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EUROPEAN SOCIAL CHARTER

14th National Report on the implementation of
the European Social Charter

submitted by

THE GOVERNMENT OF IRELAND

Articles 3, 11, 12, 13, 14, 23 and 30
for the period 01/01/2012 - 31/12/2015

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Ireland's 14th Report on the Revised European Social Charter

Articles

3,11,12,13,14,23,30

Article 3 – The right to safe and healthy working conditions

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

1. to formulate, implement and periodically review a coherent national policy on occupational safety, occupational health and the working environment. The primary aim of this policy shall be to improve occupational safety and health and to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, particularly by minimising the causes of hazards inherent in the working environment;

The Department of Jobs, Enterprise and Innovation has the role of formulating and developing occupational safety and health policy relating to and including reviewing legislative requirements and work environment developments on an ongoing basis. In Ireland the administration, enforcement and promotion of occupational safety and health has been delegated to the Health and Safety Authority (HSA). The HSA is a state agency originally established under the Safety, Health and Welfare at Work Act, 1989.

The HSA is responsible for proposing policy measures to the Minister for Jobs, Enterprise and Innovation. Such proposals are determined by the twelve members of the tripartite Board of the HSA, representing the social partners (government, employers and workers) and other interests concerned with safety and health in the workplace and chemical safety. The HSA engages in public consultation on the renewal of its three year strategic plan and in wide consultation with employers, employees and their respective organisations on the development of its legislative programme. To help develop sound policies and good workplace practices the HSA works with various advisory committees and task forces which focus on specific occupations or hazards

The HSA prepares a national strategic plan every three years. The strategy is implemented through annual programmes of work. The HSA aims to achieve a continued downward trend in work related deaths, injuries and ill-health and an increase in the safe use of chemicals.

The three foremost priorities of the HSA's strategy for the period 2016 to 2018 are :

1. **Health:** Increase the focus on work-related health risks.
2. **Safety:** Maintain and develop the advances achieved in the management of work-related safety risks.
3. **Chemicals:** Focus on the risks to human safety and health arising from chemicals used at work and by the general public.

The HSA delivers the strategy and programme of work using multiple integrated approaches including:

- prevention through inspection,

- working in partnership with key sectors and developing specific and agreed programmes of action
- targeted promotion focusing on issues contributing to good workplace health,
- intelligence gathering to focus on priority workplace issues,
- building employer competence in meeting responsibilities and to engender enthusiasm among workers in occupational health issues,
- champion occupational health and safety in the curriculum at primary, secondary and third level education in Ireland,
- deploying an educational strategy to motivate and equip existing and future workers, and
- developing strategic partnerships.

All HSA publications, including annual reports can be accessed on the HSA's website at www.hsa.ie.

Some of the measures taken to implement the Authority strategy 2013-2015 included the following:

- The HSA implements a balanced workplace inspection and enforcement programme across all of its mandates over the period of the strategy. The great majority of inspections and investigations resulted in either verbal or written advice being issued, aimed at achieving voluntary compliance. Enforcement action, up to and including prosecution, was taken where this was necessary to achieve safe and healthy working conditions and the safe use of chemicals.
- The number of inspections fell in recent years (from a level of 15,430 inspections conducted in 2011, falling to 10,719 in 2014) due to staff reductions and changes in the character of inspection activity, notably in the farm sector. Over 9,500 inspections and investigations under safety and health legislation were carried out in 2015, including almost 3,000 inspections in the agriculture sector (including forestry and fishing). The HSA uses an electronic inspection management system to provide an integrated record of all inspections, enforcement actions, correspondence and reported incidents and customer contacts.
- In the construction sector the HSA responded to the economic recovery in the sector and the influx of returning and new workers by increasing the inspection level and completing over 3,000 inspections. HSA inspectors also completed over 1,000 investigations of fatal accidents, serious injuries and complaints on safety, health and chemicals. Across their inspection programme, the HSA provided written advice in over 4,300 cases. Where inspectors found more serious breaches, they issued improvement notices (489 notices) and prohibition notices (488 notices). The HSA concluded 16 prosecutions in 2015, resulting in total fines imposed of €541,000
- The HSA completed 406 healthcare inspections and 70 investigations in the period 2014-2015. The majority of these inspections looked at Healthcare safety issues, violence and aggression in the healthcare sector, and safety with medical sharps. Twenty nine inspections were carried out in the healthcare sector as part of the EU campaign on slips, trips and falls in 2014, covering areas such as management, cleaning, housekeeping, pedestrian surfaces, entrances, stairs and footwear.

- In relation to occupational health issues, manual handling was reviewed during 585 inspections across all work sectors in 2014. The HSA published information sheets and guidance documents on manual handling of glazing sheets, Ergonomic Good Practice in the Irish Workplace. As part of the new 2015-2018 strategy with its focus on health and wellbeing, the HSA provided advice on reducing exposure to work-related stress through a range of seminars arranged in conjunction with Mental Health Ireland.
- The HSA focused particular attention on occupational health and safety initiatives regarding chemical, physical and biological agents and provided significant levels of guidance and advice including publishing guidance on writing occupational hygiene reports, legionella in water towers, composting sites, tradesman awareness flyer on asbestos etc. This guidance was coupled with extensive engagement with relevant sectors through seminars, workshops and agreed actions.
- The online risk assessment tool, BeSMART, which supports and assists small business to deal with health and safety in their workplaces, was further developed in the period 2013-2015. The online tool now caters for more than 250 different business types. In 2015, the number of BeSMART users increased by 6,896 users to bring the total users to 30,278 by year end. In addition, the HSA launched two new modules for the high risk construction and agribusiness sectors.
- In agriculture a new Farm Safety Action Plan (2016–2018), involving all major stakeholders was launched, in an effort to improve safety standards and drive a culture of change within the sector.
- In 2013, the HSA commenced a programme for the public sector. As a result of this programme, they completed 273 inspections and 50 investigations in the public sector in the years 2014-2015. These inspections involved reviews of the health and safety management systems.

The HSA completed its five-year Work related vehicle safety programme in 2014 and will finalise a new three-year programme in 2016 following a review of the outcomes in 2015. Significant levels of engagement with other public sector partners including the Road Safety Authority (RSA) and the police service remain a cornerstone of this programme. The HSA provided guidance on topics such as load-securing for high risk loads, safe delivery from vehicles and preventing falls from vehicles. In 2015 for example, 119 inspections were completed to check compliance with load-securing and a further 183 were completed in relation to driving to work.

Article 3 – The right to safe and healthy working conditions

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

2. to issue safety and health regulations;

As detailed in Ireland's response to the Sixth Report to the Council of Europe under the Revised European Social Charter, Ireland had enacted significant primary and secondary legislation governing health and safety.

The following legislation was enacted between 2008 and 2016:

Primary Legislation

- Chemicals Act 2008 (No. 13 of 2008)
- Chemicals (Amendment) Act 2010 (No. 32 of 2010)

Secondary Legislation

- Dangerous Substances (Retail and Private Petroleum Stores) (Amendment) Regulations 2016 (S.I. No 604 of 2016)
- Safety, Health and Welfare at Work (General Application) (Amendment) (No.3) Regulations 2016 (S.I. No. 370 of 2016)
- Safety, Health and Welfare at Work (Electromagnetic Fields) Regulations 2016 (S.I. No. 337 of 2016)
- Safety, Health and Welfare at Work (General Application) (Amendment) (No. 2) Regulations 2016 (S.I. No. 70 of 2016)
- Safety, Health and Welfare at Work (General Application) (Amendment) Regulations 2016 (S.I. No. 36 of 2016)
- Safety, Health and Welfare at Work (Chemical Agents) (Amendment) Regulations 2015 (S.I. No. 623 of 2015)
- Safety, Health and Welfare at Work (Carcinogens) (Amendment) Regulations 2015 (S.I. No. 622 of 2015)
- European Communities (Machinery) (Amendment) Regulations 2015 (S.I. No. 621 of 2015)
- Safety, Health and Welfare at Work (Docks) (Revocation) Regulations 2015 (S.I. No. 521 of 2015)
- European Communities (Carriage of Dangerous Goods by Road and Use of Transportable Pressure Equipment) (Amendment) (No.2) Regulations 2015 (S.I. No.288 of 2015)
- Chemicals Act (Control of Major Accident Hazards Involving Dangerous Substances) Regulations 2015 (S.I. No. 209 of 2015)
- European Communities (Pressure Equipment) (Amendment) Regulations 2015 (S.I. No. 81 of 2015)

- European Communities (Carriage of Dangerous Goods by Road and Use of Transportable Pressure Equipment) (Amendment) Regulations 2015 (S.I. No. 31 of 2015)
- Dangerous Substances (Retail and Private Petroleum Stores) (Amendment) Regulations 2014 (S.I. No 574 of 2014)
- European Union (Prevention of Sharps Injuries in the Healthcare Sector) Regulations 2014 (S.I. No. 135 of 2014)
- Safety, Health and Welfare at Work (Biological Agents) Regulations 2013. (S.I. No. 572 of 2013)
- Safety, Health and Welfare at Work (Construction) Regulations 2013 (S.I. No. 291 of 2013)
- European Communities (Carriage of Dangerous Goods by Road and Use of Transportable Pressure Equipment) (Amendment) Regulations 2013 (S.I. No. 238 of 2013)
- Safety, Health and Welfare at Work (Construction) (Amendment) Regulations 2013 (S.I. No. 182 of 2013)
- Safety, Health and Welfare at Work (Quarries) (Amendment) Regulations 2013 (S.I. No. 9 of 2013)
- Dangerous Substances (Retail and Private Petroleum Stores) (Amendment) Regulations 2012 (S.I. No. 528 of 2012)
- Safety, Health and Welfare at Work (Construction) (Amendment) No 2 Regulations 2012 (S.I. No. 481 of 2012)
- Safety, Health and Welfare at Work (Construction) (Amendment) Regulations 2012 (S.I. No. 461 of 2012)
- Safety, Health and Welfare at Work (General Application) (Amendment) Regulations 2012 (S.I. No. 445 of 2012)
- Dangerous Substances (Retail and Private Petroleum Stores)(Amendment) Regulations 2011 (S.I. No. 712 of 2011)
- European Communities (Carriage of Dangerous Goods by Road and Use of Transportable Pressure Equipment Regulations (S.I. No. 349 of 2011)
- Chemicals (Asbestos Articles) Regulations 2011 (S.I. No. 248 of 2011)
- Chemicals Act (CLP Regulation) Regulations 2011 (S.I. No. 102 of 2011)
- Safety, Health and Welfare at Work (Exposure to Asbestos)(Amendment) 2010 (S.I. No. 589 of 2010)
- Safety, Health and Welfare at Work (Construction)(Amendment) 2010 (S.I. No. 523 of 2010)
- Safety, Health and Welfare at Work (General Application)(Amendment) 2010 (S.I. No. 176 of 2010)
- Safety, Health and Welfare at Work (Construction)(Amendment)(No. 2) Regulations 2008 (S.I. No. 423 of 2008)
- Safety, Health and Welfare at Work (Construction)(Amendment) Regulations 2008 (S.I. No. 130 of 2008)
- Safety, Health and Welfare at Work (Quarries) 2008 (S.I. No. 28 of 2008)

The text of the legislation may be found on the Irish statute book website www.irishstatutebook.ie

In the same time period the HSA has published the following Codes of Practice:

- Code of Practice for Avoiding Danger from Underground Services (2016)
- Code of Practice for Safety in Roofwork (2016)
- Code of Practice for the Chemical Agents Regulations (2016)
- Code Of Practice for Biological Agents
- Code of Practice for Chemical Agent Regulations
- Code Of Practice for Safety In Roofwork
- Code of Practice for Avoiding Danger from Underground Services
- Working on Roads Code of Practice for Contractors with Three or Less Employees
- Code of Practice for the Design and Installation of Anchors
- Code of Practice for Working in Confined Spaces
- Code of Practice for Electrical Safety in Quarries
- Code of Practice for Contractors with Three or Less Employees
- Code of Practice for Access and Working Scaffolds
- Code of Practice for Managing Safety and Health in Forestry Operations

Some of the codes of practice were developed specifically for employers who have three or less employees. These employers can meet their legal obligations by complying with such agreed codes.

Codes of Practice published by the HSA can be access through the HSA's website at www.hsa.ie.

All measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework are done in consultation with employers' and workers' organisations. Details of the measures taken are contained in the response to questions relating to Article 3§1.

Article 3 – The right to safe and healthy working conditions

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

- 3. to provide for the enforcement of such regulations by measures of supervision;

Legislation was updated as detailed in 3§2 above. There have been no changes to the fundamental approach to the enforcement of occupational health and safety legislation which has been consensually developed in consultation with employers' and workers' organisations and which is enshrined in the Safety, Health and Welfare at Work Act 2005 or chemical legislation under the Chemicals Act 2008.

The following information relates to reported non-fatal and fatal accidents:

Figure 1: Injuries reported to the HSA

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Non-fatal accidents	8,027	7,976	8,303	8,069	7,002	7,583	7,094	6,804	6,598	7,431	7,775

Source: HSA database

Figure 2: Rate of fatal injuries 2008-2015



Figure 3: Number of reported fatalities (worker and non-worker) by economic sector, 2009– 2015 (HSA)

Economic sector	Number of fatalities							Total 2009- 2015
	2009	2010	2011	2012	2013	2014	2015	
A–Total agriculture, forestry and fishing	13	29	27	28	21	31	24	173
Agriculture	10	22	22	20	16	30	18	138
Forestry	1	3	0	1	0	0	1	6
Fishing	2	4	5	7	5	1	5	29
B–Mining and quarrying	2	0	1	1	2	0	2	8
C–Manufacturing	1	2	2	0	1	3	3	12
D–Electricity, gas, steam and air conditioning supply	0	0	0	0	1	1	0	2
E–Water supply, sewerage, waste management and remediation activities	0	2	3	4	1	0	3	13
F–Construction	10	6	6	8	11	8	11	60
G–Wholesale and retail trade	2	4	2	3	3	4	2	20
H–Transportation and storage	6	3	7	1	4	4	4	29
I–Accommodation and food services	1	0	1	0	0	0	0	2
J–Information and communication	0	0	0	0	0	0	0	0
K–Financial and insurance activities	0	0	0	0	0	0	0	0
L–Real-estate activities	0	0	0	0	0	0	0	0
N–Administrative and support-service activities	1	0	0	0	1	2	0	4
O–Public administration and defence	2	0	1	0	0	0	4	7
P–Education	2	0	0	0	1	0	0	3
Q–Human-health and social-work activities	1	1	1	1	0	0	2	7
R–U–Other NACE activities	1	1	1	0	1	1	1	6
Total	43	48	54	48	47	55¹	56	296

¹ Following investigation, a fatality included in the 2013–2014 report was determined not to be work related. Therefore, the total number of fatalities for 2014 has been revised from 56 to 55.

Figure 4: Numbers suffering injury and illness 2009 - 2014

	2009		2010		2011		2012		2013		2014	
	N	Rate per 1,000	N	Rate per 1,000	N	Rate per 1,000	N	Rate per 1,000	N	Rate per 1,000	N	Rate per 1,000
Total In employment	1,961		1,882.18		1,850.05		1,851.43		1,881.15		1,913.90	
Injury												
Total suffering Injury	32,010	16.3	40,584	21.6	40,097	21.7	35,001	18.9	46,574	24.8	39,319	20.5
0-3 days' absence	20,556	10.5	21,109	11.2	23,254	12.6	17,214	9.3	28,132	15.0	20,523	10.7
4+ days' absence	11,454	5.8	19,475	10.3	16,843	9.1	17,786	9.6	18,442	9.8	18,796	9.8
Days lost due to Injury ¹	283,200		666,553		590,690		n.a.		758,674		750,011	
Illness												
Total suffering illness	30,593	15.6	38,704	20.6	48,436	26.2	50,210	27.1	54,867	29.2	49,194	25.7
0-3 days' absence	18,328	9.3	20,856	11.1	28,748	15.5	22,735	12.3	36,039	19.2	25,227	13.2
4+ days' absence	12,265	6.3	17,848	9.5	19,688	10.6	27,474	14.8	18,828	10.0	23,966	12.5
Days lost due to Illness	463,700		704,494		595,951		n.a.		792,875		1,106,311	
Injury and illness												
Total Injury or illness	62,603	31.9	79,288	42.1	88,533	47.9	85,210	46	101,440	53.9	88,513	46.2
Total (4+ days' absence)	23,719	12.1	37,323	19.8	36,531	19.7	45,261	24.4	37,270	19.8	42,762	22.3
Total days lost	746,900		1,371,047		1,186,641		n.a.		1,551,549		1,856,322	

Note: The days absent in 2012 are not strictly comparable with other years due to changes in response categories (see HSA, 2014, 'Summary of Workplace Injury, Illness and Fatality Statistics 2013-2014' for details). The changes also mean that the total number of days lost cannot be calculated for 2012.

¹ Days lost data should be interpreted with care, as respondents may have included potential days lost. The figures only refer to the most recent injury or illness.

In all the statistics based on the CSO QNHS module that follow, the numbers of injuries and illnesses refer to those in employment at the time of the survey. The estimates are subject to sampling and other survey errors, and estimates and changes over time of a small magnitude can be taken to have lower precision.

Figure 5: Number of workplace inspections and investigations 2005-2015

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Total	13552	15365	13631	16009	18451	16714	15340	13835	12244	10719	10880

Detailed statistics for the number of accidents at work, including fatal accidents, are available in the Authority's annual Summary of Statistics, available on www.hsa.ie.

Detailed statistics for inspections and sanctions is available in the appendix of the HSA Annual Reports, available on www.hsa.ie.

Article 3 – The right to safe and healthy working conditions

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

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

Workplace health promotion in Ireland has evolved over the years to the point where it is currently holistically defined as the combined efforts of employers, employees and society to improve the health and well-being of people at work.

In the Irish context there have been a number of national initiatives to address health promotion in the workplace that complement the national occupational safety and health strategy 2016-2018. The most notable development is the Government's strategy *Healthy Ireland: A Framework for Improved health and Wellbeing, 2013-2015*. The objective of the Government Healthy Workplace policy is to 'support all employees to attain and maintain optimal health and wellbeing by providing them with the knowledge and opportunities to adopt healthy lifestyle behaviours'.

It applies to all workplaces – both private and public sector. It aims to take account of best practice in other jurisdictions and guidance from the World Health Organisation and other reputable bodies.

The various stakeholders at national, regional and local level in Ireland will be encouraged to work in partnership to support the implementation and evaluation of current health promotion programmes. The approach of the Healthy Workplace policy reflects the ethos of the overall *Health Ireland* Framework and the "Workplace Pillar" which is a feature of Ireland's National Plan on Corporate Social Responsibility: *Good for Business, Good for the Community 2014 - 2106*.

One of the key objectives in the HSA's Strategy 2016-2018 is an increased focus on health and wellbeing. This has come about for a number of reasons:

- Recent Central Statistics Office (CSO) Quarterly National Household Surveys and Economic and Social Research Institute (ESRI) reports citing more absence due to work related illnesses than accidents at work.
- Musculoskeletal disorders (MSDs) and work related stress (WRS) are stated as major causes of absence on Department of Social Protection (DSP) Illness Benefit (IB) certificates by general practitioners (GPs).
- Ireland's interest in current OSH developments in other European countries.

There is no statutory requirement in Ireland on employers to provide access to occupational health services. Many employers now have the knowledge and tools to systematically manage health and safety in their workplaces and the results are evident in reduced accident rates.

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

The preventive and advisory activities to be developed in light of the increased focus in the HSA's Strategy 2016-2018 on workplace health and wellbeing development will be achieved over the 3 year period of the strategy in order to promote the progressive development of occupational health services for all workers a number of ways:

- Gathering data on work related illnesses from sources such as CSO, ESRI and DSP.
- Continued development of occupational health section of the HSA website.
- Increased training and involvement by inspectors in areas such as ergonomics and manual handling (MH) risk management, respiratory dust control and sun protection for outdoor workers.
- Involvement of inspectors dealing with psychosocial issues such as work related stress (WRS) and bullying.
- Continued guidance on management of manual handling and MSDs in different sectors.
- Manual handling projects in sectors such as construction, agriculture and manufacturing.

Article 11 – The right to protection of health

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

1. to remove as far as possible the causes of ill-health;

Healthy Ireland

Ireland places a particular priority on removing the causes of ill-health. The importance of considering health and wellbeing issues across Government policies is articulated in '*Healthy Ireland, A Framework for Improved Health and Wellbeing 2013-2025*', the overarching national framework for action to improve the health and wellbeing of the country over the coming generations.

Healthy Ireland is focused on working on a 'whole of Government' and 'whole of society' approach to tackling the major lifestyle issues which lead to negative health outcomes (e.g. smoking, alcohol, poor diet, physical inactivity, obesity) as well as seeking to address the wider social and environmental factors that impact on health and wellbeing (e.g. housing, education, transport, physical environment). The framework aims to shift the focus to prevention of ill health, seeks to reduce health inequalities, and emphasises the need to empower people and communities to better look after their own health and wellbeing.

A 'Healthy Ireland Fund' was established in October 2016, with an initial kickstart allocation of € million in Budget 2017 to support the 'whole of Government' implementation of *Healthy Ireland* programmes and projects in a variety of settings, including education, local authorities, workplaces and communities. The allocation of additional funding to health and wellbeing demonstrates the Government's commitment to the implementation of '*Healthy Ireland, the National Framework for Improving Health and Wellbeing 2013-2025*'.

Non-communicable and chronic diseases

Non-communicable diseases - or NCDs - like heart attacks and strokes, cancers, diabetes and chronic respiratory disease account for over 63% of deaths in the world today. There is solid scientific evidence that the major NCDs cause suffering and undermine social and economic development. Approximately 80% of the overall disease burden in Europe is attributed to chronic disease and the pattern in Ireland is similar. It is known that three quarters of deaths in Ireland are due to three chronic disease areas: cancer, cardiovascular and respiratory diseases. Considerable work is taking place in the national Health Service Executive (HSE) to prioritise a number of chronic diseases; these are COPD, asthma, heart failure and diabetes.

A national policy framework for the prevention and management of chronic disease was developed in 2008. This chronic disease policy framework addresses the challenges of chronic disease so as to reduce the burden for individuals, their carers and the health system. One of the aims of this policy is to promote and improve the health of the population and reduce the risk factors that contribute to the development of chronic diseases.

NCDs are chronic conditions that often require lifelong monitoring and (pharmaceutical and non-pharmaceutical) treatment, but many NCDs can be prevented. They are largely preventable diseases linked to a set of four common risk factors, namely tobacco use, harmful use of alcohol, unhealthy diets, and physical inactivity.

Tobacco control in Ireland

Ireland is currently ranked 2nd out of 34 European Countries in relation to tobacco control initiatives. Ireland is a party of and is committed to the implementation of the WHO Framework Convention on Tobacco Control (FCTC).

Tobacco control measures already in place in Ireland include:

- A ban on sale of tobacco products to individuals under 18 years of age (2001)
- Work-place smoking ban (2004)
- A ban on packets containing less than 20 cigarettes (2007)
- A ban on the sale of confectionaries that resemble cigarettes (2007)
- A ban on the point of sale display and advertising of tobacco products (2009)
- A requirement for all tobacco products to be stored within a closed container which can only be accessed by the retailer (2009)
- A requirement for all retailers who wish to sell tobacco products to register with the National Tobacco Control Office (2009)
- A prohibition on self-service vending machines except in licensed premises or in registered clubs (2009)
- Combined text and photo warnings (graphic warnings) (2013)
- Social marketing and media campaigns, establishment of a National Smokers Quitline, social media and online cessation supports (on-going)
- Development of smoking cessation services (on-going)
- Nicotine Replacement Therapy available free to all medical card holders (ongoing)
- Increased excise duty on tobacco products (on-going)
- A ban on smoking in cars where children are present (2016)
- Adoption of the EU Tobacco products Directive (2016)

Ireland's tobacco policy entitled '*Tobacco Free Ireland*' sets a target for Ireland to be tobacco free by 2025. In practice, this will mean a smoking prevalence rate of less than 5%. The two key themes underpinning the policy are protecting children and the denormalisation of smoking. In line with previous measures and the '*Tobacco Free Ireland*' policy document, a number of measures are currently being progressed in Ireland. These include the introduction of the Public Health (Standardised Packaging of Tobacco) Act 2015 and the development of legislation for the sale of tobacco products and non-medicinal nicotine delivery systems.

The cumulative effect of Ireland's tobacco control legislation to date has been a decrease in the number of people smoking. The Healthy Ireland 2016 Survey found that 19% of those aged 15 years and older smoke daily, down from 24% in 2007. A further 4% of the population are occasional smokers (do not smoke every day), hence 23% are current smokers, down from 29% in 2007. The 2014 Health Behaviour in School Children Survey found that 8% of those

between 10 and 17 years currently smoke (defined as smoking at least once a month), down from 15% in 2006.

Harms of alcohol

Alcohol has major public health implications and in Ireland is responsible for a considerable burden of health, social and economic harm at individual, family and societal levels. The Government is working to reduce alcohol consumption and to address the underlying causes of alcohol misuse.

The Public Health (Alcohol) Bill is a measured and evidenced-based response to deal with the very real harms caused by alcohol. The Bill is part of a suite of measures agreed by the Government in 2013 on foot of the recommendations in the *'Steering Group Report on a National Substance Misuse Strategy'*, which was published in 2012. The Bill is one of the measures being taken under *'Healthy Ireland'* – the Government's framework for action to improve health and wellbeing.

The Government approved the publication of the Public Health (Alcohol) Bill and the introduction of the Bill in the Houses of the Oireachtas on 8 December 2015. The Bill includes provisions for:

- minimum unit pricing
- health labelling of alcohol products
- the regulation of advertising and marketing of alcohol
- the regulation of sponsorship
- structural separation of alcohol products in mixed trading outlets and
- the regulation of the sale and supply of alcohol in certain circumstances

The Public Health (Alcohol) Bill remains a priority for this Government and is currently progressing through the legislative process.

