DÁIL ÉIREANN

AN COMHCHOISTE UM SHAINCHEISTEANNA RÍTHÁBHACHTACHA A THÉANN I GCION AR AN LUCHT SIÚIL

JOINT COMMITTEE ON KEY ISSUES AFFECTING THE TRAVELLER COMMUNITY

Dé Máirt, 5 Samhain 2019

Tuesday, 5 November 2019

The Joint Committee met at 11 a.m.

Comhaltaí a bhí i láthair/Members present:

Joan Collins,	Jennifer Murnane O'Connor,
Marcella Corcoran Kennedy,	Lynn Ruane,
Gino Kenny,	Fintan Warfield.
Fiona O'Loughlin,	
Éamon Ó Cuív.	

Seanadóir/Senator Colette Kelleher sa Chathaoir/in the Chair.

Business of Joint Committee

Chairman: The quorum for this joint committee is four because that is the combined quorum of two select committees, minus one, provided at least one of the members present is a Member of Dáil Éireann and at least one of the members present is a Member of Seanad Éireann. As we have a quorum, I call the meeting to order. Apologies have been received from Senator Paudie Coffey. I propose that we now go into private session to deal with housekeeping matters. Is that agreed? Agreed.

The joint committee went into private session at 11.05 a.m. and resumed in public session at 11.09 a.m.

Traveller Health: Discussion (Resumed)

Chairman: I welcome all members of the joint committee and those who are watching. I understand these committee hearings are attracting considerable interest on Oireachtas News, which is good because not everybody can come here. I welcome our visitors to this meeting of the Oireachtas Joint Committee on Key Issues affecting the Traveller Community. The purpose of the meeting is to continue our deliberations on Traveller health. We are meeting representatives of the Cork Traveller Visibility Group, the Health Service Executive and the Irish College of General Practitioners. We all agree that health and ill health are key issues affecting Travellers who have significantly lower levels of life expectancy and higher rates of infant mortality when compared to the general population. It is not just a small difference. It is a very big difference, and that is why we are having these sessions.

The facts on the level and scale of ill-health among Travellers and the health inequalities experienced by Travellers, as presented to the committee by the submissions and the presentations, are stark in many ways and they speak for themselves. We know from the very well respected - though in need of updating - All Ireland Traveller Health Study that Traveller men's life expectancy is 66 years of age. Traveller men's lives are cut short by 15 years compared to the general population, which is a huge and serious gap. The difference for Traveller women is 12 years. Traveller mortality is three and a half times higher than for the general population.

At our last hearing, we heard that there was a recent health study done in east Limerick that bore out these statistics, and some things stand out. One was that only 29 people in the local Traveller population were over 50 years of age and only three of those were over 65 years of age. We have the All Ireland Traveller Health Study, which is still valid but needs to be updated. We have some local statistics and recent statistics which bear out those trends and those disparities. Traveller babies are almost four times more likely to die compared to babies in the general population.

These growth health inequalities facts and figures were clearly spelled out in general and in very personal terms, because when we have had speakers in here, people have spoken about statistics, trends and social determinants of health, but they have been speaking about their brothers, sisters, fathers, babies and their close family. Again, we are reminded it is a small population of about 40,000 people, and when we look at the trends on health and mental health, people are talking about their own. That has come across very strongly in the presentations we have had to date.

We heard from Kathleen Sherlock from the Minceir Whidden Society, Maria Joyce from the National Traveller Women's Forum, Nora Mooney from the Kilmallock Traveller group, and of course the veteran health campaigner, Missie Collins. We also heard from Jim Walsh from the Department of Health who outlined the Government's official response to the health crisis among Travellers. We heard the strong call for the health action plan to be published and for real and ongoing consultative measures of national and local level to established or even re-established. That is why the committee is conducting its second hearing on health today. As members know, we have had three hearings on mental health. This one is on health in general terms.

I welcome everyone. We are joined by Ms Breda O'Donoghue, the director of advocacy, and Ms Liz McGrath, the health team co-ordinator, Traveller Visibility Group; Ms Siobhán McArdle, head of operations, primary care, HSE, Concepta De Brun, HSE social inclusion unit, Ms Deirdre O'Reilly, co-ordinator of a Traveller health unit; and Dr. Mary Favier, president, and Dr. Tony Cox, medical director, the Irish College of General Practitioners.

