



05/10/09

RAP/RCha/IRE/VI(2009)

REVISED EUROPEAN SOCIAL CHARTER

6th National Report on the implementation of
the European Social Charter (revised)

submitted by

THE GOVERNMENT OF IRELAND

(Articles 3, 11, 12, 13, 14, 23 and 30
for the period 01/01/2005 – 31/12/2007)

Report registered by the Secretariat on 25 September
2009

CYCLE 2009

ÉIRE / IRELAND

SIXTH REPORT

ON THE IMPLEMENTATION

OF THE

REVISED EUROPEAN SOCIAL CHARTER

OF THE

COUNCIL OF EUROPE

SUBMITTED BY

THE GOVERNMENT OF IRELAND

IN RESPECT OF

THE ACCEPTED PROVISIONS OF

**ARTICLES 3, 11, 12, 13, 14,
23 and 30.**

FOR THE PERIOD

FROM 1st JANUARY 2005

TO 31st DECEMBER 2007.

TABLES OF CONTENTS

ARTICLE	PAGE
Article 3	3
Article 11	22
Article 12	59
Article 13	75
Article 14	89
Article 23	107
Article 30	122
List of Appended Material	139

CONFIRMATION OF COMMUNICATION OF COPIES

1. **Copies of this report have been communicated to the:**

Irish Congress of Trade Unions (ICTU)

And

Irish Business and Employers' Confederation (IBEC)

It is not yet known whether they will make any comments on the report or request that such are relayed to the Secretary-General.

ARTICLE 3: THE RIGHT TO SAFE AND HEALTHY WORKING CONDITIONS

ARTICLE 3, PARAGRAPH 1

“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 to:- formulate, implement and periodically review a coherent national policy on 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.”

Question asked of all Parties (Member States of the Council of Europe which have signed and ratified the Revised European Social Charter) :-

Please describe policy in the field of occupational safety, occupational health and the working environment and the measures taken to improve occupational safety and health and to prevent health and safety risks. Please describe also the measures of implementation of this policy as well as procedures for its periodic review and evaluation.

=====

Text of Ireland’s Sixth Report under the Revised European Social Charter in relation to Article 3, Paragraph 1 :-

Our response to the Question asked of all Parties :- Material provided by Health and Safety Policy Section, Department of Enterprise, Trade and Employment :-

- 3.1.1 Further to our detailed response in 2006, as part of the Government of Ireland’s Second Report to the Council of Europe under the Revised European Social Charter, which it is not proposed to repeat here, Ireland has enacted significant primary and secondary legislation since we last reported. The Chemicals Act 2008 came into operation in mid 2008 and while its purpose is outside workplace health and safety legislation, its effects should be positive – in improving workplace health and safety.
- 3.1.2 In the specific area of occupational health and safety, detailed Regulations have also been made to complement the Safety, Health and Welfare at Work Act 2005, including, inter alia, the Safety, Health and Welfare at Work (General Application) Regulations 2007. These new Regulations, which are designed to be user friendly, contribute towards the Irish Government’s “Better Regulation” agenda in that they include in one text virtually all of the specific safety and health laws which apply generally to all employments.
- 3.1.3 The 2007 General Application Regulations replace a range of earlier Regulations as well as re- transposing a number of EU Directives on occupational safety.

3.1.4 Ireland has also introduced individual sets of Regulations for the construction and quarrying sectors and Codes of Practice for agriculture and construction. These sectors have been identified as high risk in relation to occupational health and safety. Similar sector specific legislation is planned for other high risk areas. The introduction of sector specific legislation has helped focus both employers and employees on their responsibilities in respect to occupational health and safety with a view to reducing the levels of fatalities and accidents.

European Committee on Social Rights (ESCR) Conclusions, (2007) :- Comment in respect of our report under Article 3 Paragraph 1, Government of Ireland's Second Report to the Council of Europe under the Revised European Social Charter refers :-

3.1.5 The Committee asks for practical examples of the Authority's involvement in research and training on occupational health and safety. It also asks the next report to provide more comprehensive information on the content and implementation of the national policy on occupational health and safety, in particular:

- the main characteristics, lines or objectives of the country's policy on occupational health and safety;
- whether there are strategies for making occupational risk prevention an integral aspect of the public authorities' activity at all levels;
- the assessment of work-related risks and the introduction of preventive measures within individual firms, including the provision of information and training for employees; The Act provides that this is the responsibility of the employer to provide such training.....

Our Response

3.1.6 Practical examples of the Authority's involvement in research and training on occupational health and safety

a. Research

In 2008, the Health and Safety Authority commissioned research studies on a wide range of topics in line with its Programme of Work.

The following research projects were commissioned or completed in 2008:

- Analysis of differences between Irish national and non-Irish national workers in the construction sector;
- The Health and Occupation Reporting (THOR) Network in Ireland;
- Survey of chemicals usage in Irish workplaces;
- Evaluation of 'Choose Safety' secondary education module;
- Manual handling in the construction sector;
- Survey of work-related vehicle safety;
- Research on manual handling in construction commenced and is due for completion and publication in 2009.

In addition to the above, research and preparatory work was also carried out to explore options for the Authority in relation to intoxicants in workplaces. The Joint Prevention Initiative (JPI) with Teagasc also includes a Walsh Fellowship research project on Farmers Health.

b. Training

The Authority does not itself carry out training but in some areas it has an input into the design of training modules.

For example, a Construction Safety Partnership (CSP), launched in 1999, comprises representatives of the construction industry, professional bodies, trade unions, State agencies and Government Departments. Its overall aim is to achieve the highest possible standard of safety, health and welfare through a partnership arrangement with the main actors in construction in the Irish construction industry.

An achievement of the CSP is the Construction Safety Awareness Scheme, commonly referred to as the FÁS (Irish National Training and Education Authority) Safe Pass Scheme. Since its introduction in excess of 800,000 persons have received this training. This figure includes those who have done the refresher course after five years and also people whose work takes them on to sites but who are not site workers per se.

The purpose of this training is to ensure that, over the course of time, all workers in construction will have a basic knowledge of health and safety, and be able to work on-site without being a risk to themselves or others who might be affected by their acts or omissions. From a health and safety perspective, construction workers are bound by law to hold a valid Safe Pass card. With this background in mind the programme was developed in consultation with interested parties.

The training scheme is unique to Ireland – it is not provided for in the EU construction safety directive but it is a public policy measure in response to the dangers to workers safety which exist in the construction industry. The statistics show that since 2002, when Safe Pass became mandatory to work on construction sites, the fatality rate in construction has fallen from 11.0 per 100,000 workers to 5.0 in 2007.

The CSP was also a driving force behind the creation and introduction of the Construction Skills Certification Scheme (CSCS). Irish Construction Regulations named 14 specific tasks covered and made the possession of a valid CSCS registration card mandatory for the carrying out of any of those named tasks from 1st June 2003. The scheme was further extended by the 2006 and 2008 Construction Regulations to a total of 21, all of which require valid CSCS registration cards from 6th July 2009.

Another achievement for this construction partnership relates to the Safe-T-Cert certification scheme. This is an all-island safety certification scheme for contractors in the construction industry developed jointly by the Construction Employers Federation in Belfast and the Construction Industry Federation in Dublin and is a recognised system under both the Build Safe initiative in Northern Ireland and the CSP. Among the benefits of the scheme is assurance given to clients that certified contractors have an effective safety and health management system. Details of certified contractors will be listed on the Safe-T-Cert register which is available to public and private sector clients. A Joint Standards Advisory Panel (JSAP) including client bodies, professional bodies, Health and Safety Authority, Health and Safety Executive Northern Ireland, Trade Unions and contractors advise on the standards for certification. Certification is subject to an annual verification audit and after three years a full audit must be carried out for verification to be renewed. There is no

statutory requirement for contractors to have achieved Safe-T-Cert certification to engage in operations on a construction site.

The Department of Enterprise, Trade and Employment has provided funding to the CSP through the Authority including for the continuance of the Safety Representative Facilitation Project – a successful project, the mission of which is to promote co-operation between employers and workers and to spread the message that consultation with workers Safety Representatives is not alone a legal requirement for managers but can be used to positive advantage by site managers who are trying to encourage employee engagement with safe working practices. In excess of 1,700 Safety Representatives have been trained to date.

3.1.7 The main characteristics, lines or objectives of the country's policy on occupational health and safety;

The provisions of the Safety, Health and Welfare at Work Act 2005 require the Authority to submit to the Minister for his or her approval a 3 -year strategy statement specifying the key objectives, outputs and related strategies (including the use of resources) of the Authority. The Authority's current strategy statement 2007-2009 is available to download from its website - www.hsa.ie. The draft 2010-12 Strategy, which is currently being developed, has completed its public consultation process and is due to go to the Board of the Authority shortly before submission to the Minister.

The 2007-2009 Strategy is focused on two principal objectives:

- To persuade society, employers and employees of the need to put workplace safety at the core of everything they do.
- To enforce the 2005 Safety, Health and Welfare at Work Act through an inspection and investigation system which provides confidence for all stakeholders in the Authority's capacity to intervene with workplaces which are not safe.

The overall aim of the Strategy is to create a national culture of excellence in workplace safety, health and welfare for Ireland.

In addition, the Authority also works to a published Annual Programme of Work, which underpins its Strategy Statement and sets out its principle objectives and priorities for that year and its strategy for achieving those objectives.

All of the Authority's Programmes of Work up to and including 2009 are available to download from its website or by clicking on the following link – [HSA Corporate Publications](#)

The Health and Safety Authority's 2009 Programme of Work sets out a comprehensive range of activities to make workplaces safer and it contains a good balance between prevention, advice and enforcement.

During 2009 the Authority aims to:

Inspections

- Carry out 17,400 workplace inspections, of which 5,500 will be in the construction sector, 2,000 will be in the manufacturing sector and 1,500 will be in the agriculture sector.
- Focus on health and safety management during inspections, including safety statements, safety and health plans and, where relevant, codes of practice.

Agriculture and Fishing

- Support the work of the Farm Safety Partnership Advisory Committee and the implementation of its five-year action plan.
- Carry out 1,500 inspections in the agriculture sector, primarily focused on family farms. Focus inspections on the issues of child safety, machinery safety and slurry handling. Marts will also be inspected.
- Give advice on farm health and safety training and farm construction activities.
- Launch the Code of Practice for Fishing Vessels.

Construction

- Carry out 5,500 inspections on construction sites. During the inspection process, promote the use of the Code of Practice for Contractors with Three or Less Employees and all newly issued codes of practice and guidance in the sector.
- Continue to work actively with other organisations such as the Construction Industry Federation, Irish Congress of Trade Unions, Local Government Management Services Board and the Construction Safety Partnership to promote and foster safer workplaces.
- Continue to liaise with FÁS (the National Training and Employment Authority) and all relevant national stakeholders in relation to promoting site training and in the identification of future industry training needs, including Construction Skills Certification Scheme (CSCS) and Safe Pass initiative.
- Publish 'Clients in construction – best practice guidance'.

Quarries

- Carry out 750 inspections of quarries and an additional 20 of mines, focusing inspections on the safe use of plant, adequate edge protection, vehicle and pedestrian movement, use of explosives, and noise.
- Promote and provide information on the Quarries Regulations through the use of the guidance issued by the Authority in 2008.
- Support the work of the Quarries Safety Steering Committee in the running of the National Quarries Safety Seminar and the development of best practice approaches.
- Support FÁS in the development and take up of Quarry Safety Certificate Skills training within the quarrying sector.

Chemicals

- Meet its obligations as Competent Authority under the Chemicals Act 2008.
- Introduce the new Classification, Labelling and Packaging of Chemicals Regulations.
- Revise and update the Biological Agents Regulations and guidance.
- Introduce the revised Asbestos Regulations and publish guidance.
- Publish the updated Code of Practice for Chemical Agents.

Small and Medium Enterprises

- Produce a workplace health toolkit for small and micro companies.

Education

- Roll out the health and safety management system for post-primary schools on a national basis with the support of the Department of Education and Science.
- Engage with individual third-level institutions with a view to assisting them with the introduction of health and safety into existing and new courses.
- At primary school level, to implement Year 3 of the Junior Achievement 'Our Nation' programme and extend its pilot 'Keep Safe' project (last year: County Donegal) to another county and examine its feasibility on a wider scale.

The Authority regularly organises sectoral seminars or conferences to promote the occupational safety and health message, as part of its advocacy role e.g. the Authority's 2009 Work Positive Seminar which focused on sectors where occupational stress and absenteeism are a problem and its National Safety Representative's Conference, 2008. The Authority has also organised seminars and conferences aimed at the high-risk sectors of agriculture, quarries and construction throughout the reporting period.

The Authority publishes an Annual Report that contains information on the performance of the Authority's functions during the year having regard to the Authority's strategy statement and work programme.

The Authority also publishes in tandem with its annual report, its annual 'Summary of Workplace Injury, Illness and Accident Statistics' which presents statistical information on reported workplace incidents in a variety of different formats and is drawn from a number of sources including the Central Statistics Office's Quarterly National Household Survey (QNHS) and the Authority's own database. Again both are available from the Authority's website- www.hsa.ie or by clicking on the following link – [HSA Corporate Publications](#)

3.1.8 Whether there are strategies for making occupational risk prevention an integral aspect of the public authorities' activity at all levels

Under health and safety legislation, it is the employer's responsibility to manage and carry out a risk assessment. The processes involved in hazard identification and risk assessment form a very important part of the protective and preventive measures enshrined in the 2005 Act and are closely linked to the requirements on employers as regards safety statements.

The 2005 Act requires every employer to identify the hazards at the place of work, to assess the risks presented by those hazards and to have a written assessment of those risks as they apply to all of the employees and to any single employee and groups of employees who may be exposed to any unusual risks.

In carrying out the risk assessment, the employer must take account of health and safety laws which apply. The risk assessment must be reviewed and amended if necessary, at least annually or if it is no longer valid or if there has been a significant

change. Any improvements in safety, health and welfare identified as necessary from the most recent risk assessment, must be implemented by the employer.

The Authority has specifically targeted the local authority and health sectors in its programme to ensure occupational risk prevention in public authorities. The Authority has had a programme for some years now in relation to local authorities specifically in relation to risk prevention in the design, management and construction of road works and in refuse collection and recycling.

The Authority has prepared a strategic plan for addressing safety and health in the health sector and has put in place specialist staff to implement the strategy.

3.1.9 The assessment of work-related risks and the introduction of preventive measures within individual firms, including the provision of information and training for employees

In its 2008 Annual Report, the Authority stated that the assessment of safety and health management systems was completed on approximately 90% of inspections across all sectors. Inspectors considered indicators such as the level of awareness of safety and health responsibilities at director/owner level, the presence of a safety statement based on risk assessments, where required and the extent of the implementation of the control measures in the safety statement.

In 2008, the results of assessment of safety and health management systems indicated that 75% of employers had a safety statement prepared.

Inspectors recorded that 6% of employers were not aware of their responsibilities. The figures indicate that levels of awareness of safety and health responsibilities have continued to increase since the Authority began measuring this indicator in its inspection programmes in 2006.

**ARTICLE 3: THE RIGHT TO SAFE AND HEALTHY WORKING
CONDITIONS**

ARTICLE 3 PARAGRAPH 2

"With a view to ensuring the effective exercise of the right to safe and healthy working conditions, the Contracting Parties undertake, in consultation with employers' and workers' organisations: to issue safety and health regulations;"

=====

Questions asked of all Parties (Member States of the Council of Europe which have signed and ratified the Revised European Social Charter) :-

Question A

Please list the principal legislative or administrative provisions issued in order to protect the physical and mental health and safety of workers, indicating clearly:

- their material scope of application (risks covered and the preventive and protective measure provided for) and;
- their personal scope of application (whatever the legal status – employees or not – and whatever their sector of activity, including home workers and domestic staff).

Please specify the rules adopted to ensure that workers under atypical employment contracts enjoy the same level of protection as other workers in an enterprise.

Question B

Please indicate the special measures taken to protect the health and safety of workers engaged in dangerous or unhealthy work.

=====

Text of Ireland's Sixth Report under the Revised European Social Charter in relation to Article 3, Paragraph 2 :-

Our response to the Questions asked of all Parties :- Material provided by Health and Safety Policy Section, Department of Enterprise, Trade and Employment :-

Our Response to Question A

3.2.1 Further to our comprehensive 2006 material, (as part of the Government of Ireland's Second Report to the Council of Europe under the Revised European Social Charter), which it is not proposed to repeat here, as detailed earlier (sub-paragraph 3.1.7 above refers), in 2007 the General Application Regulations were made. These may be found on the website of the Health and Safety Authority is www.hsa.ie along with all legislation related to the area of occupation health and safety and chemicals.

3.2.2 As stated previously, occupational safety and health legislation extends to every employer, to every self-employed person and to workers in all sectors of economic activity. It also applies to members of the public who may be affected by work activity. The Irish legislation does not differentiate between atypical and other types of work contracts.

Our Response to Question B

3.2.3 Notwithstanding the above, as mentioned earlier, Ireland has also introduced individual sets of Regulations for the construction and quarrying sectors and codes of Practice for agriculture and construction - sectors which have been identified as high risk in relation to occupational health and safety. Similar sector specific legislation is planned for other high-risk areas. The introduction of sector specific legislation has helped focus both employers and employees on their responsibilities in respect to occupational health and safety with a view to reducing the levels of fatalities and accidents.

=====

European Committee on Social Rights (ESCR) Conclusions, (2007) :- Comment in respect of our report under Article 3 Paragraph 2, Government of Ireland's Second Report to the Council of Europe under the Revised European Social Charter refers :-

3.2.4 Article 3, Paragraph 2 – Issue of safety and health regulations

The Committee takes note of the information contained in the Irish report.

Protection of non-permanent workers

The report indicates that the duties falling on an employer as regards permanent employees apply equally to fixed term contract or temporary employees. The Safety, Health and Welfare at Work Act 2005 provides that workers on temporary and fixed term contracts receive appropriate information, training and medical surveillance and that they are not discriminated against in terms of occupational health and safety on account of their employment status. The employer must, prior to commencement of employment, give information to such employees relating to (i) any potential risks to the safety, health and welfare of the employee at work, (ii) health surveillance, (iii) any special occupational qualifications or skills required in the place of work, and (iv) any increased specific risks which the work may involve. The Act also requires an employer who engages the services of temporary employees to ensure that working conditions are safe for the period of time they spend with the employer.

Whilst bearing in mind this equal treatment of permanent and temporary employees by the law, the Committee notes from another source¹ that, although there are no conclusive statistics, a possible link between increased health and safety risks and

¹ Eironline, study on non-permanent employment, quality of work and industrial relations, on <http://www.eurofound.europa.eu/eiro/2002/02/study/tn0202101s.html>

non-permanent employment is observed in Ireland. The Committee asks the Government to comment on this in the next report, and to indicate if any additional measures (legislative, practical or other) are envisaged to take account of the needs of temporary workers in respect of occupational health and safety.

Personal scope of the regulations

The report does not indicate any changes in the situation, which the Committee previously considered to be in conformity.

=====

Our response

3.2.5 There is no strong evidence of increased risks to non-permanent workers in Ireland. The provisions of health and safety law apply to all workers. Therefore, special measures are not envisaged.

ARTICLE 3: THE RIGHT TO SAFE AND HEALTHY WORKING CONDITIONS

ARTICLE 3 PARAGRAPH 3

"With a view to ensuring the effective exercise of the right to safe and healthy working conditions, the Contracting Parties undertake, in consultation with employers' and workers' organisations: to provide for the enforcement of such regulations by measures of supervision."

Questions asked of all Parties (Member States of the Council of Europe which have signed and ratified the Revised European Social Charter) :-

Question A

Please indicate the methods applied by the Labour Inspectorate to enforce health and safety regulations and please also give information, inter alia, statistical, on:

- the places of work, including the home, subjected to the control of the Labour Inspection, indicating the categories of enterprises exempted from this control;
- the number of control visits carried out;
- the proportion of workers covered by these visits.

Question B

Please describe the system of civil and penal sanctions guaranteeing the application of health and safety regulations and also provide information on violations committed:

- the number of violations;
- the sectors in which they have been identified;
- the action, including judicial, taken in this respect.

Question C

Please provide statistical information on occupational accidents, including fatal accidents, and on occupational diseases by sectors of activity specifying what proportion of the labour force is covered by the statistics. Please describe also the preventive measures taken in each sector.

=====

Text of Ireland's Sixth Report under the Revised European Social Charter in relation to Article 3, Paragraph 3 :-

Our response to the Questions asked of all Parties :- Material provided by Health and Safety Policy Section, Department of Enterprise, Trade and Employment :-

Our Response to Questions A, B & C

3.3.1 Inspections are either carried out on foot of complaints, accidents or routinely by the Authority. The Authority prioritises complaints and injuries based on a number of factors including severity and conducts inspections based on risk profiling of individual sectors and based on the compliance history of individual organizations.

3.3.2 Details of health and safety inspections and of the enforcement of health and safety legislation for the reference period from 1 January 2006 to 31 December 2008 are shown in Appendices to the various individual Annual Reports, by accessing www.hsa.ie, clicking on 'Publications and Forms' click on 'Publications' and then choosing 'Corporate Publications' from the menu or by clicking on the following link – [HSA Corporate Publications](#)

3.3.3 In our previous 2006 Report, (as part of the Government of Ireland's Second Report to the Council of Europe under the Revised European Social Charter), we also set out the detailed provisions contained in the Safety, Health and Welfare Act 2005 with regard to, inter alia, powers of inspectors, directions for improvement plans, improvement notices, offences etc. and the Authority's Board. It is not proposed to repeat the details of those here.

=====

European Committee on Social Rights (ESCR) Conclusions, (2007) :- Comment in respect of our report under Article 3 Paragraph 3, Government of Ireland's Second Report to the Council of Europe under the Revised European Social Charter refers :-

3.3.4 Article 3, Paragraph 3 – Provision for the enforcement of safety and health regulations by measures of supervision

The Committee takes note of the information contained in the Irish report.

Occupational accidents and diseases

The Committee notes that the estimated number and rate of injury and illness are based on the Accidents and Illness module of the Quarterly National Household Survey (QNHS), conducted by the Central Statistics Office (CSO). Estimates for 2004 indicate that the rate of total injuries increased since 2002, from 24.3 injuries per 1,000 workers to 30.1 injuries per 1,000 workers in 2004. The Committee notes that the frequency of accidents in 2004 resembles the average in the European Union, 15 countries (the incidence rate of accidents at work in the EU calculated per 100,000 workers – not per 1,000 workers as in Ireland- was 3,221 in 2004). As regards occupational illnesses, the rate increased from 18.9 illnesses per 1,000 workers in 2001 to 31.3 per 1,000 workers in 2004.

As regards fatal accidents, there were 73 work-related fatalities reported in 2005. Of these, 64 were worker fatalities, representing a worker fatality rate of 3.2 per 100,000 workers. This represents an increase of over 25% on the fatality rate in 2004 (2.5 per 100,000 workers, which was also the average rate in the European Union that year).

The Committee takes note of the warning of the Central Statistic Office that data for injury or illnesses should be interpreted with care due to a data collection problem. They should be taken as a broad indicator but may be flawed. Moreover, the Committee notes from Eurostat that figures for Ireland on work accidents are missing and not comparable since 1998. For these reasons, the Committee is compelled to note that sufficient information enabling it to make a reliable and comparable assessment on the situation regarding the number and frequency of work accidents is not available. As this is the third consecutive report in which sufficient and reliable statistics on employment injuries is not provided and Ireland thus has not been able

to demonstrate that the situation is compatible with the requirements under Article 3§3 of the Revised Charter, the Committee can only conclude that the situation is not in conformity on this ground.

=====

Our response

3.3.5 The latest statistics regarding the number and frequency of fatal accidents are available in the Summary of Workplace Injury, Illness and Fatality Statistics 2007-08 which was published by the Health and Safety Authority in 2009 in tandem with the Annual Report. It is available electronically on the Authority's website or by clicking on the following link - [HSA Corporate Publications](#)

3.3.6 The CSO has not indicated that there is any data collection problem with current statistics beyond the normal warning that in relation to sectors employing small numbers there are difficulties in comparison. However, the estimates of total numbers themselves are conducted in accordance with best practice and are consistent year on year. The Authority does not agree that the data is not reliable or consistent.

3.3.7 In relation to the Eurostat requirements, Ireland has submitted a complete file of workplace injury data every year with the exception of one year (1999) when the accident and illness questions were not included in the annual labour force survey. The Authority has an excellent working relationship with staff in Unit F5 in Eurostat. Ireland would be interested to know the Committee's source of information in Eurostat so that the situation can be clarified for future reports.

European Committee on Social Rights (ESCR) Conclusions, (2007) :- Further Comment in respect of our report under Article 3 Paragraph 3, Government of Ireland's Second Report to the Council of Europe under the Revised European Social Charter refers :-

Activities of the Labour Inspectorate

3.3.8 The Committee examined the general framework of inspection services in Conclusions XIV-2 (pp. 391-393). The report indicates that the new Safety, Health and Welfare at Work Act 2005 empowers inspectors to enter any place he or she believes to be a place of work or believes may be used to store articles or substances or records and to enquire into, search, examine and inspect to ascertain if safety and health legislation is being complied with and to take along any necessary equipment or materials. The Committee asks the next report to indicate if any changes in the National Inspection system have taken place during the reference period.

Our response

GeoSmart

3.3.9 The development of the Authority's new Inspection Recording System – GeoSmart - was completed by the Authority in 2008 and went live in January

2009. The new system provides an integrated record of all inspections, enforcement actions, correspondence and reported incidents and customer contacts. One of its aims is to enable the Authority to better target inspections on less compliant employers and to provide targeting and research information. It is already driving efficiencies in the inspection process resulting in a more effective use of resources.

3.3.10 This large-scale award-winning project was completed on time and within budget and achieved full functionality. Quality control of the old recording system was maintained throughout the development of the new system and a critical exercise to migrate existing data to GeoSmart was completed successfully at the end of 2008. All of the Authority's inspectorate staff were trained in the GeoSmart application.

3.3.11 The Authority also operates an Inspection Process Development Unit, the objective of which is to ensure the effectiveness and optimum standard of efficiency of the inspection, investigation and enforcement processes of the Authority.

European Committee on Social Rights (ESCR) Conclusions, (2007) :- Further Comment in respect of our report under Article 3 Paragraph 3, Government of Ireland's Second Report to the Council of Europe under the Revised European Social Charter refers :-

3.3.12 To obtain a picture of the staffing resources and the number of inspections by the Health and Safety Authority the Committee has used data available from another source². In 2004, the number of staff assigned to occupational safety and health tasks in the authority was 115 persons (including 93 field inspectors).

3.3.13 The total number of inspection visits made during 2004 was 11,098. However, this information is not sufficient to assess compliance with this part of Article 3§3 of the Revised Charter. The Committee needs to know the proportion of workers covered by inspections compared with the total workforce. Given that this is the third consecutive report in which this information is missing, the Committee considers that the situation is not in conformity on this ground.

Our response

3.3.14 In 2008, the Authority carried out 16,000 workplace inspections and there was c. 2 million in employment. In 2007, the Authority had 112 staff in its Compliance Division including 95 compliance inspectors.

Estimated Worker Inspection figures for 2008

Size	Number inspected	No. of workers covered by inspection
------	------------------	--------------------------------------

² European Commission, 2004 National Labour inspections Annual Reports, in http://ec.europa.eu/employment_social/health_safety/slic_en.htm

Self Employed	1,398	1,398
1 to 9 Employees	9,030	36,120
10 to 49 Employees	3,800	91,200
50 to 249 Employees	1,077	133,548
250 to 499 Employees	159	59,466
500 or more Employees	151	37,750
Not Recorded	394	-
Total	16,009	359,482

3.3.15 Based on the above table, workplaces covering approximately 359,482 workers were inspected which is almost 18% of a workforce of two million.

3.3.16 As many of these inspections will have been to multi-site employers, the total number of workers covered will have been higher.

European Committee on Social Rights (ESCR) Conclusions, (2007) :- Further Comment in respect of our report under Article 3 Paragraph 3, Government of Ireland's Second Report to the Council of Europe under the Revised European Social Charter refers :-

3.3.17 As regards breaches to health and safety legislation, and penalties or sanctions imposed for such breaches, the Committee notes from the same source that in 2004 the inspection services imposed/proposed 232 on the spot fines (only for dangerous goods and vehicles). In 558 cases, activities were stopped under a Prohibition Notice, and 41 other cases were presented to the public prosecutor. Finally, the number of improvement notices issued was 573.