National Obesity Policy and Action Plan

'A Healthy Weight for Ireland – Obesity Policy and Action Plan 2016- 2025' was launched in September 2016. The policy and action plan aims to reverse obesity trends, to prevent health complications and reduce the overall burden for individuals, families, the health system and the wider society and economy.

In recent years, levels of overweight and obesity have increased dramatically with 60% of adults and one in four children in Ireland either overweight or obese. It is estimated that the cost to society in Ireland of adult obesity exceeds €1 billion per annum. Overweight and obesity are significant risk factors for many chronic diseases. The links between obesity and heart disease, cancers, Type 2 diabetes, mental health issues, respiratory problems and musculoskeletal conditions are well established.

A range of actions will be undertaken over the coming years to address the growing concerns about overweight and obesity. These include:

- new national Healthy Eating Guidelines

- Calorie Posting Legislation
- Development of a Nutrition Policy
- A new clinical Lead for Obesity will be appointed in the HSE
- Prioritisation of Obesity services in the HSE service plans for 2017 and subsequent years
- support for introduction of a Sugar Levy to encourage a reduction in the rates of consumption of sugar-sweetened beverages
- Working with key stakeholders to develop a voluntary industry Code of Practice regarding food advertising, promotion and marketing
- “whole of school” approaches to healthy lifestyles with the Department Education and Skills
- Development of guidelines in relation to the built environment
- Agreement on food reformulation targets with the food industry and establishment of a forum for engagement with industry on best practice initiatives towards a healthy food environment

A consultation was conducted with children and young people to ensure their input of informed ‘*A Healthy Weight for Ireland, Obesity Policy and Action Plan, 2016-2025*’. Actions in *A Healthy Weight for Ireland* directly address the issues raised at the consultations with children and young people on what helps them and what challenges they face in having a healthy lifestyle, including those on the importance of healthy food, physical activity, smoking, the home, schools and the local areas.

‘*A Healthy Weight for Ireland*’ recognises that there are socio-economic inequalities in the occurrence of obesity in Ireland with rates considerably higher in the most disadvantaged areas. This will include action by the HSE to develop community based health promotion programmes with special focus on disadvantaged areas.

Progress on implementation of the Obesity Policy and Action Plan will be reported to the Healthy Ireland Cross Sectoral Group by the Department of Health. In addition, the Department of Health will regularly review outcomes; develop a suite of performance indicators to monitor progress on implementation; and will develop a nutrition health surveillance system and a national physical activity surveillance system in order to report annually on the implementation of the Plan. The Department of Health will also conduct a mid-term review on overall progress in achieving the targets set out in the Plan.

Article 11 – The right to protection of health

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

2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;

The vision of ‘*Healthy Ireland*’ is an Ireland where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone’s responsibility.

Many health and wellbeing indicators are affected by individuals’ personal lifestyle choices. For example, the World Health Organisation attributes 60% of the disease burden in Europe to seven leading risk factors: hypertension, tobacco use, alcohol misuse, high cholesterol, being overweight, low fruit and vegetable intake and physical inactivity. The effects of these risk factors can be minimised if individuals can be motivated and supported to make healthier choices. To be effective, action to control the determinants of health must include developing understanding and skills, and promoting informed health choices.

This means informing people and communities about how to improve their health and wellbeing and empowering and motivating them to do so, whilst working to remove or at least minimise any legislative or practical barriers that impede their ability to make healthy choices. ‘*Healthy Ireland*’ will help to raise awareness and promote healthy lifestyle choices among the public by understanding and acknowledging the broad causes of ill-health and by devising targeted, intersectoral public information strategies and actions to address them.

One of the relevant actions contained in ‘*Healthy Ireland*’ is a commitment to fully implement Social Personal and Health Education (SPHE) in primary, post-primary and Youthreach settings, including implementation of the Physical Education programme and the Active Schools Flag initiative. Another example is the commitment to support, link with and further improve existing partnerships, strategies and initiatives that aim to improve the capacity of parents, carers and families to support healthier choices for their children and themselves (involving the Department of Health, Department of Education and Skills, Department of Children and Youth Affairs, other Government Departments, local authorities, HSE Directorates, statutory agencies, Community and Voluntary Bodies and the private sector).

The HSE Programmes and Campaigns team run a number of social marketing and behaviour change campaigns, which aim to use evidence and consumer insights to help people living in Ireland to improve their health and wellbeing and lead healthier lives as well as to make public health services easier to access and use for everyone. This work is done hand-in-hand with HSE services and covers a wide range of topics and service areas.

A number of examples include:

- QUIT campaign supports people to quit smoking

- [#LittleThings](#) supports positive mental health
- [THINK contraception](#) promotes good sexual health
- [Under the Weather.ie](#) supports self-care at home and aims to curb the overuse of antibiotics
- A campaign to help people to avail of [GP care without fees](#) for children aged under 6 and people aged 70 and over
- [Breastfeeding.ie](#) supports parents-to-be, and new mothers and their partners, with advice from experts on breastfeeding
- [GetIrelandActive.ie](#), a new website that supports people to get up, get out and get active
- [BreastCheck](#), [CervicalCheck](#), [BowelScreen](#) and [DiabeticRetinaScreen](#), supported with marketing communications nationwide

Article 11 – The right to protection of health

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

3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

Ireland's response to the Committee's observations

The Irish Government wishes to reassure the Committee of Social Rights (ECSR) that adequate measures are in place as part of Ireland's occupational safety and health framework to prevent and reduce accidents.

The breadth of the occupational safety and health framework across more than 200 Acts, Regulations and Conventions ensures that its provisions have a significant impact right across Irish life and business.

Promoting accident and illness prevention is a core principle of Ireland's occupational safety and health framework. This is assured by the HSA's approach to enforcing occupational safety and health law and providing information, education and advice across all economic sectors, including: retail, healthcare, manufacturing, fishing, construction, agriculture, education, waste management and food services.

The HSA's review of the implementation of its 2013-2015 Strategy confirmed that a positive outcome of the strategy was a reduction in the rates of work-related deaths, injuries and ill health.

While injury statistics are only available until the end of 2014, they show a trend of being relatively stable in the early period of the strategy. However, as employment growth in Ireland has picked up, injury and illness rates have increased too. Reported injuries had been steadily reducing between 2010 and 2013, but in 2014 the number of injuries reported to the Authority increased by 13%.

A research report published in 2015 by the Economic and Social Research Institute¹ as part of the ESRI/Health and Safety Authority Research Programme on Health, Safety and Wellbeing at Work found that

- The annual workplace injury rates have fallen by approximately one third since 2001 from 29.6 per 1,000 workers to 18.9 per 1,000 workers in 2012.
- The highest injury rates are found in five economic sectors: agriculture/forestry/fishing, Industry, Construction, Transportation and health/social work
- The fatality rate has halved in the 15 year period from 1998, with agriculture/forestry and fishing having the highest fatality figures

¹ *Trends and Patterns in Occupational Health and Safety in Ireland*, by Helen Russell, Bertrand Maitre and Dorothy Watson (ESRI), May 2015

- The risk of injury and illness in work rose during the economic boom period (2001-07) and fell during the recession (2008-12). This result confirms experience in other countries and has been attributed to the rise in the proportion of inexperienced new recruits during periods of economic growth, and to increases in work intensity and hours of work.

Asbestos

The Irish Government wishes to reassure the Committee of Social Rights (ECSR) that adequate measures are in place to prevent the risks arising from asbestos. Legislation is in place that prohibits the use, reuse, sale, supply, further adaptation etc. of materials containing asbestos fibres. The restriction conditions for asbestos fibres can be found in entry no. 6 of Annex XVII of the REACH Regulation, amended by Regulation (EC) No. 552/2009. The Health and Safety Authority is the lead Competent and Enforcement Authority for REACH in Ireland. Enforcement of REACH is facilitated under the Chemicals Acts 2008 and 2010. Further information on the REACH regulation can be found on the REACH webpages of the HSA website www.hsa.ie.

The Chemicals (Asbestos Articles) Regulations 2011 (“CAA”) (S.I. No. 248 of 2011), which came into operation on 31 May, 2011, specify how the Health and Safety Authority may issue a certificate to exempt an asbestos-containing article, or category of such articles, from the prohibition on the placing on the market of an asbestos-containing article provided for by Article 67 and Annex XVII of the EU REACH Regulation 1907/2006.

See more at:

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

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

Complementary guidance materials have been disseminated by HSA in respect to the protection of workers from all aspects of asbestos exposure. This material includes extensive guidelines on dealing with Asbestos-containing Materials (ACMs) in Workplaces this publication provides practical guidance on the management and abatement of asbestos containing materials.

Response to cross border health threats

International

Ireland has ratified and is implementing international agreements concerning the prevention of epidemic diseases. The International Health Regulations (IHR), which entered into force on 15

June 2007, put in place a system for the reporting, control and management of international health emergencies, including infectious diseases.

The IHRs are complemented by EU Decision No 1082/2013/EU on serious cross-border threats to health which came into force on 6 November 2013. The Decision provides a coherent framework for tackling all serious cross-border public health threats by:

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

Ireland, along with the other EU Member States is implementing this decision.

The Network for the Surveillance and Control of Communicable Diseases was established by the European Parliament and Council Decision 2119/98/EC. The Network includes an Early Warning and Response System (EWRS), which is formed by bringing into permanent communication with one another, through appropriate means, the Commission and the competent public health authorities in each Member State responsible for determining the measures which may be required to protect public health.

National regulations

The Health Act 1947 provides for the Minister of Health to make regulations concerning infectious diseases.

- Section 5 of Act relates to Minister's power to make regulations
- Section 29 (Part IV) – Minister may specify and define diseases that are infectious
- Section 31 (Part IV) – Minister may make regulations to provide for prevention of spread of IDs and treatment of infected persons, as set out in Second Schedule to the Act.

The original Regulations made under the 1947 Act were the Infectious Diseases Regulations 1948 (SI No 99/1948). These were revoked in 1981 and replaced by the Infectious Diseases Regulations 1981 (SI No 390/1981) which specifies infectious diseases and their pathogens in a Schedule, provides for diagnosis and treatment of infectious diseases, prevention of spread of infectious diseases and notification process. SI 390/1981, including the schedule, has since been updated on nine occasions.

National coordination

The Government Task Force on Emergency Planning provides strategic direction and coordination of emergency planning. It is comprised of senior officials/Ministers from all Government Departments and key public bodies. The Office of Emergency Planning (OEP) is

a civil/military office within the Department of Defence. It supports the Minister for Defence in his role of Chairman of the Government Task Force on Emergency Planning.

Emergency Planning in Ireland is structured around the “Lead Government Department” (LGD) principle, which means that the Government Department that is responsible for an activity in normal conditions retains that responsibility during a major emergency, particularly one that has a national level impact. The advantage of this approach is that those who deal with a particular sector on a daily basis bring their skills and expertise to bear from the start and can quickly identify who is best placed to provide support in an emergency situation.

When an emergency occurs it is the responsibility of the relevant Lead Government Department to chair the National Co-ordination Group (NCG) which deals with the emergency. The NCG includes all relevant Government Departments and state agencies and is tasked with coordinating the national response. The Department of Health is the LGD for two emergency types ‘Pandemic influenza & other public health emergencies’ and ‘Biological incidents (where incident is primarily a public health incident)’ and would chair the NCG in the event of a either of these emergencies occurring.

Health service preparedness and surveillance

The National Public Health Emergency Team (NPHE) is the forum for managing the interface between the Department of Health and the Health Service Executive during the planning and response phases of a public health emergency. NPHE meets when required to coordinate health services response to any emergency. For example, it met six times to manage the response to Ebola.

There are a number of plans in place for dealing with public health emergencies. The Pandemic Influenza Emergency Plan was published in 2007 and was formally reviewed following the pandemic in 2009. It is currently being revised to take account of the lessons learned and new international legislation. The Public Health Emergency Plan will also be revised to take account of the lessons learned during the Ebola outbreak.

In Ireland, the Health Protection Surveillance Centre (HPSC) is Ireland's specialist agency for the surveillance of communicable diseases. It is part of the HSE and works in partnership with health service providers and organisations in Ireland and around the world, to provide the best possible information for the control and prevention of infectious diseases.

Immunisation Programmes

The immunisation programme in Ireland is based on the advice of the National Immunisation Advisory Committee (NIAC). The NIAC is a committee of the Royal College of Physicians of Ireland comprising of experts in a number of specialties including infectious disease, paediatrics and public health. The committee's recommendations are informed by public health advice, international best practice and by the National Centre for Pharmacoconomics (NCPE).

In Ireland, both Childhood and Adult immunisation programmes are delivered by the Health Service Executive (HSE) through their National Immunisation Office (NIO). Their website is <http://www.immunisation.ie>

The objective of the *Primary Childhood Immunisation Programme* is to achieve an uptake level of 95%, the rate recommended by the World Health Organization, required to provide population immunity and to protect children, and the population generally, from the potentially serious diseases concerned. In Ireland, all the recommended childhood immunisations listed in the below timetable are free of charge.

The two principal components of the children’s immunisation programme are:

- The Primary Childhood Immunisation Schedule
- The Schools Immunisation Programme

Primary Childhood Immunisation Schedule

<i>Age (months)</i>	<i>Immunisations*</i>	<i>Annual target Population</i>	<i>Current delivery (free)</i>
Birth	BCG	70,000 (expected to fall to 65,000 reflecting changes in birth rate)	HSE delivered
2	6 in 1 + PCV		GPs via HSE Primary Childhood Immunisation contract
4	6 in 1 + MenC		
6	6 in 1 + PCV		
12	MMR + PCV		
13	MenC + Hib		

Latest immunisation uptake rates (i.e. for Q 1- 2016) for children at 24 months are as follows:

- 95% for three doses of 6 in 1 vaccination
- 90% for MenC
- 89% for Hib
- 93% for PCV
- 93% for MMR

The BCG programme has been suspended since April 2015 because of an interruption of supplies of the vaccine related to an ongoing production issue with the only licensed vaccine.

The programme is being expanded with the introduction of Meningococcal Group B (MenB) and Rotavirus (RV) to the schedule and the replacement of individual MenC and Hib doses with a combined Hib/MenC vaccine at 13 months for all children born on or after 1 October 2016. The first children will receive these vaccines in late 2016 or early 2017.

School Immunisation schedule

Children require booster doses of some vaccines to provide on-going protection against disease. These immunisations are also provided by the HSE often in school settings. All these vaccinations are provided free of charge.

Children aged 4 to 5 years get two vaccines - a 4 in 1 booster and a second dose of the MMR vaccine. All students in their first year of second level school are offered Tdap and MenC booster doses.

These vaccines are usually given by a HSE doctor or nurse in primary school, though in the north-west they are administered by GPs.

<i>Age (years)</i>	<i>Immunisations*</i>	<i>Annual target Population</i>	<i>Current Delivery (free)</i>
4 to 5	4 in 1 + MMR	65,000	HSE and GPs
11 to 14	Tdap + MenC	60,000	HSE
1 st year in post-primary school (girls)	HPV (3 doses)	30,000	HSE
11 to 14	BCG (if not given as neonate)		HSE

***Abbreviations used:**

BCG: Bacille Calmette Guerin

6 in 1: Diphtheria, Tetanus, Pertussis (Whooping Cough), HepatitisB, Haemophilus influenzae type b (Hib), Polio

MMR: Measles, Mumps, and Rubella

HPV: Human Papilloma virus

MenC: Meningococcal group C

PCV: Pneumococcal Conjugate

4 in 1: Diphtheria, Tetanus, Pertussis, Polio

Tdap: Tetanus/low dose diphtheria acellular pertussis

The World Health Organization (WHO) has set a target to achieve measles and congenital rubella syndrome elimination by 2015. Ireland is committed to this target. Vaccination uptake rates for MMR vaccine (measles, mumps, and rubella) continue to show improvements. National uptake rates are at 93% for quarter one 2016 for children aged two years.

Human Papillomavirus Vaccination Programme

Infection with Human Papillomavirus (HPV) is the main cause of cervical cancer. HPV vaccine provides protection against the main viruses associated with cervical cancer.

Girls in first year in secondary schools are offered HPV vaccine as part of the HSE school programme.

In August 2014 the HSE published the uptake rates for the 2012/2013 nationwide HPV vaccination campaign. The uptake rate for the routine programme for first year girls during 2012/2013 exceeded the target of 80% at 84.2%. The catch-up programme for sixth year girls produced uptake rates of 67.4%, 7.4% above the target of 60%.

Published figures for 2014/2015 show that HPV vaccine uptake was 87%, the highest rate since the programme began in 2010.

Final uptake figures for the 2015/ 2016 HPV vaccination programme are not yet available. However preliminary figures released by the HSE indicate that about 5,000 fewer girls received the HPV vaccine for this period compared with 2014/2015. This significant decline in uptake varies across the country with some Western and Southern counties most affected. This

decline may be related to unsubstantiated concerns about HPV vaccine safety raised by action groups.

Adult Immunisation

Pneumococcal vaccine is routinely recommended for all adults 65 years of age or older. Influenza vaccine is routinely recommended annually, for all adults 65 years of age or older. These and other vaccines may be recommended for adults in certain at risk groups as determined by the NIAC.

In such instances, vaccines are provided free of charge by the HSE through General Practitioners. An administration fee may be payable for those who do not have medical cards or GP visit cards.

Sexually transmitted infections

The prevention of ill-health caused by sexually transmitted infections is a key priority under 'Healthy Ireland'. The 'National Sexual Health Strategy 2015-2020' was launched in 2015 and provides a nationally coordinated approach to address sexual health and wellbeing. It takes a life course approach, which is a key underpinning concept in the Healthy Ireland Framework. It acknowledges the importance of developing a healthy attitude to sexuality in young people and of building on that foundation for positive sexual health and wellbeing into adulthood and older age.

Preventing falls and fractures

AFFINITY (Activating Falls and Fracture Prevention in Ireland Together) is the national implementation project to implement the 'National Strategy for the Prevention of Falls and Fractures in Ireland's Ageing Population' (2008).

AFFINITY is also a commitment within the European Innovation Partnership on Active and Healthy Ageing (EIP-AHA). This scheme aims to increase the average healthy lifespan of Europeans by 2 years by 2020, by improving health and quality of life (with a focus on older people); ensuring health and social care systems are sustainable and efficient in the long term; and enhancing the competitiveness of EU industry through business and expansion in new markets.

AFFINITY aims to prevent harmful falls amongst persons aged 65 years and older, enhance the management of falls and improve health and wellbeing through a focus on bone health (fracture prevention). The primary implementation pillars of AFFINITY include robust governance, an integrated service delivery model operating to a population health improvement approach and change management supports.

Article 12 – The right to social security

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;

The Committee concludes that the minimum sickness, unemployment, survivor, employment injury and invalidity benefits in Ireland are not adequate. It so concludes on the basis of a comparison of the Irish minimum welfare rates and the at-risk-of-poverty threshold calculated as 50% of median equivalised income in 2007 using data from Eurostat.

The Irish Government strongly disputes the accuracy of the data used in making this assessment. The Government asserts that national poverty data should be used when assessing the adequacy of national welfare rates. The EU confirmed the right of Member States to choose national indicators in the context of setting national poverty targets in support of the EU poverty target. Furthermore, from an analytical perspective, the national poverty data and the national welfare rates both use the same equivalence scales, whereas the Eurostat data do not.

There are substantial differences in the data used to establish the 50% median equivalised income threshold as between Eurostat and the Irish Central Statistics Office (CSO), the national statistical body. In fact, the Eurostat data comes from the same source as the national data, the CSO *Survey on Income and Living Conditions 2007*.² However, there are two main differences in how the data are compiled.

First, the CSO income concept is different to that used by Eurostat in the following regards:

- income from ‘private pensions’ is included (excluded by Eurostat);
- contributions to pension plans are included (excluded by Eurostat except private pensions);
- employer’s social insurance contributions, including private health insurance and life assurance schemes are included (excluded by Eurostat);
- the value of goods produced from own consumption are included (excluded by Eurostat);
- income reference periods (in Ireland it is a rolling twelve month period prior to the date of interview whereas in the EU it is a fixed twelve month period e.g. calendar or tax year).

Second, the national equivalence scale used by the CSO has a weight of 1 for the first adult, 0.66 for subsequent adults (aged 14+ years) and 0.33 for children aged less than 14 years. Eurostat, on the other hand, use the modified OECD equivalence scale with a weight of 1 for the first adult, 0.5 for subsequent adults (aged 14+ years) and 0.3 for every child under the age of 14 years.

² <http://www.cso.ie/en/media/csoie/releasespublications/documents/silc/2007/silchousing2007.pdf>

The 50% median income threshold using national data was €189.67 per week in 2007.³ By comparison, the Eurostat threshold was €211.44 per week.⁴ The national figure is therefore €22 per week lower, or 10% less than the Eurostat figure. This is a significant difference in the value of the threshold.

A further concern of the Government is that the minimum welfare benefits presented in the report do not represent the full range of the minimum welfare benefits provided in 2007. In addition to the minimum welfare rate for a single person, a qualified adult allowance for a couple and a qualified child increase for each dependent child, other additional welfare benefits were available. These included: the means-tested household Fuel Allowance; the Household Benefits Package (which was a universal benefit for all households over 66 years); Child Benefit (a universal benefit which was paid for all children under 19 years of age) and the means-tested Back to School Clothing and Footwear Allowance.

There were two other benefits payable for children in 2007: an Early Childcare Supplement for all children aged under 6 years and the Family Income Supplement for low paid working families. These are not included in the calculations for 2007 as they applied in specific circumstances and did not constitute part of the minimum child income package.

The Government is also concerned with the inconsistent use of weekly and monthly data in the analysis. The Conclusions compare a threshold of €23 (no time period specified, but seems to be per month) with the minimum welfare rate for a single person adjusted to €743 for a ‘four week month’. This is an erroneous temporal comparison and a standard unit should be used in the analysis with a preference for weekly data as this is the basis of Irish welfare payments.

In light of the above, the Government has prepared tables to assess the adequacy of minimum welfare benefits, based on the examples used in the 2009 Conclusions. Tables 1 to 3 present weekly data on the minimum welfare rate (including all benefits), the 50% at-risk-of-poverty threshold, using both Eurostat and national sources, and a calculation of the minimum welfare rate as a proportion of the 50% at-risk-of-poverty threshold.

Jobseeker’s Benefit and Illness (sickness) Benefit – single person

A single person in receipt of Jobseeker’s Benefit or Illness Benefit received €185.80 per week in 2007. There was a shortfall of €3.87 in the minimum welfare rate compared to the national threshold in 2007. The welfare rate represented 98% of the threshold. By contrast, the minimum welfare rate was €25.64 per week less than the Eurostat calculation of the 50% median income threshold. The welfare payment thus amounted to 88% of the Eurostat threshold.

Table 1: Jobseeker’s Benefit / Illness Benefit – single person

Welfare rate (weekly)	2007	
Personal Rate	€185.80	
	<i>National</i>	<i>EU</i>
ARP 50% median income threshold	€189.67	€211.44
Welfare rates as a % of threshold	98%	88%

³ €9,897 divided by 52.18 weeks per annum.

⁴ €11,033 divided by 52.18 weeks per annum.

State Pension (Contributory) and (Non-Contributory) – single person living alone

The State Pension (Contributory) was €209.30 per week for a single person in 2007. In addition, a single person would receive the Living Alone Increase, the Household Benefits Package and Fuel Allowance, giving a combined total of €245.60 per week. The welfare payment was €55.93 more than the national median income threshold value. The welfare payment as a proportion of the national median income threshold was 129%. Comparing the welfare rate to the Eurostat threshold gives an excess of €34.16 per week. The welfare payment thus amounted to 116% of the Eurostat threshold.

Table 2: State Pension (Contributory)* – single person living alone

Welfare rates and other benefits (weekly)	2007	
Personal Rate	€209.30	
Fuel Allowance (annualised)	€0.00	
Household Benefits Package (annualised)	€8.60	
Living Alone Increase	€7.70	
Total welfare payments	€245.60	
	<i>National</i>	<i>EU</i>
ARP 50% median income threshold	€89.67	€11.44
Welfare rates as a % of threshold	129%	116%

* If the pensioner is over age 80, they are also entitled to a weekly age allowance of €10.00.

A single person in receipt of the (means-tested) State Pension (Non-Contributory) received €200 per week in 2007. In addition, they received the Living Alone Increase, the Household Benefits Package and Fuel Allowance which gave a combined income of €236.30 per week. The minimum welfare payment was €46.63 per week more than the national threshold and equated to 124% of the threshold. The minimum welfare rate was €24.86 more than the Eurostat threshold. The welfare payment thus amounted to 112% of the Eurostat threshold.

Table 3: State Pension (Non-Contributory)* – single person living alone

Welfare rates and other benefits (weekly)	2007	
Personal Rate	€200.00	
Fuel Allowance (annualised)	€0.00	
Household Benefits Package (annualised)	€8.60	
Living Alone Increase	€7.70	
Total welfare payments	€236.30	
	<i>National</i>	<i>EU</i>
ARP 50% median income threshold	€89.67	€11.44
Welfare rates as a % of threshold	124%	112%

* If the pensioner is over age 80, they are also entitled to a weekly age allowance of €10.00.

Survivor's Pension / Invalidation Pension

The personal welfare rate for a single person aged under 66 years in receipt a Widow's, Widower's or Surviving Civil Partner's (Contributory) Pension or Invalidation Pension was €91.30 in 2007. In addition, they received the Household Benefits Package and the Fuel Allowance. The total income was €219.90 per week. The minimum welfare rate was €30.23 per week in excess of the national threshold and equated to 116% of the threshold. Comparing the welfare rate to the Eurostat threshold there was an excess of €8.46 per week. The welfare payment amounted to 104% of the threshold.

