall objective of the Strategy is to tackle the harm caused to individuals and society by the misuse of drugs.

Services for drug users in Ireland are provided within the framework of the National Drugs Strategy which takes a holistic approach to dealing with problem drug use through the five pillars of supply reduction, prevention, treatment, rehabilitation and research & information. The Strategy is coordinated by the Department of Health and outlines a series of 63 individual actions based on the five pillars. A partnership approach between statutory, voluntary and community sectors in addressing drug issues is an important dimension of the National Drug Strategy.

Periodic reviews of progress across the pillars of the Strategy are carried out through the Oversight Forum on Drugs, which is chaired by the Minister for Health, and these are posted on the Department's website.

Research carried out in 2010/2011 indicates that in Ireland 3% of the population aged 15-64 reported using illegal drugs in the month prior to the survey; 7% had used in the last year and 27% had used an illegal drug during their lifetime. The 27% lifetime prevalence was an increase from the 24% found in 2006/2007. Last year and last month use was highest for those aged 15-24 years at 15% and 6% respectively. Cannabis continues to be the most commonly used illegal drug with 25% of the adult population having ever used the drug.

The actions in the National Drugs Strategy are progressed by a range of Government Departments and agencies. Actions in relation to treatment and some actions in relation to prevention fall within the remit of the Department of Health from a policy point of view and within the remit of the Health Service Executive (HSE) in relation to management and delivery of services. The strategic objectives of the HSE Addiction Service, in line with the National Drug Strategy, are to provide, in conjunction with voluntary agencies, where appropriate, local treatment programmes. The local treatment programmes are service user focused and have a short-term objective of controlling the drug misuser's addiction and a long-term aim of returning the drug misuser to a drug free lifestyle. A comprehensive range of treatment services are provided, including: substitution treatment; psychosocial therapies such as cognitive behaviour therapy (CBT) and coping skills; and harm reduction services such as needle and syringe exchange.

There are approximately 14,500 known opiate users in Ireland and at the end of 2013 there were over 9,600 persons receiving methadone substitution treatment in accordance with the Methadone Treatment Protocol (MTP). Increases in the number of General Practitioners and pharmacists participating in the MTP and increases in the number of clinics providing the services throughout the country in recent years has made this treatment available to people in their own local area. Drug users with more complex issues are treated in the consultant led specialist clinic in the National Drug Treatment Centre in Dublin and those who achieve stabilisation on methadone are usually then transferred to the more local services.

The Report of the Working Group on Drugs Rehabilitation sets out the framework for a multifaceted approach to the delivery of rehabilitation. The National Drug Rehabilitation Implementation Committee (NDRIC), chaired by the HSE, is overseeing the implementation

of a National Drugs Rehabilitation Framework which is designed to assist services to plan and implement a range of different approaches to promote an integrated care pathway for former and current drug users. This framework is currently being rolled out nationally. More broadly, considerable advances are being made in the provision of drug treatment and rehabilitation. Opioid substitution treatment is more widely available and waiting lists are greatly reduced. More detoxification beds are available, as well as more places in rehabilitation programmes generally, with increasing focus on community-based detoxification. This work is being complemented by the refocusing of programmes to foster client progression (facilitated by individual care plans backed up by interagency working) and also greater provision of after-care to further assist clients as they move towards a drug free lifestyle where this is achievable.

In 2005 the Health Research Board was asked to establish a National Drug Related Deaths Index (NDRDI). This is jointly chaired by the Department of Health and the Department of Justice & Equality. The most recent report published in January 2014 details the number of deaths in the years 2004 to 2011 and is available on the HRB website (www.hrb.ie).

In Dublin robust needle exchange services are provided through HSE clinics and voluntary sector providers. Needle exchange services outside Dublin are being expanded through pharmacies and 129 pharmacies are currently providing such services. .

Primary Childhood Immunisation Schedule

Immunisation is regarded as one of the safest and most cost-effective of health care interventions. The importance of immunisation is acknowledged by all the major international health organisations, particularly the WHO.

Vaccines have had a major impact on the health of Irish children. Since the middle of the 20th century, serious disease such as smallpox, polio and diphtheria have become a thing of the past, while in recent decades, the burden of other vaccine preventable diseases such as pertussis, measles, meningococcal and Hib infections has been greatly reduced in Ireland.