Conclusion

3.3.18 The Committee concludes that the situation in Ireland is not in conformity with Article 3§3 of the Revised Charter on the grounds that it has not been established that the number of work accidents is not excessively high or that workers covered by inspections is adequate.

Our response

3.3.19 Recently published Eurostat figures for 2006, also contained in the Authority's Summary of Fatality, Injury and Illness 2007, indicates that Ireland continued to perform well in comparison to other EU Member States, with regard to the rate of 4+ day injuries in the EU. Ireland had the 3rd lowest rate in the EU per 100,000 workers.

3.3.20 Ireland also made a significant improvement in its workplace fatality rate for 2006 compared to 2005. A drop from 3.1 to 2.2 per 100,000 workers now sees Ireland placed 7th lowest in the EU 15 from 11th lowest in 2005.

3.3.21 In terms of inspections, coverage of almost 20% of the workforce, which focuses primarily on the high risk sectors, is regarded as a satisfactory level of coverage.

ARTICLE 3: THE RIGHT TO SAFE AND HEALTHY WORKING CONDITIONS

ARTICLE 3 PARAGRAPH 4

“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: to promote the progressive development of occupational health services for all workers with essentially preventive and advisory functions”.

Questions asked of all Parties (Member States of the Council of Europe which have signed and ratified the Revised European Social Charter) :-

Question A

Please indicate whether occupational health services (health, security and occupational health services) exist in all companies and in all sectors. If not, please state whether plans have been made to establish them, when they will be implemented in practice and/or whether provision is made for inter-company services.

Question B

Please describe the functions, organisation and operation of occupational health services.

=====

Text of Ireland’s Sixth Report under the Revised European Social Charter in relation to Article 3, Paragraph 4 :-

Our Response to Question A

3.4.1 As we stated in our previous report to the same question, (as part of the Government of Ireland’s Second Report to the Council of Europe under the Revised European Social Charter), there is no statutory requirement on employers in Ireland to provide access to occupational health services and there are no statutory plans to establish such services.

3.4.2 The Health and Safety Authority’s Workplace Health and Wellbeing Strategy was published in 2008. The objective of this National Strategy is to raise awareness of the importance of the health and well-being of our working age population and to recommend actions that will improve worker health.

3.4.3 Large employers are likely to have greater capacity to provide workplace health promotion activities and occupational health services to their employees than small and micro enterprises. As a result, employees in smaller workplaces may be more reliant on other primary care services. To help address this issue, the Strategy has specific recommendations for small and micro enterprises. The Strategy is available to download from the Authority’s website www.hsa.e or by clicking on the following link - [HSA Corporate Publications](#)

3.4.4 As also mentioned previously, the construction sector through a union funded scheme has set up the Construction Workers’ Health Trust, whereby nurses visit construction sites and provide health screening and advice on health promotion activities to workers. However, this tends to be limited to larger sites.

Our Response to Question B

3.4.5 We have nothing further to add to the material supplied on this question in 2006 (as part of the Government of Ireland’s Second Report to the Council of Europe under the Revised European Social Charter).

European Committee on Social Rights (ESCR) Conclusions, (2007) :- Comment in respect of our report under Article 3 Paragraph 4, Government of Ireland’s Second Report to the Council of Europe under the Revised European Social Charter refers :-

3.4.6 Paragraph 4 – Occupational health services

The Committee takes note of the information in the Irish report.

The Committee notes there is no statutory requirement in Irish law to provide occupational health services, and that such services do not exist in all companies and in all branches of economic activity. Some large private companies and many public sector organisations have occupational health services, but the majority of small (10 to 49 employees) and micro (1 to 9 employees) companies do not. However, the workplace health and wellbeing strategy which is currently being drafted in Ireland will recommend the provision of such services, especially to small and micro enterprises.

The report states that larger companies (especially the multinationals) normally have a team including an occupational physician, occupational health nurse, ergonomist and possibly a work psychologist. In addition, such companies normally have an occupational hygienist. Medium size companies tend to provide such services on a part time basis, mainly by using occupational health nurses carrying out health screening and health promotion activities a couple of days a week. The company has a contract with an occupational health practice that will place a nurse with a company for a day(s) per week to provide a range of services.

The Committee recalls that under Article 3§4 occupational health services should be progressively established for all enterprises. It therefore asks the next report to indicate what is the estimated number of companies and the proportion of employees that still do not have access to occupational health services.

The Committee points out that, under the appendix to Article 3§4, states party may determine the functions, organisation and conditions of operation of occupational health services by national laws or regulations, collective agreements or other means appropriate to national conditions. As the report states there are no plans to establish occupational health services under a statutory requirement, the Committee asks whether the authorities envisage to encourage the full development of occupational health services by other means, besides the abovementioned workplace health and wellbeing strategy.

Pending receipt of the information requested, the Committee defers its conclusion.

Our response to the ECSR

3.4.7 Many small and micro sized enterprises are at a distinct disadvantage in terms of resources and competence if called upon to support and implement programmes in relation to workplace health.

3.4.8 Many employees of small and micro enterprises do not have access to occupational health services. To help address this issue, this Authority's Workplace Health and Well-Being Strategy published in 2008 has specific recommendations for small and micro enterprises. It aims to –

- Develop a service delivery model that will support small and micro enterprises in implementing workplace health prevention, promotion and rehabilitation programmes.

- Develop a support service such as the UK's Workplace Health Connect.
- Establish a structure that facilitates such support. The model of the Construction Workers Health Trust (CWHT), which provides health assessment and screening, merits extension within the construction and other sectors.

ARTICLE 11: THE RIGHT TO PROTECTION OF HEALTH

General aspects (in respect of all of Article 11)

Question A

Please indicate the forms of ill-health which at present raise the greatest public health problems in your country by reason of their frequency, gravity and any sequels. Please indicate what illnesses were the main causes of death.

Question B

Please describe the measures aimed at ensuring universal access to health care. Please also indicate on what conditions the various health services are made available to the whole of your country, describing the geographical distribution of these services.

Question C

Please indicate how public health services are organised in your country and state, if possible:

1 States having accepted one or more paragraphs of Article 11 are invited to respond to the questions under this heading.

2 If the statistical information requested under this provision is available from publications of Eurostat, WHO or OECD you are invited to refer to the relevant publication.

- a. the number of private or public preventative and screening clinics (if possible distinguishing between general or specialised, particularly in the fields of tuberculosis, sexually transmitted diseases, AIDS, mental health, mother and child welfare, etc.) and the annual attendance of them making special mention of services for schoolchildren;
- b. the regular health examinations arranged for the population in general or for a part thereof, and their intervals;
- c. the number of general hospitals and public or private establishments for specialised treatment (especially for tuberculosis, psychiatry – including day hospital –, cancer, after-care, functional and occupational rehabilitation). Give the respective proportions of public and private establishments. Please indicate the number of beds available (or of places in case of day hospitals or rehabilitation clinics accepting out-patients);
- d. the number per 1 000 persons of doctors, dentists, midwives and nurses, indicating if possible, the situation in urban and rural areas;
- e. the number of pharmacies per 1 000 persons and if possible their geographical distribution;
- f. Please indicate the percentage of GDP allocated to health expenditure.

=====

Text of ARTICLE 11 PARA. 1 of the Revised European Social Charter

"With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed inter alia: to remove as far as possible the causes of ill-health."

=====

Questions asked of all Parties (member states of the Council of Europe, which have signed and ratified the Revised European Social Charter):

Question A

Please indicate infant and perinatal mortality rates for the reference period concerned.
Please indicate the life expectancy at birth in your country.

Question B

Please describe any special measures taken to protect the health of:

- a. pregnant women, mothers and babies;
- b. children and adolescents;1
- c. the elderly;
- d. disadvantaged persons or groups (for example the homeless, families with many children, drug addicts and the unemployed, etc.).

Please supply information on all measures taken to protect the reproductive health of all persons, in particular adolescents.

=====

Text of Ireland's Sixth Report under the Revised European Social Charter in relation to Article 11, Paragraph 1:

Material provided by the Department of Health and Children :-

11.1.1 Further to our detailed response in 2006, as part of the Government of Ireland's Second Report to the Council of Europe under the Revised European Social Charter,

which it is not proposed to repeat here, this is the current position of Ireland's health services.

How health services are organised in Ireland

11.1.2 Basic architecture

The Irish health system is a mix of both public and private institutions and funders. It is primarily tax-financed.

The system has been undergoing major changes as part of the Health Service Reform Programme, which was approved by Government in June 2003. The Reform Programme outlined a range of reforms to help deliver a more responsive, adaptable health system that meets the needs of the population effectively and at an affordable cost. The underlying principles of the Reform Programme are:

- Improved patient care
- A new national focus
- Reduction in fragmentation
- Improved budgetary and service planning

The Reform Programme comprises a range of reforms to help modernise the health services to better meet the needs of patients. The reforms are designed to achieve a health service that provides high quality care, better value for money and improves health care management.

The main elements of the Reform are: structural reform, legislation, modernisation and improvement coupled with increased investment and enhanced governance and accountability.

The main structural reforms included the rationalisation of health service agencies to reduce fragmentation, the establishment of the Health Service Executive (HSE) as a single national entity to manage the health services, restructuring of the Department of Health and Children and the establishment of the Health Information and Quality Authority (HIQA).

11.1.3 Establishment of the HSE

The Health Service Executive (HSE) was formally established on 1 January, 2005 under provisions of the Health Act 2004. The HSE is tasked with delivery of health and personal social services through a single national structure.

The gross provision for the Health Service Executive in 2008 was €14,337 million revenue and €594 million capital. The challenge is to transform this investment into tangible benefits for patients and staff so as to deliver the world class health service that everyone wants and that this level of investment warrants.

The reform agenda has to be supported by structural change in the health system, as well as by improved management actions and changed work practices in providing services to patients. This change is happening on a number of fronts such as the first full modernisation in 30 years in the Medical Council and the regulation of doctors, the modernisation of the law regulating the pharmacy profession and health and social

care professions, putting in place a fundamental new contract for consultants for the first time in 30 years. The establishment of HIQA and setting standards progressively that will be monitored and implemented is also a crucial development in achieving excellence in health care settings.

The HSE is making progress in the integration of a large number of health sector agencies, in setting and implementing consistent performance standards, and in improving patient care across many different service areas. The HSE endeavours to make constant and continuous improvement and has recently agreed a new management structure to ensure continued efficient provision of a patient-centred health service.

11.1.4 Basic players

The Department of Health and Children was restructured in 2005 to focus more clearly on policy, legislative and oversight functions, with executive functions gradually being transferred to the HSE. The Office of the Minister for Children was created in November 2005 to bring together functions of the Department of Health & Children, the Department of Justice, Equality and Law Reform and the Department of Education and Science related to the welfare of children. In January 2007, the Office of the Minister for Older People and the Office of the Minister for Disability and Mental Health were created within the Department. These two Offices were created along similar lines to the Office of the Minister for Children in order to bring greater cohesion to structures across the public service supporting older people and those with mental health or disability issues.

The Health Act 2004 and the establishment of the HSE in 2005, allowed the separation of roles of policy making and service delivery. Since then, the Department of Health and Children has continued to divest itself of involvement in the operational delivery of health and personal social services. It is now responsible for supporting the Minister and the overall organisational, legislative, policy and financial accountability for the health sector.

The Health Service Executive (HSE) has responsibility for delivery of health and personal social services on a national basis. A single national system for healthcare delivery facilitates clear accountability structures and the use of modern financial management systems which allow key decision makers in the health service to link activities with budgets and thus to evaluate the effectiveness of their decisions. A good working relationship between the Department and the HSE is central to the Reform Programme and both the Department and the HSE are separately accountable to the Oireachtas (the Irish Parliament) for funds allocated to them.

11.1.5 Financing of the health care system in Ireland

The public money spent on health comes from funds raised primarily through general taxes.

A relatively small portion of overall funding comes from a specific levy on income which goes on a dedicated basis to the health services. This health contribution is levied on income at a percentage rate set in pursuance of the Health Contributions Act and is paid over to the Minister for Health and Children through the annual allocation

for the Health Service Executive. The current rate of contribution is 2% of gross income up to € 1,925 per week or €100,100 per annum and 2.5 % on the balance of income in excess of those amounts in a contribution year. Subject to exemptions, the rate of contribution is applicable to all persons over the age of sixteen with reckonable income, earnings or emoluments. There are a number of exemptions to the payment of the health contribution.

11.1.6 Entitlement to health services

Entitlement to health services in Ireland is primarily based on residency and means. Any person, regardless of nationality, who is accepted by the Health Service Executive (HSE) as being ordinarily resident in Ireland is entitled to either full eligibility (Category 1, i.e. medical card holders) or limited eligibility (Category 2) for health services.

Persons in Category 1 are medical card holders and they are entitled to a full range of services including general practitioner services, prescribed drugs and medicines, all in-patient public hospital services in public wards including consultants services, all out-patient public hospital services including consultants services, dental, ophthalmic and aural services and appliances and a maternity and infant care service (see further information below). Determination of eligibility for medical cards is the responsibility of the Health Service Executive and further information can be found on the HSE's website http://www.hse.ie/portal/eng/Find_a_Service/entitlements/Medical_Cards/.

Persons not entitled to a medical card, but with an income below a certain threshold may be entitled to a GP visit card. A GP visit card entitles the holder to free GP services. For those who do not qualify for a medical card, a number of schemes exist which provide assistance towards the cost of medication. Under the Drug Payment Scheme a person and his/her dependants do not have to pay more than €100 in any calendar month for approved prescribed drugs, medicines and appliances.

Persons in Category 2 (non medical card holders) are entitled, subject to certain charges, to all in-patient public hospital services in public wards including consultant services and to out-patient public hospital services including consultant services. The current public hospital statutory in-patient charge is €75 per night, up to a maximum of €750 in any twelve consecutive months. There is no charge for outpatient services, other than in respect of attendance at accident and emergency departments which is subject to a charge of €100 where the patient does not have a referral note from his/her doctor.

The maternity and infant care scheme provides an agreed programme of care free of charge to all expectant mothers who are ordinarily resident in Ireland. This service is provided by a family doctor (GP) of your choice and a hospital obstetrician. The GP who attends the mother also provides care for the new-born baby. This entails two developmental exams during the first 6 weeks following the birth.

The Department of Health and Children has commenced work on a new legislative framework to provide for clear statutory provision on eligibility for and entitlement to health and personal social services. This is in keeping with a commitment first

signalled in The National Health Strategy 2001 and more recently in Towards 2016 (the ten year social partnership agreement 2006-2015 agreed in 2006). The purpose of the review is to clarify and simplify eligibility and entitlement to health and personal social services within the broad parameters of the existing system and to reflect developments in service delivery and technology that have occurred since the Health Act 1970.

11.1.7 Private health insurance

About a half of people in Ireland have also significant private health insurance primarily for accessing hospital services. The legislation requires insurers offering health insurance to comply with the principles of community rating, open enrolment and lifetime cover.

People can also claim tax-relief on medical expenses that are not covered by the State or by private health insurance. Those with private health insurance also get tax credits at the standard rate, which are passed directly on to the insurance company and lower the customer's premium.)

A number of companies offer voluntary private health insurance in Ireland (Voluntary Health Insurance Board (VHI) is the largest provider; it is a statutory body whose board is appointed by the Minister for Health and Children). Health insurance is used to pay for private care in public or private hospitals or from various health professionals in hospitals or in their practices.

The Health Insurance Authority is the independent statutory regulator for the private health insurance market in Ireland. The Authority aims to ensure that consumers are aware of their rights; that policies and publicity material describe cover in a fair and comparable way and that community rating, open enrolment and lifetime cover requirements are met by the insurers. One of the Health Insurance Authority's primary functions relates to the operation of a Risk Equalisation Scheme. Risk equalisation is a process that aims to equitably neutralise differences in insurers' costs that arise due to variations in the health status of their members. This process is relevant to the customer in so far as it may affect matters such as the operation of community rating or competition between insurers. The Authority maintains the register of insurance companies that are entitled to offer health insurance in Ireland. All private health insurance providers must be registered with the Health Insurance Authority. At present, companies that are offering cover for in-patient hospital services must offer a minimum level of benefits. For further information, visit the Department of Health and Children website

http://www.dohc.ie/public/information/health_insurance/private_health_insurance.html or that of the Health Insurance Authority, <http://www.hia.ie/>

11.1.8 Primary Care Services in Ireland

The principal point of reference in relation to primary care development, including re-organisation of resources and the re-orientation of GP services, is the Primary Care Strategy. The Primary Care Strategy document, “*A New Direction*” was developed as a key component of the broader Health Strategy 2001 “*Quality and Fairness; A Health System for You*”. The definition of primary care as set out at the WHO

meeting in Alma Ata in 1976 is central to the Primary Care Strategy. This Strategy represents the roadmap for the future development of primary care services in Ireland over the following ten to fifteen years. The development of primary care services is an essential component of the health service reform process and the strategy acknowledged the central role of primary care in the future development of health services.

The emphasis is on keeping people well and supporting them so that they can live in the community rather than in institutional care settings. The key objective of the strategy is to give people direct access to integrated, multi-disciplinary teams of general practitioners, nurses, home helps, physiotherapists, occupational therapists and others. These teams will be able to provide people with integrated comprehensive services to meet their health and social care needs in the communities where they live. This has been characterised as providing “the right care, in the right place, at the right time”.

Primary Care Teams (PCTs) will service a defined local population and will:

- Identify and prioritise needs at individual and population levels;
- Service people’s needs, at or close to home;
- Facilitate access to a further range of generalist and specialist services in the community;
- Provide referral to acute hospitals and work with the hospitals to ensure that people receive a seamless service before and after hospital care

11.1.9 Implementation Projects

Ten primary care implementation projects were established from 2003 onwards and enabled the primary care model to be demonstrated in action. The projects allowed a range of implementation issues to be explored, e.g. access, enrolment, team working, primary and secondary care integration, community involvement and governance. Significant points of learning have been taken from these pilot teams by the Health Service Executive (HSE) and shared with those involved in the new teams in development.

11.1.10 Funding and current position

The HSE has identified 530 Primary Care Teams and 134 Primary Care and Social Networks to be developed by 2011.

Additional funding of €52m in total has been provided to the HSE since 2002 for team development.

93 Primary Care Teams were at an advanced functioning stage by the end of 2008 i.e. holding clinical team meetings to discuss individual client cases, with an additional 117 teams planned for development in 2009.

Membership of Primary Care Teams and networks are drawn from existing professional and other staff working in primary, continuing and community care

services as well as from new frontline staff. To date, over 800 HSE allied health professionals, including 282 new frontline professionals have been assigned to PCTs.

Some 500 GPs are involved in the development of Teams.

Mapping and profiling of the HSE's national geographic area has been undertaken taking account of GP/GMS patterns, travel distances, areas of deprivation, age profiles and other indicators.

Business processes are in place.

A detailed project plan has been devised which includes specific criteria against which team developments will be measured.

A number of functioning Teams have been formally launched.

Local initiatives, for example, wound clinics, a Chronic Disease Management Project, warfarin clinics and a falls prevention programme are taking place as part of the PCTs in some areas. The HSE are examining ways of measuring the outcomes of such initiatives with a view to highlighting the positive effects which PCTs are having on local communities.

11.1.11 Implementation of the Strategy on a wider basis

The establishment of Primary Care Teams (PCTs) is a sizeable task, which encompasses much more than the recruitment of new staff and reconfiguration of existing professional resources. The process also includes identifying appropriate PCT locations, negotiation with relevant unions on recruitment issues and changes to work practices, agreeing with other service providers on their participation, team-building work, assessing the needs of the community and mapping existing services. Other requirements which are more long-term in nature include improving ICT to support interdisciplinary care and also addressing the physical infrastructural needs.

11.1.12 Access to General Practitioner Services (GP Services)

Significant changes have been made since 2005 to the way in which applicants are assessed for a medical card or GP visit card. The threshold for qualification has been adjusted and assessment arrangements have been changed to take account on a standardised basis of reasonable expenses. As of December 2008, 1.35 million people hold a medical card and over 85,000 people hold a GP visit card. Thus 1.44 million people (representing 32.5% of national population) have free access to GP services.

Ninety per cent of the population is now covered by an out-of-hours GP service. The development of GP out-of-hours co-operatives is in line with the overall health service policy of strengthening primary care services and ensuring that to the greatest extent possible, people's care needs are met in the primary care setting.

Pilot projects commenced in 2007 to provide GP out-of-hours services on a cross border basis, covering certain areas of Inishowen, County Donegal, where people can obtain a service in Derry, Northern Ireland and Keady, County Armagh where people can obtain a service in Castleblayney, County Monaghan.

11.1.13 Acute Hospital Services in Ireland

The current Programme for Government, *Towards 2016*, contains commitments to ensure greater equality in access and care between public and private patients in the healthcare system.

The Government is committed to

- increasing the number of public-only hospital beds;
- implement plans for co-located private facilities on the campuses of public hospitals in order to free up beds for public patients;
- proactively deal with waiting times for treatment.

New contractual arrangements for medical consultants were agreed in 2008. Under the new arrangements consultants will work a 37 hour week; an extended working day from 8am to 8 pm, Monday to Friday; and have a scheduled attendance of up to five hours where required on Saturday, Sunday and Public Holidays. New private practice provisions range from a total prohibition on such practice to an upper limit of 20% for newly appointed consultants (30% for existing consultants). Consultants will work in teams rather than as individuals thereby facilitating speedier access to hospital services and a more timely discharge of patients. The new arrangements provide for the appointment of Clinical Directors who will provide clinical leadership and have a pivotal role in monitoring compliance with the ratio of public to private practice.

A common waiting list operated by the public hospital will apply to both public and private patients undergoing diagnostic investigations, tests and procedures (including radiology and laboratory procedures) on an out-patient basis in public hospitals (including referrals from General Practitioners). Status on the common waiting list will be determined by clinical need only. The list will be subject to clinical validation by the relevant Clinical Director.

11.1.14 National Treatment Purchase Fund

The National Treatment Purchase Fund (NTPF) was established in April 2002 to purchase treatments, primarily in private hospitals, for public patients who had been longest on surgical in-patient waiting lists. The NTPF became a statutory body in May 2004.

Anyone who has been waiting for more than three months for surgery on an in-patient public hospital waiting list may be eligible for treatment through the NTPF. Waiting times (not numbers waiting) are the significant marker. The average median wait time for a procedure is now down to 2.9 months. For 18 of the 20 most common adult

surgical operations, patients are treated within two to five months. Children, for the most common surgical procedures, are also treated within two to five months. There has been a fall in the number of people waiting for surgical procedures from 7.4 per 1,000 population in 2002 to 4.3 per 1,000 in 2008. Over 135,000 patients have been facilitated by the NTPF to date with either treatments or out-patient appointments.

11.1.15 National Human Resources and Workforce Planning

Significant additional revenue and capital funding has been invested in pre-registration nurse education and training since 2002, in order to finance the roll out of four-year undergraduate nursing degree programmes and direct-entry midwifery and integrated general/children's nursing degree programmes. Since 2006, there has been an annual student nurse intake of 1,880. The overall number of training places available annually has doubled since 1998.

The Department of Health and Children is also working closely with An Bord Altranais (Irish Nursing Board) to ensure the introduction of a safe system by which nurses and midwives may prescribe drugs. 54 nurses/midwives have qualified as prescribers and it is expected that a further 100 prescribers will qualify in 2009. The number of nurses and midwives (WTE) has increased by over 12,215 (48%) since 1997. There are now over 37,825 (excluding Nursing Degree Students) (WTE) nurses in the public health service.

In relation to post-registration medical education and training, the implementation of two key reports – the Fottrell Report 2006 and the Buttimer Report 2006 - is being pursued in line with an ongoing programme of investment.

Building the capacity of the health service workforce is central to the achievement of the goals and objectives of the Department of Health and Children. A joint working group on workforce planning was established in June 2006 and includes representatives of the Departments of Health and Children, Finance, and Education and Science, the HSE and the Higher Education Authority. The overall approach to workforce planning has been to strengthen the coordination of workforce planning and integration with financial and service planning.

A number of steps have been taken to improve planning in this area. The working group is overseeing the development of a workforce planning strategy. The evidence for workforce planning is also being improved. FÁS - the Training and Employment Authority - is undertaking a Healthcare Skills analysis of 12 healthcare grades. A similar report in 2005 by FAS provided additional evidence for future workforce planning decisions and the current report will provide evidence and analysis for key areas (incl. GPs, Nurses, Speech and Language, Physiotherapy).

There has been a growing demand for, and investment in, therapy services over the last number of years. There has been significant investment in the education and training of such personnel in order to secure a good supply of graduates to provide for the healthcare needs of the population into the future. In this regard, since 1997, the number of training places for physiotherapy has been increased from 64 to 145 which represents an increase of 127%; the number of training places for speech and language therapy has been increased from 25 to 105 which represents an increase of

320%; and the number of training places for occupational therapy has been increased from 29 to 120 which represents an increase of 314%.

11.1.16 Health Statistics in Ireland

The very latest statistics from the Department of Health and Children “Health in Ireland - Key Trends 2007” was launched in October 2007. It provides an overview of selected key trends in health in the recent years. Tables and graphs are presented which summarise information on demographics, on health status and on health care in order to give a quick reference guide in major areas of health and health services. This information can be accessed at http://www.dohc.ie/statistics/key_trends.html

11.1. 17 Prevention of Illness/Health Promotion

The Programme for Government has set out policy measures to prevent illness and promote health across the population. These complement existing initiatives currently being taken on tobacco, alcohol and obesity. Information on health promotion campaigns in Ireland can also be found on the website of the Health Service Executive (HSE) at <http://www.healthinfo.ie/>

11.1.18 Cardiovascular Health

The Government has committed over €60 million since 2000 towards the implementation of the Cardiovascular Health Strategy, ‘*Building Healthier Hearts*’. This funding has supported a wide range of new services and initiatives. These have had a positive impact on the diagnosis and treatment of patients with heart disease. For example:

- Pre-hospital care has seen improvements in automated external defibrillator availability (emergency ambulances, Dublin Fire Brigade, some GP surgeries in the community) and the setting up of a number of first response programmes in various settings.
- Hospital care has advanced with 73% of hospitals delivering thrombolysis in Emergency Departments in 2005 and all hospitals having a dedicated cardiac investigation area with a sizable investigative throughput, e.g. 21,600 new patients seen in clinics in 2005 and over 73,000 echocardiogram investigations performed.
- Stronger intersectoral partnerships in the area of health promotion
- Reduction in emergency call to treatment times
- Substantial expansion of non-invasive cardiac investigation services
- New service developments, including chest pain clinics and cardiac rehabilitation

- Increase in certain cardiology procedures is resulting in reduced waiting lists and waiting times for operations:
 - 42% increase in coronary arteriography (1999: 7,126, 2004: 10,129)
 - 153% increase in Percutaneous Coronary Interventions (1999: 1,790, 2004: 4,527)
 - 58% increase in Coronary Artery Bypass Grafting (CABG) (1999: 911; 2004 1,437)

An audit of progress on the implementation of *'Building Healthier Hearts'*, was published by the HSE in September 2007. The report, *"Ireland: Take Heart"*, shows a continuing decline in cardiovascular disease, despite a rise in obesity and low levels of physical activity. The report also identifies where services fall short of what was recommended in *'Building Healthier Hearts'*.

The Cardiovascular Health Policy Group was established in September 2007. It will set out broad guidelines for development of policy on cardiovascular health, including stroke. Its report is due to be published in 2009.

The Task Force on Sudden Cardiac Death published its report, "Reducing the risk: A Strategic Approach" in March 2006. Action has been taken on most of its 75 recommendations, including all of the 48 recommendations considered to be "immediate."

11.1.19 Diabetes

The Department of Health and Children published a policy document "Diabetes: Prevention and Model for Patient Care" in 2006. Following that, an Expert Advisory Group on Diabetes was established to draw up standards of care for Diabetes. It published its report in November 2008.

11.1.20 Obesity

The Obesity Task Force recognised that a multi-sectoral approach is necessary, involving other state agencies and Government Departments and real engagement of the public and private sectors to implement all of the report's recommendations. Recognising the need to take a coherent 'whole of Government' approach to the wider determinants of health, and in particular to tackling the obesogenic environment, the Department of Health and Children has established an inter-sectoral group to monitor implementation of actions recommended in the Task Force report.