Table 4: Survivor's Pension / Invalidation Pension⁵ – person aged under 66

Welfare rates and other benefits (weekly)	2007	
Personal Rate	€91.30	
Fuel Allowance (annualised)	€0.00	
Household Benefits Package (annualised)	€8.60	
Total welfare payments	€219.90	
	<i>National</i>	<i>EU</i>
ARP 50% median income threshold	€89.67	€11.44
Welfare rates as a % of ARP 50 % threshold	116%	104%

2016 Update (based on 2014 data⁶)

Tables 5 to 8 present weekly data on the minimum welfare rate (including all benefits) and the 50% at-risk-of-poverty threshold, using both Eurostat and national sources for 2014. The threshold for the CSO national indicator of 50% median income in 2014 was €74.49 per week.⁷ For information purposes, the comparable Eurostat threshold is presented €186.64 per week.⁸ The tables also provide the minimum welfare rate as a proportion of the 50% at-risk-of-poverty threshold.

In addition to the minimum welfare rate for a single person, a qualified adult allowance for a couple and a qualified child increase for each dependent child aged up to 22 years⁹, other additional welfare benefits in 2014 included:

- Household Fuel Allowance – a means-tested household payment with circa 408,000 recipients in 2014;

⁵ Recipients of an Invalidation Pension under 66 years can also qualify for the Living Alone Increase.

⁶ 2014 data is the latest data available, data for 2015 will be available circa November 2016.

⁷ €9,105 divided by 52.18 weeks per annum.

⁸ €9,739 divided by 52.18 weeks per annum.

⁹ A child dependant is usually a child up to 18 years of age who lives with the person. A qualified child payment will continue to be paid for children older than this for 3 months after he or she leaves second level education or finishes the Leaving Certificate. People receiving a long-term social welfare payment with a child in full-time education continue to get the qualified child payment up to 22 years of age or up to the end of the academic year in which he or she reaches 22.

- Household Benefits Package – a benefit for all households over 70 years and to people under age 70 in certain circumstances;
- Child Benefit - benefit for all children under 16 years, or under 18 years if the child is in full-time education, Youthreach training, or has a disability. It includes those for whom a qualified child allowance was paid;
- Back to School, Clothing and Footwear Allowance – a means-tested payment per child, including for those whom a qualified child allowance was paid.

Jobseeker’s Benefit / Illness (sickness) Benefit – single person

A single person in receipt of Jobseeker’s Benefit or Illness Benefit received €188 per week in 2014. This was €13.51 per week more than the national threshold and equal to 108% of the threshold. Using Eurostat data, the welfare rate was €1.36 per week more than the threshold. The welfare payment thus amounted to 101% of the Eurostat threshold.

Table 5: Jobseeker’s Benefit / Illness Benefit – single person

Welfare rate (weekly)	2014	
Personal Rate	€188.00	
	<i>National</i>	<i>EU</i>
ARP 50% median income threshold (weekly)	€174.49	€186.64
Welfare rates as a % of threshold	108%	101%

State Pension – single person

A single person in receipt of the State Pension (Contributory) received €30.30 per week in 2014. In addition, they received the Living Alone Increase, the Household Benefits Package and Fuel Allowance which amounted to €259.08 per week. The total welfare payment was €34.59 more than the national median income threshold value or 148% of the threshold. Comparing the welfare rate to the Eurostat threshold, there was an excess of €7.44 per week. The welfare payment thus amounted to 139% of the Eurostat threshold.

Table 6: State Pension (Contributory)* – single person living alone

Welfare rate and other benefits (weekly)	2014	
Personal Rate	€30.30	
Fuel Allowance (annualised)	€9.97	
Household Benefits Package (annualised)	€11.12	
Living Alone Increase	€7.70	
Total welfare payments	€259.08	
	<i>National</i>	<i>EU</i>
ARP 50% median income threshold (€p.w.)	€174.49	€186.64
Welfare rates as a % of threshold	148%	139%

* If the pensioner is over age 80, they are also entitled to a weekly age allowance of €10.

A single person in receipt of the State Pension (Non-Contributory) received €19 per week. In addition, they received the Living Alone Increase, Household Benefits Package and Fuel Allowance. This amounted to €247.78 per week. The minimum welfare payment was €73.29 per week more than the national median income threshold or 142% of the threshold. The minimum welfare rate was €1.14 more than the Eurostat threshold. The welfare payment thus amounted to 133% of the Eurostat threshold.

Table 7: State Pension (Non-Contributory)* – single person

Welfare rate and other benefits (weekly)	2014	
Personal Rate	€19.00	
Fuel Allowance (annualised)	€9.97	
Household Benefits Package (annualised)	€1.12	
Living Alone Increase	€7.70	
Total welfare payments	€247.78	
	<i>National</i>	<i>EU</i>
ARP 50% median income threshold (weekly)	€74.49	€86.64
Welfare rates as a % of threshold	142%	133%

* If the pensioner is over age 80, they are also entitled to a weekly age allowance of €10.

Survivor's Pension / Invalidity Pension – single person

A single person aged under 66 years in receipt a survivor's pension (Widow's, Widower's or Surviving Civil Partner's (Contributory) Pension) or an Invalidity Pension received €193.50 per week in 2014. They also received the Household Benefits Package and Fuel Allowance which gave a total welfare income of €214.58 per week. The minimum welfare rate was €40.09 per week in excess of the national threshold or 123% of the threshold. Comparing the welfare rate to the Eurostat threshold gave an excess of €27.94 per week. The welfare payment thus amounted to 115% of the Eurostat threshold.

Table 8: Survivor's Pension / Invalidity Pension¹⁰ – person aged under 66

Welfare rate and other benefits (weekly)	2014	
Personal Rate	€193.50	
Fuel Allowance (annualised)	€9.97	
Household Benefits Package (annualised)	€1.12	
Total welfare payments	€214.58	
	<i>National</i>	<i>EU</i>
ARP 50% median income threshold (weekly)	€74.49	€86.64
Welfare rates as a % of threshold	123%	115%

¹⁰ Recipients of an Invalidity Pension under 66 years can also qualify for the Living Alone Increase.

Article 12(1) - Direct requests raised in the 2009 Conclusions

Risks covered, financing of benefits and personal coverage

1. The Committee asks that the next report provides figures on private coverage of the self-employed against work injury and occupational diseases.

Response

These figures are not available as there is no statutory obligation to report the level of private coverage of the self-employed against work injury and occupational diseases.

Adequacy of benefits

2. The Committee underlines that it is therefore essential that information on all social security benefits be systematically provided in all next reports so that their adequacy may be assessed. Such information should include in particular the minimum level of benefits and the duration of their payment.

Response

Eligibility for contributory benefits and the rate of payment are determined by social insurance contributions.

Illness Benefit

Illness Benefit is a payment for people who cannot work due to illness and who satisfy the Pay Related Social Insurance (PRSI) contribution conditions.

Although only intended to cater for short term illness there was, up to 2009, no limit on the amount of time for which Illness Benefit (IB) could be paid to people who had more than 260 social insurance contributions. From January 2009, where a person satisfies the PRSI conditions and qualifies for payment, they may get Illness Benefit for a maximum of 624 payment days (2 years). This change applies only to new claims and, accordingly, where a claim for IB was made prior to the 5th January 2009, the previous arrangements, where no duration limit pertained continue to apply.

Payment is normally made from the seventh day of incapacity and will continue on a weekly basis subject to receipt of medical certification.

Illness Benefit rates are graduated according to earnings in the relevant tax year. The earning bands for 2016 are as follows:

Average Weekly Earnings	Personal Rate	Increase for Qualified Adult
Less than €150.00	€84.50	€80.90
€150.00 and less than €220.00	€121.40	€80.90
€220 and less than €300	€147.30	€80.90
€300 or more	€188.00	€124.80

Occupational Injuries Benefit Scheme

The Occupational Injuries Benefit Scheme encompasses a group of benefits for people injured or incapacitated by an accident at work or while travelling directly to or from work. The scheme also covers people who have contracted a disease as a result of the type of work they do.

There are a number of benefits available and there are different conditions attached to each benefit. Eligibility for benefits depends only on the person being in insurable employment at the time that the accident occurs, or for the period prescribed in relation to certain prescribed diseases.

The benefits include Injury Benefit, Incapacity Supplement, Disablement Benefit and Death Benefit Pension. Further details of these schemes are set out below. There is also a Medical Care Scheme which allows eligible persons to get a refund of the costs of medical care and attention that are not paid by the Health Service Executive (HSE) or covered by the Treatment Benefit Scheme.

Injury Benefit

Occupational Injury Benefit is a weekly payment if one is unfit for work due to the accident or disease. Payment is normally made from the seventh day of incapacity for work. Injury Benefit can be paid for up to 26 weeks from the date of your accident or development of the disease.

Incapacity Supplement

If entitlement to Injury Benefit has been exhausted, and the person is not entitled to Illness Benefit, they may be entitled to Incapacity Supplement if they are deemed incapable of work for at least 6 months. Incapacity Supplement is paid where the loss of faculty is assessed at 20% or more and Disablement Benefit is awarded. Incapacity Supplement is paid at the same rate as Injury Benefit and Illness Benefit.

Disablement Benefit

Disablement Benefit can be paid if there is a loss of physical or mental faculty because of an accident at work, an accident travelling directly to or from work, or a prescribed disease contracted at work. Where the accident or disease was sustained before 1 January 2012 payment was made where the level of disablement following the accident was assessed at 1% or more. Since 2012 payment is made where the level of disablement is 15% or more. Payment is made irrespective of whether there has been any loss of earnings.

A lump sum may be payable where the degree of loss is assessed as between 15% and 19%. The size of the lump sum will vary depending on the degree of disablement and how long it can reasonably be expected to last. Since January 2011 the maximum lump sum for disablement is €15,320.

A level of disablement of 20% or more gives entitlement to a pension in all cases. This is payable for life or as long as the loss of physical or mental faculty persists. If a person is unable to work, payment will commence following 26 weeks on Injury Benefit. It is payable

in addition to Illness Benefit where the person is unable to work and satisfies the relevant contribution conditions. If the person is able to continue in work, it is payable from the fourth day after the loss of faculty.

There is a reduction of payment for reduced degrees of disablement as follows:

Level of Disablement	Weekly payment
100 %	€219.00
- 90%	€197.10
- 80%	€175.20
- 70%	€153.30
- 60%	€131.40
- 50%	€109.50
- 40%	€87.60
- 30%	€65.70
- 20%	€43.80

Death Benefit Pension

On the death of an insured person through occupational injury or disease, or where immediately before death the deceased person was in receipt of a 50% Disablement Pension, a Death Benefit Pension of €18.50 per week is payable to the person's widow, widower or surviving civil partner under 66 years of age. The payment is €237.70 per week where the widow, widower or surviving civil partner is over 66. The rate for a qualified child is €29.80. A weekly rate of €164.80 is paid in respect of an orphan under the Occupational Injuries Benefit Scheme.

A Death Benefit (Funeral Grant) of €350 is also payable to the next-of-kin.

Jobseeker's Benefit

A person may be paid Jobseeker's Benefit for up to 9 months (234 days) if they have 260 or more PRSI contributions paid. If a person has between 104 and 259 inclusive paid PRSI contributions, Jobseeker's Benefit is payable for 6 months (156 days). Jobseeker's Benefit is not payable for the first 3 days of unemployment.

The rates payable are graduated according to a person's earnings in the relevant tax year. The earnings bands in 2016 are as follows:

Average weekly earnings	Personal Rate	Increase for a Qualified Adult
Less than €150.00	€84.50	€80.90
€150.00 and less than €220.00	€121.40	€80.90
€220.00 and less than €300.00	€147.30	€80.90
€300.00 or more	€188.00	€124.80

Maternity Benefit

Maternity Benefit is paid for 26 weeks to employed and self-employed pregnant women, who satisfy the relevant contribution conditions.

Invalidity Pension

To qualify for Invalidity Pension, a person must satisfy the social insurance conditions and be regarded as permanently incapable of work, or have an incapacity which has existed for 12 months prior to the date of the claim and be unlikely to be able to work for one year from the date of the person’s claim. Payment lasts as long as a person satisfies these conditions, or until the person receives another social welfare pension.

It is a condition for receipt of Invalidity Pension that the person should not engage in employment. Since the introduction of the Partial Capacity Benefit, claimants of Invalidity Pension can now apply for the Partial Capacity Benefit to take up employment opportunities while continuing to receive income support from the State.

Partial Capacity Benefit

The Partial Capacity Benefit, introduced in 2012, provides an opportunity for people with disabilities to have their capacity for work assessed and receive an income support payment based on this assessment. Recipients can then avail of employment opportunities while continuing to receive this income support payment. There are no restrictions on employment income. The scheme is open to people who are in receipt of an Invalidity Pension, or who have been in receipt of Illness Benefit for a minimum of 6 months. Participation in the scheme is voluntary.

The maximum rates of Partial Capacity Benefit are as follows:

Medical Assessment	Person previously getting Illness Benefit at the maximum personal rate €188.00	Person aged under 66 and previously getting Invalidity Pension at the maximum personal rate €193.50
Moderate	€4.00	€6.75
Severe	€41	€45.13
Profound	€88	€93.50

State Pension (Contributory)

The State Pension (Contributory) is paid with reference to the 'yearly average' calculation, where the number of weekly contributions on a person’s record are divided by the duration of their working life. This includes contributions credited while on social welfare payments and provision may be made in the calculation for periods caring for children. Where someone has a reduced entitlement, such reduced payments are banded as follows:

Yearly Average	2016 Rate (per week)
48 weeks+	€233.30
40-47 weeks	€228.70
30-39 weeks	€209.70

20-29 weeks	€198.60
15-19 weeks	€152.00
10-14 weeks	€93.20

Where someone has an entitlement below 40-47 weeks, they may be more likely to be paid the State Pension (Non-Contributory) of €222 which is means-tested.

Widow's, Widower's or Surviving Civil Partner's (Contributory) Pension

This contributory pension is based on either spouse's / partner's record. As with the State Pension (Contributory) where someone has a reduced entitlement, such reduced payments are banded as follows:

Yearly Average	2016 Under 66 Rate (per week)	2016 Over 66 Rate (per week)
48 weeks +	€193.50	€233.30
36-47 weeks	€190.70	€228.70
24-35 weeks	€188.00	€223.30

Once a person qualifies for the Widow's, Widower's or Surviving Civil Partner's (Contributory) Pension, the pension remains payable so long as they remain widowed or a surviving civil partner, and not co-habiting. Since this is a contributory pension, a recipient may earn any amount of money from any other source and still remain entitled to this pension. It is taxable. However if this was a person's only source of income, they would be unlikely to have to pay tax.

Child Benefit

Child Benefit is payable to the parents or guardians of children under 16 years of age, or under 18 years of age if the child is in full-time education, Youthreach training or has a disability.¹¹ Child Benefit is not paid in respect of 18 year olds.

Rates of Benefits

The weekly rates of benefits for the years 2008 to 2016 are set out in Tables 9 and 10 below.

¹¹ <http://www.youthreach.ie/>

Table 9: Rates of Insurance Benefits 2008-2011

Benefit	Weekly Rate	2008 €	2009 €	2010 €	2011 €
Sickness, Injury and Unemployment	Personal rate	197.80	204.30	196.00	188.00
	Qualified adult	131.30	135.60	130.10	124.80
	Qualified child	24.00	26.00	29.80	29.80
Old Age	Personal rate	223.30	230.30	230.30	230.30
	Qualified adult under 66	148.80	153.50	153.50	153.50
	Qualified adult over 66	200.00	206.30	206.30	206.30
Other Work Injury benefits	Disablement Benefit (max rate for over 90% disablement)	228.90	235.40	227.00	219.00
	Incapacity Supplement (paid where not entitled to sickness benefit in addition to disablement benefit)	same rates as sickness benefit			
	Constant Attendance Allowance	214.70	221.20	213.00	205.00
Maternity	80% of earnings in previous year subject to				
	maximum of	280.00	280.00	270.00	262.00
	and minimum of	221.80	230.30	225.80	217.80
Invalidity	Personal rate (under 65)	203.30	209.80	201.50	193.50
	(over 65)	223.30	230.30	230.30	230.30
	Qualified adult (under 66)	145.10	149.70	143.80	138.10
	Qualified adult (over 66)	200.00	206.30	206.30	206.30
	Qualified child	24.00	26.00	29.80	29.80
Survivor	Under 66	203.30	209.80	201.50	193.50
	Over 66	223.30	230.30	230.30	230.30
	Qualified child	24.00	26.00	29.80	29.80
Orphan	Guardian's Payment	170.00	176.50	169.00	161.00
Child Benefit	Monthly rate for	April 2008	April 2009	April 2010	April 2011
	First and second child	166.00	166.00	150.00	140.00
	Third and subsequent children	203.00	203.00	187.00	167.00
	Fourth and subsequent children - in 2011 a new fourth and subsequent rate was introduced and the mid-rate applied to the third child only	N/A	N/A	N/A	177.00

Table 10: Rates of Insurance Benefits 2012-2016

Benefit	Weekly Rate	2012 €	2013 €	2014 €	2015 €	2016 €
Sickness, Injury and Unemployment	Personal rate	188.00	188.00	188.00	188.00	188.00
	Qualified adult	124.80	124.80	124.80	124.80	124.80
	Qualified child	29.80	29.80	29.80	29.80	29.80
Old Age	Personal rate	230.30	230.30	230.30	230.30	233.30
	Qualified adult under 66	153.50	153.50	153.50	153.50	155.50
	Qualified adult over 66	206.30	206.30	206.30	206.30	209.00
	Qualified child	29.80	29.80	29.80	29.80	29.80
Other Work Injury Benefits	Disablement benefit (max rate for over 90% disablement)	219.00	219.00	219.00	219.00	219.00
	Disablement benefit (20% to 90%)					
	-90%	197.10	197.10	197.10	197.10	197.10
	-80%	175.20	175.20	175.20	175.20	175.20
	-70%	157.30	157.30	157.30	157.30	157.30
	-60%	131.40	131.40	131.40	131.40	131.40
	-50%	109.50	109.50	109.50	109.50	109.50
	-40%	87.60	87.60	87.60	87.60	87.60
	-30%	65.70	65.70	65.70	65.70	65.70
	-20%	43.80	43.80	43.80	43.80	43.80
	Death Benefit (Pension for a widow, widower or surviving civil partner)					
	Aged under 66	218.50	218.50	218.50	218.50	218.50
	Aged 66 or over	234.70	234.70	234.70	234.70	237.70
	Increase for a qualified child	29.80	29.80	29.80	29.80	29.80
Incapacity Supplement (paid where not entitled to sickness benefit in addition to disablement benefit)	same rates as sickness benefit					
Constant Attendance Allowance	205.00	205.00	205.00	205.00	205.00	

Benefit	Weekly Rate	2012 €	2013 €	2014 €	2015 €	2016 €

Maternity	80% of earnings in previous year subject to maximum of	262.00	262.00	Standardised rate 230.00	Standardised rate 230.00	Standardised rate 230.00
	and minimum of	217.80	217.80			
Invalidity	Personal rate (under 65)	193.50	193.50	193.50	193.50	193.50
	(over 65)	230.30	230.30	N/A*	N/A*	N/A*
	Qualified adult (under 66)	138.10	138.10	138.10	138.10	138.10
	Qualified adult (over 66)	206.30	206.30	N/A*	N/A*	N/A*
	Qualified child	29.80	29.80	29.80	29.80	29.80
	<i>*Note: From January 2014 recipients were no longer eligible for an increase in their personal rate on reaching the age of 65 or in their qualified adult rate on reaching age 66.</i>					
Survivor	Under 66	193.50	193.50	193.50	193.50	193.50
	Over 66	230.30	230.30	230.30	230.30	233.30
	Qualified child	29.80	29.80	29.80	29.80	29.80
Orphan	Guardian's Payment	161.00	161.00	161.00	161.00	161.00
Child Benefit	Monthly rate for First and second child	140.00	130.00	130.00 Per Child	135.00 Per Child	140.00 Per Child
	Third child	148.00	130.00			
	Fourth and subsequent	160.00	140.00			
	<i>*Note: From 2014 a per child flat rate was introduced.</i>					

Full details are published on the Department of Social Protection's website at <http://www.welfare.ie/EN/Pages/azindex.aspx?tab=publications>. See "Rates of Payment SW19 - Post 2003 and Rates of Payment 2016.

Social Insurance Contributions – Percentage Coverage

Table 11 below updates the Committee on the percentage of personal coverage of employees under the various branches of social security in 2014:

Table 11: Contributory Benefit Coverage for Employees¹²

2014	Illness Benefit	Jobseeker's Benefit	State Pension (Contributory)	Widow's/ Widower's, or Surviving Civil Partner (Contributory) Pension & Guardian's Payment	Occupational Injury Benefit	Maternity Benefit	Invalidity Benefit
Number of Employees Covered	2,227,854	2,227,695	2,227,844	2,299,991	2,334,390	2,227,844	2,227,844
Total Number of Employees	2,342,700	2,342,700	2,342,700	2,342,700	2,342,700	2,342,700	2,342,700
% of Employees Covered	95%	95%	95%	98%	99.6%	95%	95%

In 2014, the total population of Ireland was estimated to be 4,609,600. Approximately 60% of the population, or 2,755,058 people, were active social insurance contributors. This figure also includes self-employed persons and voluntary contributors.

¹² The following classes are not counted as employees: Class K (persons not employed but paying a contribution on pension income); Class S (self-employed persons); Class M (persons with no liability for contribution); and Voluntary Contributors (persons who have ceased employment but who are contributing to maintain entitlements to long-term benefits such as pensions). Table A15 of the Annual Statistical Report for 2014 for the Department of Social Protection details the numbers and classes of insured persons. Figures relate to 2014 as this is the most recent material available and 2014 insurance coverage figures are provisional until the 2016 report is published.

<http://www.welfare.ie/EN/Policy/ResearchSurveysAndStatistics/Pages/StatInfoReportsIndex.aspx>

Detailed explanations of the Classes can be accessed at:

http://www.welfare.ie/EN/Publications/sw19/Pages/sw19_intro.aspx

3. It asks the next report to clarify the interaction between these two types of benefits [State Pension (Contributory) and State Pension (Non-Contributory)], and to confirm that all persons entitled to a minimum contributory old age benefit will receive an income above the at-risk-of-poverty threshold.

Response

Where a person of pension age makes an application for the State Pension (Contributory) (SPC), their record is checked for eligibility. If they do not qualify, or if they do not qualify for the full rate, they may qualify for the means-tested State Pension (Non-Contributory) (SPNC). They will receive a letter informing them of this and advising them that they may make an application for the SPNC. The maximum weekly personal rates of the SPC and SPNC are €233.30 and €222.00 respectively in 2016. Generally, if a person of pension age has few or no social insurance contributions paid and does not have very significant means, they will qualify for the SPNC.

If a person makes a claim for the SPNC, and if their means are such that they would qualify for the SPNC at a higher rate than the SPC, they will be paid the higher rate pension as it is the most advantageous to the person. If the means are sufficiently low (up to €30 per week), the pensioner gets a full rate of SPNC, €222 in 2016. However, if their means exceed the maximum level for entitlement, they do not qualify payment under the scheme. The means-test includes a number of earnings and capital disregards. The lowest rate of payment for those in receipt of SPNC is €4.50 (plus allowances/secondary benefits). This is paid when a claimant is assessed with a weekly means between €245-€247.50 means. Where applicable, increases in respect of a qualified adult and/or children are also payable. Table 12 below sets out the State Pension (Non-Contributory) Rates from 2012 to 2016.

Table 12 – State Pension (Non-Contributory) Rates 2012-2016

State Pension (Non-Contributory) Pension Rates	2012	2013	2014	2015	2016
	€	€	€	€	€
Personal rate (maximum)	219.00	219.00	219.00	219.00	222.00
Minimum rate	4.00	4.00	4.00	4.00	4.50
Maximum increase for qualified adult (under 66 years – personal rate is payable to each of a couple over 66)	144.70	144.70	144.70	144.70	146.70
Increase for qualified child	29.80	29.80	29.80	29.80	29.80
Increase over 80 years of age	10.00	10.00	10.00	10.00	10.00

Increase where living alone	7.70	7.70	7.70	9.00	9.00
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Additional allowances are made to persons in receipt of either the SPC or the SPNC where they are over 80 years of age, living alone, or living on certain offshore islands. They may also qualify for assistance towards the costs of household expenditure such as rent and fuel.

There are some 95,000 recipients of the SPNC. This number is reducing as a result of more people qualifying for the SPC which has a higher personal rate and is not means-tested. The increase in recipients of the SPC is a result of the extension of social insurance coverage over a number of years to include categories of people not previously insured.

Tables 2, 3, 6 and 7 above provide a calculation of the welfare rate as a proportion of the 50% at-risk-of-poverty threshold in respect of SPC and SPNC in the years 2007 and 2014. Each table shows that the welfare rate is higher than the Eurostat threshold.

Article 12 – The right to social security

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

2. 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;

Ireland ratified the European Code of Social Security on 16 February 1971. Ireland has accepted the parts of the Code relating to Sickness Benefit (III), Unemployment Benefit (IV), Old-Age Benefit (V), Family Benefit (VII) and Survivors' Benefit (X). The most recent Resolution of the Committee of Ministers on the application of the European Code of Social Security and its Protocol by Ireland was for the period 1 July 2014 to 30 June 2015. The Committee found that the law and practice in Ireland continued to give full effect to Parts V, VII and X of the Code but did not fulfil the obligations under Parts III and IV because of establishing stricter conditions for entitlement to sickness and unemployment benefits. These relate to the qualifying contribution conditions for Illness Benefit and Jobseeker's Benefit and the number of waiting days for Illness Benefit.