Before we begin, we have to remind everybody about privilege. In accordance with procedure, I am required to draw witnesses' attention to the fact that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to this committee. They are directed that only evidence connected to the subject matter of these proceedings will be given, and that they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise nor make charges against any person, persons or entity in such a way as that person might be identifiable. Members are reminded the long-standing parliamentary practice to the effect that members should not comment on, criticise or make charges against a person outside of these Houses or an official either by name or in such a way then as to make him or her identifiable.

I remind everyone to turn off their mobile phones or switch them to flight mode, as they can interfere with the sound and the recording system and affect the television coverage and web streaming.

I advise witnesses that any submission or opening statement made to the joint committee will be published on the website after this meeting so it will be on the record. After the presentations, there will be questions from the members. I call on Ms O'Donoghue to make her opening statement.

Ms Breda O'Donoghue: I thank members of the joint committee for inviting us here today and giving us this opportunity to speak. I have been asked to discuss the key issues relating to Traveller health and its impact on our community. When looking at the key issues impacting Traveller health and the community, we must first look at the root cause of these issues. Putting another way, we must ask what is killing Travellers today. There is one answer which is racism. Over the past 50 plus years, specifically since the 1963 Commission on Itinerancy, Travellers have lived in a hostile environment, where our culture and identity was to be absorbed into the settled community and our very existence repeatedly seen and referenced as a problem. While we understand that this commission's report is out of print and, as some of us would argue, is obsolete, its legacy has affected the lives of Travellers to this day. We are seeing the product of a systemic cultural denial and discrimination in our public services from education to social welfare, private enterprises, employment opportunities, accommodation and media. The effect of this historical assimilation programme on mental and physical health has impacted the Traveller community severely, leading to suicide and mental health being at crisis point, which has been rightly recognised as such by the Minister of State at the Department of Health, Deputy

Jim Daly.

At the Traveller Visibility Group, TVG, our primary healthcare workers meet on a daily basis with Travellers living in Cork. They see how a mistrust of public services, based on discriminatory attitudes and behaviours of staff, and how policies have deterred Travellers from using these services effectively. Travellers feel they are constantly struggling and resisting discrimination in their daily lives, where they witness their children struggling in schools and have their own issues with employment opportunities and appropriate accommodation.

While the social determinants of health and their effect on the general Traveller community are all important factors, accommodation is widely acknowledged as the key issue causing health inequalities for Travellers. As reflected in the social determinants of health, if one's living conditions are poor, this directly impacts on one's physical and mental health, education, employment and general well-being. The vast majority of local authority halting sites are overcrowded, badly-managed, poorly serviced, under-funded and unhygienic. Put simply, these halting sites are not fit for purpose and lead to illness, injury and stress caused by an overcrowded and high-risk living environment. We note that in some cases these confined conditions can lead to community disputes around sharing very limited spaces and facilities. As noted above, poor living conditions lead to poor health. Cardiovascular, dietary and respiratory problems are common within the Traveller community and can be directly linked to poor living conditions.

Suicide and mental health within the Traveller community is at crisis point. This can again be linked to the poor living conditions and isolation felt as a result of the poor management of Traveller accommodation. The situation is clear. Travellers living conditions and the social determinants of health have worsened since the 1963 commission. The lives of Travellers are directly impacted by an accommodation and a mental health crisis that directly impacts their physical health and many of these issues are caused by historic assimilation and discrimination. We need to distance ourselves now from reports and recommendations and start a genuine programme of legislation by creating sanctions to ultimately fix the cultural denial and racism issues that impact so drastically on Travellers lives and their children's future.

In general, Travellers tend to use health services as a last resort, often ignoring ailments or health issues until they are at emergency point. Prevention and early intervention are key to improving and addressing health inequalities and this is directly linked to improving relationships and communication between health services and the Traveller community. The statistics featured in reports such as the All Ireland Traveller Health Study paint a clear yet stark picture that Travellers are dying younger than the settled community. They are seven times more likely to commit suicide and 50 times more likely to finish school without a leaving certificate.

While this information may sound alarming today, the sad fact is that it is not shocking news within the Traveller community. In fact, it is almost identical to the statistics in the last Traveller health study in 1987. As Travellers, we can see this in front of our eyes every day. We have a situation where many Travellers are not accessing health services, for various reasons. However, it has been reported that when Travellers access these services, they often feel the services do not reflect the needs of the Traveller community. One example is that written correspondence is often delivered to another person on a halting site or maybe not delivered at all. Whether this is for genuine reasons or otherwise, the fact remains that most Travellers on halting sites miss very important appointments due to lack of postal delivery.