11.1.21 Smoking

Tobacco use is the single largest cause of cancer, accounting for 30% of all cancer deaths in developed countries. Many advances have been made with regard to smoking and smoking control in Ireland in recent years, including a ban on advertising. In March, 2004 the workplace ban on smoking was introduced in all places of work, including licensed premises. The introduction of the ban has had a significant effect in reducing the incidence of smoking among the population with the

consequent benefits to health. However, the continued prevalence of smoking in the population and the negative impact on health continues to be a cause of concern, particularly in relation to our young people. Sustained focus on smoking cessation is required in order to address the negative impact of smoking, particularly in relation to chronic conditions of the circulatory and respiratory systems.

11.1.22 Alcohol Policy

Ireland has experienced significant increases in alcohol consumption and related harm in the last decade. These increases may be attributed to rapid economic growth, changing lifestyles, increased availability of alcohol and strong marketing. The particular drinking pattern, (heavy episodic drinking known as “binge drinking”) in Ireland poses a particular risk to health and is responsible for an increased incidence of social harm, with particular regard to harm experienced by vulnerable groups such as children.

11.1.23 Strategic Task Force on Alcohol

A Strategic Task Force on Alcohol was established in January 2002 by the Minister for Health and Children. The remit of the Task Force was to recommend specific evidence-based measures to Government to prevent and reduce alcohol related harm. The Task Force produced an Interim Report in May 2002 and a Second Report in September 2004. Government approval was granted to implement the recommendations of the Task Force and the various Ministers have been asked to implement the recommendations appropriate to their Departments.

11.1.24 Working Group on Alcohol

In July 2005, a Working Group on Alcohol was established to help mobilise the stakeholders through social partnership to achieve a targeted and measurable reduction in alcohol misuse. The Working Group operates in the context of the Special Initiative on Alcohol and Drug Misuse.

The Working Group was comprised of the social partners, relevant Government Departments, Gardaí, National Drugs Strategy Team and Health Service Executive. It examined the issues of underage drinking, drink driving and high risk drinking. The report was published in June 2006.

The report included recommendations on issues such as community mobilisation, workplace alcohol policies, advertising, labeling and education and awareness. An Implementation Group was established in November 2006 to monitor and report on progress on the implementation of the recommendations. The Report of the Implementation Group was published in December 2008.

New controls on the sale and supply of alcohol have been introduced via the Intoxicating Liquor Act 2008. The introduction of mandatory Alcohol Testing has helped change attitudes to drink driving with a resultant reduction in death and injuries on Irish roads. Implementation of strengthened Codes on Advertising and

Marketing of Alcohol came into effect on 1 July 2008, and control the volume and placement of all alcohol advertising in the Irish media.

11.1.25 Management of Chronic Diseases

The general management of chronic diseases has been set out in the Department of Health and Children policy framework which was published in 2008. This describes an approach centred on **disease management programmes** to treat and delay the onset of complications and reduce emergency hospital admissions. It addresses the management of chronic diseases at different levels through a reorientation towards primary care and the provision of integrated health services that are focused on prevention and returning individuals to health and a better quality of life. The main elements include:

- The development of models of shared care which set out the roles and responsibilities of primary care and specialist services (These would be established initially for diabetes, heart disease, stroke and chronic obstructive pulmonary disease)
- The development and implementation of clinical protocols and guidelines for use in primary care and specialist services
- The central role of primary healthcare in the management of patients with chronic disease
- The development of programmes of **self-care** for patients which would allow better self-monitoring and treatment in chronic disease
- Clinical information systems, quality assurance and evaluation as an integral part of disease management.

11.1.26 Cancer Control

Government policy is to implement '*A Strategy for Cancer Control in Ireland 2006*' which aims to improve the organisation, governance and quality of cancer care from prevention and screening through to treatment services, supportive and palliative care and research. The HSE National Cancer Control Programme is designed to implement the Strategy.

The decisions of the HSE in relation to four managed cancer control networks and eight cancer centres are being implemented on a managed and phased basis.

In addition, the HIQA has a significant role in setting standards in Cancer Control, in monitoring implementation of those standards, in enhancing health information and in conducting health technology assessment.

11.1.27 Continuing Care

There is continuing demand for an increased level of service in disability, mental health and services for older people. All three areas have been the subject of major investment in recent years. This included a Multi-Annual Investment Programme for the period 2005-2009 in the disability/mental health sector and substantial additional funding for both residential and community based services for older people.

The key documents /policy drivers in continuing care are:

- The Disability Act 2005,
- The Department of Health and Children's Sectoral Plan and the Year 1 Review of that Plan,
- A Vision for Change (2006 /Mental Health),
- The Mental Health Act, 2001,
- Reach Out - a National Strategy for Action on Suicide Prevention (2005),
- The Fair Deal Nursing Home Support Scheme announced December, 2006,
- The 2005 Base Line Study on the provision of Hospice/Palliative Care Services,
- Service Plan provision of Home Care Packages
- The Health (Repayment Scheme) Act 2006.

Copies of these documents can be found on the Department of Health and Children's website www.dohc.ie.

11.1. 28 Government Policy in Relation to Disability

The overall Government objective in relation to people with disabilities is to put in place the most effective combination of legislation, policies, institutional arrangements and services to support and reinforce equal participation for people with disabilities. The policy framework includes:

- The National Disability Strategy;
- New structures and organisations;
- New legislation;
- Resources to implement the policy and strategy.

11.1.29 The National Disability Strategy

The National Disability Strategy was launched in September 2004. It provides for a framework of new supports for people with disabilities. The Strategy builds on a strong equality framework, which is reflected in several pieces of equality legislation. It puts the policy of mainstreaming public services for people with disabilities, which was adopted by Government in 2000, on a legal footing. The main elements of the Strategy were:

The Disability Act 2005;
The Education for Persons with Special Educational Needs Act 2004;
Six Outline Sectoral Plans published by Government Departments;
The Comhairle Amendment Bill 2004.

The Strategy also made provision for an Investment Programme, which was subsequently announced in the 2005 Budget, for the period 2006 to 2009 to build capacity in priority areas of support services for people with disabilities. These

included new residential, respite and day services and new community-based mental health facilities.

11.1.30 New Legislation

The Disability Act 2005 is a central element of the National Disability Strategy. The Act is a positive measure designed to advance and underpin participation by people with disabilities in everyday life and provides for:

- An independent assessment of individual needs, a related service statement and independent redress and enforcement;
- Access to public buildings, services and information;
- Sectoral Plans for six key Departments which will ensure that access for people with disabilities will become an integral part of service planning and provision;
- An obligation on public bodies to be pro-active in employing people with disabilities;
- restricting the use of information from genetic testing for employment, mortgage and insurance purposes;
- A Centre for Excellence in Universal Design.

Mainstreaming places obligations on public service providers to support access to services and facilities for people with disabilities as well as other citizens, to the greatest practicable extent. The focus on mainstreaming and social inclusion is given particular emphasis through the Sectoral Plans provided for in Part 3 of the Act. Furthermore the Act provides for, *inter alia*, the identification and delivery of individual health, education and personal social services for people with disabilities who meet the relevant eligibility criteria set out in Part 2 of the Act. In particular it provides people with disabilities with an entitlement to:

- An independent assessment of health and education needs;
- A statement of the services (Service Statement) which it is proposed to provide;
- Pursue a complaint through an independent redress mechanism if there is a failure to provide these entitlements.

The Education for Persons with Special Educational Needs Act 2004 (EPSEN Act) makes provision for the education children under the age of 18 with special education needs.

The EPSEN Act 2004 and the Disability Act together provide the new framework within which specialist support services to children and adults with disabilities will be planned and delivered. The provisions of the EPSEN Act 2004 and the Disability Act 2005 are complementary and designed to cover the spectrum of needs for both adults and children. This includes transition planning at various stages such as pre-school to primary, primary to second level and into adult services. The National Council for Special Education (NCSE) and the HSE are the two key delivery organisations for both Acts.

The same standards of assessment will apply in both Acts. A child with a disability may be assessed under either Act. Where special educational need is identified, the child must be referred to the NCSE or a school principal. Health needs identified under the EPSEN assessment will be dealt with in the Service Statement under the Disability Act 2005.

11.1.31 Resources to Implement the Policy and Strategy

Overall, approximately €2.6 billion is spent annually by the health services on disability programmes (residential, day care, respite, assessment and rehabilitation services), mental health programmes, Domiciliary Care and Respite Care grants and other allowances.

The Multi-Annual Investment Programme 2006-2009 was announced as part of the Budget Day package in December 2004. It outlined the Government's commitment to a programme of revenue and capital expenditure, amounting in total to around €900 million, on specific disability support services over that period. The bulk of this funding, around €720 million, is being spent in the health services.

The specific additional health services to be provided each year as part of this programme are as follows:

Services for Persons with Intellectual Disability and those with Autism:

- 255 new residential places annually, giving a total of 1,020 new places over the period of the programme;
- 85 new respite places annually, giving a total of 340 new places over the period of the programme;
- 535 new day places annually, giving a total of 2,140 new places over the period of the programme;
- An extra €2 million each year to continue the implementation of the transfer of persons with intellectual disability/autism from psychiatric hospitals and other inappropriate placements.

Services for Persons with Physical or Sensory Disabilities:

- 80 new residential places for persons with significant disabilities who are currently placed in inappropriate settings, giving a total of 320 new places over the period of the programme;
- 250,000 extra hours of home support and personal assistance, giving a total of 1,000,000 additional hours over the period of the programme.

In addition to the specific services outlined above, the further enhancement of other support services such as multi-disciplinary or specialist support services for people with disabilities continue to be discussed as part of the annual Estimates and Budget discussions.

In recent years, very significant additional resources have been provided for services and supports in this area. Since 2006, over €550 million has been allocated to the Health Service Executive under the Multi-Annual Investment Programme, of which €425 million was for services for people with disabilities and €125 for mental health

services. This funding included monies to provide new and enhanced services for people with disabilities, to implement Part 2 of the Disability Act 2005, which came into effect on 1 June, 2007 for the under 5's and also for the continuation of the implementation of the transfer of persons with intellectual disability from psychiatric hospitals and other inappropriate placements.

Budget 2009 provided an additional €20 million for health and education services for children with special educational needs. €10 million of this was allocated to the Health Service Executive to provide additional therapy posts in the disability and mental health services which will be targeted at children of school going age. The balance has been allocated to the Department of Education and Science.

11.1.32 Service Provision

Specialist disability services are provided in a variety of community and residential settings in partnership with service users, their families and carers, and a range of statutory, non-statutory, voluntary and community groups.

The integral role of the non-statutory, voluntary and community groups is of particular relevance in this sector. These agencies provide a very significant and broad range of services in partnership with and on behalf of the HSE. It is acknowledged that because of the historic manner in which services for people with disabilities have developed, many of these agencies were to the forefront in identifying needs in the community and developing responses to them.

Services delivered include:

- Early childhood/family support services
- Residential care
- Respite care
- Day services
- Services for persons with autistic spectrum disorder
- Specialist day and residential brain injury services
- Rehabilitative training
- Sheltered workshops
- Community-based medical, nursing and therapy services
- Aids and appliances
- Home support services
- Financial allowances
- Other services including counselling, advisory, advocacy, information and general support service

11.1.33 Mental Health Services

The full provisions of the Mental Health Act 2001 have been in operation since 1 November, 2006. The Act significantly improves safeguards for persons who are involuntarily admitted to approved centres. All involuntary admissions are now subject to an automatic and independent review by a mental health tribunal.

'*A Vision for Change*', the Report of the Expert Group on Mental Health Policy, published in January, 2006, sets out a comprehensive framework for the development of all mental health services over a 7 to 10 year time frame. '*A Vision for Change*' has been accepted by Government as the basis for the future development of mental health services.

In March, 2006 an independent **Monitoring Group** was established to monitor progress in implementing the report's recommendations. The monitoring group's first annual report was published in May, 2007. The group are currently preparing its third annual report.

The Health Service Executive (HSE) is responsible for implementing some 80% of the recommendations of '*A Vision for Change*'. Implementation of the remainder is the responsibility of Government Departments and their Agencies. The Departments are: Health and Children, Education and Science, Enterprise, Trade and Employment, Environment, Heritage and Local Government, Justice, Equality and Law Reform, Community, Rural and Gaeltacht Affairs and Social and Family Affairs.

In February 2008, the HSE approved an **Implementation Plan** which sets out six key priorities for 2008 and 2009.

The priorities which have been progressed include:

- Catchment Area Definition and Clarification
- Modernisation of the Mental Health Infrastructure
- Community Based Mental Health Teams
- Child and Adolescent Mental Health Teams
- Mental Health Services for People with Intellectual Disability
- Mental Health Information Systems

A draft implementation plan for 2009 and beyond has been prepared and will be finalised by the HSE following completion of the new structure currently being developed in the Health Service Executive.

The undesirability of admitting children to units providing care and treatment to adults is recognised but in the absence of an alternative, such admissions are sometimes necessary. The Mental Health Commission has issued a code of practice relating to the admission of children under the Mental Health Act 2001 which outlines interim arrangements and facilities that should be put in place to ensure the protection and safety of such children.

The development of child and adolescent mental health services is a priority for the HSE. During 2008, four beds were commissioned in St Anne's, Galway and work was completed on a six bedded unit at St Vincent's, Fairview, Dublin and the refurbishment of an eight bedded interim unit at St Stephen's, Cork. These beds will be brought into operation in 2009. Construction has commenced on two 20-bedded units in Cork and Galway. The provision of this additional bed capacity within the

child and adolescent service will ensure that the inappropriate admission of 16 and 17 year olds to adult psychiatric units is curtailed.

In January 2008, the Government announced the establishment of the **Office for Disability and Mental Health** to support the Minister in exercising his responsibilities across four Government Departments: Health & Children, Education & Science, Enterprise, Trade & Employment and Justice, Equality & Law Reform. Implementation of '*A Vision for Change*' is a key priority for the Office who is working in partnership with the HSE and other stakeholders to achieve implementation of agreed targets.

The new Office brings together responsibility for a range of different policy areas and State services which directly impact on the lives of people with a disability and people with mental health issues. The Office aims to bring about improvements in the manner in which services respond to the needs of people with disabilities and mental health issues, by working to develop person-centred services, focusing on the holistic needs of clients and service users and actively involving them in their own care.

11.1.34 Suicide and Self Harm

Reach Out—A National Strategy for Action on Suicide Prevention was launched in September 2005. Four levels of action comprise the main body of the Strategy i.e. - general population approach; targeted approach; responding to suicide; and information and research.

The strategy calls for a **multi-sectoral approach** to the prevention of suicidal behaviour (fatal and non-fatal) in order to foster cooperation between health, education, community, voluntary and private sector agencies.

The HSE's **National Office for Suicide Prevention (NOSP)** was established in 2005 to oversee the implementation of the Strategy and to coordinate national suicide prevention activities, consult widely in relation to the planning of future initiatives and ensure best practice in suicide prevention.

A target of 10% reduction in the national suicide rate by 2010 has been agreed with the NOSP. In addition, a target of a 5% reduction in repeated self harm by 2010 and a further 5% by 2016 has been agreed.

In the knowledge that suicidal behaviour does not recognise borders a formal commitment to all-island collaboration on suicide prevention has been made. An all-island action plan has also been agreed and implantation is on-going.

11.1.35 Funding – Suicide Prevention

Additional funding of €3.55 million has been provided since 2005 bringing the total funding available to support suicide prevention initiatives to €8 million. Funding is used to develop and implement national training programmes, implement awareness campaigns and progress actions identified in the All-Island Action Plan for Suicide

Prevention. Other suicide prevention initiatives include funding for dedicated suicide resources officers, deliberate self-harm response nurses in A&E departments, local voluntary groups.

Once-off funding of €1 million is provided in 2009 for suicide prevention initiatives.

11.1.36 Deliberate Self Harm

Ireland has a comprehensive database on self harm presentations through hospital A&E departments. Data has been collected since 2001. The 2007 Annual Report, prepared by the National Suicide Research Foundation, indicates that 11,100 presentations to hospital, due to deliberate self-harm, were made by 8,600 individuals.

11.1.37 Suicide trends and statistics

The OECD publication ‘Health at a Glance’ indicates a relatively low level of suicide in Ireland. The overall Irish rate is below the EU average and is the 7th lowest in the 27 OECD countries, however we have a higher rate of youth suicide.

Suicide figures by Year and Gender

Year	Male	Female	Total
2003	386	111	497
2004	406	87	493
2005	382	99	481
2006*	318	91	409
2007*	378	82	460

**2006 and 2007 figures are based on year of registration data and are preliminary.*

*** In 2007, the Central Statistics Office made a number of changes in the methods by which mortality figures are compiled and some of these changes may have had an impact on the suicide figures.*

11.1.38 Older People

The proportion of older people in the population is increasing. It is now at 11% of the overall population. Life expectancy is also increasing. It is expected that the numbers of people over the age of 65 years will more than triple between now and 2050. Ensuring that this sector of the population remains healthy and is provided with necessary services is a significant challenge and a strategy on positive ageing will be prepared to consider how the challenge can best be met.

Current national policy is to develop appropriate home and community based services such as home care packages, home help services and day services and to improve the quality and availability of affordable residential care for older people who can no longer live at home. The principles and commitments set out in *Towards 2016* include an agreement to develop an infrastructure of long-term care services for older people, responding to the demographic trends facing the country. With that in mind, work has commenced on new long-term care standards, as well as on an analysis of future funding options for residential and community based care for older people. It is agreed that the financial model to support long-term care services must be financially sustainable.

The cross-sectoral nature of service requirements has been recognised in the establishment of an Office for Older People in the Department of Health and Children to support the work of the Ministers of State in the Department of Health and Children, Department of Environment, Heritage and Local Government and Department of Social and Family Affairs.

11.1.39 Traveller Health

Progress continues to be made in the area of Traveller health. The Traveller Health Advisory Committee (THAC) was established in 1998. It consists of Department of Health and Children staff, members of the HSE and representatives of Traveller organisations. The THAC advises the Minister for Health and Children on policy in relation to health services for Travellers. The work of THAC was crucial to the preparation of “Traveller Health - A National Strategy 2002-2005”. This is the Strategy which provides the basis for current policy.

The All-Ireland Traveller Health Study was launched in July, 2007. It is the first such study of the health status of Travellers since 1987 and is the first that involves Travellers from both the North and South. It is jointly funded by the Department of Health and Children and the Department of Health, Social Services and Public Safety in Northern Ireland and supported by the Health Service Executive. The study will include a census of the Traveller Population and an examination of their health status and utilisation of health services in order to identify the factors which influence mortality and health status. The Study is to be completed by 2010.

Since 1997 over €12 million in development funding was allocated in addition to ongoing revenue funding to Traveller specific health services such as the appointment of designated Public Health Nurses for Travellers and the replication of the Primary Health Care for Traveller Project which established a model for Traveller participation in the development of health services. Travellers work as Community Health Workers in Primary Health Care for Traveller Projects, allowing primary health care to be developed based on the Traveller Community’s own values and perceptions so that positive outcomes which have a long-term effect can be achieved. Funding is allocated through the Traveller Health Units in each HSE area. Travellers and Traveller organisations are involved in partnership with HSE personnel through each Traveller Health Unit in the development of Traveller health services and in the allocation of resources.

11.1.40 Drug Users

Research carried out in 2006/2007 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 24% had used an illegal drug during their lifetime. The 24% lifetime prevalence was an increase from the 18.5% found in 2002/2003. Last year and last month use was highest for those aged 15-24 years at 15% and 6% respectively. While cannabis continues to be the most commonly used illegal drug, cocaine use has grown, particularly among the young adult (15-34) population. Based on a capture recapture study in 2002 there are an estimated fourteen thousand opiate users in Ireland.

Services for drug users in Ireland are provided within the framework of the National Drug Strategy 2001-2008, *Building on Experience*, which is coordinated by the Department of Community, Rural and Gaeltacht Affairs. The Strategy outlines a series of 100 individual actions based on the four pillars of supply reduction, prevention, treatment and research. A fifth pillar Rehabilitation has recently been added to the strategy to give more emphasis to reintegration. A partnership approach between statutory, voluntary and community sectors in addressing drug issues is an important dimension of the National Drug Strategy.

The actions in the National Drug 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 and Children from a policy point of view and within the remit of the Health Service Executive (HSE) in relation to management and delivery of services. For historical reasons, arising in the 1980s and 1990s, the focus of concern around drug issues has been on opiates, particularly heroin, with methadone substitution the dominant mode of treatment. In the last number of years in the context of changing patterns of drug use, the statutory provider - the HSE - as well as voluntary and community providers, have been re-orienting prevention and treatment services to tackle polydrug usage (including cocaine).

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. At the end of 2008 there were over 8,700 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 has made this treatment available in their own local area to an increased number of opiate users in recent years. In the HSE Eastern Regional Area (Greater Dublin Area) there are currently 59 drug treatment locations. These are a mix of larger addiction centres and satellite clinics. This is an increase of 47 locations since 1996. Outside the Eastern Regional

Area, 7 treatment clinics have been established; in the South East, Mid-West, West and Midlands. Drug users with more complex issues are treated in the consultant led specialist clinic in the Drug Treatment Centre Board (DTCB) in Dublin and those who achieve stabilisation on methadone are usually then released to the more local services.

The Research Outcome Study in Ireland evaluating drug (opiate) treatment effectiveness (ROSIE) found that there were marked reductions in drug use and criminal activity among study participants at 1-year follow-up (These results are available on the website of the National Advisory Committee on Drugs at <http://www.nacd.ie/activities/rosie.html>). Results of a summary of 3-year outcomes showed that the reductions in drug use and involvement in crime achieved in year one are sustained at the three-year follow up.

In 2005, the Report of the Working Group on Treatment of Under 18 Year Olds presenting to Treatment Services with Serious Drug Problems recommended an approach based on a 4-tier model that would ensure that the services provided would be based on the specific needs of the child and its family; provide a full range of drug-related education, prevention and treatment interventions; and be competent to deal with the complex ethical and legal issues surrounding such interventions. The working group agreed that the services would be adolescent-specific, local and accessible, have a combination of disciplines on site, and offer assessment, treatment and aftercare. In addition to the extra resources required to address the needs of these young people, it was suggested that greater co-ordination could maximise the impact of existing services. The Report is being implemented on a phased basis. Adolescent services have been established in Dublin and the process of establishing one in the South East is underway.

HSE addiction services are currently in a state of transition and re-orientation towards a more polydrug use (including alcohol use) focussed service, within the framework of Social Inclusion, with the intention of providing a client focused continuum of care in the setting of Primary Care Teams and Social Networks currently being rolled out on a phased basis. HSE staff are also being up-skilled to meet the needs of more polydrug using clients. The HSE has been given a lead role in relation to the implementation of the Report of the Working Group on Drugs Rehabilitation which was published by the Department of Community Rural and Gaeltacht Affairs in May 2007. The HSE has appointed a National Rehabilitation Co-ordinator who will chair the National Drug Rehabilitation Implementation Committee which has been established. This initiative will facilitate the roll-out of further actions in the Rehabilitation Strategy to support drug users along their care pathway towards re-integration into their community. The HSE Working Group on Residential Treatment and Rehabilitation (Substance Misusers) published a report in May 2007. This report provides a detailed analysis and overview of known current residential treatment services and advises on future residential requirements of those affected by drug and alcohol use.

In 2005 the Department of Health and Children and the Department of Justice Equality and Law Reform jointly requested the Health Research Board to establish a National Drug Related Deaths Index (NDRDI). The first report of the Index, covering period 1998-2005, was published in November 2008. Work is underway to address

some of the issues arising in the report including the development of an Overdose Prevention Strategy. A Report on Needle Exchange Provision in Ireland prepared jointly by the National Advisory Committee on Drugs and the National Drug Strategy Team was published in 2008. Its recommendations are being progressed by an implementation committee under the National Drug Strategy Team.

11.1.41 Food Safety

The Food Safety Authority of Ireland (FSAI) is a science-based body dedicated to protecting public health and consumer interests and is responsible for the enforcement of all food safety legislation in Ireland. It also supports the Department of Health and Children in its formulation of food policy and legislation. The FSAI is the Central Competent Authority with overall responsibility for the enforcement of food legislation in Ireland. Information on food hygiene measures in Ireland is available on the FSAI website <http://www.fsai.ie/>

Conclusions of the European Committee of Social Rights Conclusions 2007 (Ireland)

11.1.42 Article 11, Paragraph 1 – Removal of the causes of ill-health

The Committee takes note of the information in the Irish report.

State of health of the population – General indicators

Life expectancy and principal causes of mortality

Average life expectancy in 2004³ was 76.3 for men and 81.1 for women (the average for European countries in 2004⁴ was about 72 for men and 80 for women). The mortality rate in 2004⁵ was 6.9 per thousand, compared with a European average⁶ in 2004 of 9.5 per thousand.

According to the report, for several years the main causes of mortality have been diseases of the circulatory system, cancers, and coronary heart disease. These represent, respectively, 39.5%, 25% et 20.7% of all deaths. **The Committee asks whether specific awareness campaigns are conducted.**

Infant and maternal mortality

According to the report, the infant mortality rate in 2004 was 4.9 per thousand (the European average⁷ in 2004 was 4.6 per thousand). The Committee notes from another

³ WHO site: www.who.int

⁴ EUROSTAT site: <http://epp.eurostat.ec.europa.eu/>

⁵ WHO site: www.who.int

⁶ EUROSTAT site: <http://epp.eurostat.ec.europa.eu/>

⁷ Ibid.

source⁸ that the maternal mortality rate was 4 per 100 000 births in 2001 (the European average⁹ was between 5 and 6 per 100 000 in 2004). **The Committee asks for up-to-date figures in the next report.**

The Committee notes from the report that women continued to receive maternity services, via general practitioners during pregnancy and then in hospital, gynaecological care, free of charge. New born children up to the age of six also continue to receive general practitioner care free of charge.

Health care system

Access to health care

Whether eligibility for health services is full or restricted usually depends on income. It describes the method for calculating income according to family size and benefits received.

Nationals of states party to the Charter and the Revised Charter are also entitled to health care if they have been ordinarily resident in Ireland for at least one year.

Nationals of other European Union member states resident in Ireland who receive a social security pension from their country of origin may be entitled to an Irish medical card without having to satisfy the usual means test, provided they are not employed or self-employed in Ireland.

Holders of cards issued by the Health Service Executive, the national health authority, together with dependent spouses and children, are entitled to certain public health services free of charge. They are also exempt from paying the health contribution portion of social insurance. The card is issued automatically, with no means test, to persons aged over 70 and those with no income other than widows, unemployment, disability, one-parent family, orphans or infectious diseases allowances.

The medical card gives entitlement, free of charge, to family doctor services, most prescribed drugs and medicines, and public hospital, dental, optical, aural, maternity and infant care services.

Users with limited eligibility for health services are not issued with a medical card. They are entitled to hospital and specialist services, subject to certain statutory charges.

However, the Committee notes that persons in financial difficulty, together with their spouses and children, may be exempt from payment for general practitioner, dental and optometric services. The victims of long-term illnesses may also be exempt from charges for their medicines.

The Committee notes that patients are free to choose their general practitioner.

However, GPs must generally have their practice within seven miles of where patients live. Persons can normally move from one private insurer to another without loss of cover.

It is also possible to take out specific health insurance with several private companies, the largest of which is the Voluntary Health Insurance Board, a statutory body whose board is appointed by the health minister. Some health insurance providers only deal with particular groups of employees, such as prison officers. Equally, some only offer limited services, such as dental and optical care. Private health insurance providers must be registered with the Health Insurance Authority. Most of them pay their associate hospitals directly.

⁸ OECD site: www.oecd.org

⁹ EUROSTAT site: <http://epp.eurostat.ec.europa.eu/>

The Health Insurance Authority, set up under the Health Insurance Act, 1994, as amended in 2003, is the regulatory body for the private sector. It registers all private insurers and assesses the effect of any regulations or new legislation on consumers, and advises the health ministry accordingly.

The report states that the number of clients of private health insurance is rising steadily. In 1999, there were 1.5 million users. In 2004, 1.148m people, about 27.8% of the population, were covered by the public medical card scheme.

The Health Service Executive provides various specific forms of care and domiciliary services for elderly persons.

Right of access to care means that arrangements for such access must not lead to unnecessary delays in its provision. The management of waiting lists and waiting times in health care are considered in the light of Committee of Ministers

Recommendation (99) 21 on criteria for such management.

The Committee therefore asks for information about the management of waiting lists and waiting times in health care.