The Government was not in a position in Budget 2016 to alter these conditions; however, it is intended to reconsider them in the context of the ongoing review and reform of Ireland's social welfare system and the prevailing fiscal constraints. While Ireland's social security arrangements may not technically be in accordance with the Code, the spirit of those Parts is met by virtue of the comprehensive and inclusive nature of the overall system of supports.

Article 12 – The right to social security

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

3. to endeavour to raise progressively the system of social security to a higher level;

A key component of the Government's welfare policy since 2011 has been to maintain the value of core weekly rates of welfare payments, including the safety net of the welfare system, the Supplementary Welfare Allowance payment. Accordingly, there have been no reductions to the weekly rates of payment since 2011. Eligibility to means-tested welfare schemes was not restricted as welfare dependency increased. However, the requirements of fiscal consolidation until the end of 2014 meant that there was no possibility of rates increases.

Ireland's comprehensive welfare system has played a central role in protecting those who are unemployed and other vulnerable groups following the economic crisis. During the recession Ireland adopted certain practices to minimise the impact of fiscal consolidation on vulnerable groups through consultation, social impact assessment and maintaining a basic level of social protection.

As the Government has restored financial stability, exited the EU/ECB/IF Programme for Support for Ireland and delivered a return to job creation and economic growth, the intention is to broaden the recovery in a manner that benefits the daily lives of individuals, families and communities across the country.

Budgets 2015 and 2016 focused on measures to incentivise work and to improve the living standards of every family in the country. New work incentive measures like the Back to Work Family Dividend, and other reforms, were introduced in 2015 to accelerate progress by helping people back to work, thereby reducing poverty. The recovery has also allowed some leeway to increase spending in targeted areas. Budget 2016 provided over €250 million of an increase to improve the welfare support package for low-waged households, in particular those with caring responsibilities, the elderly and those who are long-term unemployed.

In order to inform policy options, the Department of Social Protection undertakes social impact assessments of a wide range of social welfare budget options and packages in advance of the budget.¹³ Some of these were included in the "Social Protection Package – Budget 2016 Issues" paper for the Department of Finance's Tax Strategy Group in advance of Budget 2016.¹⁴ The social impact assessment of Budget 2016 shows that average household incomes increased by 1.6 per cent (€14.30 per week).¹⁵ Furthermore, there were higher than average gains for the poorest households (up to 2%) which contain mainly social welfare recipients. The smallest gains were in the top quintile. The assessment found that households with children were the biggest beneficiaries of Budget 2016, including working lone parents and unemployed couples with children. The Budget provides greater rewards for working, with over 80% of those who are unemployed being substantially better-off in work.¹⁶ There is no

¹³ <http://www.welfare.ie/en/Pages/SocialImpact2016.aspx>

¹⁴ <http://www.finance.gov.ie/sites/default/files/TSG%2015%2011%20Social%20Protection%20Package.pdf>

¹⁵ <https://www.welfare.ie/en/Pages/SocialImpact2016.aspx>

¹⁶ The analysis shows that the majority of people at work (86%) or unemployed and receiving a jobseeker payment (84%) have strong financial incentives to work (i.e. replacement rates \leq 70%). As a result of Budget 2016, the proportion of the population with Marginal Effective Tax Rates (METRs) of greater than 50% was

significant change in income poverty, though social transfers continue to perform strongly in reducing poverty.

The current strong recovery phase is highlighted by the decrease in the unemployment rate from over 15% in 2012 to 8.3% in August 2016.

Intreo Service

The Social Welfare and Pensions Act 2010 provided for the integration of the Employment and Community Services of FÁS (the national employment agency) and the Community Welfare Service of the Health Service Executive into the Department of Social Protection. This enabled the development of the Intreo Service which operates a range of employment support services that are designed to encourage and assist income support recipients of working age, including lone parents, to return to work. These services are provided through the Department of Social Protection's network of locally-based case officers who work with individual recipients to help identify appropriate training or development programmes that will enhance their skills. They work in close co-operation with other State agencies and service providers including SOLAS (the Further Education and Training Authority), the local Education and Training Boards, other education and training providers, and the local community and voluntary sector.

Illness and Disability Support

As set out in the response to Article 12(1), the Social Welfare and Pensions Act 2010 introduced a Partial Capacity Benefit to provide an opportunity for people with disabilities who are assessed to have an employment capacity which is restricted when compared to the norm, to avail of employment opportunities while continuing to receive an income support payment.

The structure of illness and disability support payments are being reviewed to ensure that there is an increased focus on capacity rather than incapacity and to prevent a drift from short-term incapacity to long-term welfare dependency. The review will address issues identified in the *Comprehensive Employment Strategy for People with Disabilities*, including examining the role of early intervention and supports and making work pay.¹⁷

Social Insurance

Ireland's approach to its social insurance system has ensured that the earnings level at which a worker is required / entitled to make a contribution has remained low. The point at which a worker becomes insurable is where his or her earnings reach €8 in any week. As a result of this an employee working at the national minimum wage (€9.15 per hour) for less than 4.5 hours per week will pay a standard social insurance contribution which is fully reckonable for all benefits and pensions. Additionally, Irish rates of social insurance contributions are among the lowest in the OECD with employees earning up to and including €52 making no social insurance contribution from their wages (their employers do), and employees earning above this level paying at a rate of 4%. Information on Pay Related Social Insurance (PRSI) rates is available via http://www.welfare.ie/en/Pages/1896_Pay-Related-Social-Insurance.aspx.

reduced by more than half. In total, over three quarters of people employed are estimated to experience a reduction in their METR.

¹⁷<http://www.justice.ie/en/JELR/Comprehensive%20Employment%20Strategy%20for%20People%20with%20Disabilities%20-%20FINAL.pdf/Files/Comprehensive%20Employment%20Strategy%20for%20People%20with%20Disabilities%20-%20FINAL.pdf>

The development of the Irish social insurance system has focussed to a significant extent on broadening social insurance coverage within the working population. For instance, the Paternity Leave and Benefit Act 2016 introduces two weeks paid paternity leave for children born or placed through adoption on or after 1st September 2016. This new scheme of Paternity Benefit will be paid at a minimum of €230 for each of the 2 weeks of paternity leave. The PRSI contributions are the same as those required for Maternity Benefit.

Social Insurance and the Self-Employed

Social insurance was extended to self-employed persons on 6 April 1988. Such persons had previously been excluded from compulsory social insurance. The principal benefit of insurability as a self-employed contributor is access to long-term pensions, including State Pension (Contributory). Self-employment PRSI contributions also provide cover for Maternity and Paternity Benefit.

In 2014 the coverage was further extended to cover certain spouses and civil partners of people who are self-employed.¹⁸ This category of people will be able to access social insurance by paying PRSI to build up entitlement to social insurance benefits as a self-employed worker. In such cases liability for self-employment PRSI is subject to the same annual income threshold that applies to self-employed contributors in general, i.e. €5,000.

The contribution rate for self-employed persons is considerably less than the combined rate for employees and employers (i.e. 4% for self-employed workers compared with a combined contribution of 14.75% for employees and employers). This reflects the fact that self-employed workers have access to a more limited range of benefits¹⁹. The Actuarial Review of the Social Insurance Fund (31 December 2010) concluded that the self-employed achieve better value for money compared to the employed when the comparison includes both employer and employee contributions in respect of the employed person.

A specially commissioned Advisory Group on Tax and Social Welfare examined issues involved in extending social insurance coverage for self-employed people in order to establish whether or not such cover is technically feasible and financially sustainable. There was a requirement that any proposals for change must be cost neutral.²⁰

The Group found that extending social insurance for the self-employed was warranted in cases related to long term sickness or injuries. To this end, the Group recommended that benefits should be extended to provide cover for people who are permanently incapable of work

¹⁸ Section 19 of the Social Welfare and Pensions Act 2014 provided for the transposition of Directive 2010/41/EU on the application of equal treatment between men and women engaged in a self-employment activity, in so far as that Directive relates to ensuring that the spouse or civil partner of a self-employed worker can benefit from social protection in accordance with national law. This means that liability for social insurance contributions has been extended to spouses and civil partners of self-employed contributors who are not business partners or employees, where they perform the same or ancillary tasks as the self-employed contributor.

¹⁹ These benefits include: Widow's, Widower's or Surviving Civil Partner's (Contributory) Pension, Guardian's Payment, State Pension (Contributory), Maternity Benefit, Adoptive Benefit and Paternity Benefit.

²⁰ Advisory Group on Tax and Social Welfare (2013), Third Report : Extending Social Insurance Coverage for the Self-Employed <https://www.welfare.ie/en/downloads/Third-Report-Extending-Social-Insurance-Coverage-for-the-Self-Employed.pdf>

because of a long-term illness or incapacity through the Invalidity Pension and the Partial Capacity Benefit.

The Group further recommended that the extension of social insurance in this regard should be on a compulsory basis and that the rate of contribution should be increased by at least 1.5 percentage points. The Group's recommendation is being considered in the context of Exchequer constraints. It is considered that the nature of the short-term 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.

In the Programme for a Partnership Government (2016), the Government has stated its intention to seek to introduce a Pay Related Social Insurance (PRSI) scheme for the self-employed.²¹

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http://www.taoiseach.gov.ie/eng/Work_Of_The_Department/Programme_for_Government/A_Programme_for_a_Partnership_Government.pdf

Article 12 – The right to social security

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

4. 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.

Right to Maintenance of Accruing Rights

Once a person has made social insurance contributions in Ireland those contributions remain on a person's record and can be activated at any time to enable a person satisfy the qualifying conditions for benefits or pensions. People covered by EU regulations on the coordination of social security systems or those that come within the terms of bilateral social security agreements concluded by Ireland can aggregate contributions to enable them to qualify for payments covered by these regulations and agreements. Persons who qualify for contributory pensions can receive these payments in their home country on the same basis as payments are made in Ireland. The same applies to pensions that family members of social insurance contributors may qualify for under the Irish system.

Equal Treatment

As previously reported social security legislation in Ireland does not contain any nationality requirements. A person of any nationality can qualify for benefits on the same basis and subject to the same conditions as Irish nationals. For instance, nationals of another country who meet the residence and other qualifying conditions, which are applied equally to Irish citizens, can qualify for Child Benefit in respect of their children resident here. Accordingly, equal treatment for non-nationals in the Irish social welfare system is secured under Irish legislation without the need for bilateral agreements. In common with many other countries, payment of benefits under Irish legislation requires that, for some benefits, the person claiming, together with their dependants, is normally or habitually resident in Ireland. This applies to short-term social insurance benefits, Child Benefit and all social assistance benefits. Long-term social insurance payments such as State Pension (Contributory), Invalidity Pension and Widow's, Widower's or Surviving Civil Partner's (Contributory) Pension can be exported to another country. There are no plans to give migrant workers from other countries (through bilateral agreements or otherwise) entitlements which are not available to Irish nationals where they or their families are resident abroad.

Bilateral Agreements

As indicated in previous reports there are bilateral agreements in place between Ireland and Australia, Canada (including a separate agreement with Quebec), New Zealand, the United

States of America, Republic of Korea, Japan, the Swiss Confederation and the United Kingdom (covering the Channel Islands and the Isle of Man which are not covered by the EU Coordinating Regulations).

There are no immediate plans to expand the number of bilateral agreements Ireland has entered into with third countries. However, third country nationals who are legally resident in the EU and are in a cross border situation are, in accordance with Regulation 1231/2010, also covered by EU Regulations 883/2004 and 987/2009 on the coordination of social security systems. Accordingly, they enjoy the full benefit of the coordination regulations including aggregation of contributions made in States covered by the Regulations and export of benefits, including the export of pensions to their home countries. In addition, as part of its neighbourhood policy the EU has concluded Association and Stabilisation Agreements with a number of neighbouring States. Ireland is a signatory to these agreements in its own right. The agreements provide for measures in the area of social security and the detail of these measures are being developed by the EU through decisions of the Association Council. Apart from equality of treatment for nationals of the States in question legally employed in a Member State, the Association Council decisions generally provide for export of old age pensions, survivor's pensions, pensions covering accidents at work and occupational diseases as well as some invalidity pensions. Clarifying the contents of Association Agreements by the EU is considered the most appropriate way of expanding Ireland's social security relationships with other countries. Notwithstanding the existence of these agreements, Ireland's domestic legislation already provides for many of the provisions on which the EU is seeking agreement with other countries i.e. export of the payments outlined above.

Scheme: Blind Person's Pension

	2012	2013	2014	2015	2016	% Change
Personal weekly rate of payment	€188.00	€188.00	€188.00	€188.00	€188.00	No change
Increase for a qualified adult	€124.80	€124.80	€124.80	€124.80	€124.80	No change
Increase for a qualified child	€29.80	€29.80	€29.80	€29.80	€29.80	No change

Schemes: Widow's, Widower's or Surviving Civil Partner's (Non-Contributory) Pension and One Parent Family Payment

	2012	2013	2014	2015	2016	% Change
Personal weekly rate of payment	€188.00	€188.00	€188.00	€188.00	€188.00	No change
Increase for a qualified child	€29.80	€29.80	€29.80	€29.80	€29.80	No change

Scheme: Guardian's Payment (Non-Contributory)

	2012	2013	2014	2015	2016	% Change
Weekly rate of Payment	€61.00	€61.00	€61.00	€61.00	€61.00	No change

Scheme: Carer's Allowance (where carer is aged under 66)

	2012	2013	2014	2015	2016	% Change
Weekly rate one Caree	€204.00	€204.00	€204.00	€204.00	€204.00	No change
Weekly rate more than one Caree	€306.00	€306.00	€306.00	€306.00	€306.00	No change
Annual Respite Care Grant (Per Caree)	€1,700.00	€1,375.00	€1,375.00	€1,375.00	€1,700.00	No change overall as payment restored to 2012 level

Full details are published on the Department of Social Protection's website at <http://www.welfare.ie/EN/Pages/azindex.aspx?tab=publications>. See "Rates of Payment SW19 - Post 2003 and Rates of Payment 2016".

In its previous conclusions the Committee noted data from MISSOC in relation to additional assistance such as the Rent Supplement, Mortgage Interest Supplement and other payments. The following information is provided by way of update:

Rent Supplement

The Rent Supplement scheme provides short-term support to eligible people living in private rented accommodation, whose means are insufficient to meet their accommodation costs. The level of support depends on the location of the rented accommodation and the size of the family.

The strategic policy of the Department of Social Protection is to return rent supplement to its original purpose of being a short-term income support scheme. Under the Housing Assistance Payment (HAP), responsibility for the provision of rental assistance to those with a long-term housing need transfers to local authorities, under the auspices of the Department of Housing, Planning, Community and Local Government. HAP is currently operational in 19 Local Authority areas with a further nine expected to come on stream by the end of 2016 and the three remaining Dublin authorities following in 2017. There are currently 12,640 HAP tenancies in place.

Mortgage Interest Supplement

The Mortgage Interest Supplement scheme was discontinued for new applicants from 1 January 2014. The scheme provides short-term support to eligible people unable to meet their mortgage interest repayments in respect of a house which is their sole place of residence. The supplement assists with the repayment of the interest portion of the mortgage. Customers availing of this support prior to 1st January 2014 may, subject to meeting all the conditions of the scheme, retain entitlement until the closure of the scheme on 1st January 2018. The most appropriate support for families experiencing mortgage difficulties is on-going engagement with their lender to explore sustainable solutions.

Other Payments

The Fuel Allowance was increased from €20 to €22.50 in Budget 2016 and was paid for 26 weeks in the 2015/2016 fuel season.

The Household Benefits Package is a payment for recipients of the State Pension and all those over 70 years of age. Some welfare recipients under 66 years may also qualify. The package includes a free television licence and a free electricity or gas allowance.

The Free Travel Scheme is available to people over 66 years of age, to carers and to people in receipt of certain disability payments. The scheme permits cost-free travel on most public transport services and some 80 private transport operated services.

The Living Alone Increase is an extra payment for people on certain payments who are living alone. If a person is 66 years or over and lives alone, they will qualify for this increase if they are getting one of the following payments: State Pension (Contributory); State Pension (Non-Contributory); Widow's, Widower's or Surviving Civil Partner's (Contributory) Pension; Widow's, Widower's or Surviving Civil Partner's Pension under the Occupational Injuries Benefit Scheme; the Incapacity Supplement under the Occupational Injuries Benefit Scheme;

Deserted Wife's Benefit or Deserted Wife's Allowance. A person will also qualify if they are under 66 years and live alone and are in receipt of Disability Allowance, Invalidity Pension, Incapacity Supplement or Blind Pension.

The HSE does not collect data on the nationality of those who receive healthcare in Ireland. It also remains the case that any person who presents for healthcare will be treated. Furthermore, the HSE has, under s45(7) of the Health Act 1970, the discretion to consider any person who is not ordinarily resident in the State, if they are unable, without undue hardship, to provide a service (in the relation to their health) as being a person with full eligibility for health services and receive the service free of charge.

The Irish Public Health System provides for two categories of eligibility for persons ordinarily resident in the country, i.e. full eligibility (medical cardholders) and limited eligibility (all others). Full eligibility is determined mainly by reference to income limits. Determination of an individual's eligibility status is the responsibility of the Health Service Executive.

Persons with full eligibility are entitled to a 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. Other services such as allied health professional services may be available to medical card holders. With the exception of prescribed drugs and medicines, which are subject to a €2.50 charge per prescribed item (maximum of €25 month per month per individual/family), these services are provided free of charge.

Persons with limited eligibility are eligible for in-patient and outpatient public hospital services including consultant services, subject to certain charges. The public hospital statutory in-patient charge is €75 in respect of each day during which a person is maintained, up to a maximum payment of €750 in any twelve consecutive months. There is also a charge of €100 for attendance at Accident & Emergency departments unless, inter alia, the person has a referral letter from their General Practitioner.

Patients can also opt to be private to their Consultant and public hospital and are therefore liable for the fees of all consultants' involved in their care and the private patient charges in public hospitals.

Persons with limited eligibility must meet the first €145 of prescribed drugs costs per month, above which the Drug Payments Scheme meets all further costs. Dental and routine ophthalmic and aural services are not provided by the State, but this treatment is provided to children who have been referred from a child health clinic or a school health examination. A free maternity and infant care service is provided during pregnancy and up to six weeks after birth. Other services such as allied health professional services may be available to persons with limited eligibility. The GP Visit Card was introduced as a graduated benefit, so that people on lower incomes, particularly parents of young children, who do not qualify for a medical card, would not be deterred on cost grounds from visiting their GP. Persons who do not qualify for a GP visit card pay for GP service as a private patient.

Introduction of Universal GP Care

- The Government's Statement of Government Priorities 2014-2016 reiterated the commitment to the introduction of a universal GP service for the entire population, in line with the Programme for Government. This Government is the first in the history of the State to commit itself to implementing a universal GP service for the entire population.
- Work is continuing on the development of a scheme for the provision of a GP service without fees to the entire population. This includes consideration of approaches, timing, administrative and financial implications of a range of options with a view to bringing developed proposals to Government and a decision will be made by the Government in due course. The extension of GP services without fees will have full regard to and ensure compatibility with future developments in relation to Universal Health Insurance.
- The Government, in addition to prioritising the over 70s after the under 6 year olds in the next phase of the roll-out of free access to GP care, in the Statement of Government Priorities 2014-2016, signalled the subsequent extension of free GP care to the 6-11 year old and then the 12-17 year old cohorts.
- Slightly more than one-half of the population would have universal access to GP services without fees when the currently identified phases are implemented. This would include all children under the age of 18 years, all persons over the age of 70 years, and other persons qualifying on the basis of means/income.

(i) GP Service for Children under 6

- As part of Budget 2014, the Government announced that the first step in the phased introduction of a universal GP service would be the roll-out of a GP service without fees for all children under 6. The Report of the Expert Advisory Group on the Early Years Strategy recommended providing access to GP care without fees to all children in this age group.
- The Health (General Practitioner Service) Act 2014, which provides an entitlement for all children aged under 6 to a GP service without fees, was enacted on 25th July 2014.
- The key features of the Health (General Practitioner Service) Act 2014 are:
 - It provides an entitlement for all children aged under 6 to a GP service without fees;
 - It removes the need for children under 6 to have a medical card or GP visit card under the GMS scheme to qualify for a GP service; and,
 - It provides that the HSE may enter a contract with GPs for the provision of this GP service to children and provides that the Minister may set the rates of fees payable to GPs for this service.
- On 9th April 2015, agreement was reached between the Department of Health, the HSE and the Irish Medical Organisation on terms for the delivery of free GP care for all children aged under 6.

- The commencement of this service on 1st July 2015 has made a real difference to the lives of the youngest in our society and represents a major step forward in improving access, quality and affordability of health care in Ireland. It also marks the most tangible step forward so far along the road to universal health care.
- Under the new arrangements, an additional 270,000 children under 6 benefit from GP care free at the point of service. All children under 6 benefit from the new enhanced service under the proposed GP contract. This involves age-based preventive checks focused on health and wellbeing and the prevention of disease. These assessments will be carried out when a child is aged 2 and again at age 5, in accordance with an agreed protocol. The contract also includes an agreed cycle of care for children diagnosed with asthma, under which GPs will carry out an annual review of each child where the doctor has diagnosed asthma.
- The negotiations with the IMO also resulted in an agreement on the introduction of a Diabetes Cycle of Care. This will enable patients with a medical card or GP visit card and who have Type 2 Diabetes to avail of two annual visits to their GP practice for a structured review of their condition. This initiative will help to integrate care across the continuum of care, will improve clinical outcomes for patients and reduce complications often experienced with this condition.

(ii) **GP Service for persons aged seventy years and over**

- The Government, in the Statement of Government Priorities 2014-2016, which committed it to the introduction of a universal GP service for the entire population, prioritised the over 70s in the next phase of the roll-out of free access to GP care.
- At its meeting of 23rd July, 2014 the Government approved the drafting of a Bill to amend the Health Act 1970 to provide a GP service without fees for all persons aged 70 years and over. Following the decision to revise the Bill to ensure that dependants of persons over 70 can qualify for a GP visit card on the same basis as currently, the Bill was revised by the Attorney-General's Office. The Health (General Practitioner Service) Act 2015 was enacted on 24th June 2015 and the service commenced on 5th August 2015. This service is provided under the existing GMS contract. To date approx. 63,000 persons over 70 have registered for a GP service without fees. In total, about 415,000 over-70s now have access to a universal GP service.

Article 13 – The Right to Social and Medical Assistance

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

2. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;

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

Article 13 – The Right to Social and Medical Assistance

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

3. to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;

Citizens Information Board

The Citizens Information Board (CIB) supports the provision of information, advice (including money advice and budgeting) and advocacy services on a wide range of public and social services. It provides some services directly to the public through the www.citizensinformation.ie website which has a number of microsites and a prominent link on the www.gov.ie and www.welfare.ie homepages. It also produces a range of publications and periodicals. It provides core developmental supports and directly funds and supports an extensive range of services through its delivery partners namely:

- Citizens Information Services (CISs)
- Citizens Information Phone Service (CIPS)
- Money Advice and Budgeting Services (MABS)
- MABS helpline
- National Advocacy Service (NAS) for People with Disabilities
- Sign Language Interpreting Service (SLIS)

State funding of €50m was been made available to the CIB for 2016. From this allocation €20.6m is made available to MABS, €14.8m to Citizens Information Services (CIS's) and Citizens Information Phone Service (CIPS) and €3.9m to advocacy services. Expenditure on salaries, pensions and board members' fees amount to €5.4m and the balance to various other activities.

Main Functions

The main functions of the CIB, defined in the Comhairle Act 2000, the Citizens Information Act 2007 and the Social Welfare (Miscellaneous Provisions) Act 2008 are to:

- Ensure that individuals have access to accurate, comprehensive and clear information relating to social services.
- Assist and support individuals, in particular those with disabilities, in identifying and understanding their needs and options.
- Promote greater accessibility, coordination and public awareness of social services.
- Support, promote and develop the provision of information on the effectiveness of current social policy and services and to highlight issues which are of concern to users of those services.
- Support the provision of, or directly provide, advocacy services for people with disabilities.

Service Delivery Partners

The CIB funds and supports a range of key delivery partners to ensure that the public has access to information, advice, advocacy and budgeting services in a way that best suits them. Information on the service delivered by these partners follows.

Citizen Information Services (CIS's)

A network of 42 Citizens Information Services (CISs) operate from 223 locations nationwide. The Citizens Information Service handled almost 991,000 queries from some 608,000 people nationwide in 2015. The queries related to social welfare, health, employment, money tax, housing and local issues.

The Citizens Information Phone Service (CIPS) service is provided Monday to Friday from 9am to 8pm. The CIPS also provides a “Live Advisor” service; an instant web chat service for people with hearing and speech difficulties, on Monday to Friday from 9 am to 5 pm. In 2015, the CIPS responded to over 154,000 requests for information and advice from members of the public.

The Citizens Information Website (www.citizensinformation.ie) had almost 17 million visits in 2015. During the year, more than 4,000 updates were made to the site content. The website adapts automatically to cater for different screen sizes to suit user tablets and smartphones. The microsite www.keepingyourhome.ie is aimed at people concerned about mortgage repayments or mortgage arrears, In December 2015, following the establishment of a new dedicated mortgage arrears service within the Money Advice and Budgeting Service (MABS), keepingyourhome.ie was redesigned to provide a cleaner, more usable interface. The site recorded over 85,529 visits throughout the year. The assistireland.ie website which provides information on assistive technology (aids and appliances) for older people and people with disabilities in Ireland, recorded some 513,730 visits.

During 2015 the CIB twitter feed (twitter.com/citizensinfo) continued to grow and had 5,405 ‘followers’ in early 2016.