When using health services, Travellers have a fear of the response they will get when presenting with an issue, particularly around children's health, at accident and emergency units.

Many Travellers fear the hospital staff will make assumptions about an injury or illness that has occurred and fear blame for the situation. There is an increasing fear of hospital staff contacting Tusla or other social welfare services because of assumptions that are made about the way Travellers treat their children. While we appreciate and welcome the need to be vigilant for children's safety, time and again we see instances of Travellers being treated with distrust and suspicion within the health services, and this creates fear and mistrust among the Traveller community.

To look at health initiatives to support the Traveller community, there is clear evidence that Traveller-led health initiatives, organisations and peer-support workers build trust within the community and, from this, there is a willingness to engage more with public services. The primary health care programme and the development workers in Traveller organisations play a vital role in assuring Traveller engagement with public services. There is better uptake of health initiatives and services like screening and health checks when communicated by peers to the community. When provided with supportive and accessible information, it has been noted that there is a higher uptake and use of such services. For example, more Traveller women take part in cervical smear tests and breast checks than settled women, which is directly linked to the support of Traveller primary health care workers.

The strong relationship and knowledge sharing within the Traveller organisations is a huge support to the Traveller community on a local and national level. The support and representation of national Traveller organisations in policy and advocacy work is hugely valuable, and continued investment and support is essential. Training and capacity building within the Traveller community is vital to promoting health and well-being. Currently, Travellers are more inclined to engage with health awareness programmes or other training when Traveller organisations are directly involved in delivering the training. More support of such programmes is necessary and would have productive outcomes.

While we acknowledge that this peer support is vital, we need to see development within the public services to encourage Travellers to be able to use these services directly, with reduced or little support from Traveller organisations. Traveller cultural awareness training should be funded properly and adapted to ensure that all public service staff, especially customer facing officers, are fully aware of Traveller culture and can engage with their customers in a culturally appropriate manner. In order for Traveller culture to be understood and appreciated, Traveller cultural awareness training should be mandatory as part of public service staff induction training. Refresher training for longer-term staff should take place on a regular basis in such services as health, education, social welfare and local authority services, which are the main areas affecting the social requirements of Traveller health and well-being.

It is not good enough for front-line public staff who work directly with Travellers to have no understanding or background knowledge of the Traveller community. Travellers are part of Irish society and need to be treated as such, with the same understanding and nuance that would be afforded to any individual coming in, looking for assistance from a public service.

I have spoken to the committee today about the key issues affecting Traveller health and the community. At its root is an historic policy that has been in play for over 50 years. This needs to change and everybody has a responsibility to drive this change. There is an institutional prejudice that has been passed down from a group of people who saw us as a problem, not a people. We have moved a lot in some ways, in that Travellers are recognised as an ethnic group and not something to be absorbed into the general community as the 1963 commission hoped for. While on paper we are recognised as an ethnic minority, the reality is the deep-rooted feel-

ings of mistrust towards my community have not changed or moved on. Until they do, then and only then will we start to see a positive change in the health status of the Traveller community.

For the past 20 or 30 years, Travellers have consulted with Government bodies on what can be done for the Traveller community. We have sat on countless committees and boards to advise and assist. While we must recognise there has been some positive change in this period, we must also agree the process is slow and, in some areas, ineffective. The time for recommendations is over. We need real support and resolute actions where the recommended budgets, guidelines and plans are fully realised and brought into everyday life. There is no more we can do to assist in the societal change that is necessary to improve the lives of Travellers in Ireland. We consult but who decides?

Chairman: I thank Ms O'Donoghue. This is her second time meeting the committee as she provided us with Traveller cultural awareness training before we began our deliberations. Those of us who were present found it illuminating and it has assisted us in our passage. There is more to learn and more to go. I also thank Ms McGrath for coming before the committee today. There will be questions afterwards.

We now turn to the HSE representatives and I invite Ms Siobhán McArdle to give her opening statement.