Health professionals and equipment

The Committee notes from another source¹⁰ that there were 11 141 physicians in 2004, or 279 per 100 000 inhabitants. It asks the next report to precise the exact proportion of general practitioners.

There were also a total of 2237 dentists (or 56 per 100 000 inhabitants), 60 774 nurses and midwives (1520 per 100 000), 16 486 midwives (427 per 100 000) and 3898 pharmacies (97 per 100 000).

The Committee notes from another source¹¹ that there were 13 017 hospital beds in 2004. **In the absence of information on number of beds per head of population the Committee asks for this to be included in the next report.**

The Committee asks whether these facilities and professionals are evenly distributed throughout the country.

Conclusion

Pending receipt of the information requested, the Committee concludes that the situation in Ireland is in conformity with Article 11§1 of the Revised Charter.

11.1.43 Our Response :-

In relation to the ECSR questions above, please see sub-paragraphs 11.1.17 to 11.1.41 above. Concerning the query relating to specific awareness campaigns, please see sub-paragraphs 11.1.21 to 11.1.26 in particular. Concerning the queries relating to statistical information, please see sub-paragraph 11.1.16 above.

¹⁰ WHO site: www.who.int

¹¹ *ibid.*

ARTICLE 11: THE RIGHT TO PROTECTION OF HEALTH

ARTICLE 11 PARA. 2

Text of ARTICLE 11 PARA. 2 of the Revised European Social Charter

"With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed inter alia: to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;"

Questions asked of all Parties (member states of the Council of Europe, which have signed and ratified the Revised European Social Charter):

Question A

Please indicate what advisory and screening services exist:

- a. for schools;
- b. for other groups.

Question B

Please describe any measures taken to further health education, including information campaigns.

=====

Text of Ireland's Sixth Report under the Revised European Social Charter in relation to Article 11, Paragraph 2:

Material provided by the Department of Health and Children :-

Our Response to Questions A and B refer:

11.2.1 Please see our response under Article 11, Paragraph 1 above, in particular subparagraphs 11.1.8 to 11.1.12 inclusive and 11.1.17 to 11.1.41 inclusive.

Conclusions of the European Committee of Social Rights Conclusions 2007 (Ireland)

Article 11, Paragraph 2 – Advisory and educational facilities

11.2.2 The Committee notes the information in the Irish report.

Developing a sense of individual responsibility

Health education in schools

According to the report, the National Health Promotion Strategy 2000-2005 highlighted the particular role of health promotion in school, from primary level on, in preventing alcohol and drug abuse. There is also specific training on drugs for teachers.

The Committee notes from the report that the Department of Health and Children has introduced various measures, particularly nutritional programmes, to promote a healthy diet and combat obesity, and encourages regular sporting activities. It asks whether health education continues throughout the period of schooling and also includes such topics as sex education, smoking and the environment.

Public information and awareness

Various public information and awareness campaigns were undertaken during the reference period, sometimes in several stages, on such topics as alcohol and drug use and obesity. A special drugs site¹² and a voice server have been introduced. In addition there was a campaign in 2004 to encourage women to breastfeed.

Counselling and screening

Pregnant women, children and young persons

The Committee points out that free medical checks must be carried out throughout the period of schooling. In assessing compliance, it takes account of the frequency of school medical examinations, their objectives, the proportion of pupils concerned and the level of staffing (Conclusions XV-2, France, pp. 208-211).

In the absence of information on how school medical checks are organised, it asks for this information in the next report.

According to the report, cancer screening was carried out during the reference period, with 167 000 women taking part in 2004. Cervical cancer screening, as described in previous reports (Conclusion XIII-4, p. 133-134), is still available free of charge, as are the follow-up measures and medical consultations.

Rest of the population

The Committee points out that there should be screening, preferably systematic, for all the diseases that constitute the principal causes of death (Conclusions 2005, Moldova, pp. 450-452) and has ruled that "where it has proved to be an effective means of prevention, screening must be used to the full" (Conclusions XV-2, Belgium, pp. 96-99). **It therefore asks whether screening is carried out for diseases of the circulatory system, cancers, and coronary heart disease.**

Conclusion

Pending receipt of the information requested, the **Committee defers its conclusion.**

11.2.3 Our Response :-

¹² www.drugsinfo.ie

Please see our response under sub-paragraphs 11.1.17 to 11.1.27 above, in relation to query concerning screening for diseases of the circulatory system. Details on the school health services are available on

http://www.citizensinformation.ie/categories/health/children-s-health/school_health_services or

http://www.dohc.ie/public/information/childrens_health/child_health_services.html?lang=en

ARTICLE 11: THE RIGHT TO PROTECTION OF HEALTH

ARTICLE 11 PARA. 3

Text of ARTICLE 11 PARA. 3 of the Revised European Social Charter

"With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed inter alia: to prevent as far as possible epidemic, endemic and other diseases, as well as accidents." If your country has accepted paragraphs 9 and 10 of Article 7, it is not necessary to repeat the information given thereon here.

Questions asked of all Parties (member states of the Council of Europe, which have signed and ratified the Revised European Social Charter):

Question A

Please indicate what measures other than those mentioned above are taken to prevent epidemic, endemic and other diseases (compulsory or optional vaccination, disinfection, epidemics policy).

Question B

Please indicate what general measures are taken in the public health field, such as:

- a. – prevention of air pollution,
- prevention of water pollution,
- prevention of soil pollution;
- b. protection against radioactive contamination;
- c. protection against noise pollution;
- d. food hygiene inspection;
- e. minimum housing standards;
- f. measures taken to combat smoking, alcohol and drug abuse, including multiple addiction, as well as against sexually transmitted diseases.

Text of Ireland's Sixth Report under the Revised European Social Charter in relation to Article 11, Paragraph 3:

Material provided by the Department of Health and Children :-

11.3.1 Please see our response under Article 11, Paragraph 1 above, in particular subparagraphs 11.1.17 to 11.1.41 inclusive.

Conclusions of the European Committee of Social Rights Conclusions 2007 (Ireland)

11.3.2 Article 11, Paragraph 3 – Prevention of diseases

The Committee notes the information in the Irish report.

Preventing avoidable risks

Reduction of environmental risks

Air pollution – according to the report, steps were taken during the reference period to reduce air pollution emissions arising from energy production, such as reducing the number of cars in towns and cities, building cycle tracks and encouraging the use of biofuels.

Several regulations published in 2002 transposed the EU directive on limit values for sulphur dioxides¹³ and Directive 2000/69/EC on limit values for benzene and carbon monoxide. Further regulations published in 2004 transposed Directive 2002/3/EC, which establishes objectives for ozone concentrations in ambient air. Regulations approved in 1999 and 2000 laid down limits for benzene and sulphur concentrations in petrol and diesel fuel.

The Committee notes that, in conjunction with local authorities, the Environmental Protection Agency (EPA) has established procedures for monitoring and measuring air pollution, information on which can be consulted by anyone.

Water pollution – The Committee asks who is responsible for monitoring pollution caused by the disposal of hazardous substances.

An assessment of the pressure and impact of human activities on water supplies is currently being undertaken in connection with the transposition of the European Water Framework Directive (2000/60 EC).

Soil pollution – responsibility for waste management is shared between local authorities, which are combined into ten general groupings for general waste management purposes, and the EPA, which under the relevant 1996 legislation must draw up a hazardous waste management plan for the whole country. This plan must be updated every five years. The Department of the Environment and Local Government has also launched a public campaign, with the aid of a web site, to encourage industrial and domestic waste prevention, reduction and recycling.

Noise – according to the report, Directive 2002/49/EC relating to the assessment and management of environmental noise should shortly be transposed into domestic law. The Committee wishes to be informed of progress.

The environmental information service has also produced a practical guide for the public that can be consulted on the internet¹⁴.

¹³ Council Directive 1999/30/EEC relating to limit values for sulphur dioxide, nitrogen dioxide and oxides of nitrogen, particulate matter and lead in ambient air, *Official Journal No L 163 of 29/06/1999 p. 0041 - 0060*

¹⁴ www.enfo.ie

The Committee asks whether there have been any epidemiological studies on noise-related health problems.

Asbestos – the last conclusion (Conclusions XV-2, p. 25-30) asked for a reply in the next report to the general question in Conclusions XIII-4 steps taken to detect the presence of asbestos in residential and public buildings. It also asked about firms' obligations concerning waste containing asbestos.

Since there is nothing in the current report, the Committee concludes that the situation in Ireland is incompatible with the revised Charter, because of repeated lack of information.

Ionising radiation – in answer to the Committee the report states that the Department of the Environment and Local Government has developed an emergency plan for nuclear accidents, whether within Ireland or emanating from overseas, aimed at alerting and informing the public. The plan has been drawn up in conjunction with the Radiological Protection Institute of Ireland and other specialist agencies. Where necessary, restrictions may be imposed on the consumption of certain foodstuffs and persons may be required temporarily to remain indoors.

The environment department has also prepared an information leaflet for the public on nuclear accidents. The Radiological Protection Institute, in collaboration with local authorities and the Department of Defence, operates a national network of permanent radiation-monitoring stations.

Food safety

The Committee previously (*ibid*) asked for up-to-date information on standards, monitoring and prevention. The report simply refers to several pieces of draft legislation on food safety that were prepared during the reference period.

In the absence of information, the Committee reiterates its question. It wishes to emphasise that if the information requested is not included in the next report there will be nothing to show that the situation is compatible with the Charter.

Measures to combat smoking, alcoholism and drug addiction

Smoking – according to the report, Directive 2001/37/EC on the manufacture, presentation and sale of tobacco products was transposed by several regulations approved in 2003. Public health regulations approved in 2004 have led to a ban on smoking in all work places, bars and restaurants. No special locations have been established for smokers. Smoking is also forbidden in public transport. The Office of Tobacco Control has set up a telephone line to receive complaints of failure to comply with the legislation. The Bureau also monitors enforcement of the legislation banning tobacco advertising.

The Department of Health and Children launched various anti-smoking campaigns during the reference period. As part of one of the campaigns, a national smokers quitline has been established, in partnership with the Irish Cancer Society.

The Committee notes from another source¹⁵ that 31.5% of the population smoked in 2004 while the proportion of 15 to 24 year-olds who smoked in the same year was 27.3%. **The Committee asks for this information to be provided systematically in each report.**

¹⁵ EUROSTAT site: <http://epp.eurostat.ec.europa.eu/>

Alcohol abuse – the report states that draft legislation is being prepared on alcohol advertising. **The Committee asks to be informed of progress and of any other planned legislation to prevent excessive alcohol consumption.**

A strategic task force published a series of recommendations on alcohol consumption during the reference period, which will form the basis for a new action plan on the subject. Another working party was specially created during the reference period, mainly drawn from members of the government departments concerned and the social partners. **The Committee asks to be informed of the results of its work.**

A new anti-drinking campaign aimed at young persons was also launched in 2004. **The Committee has found no statistical information in the report on alcohol consumption. It asks for this information to be provided systematically in each report.**

Drug addiction – apart from drug campaigns and prevention programmes in schools, the report states that a three year drug awareness campaign was launched in 2003. It is accompanied by an internet site¹⁶ and telephone help lines.

In addition, primary and secondary health care services also include drug treatment programmes.

Preventive measures

Epidemiological monitoring

The report refers to the treatment of sexually transmitted diseases, including AIDS. Certain specific national and regional awareness activities have been launched under the government's National Health Promotion Strategy 2000-2005. The National AIDS Strategy Committee, in conjunction with various non-governmental organisations, has also initiated certain measures aimed more specifically at groups at risk, including migrants.

The Committee asks whether AIDS is a notifiable disease and whether screening is conducted free of charge.

Immunisation

The Committee notes that in 2002 there was 83% vaccination cover for diphtheria, tetanus, poliomyelitis and Hib meningitis (compared with 76% in 1997), 82% for whooping cough, and 73% for mumps, measles and rubella (80% in 1997).

The Committee notes that progress has been made regarding diphtheria, tetanus, poliomyelitis and Hib meningitis, but that coverage of mumps, measles and rubella has declined. It asks what measures are planned to meet the WHO objectives.

Traffic accidents

There is no information in the report. The Committee points out that states must take steps to prevent accidents. The main sorts of accident covered are road accidents, domestic accidents, accidents at school, accidents during leisure time, accidents caused by animals (Conclusions 2005, Romania, pp. 603-606) and accidents at work. Trends in accidents at work are considered from the standpoint of health and safety at work (Article 3). **The Committee asks for this information to be provided in the next report.**

Conclusion

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

¹⁶ www.drugsinfo.ie

it has not been established that sufficient measures have been adopted to prevent the risks related to asbestos.

11.3.3 Our Response :-

In relation to the ECSR questions above, please see sub-paragraphs 11.1.17 to 11.1.41 above. Concerning the query relating to the monitoring of water pollution, please see the following websites :- <http://www.envirocentre.ie/Content.aspx?ID=d582c855-70c8-421c-85ca-e3c94f3120d7&PID=518acceaeec4-4cdf-b034-78ce58each4d#waterpollution10>

and

<http://www.irishstatutebook.ie/1977/en/act/pub/0001/index.html>
<http://www.irishstatutebook.ie/1990/en/act/pub/0021/index.html>

Concerning the query relating to management of environmental noise, please see the following websites :-

http://www.citizensinformation.ie/categories/environment/environmental-protection/noise_regulations

<http://www.irishstatutebook.ie/2006/en/si/0140.html>

http://www.environ.ie/en/Environment/Atmosphere/News/MainBody_16105.en.htm

<http://www.environ.ie/en/Environment/NoiseIssuesConsultationPaper/>

Concerning the query relating to epidemiological studies on noise –related health problems, please see :-

<http://www.google.ie/search?hl=en&source=hp&fkt=10391&fsdt=69859&q=epidemiological+studies+on+noise+related+health+problems&btnG=Google+Search&meta=cr%3DcountryIE&aq=f&oq=&aqi=>

Concerning the queries relating to food safety, please see the Food Safety Authority website at :-

<http://www.fsai.ie/>

Concerning the queries relating to smoking and alcohol abuse, please see the following sub-paragraphs above 11.1.17 to 11.1.27 inclusive, particularly sub-paragraph 11.1.21 in relation to smoking and sub-paragraphs 11.1.22 and 11.1.23, in relation to alcohol abuse.

Concerning the queries relating to AIDS / notifiable diseases, please see the Health Service Executive (Health Protection Surveillance Centre) website at :-
<http://www.ndsc.ie/hpsc/NotifiableDiseases/ListofNotifiableDiseases/>

ARTICLE 12 :- THE RIGHT TO SOCIAL SECURITY

Article 12, Paragraph 1 :-

"With a view to ensuring the effective exercise of the right to social security, the Parties undertake:

1. to establish or maintain a system of social security;"

Question asked of all Parties (member states of the Council of Europe, which have signed and ratified the Revised European Social Charter):

Please indicate the measures taken to give effect to this undertaking, specifying the nature of the existing system, in particular funding arrangements, giving information allowing the percentage of the population covered and the level of benefits to be determined.

=====
=====
=====

Article 12, Paragraph 1 :- Text of Our Report

Material supplied by the Department of Social and Family Affairs :-

12.1.1 Ireland continues to maintain a system of social security, as detailed in previous reports.

12.1.2 The following legislation and publications of interest to our adherence to Article 12.1 may be accessed via the links shown.

The Social Welfare Consolidation Act 2005 replaced the previous Consolidation Act of 1993 with effect from 1st December 2005.

Social Welfare Acts of 2005 and 2006 provided increased rates of benefits which applied during the following calendar year.

Social Welfare Law Reform and Pensions Act 2006 and the Social Welfare and Pensions Act 2007 introduced other changes in insurance and assistance schemes.

Electronic versions of these Acts are available at www.oireachtas.ie – see under Legislative Information, Acts in .pdf format 1997-2009 and also on the Department's website (see below).

Annual Reports of the Department for 2006 and 2007.

Annual Statistical Reports of the Department for 2006 and 2007.

Rates of Payment 2006 and 2007 – SW 19 booklets.

Electronic versions of these reports and booklets are available on the Department's website at <http://www.welfare.ie/EN/Pages/azindex.aspx>

12.1.3. The rates of insurance benefits which applied during the period under review were as follows (assistance rates are reported under Article 13.1):

Benefit	Weekly Rate	Jan – Dec 2006	Jan – Dec 2007
Sickness, Injury and Unemployment	Personal rate	165.80	185.80
	Qualified Adult	110.00	123.30
	Qualified child	16.80	22.00
Old Age	Personal rate	193.30	209.30
	Qualified Adult under 66	128.80	139.50
	Qualified Adult over 66	149.30	173.00
Other Work Injury benefits	Disablement benefit (max rate for over 90% disablement)	196.90	216.90
	Unemployability Supplement (paid where not entitled to sickness benefit in addition to disablement benefit)	same rates as sickness benefit	same rates as sickness benefit
	Constant attendance allowance	180.70	200.70
Maternity	70% of earnings in previous year subject to maximum of	265.60	280.00
	and minimum of	182.60	207.80
Invalidity	Personal rate (under 65)	171.30	191.30
	(over 65)	193.30	209.30
	Qualified Adult (under 66)	122.20	136.50
	Qualified Adult (over 66)	149.30	173.00
	Qualified child	19.30	22.00
Survivors	Widows under 66	171.30	191.30
	Widows over 66	193.30	209.30
	Qualified child	21.60	22.00
	Orphans	138.00	158.00
Child Benefit	Monthly rate for	April 2006	April 2007
	First and second child	150.00	160.00
	Third and subsequent children	185.00	195.00

Full details are published on the Department's website at <http://www.welfare.ie/EN/Pages/azindex.aspx?tab=publications>. See "Rates of Payment 2006" (and 2007).

12.1.4 The increases introduced in January 2006 ranged between 7.8% and 11.4% and compare favourably with the increase of 5% in the Consumer Price Index in 2006. The increase in the Average Industrial Wage was approximately 3.2% in 2006.

12.1.5 The increases introduced in January 2007 ranged between 6% and 12% and compare favourably with the increase of 4.7% in the Consumer Price Index for the year to December 2007. The increase in the Average Industrial Wage was approximately 4.9% for the 12 months ended June 2007.

Conclusions of the European Committee of Social Rights Conclusions 2006 (Ireland)

Answers to comments and questions in the last Conclusions of ECSR:

Question:

“The Committee notes from MISSOC that the work accidents and occupational diseases insurance scheme does not apply to self-employed and that no voluntary insurance scheme exists. It recalls that, according to its case law, self-employed shall be covered by the social security system and, therefore, asks how the self-employed are covered for that particular risk.”

12.1.6 Response:

The Irish social insurance system is based on the payment of compulsory social insurance contributions to the Social Insurance Fund, in return for which – and subject to the fulfillment of certain prescribed conditions – contributors become eligible for a range of income replacement benefits such as the State Pension (Contributory). This rationale underlines the general principle that there should be a reasonable link between the amount that persons pay into the system and their subsequent access to income replacement benefits and pensions. This in turn reflects the contributory principle behind the ‘pay-as-you-go’ nature of the Pay Related Social Insurance (PRSI) system.

Social insurance was extended to self-employed persons on 6 April, 1988. These had previously been excluded from compulsory social insurance. The contribution rate for self-employed persons was and remains considerably less than the combined rate for employees and employers (i.e. 3% for self-employed workers and a combined contribution of 14.75% for employees and employers on income of about €400 weekly). This reflects the fact that self-employed workers have access to a more limited range of benefits¹⁷. Coverage for short-term insurance-based payments was excluded on the grounds that it would prove administratively and legally complex and would be costly to implement.

In regard to work accident and occupational disease, an employer has obligations not only to protect his or her employees from danger, but also to investigate and report on all accidents or injuries sustained. In the case of a self-employed person there is no similar third party to provide confirming evidence to the Department in the event of a claim. In the Irish context, it is felt that the nature of the risks involved and the control and investigation measures required for self-employed situations are more effectively handled by private income protection from the commercial insurance sector.

Question:

¹⁷ Widow’s/Widower’s (Contributory) Pension, the Orphan’s (Contributory) Allowance, the State Pension (Contributory), Maternity Benefit, Adoptive Benefit and the Bereavement Grant

“The Committee recalls that Article 12§1 of the Revised Charter requires that social security benefits are adequate, which means that, when they are income-replacement benefits, their level should be fixed such as to stand in reasonable proportion to the previous income and it should never fall below the poverty threshold defined as 50 % of median equivalised income and as calculated on the basis of the Eurostat at-risk-of-poverty threshold value. The report indicates that, in 2004, the sickness benefit was 566 € per month, to which supplements for dependant adult (375.40 €) and/or child (70.50 €) could be added. Considering that the poverty threshold calculated as defined above was 747.40 € in 2004, the Committee notes that the sickness benefit is adequate because it is above the poverty threshold only if the supplements are included. The Committee therefore considers that the situation is not in conformity for a single worker since the level of the benefit is manifestly inadequate.

..... In 2004, the level of the unemployment benefit was the same as the sickness benefit. The Committee therefore refers to its previous reasoning and considers the situation not to be in conformity with the Revised Charter.”

12.1.7 Response:

The Government of Ireland (1) does not accept that 50% of the median equivalised income is a reliable benchmark of the poverty threshold, and (2) questions the conclusion of non-conformity with the Revised Charter on this basis.

(1) A reliable benchmark?

We refer again to our reasons set out in previous reports for not accepting the median equivalised income as a reliable benchmark including:

- the widespread rejection within the EU of this statistic as a reliable indicator of poverty,¹⁸
- the fact that the median in Ireland rose by 140% in a 10 year period in which the average industrial earnings (AIE) rose by only 62% and the consumer price index (CPI) rose by only 35% evidences the distortion in this figure, resulting from (among other factors) a large increase in the number of 2 income families. In particular, this shows it to be an unfair indicator with reference to

¹⁸ The problems inherent in using the ‘at risk of poverty’ indicator for international comparisons were also restated in an article in the UN Development Programme journal “Development and Transition”, which concluded that:

The results too often belie common sense;

The ‘at risk of poverty’ label sends the wrong signal to the public and policy makers;

The ‘risk of poverty’ logic does not lead to effective national policy.

A copy of this article can be accessed on the following website:

<http://www.lse.ac.uk/collections/developmentAndTransition/DevAndTransFour.pdf>

single persons. In the same period the rates of social welfare benefits increased by around 81%.

This indicator measures income alone and does not adequately reflect other factors that contribute to poverty or standard of living like home ownership, and household allowances and supports provided by the State. (See comment on rent supplement in the answer below concerning maternity benefit.)

Please see also the information provided under Article 30 regarding the Irish approach to and progress in the elimination of poverty.

It is a well-established principle that the fundamental answer to consistent poverty is employment rather than social welfare supports. In the case of Ireland the following factors warrant consideration in this context.

One of the elements that contributed to the strong Irish economy in the late 90's and early 00's was the conclusion of social partnership agreements which agreed to forego wage increases in favour of reduced taxation, and to keep social insurance contributions low, in order to keep the employment cost of the Irish workforce as low as possible. The success of this policy, through changing the economic situation, resulted in a huge reduction to 4% in the rate of unemployment, the social insurance fund became self-supporting throughout this period for the first time, and both that fund and the national exchequer were able to grant substantial increases in social supports, raising the standard of living for all and taking many people out of consistent poverty.

The difficulties experienced by Ireland as a result of the recent downturn in the economy would be greatly increased if the social welfare rates were tied to the median income. A more studied evaluation of this will be possible as the statistics become available, but it is already known that unemployment has risen to an unprecedented figure over 400,000, wages of many (especially the higher earners) have dropped so it can be safely assumed that the median income will also have dropped, the social insurance fund is no longer self-supporting, and there has been a serious fall in exchequer income. It could well be argued therefore that the median income in the good times was unrealistic and unsustainable and if the social welfare rates had been tied to such a benchmark they would be equally unrealistic and unsustainable.

It has been widely recognised also that current policy with regard to benefit rates and conditions has to be determined with a careful eye on the long-term sustainability aspect.

An additional consideration is that, certainly in the Irish experience, benefit levels have a significant impact on activation measures. Currently the national minimum wage of €8.65 per hour results in €346 wages for a 40 hour week. Standard rates of payment for illness or jobseekers benefit are currently €204.30 for a single person, €339.90 for a couple and €391.90 for a couple with two children, plus in many cases additional supports towards rent for accommodation (see answer below re maternity benefit for details). To increase the single rate of benefit would have a direct knock-on effect on all rates, negatively affecting activation measures and, by creating unrealistic expectations regarding wages, would be counter-productive to the recovery of the economy.

The Irish Government therefore maintains that the benefit rates provided were appropriate to the economic circumstances that prevailed and that it is a wiser approach to determine such rates in the light of wage levels in general, the cost of living indices, and the general affordability of those rates, rather than artificially tying the rates to the median equivalised income.

(2) The conformity issue

It appears from the information available that the median income standard was not referred to by the Committee until 2006, and was therefore not in view when Ireland undertook to be bound by this Article.

It is the view of the Irish Government that the question of adequacy of the social security system is explicitly dealt with in paragraph 2 of Article 12. The opening words of that paragraph (“with a view to ensuring the effective exercise of the right to social security”) obviously show that the intention is to define and particularise the understanding of paragraph 1 in regard to adequacy of the national provisions. To introduce a second (and conflicting standard) into paragraph 1 of that Article is to create internal conflict and inconsistency within the Charter.

It seems mutually contradictory to find on the basis of paragraph 2 that Ireland is in conformity with its obligations under the Charter and to find on the basis of paragraph 1 *with regard to the same issue of adequacy* that Ireland is not in conformity with the Charter.

The table included in the report under Article 12.2 shows that in most cases the rates of benefit payable far exceed the rates required by the Code.

For the above reasons the Government of Ireland does not accept (1) that the median equivalised income is an appropriate measure of adequacy or (2) that Ireland is not in conformity with the Charter in this respect.

Question:

“As regards maternity benefits, the Committee notes that there is no statutory obligation for the employer to continue paying the salary. The benefit is 70 % of earnings in the previous year, subject to a maximum and a minimum. The minimum benefit was 636.70 € per month in 2004. This level stands in between the poverty threshold defined as 50 % (747.40 €) and 40 % (579.60 €) of the median equivalised income. In such case, the Committee asks whether the maternity benefit is supplemented by other forms of financial assistance and reserves its position as to the conformity of the situation.”

12.1.8 Response:

The benefit level was increased to 75% of previous earnings from January 2004 and to 80% from January 2005. Maximum and minimum levels continued to apply. In the period under review in this report the weekly levels were:

Period	Maximum level €	Minimum level €
Year 2006	265.60	182.60
Year 2007	280.00	207.80

Additional factors that could be considered are:

The 75 or 80% benefit level is calculated on the pre-tax earnings in the governing contribution year, whereas maternity benefit is not taxable. If the person was paying 20% tax, the replacement level (for persons between the maximum and minimum levels) would be effectively 100% of earnings in the governing year.

Rent supplement under the supplementary welfare scheme is payable where a person is in receipt of social security income. A person in receipt of maternity benefit would receive such a supplement covering most of her rent if she was the sole adult occupier of the premises or if her spouse or partner was not in employment. Similarly mortgage interest supplement may be claimed if the person owns her home subject to mortgage.

The amount of supplement is subject to a means test and to the rent in payment being reasonable considering the going rates in the particular locality and the needs of the claimant or family. A person in suitable accommodation with no assessable means could be asked to pay (currently) €24 weekly towards the rent, and the balance would be covered by the rent supplement.

(Note: entitlement to rent supplement would be available in similar circumstances to a person dependent on other social welfare benefits, including single persons on unemployment or illness benefit.)

Question:

“The Committee asks the next report to provide figures, for the period of reference, for every branch in percentage in order to be able to assess the effective coverage of the total population (health care, sickness insurance and family benefits) or of the active population (sickness and maternity benefits, unemployment benefits, pensions, and work accidents or occupational diseases benefits).”

12.1.9 Answer:

Coverage for the various branches (including the branches not yet accepted by Ireland under the European Code of Social Security) are as follows:

Branch	Most relevant criterion in Code	% required by Code	% covered in Ireland
Medical Care	Prescribed classes of residents	50% of all residents	To be supplied by DOHC
Sickness	Prescribed classes of employees	50% of all employees	93%

Unemployment	Prescribed classes of employees	50% of all employees	93%
Old age	Prescribed classes of economically active	20% of all residents	59%
Work Injury/ disease	Prescribed classes of employees	50% of all employees	99%
Family	All residents	subject to means limit	100% (no means limit)
Maternity	Prescribed classes of economically active	20% of all residents	59%
Invalidity	Prescribed classes of employees	50% of all employees	93%
Survivors	Prescribed classes of economically active	20% of all residents	62%

The above table and the table under Article 12.2 show that with regard to both coverage and rates of payment, the Irish provisions in most cases greatly exceed the standards required by the Code.