Money Advice and Budgeting Service

The Money Advice and Budgeting Service (MABS) provides assistance to people who are over-indebted and need help and advice in dealing with debt problems. The National Traveller MABS advocates for the financial inclusion of Travellers to help them access legal and affordable savings and credit.

MABS National Development Limited was established in 2004 to support and develop the Money Advice and Budgeting Service throughout the country. There are 52 independent MABS companies operating the local MABS services from 65 locations throughout the country. In 2015 MABS dealt with over 17,000 new clients and over 19,000 clients contacted the MABS telephone helpline. The MABS helpline is available from 9am to 8pm Monday to Friday and the MABS website (www.mabs.ie) can be accessed 24 hours a day.

MABS expanded its services in 2015 to include a Dedicated Mortgage Arrears service and the Approved Intermediary Service under the Personal Insolvency Act became part of the mainstream MABS service. Over the course of the year, a court mentoring service was piloted for people facing repossession in the courts and a Relief Money Adviser model was tested. These services are now mainstreamed.

As improved systems for managing demand have been implemented, waiting times for appointments have been reducing for the majority of services. The average national waiting time in 2015 was just under 3 weeks.

National Advocacy Service for People with Disabilities

The National Advocacy Service (NAS) provides an independent, confidential, and free representative advocacy service to vulnerable people with disabilities. NAS had total client numbers of 1,288 during 2015 of which 367 were new clients. In 2015, 44% of NAS cases related to people with intellectual and learning disabilities followed by people with physical disabilities, mental health difficulties and people with autistic spectrum and sensory disabilities. Most of the people who accessed NAS in 2015 lived in residential services such as traditional institutions, group homes, mental health wards and supported accommodation.

Sign Language Interpreting Service

The Sign Language Interpreting Service (SLIS) seeks to ensure that quality interpretation services are available to deaf people in Ireland so they can access public and social services. SLIS provides a referral service by putting clients (mainly public service providers) in touch with suitably qualified interpreters. In 2015, there were 1,229 such referrals.

The Irish Remote Interpreting Service (IRIS)

The Irish Remote Interpreting Service (IRIS) offers a video-link service to an Irish Sign Language interpreter. In 2015, IRIS expanded its service provision to offer a Monday to Friday service from 10am to 4pm. Demand for the service continues to increase with over 1,200 requests made for the facility in 2015.

Article 13 – The Right to Social and Medical Assistance

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

4. to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953.

There are no changes to report to the information on access to emergency social assistance for non-residents previously provided to the Committee. Exceptional Needs Payments and Urgent Needs Payments under the Supplementary Welfare Allowance Scheme are exempt from the habitual residence condition.

There are two types of protection status in Ireland: refugee status and subsidiary protection status.

- Refugee status derives from the 1951 Geneva Convention relating to the Status of Refugees, to which Ireland is a party. Refugee status is given to persons who demonstrate a fear of persecution in their home country due to certain aspects, imputed or otherwise of their identity, such as their religion or their political opinion.
- Subsidiary protection status derives from European law – the Common European Asylum System (CEAS) – and is given to persons who do not qualify as refugees, but who, nevertheless, cannot return home because they risk facing serious harm, such as torture or inhuman or degrading treatment or punishment, or generalised violence in a war.

The State provides support services to persons seeking international protection in Ireland through a system known as the direct provision system. Asylum seekers can choose to avail of direct provision accommodation.

This system is consistent with that envisaged by the decisions of the European Union when dealing with the refugee crisis in southern Europe which require that benefits and services are provided in kind rather than cash.

At the end of April this year there were some 4,400 persons living in the direct provision system in Ireland and about 25% of those were children in the company of their parents or guardians.

The quality of the services provided to those in the direct provision system is under constant review. Each centre is inspected without notice three times a year and those inspection reports are published on the internet. One of these inspections is carried out by an independent company who specialise in this service.

Contracts with service providers are continually updated so that best practice in the provision of care to those seeking international protection is continually provided.

The HSE does not collect data on the nationality of those who receive healthcare in Ireland. It also remains the case that any person who presents for healthcare will be treated. Furthermore, the HSE has, under s45(7) of the Health Act 1970, the discretion to consider any person who is not ordinarily resident in the State, if they are unable, without undue hardship, to provide a service (in the relation to their health) as being a person with full eligibility for health services and receive the service free of charge.

Meeting the needs of Asylum Seekers and Migrants

Additional funding is being made available in 2016 and 2017 to support a wide range of marginalised service users. The two projects being funded are a Mobile Health Screening Unit (€1,460,000) and an Intercultural Health Project for Refugees (€450,000). The objective of the Mobile Health Screening Unit is to provide an accessible, targeted screening and primary care service to a wide range of marginalised service users in settings such as hostels, prisons, Direct Provision Centres and Refugee Reception and Orientation Centres.

The Intercultural Health Project for Refugees will support the delivery of a range of health services to meet the emerging needs of the new residents of the Emergency Reception and Orientation Centres (EROCs) established in Ireland as temporary holding centres (between 3 to 4 months) for refugees pending transfer to permanent housing.

Article 14 – The right to benefit from social welfare services

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

1. to promote or provide services which, by using methods of social work, would contribute to the welfare and development of both individuals and groups in the community, and to their adjustment to the social environment;

Early Intervention

Area Based Childhood (ABC) Programme (2013-2017)

The ABC Programme is a prevention and early intervention initiative consisting of committed funding for an area-based approach to helping to improve outcomes for children by reducing child poverty. The programme builds on and continues the work of the Prevention and Early Intervention Programme (PEIP) 2007 - 2013 which was co-funded by the Department of Children and Youth Affairs (DCYA) and The Atlantic Philanthropies (AP).

The ABC Programme targets investment in evidence-informed interventions to improve the long-term outcomes for children and families living in areas of disadvantage. It aims to break “the cycle of child poverty within areas where it is most deeply entrenched and where children are most disadvantaged, through integrated and effective services and interventions”. The focus of activities under the ABC programme covers in the main Child Health & Development; Children’s Learning; Parenting; Integrated Service Delivery.

The ABC Programme is jointly funded by the Department of Children and Youth Affairs and The Atlantic Philanthropies. The total amount of committed funding from both the Department of Children and Youth Affairs and The Atlantic Philanthropies available in the period 2013-2016 will be €29.7m.

In 2013, 13 sites were approved for inclusion in the ABC Programme. The operation of each of the 13 ABC sites is overseen by a consortium consisting of local and state bodies. Each consortium has a lead organisation which manages the implementation of their ABC programme.

The Centre for Effective Services (CES) in cooperation with an Expert Advisory Group developed the evaluation programme for the ABC Programme. The evaluation is focusing on the outcomes achieved by the ABC programmes for children and families directly involved in the ABC Programme. The final national evaluation reports will be produced in 2018.

Services to children and young people in the area of Alternative Care

Foster Care

Foster care is the placement of children outside their own home with carers who are not their parents as their parents are unable or unwilling to look after them. The foster care arrangement can be entered into on a voluntary basis with the consent of the parents or by court order where there are serious care and welfare concerns for the child and the parent is not agreeable to a voluntary arrangement. Foster carers work closely with social workers, parents and other professionals who are involved in the children's lives. Foster carers can be general foster carers who are not connected to the child or they can be relative foster carers who are relatives of the child, or a person who has acted in loco parentis with whom the child or the child's family has had a relationship prior to the child's admission to care. There are different types of foster care placements depending on the needs of the child:

- **Short-term placements** provide temporary care for a child who may, after a period, be able to move back to their family;
- **Long-term placements** are provided for children who are unlikely to be able to live with their birth family again;
- **Emergency care placements** are provided for children who come into care as a result of immediate risk or who need to move placement quickly;
- **Day foster care** is a support system for the family. The child benefits from care in a foster family during the day but can go home each evening. The parents can obtain practical help, advice and support from the foster parents;
- **Parent and child placements** are provided to young parents in care who are placed in foster care with their baby;
- **Supported lodgings** is the provision of accommodation, support and a family setting to young people, aged 16 and above, who cannot live at home, but are not ready to live independently;
- **Special foster care** is care provided to children with challenging behaviour by foster carers who are specifically trained and skilled to care for children with high-level needs;
- **Respite care** is short-term foster care providing a break for the child and his or her parent(s) or foster carers.

Residential Care

Residential care is provided for children who cannot live at home or in a foster care arrangement. They are normally standard houses where a small number of children live together in a group setting supervised by social care workers and a centre manager. Residential care aims to meet, in a planned way, the physical, educational, emotional, spiritual, health and social needs of each child. The child in residential care is prepared for a successful return home; a successful transition to foster care; or a successful transition to independent living.

Special Care

Special Care involves the detention of a child for his or her own welfare and protection in a Special Care Unit (SCU) on order of the High Court. Special Care Units differ from ordinary residential care in that the Units offer higher staff ratios, on-site education as well as specialised input such as psychology and child psychiatric services. Special care is intended as a short term secure care placement in a therapeutic environment with the intention of returning the child to a community or family based setting as soon as possible. Special care is used to address the risk of harm that may be caused to a child's life, health, safety, development or welfare by their behaviour. Children are admitted to Special Care following a successful application to the Child and Family Agency's Special Care Admissions Committee and then to the High Court for a Special Care Order, in line with the provisions of the Child Care Act 1991, as amended. The age range for admission is 11 to 17 years.

International Residential Care

For children with highly specialised needs arising from severe behavioural or other difficulties, which, despite the ongoing development of therapeutic services for children in care, cannot be met in Ireland, arrangements are made for the placement of these children in care and treatment facilities outside of the State, primarily in the UK, to allow for access to an individually tailored mix of care and therapeutic services and sometimes secure psychiatric treatment not currently available in this country. Such placements are overseen by HIQA.

Unaccompanied Minors

When a child arrives into Ireland without their parents or care providers at the airports or seaports the Garda National Immigration Bureau (GNIB) contacts Tusla's dedicated Social Work Team for Separated Children Seeking Asylum. The social workers carry out an immediate assessment of need and risk, and make appropriate arrangements for the accommodation, care and protection of the child in accordance with the Child Care Act, 1991. Each separated child is allocated a child protection social worker, who is responsible for the development and implementation of an individualised statutory care plan for the child. They also supervise the standard of the child's placement and provide services and support to meet the child's needs. If the social work assessment indicates that applying for asylum in Ireland is in the child's best interest, the social worker assists with the application for refugee status in accordance with the Refugee Act, 1996.

Aftercare

Aftercare involves planning for a young person leaving care at 18 years of age and making the transition to independent living. An aftercare plan is prepared identifying relevant aftercare supports for the eligible young person. Aftercare supports, such as advice and financial assistance, are available from 18 until 21 years of age but can be extended in certain

circumstances up to the age of 23 e.g. for those in full-time education to complete their course of education. Young adults leaving care at 18 years are not obliged to avail of an aftercare service, and those that choose not to engage are encouraged and supported to avail of the services at any stage up to the age of 21 years.

Youth

The Department of Children and Youth Affairs provides a range of funding schemes, programmes and supports to the youth sector. Funding of €51m for current expenditure was made available in 2016 to support the provision of youth services and programmes to young people throughout the country including those from disadvantaged communities. Article 14 refers to the "Right to benefit from social services". In that regard it is important to note that this funding is not paid directly to young people by way of social transfers. The funding schemes support national and local youth work provision to some 380,000 young people. It is estimated that the voluntary youth services involve approximately 1,400 youth work staff in 477 projects and 40,000 volunteers working throughout the country. In addition €2.6m in capital funding has been made available and will be used to support small scale projects, including refurbishment, health and safety fit-outs and accessibility improvements in local youth services. If you require any further detail on any of these 477 projects and the services they provide we can provide same.

The Department of Social Protection has primary responsibility in the area of provision of social transfers to children and young people while the Department of Education and Skills also has a role in the provision of social services to children and young people.

Domestic, Sexual and Gender-based Violence Services²²

Under the Child and Family Agency Act, 2013, responsibility for provision of Domestic, Sexual and Gender-Based Violence Services (DSGBV) transferred from the Health Service Executive (HSE) to the Child and Family Agency on 1 January 2014. The Child and Family Agency has a statutory responsibility under the Child and Family Agency Act, 2013 to provide care and protection to victims of domestic, sexual and gender-based violence, whether in the context of the family or otherwise. In that context, it provides or facilitates the provision of a range of services and supports to victims of domestic, sexual and gender-based violence.

Since its establishment in 2014, the Child and Family Agency has developed a strategic and integrated approach to the organisation and delivery of services to victims of domestic, sexual and gender-based violence. A national framework has been developed, with national oversight of what is now a consolidated overall budget for these services.

²² Cosc, the National Office for the Prevention of Domestic, Sexual and Gender-based Violence, an executive office of the Department of Justice and Equality co-ordinates actions and strategy to combat Domestic, Sexual and Gender-based Violence. Cosc's Second National Strategy on Domestic, Sexual and Gender-based Violence, 2016 – 2021 was published in January 2016.

In 2016, the Child and Family Agency has an overall budget of €20.6 million for the provision of domestic, sexual and gender-based violence services.

A network of some 60 organisations provide services to victims of domestic, sexual and gender based violence in Ireland, including 16 rape crisis centres, 20 services providing emergency refuge accommodation to women and children and 24 community-based domestic violence services.

Domestic violence support services are provided through integrated community based responses, with emergency refuge accommodation as one component of service delivery. The Child and Family Agency's primary focus is on achieving the optimum use of emergency shelter accommodation and focusing on prevention and effective community based services to avoid in so far as possible the need for use of refuges by vulnerable women and families.

The Child and Family Agency proposes to commission two national 24-hour Freephone helplines:

1. 24-hour domestic violence freephone helpline
2. 24-hour sexual violence freephone helpline.

The helplines will support the availability of co-ordinated, accessible services that will provide both initial contact points and facilitate integrated responses to victims of domestic, sexual and gender based violence wherever they are in the country.

Family Support

Statutory level

The Child and Family Agency, established in 2014 pursuant to the Child and Family Agency Act 2013, assumed responsibility for a range of functions including those of the Family Support Agency. The Child and Family Agency provides core funding for the operation of Family Resource Centres throughout the country. The functions of the Child and Family Agency under the 2013 Act include supporting and encouraging the effective functioning of families and, to that end, providing preventative family support services aimed at promoting the welfare of children. In addition, the Agency is required to facilitate and promote enhanced inter-agency cooperation to ensure that services for children are co-ordinated and provide an integrated response to the needs of children and their families.

Policy level

In April 2015, in line with a commitment in *Better Outcomes, Brighter Futures – The national policy framework for children & young people 2014-2020*, the Department of Children and Youth Affairs published a '**High-Level Policy Statement on Supporting Parents and**

Families²³. The Statement provides the policy context for the discharge by the Child and Family Agency of its family support function. The Statement specifies that it is essential that parenting and family supports and services are designed to be fully inclusive and take full cognisance of evolving family forms. It also underscores the importance of developing cross-agency coordination of services to children and their families.

At the core of this High-Level Policy Statement are a number of specific messages that set the policy agenda for strengthening the impact of supports to parents and families. These 29 high-level policy messages are articulated around improved interagency working, workforce development, information and evidence to inform the targeting of resources, integration of service planning and delivery, and partnership with children and their parents.

Family Resource Centre (FRC) Programme

There are 108 communities supported through the Child and Family Agency's Family and Community Services Resource Centre Programme (FRC programme) providing services and supports to local communities. The Child and Family Agency provides core funding to its established network of 106 Centres nationwide, and two outreach Centres.

In 2016, the Child and Family Agency has allocated an overall budget of €13.5 million to the FRC programme.

The FRC programme is Ireland's largest family support programme delivering universal services to families in disadvantaged areas across the country based on a life-cycle approach. The aim of the FRC programme is to combat disadvantage and improve the functioning of the family unit. Each FRC operates autonomously working inclusively with individuals, families, communities, and both statutory and non-statutory agencies. The programme emphasises involving local communities in tackling the problems they face, and creating successful partnerships between voluntary and statutory agencies at community level.

Irish Youth Justice Service

Overview

- From January 2012 the Irish Youth Justice Service (IYJS) has operated as a Division in the Department of Children and Youth Affairs. It has responsibility for leading and driving reform in the area of youth justice. It is staffed by officials from the Department of Children and Youth Affairs and the Department of Justice and Equality.

²³<http://www.dcy.gov.ie/documents/publications/20150413HighLevPolicyStatonFamilySupportParentsandFamENGLISH.pdf>

- Responsibility for the Children Act, 2001 is shared between the Minister for Children and Youth Affairs and the Minister for Justice and Equality:-
 - The Minister for Children and Youth Affairs is responsible for children detention schools. From 1 June 2016 the 3 children detention schools based at Oberstown, Lusk, Co. Dublin were amalgamated into one entity namely, the Oberstown Children Detention Campus (Oberstown). Oberstown provides detention places to the Courts for girls up to the age of 18 years and boys up to the age of 18 years ordered to be remanded or 17 years when ordered to be committed on criminal charges.
 - The Minister for Justice and Equality retains responsibility for youth crime policy and law, including crime prevention, reduction, criminal proceedings, and diversion and community sanctions (including community projects).
- The remit of the IYJS is to improve the delivery of youth justice services and reduce youth offending. This challenge is met by focusing on diversion and rehabilitation involving greater use of community-based interventions and the promotion of initiatives to deal with young people who offend. Providing a safe and secure environment for detained children and supporting their early re-integration back into the community is also a key function.

General Legal Framework

The primary role of the Oberstown Campus is to provide a programme of care and education aimed at rehabilitating those children referred to Oberstown by the Courts. As per Section 158 of the Children Act 2001, the principal object of Oberstown is to provide -

“appropriate educational, training and other programmes and facilities for children referred to them by a court and, by—

- (a) *having regard to their health, safety, welfare and interests, including their physical, psychological and emotional wellbeing,*
- (b) *providing proper care, guidance and supervision for them,*
- (c) *preserving and developing satisfactory relationships between them and their families,*
- (d) *exercising proper moral and disciplinary influences on them, and*
- (e) *recognising the personal, cultural and linguistic identity of each of them,*

to promote the child’s reintegration into society and prepare the child to take his/her place in the community as a person who observes the law and is capable of making a positive and productive contribution to society”.

In order to support an integrated approach to the care of children in detention, a revised model of care known as “*CEHOP*” was developed by Oberstown during 2015. This stands for “*Care, Education, Health and Wellbeing, Offending Behaviour and Preparation for returning to families and community*”. Relationships are key to the “*CEHOP*” model of care and in order to ensure best practice the Centre for Effective Services was commissioned in 2015 to identify the

lessons that could be learned from research as to how a model of relationship building with detained young people could be further developed. This work will inform the ongoing development of standards in Oberstown into the future.

Assessment, Consultation and Therapy Service (ACTS)

The Irish Youth Justice Service and Tusla - the Child and Family Agency - have together developed a new clinical service for children in special care and detention, arising from the Report of the Commission to Inquire into Child Abuse, 2009: Implementation Plan published in 2009. The Assessment, Consultation and Therapy Service, known as ACTS, is a national service that provides clinical services to children placed in special care units, managed by Tusla, and the Oberstown Children Detention Campus. The service commenced operation in late 2013 and is the subject of ongoing review in conjunction with Tusla. ACTS also engages in short term interventions, to support children when they return to their communities, to re-engage with mainstream services as appropriate. The service is flexible in that, as children move between placements, it continues to provide clinical services. The role of the service is to determine, based on the results of the mental health screening in conjunction with other available reports, if young people need more specialist assessment or intervention from specialists within the clinical team. Provision of an in-reach psychiatric service is provided through the Health Service Executive mental health section. Currently the service acts as part of the multidisciplinary team with a psychiatrist and psychiatric nurse available to the campus.

Advocacy and mentoring services

Oberstown has entered into a service level agreement with the following organisations-

1. *Empowering People in Care (EPIC)* provide advice, support and individual advocacy services to children and young people in care, those preparing to leave care and those in aftercare. EPIC provide an in-reach service to Oberstown whereby they meet with young people individually to provide advice and support and advocate on their behalf. They also provide a visiting advocacy service to Oberstown on a monthly basis.
2. The *Youth Advocate Programmes (YAP)* Ireland organisation build partnerships between vulnerable young people, their families and communities to support their full potential through a community based, strengths focused, intensive support model. YAP provide intensive support to selected young persons for up to six months on their discharge to aid their re-integration into their community where the child does not have other adequate supports in place. A service agreement was put in place for the extension of the YAP service to Oberstown on a pilot basis during 2015. This programme will provide intensive support of up to 15 hours per week for 6 months for 10 young people as part of their discharge plans.
3. The *Le Cheile Mentoring Project* provides a mentoring service to clients aged 12-18 years, through local volunteers to support, guide and mentor young persons (individual

mentoring) and/ or parents (parent to parent mentoring) in addition to the delivery of parenting programmes and Restorative Justice Service programmes. Le Cheile's overall aim is through working "*together with Young Person's Probation, and with other relevant stakeholders, to affect positive change in the lives of young people who offend and their families, through the provision of Mentoring, Youth Justice and Family Support Services*". Le Chéile has also been engaged to work with children in Oberstown. They support children in advance of and in preparation for the child leaving Oberstown.

Campus School and Education Strategy

The Department of Education and Skills is responsible for providing education to the Oberstown Campus and since 2007 the education provision on the campus has been managed by Dublin Dun Laoghaire Education and Training Board (DDLETB). A new education, training and recreation unit for the Oberstown Campus was a key element of the Oberstown Children Detention Campus project. (Between 2013 and 2015 approximately €6m in capital funding was provided by the Government for the development of the new Oberstown Children Detention Campus.)

IYJS works in tandem with the Department of Education and Skills and the DDLETB to provide the necessary and vital educational services to young people in the children detention schools. Working together, both the IYJS and the DDLETB, then known as County Dublin VEC, published the "*Education Strategy for the Children Detention School Service 2010-2014*". The IYJS, in conjunction with the DDLETB and the DES, has initiated work on the follow-on strategy which will plan for the detention of all young people up to the age of 18 years. It was agreed that the present strategy would cover the 2015 academic year. This is currently being reviewed in preparation for the full transfer of responsibility of 17 year olds and the provision of more vocational places in the schools.

Bail Supervision Scheme

In the context of resourcing projects under the IYJS strategic plan "*Youth Justice Action Plan 2014 – 2018*", funding of €600,000 was assigned in October 2015 for the development of a new "bail supervision scheme" on a pilot basis. It is intended that the Scheme will provide more therapeutic supports in the community for children who are subject to bail conditions. The goal of this measure will be to achieve a reduction in the number of children remanded in custody due to breach of bail conditions. The intention is to replicate the scheme nationally (centred around major population areas) to deliver a "*wrap around*" type service to ensure that young people adhere strictly to bail conditions as laid down by the courts. The Scheme will operate in the Dublin area initially. From the court's perspective the programme will be promoted primarily as a bail supervision scheme (incorporating the selected intervention programme) with the intent to closely monitor adherence with bail conditions. On foot of a public tender, this pilot scheme is due to commence in Q4 2016.

Complaints

Oberstown has a system in place to ensure children are informed of their rights. Children in Oberstown have access to advocacy and guardian-*ad-litem* services and an external advocacy service, provided by Empowering People in Care (EPIC), who visit the Campus each month. Oberstown staff actively encourage children to avail of these services.

Oberstown has a published “*Complaints Policy*” of which children are informed and a Designated Liaison Person has been appointed to address any complaints from children or staff. In addition children may contact the Office of the Ombudsman for Children and/or EPIC with any issues.

Medical Suite

All young people in Oberstown are provided with access to an onsite Doctor, Nurse and Dentist. This allows for routine medical check-ups without the need to bring a young person off site. Any serious injuries or illnesses are treated in hospital.

Health Budget 2017

For 2017, a total budget of €4.6 billion will be available for health. This is the highest ever health budget and demonstrates the Government’s commitment to investing the gains from a recovering economy in a better health service. The budget includes funding of €4,152 million for current expenditure and €454 million for capital expenditure. This represents an increase of €77 million on the 2016 budget for current expenditure and €40 million for capital expenditure.

Drugs and social inclusion measures

An additional €3 million has been allocated in Budget 2017 to support drugs and social inclusion measures. This extra funding will enable the HSE to continue providing interventions aimed at improving the health outcomes of the most vulnerable in our society, including Traveller and Roma communities, those affected by addiction issues, those experiencing homelessness and asylum seekers and refugees. It will bring the funding available to the HSE for social inclusion services to over €31m next year.

Services for older people

Overall funding for services for older people will increase to €765 million in 2017. There will be a particular focus on homecare services aimed at supporting people to continue to live in their own homes and also at facilitating discharge of older people from acute hospitals. An additional €10m in new development funding is being provided for homecare (including home help and home care package provision) to build on the very significant additional homecare funding provided in 2016. A further sum of €3.8m is being made available to support the increased cost of existing services. The budget provides for continuation of the additional

€30m for homecare announced in July 2016. Furthermore, a sum of €24m will be available to support homecare provision from funding made available under the Winter Initiative which will continue next year.

Disabilities

The Programme for Government contains a commitment that all 18-year-old school leavers with disabilities should have access to supports and services which meet their needs as they make the transition from school to adult life. In 2017, approximately 1,500 young people with disabilities who leave school and Rehabilitative (Lifeskills) Training programmes will require continuing HSE funded supports and services. Additional funding of €10 million will also contribute towards the development of a number of other Programme for Government commitments including therapies, respite and other supports.

Funding is also included for a further €12m of additional costs associated with additional services introduced during 2016 and €8m in respect of the costs of compliance with national standards and pressures arising from emergency placements. The budget also provides for the continuation of the additional €31m announced in July 2016.