Ms Siobhán McArdle: I thank the committee for the invitation to the HSE to attend the committee meeting. I am the assistant national director with responsibility for primary care services. I am joined by my colleagues, Ms Concepta de Brun, the HSE regional social inclusion specialist and Ms Deirdre O'Reilly, the Traveller health co-ordinator for the Cork and Kerry community healthcare area.

The All Ireland Traveller Health Study in 2010 provided evidence of a widening gap in health status between the Traveller community and the general population. It found that people from the Traveller community experience lower levels of life expectancy than the general population and higher levels of morbidity associated with chronic disease conditions and other causes.

The goals of the HSE are to promote health and well-being as part of everything we do in order that people will be healthier; to provide fair, equitable and timely access to safe quality health services that people need; and to foster a culture that is honest, compassionate, transparent and accountable. The HSE is committed to ensuring that health services for people from the Traveller community are provided in accordance with these values and objectives. The national Traveller health advisory forum, which was established in 2008, supports models of good practice in the delivery of health initiatives to the Traveller community at local, regional and national level. It operates under the governance of the HSE social inclusion service, which is part of primary care and supports the delivery of actions in Government policies to improve access to health services and address health inequalities within the Traveller community.

Each year, in the HSE approximately €10 million is allocated through social inclusion services for Traveller health initiatives. This funding supports staff working in Traveller primary healthcare projects and Traveller health units. Additional funding is also provided through dormant accounts and mental health services. The majority of HSE funding for Traveller health is used to support Traveller primary healthcare projects. There are 27 such projects nationally, which are staffed by members of the Traveller community. They adopt a peer-led approach, supporting members of the Traveller community to support others in achieving health out-

comes. The projects promote population health initiatives by providing information to families on vaccination and health screening programmes. This approach has played a key role, as Ms O'Donoghue has pointed out, in improving vaccination rates in the Traveller community. Traveller primary healthcare projects play an important health promotion role. For example, they provide education on antenatal care, child development checks, smoking cessation, diabetes care and asthma medication management. The positive impact of the work of the projects was highlighted in the All Ireland Traveller Health Study.

All Traveller primary healthcare projects fall under the remit of eight Traveller health units. They are located in the nine community healthcare organisations and serve a Traveller population of approximately 36,000. The Traveller health units are key bodies in delivering appropriate targeted services to members of the Traveller community, overseen by co-ordinators such as Ms O'Reilly. Every Traveller health unit has an annual action plan relating to the local health needs of the Traveller community in that given area. These plans contain actions relating to primary care, mental health, public health and health and well-being. Traveller health units have established regional networks to share learning, ensure consistent practice, and optimise efficiency and value for money. Arising from these networks, regional initiatives have made a positive impact on the healthcare needs of the Traveller community.

We have provided a great deal of information in our written submissions on the range of actions being undertaken in general by the HSE, specifically in the Cork-Kerry area, in partnership with the Traveller community and other organisations to support Traveller health. The key aims of the work are to improve access, opportunities, participation rates and outcomes in the healthcare system, to reduce health inequalities experienced by Travellers, to deliver health services in a way that is culturally appropriate, to support positive mental health initiatives and to reduce the rate of suicide and mental health problems.

I thank committee members for their attention and for their interest in the actions being undertaken to improve Traveller health outcomes. I acknowledge and commend the commitment and motivation of staff working in the Traveller primary healthcare projects, the Traveller health units, primary care services and the wider health service. Through them, we are committed to providing fair and equitable access to health services and to supporting improvements in health outcomes for the Traveller community.

Ms De Brun, Ms O'Reilly and I are free to take members' questions, if they have any.

Chairman: I thank Ms McArdle. I call on Dr. Favier, president of the Irish College of General Practitioners, ICGP, to make her opening statement.

Dr. Mary Favier: On behalf of the ICGP, I thank the committee for its invitation to discuss key health issues affecting the Traveller community. The ICGP is tasked with providing education and training to the general practitioners, GPs, of the country. We are a membership organisation that sets quality and standards. Approximately 85% of GPs are members of the ICGP.

As has been well elaborated on at this meeting, a recent study has found that the Traveller community is affected by several significant social determinants. As the ICGP, we want to concentrate on those that most impact on general health. The life expectancy statistics show stark inequalities in health among the Traveller population compared to the general population. Studies in maternal health, communicable diseases, addiction and mental health, including suicide, serve as clear indicators of the extent of this health inequity.