ARTICLE 12 :- THE RIGHT TO SOCIAL SECURITY

Article 12, Paragraph 2 :-

"With a view to ensuring the effective exercise of the right to social security, the Contracting Parties undertake: to maintain the social security system at a

satisfactory level at least equal to that necessary for the ratification of the European Code of Social Security;”

Questions asked of all Parties (member states of the Council of Europe, which have signed and ratified the Revised European Social Charter):

Question A

Please specify the branches of social security in which the social security system in force in your country fulfils (or goes beyond) the requirements of the European Code of Social Security.

Question B

With regard to the branches of the social security system in force which do not reach the level provided for in the Code, please indicate the differences between your established standards and those of the Code.

=====

=====

=====

Article 12, Paragraph 2 :- Text of Our Report :-

Material supplied by the Department of Social and Family Affairs.

Questions A and B above refer :-

12.2.1 The Department has ratified the European Code of Social Security. The parts accepted at present are:

- Part III – Sickness Benefit
- Part IV- Unemployment Benefit
- Part V – Old Age Benefit
- Part VII – Family Benefit
- Part X – Survivor’s Benefit.

In respect of the period in question (2006 and 2007) the Department responded to the satisfaction of the Committee of Experts on each point raised, and to date has been accepted as complying with the requirements of the Code.

12.2.2 In view of the current economic situation, the Department has postponed seeking Government approval for undertaking compliance with additional Parts until a more favourable political climate is re-established.

12.2.3. Comparison of benefit rates with the requirements of the Code of Social Security (April 2006):

Benefit	Standard Beneficiary per Schedule to	Reference wage calculated per Article	Benefit calculated per Article 66 (€)	Required percentage	Actual percentage

	Part XI	66 (€)			
Sickness	Couple + 2 children	537.76	378.63	45	70
Unemployment	Couple + 2 children	537.76	378.63	45	70
Old age	Couple over pension age	389.53	342.60	40	88
Injury benefit	Couple + 2 children	537.76	378.63	45	70
OIB invalidity	Couple + 2 children	537.76	575.53	50	107
OIB survivors	Widow + 2 children	537.76	307.03	40	57
Maternity (minimum rate)	Woman	389.53	182.60	45	47
Invalidity	Couple + 2 children	537.76	401.33	40	75
Survivors	Widow + 2 children	537.76	283.73	40	55

With regard to the Parts of the Code not yet undertaken by Ireland, the following indicates the position:

Part II Medical Care- the percentage of the population fully covered for free doctor and prescription services does not meet the standard required.

Part VI Injury benefit – Ireland complies with ILO Convention 121 and could undertake this Part. This matter is under consideration by the Department.

Part VIII Maternity benefit – The minimum rate of benefit is too close to the relevant standard to allow undertaking this Part without fear of being able to maintain the standard required.

Part IX Invalidity benefit – there is no provision under current Irish legislation for payment of benefit where the incapacity is partial (“to an extent prescribed”).

ARTICLE 12 :- THE RIGHT TO SOCIAL SECURITY

Article 12, Paragraph 3 :-

*"With a view to ensuring the effective exercise of the right to social security, the Parties undertake:
to endeavour to raise progressively the system of social security to a higher level;"*

Questions asked of all Parties (member states of the Council of Europe, which have signed and ratified the Revised European Social Charter):

Question A

Please describe any measures taken to establish higher social security standards, in particular any measures raising the system to a higher level than that of the European Code of Social Security. Please also provide information in relation to the standards of the Protocol to the European Code of Social Security and/or the revised European Code of Social Security.

Question B

As far as any other changes in the social security field are concerned, especially in so far as they are not aimed at bringing the system to a higher level, please include the following elements:

- the nature of the changes (field of application, conditions for granting allowances, amounts of allowance, lengths, etc.);*
- the reasons given for the changes, the framework of social and economic policy they come within and their adequacy in the situation which gave rise to them;*
- the extent of the changes introduced (categories and numbers of people concerned, levels of allowances before and after alteration);*
- the existence of measures for those who find themselves in a situation of need as a result of the changes made (this information can be submitted under Article 13);*
- the results obtained by such changes.*

=====

=====

=====

Article 12, Paragraph 3 :- Text of Our Report :-

Material supplied by the Department of Social and Family Affairs.

Questions A and B above refer:-

- 12.3.1 Details of annual increases in 2006 and 2007 have been shown above under Paragraph 1 of Article 12.
- 12.3.2. Increases in the rates of maternity benefit are dealt with at paragraph 12.1.8 above.
- 12.3.3 The Social Welfare Law Reform and Pensions Act 2006 introduced the following improvements: the duration of carer’s benefit was extended from 65 weeks to 104 weeks; automatic transfer at pension age to old age contributory pension was introduced for persons in receipt of invalidity pension or retirement pension. Several benefit schemes were renamed – e.g. old age pensions were renamed State pensions.
- 12.3.4 Early Childcare Supplement – new scheme

From 1st April 2006, an early childcare supplement was introduced for each child under 6 years of age at the rate of €250 every 3 months in recognition of the cost of childcare, but is payable regardless of whether the parents are

paying for childcare or providing that care themselves. The Government has undertaken to introduce in its place from January 2010 a free pre-school year of Early Childhood Care and Education for all children between the ages of 3 years 3 months and 4 years 6 months.

- 12.3.5 The Social Welfare and Pensions Act 2007 included additional provisions protecting a person's entitlement if they transfer from one scheme to another, or into short-term employment. It also provided that the increase for a qualified adult would be paid direct to that adult instead of being paid to the principal beneficiary in the case of persons over pension age.
-
-

ARTICLE 12 :- THE RIGHT TO SOCIAL SECURITY

Article 12, Paragraph 4 :-

*"With a view to ensuring the effective exercise of the right to social security, the Parties undertake:
to take steps, by the conclusion of appropriate bilateral and multilateral agreements, or by other means, and subject to the conditions laid down in such agreements, in order to ensure:*

(a) equal treatment with their own nationals of the nationals of other Parties in respect of social security rights, including the retention of benefits arising out of social security legislation, whatever movements the persons protected may undertake between the territories of the Parties;

(b) the granting, maintenance and resumption of social security rights by such means as the accumulation of insurance or employment periods completed under the legislation of each of the Parties."

Questions asked of all Parties (member states of the Council of Europe, which have signed and ratified the Revised European Social Charter):

Question A

Please give the list of bilateral and multilateral agreements as provided for in this provision and indicate how they allow, for the various social security benefits, the implementation of the principles provided for in sub-paragraphs a) and b).

Question B

Please indicate whether, in the absence of any bilateral or multilateral agreements, the nationals of other Contracting Parties concerned are granted the implementation of the principles provided for in sub-paragraphs a) and b) for the various social security benefits.

Question C

Please indicate the length of the prescribed period of residence before nationals of the other Contracting Parties become eligible for benefits which are available independently of any contribution.

=====
=====
=====

Article 12, Paragraph 4 :- Text of Our Report :-

Material supplied by the Department of Social and Family Affairs.

Questions A, B and C above refer :-

12.4.1 Bilateral agreements are in place between Ireland and Australia, Canada (including a separate agreement with Quebec), New Zealand, USA and the UK. A revised agreement with Australia came into effect from 1 January 2006 updating and extending the list of Irish payments excluded from assessment in determining Australian entitlements. A revised agreement with the UK came into effect on 1 October 2007, replacing previous agreements with a comprehensive provision covering those parts of the UK not governed by the EU Regulations (i.e. the Channel Islands and the Isle of Man). An agreement was also concluded with the Republic of Korea, and this came into effect on 1 January 2009.

Conclusions of the European Committee of Social Rights Conclusions 2006 (Ireland)

Question:

“... EU member States must guarantee to at least those nationals of other States parties to the Charter and to the Revised Charter equal treatment with respect to social security rights provided they are legally resident. The Committee asks the next report to provide information about the extension in practice of the equal treatment principle to the third country nationals.”

12.4.2 Response:

There are no nationality clauses in Irish Social Welfare legislation. Therefore non-nationals have the same entitlement to contributory and non-contributory payments, subject to the same conditions. The implications of the extension of EC Regulation 1408/71 to third country nationals were advised to all relevant deciding officers in a detailed note, and included in the Department’s guidelines on the application of the EU Regulations.

<http://www.welfare.ie/EN/Policy/EU/Euguide/Pages/euguideindex.aspx>

Question:

“The report indicates that no bilateral agreements exist with the other states party to the Charter and to the Revised Charter not covered by Community legislation. The Committee asks whether there is any agreement foreseen with the following countries (Albania, Andorra, Armenia, Azerbaijan, Bulgaria, Croatia, Georgia, “the former Yugoslav Republic of Macedonia”, Moldova, Romania, and Turkey) and whether they would guarantee equal treatment, accrued retention of benefits and aggregation of insurance or employment periods. The Committee recalls that States party can comply with their obligations not only through bilateral or multilateral agreements, but also through unilateral measures.

The report does not provide information as to whether the situation regarding accumulation of insurance or employment periods for nationals of other states party not covered by Community legislation or by any agreement, which it previously found not to be in conformity with the Revised Charter, has changed. The Committee, therefore, considers it to be still not in conformity.”

12.4.3 With regard to bilateral agreements with the countries listed in the 2006 Conclusions: Bulgaria and Romania have been covered by EC Regulation 1408/71 since 1 January 2008 and there is no requirement for additional measures. No action has been taken with regard to bilateral agreements with the other countries. It is noted that several of these countries have not ratified Article 12.4 and there are relatively few movements of workers between Ireland and any of these countries. Equal treatment is granted under Irish

legislation without the need of a bilateral agreement, but no provisions exist in such cases for the aggregation of insurance periods.

Question:

“As regards the payment of family benefits States applying the 'child residence requirement' are under the obligation, in order to secure equal treatment within the meaning of Article 12§4, to conclude within a reasonable period of time bilateral or multilateral agreements with those states which apply a different entitlement principle. The Committee notes that no bilateral agreements exist with the following countries: Albania, Armenia, Georgia and Turkey, and asks whether it is envisaged to conclude them and in what time delay.”

Answer:

12.4.4 Ireland continues to provide child benefit as a child-centred universal support to all children resident in Ireland, not related to the nationality, income, contribution or employment status of either parent. It is paid to the parent with whom the child or children reside. There is no intention to introduce an entitlement to migrant workers from other countries (whether through bilateral agreement or otherwise) which is not available to Irish nationals whose children reside abroad.

The reference in the 2006 Conclusions that the habitual residence requires “*inter alia* a two years residence before applying for a benefit” is not accurate. The legislative reference to the period of two years is **a rebuttable presumption** that a person who has not lived in Ireland for 2 years is not habitually resident unless they show evidence to the contrary. The criteria laid down by case law of the European Court of Justice with regard to determination of habitual legislation have been included in the domestic legislation (see Section 30 of the Social Welfare and Pensions Act 2007 - <http://www.oireachtas.ie/documents/bills28/acts/2007/a807.pdf>). A person is not prohibited from applying for an assistance payment or child benefit on arrival in the country, and it is quite feasible for a person to show that their main centre of interest and future intentions lie in Ireland from the time of their arrival, depending on the circumstances of the particular case.

Question:

The Committee recalls that old age benefit, invalidity benefit, survivor's benefit and work accidents or occupational disease benefit acquired under the legislation of one state according to the eligibility criteria laid down under national legislation are maintained whatever the movements of the beneficiary. In its previous conclusion (Conclusions 2004, p. 279) it found the situation to be in conformity with the Charter because longterm work accidents or occupational disease benefits were exportable. Taking into consideration that during the period of reference there were no bilateral agreements applying, the Committee asks the next report to clarify if also the other above-mentioned benefits (old age benefit, invalidity benefit, survivor's benefit) are paid abroad for non-nationals who are not covered by Community legislation.

Answer:

12.4.5 State Pension (contributory) and (transition) – payable respectively at age 66, or at age 65 if retired – are exportable in all cases. The same is true of invalidity pension and contributory survivor’s benefits.



Article 13

ARTICLE 13: THE RIGHT TO SOCIAL AND MEDICAL ASSISTANCE ARTICLE 13 PARA. 1

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

Questions asked of all Parties (member states of the Council of Europe, which have signed and ratified the Revised European Social Charter):

Question A

Please describe the general organisation of the current public social and medical assistance schemes.

Question B

Please provide detailed information on the different types of social and medical assistance, specifying for each one:

- its form (benefits in cash and/or in kind);
- the categories of persons covered and the number of persons who were in receipt of assistance during the reference period;
- the conditions for the granting of assistance, the criteria used to assess need, the procedure for determining whether a person is without adequate resources, and the body which decides when assistance is to be granted;
- as far as possible, information demonstrating the adequacy of the assistance with respect to the cost of living.

Question C

Please indicate the means by which the right to assistance is secured, indicating whether individuals may uphold their right before an independent body...- 53 -

Question D

Please give the amount of public funds (central government or local authorities) allocated to social and medical assistance as well as the percentage of GDP this represents, and, if possible, give an estimation of the amount of private funds devoted to assistance.

Article 13, Paragraph 1 :- Text of Ireland's Sixth Report under the Revised European Social Charter : -

Material supplied by the Department of Social and Family Affairs:-

Questions A- D above refer :-

The reply given in the previous report continues to apply. The updated tables are as follows:

<u>Social Assistance Payments –</u>	<u>Weekly Rates</u>	<u>Weekly Rates</u>	<u>Weekly Rates</u>	Increase
	€	€	€	
	2005	2006	2007	%
Jobseeker's Allowance				
Pre-Retirement Allowance				
Disability Allowance				
Farm Assist				
Supplementary Welfare Allowance				
Personal Rate	148.80	165.80	185.80	25
Increase for qualified adult	98.70	110.00	123.30	25
State Pension (Non-Contributory)	2005	2006	2007	%
Personal Rate	166.00	182.00	200.00	20
Increase for qualified adult	109.70	120.30	132.20	20
Blind Person's Pension:	2005	2006	2007	%
Personal Rate (Under age 66)	148.80	165.80	185.80	25
Personal Rate (Aged 66 or over)	166.00	182.00	185.80	12
Increase for qualified adult	98.70	110.00	123.30	25
Widow(er)'s (Non-Contributory) Pension, and One Parent Family Payment	2005	2006	2007	%
Personal Rate (Under age 66)	148.80	165.80	185.80	25
Personal Rate (Aged 66 or over)	166.00	182.00	185.80	12
Guardian's Payment(Non-contributory)	2005	2006	2007	%
	121.00	138.00	158.00	30
Carer's Allowance:	2005	2006	2007	%
One Caree	153.60	180.00	200.00	30
More than one Caree	230.40	270.00	300.00	30

Increases:				
For Carer's aged 66 or over (One Caree)	16.20	20.00	n/a	
For Carer's aged 66 or over (More than one Caree)	24.30	30.00	n/a	
Respite Care Grant (One Caree) annually	1,000.00	1,200.00	1,500.00	50
Respite Care Grant (More than one Caree) annually	2,000.00	1,200.00 per person cared for	3,000.00	50

13.1.2 The increases during the above period compare favourably with the increase of 10% in the Consumer Price Index and of 8% in the Average Industrial Wage.

13.1.3 Statistics for Expenditure in 2006 and 2007 are available in the Statistical Report published on the Department's website at <http://www.welfare.ie/EN/Policy/ResearchSurveysAndStatistics/Pages/2007stats.aspx>

13.1.4 Total expenditure on social assistance services and the numbers of recipients are detailed in the answer to the Committee's question under paragraph 13.3 below. The total expenditure of the Department of Social and Family Affairs on social assistance and social insurance increased from 7.5% of GDP in 2005 to 8.1% in 2007. In the same period, this expenditure increased from 28.2% to 29.4% of gross current Government expenditure.

13.1.5 Apart from the above changes in rates, there were no major changes in the administration or provisions regarding entitlement during the years 2006 and 2007.

13.1.6 The Social Welfare Law Reform and Pensions Act 2006 provided for the closure of the pre-retirement allowance to new claims. The decision to phase out this scheme reflected the strength of the labour market at that time, the value to the worker of maintaining attachment to the labour force, and the recognition that early retirement schemes are inconsistent with the long-term need to ensure a sustainable insurance fund.

13.1.7 The same Act provided for the merging of all non-contributory payments over pension age into a single age pension, renamed the State Pension (non-contributory).

13.1.8 Various amendments to the means test were introduced both in the above 2006 Act and in the Social Welfare and Pensions Act 2007, in each case improving the rate of entitlement to persons with low means. For instance, a specific earnings disregard of €200 per week for the State Pension (Non-contributory) was introduced so that additional income from employment can be earned without losing pension entitlements.

13.1.9 The 2007 Act also included in domestic legislation the factors set out in ECJ judgments for determining habitual residence.

13.1.10 There has been no change to the right and process of appeal as described in our last report.

Material supplied by the Department of Health and Children:-

13.1.11 Further to our detailed response in 2006, as part of the Government of Ireland's Third Report to the Council of Europe under the Revised European Social Charter, which is not repeated here, the following is the current position of Ireland's health services in relation to the provisions of Article 13 of the Revised European Charter.

13.1.12 Financing of the health care system in Ireland

The public money spent on health comes from funds raised primarily through general taxes.

A relatively small portion of overall funding comes from a specific levy on income which goes on a dedicated basis to the health services. This health contribution is levied on income at a percentage rate set in pursuance of the Health Contributions Act and is paid over to the Minister for Health and Children through the annual allocation for the Health Service Executive. The current rate of contribution is 2% of gross income up to € 1,925 per week or €100,100 per annum and 2.5 % on the balance of income in excess of those amounts in a contribution year. Subject to exemptions, the rate of contribution is applicable to all persons over the age of sixteen with reckonable income, earnings or emoluments. There are a number of exemptions to the payment of the health contribution.

13.1.13 Entitlement to health services

Entitlement to health services in Ireland is primarily based on residency and means. Any person, regardless of nationality, who is accepted by the Health Service Executive (HSE) as being ordinarily resident in Ireland is entitled to either full eligibility (Category 1, i.e. medical card holders) or limited eligibility (Category 2) for health services.

Persons in Category 1 are medical card holders and they are entitled to a full range of services including general practitioner services, prescribed drugs and medicines, all in-patient public hospital services in public wards including consultants services, all out-patient public hospital services including consultants services, dental, ophthalmic and aural services and appliances and a maternity and infant care service (see further information below). Determination of eligibility for medical cards is the responsibility of the Health Service Executive and further information can be found on the HSE's website

http://www.hse.ie/portal/eng/Find_a_Service/entitlements/Medical_Cards/

Persons not entitled to a medical card, but with an income below a certain threshold may be entitled to a GP visit card. A GP visit card entitles the holder to free GP services. For those who do not qualify for a medical card, a number of schemes exist which provide assistance towards the cost of medication. Under the Drug Payment Scheme a person and his/her dependants do not have to pay more than €100 in any calendar month for approved prescribed drugs, medicines and appliances.

Persons in Category 2 (non medical card holders) are entitled, subject to certain charges, to all in-patient public hospital services in public wards including consultant services and to out-patient public hospital services including consultant services. The current public hospital statutory in-patient charge is €75 per night, up to a maximum of €750 in any twelve consecutive months. There is no charge for outpatient services, other than in respect of attendance at accident and emergency departments which is subject to a charge of €100 where the patient does not have a referral note from his/her doctor.

The maternity and infant care scheme provides an agreed programme of care free of charge to all expectant mothers who are ordinarily resident in Ireland. This service is provided by a family doctor (GP) of your choice and a hospital obstetrician. The GP who attends the mother also provides care for the new-born baby. This entails two developmental exams during the first 6 weeks following the birth.

The Department of Health and Children has commenced work on a new legislative framework to provide for clear statutory provision on eligibility for and entitlement to health and personal social services. This is in keeping with a commitment first signalled in The National Health Strategy 2001 and more recently in Towards 2016 (the ten year social partnership agreement 2006-2015 agreed in 2006). The purpose of the review is to clarify and simplify eligibility and entitlement to health and personal social services within the broad parameters of the existing system and to reflect developments in service delivery and technology that have occurred since the Health Act 1970.



Conclusions of the European Committee of Social Rights Conclusions 2006 (Ireland)

13.1.14 Question:

- The Committee asks that the next report contain detailed information:*
- on how the (habitual residence) condition and the above-mentioned criteria are applied in practice, including on the number of foreign nationals who have been refused social assistance on the ground that they do not satisfy the habitual residence condition;
 - on the situation of applicants, be nationals or foreigners, who have been habitually resident in Ireland, have subsequently left the country to live abroad and have then returned in Ireland.

13.1.15 Our Answer:

Application in practice:

When a claim for a payment subject to the habitual residence condition (HRC) is received, it is initially vetted to see if the condition is obviously satisfied or if there is need for particular investigation of this aspect. If particular investigation is required a questionnaire is issued to obtain the relevant information from the claimant and on return the case is passed to a specially trained deciding officer for decision. Detailed guidelines used by the deciding officers for the application of the condition in general and the application of the relevant criteria are published on the Department's website at:

<http://www.welfare.ie/EN/OperationalGuidelines/Pages/habres.aspx>

Statistics:

A survey of 2006 statistics showed that, for each of the schemes involved, between 91% and 99% of cases satisfied HRC without the need for particular investigation. For instance, only 9,100 of 104,500 claims for Jobseeker's Allowance were so referred (9%), only 7,000 of 188,500 claims for child benefit (4%), and 11 of 1200 claims (1%) for widow's non-contributory pension, guardian's non-contributory payment and blind pension.

The attached table shows the outcome of decisions in cases that required particular investigation in the period 1 May 2004 (when HRC was introduced) and end December 2007.

Nationality Group	IRISH	UK	EU 13	NEW EU MEMBER STATES	OTHER	Total
Decisions –HRC satisfied -	14558	5120	1788	6871	19956	48293
Decisions – HRC not satisfied -	1684	708	2997	7475	3509	16373
Total Cases Decided -	16242	5828	4785	14346	23465	64666
As % of all HRC Decisions	25%	9%	7%	22%	36%	100%
% YES Decisions	90%	88%	37%	48%	85%	75%
% NO Decisions	10%	12%	63%	52%	15%	25%

The statistics were not disaggregated according to the issues involved, but discussion with the relevant managers revealed that the most significant groups of disallowances included EU nationals claiming jobseeker's allowance who had no previous employment in Ireland and no arrangements made for employment on arrival here, Romanian and Bulgarian nationals who had no work permit and no clear means of being self-supporting, and child benefit claims from asylum seekers whose basic needs were met through direct provision.

Returning migrants:

Each case is decided on its own merits in accordance with the circumstances of the person on their return from abroad. If it is shown that the person is intending to resume residence in Ireland, and there is nothing inhibiting their freedom to do so, a positive decision will be made. The relevant considerations are detailed at section 5.2 of the guidelines referred to above, which inter alia outline clearly the application of the ECJ Swaddling judgment.

Some NGOs in Ireland have been critical of the application of HRC to Irish nationals returning to Ireland. (1) Initially it came to notice that Irish missionaries over pension age used to claim and receive non-contributory age pensions for the period of their temporary return from abroad. Representatives of the Department met with the Irish Missionary Union (IMU) early in 2005 to discuss this issue and, following clarification that the habitual residence test would only prevent access to old age pension for temporary visitors to Ireland and would not affect a missionary retiring permanently to Ireland, the IMU expressed its satisfaction on the matter. (2) In the light of continuing criticism from other NGOs, the Department examined its own records of cases decided and repeatedly offered to re-examine any case the critics considered to have had an inappropriate decision, but the allegations of refusal of benefit to persons who have returned permanently were not substantiated. The Department is very conscious that it cannot treat Irish nationals who are returning temporarily to Ireland differently to the way it treats other nationals.

In the context of examining this issue, it was found that 80% of the claims from Irish nationals refused on the grounds that they had not re-established habitual residence in Ireland were for jobseeker's allowance, 10% were for age pension, and the remainder were divided between child benefit, disability allowance, carer's allowance and one-parent family allowance.

ARTICLE 13 PARA. 2

"With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake: to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;"

Question asked of all Parties (member states of the Council of Europe, which have signed and ratified the Revised European Social Charter):

Please indicate briefly how this Article is implemented and what measures are used to ensure in particular, the absence of any direct or indirect diminution of political or social rights

Article 13, Paragraph 2 :- Text of Ireland's Sixth Report under the Revised European Social Charter : -

Material supplied by the Department of Social and Family Affairs:-

13.2.1 The receipt of social assistance does not diminish political or social rights in any way.



ARTICLE 13 PARA. 3

"With a view to ensuring the effective exercise of the right to social and medical

assistance, the Parties undertake:

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;"

Question asked of all Parties (member states of the Council of Europe, which have signed and ratified the Revised European Social Charter):

Please describe the main services covered by this provision, especially the manner in which they are organised and operate, including their geographic distribution. Please give as far as possible information about:

- the staff responsible for providing advice and personal help, as well as an indication of their qualifications and duties;
- measures aimed to ensure an adequate response to the needs of individuals and families.

Article 13, Paragraph 3 :- Text of Ireland's Sixth Report under the Revised European Social Charter :-

Material supplied by the Department of Social and Family Affairs:-

13.3.1. The only change with regard to the information supplied by the Department of Social and Family Affairs in previous reports under this paragraph is that the State information service previously known as Comhairle has been renamed the Citizen's Information Board.

=====

Material supplied by the Department of Health and Children:-

13.3.2 Further to our detailed response in 2006, as part of the Government of Ireland's Third Report to the Council of Europe under the Revised European Social Charter, which is not repeated here, the up to date position of Ireland's health services in relation to the provisions of Article 13 of the Revised European Charter is as outlined in sub-paragraphs 13.1.12 and 13.1.13 above.

Conclusions of the European Committee of Social Rights Conclusions 2006 (Ireland)

Article 13, Paragraph 3 :- Text of Ireland's Sixth Report under the Revised European Social Charter : - Material supplied by the Department of Social and Family Affairs, continued.

13.3.3 Question:

The Committee also notes that there has been an increase in the number of staff in the Public Health Service between the years 2002 and 2005. The Committee asks that the next report contain statistical information on all staff involved in the provision of social services. In this respect it further asks whether it is possible from existing statistical data on social services to identify staff specifically responsible for advice and assistance to prevent, remove and alleviate want, the corresponding expenditure and the number of applicants for and recipients of these services.

13.3.4 Our Answer:

In respect of the administration of the Supplementary Welfare Allowance (SWA) schemes, the following statistics apply: about 970 staff were engaged in the administration of these schemes. Expenditure rose from €550 million in 2006 to over €570 million in 2007. The number of applications are not available (as there would be, for instance, a high turnover of applications from persons seeking short-term assistance while waiting for decision on another social welfare claim) but the numbers of recipients for basic SWA were over 25,000 at the end of 2006 and over 27,000 at the end of 2007. Rent Supplement was paid to nearly 60,000 persons in each year and other supplements (including mortgage interest supplement) to over 20,000.

It is not possible to distinguish the number of staff employed by the Department of Social and Family Affairs (DSFA) dealing with their assistance schemes from those dealing with insurance schemes as many staff would have duties related to both sides of the work. There were approximately 4,300 fulltime posts in this Department throughout the relevant period.

The Committee may wish to note that of these, about 30 work in the central information services unit which maintains the provision of information leaflets and the Department's website, engages with the Citizens Information Board regarding its distribution of information, and deals with about 1,000 phone calls daily from the public. In addition to this the Department has 58 local offices throughout the country and 69 branch offices, all of which have an information role. The larger local offices have dedicated information officers while the smaller offices have trained information providers working on other duties as well as answering information queries. Some schemes whose administration is based in centralised offices have dedicated phone banks dealing with general queries related to those schemes as well as claim specific

queries. The total number of staff working between these various services is not available.

Expenditure by DSFA (the Department of Social and Family Affairs) on assistance schemes (excluding child benefit) in 2006 came to €5.2 billion and in 2007 came to €6.0 billion, compared to €8.4 and €9.5 billion in the same two years for social insurance and child benefit payments.