The objective of the *Primary Childhood Immunisation Schedule* is to achieve a national uptake level of 95%, which is the rate required to provide population immunity and to protect children, and the population generally, from the potentially serious diseases concerned. Ireland's recommended immunisation programme is based on the guidelines of the National Immunisation Advisory Committee (NIAC).

National Immunisation Advisory Committee (NIAC)

The immunisation programme in Ireland is based on the advice of the National Immunisation Advisory Committee (NIAC), which was established by the Royal College of Physicians to advise the Minister and the Department, at the request of the Department. The advice of the Committee is informed by evidence based public health advice and international best practice.

Since its establishment in the late 1990's, NIAC has advised on significant changes to the childhood immunisation programme which have greatly improved the health of Irish children, including the introduction of Meningococcal C (Men C) and Hib vaccines, both

leading causes of meningitis in young people. Since the introduction of these vaccines, the incidence of meningitis caused by these bacteria has fallen dramatically.

NIAC guidance is published and distributed to all general practitioners and physicians involved in immunisation. The guide is designed to be simple and concise and does not claim to contain all information on any pharmacological material. It does, however, give current information and guidelines concerning immunisation as vaccines are continually evolving and the guidelines are updated regularly.

Article 13 – The right to social and medical assistance

With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake:

1. *to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;*
2. *to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;*
3. *to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;*
4. *to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953.*

Article 13 - Right to social and medical assistance

Paragraph 1 - Adequate assistance for every person in need

The Committee takes note of the information contained in the report submitted by Ireland.

Types of benefits and eligibility criteria

The Committee refers to its Conclusions 2006 for a description of the social assistance schemes available and notes that there have been no changes to the types of benefits and eligibility criteria: the Supplementary Welfare Allowance schemes provide differential flat-rate cash benefits for persons whose means are insufficient to meet their needs. In addition,

there is a range of different non-contributory schemes for specific categories of people with limited means, such as job-seekers, people with disabilities, widows and widowers, one parent families, low income farmers etc.

Level of benefits

To assess the level of assistance during the reference period, the Committee takes account of the following information:

- Basic benefit: according to MISSOC the basic monthly minimum allowance paid to a single person amounted to €849 in 2010 and €806 in 2011. The report indicates on the other hand that the weekly rates were respectively €196 in 2010 and €188 in 2011 (i.e. monthly €784 and €752).
- Additional benefits: MISSOC indicates that a rent supplement scheme provides short-term support to eligible people living in private rented accommodation, whose means are insufficient to meet their accommodation costs. The level of support depends on location of the rented accommodation and family size. Other available allowances are the Mortgage interest supplement (short-term support to eligible people living in accommodation owned by the claimant, the level of support depends on the level of mortgage interest payable), the Fuel allowance (€20 per week, payable for 32 weeks per year), the Smokeless Fuel allowance (€3.90 per week for 32 weeks per year – it may be paid in addition to a Fuel allowance).
- Medical assistance: persons fully dependent on a non-contributory minimum have full eligibility for health services.
 - Poverty threshold (defined as 50% of median equivalised income and as calculated on the basis of the Eurostat at-risk-of-poverty threshold value): it was estimated at €828 in 2010 (MISSOC). According to another source (Social Justice Ireland), the estimation for 2011 would be €741.

In the light of the above data, the Committee considers that the level of social assistance is adequate.

Right of appeal and legal aid

The Committee notes that there have been no changes to the situation which was previously found to be in conformity with the Charter (Conclusions 2006 and 2009).

Personal scope

The Committee noted in its previous conclusions (Conclusions 2006 and 2009) the "habitual residence" and "ordinary residence" conditions required to benefit respectively from social and medical assistance.

With regard to the social assistance, in the light of the information presented, the Committee concluded that Ireland satisfied the requirements of the Charter as concerns the granting of social assistance to legally resident foreign nationals.

As regards medical assistance, the Committee noted that any person "ordinarily resident" in Ireland (i.e. having resided or intending to reside at least one year) is entitled to full or limited eligibility for health services, and that Regional Health Boards have a discretion to provide medical treatment to those who do not qualify as "ordinarily resident". In this respect, the Committee asked how the Regional Health Boards exercise their powers in practice, whether guidance exists on this matter and whether any data exists as to the number of cases where medical assistance has been refused on the basis of a failure to satisfy the requirement to be

ordinarily resident. The Committee also asked for information on the nature and extent of urgent medical care granted to persons who are not ordinarily resident. Furthermore, the Committee asked to be informed about the developments concerning the legislative work under way on eligibility for and entitlement to health and personal social services. In the absence of a reply to these questions, the Committee does not find it established that foreign nationals, legally resident in Ireland, have adequate access to medical assistance.