The high levels of mortality and morbidity among Travellers are well documented. The life expectancy figures are most stark. A male Traveller can expect to die 15 years sooner than a male in the general population, with a female Traveller 11.5 years earlier than her counterpart in the general population. The infant mortality rate is 3.6 times higher for Traveller children than in the general population. While there have been improvements among Traveller mothers attending antenatal services and having shared antenatal care between maternity hospitals and GPs, more than 2% of Traveller mothers still receive no antenatal care.

It is encouraging to know that many Travellers engage with primary healthcare services in particular, as evidenced by the 2010 All Ireland Traveller Health Study. The study found that up to 91% of Travellers obtained their health information from GPs. Travellers' own health beliefs may impact on access to health services, however. For example, GPs treat appointments as the start of a process in treating their patients whereas Travellers may view the consultation as a single issue that should be dealt with in one visit. These are matters of which we need to be aware. In some cases, if symptoms do not improve, it can lead to a visit to a hospital emergency department rather than a return to the GP.

Health initiatives for the Traveller community must be informed by the principles of equality, human rights, social inclusion and respect for Traveller values, beliefs, culture and perceptions. As with the general population, Travellers should have improved access to, participation rates in and outcomes from healthcare services.

The very high prevalence of suicide among Travellers is of particular concern. Measures that would help include on-site sessional counselling and general practice, culturally appropriate awareness campaigns and outreach services signposted to primary care. Targeted health initiatives and associated information materials for Travellers and healthcare providers should be culturally appropriate. Any identified interventions should be designed to improve self-esteem among Travellers, reduce stigma and remove barriers to care. Regardless of the health policy initiatives instigated for Travellers, the views of Travellers must be included when designing such interventions. Traveller participation and co-operation in previous studies, research and information design have been key to their success.

While Travellers experience issues with access to GPs, the same is true for large sections of the population. Clearly, access to GP services needs to be improved and some basic improvements could make large differences. Practices that offer a combination of booked appointments and some same-day appointments would improve Travellers' access to GP services. Cultural awareness training is appropriate for all practice staff and should be developed with input from the Traveller community.

The process of obtaining and retaining a medical card needs to be streamlined and simplified. The health outcome differences between Travellers and the general population are avoidable and with appropriate resourcing and planning, these issues can, and should be, addressed urgently. The Irish College of General Practitioners looks forward to playing a significant role in this area.

We are happy to take questions.

Chairman: I thank Dr. Favier for her opening statement. It is encouraging to hear from her statement that the health differences between Travellers and the general population are avoidable if we take the right steps. I call Senator Lynn Ruane, who will be followed by Deputies Corcoran-Kennedy and Joan Collins.

Senator Lynn Ruane: I have a few questions which I hope the Chairman will afford me the time to get through. My first set of questions are directed to the HSE. It was mentioned that one of the key aims of the HSE is to deliver health services in a way that is culturally appropriate. How is this implemented? What training do HSE staff receive and who delivers that training? Is the €10 million annual funding to Traveller health initiatives sufficient given the health needs of the community? Was an increase in funding sought under budget 2020 or in any of the last five budgets? If so, what was the response from the Department of Health? Ms McArdle described a Traveller health provision structure which is siloed from the rest of general service provision within the health service. What are the documented experiences of Travellers accessing general health services or in other words, services that are not Traveller-specific? Is there a long-term shift planned to mainstream Traveller healthcare within general services, perhaps as part of the Sláintecare reforms?

My next set of questions is to the ICGP. We heard previously in our sessions on Traveller mental health that many Traveller patients have had their medical cards revoked. If there is documented impact in this regard, what has been the impact thus far on Traveller patients? I made the suggestion at a previous committee hearing that regardless of a Traveller's circumstances, until such time as we exit the current health crisis every Traveller should be given access to a medical card. I would like to know if the witnesses agree with me in that regard. Are the HSE and the ICGP doing enough in the face of the Traveller health crisis? Is there prejudice when it comes to healthcare services and what is being done to root it out?

My final questions are to the representatives of the Traveller Visibility Group, Ms Breda O'Donoghue and Ms Liz McGrath. Ms O'Donoghue mentioned that the main cause of poor health outcomes is substandard living conditions. What type of engagement has the group had with local authorities in regard to raising the standards on that ground and has there been real dialogue between Traveller organisations and local authorities on how the issue can be addressed? It was also mentioned that the uptake in cervical screening is higher among Traveller women than in the general population and that this is due to the Traveller-led nature of the health intervention. Ms O'Donoghue also mentioned that the group is constantly consulted to give advice but that while there is consultation, when it shifts to Traveller-led services, it changes. How can this model be developed for further inclusion and development within the HSE in respect of other forms of Traveller healthcare?