The number of recipients for the various assistance schemes are detailed in the following table (the numbers of applicants are not available):

Type of payment	2006	2007
State Pension (Non-Contributory)	97,404	97,726
Pre-Retirement Allowance	11,149	10,624
Widow/er's (Non-Contributory) Pension	2,168	2,138
Deserted Wife's Allowance	766	693
Prisoner's Wife's Allowance	2	2
One-Parent Family Payment	83,081	85,084
Guardian's Payment (Non-Contributory)	441	442
Disability Allowance	83,697	89,048
Blind Pension	1,476	1,474
Carer's Allowance	27,474	33,067
Jobseeker's Allowance	75,801	80,268
Back to Work Allowance Employee	3,963	4,305
Back to Work Enterprise Allowance Self Employed First Year	1,683	1,811
Back to Work Enterprise Allowance Self Employed Years 2 - 4	2,690	3,017
Back to Education Allowance	5,679	5,980
Part-Time Job Incentive Scheme	201	210
Family Income Supplement	21,800	22,823
Farm Assist	7,480	7,376
Supplementary Welfare Allowance	25,331	27,379
Rent Allowance (a separate scheme from the SWA rent supplement scheme)	250	227
Total Social Assistance	452,536	473,694

Further details re numbers of recipients, and expenditure on these schemes may be obtained from the 2007 statistics publication at :

<http://www.welfare.ie/EN/Policy/ResearchSurveysAndStatistics/Documents/2007stats.pdf>

=====

=====

=====

ARTICLE 13 PARA. 4

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

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 Contracting Parties lawfully within

their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11th December 1953."
[The Appendix to the Charter stipulates that Governments not parties to the European Convention on Social and Medical Assistance may ratify the Social Charter in respect of this paragraph provided that they grant to national of other Contracting parties a treatment which is in conformity with the provisions of the said Convention.]

Question asked of all Parties (member states of the Council of Europe, which have signed and ratified the Revised European Social Charter):

Please indicate the guarantees which ensure conformity with this provision. Please describe more specifically the provisions which ensure that any repatriation of nationals of other Contracting Parties who are legally within the territory on the sole ground that they are in need of assistance is carried out according to the conditions laid down in Article 6 to 10 of the European Convention on Social and Medical Assistance 1953.

Article 13, Paragraph 4 :- Text of Ireland's Sixth Report under the Revised European Social Charter : -

Material supplied by the Department of Social and Family Affairs :-

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

Questions asked of all Parties (member states of the Council of Europe, which have signed and ratified the Revised European Social Charter):

13.4.2 Question:

With respect to social assistance, the Committee notes the introduction of a habitual residence condition (see the conclusion under Article 13§1) and requests confirmation that this condition does not preclude the granting of emergency assistance to non-residents.

The Committee invites the Government to reply to its question in the general introduction to these Conclusions on the social and medical assistance to which foreign nationals unlawfully in the country are entitled.

13.4.3 Our Answer:

Exceptional needs payments and urgent needs payments under the supplementary welfare allowance scheme (provided for in Sections 201 and 202 of the Social Welfare Consolidation Act 2005) are specifically exempted from the habitual residence condition. Both types of payments are also available to persons unlawfully present.

=====
=====
=====

Text of ARTICLE 14 PARA. 1

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

Standard Questions asked of all Parties (member states of the Council of Europe, which have signed and ratified the Revised European Social Charter) :-

Question A

Please describe the measures taken to apply this provision and list the principal social services of the type mentioned, describing their functions and the target groups they serve.

Question B

Please describe the organisation and administration, the financial resources and working methods of these services, their financial and other relations to the organs of social security and the qualifications of the staff employed by these services.

Question C

Please state what measures have been taken to promote these services during the reference period, whether the individuals are entitled by law to their use or whether those administering have a discretion in granting or withholding them. Please indicate also whether there is a right of appeal against decisions to grant or withhold services.

Article 14, Paragraph 1 :- Text of Ireland's Sixth Report under the Revised European Social Charter :-

Material supplied by the Department of Social and Family Affairs :-

Article 14 — The right to benefit from social welfare services

Paragraph 1 – Provision or promotion of social welfare services

General Introduction :-

14.1.1 We refer to the information provided in the Government of Ireland’s Second Report to the Council of Europe under the Revised European Social Charter. The following is an update of that material. Ireland fully recognises that partnership between the social partners is a key element in economic and social development. In addition to the partnership initiative in relation to the National Economic and Social Forum, (details in the Fourth Periodic Report of the NESF, a copy of which may be accessed at <http://www.nesf.ie/dynamic/pdfs/No-30-Fourth-Periodic.pdf>), the voluntary and community sector, who are involved in the provision of various welfare services, were represented in the negotiations relating to the most recent partnership agreement, the “Towards 2016 Partnership Agreement” which was agreed in 2006. A copy of “Towards 2016” may be accessed at http://www.taoiseach.gov.ie/attached_files/Pdf%20files/Towards2016PartnershipAgreement.pdf

14.1.2 In recent years, the Department of Social, Community and Family Affairs has changed its name to the Department of Social and Family Affairs. Information from the Department of Health and Children and the Department of Community, Rural and Gaeltacht Affairs is also given hereunder.

Material Supplied by the Department of Social and Family Affairs :-

National Action Plan against Poverty and Social Exclusion

14.1.3 Arising from the objective set by the European Council at Lisbon in 2000, “to make a decisive impact on the eradication of poverty and social exclusion by 2010”, Ireland submitted its first National Action Plan to the EU in June 2001 and its second Plan, which applies for the period 2003 to 2005, was submitted in July 2003. This Plan incorporates the strategic approach to tackling poverty as set out in the National Anti-Poverty Strategy (NAPS) and also the Social Partnership agreement, Sustaining Progress. A copy of that Plan may be accessed at http://www.socialinclusion.ie/publications/napincl_plan0305.pdf

14.1.4 The key aim of this plan is “to build a fair and inclusive society and ensure that people have the resources and opportunities to live a life with dignity and have access to the quality public services that underpin life chances and experiences”. Apart from ensuring, through the National Action Plans, that combating poverty and social exclusion is a key part of national efforts to promote economic and social development, the NAPs/Inclusion process enables us to learn from the varied approaches of other Member States in meeting common objectives. It provides us with a better understanding of exclusion in all its manifestations, facilitates exchanges of good practice on how to combat it, and on targets and indicators, and also on how to reconcile progress in this area with maintaining economic competitiveness.

14.1.5 A key element of the Plan has been an innovative equality proofing exercise which was carried out on the draft plan in partnership with the Equality Authority and with the participation of groups from across the nine grounds covered by the equality legislation. This explored the accommodation of diversity in the mainstream elements of the Plan, the capacity of institutional arrangements to address the poverty and inequality link, and the rationale for targeting. It is intended to continue and further develop this process over the life of this plan.

The Office for Social Inclusion (OSI)

14.1.6 The Office for Social Inclusion effectively became operational in January 2003, taking over from the NAPS Unit which had previously exercised the co-ordinating role. The Office is located in the Department of Social and Family Affairs and is the Government Office with overall responsibility for developing, co-ordinating and driving the Irish NAP/inclusion process. It supports government departments and others to implement

NAPS and NAP/inclusion. The work of the Office is overseen by the Management Group of Assistant Secretaries, which is comprised of highlevel representatives of the key Departments involved in combating poverty and social exclusion. It monitors implementation of the NAPS and NAP/inclusion and also has a key role in co-ordinating the work of the various Departments in implementing and developing them.

14.1.7 For further information, please see:

<http://www.socialinclusion.ie>

<HTTP://WWW.SOCIALINCLUSION.IE/DOCUMENTS/NAPINCLUSIONREPORTPDF.PDF>

Family Policies & Services

14.1.8 Family Affairs Unit

A Family Affairs Unit was established within the Department of Social, Community & Family Affairs in 1998 to co-ordinate family policy, pursue the findings of the Commission on the Family, to promote awareness about family issues and undertake research into family issues. It had responsibility for a number of family services including Marriage, Child and Bereavement Counselling Service and the Family Mediation Service.

14.1.9 Family Support Agency

The Family Support Agency was established by the Government in 2003 under the terms of the Family Support Agency Act, 2001. The purpose of the Agency was to bring together the main pro-family programmes and services introduced by the Government, which are designed to:

Promote local family support
Support ongoing parenting relationships for children; and
Help prevent marital breakdown

Throughout 2006 and 2007 the Agency continued to:

Support, promote and develop the provision of marriage and relationship counselling services, child counselling services and bereavement support for families and provide grant aid, with the approval of the Minister for Social and Family Affairs, to voluntary organisations providing these services in the community.

Provide a Family Mediation Service.

Support, promote and develop the Family and Community Services Resource Centre Programme.

14.1.10 Family Mediation Service

This is a free, professional and confidential service which enables couples, who have decided to separate to reach agreement on all issues related to their separation. It facilitates couples in making decisions on matters such as the family home, future parenting arrangements and their financial affairs. The service is currently provided in 16 centres throughout the country.

14.1.11 Family and Community Services Resource Centre Programme

The aim of the Family and Community Services Resource Centre Programme is essentially to help combat disadvantage by improving the function of the family unit. The emphasis in the projects is on the involvement of local communities in developing approaches to tackle the problems they face and on creating successful partnerships between the voluntary and statutory agencies in the area concerned. Family Resource Centres involve people from marginalised and most vulnerable groups and areas of disadvantage at all levels in the project.

14.1.12 Family Services Project

The Family Services Project (FSP) is designed to provide a high quality information service on the range of supports available to families from State agencies and from the community and voluntary sector with a particular emphasis on the services available locally. Within the project, an enhanced programme of support is available to a small group of customers with particular needs, for example, very young lone mothers, other parents rearing children without the support of a partner and dependent spouses in households with children dependent on social welfare payments.

14.1.13 Funding is provided to support the following categories:

Voluntary organisations

Locally-based community & family support groups

Community Development Programme

Family & Community Services Resource Centre Programme

Development of Money Advice and Budgeting Service to assist individuals and families to cope with debts problems and regain control of their finances

Initiatives to improve the security of vulnerable older people in the community

14.1.14 The range of activities undertaken include home management programmes, counselling and advice services, self-development programmes, community education, health programmes, parenting skills, literacy programmes, anti-money lending and money advice and self-help, leadership skills and community development.

Material supplied by the Department of Health and Children :-

14.1.15 Entitlement to health services

Further to the information provided, as part of the Government of Ireland's Second Report to the Council of Europe under the Revised European Social Charter, the following is the current position of Ireland's health services in relation to the provisions of Article 14 of the Revised European Charter.

Entitlement to health services in Ireland is primarily based on residency and means. Any person, regardless of nationality, who is accepted by the Health Service Executive (HSE) as being ordinarily resident in Ireland is entitled to either full eligibility (Category 1, i.e. medical card holders) or limited eligibility (Category 2) for health services.

Persons in Category 1 are medical card holders and they are entitled to a full range of services including general practitioner (GP) services, prescribed drugs and medicines, all in-patient public hospital services in public wards including consultants services, all out-patient public hospital services including consultants services, dental, ophthalmic and aural services and appliances and a maternity and infant care service (see further information below). Determination of eligibility for medical cards is the responsibility of the Health Service Executive and further information can be found on the HSE's website

http://www.hse.ie/portal/eng/Find_a_Service/entitlements/Medical_Cards/.

Persons not entitled to a medical card, but with an income below a certain threshold may be entitled to a GP visit card. A GP visit card entitles the holder to free GP services. For those who do not qualify for a medical card, a number of schemes exist which provide assistance towards the cost of medication. Under the Drug Payment

Scheme a person and his/her dependants do not have to pay more than €100 in any calendar month for approved prescribed drugs, medicines and appliances.

Persons in Category 2 (non medical card holders) are entitled, subject to certain charges, to all in-patient public hospital services in public wards including consultant services and to out-patient public hospital services including consultant services. The current public hospital statutory in-patient charge is €75 per night, up to a maximum of €750 in any twelve consecutive months. There is no charge for outpatient services, other than in respect of attendance at accident and emergency departments which is subject to a charge of €100 where the patient does not have a referral note from his/her doctor.

The maternity and infant care scheme provides an agreed programme of care free of charge to all expectant mothers who are ordinarily resident in Ireland. This service is provided by a family doctor (GP) of your choice and a hospital obstetrician. The GP who attends the mother also provides care for the new-born baby. This entails two developmental exams during the first 6 weeks following the birth.

The Department of Health and Children has commenced work on a new legislative framework to provide for clear statutory provision on eligibility for and entitlement to health and personal social services. This is in keeping with a commitment first signalled in The National Health Strategy 2001 and more recently in Towards 2016 (the ten year social partnership agreement 2006-2015 agreed in 2006). The purpose of the review is to clarify and simplify eligibility and entitlement to health and personal social services within the broad parameters of the existing system and to reflect developments in service delivery and technology that have occurred since the Health Act 1970.

14.1.16 Services for Persons with a Disability

Specialist disability services are provided in a variety of community and residential settings in partnership with service users, their families and carers, and a range of statutory, non-statutory, voluntary and community groups.

The integral role of the non-statutory, voluntary and community groups is of particular relevance in this sector. These agencies provide a very significant and broad range of services in partnership with and on behalf of the HSE. It is acknowledged that because of the historic manner in which services for people with disabilities have developed, many of these agencies were to the forefront in identifying needs in the community and developing responses to them.

Services delivered include:

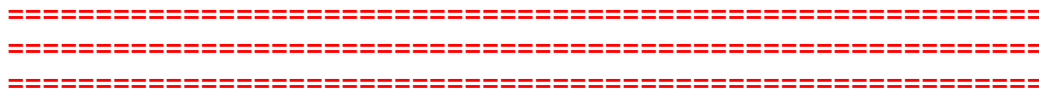
- Early childhood/family support services
- Residential care
- Respite care
- Day services
- Services for persons with autistic spectrum disorder
- Specialist day and residential brain injury services

Rehabilitative training
Sheltered workshops
Community-based medical, nursing and therapy services
Aids and appliances
Home support services
Financial allowances
Other services including counselling, advisory, advocacy, information and general support service

14.1.17 Services for Older People

The Health Service Executive (HSE) provides a broad range of services for older people in our community, including in-patient acute services, step down and convalescent care, day services, rehabilitation, community services, home care and home helps. Further information available at http://www.hse.ie/eng/Find_a_Service/Older_People_Services/

Current national policy is to develop appropriate home and community based services such as home care packages, home help services and day services and to improve the quality and availability of affordable residential care for older people who can no longer live at home.



Material supplied by the Department of Community, Rural and Gaeltacht Affairs :-

14.1.18 The purpose of the Department of Community, Rural and Gaeltacht Affairs is to promote and support the sustainable and inclusive development of communities, both urban and rural, including Gaeltacht (those parts of Ireland where Gaeilge (the Irish Language) is the community language) and island communities, thereby fostering better regional balance and alleviating disadvantage, and to advance the use of the Irish Language. Further information about the Department may be accessed at <http://www.pobail.ie/>

14.1.19 The Department funds, and in some cases administers, a range of programmes of support for community development so that socially excluded groups and local communities can be active participants in

identifying and meeting their own development needs, working alongside the Statutory Agencies and others involved in local development initiatives.

14.1.20 The Department administers the following Programmes and Schemes:

Community Development Programme

This Programme provides financial assistance to fund community development projects in disadvantaged areas. It also provides support for self-help work in specific target groups that experience disadvantage - disadvantaged women and men, lone parents, travellers, etc. - in order to help them articulate their point of view and participate in a process of personal and community development. The Programme is included in the National Development Plan as a sub-measure in the social inclusion measures in the Regional Operational Programmes.

Local Development Social Inclusion Programme (LDSIP)

The Local Development Social Inclusion Programme is a series of measures that are designed to counter disadvantage and to promote equality and social and economic inclusion. [Further information on LDSIP is available through this link.](#)

Community Services Programme

The purpose of the Community Services Programme is to support 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 2006 – 2008 was approximately €40.3m in 2006, €44.5m in 2007 and €47m in 2008. At the end of 2008, over 400 projects had been approved for funding under the Community Services Programme, supporting in the region of 2,200 employees.

By the end of August 2009, more than 450 projects had been approved for funding, with a total of 416 in receipt of funds. It is anticipated that the Programme will support around 2,700 workers by the end of 2009. Expenditure under the Programme in 2009 is expected to be in the region of €48.7m.

[Further information on the Community Services Programme is available through this link](#)

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.](#)

And access the following material from the box - This Section

[Community Development Programme](#)

[Local Development Social Inclusion Programme \(LDSIP\)](#)

[Contact Us](#)

[Community Services Programme](#)

[Review of Community and Local Development Structures](#)

[Downloadable Leaflets / Forms](#)



Original European Social Charter (1961) – European Committee of Social Rights (ECSR) Addendum to Conclusions **XV-2** (Ireland) **Articles 7, 8, 11, 14, 17 and 18** and Questions for answer by Ireland arising from our **19th** Report, submitted in **2001**, under the original European Social Charter (1961) :-

Article 14 — The right to benefit from social welfare services

Paragraph 1 – Provision or promotion of social welfare services

14.1.21

The Irish report states that the government department responsible for social services (the Department of Social Welfare) has changed its name to the Department of Social, Community and Family Affairs, in order to reflect its evolving engagement with the voluntary and community sectors and to emphasise the stronger focus on developing policy and services for the family. The report refers to the government's 10-year National Anti-Poverty Strategy (NAPS), the target of which is to reduce the number of people in consistent poverty to less than 5 % by 2004.

In reply to the Committee's request for detailed information on social welfare services for elderly people, the disabled, children and adolescents, the report explains that the Department of Social, Community and Family Affairs does not provide social services directly, but supports organisations in civil society that provide services for the target groups concerned. Activities are funded on a case-by-case basis and cover all socially deprived areas, rural as well as urban. Support is made available through a range of grant schemes and it appears from the report that expenditure on these schemes has grown steadily since the mid-1990s.

The Committee notes that activities include home management programmes, counselling and advice services, self-development programmes, community education, health programmes, parenting skills, literacy programmes, anti-money lending and financial advice, self-help, leadership skills and community development. It asks that the next report furnish more details on the services provided for the above-mentioned target groups, including on the number of beneficiaries and on expenditure. **In the latter respect the Committee notes from another source¹⁹ that expenditure on the scheme of Community Support for Older People decreased by about 40 % from 1998 to 1999.** The Committee asks that the next report indicate the reasons for this reduction in expenditure, its impact on the standard of service to older people and whether any additional measures have been taken to avoid hardship. Finally, the Committee asks what measures have been taken to ensure and inspect the quality of social services provided by voluntary organisations, community groups and other civil society providers. Pending receipt of the information requested, the Committee concludes that the situation in Ireland is in conformity with Article 14 para. 1 of the Charter.

14.1.22 Response :- Please see our report above.

¹⁹ Statistical Report on Social Welfare Services 1999.

ARTICLE 14: THE RIGHT TO BENEFIT FROM SOCIAL WELFARE SERVICES

Text of ARTICLE 14 PARA. 2 of the Revised European Social Charter

ARTICLE 14 PARA. 2

"With a view to ensuring the effective exercise of the right to benefit from social welfare services, the Parties undertake: to encourage the participation of individuals and voluntary or other organisations in the establishment and maintenance of such services."

=====
Question asked of all Parties (member states of the Council of Europe, which have signed and ratified the Revised European Social Charter) :-

Please indicate the measures taken to provide for or to encourage the participation of individuals and charitable organisations and other appropriate organisations in the establishment and maintenance of such services.

=====
=====
Original European Social Charter (1961) – European Committee of Social Rights (ECSR) Addendum to Conclusions XV-2 (Ireland) Articles 7, 8, 11, 14, 17 and 18 and Questions for answer by Ireland arising from our 19th Report, submitted in 2001, under the original European Social Charter (1961) :-

The Committee notes from the Irish report that a consultation document, "Supporting Voluntary and Community Activity", was published in 1997 concerned with examining the relationship between the State and the voluntary and community sectors. On the basis of a consultation process with the various stakeholders a White Paper is to be published. The Committee wishes to be informed of the conclusions of the White Paper and any measures taken.

As regards the quality of social services provided by non-state providers, the Committee refers to its questions under Article 14 para. 1.

The Committee concludes that the situation in Ireland is in conformity with Article 14 para. 2 of the Charter.

Material supplied by the Department of Community, Rural and Gaeltacht Affairs in respect of Ireland's Second Report under the Revised European Social Charter in relation to Article 14, Paragraph 2:

Article 14, Paragraph 2 – Public participation in the establishment and maintenance of social welfare services

Department of Community, Rural and Gaeltacht Affairs :-

Please also see our report under Article 14, Paragraph 1 above.

14.2.1 The Department of Community, Rural and Gaeltacht Affairs 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 was published in September 2000 and may be downloaded from this website

<http://www.pobail.ie/en/CommunityVoluntarySupports/WhitePaperonCommunityandVoluntaryActivity/file,2200,en.doc>

14.2.2 The White Paper committed the Government to provide a range of funding measures to support the Community and Voluntary Sector. For the period (2003-07), funding was provided to Federations, Networks and Umbrella Bodies, to National Anti-Poverty Networks and for a scheme of funding for training and support in the Community and Voluntary sector.

The new funding scheme to support National organisations in the Community and Voluntary sector commenced in 2008. This scheme amalgamated and replaced the schemes previously operated under the White Paper on Supporting Voluntary Activity. Applications under this new scheme were invited from community and voluntary organisations that operated at a National level with evidence of a nationwide membership.

The scheme aims are to provide multi-annual funding to such National organisations towards core costs associated with the provision of services. Priority is given under this scheme to supporting National organisations which provide coalface services to disadvantaged target groups. Contracts were

entered into with 65 National organisations and the estimated cost of the scheme is in excess of €17.5m in total

14.2.3 The Department also administers the following Programmes and Schemes:

Programme of Grants for Locally-Based Community and Voluntary Organisations

This Programme consists of three Schemes, which provide a range of once-off grants to a wide variety of both National and locally-based community and voluntary groups to support their activities in addressing disadvantage in their communities or where evidence of need is identified.

The Scheme of Refurbishment Grants provides funding for the refurbishment of existing premises used by such groups. This is complimented by the Scheme of Equipment Grants, which funds the purchase of equipment such as office, kitchen and I.T. equipment for qualifying groups. The primary purpose of the Scheme of Training Grants is to provide once-off grants to fund training and initiatives aimed at enhancing the effectiveness of both National and locally-based communities. Innovative projects, which develop new ideas in the area of personal development for disadvantaged people, are also eligible.

Project Expenditure is set out below.

Year	Value of the Grants Paid
2006	€4,642,988
2007	€6,505,547
2008	€3,460,066

The Programme is currently suspended.

<http://www.pobail.ie/en/CommunityVoluntarySupports/ProgrammeofGrantsforLocallyBasedCommunityVoluntaryGroups/> see box “This Section” for further details.

Community Support for Older People

The purpose of the Scheme is to encourage and assist the community's support for older people by means of a community-based grant scheme to improve the security of its older members. The Scheme is administered and funded by the Department with the services delivered by local community and voluntary groups. Funding is available inter alia for socially-monitored alarms, external security lighting, smoke alarms, window and door locks, etc. for persons aged 65 and over who have a genuine need for assistance under the Scheme.

The Scheme is advertised in the national and local newspapers and applications are accepted throughout the year.

Expenditure on this Scheme is set out below.

Year	Value of the Grants Paid
2006	€2,054,950
2007	€3,590,750
2008	€4,311,576

The Scheme is currently under review and is suspended pending the outcome of the review. The review is expected to be completed in Autumn 2009.

This Section

[White Paper on Community and Voluntary Activity](#)

[White Paper Grants by County](#)

[Community Support for Older People](#)

[Programme of Grants for Locally Based Community & Voluntary Groups](#)

[Contact Us](#)

Regulation of Charities :-

14.2.4 News

The Charities Bill 2007 was published on 16 April and presented to Dáil Éireann (Lower House of the Irish Parliament) on 24 April 2007. The Dáil was dissolved on 29 April, and the Government, following the General Election, demonstrated its commitment to the statutory regulation of charities in Ireland by bringing the Bill through its second stage in Dáil Éireann on 15 November 2007. It is anticipated that the Bill will move to the next stage early in 2008.

14.2.5 Key Policy Reform Issues

The charities sector in Ireland is unregulated

This effectively means that there is no body which has:

the specific aim of supervising the sector

the statutory powers to either maintain a register of charities or to subject the sector to regulatory scrutiny

There is therefore no such thing as a registered charity in Ireland at present

There is no statutory definition of what a "charity" is

There is no reliable information on

the number of active charities

what their financial worth is

how they spend their funds.

14.2.6 Impetus for Reform

No charity legislation has been enacted for over 40 years.

The [Agreed Programme for Government](#) 2002 set out to change this situation, by making a commitment to comprehensively reform the law to ensure accountability and to protect against abuse of charitable status and fraud.

The Department of Community, Rural and Gaeltacht Affairs has been given responsibility to deliver on this commitment.

Publication of the Consultation Paper on Establishing a Modern Statutory Framework for Charities represents the first public milestone in the work involved in delivery.

14.2.7 Approach to Reform

The work on charities regulation is informed in particular by:

[Sustaining Progress](#), 2003, which contains a commitment to prepare regulation in a fully transparent way that maximises public participation in its formulation

The [Government White Paper:Regulating Better](#), 2004, which sets out the principles of Better Regulation; and contains a detailed Action Programme for achieving Better Regulation

Complementary work cooperation between the Department of Community, Rural and Gaeltacht Affairs and the [Law Reform Commission](#), arising from the Commission's Second Work Programme, 2000-2007, which lists the law of charitable trusts among the priority items for examination

Government policy on statute law revision and restatement, in response to which the existing charities legislation will be replaced in its entirety by the new legislation, so that there will be one comprehensive piece of legislation, in stand-alone form, governing charities.

14.2.8 Existing Charities Legislation

The main existing charities legislation, prior to the publication of the Charities Bill 2007, comprised:

The Charities Acts 1961 and 1973 (with the most recent significant amendment made by the Social Welfare (Miscellaneous Provisions) Act 2002)

Aspects of fund-raising by charities are addressed in:

The Street and House to House Collections Act 1962

The Casual Trading Act 1995.

The existing charities legislation can be accessed at www.irishstatutebook.ie

14.2.9 Concrete Action

Regulation of the charities sector represents a significant policy initiative. Examination and research have been undertaken over the past 17 years in relation to the reform issues involved, notably resulting in the Costello (1990), Burton (1996) and [Law Society](#) (2002) Reports, as well as the [Arthur Cox](#)-led Review (2002). The substantial reform and simplification of company law, recommended in the [Company Law Review Group](#) Report (2002) is of relevance as well, in relation to the question of a new form of incorporation for charities.

In moving forward now with concrete action, the main steps to be taken would be as follows:

As far as the regulation of charities is concerned, as stated above at 14.2.4, following an extensive public consultation process, the Charities Bill 2007 was drafted and published on 16 April 2007 by the Minister of State at the Department of Community, Rural and Gaeltacht Affairs. By the end of 2007, the Bill had completed second stage in Dáil Éireann, with further progress anticipated in 2008.

Further information on the progress of the Charities Bill 2007 and its enactment as the Charities Act 2009 is available on the website of the Department of Community, Rural and Gaeltacht Affairs at <http://www.pobail.ie/en/CharitiesRegulation/>

14.2.10 Charity Trustees

In addition to statutory regulation, informed and vigilant charity trustees have a crucially important role to play in the general control and management of the administration of their charities.

Boardmatch Ireland (www.boardmatchireland.ie) can provide support for charities (as well as wider non-profit organisations) to enhance skill sets and build governance capacity, by matching their needs with people from the corporate and public sectors who have volunteered to share their specific skills, such as accounting, legal, strategic planning, marketing, IT.

14.2.11 The Revenue Commissioners' List

The Revenue Commissioners determine whether a body is entitled to charitable tax exemption under the Taxes Consolidation Act 1997.

They issue a charity reference number (eg, CHY 123) to bodies which are granted charitable tax exemption.

They maintain and publish on their website, www.revenue.ie, a list of these bodies. This list is sometimes interpreted as a register of charities.