Conclusion

The Committee concludes that the situation in Ireland is not in conformity with Article 13§1 of the Charter on the ground that it is not established that foreign nationals without resources, legally residing in Ireland, have adequate access to healthcare.

Response

Note please that regional health boards no longer exist – all references to same in legislation is now taken to refer to the local health manager.

As has been acknowledged above by the Committee the Health Service Executive (HSE) makes determinations on an individual's eligibility for health services on the basis of the person being 'ordinarily resident' in Ireland. The condition of being ordinarily resident differs to the habitual residence condition applied in respect of social services. A non-EU national should be regarded as “ordinarily resident” in Ireland if he/she satisfies the HSE that it is his/her intention to remain in Ireland for a minimum period of one year. Examples of the evidence which may be sought in this context include:

- proof of property purchase or rental, including evidence that the property in question is the applicant's principal residence;
- evidence of transfer of funds, bank accounts, pensions;
- work permits or visas, statements from employers etc.

Non-residents from other member states within the EU/EEA area are entitled to necessary healthcare in line with the EU Regulations where they satisfy the criteria that they are not insured in Ireland and are on temporary stay. This cohort is provided with healthcare which permits the person to continue their stay in Ireland or else until the person is well enough to return home. The treatment does not extend to non-urgent or elective treatment which can reasonably be postponed until they return to their own member state. Entitlement is granted by having a valid EHIC issued by another member state and although not resident here they are granted full eligibility. Hence the Health Service Executive (HSE) does not have to exercise its power in granting entitlement once it is determined by a medical practitioner that care is necessary.

Any other person lawfully present and not ordinarily resident are granted healthcare at the discretion of the local health manager (for an individual service when s/he considers this to be justified on hardship grounds) under section 45[7] of the Health Act 1970, to allow them to continue their stay in Ireland or else until the person is well enough to return home. The treatment does not extend to non-urgent or elective treatment which can reasonably be postponed until they return to their own country.

Those persons seeking asylum or who are resident in a direct provision centre are given medical cards for the period during which their application for refugee status is being

considered. If given refugee status, then the person is regarded as ordinarily resident and will come under the usual rules for entitlement to health services.

At an operational level, the provision of emergency medical care is through the utilisation of a "Generic Medical Card" which provides access to a GP and prescribed medications in emergency situations. Most of the emergency accommodation hostels/ facilities would have a Generic Medical Card. In addition, there are dedicated outreach G.P/ nursing services in the major cities, which have the capacity to respond to emergency medical care situations regardless of the status of those presenting. (see next section re paragraph 4 for emergency hospital care)

No data exists as to the number of cases where medical assistance has been refused on the basis of a failure to satisfy the requirement to be ordinarily resident.

<u>Social Assistance Payments –</u>	<u>Weekly Rates</u> €	<u>Weekly Rates</u> €	<u>Weekly Rates</u> €	<u>Weekly Rates</u> €	Decrease
	2011	2012	2013	2014	%
Jobseeker's Allowance Disability Allowance Farm Assist Supplementary Welfare Allowance					
Personal Rate	188.00	188.00	188.00	188.00	0%
Increase for qualified adult	124.80	124.80	124.80	124.80	0%
State Pension (Non-Contributory)	2011	2012	2013	2014	%
Personal Rate	219.00	219.00	219.00	219.00	0%
Increase for qualified adult	144.70	144.70	144.70	144.70	0%
Blind Person's Pension:	2011	2012	2013	2014	%
Personal Rate	188.00	188.00	188.00	188.00	0%
Increase for qualified adult	124.80	124.80	124.80	124.80	0%
Widow(er)'s (Non-Contributory) Pension, and One Parent Family Payment	2011	2012	2013	2014	%
Personal Rate	188.00	188.00	188.00	188.00	0%
Guardian's Payment(Non-contributory)	2011	2012	2013	2014	%
	161.00	161.00	161.00	161.00	0%
Carer's Allowance:	2011	2012	2013	2014	%
One Caree	204.00	204.00	204.00	204.00	0%
More than one Caree	306.00	306.00	306.00	306.00	0%

Respite Care Grant (Per Caree) annually	1700.00	1700.00	1375.00	1375.00	-19%
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Article 13 - Right to social and medical assistance

Paragraph 4 - Specific emergency assistance for non-residents

The Committee takes note of the information contained in the report submitted by Ireland.