Chairman: I will call the representatives of the HSE in the order in which questions were asked of them. If the witnesses from the ICGP wish to respond, they may come in as well. I will also give Ms O'Donoghue and Ms McGrath an opportunity to answer the questions put to them by Senator Ruane.

Ms Siobhán McArdle: I thank the Senator for her questions, the first of which related to culturally appropriate services. There are two or three parts to our approach in this regard. The Traveller primary care health projects are co-designed with Travellers as part of an approach to health services, or health service pathways, that is led by Travellers. This is not a health service in itself; it is a location where Travellers can help other people within the community to access health services in their areas. My colleague, Ms de Brun, will give further details on that in a moment. The other role of the Traveller health units is to produce culturally appropriate materials that are co-designed with the Traveller community, are tailored to meet people's needs and have messages that are suited to the Traveller population. This is not about setting up a separate health service; it is about ensuring the services we provide through the health services are as accessible as possible to the Traveller community. The different Traveller health

units take a prioritised approach. They may prioritise particular actions, for example relating to chronic diseases or screening programmes, in different areas. The HSE materials are designed to be appropriate to and supportive of the Traveller community. I ask Ms de Brun to talk about cultural awareness training.

Chairman: I have a question on budgets-----

Ms Siobhán McArdle: We will come back to that.

Ms Concepta de Brun: Although we adhere to the principle that staff should be trained in cultural appropriateness, the approach taken is inconsistent because it depends on where one is and on how close one's working relationship with one's Traveller health unit is. If one has a strong Traveller health unit, more of one's staff will be trained. Our new health plan includes a commitment to improve our cultural awareness training. We rely heavily on the peer support workers in the Traveller primary healthcare projects to provide culturally appropriate training. All staff who attend and sit with Traveller health units have participated in cultural awareness training. In addition, we culture-proof and literacy-proof anything we co-design or deliver alongside our cultural awareness training. We do not develop any materials without working in partnership with the Traveller community. All small local projects that are achieving or are doing very well are brought to the regional network and the learning is disseminated among the peer support workers in that network. Models of good practice then come to the national Traveller health advisory forums. One of the projects we are working on at the moment is the national mental health promotion training programme, which is a "train the trainer" programme. Twenty trainers have been trained as part of the pilot and we are ready to try to roll it out. The project was co-designed by members of the Traveller community and mental health staff. I will set out where we are falling down with our work. We probably need a much more robust framework to ensure culturally appropriate training is given to people beyond primary care and not just in the primary care and social inclusion services where the Travellers are located. I accept we need to do more with other care directorates.

Chairman: I ask Ms McArdle to speak about budgets.

Ms Siobhán McArdle: We always want more money. The €10 million allocation for primary care services is going into the structure we have described. Each year, including this year, we have applied for additional funding under social inclusion. Each year, we receive small amounts of funding in addition to that €10 million from the Dormant Accounts Fund. We would welcome any increase in funding. We know there has been a dedicated increase in funding for Traveller mental health initiatives. However, the Traveller primary healthcare units model we have described has real potential to be used to assist the wider care group. For instance, the same group of people is being asked to work on health promotion or mental health initiatives. Additional investment in the area would help us to increase capacity, allow us to sustain the number of people working in the area and help us to grow and expand the work that is being done. We would welcome any such increase. We do a lot with what we have. We outlined in our statement the wide range of initiatives being carried out through our projects and the Traveller healthcare units nationally. That demonstrates very good progress and outcomes for the amount of money we have. We acknowledge that we are not there yet; this is a journey. We would welcome any further investment.

The Senator asked about a siloed approach. It is important to state that the network or structure we have described is not about a replacement or siloed health service but, rather, about having a place where we can support people to access health services. It is not a separate service.

The aim is to ensure that people from all communities, including the Traveller community, are enabled to access health services. Our data show that the value of the Traveller networks and projects is that many people from the Traveller community rely on them as their first point of contact because they trust the information provided by their peers. That is a very important part of health service delivery.