Primary Care

The budget provides for the commitment in the Programme for Government to provide a medical card to all children in respect of whom a Domiciliary Care Allowance (DCA) payment is made. In the region of 10,000 children for whom a DCA payment is made do not currently hold a Medical Card and will benefit from this measure once the necessary legislative changes are enacted by the Oireachtas.

Legislation will be enacted to reduce the monthly cap on prescription charges for those over 70 years of age from €25 to €20.

The Estimate also provides additional funding of €18.5 million to support the development of primary care services, including enabling the support of complex paediatric cases at home, maintaining increased Community Intervention Team capacity and meeting lease costs of new Primary Care Centres. Preparations for the next phase of discussions on a new GP contract are under way and will be a key priority in the months ahead.

Acute Services

Implementation of the National Maternity Strategy commenced in 2016, and further investment of €3m is provided in 2017. The expansion of Paediatric Services commenced in 2016 will be continued with additional investment in 2017 bringing the total funding available to €7.3m in 2017. This includes the development of an All Island Paediatric Cardiology Service.

2016 also saw the rollout of technology upgrades to the National Ambulance Service with an initial investment of €2m, increasing to an annual sum of €3.6m in 2017.

An additional €m is being made available in 2017 for the development of new initiatives within the Acutes Services (including the National Ambulance Service and the National Cancer Control Programme).

Additional funding is also provided in 2017 to support the New Children's Hospital Integration Programme.

Funding of €50 million is also provided to meet the increased costs of acute hospital services in 2017 associated with changes in the level and complexity of hospital activity.

Staffing numbers

As of August 2016, the total number of whole-time equivalent staff working in the HSE and Section 38 Agencies funded by the HSE was 105,578. This figure does not cover staff of the Department of Health or agencies which operate under the aegis of the Department. The number working in such agencies is 1534.79 whole-time equivalents.

National Clinical Programmes

There are over 30 National Clinical Programmes (NCPs) underway in Ireland, covering areas such as diabetes and stroke, which aim to improve and standardise patient care by designing models of care, guidelines, pathways and associated strategies for the delivery of clinical care.

Each programme has a Clinical Lead, a multi-disciplinary Working Group (which includes patient representatives), and a Clinical Advisory Group. Having a wide range of clinicians involved ensures that proposed solutions will be more robust and that solutions will be accepted by colleagues at implementation.

Examples of National Clinical Programmes include:

Stroke National Clinical Programme

- The aims of the HSE national stroke programme are to improve quality, access and cost-effectiveness of stroke services in Ireland
- National 24/7 access to safe stroke thrombolysis
 - Emergency thrombolysis provided now to patients in all regions of the country, via improved hospital and ambulance protocols, health professional training and the appointment of new physicians.
 - The national stroke thrombolysis rate has increased from 1% in 2006 to a rate of 11.6% in 2014, exceeding the national target of 9%;
- Improved access to stroke unit care, bringing the total number of stroke units in acute hospitals to twenty-two;
- Less stroke patients dying in hospital;
- Less stroke patients discharged to nursing homes;
- More patients discharged home directly from acute hospitals;
- The median acute hospital length of stay for stroke has fallen from 10 days in 2009 to 9 days in 2014, with an estimated 19,000 bed days saved in the 2011-2014 period.

Heart Failure Clinical Programme

The Heart Failure programme was one of the first National Clinical Care programmes established by the HSE. The programme has seen some very positive developments both in terms of implementing structured acute services and in initiating community heart failure projects.

Heart Failure is one of the major chronic diseases in Ireland today. Heart Failure is reported to account for 5% of all emergency medical admissions, of which 80% are patients greater than 65 years of age. Heart Failure essentially means the heart is not working well enough to meet the needs of the body and its prevalence continues to rise because of three major driving factors:

- The ageing population
- Improved survival post myocardial infarction
- Continuing difficulty managing cardio-metabolic diseases (obesity, hypertension, type 2 diabetes) in the general population.

Structured specialist hospital services for patients with Heart Failure have been introduced in 13 sites. They deliver an integrated service through the Model of Care for Heart Failure developed by the National Clinical Programme for Heart Failure, which follows international best practice. The results to date show a notably low readmission rate.

National Carers' Strategy

Published in July 2012, the '*Carers' Strategy*' sets the strategic direction for future policies, services and supports provided by Government Departments and agencies for carers. The Strategy also contains a Roadmap for Implementation with 42 Actions to be achieved on a cost-neutral basis in the short to medium term. The HSE has set up a multi-divisional working group to bring forward implementation of the health aspects of the Strategy.

Mental Health Services

The overall gross non-capital mental health budget for 2012 – 16 is as follows:

2012	2013	2014	2015	2016
€11m	€37m	€66m	€91.8m	€26.6m

€35 million in new services will be initiated in 2017

In line with the recommendations of '*A Vision for Change*', the HSE has prioritised the mental health needs of those under age 18 by developing services in accordance with the HSE National Service Plan, and Operational Plans for 2016. Child and Adolescent Mental Health services fall within the secondary and tertiary levels of specialist care. A young person therefore must have a moderate to severe mental illness in order to access specialist services, based on professional assessed need.

The publication of a new Standard Operating Procedures in June 2015 has provided greater clarity and consistency on how this specialist mental health service for children should be delivered nationally.

Additional funding has served to modernise mental health services in line with '*A Vision for Change*' and previous Programme for Government commitments. A key focus has been additional posts to strengthen Community Mental Health Teams for both adults and children. It has also been used to enhance specialist community mental health and forensic services, increase the access to counselling and psychotherapy and for suicide prevention initiatives. Approximately 1,550 new posts have been approved since 2012 up to the end of 2016, of which some 1,153 have been recruited or are in the recruitment process, by the end of 2015. These posts facilitate the policy of moving away from traditional institutional based care to a patient-centred, flexible and community based mental health service where hospital admissions are greatly reduced, while still providing in-patient care when appropriate.

Priority initiatives in the area of mental health in 2016 include:

- The continued development of counselling services across both primary and secondary care, including the provision of new youth mental health services.
- The continued development of Community Mental Health Teams and improved 24/7 response and liaison services.
- Psychiatry of Later Life.
- Perinatal Mental Health.
- Two new mental health clinical programmes, specifically, ADHD in Adults and Children, and Dual Diagnosis of those with Mental Illness and Substance Misuse.

'*A Vision for Change*' has guided national mental health policy for the past 10 years and its term comes to an end this year. The Department published a request for tender in August 2016 for a review and analysis of international evidence and best practice in the development of mental health services, including a review of current delivery of services in Ireland and a contract has been awarded. This review will provide evidence to determine the policy direction for a revision of '*A Vision for Change*'. The review will also have regard to both human rights and health and well-being objectives. When the review is completed, the Department will examine the output and will then decide on the need for a monitoring group to oversee any required policy changes.

Child and Adolescent Mental Health Services (CAMHS)

The HSE is committed to ensuring that all aspects of CAMHS services are delivered in a consistent and timely fashion, including improved Access. The Executive introduced in mid-2015 a new Standard Operating Procedure for both in-patient and community CAMHS services. This has helped improve the service overall, such as reducing inappropriate admissions of adolescents to adult units, and reducing Waiting Lists, particularly for those waiting over 12 months. There are 67 Child and Adolescent Mental Health Services Teams and extra services for special service needs have also been introduced in recent years. The HSE is committed to addressing all Child and Adolescent Mental Health Service needs, including the 16-18 age cohort. Using additional funding provided in recent years, the staffing and range of Child and Adolescent Mental Health Service teams has been significantly expanded. This will continue in 2017 using the additional funding for mental health services recently announced in Budget 2017.

Review of Mental Health Act 2001

The report of the Expert Group set up to review the Mental Health Act 2001 was published by Minister Lynch on 5 March 2015. The report contains 165 recommendations and proposes a move away from the often paternalistic interpretation of the existing legislation as well as including provisions which are intended to strengthen the protections for people who are detained without consent in approved centres. The Minister has accepted the broad thrust of the changes recommended by the Expert Group and Government approval has been received for the drafting of a General Scheme of a Bill to amend the existing legislation to reflect the recommendations of the Expert Group and work is progressing in the Department of Health on these important amendments.

National Taskforce on Youth Mental Health

A National Taskforce on Youth Mental Health has been convened for approximately 9-12 months that brings together perspective and insights from public, private, community and voluntary sectors. It is chaired by Helen McEntee TD, Minister of State for Mental Health and Older People. It will meet monthly, and held its first meeting on 6th September 2016. The Taskforce is operating as an action-oriented, decision making group focussed on making improvements and getting things done. It is working in collaboration with different sectors and communities to improve:

- Emotional literacy around talking about mental health and reduce stigma
- Awareness of services and supports
- Accessibility to services and supports at different times and in different areas
- Alignment of services and supports across different providers (public, private, community, and voluntary)

The Taskforce is maintaining an exclusive youth focus, defined as children and young people aged 0 to 25. The Taskforce is involving and including young people in its work, as well as engaging widely with key stakeholders.

Cancer services

The development of cancer services in Ireland has been governed by a programmatic approach to cancer control covering prevention; early detection; follow up; research and centralisation based on international evidence for improved outcomes. The National Cancer Control Programme has reorganised cancer surgery based around eight designated cancer centres to ensure that these centres have sufficient activity to provide and maintain on-going surgical expertise. An important element of cancer control in Ireland is evidence-based cancer screening programmes to detect early cancerous, or pre-cancerous, cells with a view to reducing cancer mortality. Quality assurance standards are in place for three cancer screening programmes, including for breast and cervical cancer.

Health services for Travellers and Roma

Elements of mainstreaming and targeted approaches are accepted as necessary in order to ensure equality of access, participation and outcomes for all groups. While mainstream healthcare is the primary vehicle through which all service users, including Travellers and Roma, are enabled to access care and support, it has proved necessary to develop additional programmes that target the specific needs of this group.

At present, ethnic identifiers are not used in the health service. This acts as a significant barrier to evidence based planning around the health needs and outcomes of diverse groups of service users, including Travellers and Roma. It is envisaged that the continued development of such identifiers across health services will facilitate improved monitoring of uptake of services and provide information on emerging trends.

Positive steps have been taken towards improving Traveller health outcomes. The All Ireland Traveller Health Study (AITHS)²⁴ offered an evidence based overview of the health status of Travellers, both female and male. Key findings of this study reflected a widening gap in health status between Travellers and the settled population, with particularly worrying figures in respect of Traveller mortality and morbidity, compared to the settled population. The AITHS also demonstrated that Travellers' access to health services is good, with Travellers stating that their access is at least as good as that of the rest of the population. This is noteworthy as access to primary care services is an important element of health services delivery.

Over 94% of Travellers have a Medical Card, with this figure rising to 99% in the older age group. Nearly 97% of all Travellers are registered with a GP. However, the research reports that the healthcare experience is not as good as the general population, with communication cited as a major issue by both Travellers and service providers.

Work in relation to Traveller health in the HSE is guided by findings of the AITHS while associated strategies such as the Primary Care Strategy and HSE National Intercultural Health Strategy provide frameworks within which care and support needs may be effectively addressed. The Social Inclusion care group located within the Primary Care Division of the HSE holds a remit for Traveller and Roma health. The overall structure of the HSE National Traveller Health Advisory Forum, comprising health service staff, Traveller Health Unit (THU) representatives and Traveller representation, continues to provide a strategic and operational framework towards promotion of a consistent approach across THUs to addressing Traveller health priorities identified in the AITHS. Specific measures are being taken in key areas such as asthma, diabetes, suicide prevention and drugs and other addictions.

Targeted services are in place to address the needs of the Roma community. The Tallaght Roma Integration Project (TRIP) along with the Safetynet Primary Care Network and Tallaght Hospital, Dublin, provides the mobile Safetynet Roma GP service to members of the Roma Community, the majority of whom are from the Tallaght and surrounding area of South West Dublin. The Roma GP clinic deals with many health issues, particularly with respect to screening for chronic and acute illnesses, childhood vaccinations and ante-natal care.

The Department of Health has been allocated an additional €1,460,000 from Dormant Accounts Funding to provide a Mobile Health Screening Unit from 2016-2017. The objective of this measure is to provide an accessible, targeted screening and primary care service to a wide range of marginalised service users in settings such as hostels, prisons and Direct Provision Centres. The measure will benefit a diverse cohort of marginalised groups including those affected by homelessness, migrants and asylum seekers, Roma, Travellers and those who suffer from addiction.

²⁴ <http://health.gov.ie/blog/publications/all-ireland-traveller-health-study/>

The Department of Justice and Equality is leading on the development of a new National Traveller and Roma Inclusion Strategy. The Strategy aims to provide a set of specific actions that need to be taken to bring about a real improvement in quality of life for Travellers and Roma. A number of cross-cutting themes have emerged in the consultation process for the Strategy such as accommodation, employment, health and education. It is intended that the Strategy will include agreed actions in relation to improving the health of travellers. The Strategy is expected to be completed in late 2016 and will cover the period up to 2020.

Information on health services for older people is provided under Article 23

Article 14 – The right to benefit from social welfare services

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

2. to encourage the participation of individuals and voluntary or other organisations in the establishment and maintenance of such services.

14.2: Charities legislation

The Charities Regulator is Ireland's national statutory regulator for charitable organisations. The Charities Regulator is an independent authority and was established on the 16th of October 2014 under the Charities Act 2009.

The key functions of the Regulator are to establish and maintain a public register of charitable organisations operating in Ireland and ensure their compliance with the Charities Acts.

The Regulator also engages in the provision of services to charities including the authorising of appointments of new charitable trustees, the framing of schemes of incorporation, authorisation of certain schemes, and disposition of lands held upon charitable trusts.

Under Part IV of the Charities Act 2009, the Regulator has the power to conduct statutory investigations into any organisation believed to be non-compliant with the charities acts. Anyone with information of wrongdoing can contact the Regulator by email. All concerns raised are dealt with in confidence.

14.2: How does the Govt monitor private sector social services are effective and provided in a non-discriminatory way

Ireland has comprehensive and robust equality legislation in place, which prohibits discrimination on nine specified grounds: gender, civil status, family status, age, race, religion, disability, sexual orientation and membership of the Traveller community.

The legislation is designed to promote equality, prohibit discrimination – direct, indirect and by association – and victimisation. It allows positive measures to ensure full equality across the nine grounds.

The Equal Status Acts 2000–2012 outlaw discrimination outside the workplace, in particular in the provision of goods and services. Equality legislation also provides for remedies for those who have suffered discrimination. The Acts outlaw discrimination in all services that are generally available to the public whether provided by the state or the private sector.

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;

The interaction between the State Pension (Contributory) (SPC) and State Pension (Non-Contributory) (SPNC) has been set out in the response to the Committee’s direct request in Article 12. The response to Article 12(1) also provides the calculation of those payments as a proportion of the 50% at-risk-of-poverty threshold using both national and Eurostat sources. The State Pension (Transition) was discontinued in 2014.

In general, older people have the lowest poverty rates. Pension rates have largely protected this group over the years. While the figures quoted by the Committee indicate 96-98% of pensioners are over the 40% threshold, there are some who will not be included in that cohort for a number of reasons. These include errors in reporting household income, or where the value of an asset held by the SPNC recipient is considered in the SPNC means-test, for example, a second residential property or farmland.²⁵ The numbers of pensioners likely to be in these circumstances are low, so it is considered that a figure of some 3% would be reasonable. As there is no evidence of a significant number of people among those of pension age being in situations other than the foregoing, no initiatives are planned to enhance supports for additional groups.

In addition, while pensioners may have an income significantly above any given poverty threshold, the household equivalised income measure means that a lack of income from another adult in the house might mean the equivalised household income might be below that threshold. This may occur, for example, when an adult child is at university, while such cases would not be the norm, they would not be unusual either and would generally be for a short duration.

Maintaining the rate of the State Pension is critical in protecting pensioners from poverty, and doing so in a sustainable manner is challenging given the upward pressure on pensions’ expenditure. The biggest single block of expenditure in the Department of Social Protection is on pensions. In light of ongoing demographic change, and in the context of very significant increases in the rates in the decade prior to the economic downturn, a number of reforms, outlined below, have been introduced to maintain the sustainability of payments.

²⁵ While it may be more advantageous in the short term for a person to dispose of the asset, there may be other reasons that they may choose not to or to delay in doing so. These include a belief that the asset will appreciate in value and/or a desire to pass it on to a relative as part of an inheritance.

The rates were maintained despite an overarching requirement for fiscal consolidation in recent years. There was a €3 per week increase in the State Pension (Contributory) and State Pension (Non-Contributory) in Budget 2016. Despite significant reforms introduced from 2012 to 2014, including an increase in the pension age, spending on pensions continue to rise and further increases are required year-on-year to keep pace with this demographic change. Tables 1 and 2 below show the increases in the total expenditure and number of beneficiaries from 2010 – 2015.

Table 1 - Total expenditure by the Department of Social Protection on pensions* and related payments for persons aged 65 or over 2010 – 2015

Payment Type	2010	2011	2012	2013	2014	2015	% Increase of Payments 2010 – 2015
€Millions							
Social Insurance							
State Pension (Contributory)	3,452	3,623	3,803	3,983	4,185	4,476	30%
State Pension **(Transition)	108	132	147	137	74	1	-99%
Social Assistance							
State Pension (Non – Contributory)	976	972	963	952	954	972	0%
Total Payment	4,536	4,727	4,913	5,072	5,213	5,449	20%

Table 2 – Total Beneficiaries of State Pensions* age 65 and over 2010-2015

Payment Type	2010	2011	2012	2013	2014	2015	% Increase of Beneficiaries 2010 – 2015
Social Insurance							
State Pension (Contributory)	280,419	296,995	312,314	329,531	346,420	361,725	29%
State Pension **(Transition)	10,206	12,110	14,372	12,630	1,548	N/A	-100%
Social Assistance							

State Pension (Non – Contributory)	97,179	96,749	96,126	95,801	95,570	95,179	-2%
Total Beneficiaries	387,804	405,854	422,812	437,962	443,538	456,904	18%

*These figures do not include Widow, Widower and Surviving Civil Partner's (Contributory) Pensions (WCP), which, while paid to adults of all ages, are predominantly paid to people over 65. The rate for over 66s matches the top rate of the State Pension (Contributory). Expenditure on WCP was: €1.34 billion in 2010-12; €1.35 billion in 2013; €1.37 billion in 2014; and €1.42 billion in 2015. WCP beneficiaries amounted to: 114,579 in 2010; 115,762 in 2011; 116,751 in 2012; 117,417 in 2013; 118,670 in 2014; and 119,712 in 2015.

** State Pension (Transition), which was a payment for up to 12 months, was abolished for new pensioners, effective from 1 January 2014. It was phased out over the course of 2014 as pensioners moved to State Pension (Contributory) on their 66th birthday. There were a small number of payments made to some pensioners at the start of 2015.

Challenges facing the Irish Pension System

There are a number of challenges facing the Irish pension system in the future. Life expectancy is increasing, which in turn increases the duration of the average pension. In 2010 there were 5.3 people of working age for every pensioner and, without policy change, this ratio was expected to decrease to approximately 2.1 to 1 by 2060. The population aged over 65 is projected to increase from 11% of the total population in 2010 to 15% in 2020 and to 24% in 2060.²⁶ This has significant associated pension costs for the State, as well as other costs, such as health and social care.

Reforms to the State Pension

A number of significant reforms to the State pension system have been introduced as follows:

- With effect from April 2012, the number of paid contributions required to qualify for a SPC increased from 260 (weekly) paid contributions to 520 paid contributions.
- In September 2012, new rate bands for the SPC were introduced. These additional payment rate bands will more accurately reflect the social insurance history of a person and ensure that those who contribute more during a working life benefit more in retirement compared to those with lesser contributions.
- From December 2013, the number of paid contributions required for Widow's Widower's or Surviving Civil Partner's (Contributory) Pension increased from 156 contributions to 260 contributions.
- Encouraging longer working is part of the strategy to address the issues of adequacy and sustainability of the State pension system. In this context, the State Pension (Transition) was abolished in 2014. It had been paid at age 65 but had a requirement to

²⁶ These projections are from the most recently published Actuarial Review of the Social Insurance Fund. More current projections will be contained in the next such Review, which is expected to be published in mid-2017.

retire. As a result of its discontinuance, the State pension age has been standardised at 66 years. There is no retirement requirement associated with either the SPC or the SPNC. The State pension age will increase to 67 years in 2021 and 68 years in 2028.

Supports for Older Jobseekers

There are some special administrative provisions in place for older jobseekers. These provisions aim to help people transition from the labour force into retirement. These provisions recognise that older jobseekers may have more difficulty re-training and re-entering the workplace if they lose their job when they are near to retirement age.

Since 1 January 2014, people aged over 62 or over who are in receipt of Jobseeker's Benefit or Allowance are not required to engage with the activation process. However, they can voluntarily avail of a range of supports, for example, training or employment support programmes. In addition, most jobseekers aged 62 or over will be placed on a yearly signing arrangement with their Intreo centre or social welfare local office and most will be transferred to electronic fund transfer payments so payment can be made directly into their bank account.

People over 65 who are claiming Jobseeker's Benefit, and who have the required number of social insurance contributions, can continue to receive Jobseeker's Benefit until their 66th birthday even if their entitlement is due to end before that date. This special provision extends the duration of Jobseeker's Benefit for people aged 65 and over and aims to support the transition of older workers from the labour force into retirement. Jobseeker's Allowance is payable up to State pension age i.e. 66 years of age.

State Pension (Contributory) Qualifying Supports

For persons who have insufficient contributions to qualify for a full SPC, there are provisions in the overall State pension system to assist qualification for the scheme based on factors such as the contributions made by their spouse/civil partner. These include the Homemaker's Scheme, which was introduced to make qualification for SPC easier for those who take time out of the workforce for caring duties. They also include the measure that qualification for entitlement to the Widow's, Widower's and Surviving Civil Partner's Pension (Contributory) can be based on either the PRSI record of the widow, widower or civil partner, or their deceased husband, wife or civil partner.

Pension adequacy

Despite economic pressures, the rate of the State pension has increased, both in real and actual terms, since the economic downturn. Budget 2006 set the weekly personal rate for the SPC at €193.30. The 2016 full rate of SPC payment is 19% higher. Even for those with an average of only 20 contributions per year, they are paid a higher rate currently than the full rate was at that time. During the economic downturn, there was an increase in the rate of the SPC in Budget 2009 of over 3%, despite very significant negative inflation at that time, and it has not been eroded by inflation in the period to 2015. In Budget 2016 the rate of State pensions was increased by €3, which is significantly in excess of inflation.

Information on age discrimination is as per 14.2 above. There are two State bodies responsible for ensuring that the equality laws are upheld, IHREC (Irish Human Rights and Equality Commission) and the WRC (Workplace Relations Commission). IHREC may represent an

individual bringing a discrimination claim. The WRC is similar to a court and has the power to investigate, judge and decide on equality cases. There is a two-stage procedure for making an Equal Status complaint, set out on the website of the WRC.

The National Positive Ageing Strategy (NPAS) was published on 24th April 2013. It provides the blueprint for a whole of Government and whole of society approach to planning for an ageing society. The Strategy provides a vision for an age-friendly society and includes four National Goals (participation, health, security, research) and underpinning objectives to provide direction on the issues that need to be addressed to promote positive ageing.

This Strategy is a cross-Departmental one, with the Department of Health having the overall coordinating and collating role and a more direct role for the health-related objectives. A key objective of this Strategy is to change the mind-sets of decision makers across Government agencies and to raise the priority that is given to the concerns of older people and there have been on-going contacts with a wide range of Government Departments and agencies to progress this. It is therefore an on-going process rather than a set of concrete actions with clearly defined completion dates.

The Department of Health has developed a detailed proposal for on-going structured engagement between relevant Government Departments and State Agencies and relevant stakeholders. The most obvious template is the arrangement now in place around the Carers Strategy, which includes an annual Forum for stakeholders and Departments/agencies, along with clear channels of communications and regular more direct engagements between stakeholders and the relevant Department or agency on specific issues.

The Cabinet Committee on Social Policy and Public Sector Reform (or its successor) will oversee the implementation of the Strategy and these new proposals will be brought to them after a new Government has been formed.

A Healthy and Positive Ageing Initiative (HaPaI) has also been established to implement the research objective of the NPAS. It is a joint initiative between the Department of Health, the HSE's Health and Wellbeing Programme and the Atlantic Philanthropies and will run from October 2014 to December 2017, with a commitment to Department of Health funding for a further two years.

The Initiative will monitor changes in older people's health and wellbeing, primarily through the development of positive ageing indicators to be published every two years. The HSE will also develop a physical activity communications campaign under the Initiative.

Housing

The Irish Government is taking urgent action to deal with the challenges which currently exist in relation to the housing sector in Ireland. The Programme for Government published in May 2016 committed to addressing fully the housing challenges in an action plan to be published within the first 100 days of the Government's term in office. The publication of *Rebuilding Ireland: an Action Plan on Housing and Homelessness* in July 2016 clearly demonstrates the national commitment to end the current housing shortage and to tackle homelessness.

This Plan sets out a clear roadmap to achieve the Government's goals to significantly increase and expedite the delivery of social housing units, boost private housing construction, improve the rental market, and deliver on the commitment to see housing supply, in overall terms, more than double to some 25,000 new homes every year by 2020. The key targets of this Action Plan will be subject to regular review by a Cabinet Committee on Housing, chaired by the Taoiseach.

This is a cross-Government plan, which also stretches beyond into the local government and voluntary sectors. The Government's mission is to ensure that everyone can access a home, either on their own or with State support. There is a clear determination at the highest level nationally to deal with the under-supply of housing and the problems it generates for families and communities.

Specifically the Plan sets ambitious targets and detailed initiatives to:

- comprehensively deal with homelessness,
- double the annual level of residential construction to 25,000 homes,
- deliver 47,000 units of social housing with investment of €3.35 billion,
- make the best use of the existing housing stock, and
- create the right conditions for a more vibrant and responsive private rented sector.