In its previous conclusion (Conclusions 2009), the Committee noted that individuals seeking exceptional needs payments and urgent needs payments under the supplementary welfare allowance scheme are specifically exempted from the "habitual residence" condition. Both types of payments are also available to persons irregularly present. It asked what is the nature and extent of social and medical assistance provided in such circumstances. In this respect, the report indicates that exceptional needs payments concern items such as special clothing for seriously ill people, bedding or cooking utensils for someone setting up a home for the first time, costs related to funerals or visits to relatives in hospital or prison etc. Practice in relation to fuel bills is set out in the Code of Practice agreed between the Departments officials administering the Supplementary Welfare Allowance scheme and the electricity and gas energy supply companies. The report further indicates that exceptional needs payments are granted to assist people with one-off exceptional expenditure, therefore the rates vary depending on the type of assistance required. The Committee notes from Fundamental Rights Agency' studies of 2011 (Migrants in an irregular situation: access to healthcare in 10 European Union Member States; Fundamental rights of migrants in an irregular situation in the European Union) that irregular migrants are however not entitled to accommodation. The Committee asks what is meant in this regard by accommodation.

As regards medical assistance, the Committee notes from another source (Citizens Information Board website) that nationals of EU/EEA member states and Switzerland, visiting Ireland, are entitled to health services for conditions which become medically necessary during their stay, taking into account the nature of the health service and the expected length of stay. These services are provided free of charge through the public health system on production of a valid European Health Insurance Card (the costs are however not covered when the person travels to Ireland for the specific purpose of receiving health services). The Committee had previously noted (Conclusions 2006) that the Regional Health Boards can provide medical services at reduced rate or free of charge also to people who are not "ordinarily resident" in Ireland, including migrants in irregular situation, and who would

face undue hardship. In this respect, the Committee asked, under Article 13§1, how the Regional Health Boards exercise their powers in practice, whether guidance exists on this matter and whether any data exists as to the number of cases where medical assistance has been refused on the basis of a failure to satisfy the requirement to be ordinarily resident. The Committee also asked for information on the nature and extent of urgent medical care granted to persons who are not ordinarily resident. In the absence of a reply to these questions, the Committee does not find it established that all foreign nationals, legally or irregularly present in Ireland, have adequate access to emergency medical assistance.

Conclusion

The Committee concludes that the situation in Ireland is not in conformity with Article 13§4 of the Charter on the ground that it does not find it established that all foreign nationals, legally or irregularly present in Ireland, have adequate access to emergency medical assistance.

Response

Note please that regional health boards no longer exist – all references to same in legislation is now taken to refer to the local health manager.

In the majority of cases, emergency medical care is sought by the person presenting at an Accident and Emergency Department of a hospital. The Health Service Executive (HSE) provides that any non-EU\EEA persons who are not ordinarily resident in Ireland requiring emergency healthcare will be granted healthcare under section 45[7] of the Health Act 1970 at the discretion of the local health manager. Such discretion is not prescribed, however in practice, there is no question of urgent medical care being refused to persons who are not ordinarily resident and neither is distinction made as to whether the person is legally present or otherwise. The person presenting with an urgent medical need, as determined by a medical practitioner, is given the necessary treatment regardless of status in respect of being legally present. Consequently no data exists as to the number of cases where medical assistance has been refused on the basis of a failure to satisfy the requirement to be ordinarily resident – as such refusals do not occur. Denial of access to care for any group is not an option.

The level of care provided in such cases is such as is necessary to allow them to continue their stay in Ireland or else until the person is well enough to return home, The treatment does not extend to non-urgent or elective treatment which can reasonably be postponed until they return to their own country. However, treatment which a clinician considers as being immediately necessary, or urgent enough that it is not advised to wait until the person has returned to their home country, will always be provided without reference to whether or not that person is ordinarily resident or legally present.