**ARTICLE 23: THE RIGHT OF ELDERLY PERSONS TO SOCIAL
PROTECTION**

[Text of ARTICLE 23 of the Revised European Social Charter](#)

ARTICLE 23: THE RIGHT OF ELDERLY PERSONS TO SOCIAL PROTECTION

“With a view to ensuring the effective exercise of the right of elderly persons to social protection, the Parties undertake to adopt or encourage, either directly or in co-operation with public or private organisations, appropriate measures designed in particular: – to enable elderly persons to remain full members of society for as long as possible, by means of:

a. adequate resources enabling them to lead a decent life and play an active part in public, social and cultural life;

*b. provision of information about services and facilities available for elderly persons and their opportunities to make use of them;
– to enable elderly persons to choose their life-style freely and to lead independent lives in their familiar surrounding for as long as they wish and are able, by means of:*

a. provision of housing suited to their needs and their state of health or of adequate support for adapting their housing;

*b. the health care and the services necessitated by their state;
– to guarantee elderly persons living in institutions appropriate support, while respecting their privacy, and participation in decisions concerning living conditions in the institution.”*

Standard Questions asked of all Parties (member states of the Council of Europe, which have signed and ratified the European Social Charter) :-

Question A

Please describe the measures of social protection and the social services in your country to enable elderly persons to remain full members of society as long as possible.

Question B

Please indicate the measures taken to ensure that elderly persons have adequate monetary and non-monetary resources within the meaning of this provision.

Question C

Please provide information on total public expenditure during the reference period on social protection and social services for the elderly.

Question D

Please indicate by which ways information about the services and facilities available for elderly persons are provided to the persons concerned.

Question E

Please describe the measures taken to enable elderly persons to choose their life-style

freely and to lead independent lives in their familiar surroundings for as long as they wish and are able, in particular by means of:

- a. provision of housing suited to their needs and their state of health or adequate support for adapting their housing;
- b. the health care and any other services in the home necessitated by their state.

Question F

If private services exist, please describe the forms of co-operation between public and private services in the areas covered by this provision.

Question G

Please provide information on the number of elderly living in institutions, public or private, giving as far as possible the number of institutions and their staff and on the availability of places in relation to the number of applications. Please also indicate what form of assistance is granted to elderly persons living in institutions (eg. covering the costs of their stay).

Question H

Please provide information on any regulations applicable to institutions for the elderly, public or private, including procedures observed when institutionalising elderly persons.

Please indicate how control of these institutions is carried out.

Question I

Please indicate the measures taken to guarantee respect for the privacy of elderly persons in institutions and their participation in decisions concerning living conditions in such institutions.

Material supplied by the Department of Health and Children :-

Questions A – I above refer :-

Material from the Department of Health and Children:

23.1 Health Services for Older People

We refer to the information provided in the Government of Ireland's Second Report to the Council of Europe under the Revised European Social Charter. The following is an update of that material.

Life expectancy at age 65 in Ireland is increasing and most people are fit and active and living healthy lives for longer. It is estimated that there are approximately 463,000 people aged 65 years and over in Ireland today. Latest population projections suggest that this figure will increase to 1,105,000 by 2036, increasing the number of people over 65 as a percentage of working age population from 18% to 39%. Within this, the number of people aged over 85 is projected to increase from 46,700 to 155,500. This trend is expected to continue out to 2056 when the old age dependency ratio is projected to reach 60%.

While an increase in life expectancy is a product of successful social, health and economic policies, it also creates challenges in terms of planning, development and implementation of long term care policy and practice. It is important to note that the cost of long-term care is only one implication of demographic trends. Wider implications, for example in relation to the cost of acute medical care and pensions, will also have to be considered.

Government Policy in relation to Older People and Long Term Care is set out in the Programme for Government 2007-2012 and the latest Social Partnership Agreement “Towards 2016”. A copy of “Towards 2016” may be accessed at http://www.taoiseach.gov.ie/attached_files/Pdf%20files/Towards2016PartnershipAgreement.pdf In that Agreement, the Government and the Social Partners agreed to work together to develop an infrastructure of long-term care services for older people in accordance with the following principles:

All relevant public services should be designed and delivered in an integrated manner around the needs of the care recipient based on a national standardised needs assessment. Care needs assessments should be available in a timely, consistent, equitable and regionally balanced basis.

Access to joined up, user-friendly, customer-focused service consistent with individual needs

The use of community and home-based care should be maximised and should support the important role of the family and informal care.

The continued development of sheltered housing options, with varying degrees of support will be encouraged.

Where community and home-based care is not appropriate, quality residential care should be available.

There should be appropriate and equitable levels of co-payment by care recipients based on a national standardised financial assessment.

The level of state support for residential care should be indifferent as to whether that care is in a public or private facility.

No current resident of a nursing home, public or private, should be put at a disadvantage by whatever new co-payment arrangements for residential care are introduced.

Information about entitlements and benefits should be clearly set out and communicated to older people, and

The financial model to support any new arrangements must be financially sustainable.

23.2 Office for Older People

A new Office for Older People was formally established on 30 January, 2008. The Office is based in the Department of Health & Children to support the Minister of State with responsibility for Older People. The main functions of the Office will be to draw up and implement a Strategy for Positive Ageing; to bring greater coherence to the formulation of policies affecting older people; and, to develop policy and oversee and monitor the delivery of health and personal social services for older people.

23.3 Human Resources

Building the capacity of the health service workforce is central to the achievement of the goals and objectives of the Department. A joint DOHC / HSE (Department of Health and Children / Health Service Executive) working group on workforce planning was established in June 2006 and includes representatives of the Departments of Finance, Education and Science, and the Higher Education Authority.

Work began on a national workforce planning strategy in conjunction with the Health Service Executive late in 2007. This work is being coordinated through the Joint Working Group. The strategy steering group is at an advanced stage of producing a strategy document.

23.4 Elder Abuse

The National Implementation Group on Elder Abuse (EANIG) was established in 2003 to oversee the implementation of the recommendations contained in the Report "*Protecting our Future*". A copy of this Report may be accessed at <http://www.dohc.ie/publications/pdf/pof.pdf?direct=1>. The Report made recommendations in relation to the development of health and non-health services necessary to deal with elder abuse. It recommended that the issue of elder abuse be placed in the wider context of health and social care services for older people. In this context, the Group is now operating under the auspices of the newly established Office for Older People.

EANIG identified the following three priority issues for the implementation of the elder abuse programme:

- Appropriately composed steering groups in each HSE region
- Appointment of senior case workers in each local health area plus a dedicated Elder Abuse Officer in each HSE region
- Development of appropriate management support for senior case workers.

Four regional steering groups were established and a national steering group was put in place to oversee progress. As of April 2008, 26 senior case workers and 3 dedicated elder abuse officers had been appointed.

23.5 Carers

Towards 2016 also contains a commitment to develop a National Carers Strategy to cover the period 2008 to 2016. The strategy will focus on supporting informal and family carers in the community. All relevant departments and agencies are involved in the development of the National Carer's Strategy and there is appropriate consultation with the social partners. The Department of Social & Family Affairs has lead responsibility for the development of the Strategy.

23.6 Nursing Home Support Scheme (A Fair Deal)

The Nursing Homes Support Scheme Act 2009 was signed into law on the 1st July 2009. A copy of that Act may be accessed at <http://www.attorneygeneral.ie/eAct/2009/a1509.pdf>

The Scheme is designed to remove real financial hardship from many individuals and their families who, under the current system of Nursing Home Subvention, have to sell or re-mortgage homes to pay for the cost of nursing home care.

The Scheme will also equalise State support for public and private long-term care recipients. In the future, there will be one, transparent system of support towards the cost of care that will be fair to all, irrespective of whether they are in public, private or voluntary nursing homes. It also aims to render private long-term care affordable and anxiety-free, and ensure that no-one has to sell their home during their lifetime to pay for their care.

Finally, the Fair Deal will replace the existing Nursing Home Subvention Scheme. However, it is important to note that individuals already in receipt of subvention may opt to transfer to the new scheme or may retain their existing arrangements if they so wish.

For more detailed information, please see the Department of Health and Children website http://www.dohc.ie/issues/fair_deal/

23.7 Home Care Packages

Government policy is to support older people to remain in their own homes for as long as possible in accordance with their expressed preferences. Home care packages are intended for people who are using core services, such as home helps, but who need more assistance to continue to live in the community. The packages include the services of nurses, home care attendants, home helps and various therapists including physiotherapists and occupational therapists. The particular target groups for receipt of Home Care packages are older people currently in residential or hospital care, who have the capacity to return to their homes, and people in the community who are considered as possibly requiring residential care in the absence of such intervention.

The packages are delivered through the HSE and by voluntary groups, the private sector and the HSE itself. The delivery is flexible and responsive to the needs of individuals, for example, a person who is under 65 and who may need a package can receive it as appropriate.

Significant additional funding has been provided in recent years to increase the community support services for older people. This has allowed for increases in the number of Home Care Supports, Home Help hours and Day/Respite places. These services are designed to help older people to continue to live in their own homes. The policy is to build up sufficient home and community based care so that less than one in twenty people over 65 will need residential care.

An Inter-Departmental Working Group was recently established to oversee an independent Evaluation of the Home Care Package Initiative. Terms of Reference have been drawn up to engage an external Consultancy agency for the evaluation, which is expected to take place in 2008. The working group is representative of the Departments of Health and Children, Finance, Social and Family Affairs and the Health Service Executive. Following completion of the evaluation, the DOHC (Department of Health and Children) will give priority to the development of standards for Home Care Services.

23.8 Standards for Residential Care

Government policy is to develop and improve health services in all regions of the country and to ensure quality and patient safety. The present standards for nursing homes are set out in the 1993 Care and Welfare Regulations. The HSE inspects private nursing homes on the basis of these standards, but public homes are not inspected.

In January 2007 the Minister for Health & Children published a new set of draft national standards for all nursing homes – public, private and voluntary. The standards were developed by a working group chaired by the Department of Health & Children and included the Health Service Executive, Social Service Inspectorate and the Irish Health Services Accreditation Board.

As the Health Act, 2007 provides that the enhanced inspection function will be taken over by the Health Information and Quality Authority (HIQA), the draft standards were formally referred to HIQA for consultation and finalisation. HIQA established a wide-ranging Working Group to finalise the draft standards. The terms of reference of the Group were to:

- review and develop the draft standards
- establish a process for targeted and public consultation
- oversee the public consultation process
- consider feedback from the public consultation process
- finalise the draft standards for publication and inspection

HIQA completed its work early in 2008 and these standards have now been approved and published by the Minister for Health & Children. HIQA has commenced the registration and inspection of both public and private residential care services since

1 July, 2009. For further information see HIQA's website at:- http://www.hiqa.ie/functions_ssi_residential_care_older_people.asp.

23.9 Carers

In December 2007, the Government agreed to develop a National Carer's Strategy. The working group to develop the Strategy is chaired by the Department of the Taoiseach with the secretariat provided by the Department of Social and Family Affairs. The working group includes officials from the Departments of Finance, Enterprise, Trade & Employment, Health & Children, as well as agencies such as the Health Service Executive and FÁS. The expertise of other departments and agencies is called on as required, including Environment, Heritage & Local Government, Transport and the Revenue Commissioners.

The Strategy will cover areas such as income support, health and care Services, training, labour market issues, transport, housing and information services.

23.10 National Positive Ageing Strategy

The Programme for Government 2007-2012 contains a commitment in relation to the development of a National Strategy for Older People. The newly established Office for Older People will take the lead in developing a National Positive Ageing Strategy, which will include:

the development of operational plans by Government Departments clearly setting out objectives relating to older people;
joined up thinking on initiatives serving older people;
ongoing mechanisms to monitor progress and identify challenges;
liaison with recognised voluntary groups in the area; and
consideration of the appointment of an Ombudsman for Older People.

Material supplied by the Department of Social and Family Affairs :-

23.11 Question B

Please indicate the measures taken to ensure that elderly persons have adequate monetary and non-monetary resources within the meaning of this provision.

Response :-

23.11.1 In addition to social insurance schemes for old age (see Report on Article 12), the Department of Social and Family Affairs administers non-contributory pensions for persons over 66. In the period under review, these pensions

were payable to all residents, regardless of nationality, who satisfied the conditions as to age and means and habitual residence.

23.11.2 A person may switch from contributory old age pension (or from receipt of a qualified adult increase thereon) to the non-contributory pension if the non-contributory entitlement is higher.

23.11.3 The means assessment includes income and assets, but the assessment of assets does not include the value of the place of residence. The first €7.60 weekly (raised to €30 from January 2007) does not affect the rate of pension, which is reduced thereafter in steps of €2.50 weekly. The rates of pension between 2005 and 2007 were as follows:

Table 23.x

	Jan 2005 €	Jan 2006 €	Jan 2007 €
Personal rate (maximum)	166.00	182.00	200.00
Minimum rate	3.50	4.50	2.50
Maximum increase for qualified adult (under 66 years – personal rate is payable to each of a couple over 66)	109.70	120.30	132.20
Increase for qualified child	16.80	16.80	22.00
Increase over 80 years of age	6.40	10.00	10.00
Increase where living alone	7.70	7.70	7.70

For further information please see:

<http://www.welfare.ie/EN/Publications/SW116/Documents/sw116.pdf>

The Social Welfare Law Reform and Pensions Act 2006 provided for the merging of all non-contributory payments over pension age into a single age pension, renamed the State Pension (non-contributory).

Various amendments to the means test were introduced both in the above 2006 Act and in the Social Welfare and Pensions Act 2007, in each case improving the rate of entitlement to persons with low means. A specific **earnings** disregard of €200 per week for the State Pension (Non-contributory) was introduced so that income from employment can be earned without losing pension entitlements.

The 2006 Act provided for the closure to new claims of the pre-retirement allowance (previously payable to persons between 55 and 66 years of age). The decision to phase out this scheme reflected the strength of the labour market at that time, the value to the worker of maintaining attachment to the labour force, and the recognition that early retirement schemes are inconsistent with the long-term need to ensure a sustainable insurance fund.

23.11.7 A range of non-statutory schemes (commonly known as “Free Schemes”) are administered by the Department of Social and Family Affairs. These include:

Free travel – which is a universal scheme for all resident persons over 66 years of age, and persons in receipt of certain disability payments. The transport companies (including national rail, provincial buses, city buses, and some private bus operators) receive an annual payment from the Department in respect of free travel provided to persons holding a “travel pass”. The restriction on “rush hour” travel on city buses has been removed.

Fuel Allowance – a supplement of €18.00 per week to recipients of specified benefits, including social insurance and assistance old age pensions, paid during 29 weeks from October to April to offset the additional cost of heating in the winter. In urban areas subject to the smokeless fuel Regulations it is increased by €3.90 weekly.

***Free Electricity (or gas) Allowance** – the fixed charges on electricity accounts, plus a standard amount of usage, is free to recipients of specified benefits. If a person does not have electricity, a comparable concession is allowed on gas expenses.

***Free Telephone Allowance** – covers the cost of line rental plus a certain amount of call-charges in each billing period.

***Free Television licence** – covers the annual licence fee for a colour television set.

*The last 3 of these (collectively known as household benefits) are payable in respect of all persons who are over 70 years of age or, subject to certain conditions, persons under 70 who are in receipt of specified payments.

For further information, please see:

<http://www.welfare.ie/EN/Publications/SW40/Documents/sw40.pdf> (Free travel)

<http://www.welfare.ie/EN/Publications/SW107/Documents/sw107.pdf> (Household Benefits)

23.12 Question C

Please provide information on total public expenditure during the reference period on social protection and social services for the elderly.

Our Response :-

23.12.1 The total expenditure by the Department of Social and Family Affairs in relation to services for the elderly during 2007 was:

Table 23.y

	2007 € million
Social insurance schemes	2,834
Social assistance schemes	1,045
Total	3,879

23.13 Question D

Please indicate by which ways information about the services and facilities available for elderly persons are provided to the persons concerned.

Our Response :-

23.13.1 Leaflets and application forms for all the schemes and services administered by the Department of Social and Family Affairs can be obtained from

- the Central Information Services Unit LoCall Leaflet Line on a 24/7 basis.
- the 58 Social Welfare Local Offices and 69 Branch Offices, spread throughout the country
- over 1,000 post offices nationwide;

-the Department's website at www.welfare.ie

23.13.2 In addition, the Citizens Information Board is the national agency in Ireland responsible for supporting the provision of information, advice and advocacy on social services. It provides information to the public through the nationwide network of Citizens Information Centres, the Citizens Information Phone Service and through the OASIS and Citizens Information Databases.

=====
Material supplied by the Department of the Environment, Heritage and Local Government :-

Question E (a) refers :- provision of housing suited to their needs and their state of health or adequate support for adapting their housing;

23.14 A person can apply for Local Authority Housing if you are in need of housing and cannot afford it from his /her resources. In assessing his/her application, the Local Authority will consider such factors as household size, household income, his/her present accommodation (if any), the condition of that accommodation, and any special circumstances including **age**, disability, medical circumstances etc. Houses are allocated to applicants in order of priority, taking all circumstances into account. The rents are related to ability to pay.

23.15 Houses are allocated in accordance with each Council's Scheme of Letting Priorities. This scheme is to provide a means of prioritising applicants for Council housing. To apply for Local Authority Housing i.e. Flats, Houses you must contact your Local Authority.

23.16 Voluntary & Co-operative Housing

Voluntary and Co-operative housing is supported by local authorities and the Department of Environment, Heritage and Local Government under two separate schemes which provide social rented accommodation, as follows:

23.17 Capital Assistance Scheme

Under this scheme, voluntary housing bodies provide accommodation to meet special housing needs such as those of the elderly, people with a disability, homeless,

returning emigrants or smaller families. The approved voluntary housing bodies are responsible for tenancy allocations in consultation with the local authorities. A minimum of 75% of the houses in each project are reserved for persons whose applications for local authority housing have been approved by the local authority, homeless persons, or local authority tenants and tenant purchasers who return their dwellings to the local authority. However, one third of these may be allocated to eligible elderly returning emigrants. The remaining houses in a project are let to people nominated by the voluntary housing body. Rents are determined having regard to tenants means and the cost of managing and maintaining the dwellings.

23.18 Capital Loan and Subsidy Scheme

Under this scheme, voluntary housing bodies provide housing for renting, particularly to meet the needs of low-income families. Not less than threequarter of the dwelling units are let to households that have qualified for local authority housing. Rents are determined taking account of household earnings and circumstances. Tenants of the houses are centrally involved in the management of their estates.

23.19 Note on Memorandum on the Capital Funding Schemes for voluntary and co-operative housing with addendum

The Memorandum consolidates and updates all the information and guidance issued since the introduction of the Capital Funding Schemes to the date of its issue (July 2002) and is intended to assist housing authorities and approved housing bodies in their efforts to maximise output under the Schemes.

The Memorandum is set out in nine Parts with four Appendices. There are separate Parts for each Capital Funding Scheme, Technical Guidelines and Contract Procedures as well as Parts on General Provisions which are common to the Capital Funding Schemes.

In the Memorandum the term "Capital Funding Scheme" refers to the Capital Assistance Scheme (CAS), the Capital Loan and Subsidy Scheme (LSS) – previously known as the Rental Subsidy Scheme and the Lottery Funds Grant Scheme for Communal Facilities.

23.20 Development Costs

Provision may be made for project development costs incurred by an approved housing body when calculating loan amounts under the CAS and LSS. A development allowance of 1.5% of the net tender sum, up to a maximum of no more than €127,000 on any particular project is available in this regard.

23.21 CLSS Management & Maintenance Allowance

The allowance has been adjusted each year in line with movements in the Consumer Price Index. For the subsidy year 1st July, 2004 to 30th June 2005, the allowance is €467 per house in areas to which the general cost limit applies and €620 per house in the administrative areas of the city councils, the counties of Fingal, Dun Laoghaire-Rathdown and South Dublin and the specified islands where higher unit cost limits apply.

23.22 Requirement for Loan Sanction at Pre-Tender and Again at Post – Tender Stage for LSS and CAS projects

Since April, 2003, it is necessary for authorities to obtain loan sanction for all projects from the Department at planning stage i.e. prior to tenders being sought by an approved body for a housing project. In addition, it is necessary for authorities to obtain revised loan sanction for all projects from the Department at the post-tender stage before contracts are signed by the approved body.

23.23 Useful links

http://www.icsh.ie/eng/housing_in_ireland/capital_funding

www.nabco.ie

www.focusireland.ie

www.simoncommunity.ie

<http://www.respond.ie/>

<http://www.cluid.ie/>

<http://www.habitatireland.ie/>

23.24 Improvements to existing dwellings

Local Authority Extensions Scheme

Low Cost Sites

[http://www.environ.ie/en/DevelopmentandHousing/Housing/SocialHousingSupport/Improvementstoexistingdwellings/ - Low Cost Sites](http://www.environ.ie/en/DevelopmentandHousing/Housing/SocialHousingSupport/Improvementstoexistingdwellings/-LowCostSites)

Central Heating Scheme

Local Authority Extensions Scheme

This scheme enables local authorities to extend rented local authority houses to cater for households who would otherwise qualify for inclusion in a housing assessment. The scheme applies to rented local authority houses, which can be economically extended to cater for persons accepted as in need of local authority housing. It includes cases where the need is due to overcrowding, where an approved applicant not living in the house can be adequately accommodated in the house after it has been extended, and where a tenant or tenant purchaser surrenders a dwelling on being accommodated in the extended house.

Low Cost Sites

Under this scheme, a local authority may make housing sites available at low cost to households been approved for social housing by the local authority, or local authority tenants or tenant purchasers or certain tenants of voluntary housing associations. Voluntary Housing bodies providing houses under the Capital Assistance or Capital Loan and Subsidy Schemes may also avail of the sites scheme, as may persons taking shared ownership through a group housing project sponsored by a housing cooperative or local authority.

Central Heating Scheme

In July 2004 a special programme was introduced for the installation of central heating in existing local authority rented dwellings, which lacked such

facilities. The scheme is administered locally and the planning and execution of works is a matter for each local authority. Under the Programme a grant of €6,000 or up to 80% of the cost, whichever is the lesser, is payable for each house. The balance of the cost is met by the housing authority. In addition to central heating facilities the work may also include related energy improvement and smoke detection measures.

Grants totalling €70m have been paid to local authorities to the end of 2006 allowing more than 15,000 houses to be provided with central heating under the programme. When account is taken of other programmes such as the various area regeneration and remedial works schemes which also provide for the installation of heating facilities, the Department estimates that the number of local authority dwellings without central heating has decreased by almost a half since the year 2000.

Funding of up to €40m has been earmarked for the programme in 2007. More than 7,000 houses are expected to benefit from the programme in the current year. It is hoped that the national programme will be substantially completed by 2008.

23.25 [Publications & Documents](#)

[Housing Needs Assessment 2005 Detailed Results July 2006](#) (xls, 2,416 kb)

[more publications](#)

23.26 [News and Speeches](#)

09/07/07: [Annual Housing Statistics Bulletin 2006- Over 14,600 families benefit from housing support in 2006](#)

03/07/07: [Minister Batt O’Keeffe responds to academic’s comments on the housing market](#)

23/04/07: [Minister Ahern announces record housing allocations of €1.2 billion for 2007](#)

23/04/07: [Minister Ahern Announces Record Housing Allocations of €1.2 billion for 2007](#)

[more news](#)

23.27 [Special Needs](#)

Schemes for people with special needs are administered through [Local Authorities](#) and the Health Service Executive

Essential Repairs Grant

The Essential Repairs Grant scheme is administered by the local authorities. The scheme is directed primarily at providing grant aid to elderly people living in poor housing conditions. It is intended to facilitate having those conditions improved sufficiently to allow them to remain in their homes for their lifetime and to prevent them having to move to a different area or to be rehoused by the local authority. The grant may cover 100% of the cost of the works.

Essential Repairs Grant Scheme

Q. Who can apply?

A. The scheme is directed primarily at providing grant aid to elderly people living in poor housing conditions.

Q. How do I apply?

A. Contact the Essential Repairs Grants Section of your local authority.

Q. What type of work is allowable?

A. The regulations do not specify what works qualify for grant assistance. It is a matter for the local authority to assess the circumstances of each individual case and decide what work is necessary to prolong the useful life of the dwelling for occupancy.

Task Force on Special Housing Aid for the Elderly

The Task Force on Special Housing Aid for the Elderly was set up in 1982 to undertake an emergency programme to improve the housing conditions of elderly persons living alone in unfit or unsanitary accommodation. The Task Force includes representatives from the Society of St. Vincent de Paul, FAS, A.L.O.N.E., Local Authorities and the Departments of Environment, Heritage and Local Government, Health and Children and Social and Family Affairs. The scheme is operated on the ground by the Community Care Departments of the Health Services Executive and the work is carried out by contract or by the use of FAS Schemes.

Ahern announces €12m for Housing Aid for the Elderly

13/06/07

Noel Ahern, T.D., Minister for Housing and Urban Renewal, today (13 June 2007), announced allocations for 2007 under the Special Housing Aid for the Elderly scheme. A sum of €12m is initially being made available for the carrying out of essential repairs to houses occupied by elderly persons living on their own. The funding is provided by the DoEHLG and is administered by the HSE.

"The scope of the scheme was extended in 2000 to include the provision of suitable heating systems. This along with all other aspects of the scheme continues to aid improvements to the living conditions of the elderly, enabling them to live comfortably in their own homes for as long as possible. In 2006 the total allocated to the scheme was over €22m with up to 5,100 households assisted," said Minister Ahern.

Announcing the funding the Minister went on to say that he was delighted with the effectiveness of the scheme in helping elderly people to live in their own homes and since its introduction in 1982 to December 2006 over 71,000

households have had repairs carried out to their homes under the scheme. Almost €130m has been provided for the scheme since 1997.

Media queries:

Press and Information Office

Tel: (01) 888 2638 (direct)

(01) 888 2000

E-Mail: press-office@environ.ie

23.28 Housing Grants and Financial Assistance

These schemes which are administered largely by the local authorities - with the exception of the thatching grant which is administered directly by the Department, provide support for people seeking accommodation in the owner occupier sector. They also assist in the upgrading of certain categories of private housing with particular emphasis on those in most need such as older people and people with a disability.

Housing statistics may be accessed at

<http://www.environ.ie/en/Publications/StatisticsandRegularPublications/HousingStatistics/>



ARTICLE 30: THE RIGHT TO PROTECTION AGAINST POVERTY AND SOCIAL EXCLUSION

“With a view to ensuring the effective exercise of the right to protection against poverty and social exclusion, the Parties undertake:

- a. to take measures within the framework of an overall and co-ordinated approach to promote the effective access of persons who live or risk living in a situation of social exclusion or poverty, as well as their families, to, in particular, employment, housing, training, education, culture and social and medical assistance;
- b. to review these measures with a view to their adaptation if necessary.”

Standard Questions asked of all Parties (member states of the Council of Europe, which have signed and ratified the Revised European Social Charter):

Question A

If there is an official poverty line please describe its main methodological features. If not, please indicate the methodology followed or criteria used to measure poverty. Please indicate the methodology followed or criteria used to measure social exclusion. Please provide information taken from studies or enquiries concerning the nature and extent of poverty and social exclusion showing the number of persons and/or households who are socially excluded or live in poverty (if possible broken down according to sex, age, family characteristics, regional situations, etc.).

Question B

Please describe the global and co-ordinated approach taken to prevent and combat poverty and social exclusion, indicating:

- a. the measures implemented in particular to promote the employment of persons who are, or who risk being in a situation of poverty or social exclusion;¹
- b. the methodology and level of funding devoted to this policy;
- c. the number of beneficiaries and the results obtained.

Question C

Please provide information on whether and how poverty and social exclusion measures are monitored and evaluated with a view to their adaptation if necessary.

Please indicate whether and how the social partners and the relevant non-governmental organisations participate in the formulation, implementation, evaluation and adaptation of measures to combat poverty and social exclusion.

Text of Our Report :-

Material supplied by the Department of Social and Family Affairs:-

Question A

30.1 If there is an official poverty line please describe its main methodological features. If not, please indicate the methodology followed or criteria used to measure poverty. Please indicate the methodology followed or criteria used to measure social exclusion. Please provide information taken from studies or enquiries concerning the nature and extent of poverty and social exclusion showing the number of persons and/or households who are socially excluded or live in poverty (if possible broken down according to sex, age, family characteristics, regional situations, etc.).

Response :-

30.2 Ireland does not have an official poverty line. However, it has been implementing national anti-poverty and social inclusion strategies since 1997 and also fully participates in the EU Open Method of Coordination process on social inclusion. Both processes incorporate the use of indicators (See reply to Article 30 Question C below).

Measuring Poverty

30.3 Poverty is multi-faceted requiring a multi-policy approach. A series of indicators are required to measure and evaluate the outcomes being achieved for each policy. The EU Common Indicators are used for this purpose and certain of the most recent comparative results are set out in the following table.