Ms Deirdre O'Reilly: On silos and a lack of proper access to health services, one of the big questions for me is how we address the historical marginalisation and racism that has impacted on the community. I work in counties Cork and Kerry and have the privilege of working with some of the other delegates who are present. Silos can occur and people can be left out or marginalised further. If we wish to address the marginalisation of the community, we must take two approaches, namely, a targeted approach and a mainstream approach. Those types of approaches run the risk of becoming worse or siloed unless there is genuine commitment to Traveller leadership, Traveller voice and community development through an empowering model. Those of us in the HSE must listen when we are told that we are getting it wrong or that the Traveller community has an approach which it knows works within its community. It is always very important to explore such options. One can look at the issue through equality frameworks and analyse whether the targeted work we are doing is genuine or indirectly creating worse situations. The latter is something we never want to happen. It is a very good question. In counties Cork and Kerry, we try to work from a community development approach. We do not view the social determinants of health as aspects of health that are outside the control of the HSE but, rather, try to work closely and, it is to be hoped, respectfully with Traveller organisations in the area to see what we can do to address the health inequalities caused by discrimination, lack of education or poor accommodation. We explore whether there is something we can do to influence these factors or ensure the voices of various groups are heard. People have differing understandings of these matters. It is a very good question. There are many ways we can ensure that, rather than creating another silo, we genuinely address historical marginalisation.

Dr. Tony Cox: On access to a medical card, I practise in County Clare. As the Senator is probably aware, a Traveller health needs assessment was published in July of this year. Some 99% of the Traveller community has registered with a GP and 98% has a medical card, which is encouraging. However, it is not just about having a medical card; it is about accessing services and turning up for healthcare, preventative services and acute services.

In that same report, it is detailed that 83% access care with their GP even though 98% have the medical card, only 57% attend hospitals and less than 5% attend the mental health services. Therefore, it is not just about having access to the medical card, but we would agree that all members of the Traveller community should have medical cards. We have heard the shocking statistics about the mortality, life expectancy and suicide rates. It is just shocking. To think that group of patients in society would not have medical cards would be appalling and we would support all members of the Traveller community automatically having medical cards. Those who do not have medical cards would not be turned away or refused access to services. We all work in an out-of-hours service and we work in our practices and nobody is turned away because they do not have the means of paying for the service. If somebody has a medical need, they will be seen. That is my experience and that would be the experience of all my colleagues. Medical card access is important but access to the services that are available is also important.

The Senator asked if we are doing enough in working with the HSE and in working to address prejudices. I have a son who has started his four years of general practice training. We have a core curriculum in the college, and within that core curriculum we have several learning

outcomes that specifically address the problems of the Traveller community. I brought that document in and I could read some of those outcomes to the Senator but we have several learning outcomes such as:

> Understand the consulting behaviours of specific marginal groups - homeless, travelers' drug users, new communities etc... Be aware of cultural diversity between the Irish settled community and those from other cultures... Address prejudicial attitudes and discriminating behaviour that they and practice staff might have towards marginalized groups... Be sensitive to the differing cultural needs of non-Irish patients and travellers.

We have others as well.

Senator Lynn Ruane: I want to pick up on that point. For me, this is the same with teachers. One can sit in a classroom and look at matters theoretically all day long but it does not mean a doctor or a teacher or anybody who has that level of understanding and empathy with the trauma of a particular community will be produced. Should a core curriculum always be matched with GPs in training having to spend time in the communities in which they will serve? Should they train directly with Traveller organisations and with the working class communities to understand the social context, rather than just learning in a classroom?

Dr. Tony Cox: We do that. We have four-year training programmes and the first two years are in the hospital posts getting paediatric, obstetric and accident and emergency experience but the final two years are spent with a GP in a practice. I am a GP trainer myself-----

Senator Lynn Ruane: That is an issue. I am talking about training directly with Traveller organisations and doing training that is not medical-led. They should have experience of people's lives that is not necessarily a medical placement.

Dr. Tony Cox: We all have Traveller patients. In my practice in Ennis, I have many Traveller patients, as does Dr. Favier in Cork. Our trainees and registrars will encounter Traveller patients all the time in normal practice in the community. They will live those lives with them, share their stories and understand their healthcare needs and the problems they have. Hopefully, by being mentored by those of us who have been in practice for a long time and who have been working in the community with our patients, they will take on the objectives we have put down in our core curriculum.