The person's status regarding being ordinarily resident is however determined when it comes to the treatment provider's attempts to recoup the costs of the treatment provided, due to

those persons as described above being liable to be charged for the economic cost of treatment received. Section 45(7) of the Health Act 1970 provides discretion to the local health manager in determining if paying for the service provided will cause the person undue hardship. This does not mean that the treatment is provided free of charge. An appropriate charge is raised and hospitals must take reasonable steps to recover any such charge, but may, on direction of the local health manager, not actively pursue recovery of that charge where it is considered not to be cost effective to do so.

Emergency primary care

As set out above, at an operational level, the provision of emergency medical care is through the utilisation of a "Generic Medical Card" which provides access to a GP and prescribed medications in emergency situations. Most of the emergency accommodation hostels/facilities would have a Generic Medical Card. In addition, there are dedicated outreach G.P./nursing services in the major cities, which have the capacity to respond to emergency medical care situations regardless of the status of those presenting.

Irish legislation relating to social assistance schemes does not contain any nationality conditions, and applies equally to nationals and non-nationals.

Exceptional Payment Needs

An Exceptional Needs Payment is a single payment to help meet essential, once-off, exceptional expenditure, which a person could not reasonably be expected to meet out of their weekly income. For example, the payments can be for special clothing for a person who has a serious illness, bedding or cooking utensils for someone setting up a home for the first time, visiting relatives in hospital or prison, or funeral costs. You can also apply for financial help for clothing for children.

You may be eligible for an Exceptional Needs Payment to help you with the cost of a funeral if your income is low. Each case is decided on its merits by the Department of Social Protection's representative, at your local health centre.

You may get help with the cost of your electricity or natural gas bill but only in exceptional circumstances. The Department's representative will make a decision on your case using the Code of Practice on Fuel Debt.

Urgent needs payments

An Urgent Needs Payment may be paid to people in emergency situations. For example, in the case of a fire, flood or other disaster, you may get a payment to help with the immediate cost of food and clothing. Depending on your circumstances, for example, if you are working or when an insurance claim has been settled, you may have to pay some or all of this back at a later date.

Article 14 – The right to benefit from social welfare services

With a view to ensuring the effective exercise of the right to benefit from social welfare services, the Parties undertake:

- 1. to promote or provide services which, by using methods of social work, would contribute to the welfare and development of both individuals and groups in the community, and to their adjustment to the social environment;*
- 2. to encourage the participation of individuals and voluntary or other organisations in the establishment and maintenance of such services.*

Article 14 - Right to benefit from social services

Paragraph 1 - Promotion or provision of social services

The Committee takes note of the information contained in the report submitted by Ireland.

Organisation of the social services

The Committee refers to its previous conclusion concerning the description of the organisation of social services.

In its previous conclusion, the Committee asked for information on specific services for children and young persons. The report does not reply to this request. The Committee therefore reiterates its question. Should the next report not provide the information requested, there will be nothing to establish that the situation is in conformity with Article 14§1.

Effective and equal access

In its two previous conclusions, the Committee had asked about updated information on the fees for social services. The report does not reply to this request. The Committee therefore concludes that the situation is not in conformity with the Charter on the ground that it has not been established that there is an effective and equal access to social welfare services.

The Committee asks that the next report indicate, whether nationals of other States Parties to the Charter lawfully resident or regularly working in Ireland have the same entitlement regarding access to social services as citizens from Ireland, and if not what restrictions are applied.

Quality of services

Despite the request of the Committee, no statistics are provided on the total amount of annual spending on social services nor the total number of staff of all the social welfare services staff.

Given the lack of information on all these issues, the Committee concludes that the situation is not in conformity with the Charter on the ground that it has not been established that the quality of social welfare services meets users' needs.

The Committee asks whether there is any legislation on personal data protection.

Conclusion

The Committee concludes that the situation in Ireland is not in conformity with Article 14§1 of the Charter on the grounds that it has not been established that:

- there is an effective and equal access to social welfare services;
- the quality of social welfare services meets users' needs.

Response

As set out in the response to Article 13, Irish legislation relating to social assistance schemes does not contain any nationality conditions, and applies equally to nationals and non-nationals.

The Data Protection Act 1988, which applies to both the public and private sectors, gives effect to the Council of Europe Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data (Convention 108). Ireland ratified the Convention in 1990.