Certain EU Common Indicators for Poverty and Social Exclusion

Indicators	Year	Ireland %	EU-25 average %
INCOME INDICATORS	2006		
At-risk-of-poverty rate		18	16
- After social transfers (60% median income threshold)		33	26
Before social transfers (income including pensions)		40	43
Before social transfers (income excluding pensions)			
Relative median at risk of poverty gap (%)	2006	16	22
Income distribution (income quintile share ratio)	2006	4.9	4.8
Gini coefficient (%)	2006	32	30
Non-monetary indicators	Year	Ireland %	EU-27 average %
Long-term unemployment rate –Total	2006	1.4	3.7

Long-term unemployment rate –Male		1.7	3.5
Long-term unemployment rate - Female		1.0	4.0
Life expectancy at birth – Total male	2006	77.3	74.6
Life expectancy at birth – Total female		82.1	80.9

(source: *Measuring Ireland's Progress 2007 - Central Statistics Office*)

30.4 The Survey on Income and Living Conditions (SILC) is carried out in Ireland by the Central Statistics Office. The primary focus of the survey is the collection of information, on the income and living conditions of the population, from which indicators on poverty, deprivation and social exclusion are derived. The annual SILC replaced the Living In Ireland Survey (LIIS), conducted by the Economic and Social Research Institute (ESRI) during the period 1994 to 2001. Due to the change in methodologies from the LIIS to the SILC, it was not possible perform sequential comparisons using pre and post 2002 data. The latest SILC data available is for 2007.

At Risk of Poverty Indicator

30.5 The main income indicator among the EU indicators is the 'at risk of poverty' indicator. This is based on the percentage of persons below 60 per cent of median income. The percentage below the 60% threshold has fallen significantly in recent years from 19.7% in 2003 to 16.5% in 2007.

AT RISK OF POVERTY RATES - Percentage of persons below 60% of median income		2006 (%)	2007 (%)
	Overall		17.0
Poverty Gap		17.5	17.4
'At risk of poverty anchored at a point in time' (2005)		16.3	11.9
Men		16.6	16.0
Women		17.4	17.0
Age 0-17		22.3	19.9
18-64		15.4	15.0
65+		13.6	16.6
At Work		6.5	6.7
Unemployed		44.0	38.7
Student		29.5	25.2
Home Duties		23.8	25.3
Retired		14.8	17.6
Ill/Disabled		40.8	37.0
1 adult aged 65+, no children		19.3	24.3
1 adult aged <65, no children		31.0	29.6
2 adults, at least 1 aged 65+, no children		10.8	11.5
2 adults, both aged <65, no children		14.8	15.0
3 or more adults, no children		10.0	10.2
1 adult with children		45.6	37.6
2 adults with 1-3 children		12.0	13.7
Other households with children		20.8	16.5

(source: SILC - Central Statistics Office)

Consistent Poverty

30.6 The key goal of Ireland’s national anti-poverty and social inclusion strategies has been to significantly reduce and eliminate consistent poverty. The consistent poverty indicator, devised by the ESRI, identifies the proportion of the population below 60% of median income and experiencing enforced basic deprivation using a set of eleven indicators.

30.7 The overall goal of the National Action Plan for Social Inclusion 2007 to 2016 (NAPinclusion) is to reduce the number of those experiencing consistent poverty to between 2% and 4% by 2012, with the aim of eliminating consistent poverty by 2016. The consistent poverty percentage has fallen significantly in recent years from 8.2% in 2003 to 5.1% in 2007.

CONSISTENT POVERTY RATES - Percentage of persons below 60% of median income and experiencing deprivation		2006 (%)	2007 (%)
		Overall	6.5
	Men	6.4	5.0
	Women	6.6	5.2
	Age 0-17	10.3	7.4
	18-64	5.6	4.7
	65+	2.2	2.0
	At Work	1.5	1.3
	Unemployed	22.0	17.5
	Student	10.8	7.6
	Home Duties	8.3	6.6
	Retired	3.2	2.1
	Ill/Disabled	17.9	15.8
	1 adult aged 65+, no children	3.4	4.1
	1 adult aged <65, no children	12.5	12.5
	2 adults, at least 1 aged 65+, no children	1.7	1.0
	2 adults, both aged <65, no children	4.4	3.4
	3 or more adults, no children	4.3	3.5
	1 adult with children	33.9	20.1
	2 adults with 1-3 children	3.8	2.6
	Other households with children	5.9	6.0

(source: SILC - Central Statistics Office)

Question B refers :-

30.8 Employment Support Services

The Department of Social and Family Affairs provides a wide range of supports through its Employment Support Services (ESS) for persons who are, or may be at risk of being, in a situation of poverty or social exclusion. The overall aim of ESS is to assist unemployed people, particularly the long-term unemployed, lone parents, and

sickness related welfare recipients to return to the active labour market through education, employment or training.

The Department's facilitators engage systematically under the auspices of the Employment Action Plan with those persons who are registered as unemployed. This engagement is in conjunction with FAS to ensure that optimum value is obtained from the following supports.

30.9 The Back to Education Allowance Scheme

Formalised in 1998, after over 10 years interventions, this non statutory scheme facilitates persons on an unemployment or other relevant social welfare payment to engage in full time Second or Third Level courses of education. It provides a weekly income support over the academic year and an annual Cost of Education allowance (currently €500). The qualifying conditions are outlined in Article 10 Paragraph 5. See also <http://www.welfare.ie/EN/Schemes/BackToEducation>

Table 30.t shows the participation rate on the Back to Education Allowance scheme with a breakdown of Second Level Option (SLO) and Third Level (TLO) from 2004 to 2007.

Table 30. t Participation rate

Academic year	SLO	TLO	Total
2004/05	3,023 (41.37%)	4,285 (58.63%)	7,308 (100%)
2005/06	2,975 (40.83%)	4,310 (59.17%)	7,285 (100%)
2006/07	3,359 (41.52%)	4,731 (58.48%)	8,090 (100%)
2007/08	4,242 (47.75%)	4,641 (52.25%)	8,883 (100%)

Table 30.u gives a breakdown of expenditure on the Back to Education Allowance scheme for the years 2004 to 2007.

Table 30.u Scheme expenditure

Year	2004	2005	2006	2007
Expenditure	€44.16m	€46.69m	€52.06m	€64.14

30.10 The Back to Work Allowance Scheme/The Back to Work Enterprise Allowance Scheme

Introduced in 1993 this non statutory scheme assists social welfare recipients into self employment by providing tapered non taxable retention of the person's social welfare payment over a 2 year period. The rate of payment of the Allowance is 100% of the qualifying payment for the first year and 75% for

the second year. Secondary Benefits may be retained subject to certain conditions. There are also further supports available to participants.

The Department's Facilitators provide a service to the long term unemployed, lone parents, people with disabilities and other long term welfare recipients. Locally based, they offer advice and guidance and organise specialised training courses/programmes. They also administer grants to those furthest from the labour market to assist them progress from social welfare dependency into training, education and employment. The Technical Assistance and Training (TAT), and the Special Projects Funds are in place to provide financial assistance and support. The Family Services Project fund is administered by Facilitators and Regional Co-ordinators. It provides them with opportunities to co-fund courses to increase the capacity of those in most difficult circumstances to improve their self esteem and personal and family situations. From January 1, 2008 the Special Projects Fund and Family Services Project merged to form the Activation and Family Support Programme (AFSP) with a combined budget of €6m. The following Table sets out the amounts allocated to the funds between 2004 and 2007.

Table 30.v

YEAR	2004	2005	2006	2007
TAT	€1.5m	€1.8m	€2.2m	€3.0m
Special Projects	€2.7m	€2.8m	€3.1m	€2.1m

The qualifying conditions are outlined in

<http://www.welfare.ie/EN/Schemes/JobseekerSupports/BackToWork/Allowance/Pages/btwa.aspx>

Table 30.x below shows the numbers participating on the employee and self employed strand of the Back to Work Allowance Scheme at each year end from 2004 to 2007

Table 30. x. Participation Levels

Year end	2004	2005	2006	2007
Employees	4,711	3,646	3,963	4,305
Self employed	6,855	5,297	4,373	4,828
Total	11,566	8,943	8,336	8,162

Table 30.y Scheme Expenditure

Year	2004	2005	2006	2007
Expenditure	€65.71	€53.56m	€56.50m	€71.07m

For further information please see:

<http://www.welfare.ie/EN/Publications/SW92/Pages/1WhatistheBacktoWorkEnterpriseAllowance.aspx>

<http://www.welfare.ie/EN/Publications/SW93/Pages/1WhatisBacktoWorkAllowance.aspx>

30.11 Very Long Term Unemployed (VLTU) Scheme.

Introduced in May 2000, this scheme was designed to encourage social welfare customers who are not quite ready to enter employment to test out the work environment with a view to entering/re-entering the workforce. Participants received informal training for up to 6 weeks, retaining their social welfare payment and receiving a further weekly payment of €44.50 for the duration of the training.

Participation in this scheme was lower than expected in 2004 - 2007, due to buoyant labour market forces and relative ease in which the unemployed can re-enter the workforce. The Very Long Term Unemployed (VLTU) is being phased out from 2009 in response to the changed economic situation and the Government decision to prioritise available resources to the Back to Work Enterprise Allowance supports for self-employment in order to stimulate new enterprises.

30.12 The Employer's PRSI exemption Scheme.

Employer's PRSI exemption Scheme was introduced in the late 1980s during a period of high unemployment and emigration. It was designed to encourage employers to take on unemployed, disabled, and third level graduates, by exempting them from their share of the PRSI contribution. The initial exemption was for 1 year, and later it was extended to 2 years. In September 2003, to reflect the transformed labour market conditions, and to address the needs of those most distant from the workforce, the scheme was directly aligned to the Back to Work Allowance Scheme.

The following table shows the number of exemptions awarded during 2004 to 2007

Table 30.z

Year	2004	2005	2006	2007
Exemptions awarded	486	809	819	943

For further information please see:

<http://www.welfare.ie/EN/Publications/SW73/Documents/sw73.pdf>

30.13 Retention of Secondary Benefits:

A crucial area in removing the disincentives of transferring from welfare dependency to employment relates to the full or partial retention of secondary benefits. This embraces a range of schemes across different Government Departments including:

Rent or Mortgage Interest Supplement (DSFA- Department of Social and Family Affairs)

Fuel Allowance (DSFA)

Back to School Clothing and Footwear Allowance (DSFA)

medical card (administered by the various Health Boards under the auspices of the Department of Health & Children)

differential rent (administered by Local Authorities under the auspices of the Department of Environment & Local Government).

It is not possible to provide a summary costing for retention of secondary benefits, because of the spread between Departments and because payments of the DSFA secondary benefits to Active Labour Market Programme participants are not identified separately on the Department's payment systems from payments to other recipients.

Question C refers :-

30.14 Framework for action

The first 10-year Irish National Anti-Poverty Strategy (revised 2002), which arose from commitments made at the UN World Summit for Social Development in 1995, provided a framework for action to help achieve the objective of eliminating poverty in Ireland. The National Action Plan for Social Inclusion 2007 to 2016 (NAPinclusion) contains the overall goal of eliminating consistent poverty by 2016 and includes a wide range of targets and actions, in that regard, covering the areas of income support, employment, housing, education, health and communities. The NAPinclusion's focus is on a co-ordinated and multi-pronged approach linked to the lifecycle stages of children, working age and older people with specific provisions for people with disabilities.

The European Council in Lisbon in 2000 pledged that Member States would work to make "*a decisive impact on poverty*" by 2010. Pursuant to that commitment and as part of the EU open method of co-ordination, Ireland submitted to the EU national action plans to combat poverty and social inclusion covering the period 2001 to 2005, followed by Ireland's Reports on National Strategies for Social Protection and Social Inclusion covering the period 2006 to 2010.

30.15 Monitoring and Evaluation/ Consultation and Participation

Ireland's National Partnership Agreements have included the community and voluntary sector since 1998. In accordance with the current agreement, *Towards 2016*, a copy of which may be accessed at http://www.taoiseach.gov.ie/attached_files/Pdf%20files/Towards2016PartnershipAgreement.pdf ; an annual report on social inclusion developments, produced by the Office for Social Inclusion, must be submitted to the social partnership steering committee, which includes community and voluntary sector representation. The Office for Social Inclusion is the Government Office with overall responsibility for developing, co-ordinating and reporting on the social inclusion process.

Ireland's active participation in the EU open method of co-ordination continues to be a primary focus for the national strategic approach and, correspondingly, the national process links closely to Ireland's participation at EU level. A key factor, in that regard, is the involvement of government departments, state agencies, local government, social partners, relevant non-governmental organisations and people experiencing poverty in Ireland's social inclusion process. The EU Commission and Council of Ministers monitor and evaluate Ireland's social inclusion plans /reports and produce an annual Joint Inclusion Report containing their assessment of same.

A fundamental aspect of the development and ongoing monitoring of strategic policy on social inclusion has been the operation of an extensive consultation process. From the production of the 1997 strategy to the current NAPinclusion, the Government has sought to regularly promote a societal response to the challenge of combating poverty and social exclusion, to involve those experiencing poverty and those who work with them in the process, to promote dialogue and partnership between all key stakeholders and to mainstream inclusion in overall policy. Modes of public consultation, to inform social inclusion policy development, include invitations to participate through national and regional seminars/discussion groups plus a process of written submissions.

The ongoing consultative and participative arrangements include the involvement of NGOs and the social partners through the National Economic and Social Forum (NESF). The NESF, with the assistance of the Office for Social Inclusion, organises an annual Social Inclusion Forum which facilitates those who are not directly represented in the social partnership process to express their views and experience on a wide range of policy and implementation issues relating to poverty and social inclusion. The 2007 Social Inclusion Forum was subject to Peer Review under the EU Open Method of Co-ordination.

The institutional mechanisms for monitoring and evaluating social inclusion developments include the Cabinet Committee on Social Inclusion, Children and Integration, the Senior Officials Group on Social Inclusion and the Office for Social Inclusion. Under the process of Poverty Impact Assessment, government departments are required to take account of the impact of policy initiatives and legislation on people at risk of poverty. In addition, the NAPinclusion Technical Advisory Group, involving State and social partner data experts, is working to improve the availability and analysis of social inclusion data for ongoing monitoring purposes.

For further information, please see the website of the Office of Social Inclusion at www.socialinclusion.ie

=====
=====
=====

FÁS (An Foras Áiseanna Saothair – the National Training and Employment Authority)

See the following website for FÁS annual report.

http://www.fas.ie/en/PubDocs/AnnualReports/ANNUAL_REPORT05/services_social_inclusion.htm#

Information on the FÁS Employment Services and Social Inclusion :-

30.16 Aims :-

The primary aims of FÁS Employment Services are to help job-seekers to obtain jobs, either directly or following a period of further training, education or work experience and to help employers to fill their vacancies. The Social Inclusion Unit ensures that FÁS policies and services reflect best social inclusion and equality practice and increase participation and progression levels of disadvantaged groups into the labour market.

30.17 Social Inclusion :-

In 2005, the focus of the Social Inclusion Unit was on integrating equality objectives into the FÁS Business Planning process - as a key mechanism to begin measuring progress regarding equality outcomes being achieved by FÁS. A range of diverse activities in respect of social inclusion were carried out during the year, including:

- developing, promoting and disseminating policies and best practice, including equality proofing, across FÁS divisions;
- monitoring, analysing and reporting on benchmarking data to inform FÁS policy in relation to social inclusion;
- ensuring appropriate provision of FÁS services to key groups and addressing barriers and gaps in provision of services;
- distributing Guidelines on Supporting Learners with Dyslexia;
- evaluating the Employment Support Scheme.

The Social Inclusion Unit continued to assist in building the capacity of the organisation to meet the needs of socially excluded and/or diverse groups in co-operation with the other functions of FÁS, including working with Services to Business in promoting basic education within the workforce. The Unit also worked with numerous external organisations in its drive to ensure social inclusion within a labour market context; including the Office of Social Inclusion as part of the consultation process on the National Anti-Poverty Strategy; the NESF Project Team on Creating a More Inclusive Labour Market; the Equality Authority, on Implementing Equality for Carers; the Sub-Group on the Employment of Travellers - chaired by Minister Killeen; the Equality Proofing Working Group and the National Childcare Committee under the Department of Justice, Equality and Law Reform.

In 2005, the Social Inclusion Unit also participated in a number of European Initiatives under EQUAL, a Peer Review in Portugal under the European Union Open Co-ordination Process, and presented an overview of Ireland's policies in relation to the employment of disabled people to a Conference of the European Blind Union. It also worked closely with the Department of Enterprise, Trade and Employment in matters of social inclusion and particularly labour market provision for disabled people.

30.18 Employment Services

FÁS Employment Services acts as a Gateway to all FÁS training and employment services and is responsible for the development and delivery of a wide range of vocational guidance and placement services - which help jobseekers to find the best possible job and employers to find the most suitable staff. (An illustration of the services provided by FÁS Employment Services through its Gateway is given in the diagram overleaf.)

FÁS has a network of 70 plus Employment Services Offices throughout the country. During 2005, FÁS registered 76,893 new clients. On average, each FÁS jobseeker will have at least three interactions with a FÁS Employment Services Officer. During the year, the service placed 15,560 jobseekers in training, 17,336 in employment and 24,966 on employment programmes. A customer satisfaction survey in 2005 showed that 76% of jobseekers were satisfied/fairly satisfied with the service they had received from FÁS Employment Services.

30.19 The FÁS Gateway for Jobseekers

FÁS Employment Services provides services to a wide range of client groups including:

Persons who remain unemployed on the Live Register for six months, and who are then referred by the Department of Social and Family Affairs to FÁS under the National Employment Action Plan process (NEAP). Long-term unemployed Live Registrants are similarly referred to FÁS and provided with an intensive guidance service.

Other jobseekers who are likely to have difficulty in accessing the labour market e.g. Travellers, women returners, ethnic minorities, ex-prisoners/offenders, disabled persons, early school leavers and lone parents.

Employees facing redundancy.

30.20 The FÁS Gateway for Jobseekers



30.21 Gateway for Employers



30.22 Services to Employers

FÁS continued to provide a free recruitment service to employers wishing to advertise vacancies with FÁS. Employers have the option of telephoning, faxing or e-mailing details of the job vacancy directly to the National Contact Centre staff, or they can input the vacancy directly on to the FÁS Jobs Ireland website. Employment Services Officers are available to assist in drafting job vacancies for display on the FÁS Jobs Ireland website, as well as providing information on employment and equality legislation and salary rates to prospective employers. Vacancies are also viewable on the touch-screen kiosks located in all FÁS Employment Service Offices and Training Centres nationwide.

FÁS developed an *Employer Strategy* to enhance interaction with employers. The strategy comprised an Action Plan for engaging with employers and all Employment Services Officers undertook appropriate staff development to support the delivery of the new strategy. An employer pack, consisting of comprehensive information on services available to employers and how FÁS services can improve their recruitment

needs, was also developed. A survey was undertaken to establish the extent of employers' knowledge of, and satisfaction with, FÁS services.

During the year, the FÁS National Contact Centre (NCC) promoted its services to jobseekers and job-ready clients were encouraged to use the freephone number where FÁS staff were available to provide them with up-to-date information on the vacancies that most suited their needs.

The number of job vacancies notified to FÁS in 2005 rose by 28% to 132,000 compared to 105,500 in 2004. A follow-up survey with employers, for the first six months of the year, showed that 82% of vacancies notified to the NCC were filled. Of these, 37% were filled by a FÁS referral, 35% from non-FÁS referrals and 28% of vacancies were filled from unknown sources.

30.23 Recognised Quality Systems in FÁS Employment Services

One of the benefits of a national quality system, based on the Q Mark, is that it guarantees a consistent level of service to customers throughout the country. An ethos of continuous improvement is required to ensure that services remain customer-focused and that on-going efforts are made to meet the changing needs of the clients. During 2005, the Excellence Ireland Quality Association (EIQA) undertook an external audit of FÁS Employment Services nationwide. The application was successful and FÁS became the first organisation in Ireland to achieve the Q Mark for a national system.

30.24 Self-Service Facilities

FÁS Employment Services Offices (ESOs) operate as resource centres or 'One Stop Shops', providing ease of access to information and a customer-friendly atmosphere for clients. Free services available to clients include details of job vacancies, a customer service desk, newspapers, free use of telephone to contact employers, internet access, photocopying, and access to PCs, printers and fax machines.

The range of self-service resources available to jobseekers includes:

Touch-screen kiosks, with print facility, to provide up-to-date details on current jobs, training courses and allowances. 2.3 million 'hits' (*number of times clients accessed and printed information*) were recorded from self-service touch-screen kiosks in 2005.

Self-help guidance facilities including Career Directions (database of information on 720 careers) and Qualifax (information on post-secondary courses).

Access to, and advice on, creating a Curriculum Vitae online via the FÁS Jobs Ireland website.

FÁS also offers a 'screening' service to jobseekers interested in vacancies advertised with FÁS. Employment Services staff will assess the jobseeker's suitability for a

particular vacancy, based on the information which has been provided by the employer with respect to a vacancy. 175,000 such screened referrals were made to employers' vacancies from FÁS Employment Services Offices in 2005.

Local Labour Market Consultative Groups were set up as a response to Section 18 of the Sustaining Partnership Agreement 2003-2005. It was agreed that FÁS would facilitate these groups and representation would be drawn from FÁS and the parties to the Agreement. These groups were in operation in all FÁS regions in 2005.

National Resource Centres for Vocational Guidance (NRCVG) acts as information centres for EU Member States to access information, advice and guidance on the placement of young people who wish to undertake a period of study or training in another Member State. In Ireland, there are two National Resource Centres, the FÁS National Resource Centre for Vocational Guidance (NRCVG) providing information on vocational training and labour market opportunities within the EU and the National Centre for Guidance in Education (NCGE) providing information on educational opportunities within the EU. These Centres form part of the Euroguidance Network. In 2005, the FÁS National Resource Centre was involved in delivering an information service to EU and EEA nationals, hosting regular study visits from visiting practitioners from, for example, Latvia, Denmark, Israel, Italy and Hungary; and promoting its services through exhibitions and other forms of media.

FÁS continued to play a significant role on the National Guidance Forum (NGF) - a collaborative initiative between the Department of Education and Science and the Department of Enterprise, Trade and Employment. The NGF was established in 2004 to enable quality lifelong and life wide guidance to become a reality. FÁS continued to participate on the NGF Steering Group, the NGF Quality in Guidance Sub-Committee and the NGF Competencies Framework Sub-Committee. The two Sub-Committees are currently developing guidelines to assist organisations/agencies involved in guidance-related activities to improve the quality of service provision to clients and to establish a competency framework to identify the competencies required of a guidance service.

30.25 National Employment Action Plan

During 2005, FÁS continued to operate the National Employment Action Plan (NEAP) Preventive Strategy. NEAP was adopted by the Irish Government in response to the European Employment Guidelines; and includes a commitment to a more systematic engagement by the Employment Services with the unemployed.

During the year, a total of 40,718 persons were referred to FÁS, and 28,714 persons were interviewed by FÁS staff. Of all those referred to FÁS, 60% had left the Live Register by the end of January 2006. Equally, 60% of those interviewed by FÁS had left the Live Register. (See Appendix 4 for more details.)

As the NEAP Preventive Strategy evolved over the years, FÁS developed a number of special initiatives in response to the emerging needs of clients. These include the *Customised Training Fund*, the *High Support Process* and the *Pathways Programme*. The *Customised Training Fund* continued to provide a fast and flexible response to the particular training needs of individual clients. In 2005, expenditure on customised

training was €1.4 million, an increase of €200,000 on 2004 expenditure. Approximately 3,000 clients benefited from training courses such as *ECDL*, *Safepass*, *Driving Lessons (incl. HGV)*, *Forklift Driving*, *Scaffolding and Childcare*. An evaluation of the Customised Training Fund was conducted by FÁS Planning and Research in 2005 and demonstrated the benefits of the programme. Certain areas for improvement were identified and these will be addressed in 2006.

The High Support Process (HSP) is a flexible process designed to assist FÁS Employment Services Officers to better meet the needs of clients who, because of health, literacy or other difficulties are experiencing major barriers in progressing from unemployment to work. Multi-agency teams play an integral part in the HSP and include representatives from agencies currently involved in the provision of services (e.g. *FÁS*, *Department of Social and Family Affairs*, *the Health Services Executive*, *VECs*).

An external evaluation of the programme was conducted and considered in early 2005. In response, eligibility for the HSP was extended to a wider range of disadvantaged client groups who have difficulty accessing employment. The eligible supports were also extended to other employment-related needs such as counselling, interview travel costs, purchase of tools and/or clothing. The funding available for the purchase of any required intervention was increased from €2,200 to €2,500.

In 2005, approximately 1,400 clients were interviewed under the HSP, of whom approximately 700 (an increase of approx 85% on 2004) availed of interventions purchased through the HSP budget. Expenditure under HSP in 2005 was approximately €460,000 (an increase of almost 56% on 2004).

A review of the National Employment Action Plan (NEAP) process was carried out for the Department of Enterprise, Trade and Employment (DETE), in conjunction with FÁS and the Department of Social and Family Affairs (DSFA), by Indecon Consultants and was completed in 2005. The overall thrust of the report was positive.

The Consultants, in their conclusion, state that, “having regard to the data available and taking account of constraints, our analysis suggests that the NEAP process has been a success”. The report highlighted that this finding was consistent with previous research which has shown positive outcomes for this form of active measure, i.e. that counselling and jobsearch assistance measures are effective and relatively inexpensive. The report makes a number of recommendations for the future operation of the NEAP; which will be part of an action plan for the future operation of NEAP to be developed by FÁS in co-operation with its partners in the process.

The results of an econometric assessment carried out by the Consultants on the net impact of NEAP suggest that “NEAP participation impacts positively and significantly on labour market outcomes i.e. exit probabilities are higher for programme participants than for non-participants”. The econometric analysis suggests an improvement in exit probability of between 10% and 20%, depending on the model specification. However, in the light of uncertainty with the estimates, the Consultants adopt a cautious approach in assessing benefits and assume that the likely savings on unemployment payments could be up to 5% of total expenditures. The figures quoted in the report translate into a positive net benefit of about €35 million per annum due to the NEAP.

The report notes that the NEAP has encouraged early exiting from the Live Register and appears to have reduced the likelihood of long-term unemployment and has also helped to reduce Ireland's estimated structural rate of unemployment. It further notes that there is some evidence that NEAP has encouraged a migration to other Social Welfare schemes. However, the Consultants conclude that they do not believe that this effect would significantly reduce the estimated positive effects of the NEAP.

30.26 Pilot initiatives for Disadvantaged Groups

FÁS frequently conducts new pilot initiatives to seek ways of better meeting the needs of its clients. In January 2005, FÁS, in conjunction with the Department of Social and Family Affairs (DSFA) and the Health Services Executive (HSE), commenced a pilot employment initiative for disabled people in the Midlands region. The aim was to provide an integrated employment support approach for disabled people. It was recognised that though a range of employment supports for people with a disability were already available from DSFA, HSE and FÁS, they were provided on a separate agency basis and generally operated independently of each other. The pilot examined whether a more integrated approach to the delivery of training and employment supports for disabled people was warranted. The pilot was implemented over a 12-month period and operated in the Midlands Region - comprising the counties of Longford, Laois, Offaly and Westmeath. A final report on this pilot is expected in 2006.

FÁS and officials of the DSFA also implemented two pilot programmes to address the issue of progression of younger persons under 25 years of age, who were long-term unemployed, or in danger of becoming long-term unemployed. These programmes were conducted in Donegal and showed promising results.

30.27 Local Employment Services

The Local Employment Services (LES) is part of the dual-stranded National Employment Service. The overall service consists of the FÁS Employment Service and the Local Employment Service (LES) - which operates under contract to FÁS, mainly through locally-based Partnership Companies. The objectives of the LES are to focus on the provision of services to the most disadvantaged and socially excluded in the labour market and to provide a direct local response. In 2005, the LES operated with a budget of € 18 million and registered 5,447 clients.

In 2005, FÁS negotiated with PLANET (the Network of Area Partnership Companies) a new Agreement and Activity Schedule in relation to the operation of the LES. It includes clear targeting of socially-excluded client groups, having regard to local and regional needs, and will result in a greater complementary of service delivery within the dual-stranded National Employment Service. A comprehensive set of financial and monitoring guidelines for the LES was put in place during 2005.

Críoch / End

Sixth Report of the Government of Ireland to the Council of Europe under the Revised European Social Charter :-

List of Appended Material :-

=====

There is no appended material to this Report.

Críoch / End