Addressing the unacceptable level of homeless families and long-term homeless people in emergency accommodation takes precedence in this Plan. It is acknowledged that housing is the key to solving homelessness and immediate initiatives such as the delivery of a significant number of rapid build homes will be prioritised in the Plan. However, it is also recognised that homelessness and the reasons for it are complex and require concerted action across Government. The links between homelessness, ill-health, poverty and social exclusion are well understood and wider Government policy initiatives across a range of social policy areas including health, welfare etc. are acknowledged in the Plan and will be harnessed in order to provide sustainable pathways out of homelessness and to mitigate against the risk of homelessness.

A detailed summary/overview of the Plan is set out in the paragraphs below.

Rebuilding Ireland: Action Plan for Housing and Homelessness- Summary Overview

The overarching aim of this Action Plan is to ramp up delivery of housing from its current under-supply across all tenures to help individuals and families meet their housing needs, and to help those who are currently housed to remain in their homes or be provided with appropriate options of alternative accommodation, especially those families in emergency accommodation.

The Action Plan sets ambitious targets to double the annual level of residential construction to 25,000 homes and deliver 47,000 units of social housing in the period to 2021, while at the same time making the best use of the existing housing stock and laying the foundations for a more vibrant and responsive private rented sector. Achieving the aim of accelerated delivery will contribute to the following core objectives:

- Addressing the unacceptable level of households, particularly families, in emergency accommodation;
- Moderating rental and purchase price inflation, particularly in urban areas;
- Addressing a growing affordability gap for many households wishing to purchase their own homes;
- Maturing the rental sector so that tenants see it as one that offers security, quality and choice of tenure in the right locations and providers see it as one they can invest in with certainty;
- Ensuring housing's contribution to the national economy is steady and supportive of sustainable economic growth; and
- Delivering housing in a way that meets current needs while contributing to wider objectives such as the need to support sustainable urban and rural development and communities and to maximise the contribution of the built environment to addressing climate change.

In order to meet these objectives, the plan sets out a broad range of well-resourced actions (see summary table below) designed to increase housing output, particularly at more affordable prices, encourage the delivery of more and better rental options, keep people in their homes and bring vacant and under-utilised properties back into full use.

The Action Plan, a central component of the *Programme for a Partnership Government*, has been informed, in particular, by the *Report of the Oireachtas Committee on Housing and Homelessness (June 2016)* and extensive engagement with key stakeholders.

In order to ensure the ambition of the Action Plan is fully realised, implementation will be overseen by a special Cabinet Committee on Housing, chaired by An Taoiseach. A specific forum for stakeholder engagement for the implementation phase will be established and chaired at Ministerial level. A new Housing Delivery Office is being established in the Department and a Centre of Excellence for Procurement in the Housing Agency. Monthly updates on housing activity will be published and overall progress reports on the Plan will be published on a quarterly basis on the dedicated website, rebuildingireland.ie.

Five Key Pillars of the Plan

These high-level actions will support a range of actions across the five key pillars of the Action



Plan.

The actions proposed under each of these five Pillars can be summarised as follows:

Pillar 1 – Address Homelessness

Provide early solutions to address the unacceptable level of families in emergency accommodation; deliver inter-agency supports for people who are currently homeless, with a particular emphasis on minimising the incidence of rough sleeping, and enhance State supports to keep people in their own homes.

Pillar 2 – Accelerate Social Housing

Increase the level and speed of delivery of social housing and other State-supported housing, with funding of €5.35 billion to deliver 47,000 units by 2021.

Pillar 3 – Build More Homes

Increase the output of private housing to meet demand at affordable prices. Infrastructure Fund of €200m to open up large sites in areas where people need homes.

Pillar 4 – Improve the Rental Sector

Address the obstacles to greater private rented sector delivery, to improve the supply of units at affordable rents.

Pillar 5 – Utilise Existing Housing

Ensure that existing housing stock is used to the maximum degree possible - focusing on measures to use vacant stock to renew urban and rural areas

Many of these actions are inter-related and inter-dependent. In outlining the actions, this Action Plan contains key targets and deadlines for delivery by a number of Government Departments, local authorities and other bodies which will be subject to regular Cabinet Committee review.

Pathfinders

What people want to see most flowing from this Action Plan is increased delivery of housing on the ground. This will require implementation of all the actions outlined in the Plan. However, in order to provide visible evidence of the Plan’s capacity to drive the delivery of the homes that people need, where they need them, a series of Pathfinder Projects will be the focus of particular attention, to test and demonstrate the Action Plan’s effectiveness.

Key Actions to be delivered under the Action Plan

Pillar objective	Key actions
<i>Pillar 1 - Address Homelessness</i>	

Pillar objective	Key actions
<p>Provide early solutions to address the unacceptable level of families in emergency accommodation; deliver inter-agency supports for people who are currently homeless, with a particular emphasis on minimising the incidence of rough-sleeping; and enhance State supports to keep people in their own homes.</p>	<ul style="list-style-type: none"> • Ensure that by mid-2017, hotels are only used in limited circumstances for emergency accommodation for families, by meeting housing needs through the Housing Assistance Payment (HAP) and general housing allocations, and by providing new supply to be delivered through: <ul style="list-style-type: none"> ○ An expanded Rapid Build Housing programme [1,500 homes – 200 in 2016; 800 in 2017 and 500 in 2018] ○ A Housing Agency initiative to acquire vacant houses [1,600 units by 2020 - €70m revolving fund] • Triple the targets for tenancies to be provided by Housing First teams in Dublin from 100 to 300 and extend the housing-led approach to other urban areas • Enhance supports for homeless families with children • Enhance supports for homeless people with mental health and addiction issues - triple the funding, from €2m to €6m, will be provided to the HSE. • Ensure an adequate supply of emergency accommodation nationally • Extend tenancy sustainment measures nationwide • Increased Rent Supplement and HAP limits • New mortgage Arrears Resolution Service to standardise supports for borrowers • New initiative to provide access to independent expert financial and legal advice for people facing serious mortgage arrears • Potential for further legislative measures in relation to mortgage arrears to be examined • Facilitate more households with Mortgage to Rent

Pillar 2 – Accelerate Social Housing

Increase the level and speed of delivery of social housing and other State-supported housing.

- 47,000 social housing units delivered by 2021, supported by investment of €5.35 billion
- Accelerated Housing Assistance Payment (HAP) delivery – [12,000 in 2016 and 15,000 in 2017]
- NTMA/Private Housing Fund to deliver increased housing supply [potential to fund delivery of some 5,000 social houses]
- Mixed-tenure developments on State lands and other lands
- Establishment of a dedicated Housing Delivery Office and Housing Procurement Unit
- Extensive supports for Local Authorities and Approved Housing Bodies – e.g. AHB Innovation Fund
- Streamlined approval processes (e.g. Part 8 planning)
- Housing for specific groups: meeting the needs of the vulnerable.
- Increased target for Housing Adaptation Grants drawdown [increasing from 8,000 in 2016 to 10,000 in 2017]
- Pilots to support innovative design and housing solutions for older people
- Extending National Housing Strategy for People with Disabilities beyond its 2016 timeframe out to 2020

Pillar 3 – Build More Homes

Increase the output of private housing to meet demand at affordable prices.

- Doubling of output to deliver over 25,000 units per annum on average over the period of the Plan [2017-2021], aided by
 - Opening up land supply and low-cost State lands
 - Local Infrastructure Housing Activation Fund (LIHAF) - €200m
 - NTMA financing of large-scale “on-site” infrastructure for developers, complementing LIHAF
 - Prioritising large pathfinder sites in key urban locations to release housing more quickly
 - Planning reforms – large housing development applications to go directly to the Board, new streamlined Part 8 process, on-line planning facilities
 - Putting in place a National Planning Framework and land management actions – multi-tenure developments on State lands.
 - Efficient design and delivery methods to lower housing delivery costs
 - Measures to support construction innovation and skills

Pillar 4 – Improve the Rented Sector	
Address the obstacles to greater private rented sector delivery, to improve the supply of units at affordable rents.	<ul style="list-style-type: none"> • Develop a strategy for a viable and sustainable rental sector • Introduce legislation on balanced arrangements for tenancy terminations – in sales of 20+ units in a single development, tenants to remain in situ. • Review the standards for rental accommodation • Enhance the role of the Residential Tenancies Board, including its enforcement powers • Introduce an Affordable Rental Scheme - €10m annually to support 2,000 rental properties by 2018. • Encourage “build to rent” • Support greater provision of student accommodation – develop national strategy, additional 7,000 places by 2019, assistance to find additional short-term student accommodation.
Pillar 5 – Utilise Existing Housing	
Ensure that existing housing stock is used to the maximum degree possible - focusing on measures to use vacant stock to renew urban and rural areas.	<ul style="list-style-type: none"> • Better management of social housing through rapid re-letting of vacant units (Voids) and introduction of choice-based letting • Review of the Tenant (Incremental) Purchase Scheme • Housing Agency purchases of vacant houses held by banks and financial institutions – [1,600 units - €70m revolving fund - same action as under Pillar 2] • New vacant Housing Repair and Leasing Initiative • Removing regulatory barriers to re-using vacant or under-utilised properties – e.g. change of use from commercial to residential • Urban regeneration actions, including Living City Initiative • Village and rural renewal initiatives to revitalise town centres and villages – DAHRRGA working with DHPCLG • Continue work to resolve unfinished estates

Process for the assessment and qualification of households for social housing support

The qualification criteria for social housing support are set down in section 20 of the Housing (Miscellaneous Provisions) Act 2009 and in the Social Housing Assessment Regulations made in 2011 and 2016 under the 2009 Act (S.I. Nos 84 of 2011, 136 of 2011, 321 of 2011 & S.I. 288 of 2016) and are applied by all local authorities in assessing individual households for support.

The application process commences with the submission by the household of a fully completed application form (prescribed in the Social Housing Assessment Regulations 2011, S.I. 84 of

2011). If the application is valid, it is then assessed. The first step involves an assessment of the qualification of the household for support based on four main eligibility criteria:

- Residency status;
- Income;
- Previous Rent Arrears; and
- Availability of Alternative Accommodation.

In relation to Residency Status, social housing applicants who are not Irish or UK nationals must meet additional criteria in order to be assessed for social housing support as set down in Housing Circular 41/2012. EEA nationals must, generally speaking, be or have been, employed in the State in order to be assessed. Non-EEA nationals who have been granted refugee, programme refugee or subsidiary protection status may be assessed for social housing support. Asylum seekers are not eligible for support.

In order for a local authority to assess a household for social housing support, the household concerned must be normally resident in the area or have a local connection to the area (in terms of past residence there, employment or education or relatives living in the area, etc.). However, a local authority may, at its discretion, assess a household that does not meet these particular criteria. Decisions on the eligibility of households for social housing support are a matter for the local authority concerned.

In relation to income a person is deemed eligible for social housing support if their income is lower than a set amount. This amount varies depending on location authority and can also be adjusted upwards to reflect an applicant household size and composition. Typically a person with a net income (i.e. income after taxes and various other deductions) of less than €30,000-35,000 per year can qualify for social housing.

Where a household is deemed to meet the eligibility criteria, only then is its housing need assessed under the criteria in Regulation 23 of the 2011 Regulations, having regard to its current accommodation. In this regard, *Regulation 14 – Sequencing of assessment* in the 2011 Regulations provides that a local authority shall not proceed to assess a household for support where the household has been deemed to be ineligible for such support. Thus, where a household fails to meet any of the eligibility criteria, the condition or nature of its current accommodation and the severity of its housing need arising, is not assessed.

Under Regulation 23 of the 2011 Regulations, a household's need is assessed by determining whether the applicant is homeless with the meaning of the Housing Act 1988 or its current accommodation is:

- An Institution, emergency accommodation or hostel
- Overcrowded
- Unfit

- Meets specific accommodation requirements of household member with a physical, sensory, mental health or intellectual impairment
- Involuntary sharing
- Subject to an Unsustainable Mortgage
- Otherwise unsuitable, having regard to particular household circumstances or on exceptional medical or compassionate grounds

Households that meet the eligibility and need criteria and deemed to qualify for social housing support and are entered onto the local authority's waiting list to be considered for the allocation of suitable tenancies in accordance with the authority's allocation scheme.

Cost of Social Housing

Local authorities charge rent for social housing on a differential basis related to household income, with lower income households paying a lower rent. While all local authorities do charge rents related to household income, similar households in similar accommodation can be charged varying amount of differential rent, depending on which local authority they are located in. Typically urban rents tend to be lower than those in rural parts of the country. Although there is no national framework for rents in place (the proposal for moving to a national system is under review as part of the Department's Action Plan for Housing known as "Rebuilding Ireland") a consensus for a maximum amount of social rents has emerged over the past number of years i.e. that rent charged should generally not be more than 15% of a household's net income- this is deemed to be "affordable" for social renting purposes (and compares favourably to a similar figure in the private sector of 30-35% of net income for rents/mortgage payments). Many local authorities do treat income progressively by requiring that as a household earns more income they pay more rent. However, so as not to create a welfare trap and a disincentive to work, this progressive approach only takes effect at a level well above that of the basic rate of social welfare payment.

Legal Framework for Assisted Decision Making

The Assisted Decision-Making (Capacity) Act 2015 was signed into law by the President of Ireland on 30 December 2015 but has yet to come into force. Phased commencement of the Act will begin as soon as possible before the end of 2016.

The Act is a comprehensive reform of the law on decision-making capacity and is fully compliant with international human rights standards. It is underpinned by a series of guiding principles which govern all actions encompassed by the Act. These enshrine a human rights approach into the legislation.

A person is presumed to have capacity unless otherwise determined. An intervention must be made in a manner that minimises the restrictions on a person's rights and freedom of action. It

must have due regard to the need to respect the right of the person to his or her dignity, bodily integrity, privacy and autonomy. The person's will and preferences are central to the decision-making process.

The Act proposes a graduated series of options to support a person to exercise decision-making capacity.

A person can appoint a decision-making assistant to advise him or her on decisions and to source any necessary information.

A person who has capacity difficulties can appoint a co-decision-maker to take decisions jointly.

A person can exercise his or her choice to appoint an attorney to take decisions on his / her behalf should he or she lose decision-making capacity.

A person can also make an advance healthcare directive to set out his or her preferences in terms of the refusal of healthcare treatment should she / he lose decision-making capacity.

As a last resort option, where a person is found to lack decision-making capacity, a decision-making representative can be appointed by the court to take decisions on the person's behalf.

Robust safeguards have been included in the legislation to guard against exploitation of the person and to ensure that any intervener abides by his / her responsibilities under the legislation. A Decision Support Service is being established in the Mental Health Commission to supervise all interveners under the Act.

The Assisted Decision-Making (Capacity) Act 2015 provides for legal aid for people who are at risk of losing capacity.

Legal framework relating to assisted decision-making

The Assisted Decision-Making (Capacity) Act 2015 provides a statutory framework for individuals to make legally-binding agreements to be assisted and supported in making decisions about their welfare, property and affairs. This assistance and support is particularly required where the person lacks, or may lack, the capacity to make the decision unaided. The legislation is detailed and far-reaching and very much focuses on the rights of the individual and implementing his or her known will and preferences. A number of new arrangements are covered by the Act, including Assisted Decision-Making and Co-Decision-Making. A process is also set out for the court to appoint a Decision-Making Representative for an individual. The Act sets out the parameters within which each of these classes of assistant or representative must act. A legal requirement is placed on service providers to comprehensively enable a person to make a decision through the provision of a range of supports and information appropriate to their condition. Advance Healthcare Directives are introduced into Irish law for the first time as part of the Act. As well as introducing new decision-making procedures, the Act sets out new arrangements for Wards of Court and for people who wish to make an Enduring Power of Attorney. A Decision Support Service is to be set up within the Mental Health Commission to provide a range of functions in relation to the new arrangements. The

Assisted Decision-Making (Capacity) Act 2015 was enacted on 30 December 2015 and is due to be commenced by Ministerial Order during 2016.

Safeguards against the arbitrary deprivation of autonomous decision making

The Department of Health is at an advanced stage of framing legislative provisions to define who has statutory responsibility for a decision that a patient can be admitted to or prevented from leaving a nursing home or similar residential care facility in the State. A number of safeguards including a review process and court appeal have been incorporated into the provisions. This piece of legislation will allow Ireland to ratify Article 14 of the UN Convention on the Rights of People with Disabilities and will form part of the Equality/Disability (Miscellaneous Provisions) Bill of the Department of Justice and Equality.

Prevention of elder abuse

There is currently no specific legislation on elder abuse. In December 2014, the Health Service Executive (HSE) launched its '*Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures*'. This new national policy on the protection of vulnerable adults from abuse has been developed by the HSE's Social Care Division (responsible for the provision of services for older persons and persons with a disability). This new policy is for all HSE and HSE funded services and builds on, and incorporates, existing policies in HSE Disability and Elder Abuse services and in a range of other Disability Service providers.

The policy defines a vulnerable adult as "*an adult who may be restricted in capacity to guard himself / herself against harm or exploitation or to report such harm or exploitation. Restriction of capacity may arise as a result of physical or intellectual impairment. Vulnerability to abuse is influenced by both context and individual circumstances*".

The HSE is committed to safeguarding vulnerable persons from abuse and a key priority for 2014 was to publish one policy spanning both older persons and disability services. '*Safeguarding Vulnerable Persons at Risk of Abuse*' now provides one overarching policy ensuring –

- A consistent approach to protecting vulnerable people from abuse and neglect
- All services have a publicly declared 'No Tolerance' approach to any form of abuse
- A culture which supports this ethos is supported.

A number of principles underpin this policy, including respect for Human Rights, Person-Centredness, Advocacy, Confidentiality, Culture, Empowerment and Collaboration.

Since the publication of the HSE's '*Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures*,' a significant number of structures and resources have been put in place in a relatively short space of time:

- Nine Safeguarding and Protections Teams (one in each Community Healthcare Organisation) have been established;
- a National Safeguarding Office has been created to implement the Policy
- a National Safeguarding Committee and several Safeguarding and Protection Committees have been established in various Community Health Organisations

- a standardised safeguarding training programme has been developed for all staff and there is a target to train 8,000 staff this year.

Healthy Ireland

'Healthy Ireland, the Framework for Improved Health and Wellbeing 2013-2025' is the national framework for action to improve the health and wellbeing of the people of Ireland. Its main focus is on prevention and keeping people healthier for longer. Healthy Ireland's goals are to:

- Increase the proportion of people who are healthy at all stages of life
- Reduce health inequalities
- Protect the public from threats to health and wellbeing
- Create an environment where every individual and sector of society can play their part in achieving a healthy Ireland

Healthy Ireland takes a whole-of-Government and whole-of-society approach to improving health and wellbeing and the quality of people's lives.

The National Positive Ageing Strategy

The *'National Positive Ageing Strategy'* published in 2013 is a high level document outlining Ireland's vision for ageing and older people and the national goals and objectives required to promote positive ageing. The Strategy highlights that ageing is not just a health issue, and that we need a collaborative response to address a range of social, economic and environmental factors that affect the health and wellbeing of our ageing citizens. The development of the Strategy was informed by the UN Principles for Older Persons, the WHO Active Ageing Policy Framework, a public consultation process and consultations with a Cross-Departmental Group and an NGO Liaison Group which were both established to assist in the development of the Strategy.

The Vision Statement of the *'National Positive Ageing Strategy'* seeks to foster a shared understanding across Government and all sectors of society about the meaning of positive ageing for older people and to direct and guide policy and service delivery towards that purpose.

"Ireland will be a society for all ages that celebrates and prepares properly for individual and population ageing. It will enable and support all ages and older people to enjoy physical and mental health and wellbeing to their full potential. It will promote and respect older people's engagement in economic, social, cultural, community and family life, and foster better solidarity between generations. It will be a society in which the equality, independence, participation, care, self-fulfilment and dignity of older people are pursued at all times"

The National Positive Ageing Strategy contains four National Goals which are as follows:

1. Remove barriers to participation and provide more opportunities for the continued involvement of people as they age in all aspects of cultural, economic and social life in their communities according to their needs, preferences and capacities.

2. Support people as they age to maintain, improve or manage their physical and mental health and wellbeing.
3. Enable people to age with confidence, security and dignity in their own homes and communities for as long as possible.
4. Support and use research about people as they age to better inform policy responses to population ageing in Ireland.

Each of these goals is underpinned by a number of objectives that are relevant to specific policy areas. However, there are two cross-cutting objectives for all policies and service delivery for older people across all policy areas, namely:

1. Combating Ageism
2. Improving Information Provision

The Department of Health has developed a proposal for on-going structured engagement between relevant Government Departments and State Agencies and relevant stakeholders, as it is recognised that ageing is not solely a health issue – it requires a whole of Government response.

A *‘Healthy and Positive Ageing Initiative’* has been established to implement the research objective of the *‘National Positive Ageing Strategy’*. It is a joint initiative between the Department of Health, the HSE’s Health and Wellbeing Programme and the Atlantic Philanthropies and will run from October 2014 to December 2017, with a commitment to Department of Health funding for a further two years. The Initiative will monitor changes in older people’s health and wellbeing, primarily through the development of positive ageing indicators to be published every two years.

The Irish Longitudinal Study on Ageing (TILDA)

The Irish Longitudinal Study on Ageing (TILDA) is a large-scale, nationally representative, longitudinal study on ageing in Ireland. TILDA collects information on many aspects of the health, economic and social circumstances; data on 8,000 older adults is collected once every 2 years. The Department of Health, with co-funding from the Atlantic Philanthropies and Irish Life, has supported four waves of TILDA since 2010 at a total cost to the Department of €12 million. TILDA was initiated and has been operated and managed since its inception by Trinity College Dublin (TCD). The Department has agreed to provide funding of up to €10m for the next Phase of the Project over the years 2017 to 2021. Atlantic Philanthropies will also contribute an amount of €5m.

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 choose their life-style freely and to lead independent lives in their familiar surroundings 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;

Government Policy

The overarching policy is to support people to live in dignity and independence in their own homes and communities for as long as possible and to support access to quality long-term residential care where this is appropriate. There is an obvious need to provide high quality and flexible services that not only best meet the needs of individual clients, but also balance pressures across the wider health system including Acute Hospitals, Long Term Residential Care and the Community Care Sector. There will, however, always be a cohort of older people who require a quality long-term residential care option.

Services and facilities

The Health Service Executive (HSE) provides a wide range of services for people growing older in Ireland. The HSE National Service Plan sets out the type and volume of health service to be provided in a given year within the overall level of funding allocated by Government.

The HSE has management systems in place to monitor service delivery throughout the course of the year. The HSE's Performance Assurance Report provides an overall analysis of key performance data from Divisions, such as Acute, Mental Health, Social Care, Primary Care, Health and Wellbeing as well as Finance and HR. The activity data reported is based on Performance Activity and Key Performance Indicators outlined in the current National Service Plan. Monthly performance reports are published by the HSE.

Home Support Services for Older People

The HSE provides a range of community-based services aimed at ensuring older people receive safe, timely and appropriate care and treatment at the lowest level of complexity, and as close to home as possible. Home support services are provided either directly by the HSE or through service agreements with private and voluntary sector providers, to assist older people to live independently in their own homes.

In addition to the mainstream Home Help Service, which offers up to 5 hours per week of personal care and help with domestic chores, enhanced home care is provided through the

Home Care Package (HCP) Scheme. Other HSE-provided or HSE-funded services include day care, meals-on-wheels and respite care. The HSE also provides Intensive Home Care Packages for clients with complex needs.

- Services are provided on the basis of assessed health-care need and there is no means-testing.
- The HSE target for 2016 is to provide 10.57m home help hours and 15,800 Home Care Packages and 130 Intensive Home Care Packages for clients with complex needs. A further 60 clients with dementia will be supported with co-funding from Atlantic Philanthropies under the Irish National Dementia Strategy.
- In addition the HSE will provide 950 Home Care Packages as part of the Winter Initiative Plan for 2016/2017.

There are 108 Day Care Centres across the country that offer a similar type service which is inclusive of nursing, therapy supports, social activities and some personal care. Services are interlinked with local primary care team services. Some centres are on site within community hospitals while others may be provided in communal social centres in sheltered housing complexes.

The HSE also supports a wide range of community initiatives and smaller local voluntary agencies, maintaining a sense of community, combatting loneliness and isolation while providing practical services like meals-on-wheels, laundry, basic essential repairs, and housekeeping.

Residential Care for Older People

There are about 2,000 short stay public beds including 'step up/step down' care, intermediate, rehab and respite care, which are used in a flexible manner to meet local needs at any given time.

Long-term nursing home care is provided through a mix of public and private provision, with the public sector providing about 20% of all beds. Introduced in 2009, the Nursing Homes Support Scheme, also known as the 'Fair Deal', is a system of financial support for those in need of long-term nursing home care. The Scheme aims to ensure that long-term nursing home care is accessible and affordable for everyone and that people are cared for in the most appropriate settings. In order to apply for the Scheme an applicant must be ordinarily resident in the State (i.e. living in the State for at least a year or intending to live in the State for at least a year).

Participants contribute to the cost of their care according to their means while the State pays the balance of the cost. The applicant can choose any public, voluntary or approved private nursing home. The home must have availability and be able to cater for the applicant's particular needs. The Nursing Home Loan (Ancillary State Support) is an optional benefit of the Nursing Homes Support Scheme, the purpose of which is to ensure that a person does not have to sell their home during their lifetime to pay for long-term nursing home care.

In order to manage the available funds within the Scheme's budget throughout the year, a national placement list is operated by the Health Service Executive. Funding approvals issue to applicants in chronological order. Waiting times for funding is on average 4 weeks.

The net budget for long-term residential care in 2016 is €940m and the Nursing Homes Support Scheme will support 23,450 clients (on average per week) – an increase of 649 clients per week on 2015 projections.