The Data Protection (Amendment) Act 2003 gives effect to the Additional Protocol to the Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data, regarding supervisory authorities and transborder data flows (No 181). Ireland ratified the Additional Protocol in 2009.

Local and Community Development Programme (LCDP)

The LCDP was introduced in January 2010. It replaced the Local Development Social Inclusion Programme and the Community Development Programme. It aims to tackle poverty and social exclusion through partnership and constructive engagement between Government and its agencies and people in disadvantaged communities. It is a key tool of Government in providing employment supports, training, personal development/capacity building and other supports for the harder to reach in the most disadvantaged areas in society. It is a locally accessible, frontline intervention, supporting disadvantaged communities.

The LCDP is underpinned by four high level goals:

- To promote awareness, knowledge and uptake of a wide range of statutory, voluntary and community services;
- To increase access to formal and informal educational, recreational and cultural development activities and resources;
- To increase peoples' work readiness and employment prospects; and
- To promote engagement with policy, practice and decision making processes on matters affecting local communities.

The objectives of the LCDP include the following:

- Develop and sustain a range of services to support, prepare and assist people to enter the Labour Market;

- Develop and sustain strategies with local enterprises to increase local employment prospects; and
- Develop and sustain strategies to increase local self-employment prospects.

Measures to provide services to children and young people focus on increasing awareness and supporting access to opportunities for education, recreational and cultural development. The uptake of formal educational opportunities for children, young people and adults includes pre-school, compulsory and post-compulsory accredited education or training, while informal opportunities include youth work and non-accredited post-compulsory education and training. Specific activities in the area of early childhood education include speech and language supports, play therapy and transition to primary school programmes. A range of initiatives are delivered to engage with those at risk of leaving school such as youth clubs/cafes, mental health programmes, guidance and counselling and youth leadership training. Sport and recreational activities are a popular method for engaging young people and to build trust and confidence amongst those involved. Most of the activities in this area combine sports/recreation with other personal development supports to enhance mental and physical wellbeing and participation in the community.

The LCDP officially ended at the end of 2013 having operated for four years with funding of €281m over that period. It is being implemented on a transitional basis for 2014 with a budget of €47m pending the roll out of a new Social Inclusion Programme in April 2015. As a key intervention for the harder to reach the new Programme (Social Inclusion and Community Activation Programme (SICAP)) will target the following groups:

- Children and Families from Disadvantaged Areas
- Lone Parents
- New Communities (including Refugees/Asylum Seekers)
- People living in Disadvantaged Communities
- People with Disabilities
- Roma
- The Unemployed (including those not on the Live Register)
- Travellers
- Young Unemployed People from Disadvantaged areas

In accordance with the Public Spending Code, good practice internationally, legal advice and in order to ensure the optimum delivery of services to clients; the new Programme, SICAP will be subject to a public procurement process. The public procurement process, which is currently under way, is a competitive process that is open to Local Development Companies, other not-for-profit community groups, commercial firms and national organisations that can provide the services to be tendered for to deliver the new Programme.

The proposals outlined in Putting People First - Action Programme for Effective Local Government seek to position local government “as the primary vehicle of governance and public service at local level – leading economic, social and community development,

delivering efficient and good value services, and representing citizens and local communities effectively and accountably”. As part of the programme of reform of local government, Local Community Development Committees (LCDCs) are being established in all local authority areas. These Committees, comprising public-private socio-economic interests, will have responsibility for local and community development programmes on an area basis including the SICAP. They will develop, co-ordinate and implement a more coherent and integrated approach to local and community development than heretofore, with the aim of reducing duplication and overlap and optimising the use of available resources for the benefit of citizens and communities.

Web links:

Local and Community Development Programme:

<http://www.environ.ie/en/Community/LocalCommunityDevelopment/>

The Seniors Alert Scheme

The Community Support for Older People (CSOP) Scheme was suspended in April 2009 to allow the Department an opportunity to review its operation. The Scheme changed from CSOP to the Seniors Alert Scheme in May 2010. The Seniors Alert Scheme provides grant assistance towards the purchase and installation of personal monitored alarms to enable older persons, of limited means, to continue to live securely in their homes with confidence, independence and peace of mind. The Scheme is administered by local community and voluntary groups with the support of the Department.

Year	Expenditure€
2009	2.13
2010	1.94
2011	2.43
2012	2.52
2013	2.33

Further information regarding the Scheme is available at:

<http://www.environ.ie/en/Community/SeniorsAlert/>

RAPID

The RAPID (Revitalising Areas by Planning, Investment and Development) Programme is a Government initiative, which targets 51 of the most disadvantaged areas in the country.

Further information on RAPID is available through this link.

Article 14 - Right to benefit from social services

Paragraph 2 - Public participation in the establishment and maintenance of social services

The Committee takes note of the information contained in the report submitted by Ireland.

In its last conclusion the Committee asked for the following information:

- information on the enactment of the draft legislation on charities and its content;
- the steps taken to foster user participation in the management of social welfare services;
- the monitoring of standards that apply to social welfare services' providers.

Given that the report contains no new information, the Committee concludes that the situation is not in conformity with the Charter on the ground that it has not been established that the quality of social services delivered by non state providers meets users' needs.

In the absence of information concerning the issue of discrimination, the Committee wishes to know whether and how the Government ensures that services managed by the private sector are effective and are accessible on an equal footing to all, without discrimination at least on grounds of race, ethnic origin, religion, disability, age, sexual orientation and political opinion.

Conclusion

The Committee concludes that the situation in Ireland is not in conformity with Article 14§2 of the Charter on the grounds that it has not been established that the quality of social services delivered by non state providers meets users' needs.

Response

The Charities Regulatory Authority (CRA) was established on 16 October 2014, under the terms of the Charities Act 2009. The CRA is an independent agency of the Department of Justice and Equality. Its functions under the Charities Act are as follows:

- (a) increase public trust and confidence in the management and administration of charitable trusts and charitable organisation
- (b) promote compliance by charity trustees with their duties in the control and management of charitable trusts and charitable organisations
- (c) promote the effective use of the property of charitable trusts or charitable organisations
- (d) ensure the accountability of charitable organisations to donors and beneficiaries of charitable gifts, and the public,
- (e) promote understanding of the requirement that charitable purposes confer a public benefit
- (f) establish and maintain a register of charitable organisations
- (g) ensure and monitor compliance by charitable organisations with this Act,
- (h) carry out investigations in accordance with the Act
- (i) encourage and facilitate the better administration and management of charitable organisations by the provision of information and advice, including in particular by way of issuing (or, as it considers appropriate, approving) guidelines, codes of conduct, and model constitutional documents,
- (j) carry on such activities or publish such information (including statistical information) concerning charitable organisations and trusts as it considers appropriate,
- (k) provide information (including statistical information) or advice, or make proposals, to the Minister on matters relating to the functions of the Authority.

The CRA also takes on the functions of the Commissioners of Charitable Donations and Bequests for Ireland.

The key priority of the CRA at present will be compiling the Register of Charities. Its other statutory functions will be introduced on a phased basis.

The website of the CRA is www.charitiesregulatoryauthority.ie.

Supports for the Community & Voluntary Sector

The Department of The Environment, Community & Local Government has lead responsibility for developing the relationship between the State and the Community and Voluntary Sector. This includes implementation of the White Paper on a Framework for Supporting Voluntary Activity and for developing the relationship between the State and the Community and Voluntary Sector.

The White Paper committed the Government to provide a range of funding measures to support the Community and Voluntary Sector. The new ‘Scheme to Support National Organisations (SSNO) in the Community and Voluntary sector’ commenced in 2008. The Scheme aims to provide multi-annual funding to national organisations towards core costs associated with the provision of services. The first Scheme ran until 2011, with the second scheme running until 30 June 2014. The current scheme commenced on 1 July 2014 and will run for a period of 2 years. Priority is given under this scheme to supporting national organisations which provide coalface services to disadvantaged target groups. Contracts were entered into with 55 national organisations and the estimated cost of the scheme is in excess of €8m over the 24 month period of the scheme.

In recognition of the challenges faced by the member organisations of the Community & Voluntary Pillar in contributing to the social partnership process, the Department also provides funding to the 17 member organisations of the C&V Pillar. Social Partners Funding allocation in 2014 is almost €600,000.