The Review of the Nursing Homes Support Scheme was published in July 2015 and the recommendations contained in the review are in the process of being implemented.

Ensuring sufficient supply of residential care

The position regarding the availability of nursing home beds is that there are some areas where individuals sometimes have to wait for a place in the facility of their choice, but in overall terms there are enough nursing home beds to meet demand.

Work is underway to increase the provision of residential care to older persons in Ireland in order to meet the projected increase in the population aged over 65 years:

There was an increase in the numbers of centres in 2015, from 565 centres with 29,060 beds in 2014 to 577 centres and 30,106 beds in 2015. €385 million in capital funding has been secured for a programme for the replacement and refurbishment of public nursing homes across the country over the next five years which will consolidate our existing public stock and is expected to provide 250 additional beds. With regard to private facilities, it was announced in Budget 2016 that nursing home expansion works would henceforth be included in the Employment and Investment Incentive Scheme.

The Programme for Government commits to seeking ways to incentivise private nursing home investment and new supported living/assisted living arrangements.

Independent Regulation

The Health Information and Quality Authority (HIQA) is an independent authority established under the Health Act 2007. Since 2009, all designated centres for older people (nursing homes) whether public, private or voluntary have been registered and inspected by HIQA.

This responsibility is underpinned by a comprehensive framework including Care and Welfare Regulations and *National Quality Standards*. The Regulations are aimed at ensuring proper standards of care for nursing homes and include provisions on residents' rights and protection from abuse. The National Standards set out what is expected in terms of the service provided to residents, with a focus on continuous development of safe and effective care.

A register of all nursing homes is available on the HIQA website, www.hiqa.ie. At the end of 2015 there were 577 nursing homes registered with HIQA providing 30,106 residential beds. A total of 411 inspections were completed in 2015 in 343 registered centres. All inspection reports are published by HIQA.

Registered providers of nursing home care are obliged to provide an accessible and effective complaints procedure. Concerns should in the first instance be taken up with the nursing home provider. The Office of the Ombudsman can examine complaints about the actions of a range

of public bodies and, from 24 August 2015, complaints relating to the administrative actions of private nursing homes.

Additional Information

Supports are also available from other agencies like the Department of Social Protection, Local Authorities and Voluntary Organisations.

Detailed information on services for Older People provided by the HSE is available at www.hse.ie. The information provided covers supports available at home, in the community and residential services. Further information available includes tips on healthy living, benefits and entitlements and protecting older people and helpful information for carers and relatives.

The HSE provides a range of leaflets and guidance documents on the services it provides. Examples include literature on the Home Care Package Scheme and the Nursing Homes Support Scheme. The HSE also provides an infoline which is open from Monday - Saturday, 8am - 8pm.

National Dementia Strategy

In response to the rising number of people with dementia, the Irish '*National Dementia Strategy*' was launched in December 2014. It delivers on a Government commitment to develop a national Alzheimer's and other dementias strategy to increase awareness, ensure early diagnosis and intervention and develop enhanced community-based services.

The Strategy emphasises that most people with dementia live in their own communities and can continue to live well and to participate in those communities for far longer than many people appreciate.

The Strategy contains 14 priority actions under five headings:

- Better awareness and understanding
- Timely diagnosis and intervention
- Integrated services, supports and care
- Training and education, and
- Leadership.

The implementation of the actions contained in the Strategy is coordinated by the National Dementia Office in the HSE.

National Dementia Strategy Implementation Programme

The National Dementia Strategy Implementation Programme between the Department of Health, the HSE and the Atlantic Philanthropies, represents a combined investment of €27.5m, with Atlantic Philanthropies contributing €2m, and the HSE contributing €15.5m over the period 2015-2017. The Department of Health and HSE have committed to maintaining the National Dementia Implementation Programme structures and oversight arrangements for at least a period of 5 years up to the end of 2019.

Key elements of the initiative include:-

- the rollout of Intensive Homecare Packages for people with dementia (€2.1m)
- the provision of additional dementia-specific resources for GPs, who are the critical and initial point of contact with the health system for those with dementia. The resource material will include training materials and guidance on local services and contact points, etc. (€1.2m)
- Measures to raise public awareness, address stigma, and promote the inclusion and involvement in society of those with dementia (€2.7m)
- The establishment of a National Dementia Office (€1.5m).

National policy on Palliative Care

National policy on Palliative Care is contained in the *'Report of the National Advisory Committee on Palliative Care'* (2001), the Health Service Executive (HSE) *'5 year/Medium Term Framework for Palliative Care Services 2009-2013'* and, in relation to children, *'Palliative Care for Children with Life-Limiting Conditions in Ireland – A National Policy'*. Palliative Care is moving beyond the traditional life-limiting area of cancer to address other non-malignant or chronic conditions (primary diagnosis: 77% cancer, 23% non-cancer).

Palliative Care Budget and service provision

The 2016 palliative care budget amounts to €72 million. The total number of specialist palliative care beds in 11 locations countrywide is 217. All HSE areas have Community Specialist Palliative Home Care Teams. The budget does not include expenditure on specialist palliative care provided in 38 acute hospitals, nor does it include the 170 palliative care support beds in 80 locations, or designated home care packages. Most of the funding is channelled through service level agreements with voluntary hospices and homecare providers.

Palliative Care for Children

'Palliative Care for Children with Life-limiting Conditions in Ireland – a National Policy' (2009) sets out a clear direction for the development of an integrated palliative care service for children and their families, across all care settings. In 2010 the HSE established the National Development Committee for Children's Palliative Care to implement the policy's recommendations. The Committee has statutory, voluntary, professional and parent representation.

To respond to the increasing demand for palliative care services for children, the HSE and Irish Hospice Foundation established a programme of care for children with life limiting conditions including eight children's outreach nurses (with an additional two being recruited in Dublin and Donegal), and the first consultant paediatrician with a special interest in children's palliative care based in Our Lady's Hospital for Sick Children, Crumlin. The HSE intends to seek funding in the 2017 estimates for 2-3 additional children's outreach nurses to address the dual issues of geography and population density.

An evaluation of the children's palliative care programme, to be published in late 2016, will recommend a strengthening of children's palliative care to include more children's outreach nurses and additional respite services. The demands on the available services reflect the fact that the prevalence of life-limiting conditions in children in Ireland is now estimated to be

more than double what was previously thought. This amounts to 3,850 children, with 50% requiring palliative care at some point.

Training for individuals caring for elderly persons

The responsibility to provide safe and high quality care is underpinned by a comprehensive framework, including the '*National Quality Standards for Residential Care Settings for Older People*' and the *Health Act, 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations, 2013*. The National Standards, which are based on the legislation, set out what is expected in terms of the service provided to residents, with a focus on continuous development of safe and effective care.

The legislation sets out that a person in charge of a residential care service is required to have a post registration management qualification in health or a related field and not less than 3 years' experience in a management capacity in the health and social care area. The number and skill mix of staff must be appropriate and staff must have access to appropriate training. The '*National Standards for Residential Care Settings for Older People in Ireland*' provide further guidance in this regard.

Both the Regulations & National Standards are available online.

Training for family carers of older people is provided by the Health Service Executive and various voluntary organisations. Such training includes topics such as moving and handling, palliative and end-of-life care.

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 guarantee elderly persons living in institutions appropriate support, while respecting their privacy, and participation in decisions concerning living conditions in the institution

The Health Information and Quality Authority (HIQA) is an independent authority established under the Health Act 2007. Since 2009, all designated centres for older people (nursing homes) whether public, private or voluntary have been registered and inspected by HIQA.

The responsibility to guarantee elderly person living in institutions appropriate support and safe and high quality care is underpinned by a comprehensive framework including *National Quality Standards for Residential Care Settings for Older People*’ and the *Health Act, 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations, 2013*.

The *Regulations* are aimed at ensuring proper standards of care for nursing homes and include provisions on residents’ rights and protection from abuse. An assessment of the personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person’s admission to a designated centre must be completed and a care plan prepared based on this. The care provided is intrinsically linked with individual assessment and care planning process. Providers must have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident. Residents must be provided with facilities for occupation and recreation, and opportunities to participate in activities in accordance with their interests and capacities. They may also be consulted about and participate in the organisation of the designated centre concerned.

The *National Standards* focus on outcomes which enhance the ability of people to participate in, and contribute to, daily life. These include promoting the rights of people and respecting their autonomy, privacy and dignity, facilitating people to be as independent as possible and to exercise personal choice in their daily lives. Residents must be safeguarded and protected from abuse and they must be provided with accessible information.

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.

The Irish Government has adopted the following official definition of poverty:

People are living in poverty if their income and resources (material cultural and social) are so inadequate as to preclude them from having a standard of living which is regarded as acceptable by Irish society. As a result of inadequate income and resources people may be excluded and marginalised from participating in activities which are considered the norm for other people in society.

Source: *National Action Plan for Social Inclusion 2007-2016*²⁷

This definition of poverty is in line with a human rights approach, as set out by the European Social Charter. Thus, the lack of adequate resources includes both financial resources as might be provided through the social protection system, and minimum standards of living, such as adequate heating, adequate food and nutrition and adequate clothing. Social exclusion refers to social participation, which includes social outings, friendships and community networks. This is further supported by equality and anti-discrimination legislation across nine specified grounds, including gender, Traveller community, disability, race and sexual orientation.

National Poverty Target

²⁷ <http://socialinclusion.ie/documents/NAPinclusionReportPDF.pdf>

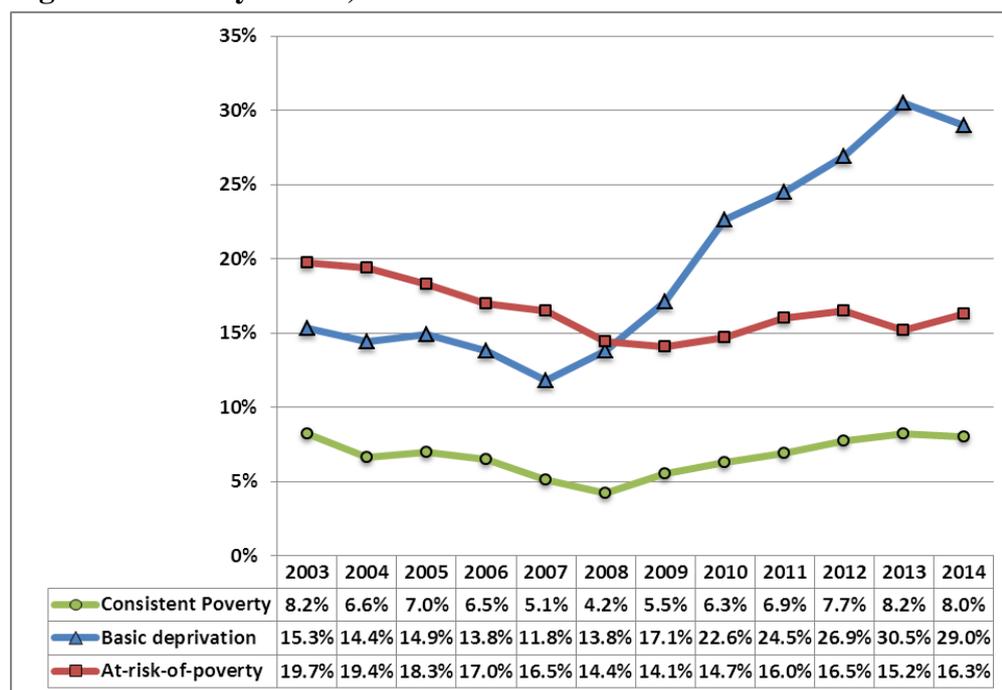
Following a review of the national poverty target in 2012, a revised national social target for poverty reduction was adopted by the Government. The overall aim of the target is to reduce consistent poverty to 4% by 2016 and to 2% or less by 2020, from a baseline rate of 6.3% in 2010.²⁸ There are two other components of the national social target:

- The Irish contribution to the EU2020 poverty target is to reduce by a minimum of 200,000 the population in combined poverty between 2010 and 2020.²⁹
- The child-specific poverty target is to lift over 70,000 children (aged 0-17 years) out of consistent poverty by 2020, a reduction of at least two-thirds on the 2011 level.

Progress towards the target, which applies across all life-cycle groups, is reported annually in the Social Inclusion Monitor.³⁰ The latest Monitor is based on the *CSO Survey on Income and Living Conditions for 2014*. This shows that poverty levels stabilised in 2014 for the first time since the crisis. It is expected that with further increases in employment and the impact of new welfare measures, household incomes and living standards will continue to recover.

Figure 1 below shows the trends in poverty rates from 2003 to 2014. Poverty levels fell in the early part of this period (i.e. 2003 to 2007-09): at-risk-of-poverty declined from 19.7% to 14.1%, basic deprivation reduced from 15.3% to 11.8% and consistent poverty fell from 8.2% to 4.2%.

Figure 1: Poverty trends, 2003 to 2014



Source: SILC, various years

²⁸ The official measure of poverty in Ireland is consistent poverty. People are in consistent poverty if their income is below 60% of the median income and they are deprived of 2 or more of the 11 basic deprivation items because they could not afford them.

²⁹ Combined poverty is the combination of at-risk-of-poverty and/or basic deprivation.

³⁰ http://www.welfare.ie/en/downloads/2016-04-21_SocialInclusionMonitor2014_rpt_Final.pdf

With the onset of the economic crisis, basic deprivation increased to 30.5% in 2013. It fell by 1.5 percentage points to 29% in 2014. This is the first reduction in the rate since 2007, though the change was not statistically significant. Consistent poverty stabilised in 2013/2014 at around 8%.

The at-risk-of-poverty rate increased to 16.5% in 2012, before falling to 15.2% in 2013. In 2014, it increased by 1.1 percentage points to 16.3%. This was mainly due to a rise in real median disposable income of 3.5%, driven by higher direct income from employment.

Policy response

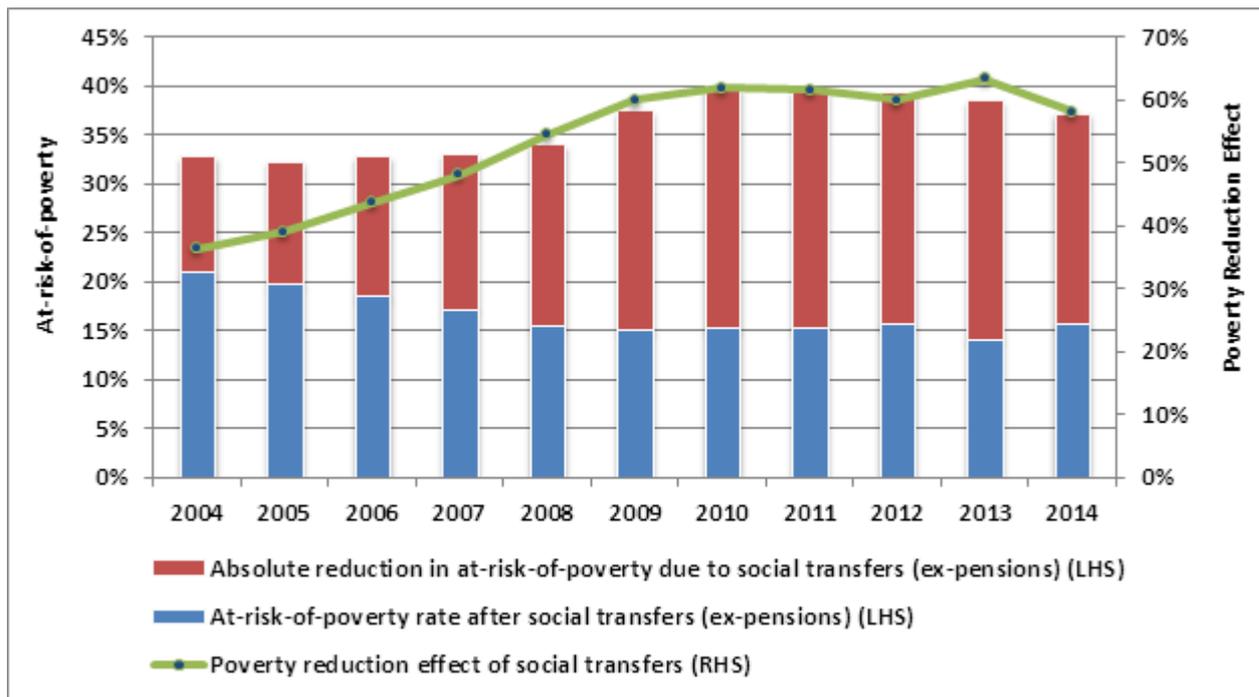
Ireland's social protection system plays an important role in alleviating poverty and income inequality. Social protection expenditure increased by €3.2 billion from the start of the economic crisis in 2008 to the peak year 2011. It rose from €17.8 billion (11.1% of GNP) in 2008 to a high of €21 billion (15.1% of GNP) in 2011. Expenditure in 2015 was €19.9 billion reflecting a slight reduction on previous years and reduced demand due to employment effects. It is still significantly ahead of pre-crisis expenditure in 2008.

In 2015, almost 1.4 million people were in receipt of a weekly social welfare payment, which was paid in respect of over 2.1 million beneficiaries. As stated in the response to Article 12(3), a key component of the Government's income policy since 2011 has been to maintain the value of core weekly rates of welfare payments, including the safety net of the welfare system, the Supplementary Welfare Allowance payment.

Ireland is the best performing EU Member State in reducing poverty through social transfers (excluding pensions).³¹ Using comparable data from Eurostat for 2014, Ireland's performance in reducing poverty at 58.1% was far in excess of the EU-28 norm of 34.1%. Over time, the poverty reduction effectiveness of social transfers increased by 14.6 percentage points from 46.3% during the economic boom (2005-2008) to 60.8% in 2009-2014. Figure 2 below outlines the impact social transfers on the at-risk-of-poverty rate in the years 2004 to 2014.

Figure 2: Impact of social transfers on the at-risk-of-poverty rate, 2004 to 2014

³¹ It is conventional to exclude pensions in the analysis since their role is not only to redistribute resources across income groups, but also between generations.



Source: Eurostat EU-SILC, various years

Research from the Economic and Social Research Institute (ESRI) found that social transfers maintained their poverty reduction effectiveness and efficiency in Ireland in the face of the economic crisis, and the requirements for significant welfare savings as part of fiscal consolidation under the EU-IMF economic programme.³²

Income support is only one aspect of the policy response to addressing poverty and deprivation. The other components are inclusive labour markets and access to quality services. Since 1997, Ireland has developed national anti-poverty strategies to provide a strategic framework in which to tackle poverty and social exclusion. The current strategy, the updated National Action Plan for Social Inclusion, identifies a wide range of targeted actions and interventions to achieve the overall objective of achieving the national social target for poverty reduction. The Plan adopts a life-cycle approach with goals set for each group: children; people of working age; older people and communities.

The Plan was updated for the period 2015 - 2017 to reflect the current issues and interventions to tackle poverty. There is a greater focus on modernising the social protection system, improving effectiveness and efficiency of social transfers and strengthening active inclusion policies. The Updated Plan contains reformulated goals which include a focus on early childhood development, youth exclusion, access to the labour market including measures for people with disabilities, migrant integration, social housing and affordable energy.³³

Growing employment and providing access to the labour market is important for tackling poverty, particularly in welfare-dependent households. The new Pathways to Work 2016 - 2020 strategy focuses on ensuring jobseekers can access good quality work, training and

³² http://www.socialinclusion.ie/SocialTransfersandPovertyAlleviation_000.html

³³ http://www.socialinclusion.ie/documents/2016-02-12_UpdatedNAP_English_Final.pdf

education opportunities.³⁴ It continues to prioritise the activation of long-term and young unemployed people, with supports provided through the network of Intreo offices.

Details of recent budget measures to incentivise work and to improve living standards were set out in response to Article 12(3). The ESRI examined the distributive impact of Budgets 2009 to 2016.³⁵ The analysis shows that most income deciles lost between 7.5% and just over 10% over this period. The top decile experienced the biggest losses at 14.5%, while the bottom decile lost 12.75%. In contrast, the smallest losses (7.5%) were in the third decile. This decile contains a higher than average share of pensioner households. Most family types saw losses of between 8% and 11%. Single unemployed people without children experienced the biggest losses (22.3%). In comparison retired single people and couples experienced the lowest losses of 5% to 6%.

Further details on how Ireland implements its active inclusion strategy are outlined in the series of National Reform Programmes from 2010 to 2016.³⁶

The fifth biennial Social Inclusion Report 2013 and 2014 was published in September 2015 as part of the monitoring mechanisms under the national action plan.³⁷ These reports outline progress from relevant Government Departments on the implementation of national policy commitments to tackle poverty and social exclusion during those years.

The Government continued to engage with a wide range of stakeholders with an interest and involvement in social inclusion through institutional structures such as the Social Inclusion Forum and the Pre-Budget Forum, and various social inclusion initiatives, such as the UN Day for the Eradication of Poverty. These include people experiencing poverty and social exclusion and those groups that work with them.

Minimum social welfare rates as a proportion of the at-risk-of-poverty threshold

Figure 3 below shows the minimum personal social welfare rate as a proportion of the at-risk-of-poverty threshold (60% of median income) for a single person in the period 2004 to 2014. A variation of the minimum personal rate includes the Fuel Allowance, which is a means-tested household payment. It is not possible to express minimum welfare rates in comparison to the other national poverty indicators.

Over the period 2004 to 2014, the minimum personal welfare rate as a proportion of the at-risk-of-poverty threshold has increased from 73% to 90%. Including the Fuel Allowance in the minimum personal welfare rate, it increased as a proportion of the at-risk-of-poverty from 75% to 95%. Since 2010, the minimum personal welfare rate with the Fuel Allowance has remained between 95-97% of the at-risk-of-poverty threshold.

To illustrate this situation, in 2014 the minimum personal welfare rate for a single person was €188 per week and the 60% median equivalised threshold was €209.39 per week. The Fuel Allowance was worth the equivalent of €9.97 per week, giving a combined figure of €197.97.

³⁴ <https://www.welfare.ie/en/downloads/PathwaysToWork2016-2020.pdf>

³⁵ http://www.esri.ie/pubs/QEC2015WIN_SA_Callan.pdf

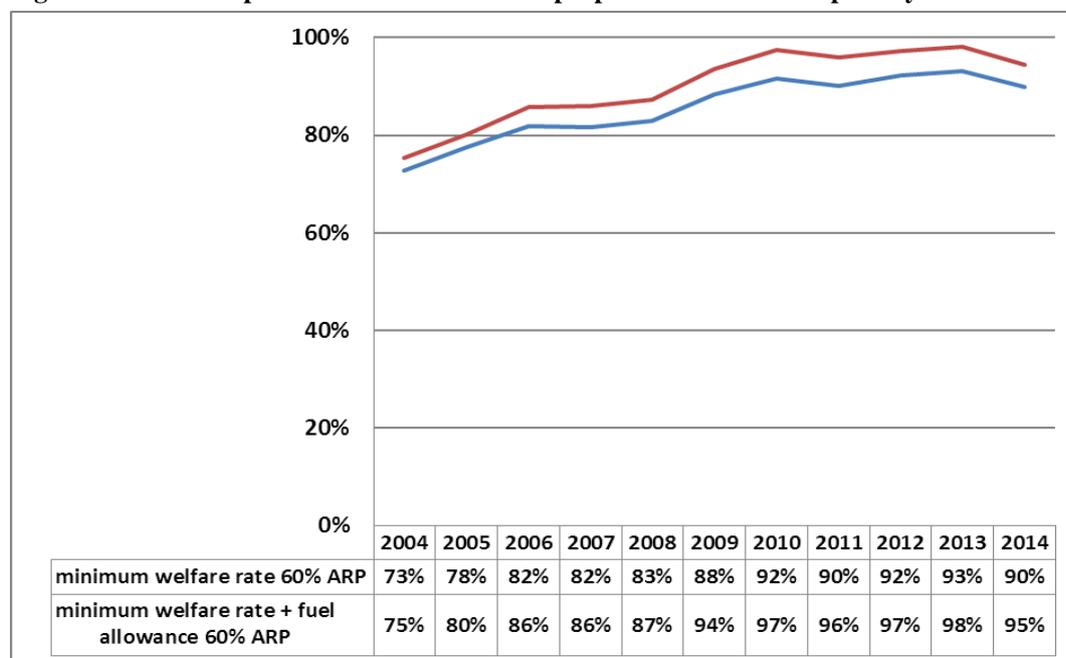
³⁶ <http://www.welfare.ie/en/Pages/Europe-2020-Reporting.aspx/>

³⁷ <http://www.socialinclusion.ie/publications/documents/SocialInclusionReport20132014.html>

Budget 2016 provided for an increase in the Fuel Allowance, which is now worth the equivalent of €1.25 per week.

The comparable figures for couples and families with children on minimum personal welfare rates are the same as those for a single person, as minimum welfare rates apply the same equivalence scales as are used in the official poverty statistics.

Figure 3: Minimum personal welfare rates as a proportion of at-risk-of-poverty threshold 2004 to 2014



Source: Social welfare statistics and CSO Survey on Income and Livings Conditions

The improvement in the minimum personal welfare rate as a proportion of the at-risk-of-poverty threshold is primarily due to increases in welfare rates in the 2000s. However, in 2010, the minimum personal welfare rate was reduced to €196 per week and to €188 in 2011. There have been no further reductions since 2011. The at-risk-of-poverty threshold (60% of median income) fell from €213.78 in 2010 to a low of €201.82 in 2013, but increased to €209.39 in 2014. This increase reflects the economic improvement and increased wages from employment in 2014.

The minimum welfare benefits presented above do not represent the full range of the minimum welfare benefits provided in Ireland. For example, other household benefits not accounted for include the Household Benefits Package, Child Benefit and the Back to School, Clothing and Footwear Allowance.