<http://www.environ.ie/en/Community/CommunityVoluntarySupports/SchemetoSupportNationalOrganisations/>

<http://www.environ.ie/en/Community/CommunityVoluntarySupports/SocialPartnership/>

Community Services Programme

The purpose of the Community Services Programme is to support non-governmental community businesses and social enterprises by funding local services and employment opportunities where public and private sector services are lacking, either through geographical or social isolation. The programme is a source of economic and social regeneration for local communities and enables the utilisation of community assets in the provision of quality services and employment opportunities to those who might otherwise be unable to access them. The programme supports the delivery of services under three broad categories:

- Management and Supervision of Community Halls and Facilities,
- Delivering Community Services, and
- Community Enterprises.

Expenditure across the Programme in the period 2009 – 2014 was approximately €45 million per annum. In 2014, some 405 contracts were operational with non-governmental organisations. The programme supports in the region of 2,800 employees in the provision of a broad range of services.

Further information on the Community Services Programme is available through this links:

<http://www.welfare.ie/en/pages/community-services-programme.aspx>

<https://www.pobal.ie/FundingProgrammes/CommunityServicesProgramme/Pages/CSP%20Home.aspx> or

APPENDIX 1

Occupational Health and Employee Assistance Services in the HSE

The health service is Ireland's largest employer with approximately 100,000 staff. One way in which the Health Service Executive ensures the effective exercise of the right to safe and health working conditions is through the provision of Occupational Health and Employee Assistance Services. In outline, the Health Service Executive has established Occupational Health Services to cover Dublin Mid-Leinster, Dublin North East, the South and West. Occupational Health (OH) Departments are generally based at major hospital sites giving direct, convenient access to large staff groups (e.g. Cork University Hospital, which has a staff of approximately 3500). These central locations are also accessible to staff from all Community Hospitals and Services. Voluntary Hospitals have similar, standalone OH services for staff. Some services also run satellite clinics at other locations.

OH Departments aim to promote and maintain the physical, mental and social well-being of employees, looking at how work and work surroundings may affect people's health and also how an employee's health may affect their ability to work. Occupational Health services are confidential, independent and provide an advisory service to managers, focussing on fitness for work. Where an employee presents with a work related condition it aims to assist the employee in regaining good health and returning to suitable work as soon as his or her recovery allows. Services can be accessed either through self-referral or management referral.

As mentioned OH is also a preventative, health-promoting service. It achieves these objectives through links with local Safety Committees, the monitoring of local occupational illness and injury trends, the provision of information and advice, pre-employment screening, employee health surveillance, statutory medicals and preventative measures such as immunisation screening, vaccination and the delivery of an annual flu vaccination campaign. Advice is also given in relation to the prevention of sharps injuries and post exposure management.

Occupational Health services are not a treatment facility and are not a substitute for the employee's General Practitioner. OH services seek to benefit both the employee and employer.

Occupational Health records are kept separate from all other health or personnel records, under the sole control of Occupational Health staff who are bound by professional and ethical codes of practice.

An Occupational Health Advisors Group (OHAG) has been established, with the purpose of facilitating the integrated and consistent delivery of OH services across the sector in line with best practice and international standards. The Group is representative of Occupational Health Physicians and Occupational Health Nurses from across the Health Service. Regular meetings take place to review and contribute to any changes or developments which affect the role of OH services in the health sector.

Within Ireland Professional Societies/Associations exist for both Occupational Health Physicians and Occupational Health Nurses.

In support of and complementary to OH services, staff also have access to Employee Assistance Services (Employee Assistance Programme).

The Employee Assistance Programme (EAP) provides a confidential counselling support and referral service for all employees with personal or work related difficulties. Advice and guidance is also available to managers in dealing with staff welfare issues. In addition the EAP provides formal structured support to groups of staff who have experienced stress reactions as a result of a critical incident in the work place. The service is provided by trained and experienced counsellors who are professionally qualified and bound by codes of conduct. The service is available to all employees for support with both personal and work-related concerns and is free of charge.

Finally, the Health Service has produced and continues to develop and review health and safety policy documents covering key risk areas and contributing to safe and healthy working conditions. The following list gives some examples of such policy documents:

- HSE Corporate Safety Statement
- Manual Handling and People Handling Policy
- Lone Working Policy and Guidelines
- Policy on the Prevention and Management of Latex Allergies
- Policy for the Prevention and Management of Stress in the Workplace
- Policy for Preventing and Managing Critical Incident Stress
- Dignity at Work Policy
- Policy on Management of Work Related Aggression and Violence