Chairman: I invite Ms O'Donoghue and Ms McGrath to answer Senator Ruane's questions before we move on to Deputy Corcoran Kennedy's questions.

Ms Breda O'Donoghue: I will respond to what I can remember of the questions. Was Senator Ruane asking about what dialogue we have had around poor living conditions with local authorities?

Senator Lynn Ruane: I asked about what real engagement has taken place.

Ms Breda O'Donoghue: I have been part of the local Traveller consultative committee for the last 20 years and I have also sat at the high level group of Traveller issues and the Traveller inter-agency group. We have had real dialogue and real consultation with local authorities. Unfortunately, again I will have to come back on that point. While we have loads of brilliant reports and recommendations, until we see sanctions being put in place as to why these recommendations are not being followed through on, as Traveller organisations we believe we will not see any real change.

Did the Senator ask about the primary healthcare team?

Senator Lynn Ruane: I was asking how we can further develop that model of that Traveller-led health piece? It has been a real success in the area of CervicalCheck, for example. How can we take that model and integrate it into all Traveller healthcare?

Ms Breda O'Donoghue: It is one of the initiatives that we feel is working well. It is about the promotion of it and the acceptance that it is working right now and protecting it. We are looking at primary healthcare workers who are at the end of their rope. They are working within their own communities so they work all day on the issues affecting their own community and then they go home to the same issues in the evening. The problem is that we do not have enough primary healthcare workers. That is the biggest issue.

Senator Lynn Ruane: An increase in primary healthcare workers would help to further expand that model.

Ms Breda O'Donoghue: Absolutely.

Chairman: The medical card is a major issue as well.

Ms Breda O'Donoghue: Absolutely. Like Dr. Favier said earlier, it is about helping and supporting Travellers not only to have a medical card but also to retain it. Going back to the postal service, people on sites are not getting the notices that their medical card is up for appeal or renewal and then before they realise, their medical card is gone. There is need for real support around that and maybe more long-term medical cards for Travellers.

Deputy Marcella Corcoran Kennedy: I thank the witnesses for coming in to help us with this important work that we are doing. I will follow on from Senator Ruane because it was something I was thinking about as well as regards mainstreaming cultural awareness training. Dr. Favier mentioned in her presentation that it should be mainstreamed, which means it is not at the minute. Perhaps we should think about making interdepartmental and cross-agency training available to everybody who encounters the Traveller community in their walk of life, whether they are teachers, members of An Garda Síochána, doctors or whatever. That might help to address that issue so that people would understand if, for instance, someone turns up for one meeting but does not appear again afterwards. Would that kind of all-encompassing approach work?

Ms O'Donoghue referred to people missing appointments and losing important documents because their addresses are not fixed. The housing issue is very complex, but if that could be sorted out, that would get to the root of it. Everything else will flow if we can sort out the housing issue. There seems to be a lot of money available for housing but in identifying need, has a proper analysis been conducted on the type of housing that is required? I know Travellers who are settled. They are in a house and they are very happy there. I know other Travellers who are part of a group housing scheme, for example, and who like to move in the summer or whenever. There are others for whom movement is what it is all about and they cannot think of staying in one place. How do we identify how much housing is needed? Has any work been done on that? In respect of architects and people who design accommodation, has an analysis been conducted on whether there should be training for them as well? I am thinking of when they are required to design group housing and how they would do that in order that it would fit into the landscape and so on. Is that being done or should it be done?

On the HSE, it is great to hear the kind of connections it is making with people and that

much of what the executive is doing is informed by consultation. I also acknowledge the frustration of the witnesses that everybody is not aware of the type of information they need to deal effectively with members of the Travelling community. How could that be improved within the HSE or do the witnesses see that deficiency in other organisations?

Chairman: The Deputy asked questions about cultural awareness training, accommodation and influencing others to make progress.

Ms Breda O'Donoghue: I thank the Deputy for those questions. I mentioned the postal service and people not receiving their mail. That is just one example. Travellers live in the present. Sometimes their personal appointments can be put on the back burner, especially in view of what is going on around them at the time.

Regarding accommodation, a member mentioned that there seems to be money around, and there always has been. Fortunately, funding has never been a problem for us. For the past 20-odd years, we, as a Traveller organisation, have made submissions to the five-year Traveller accommodation programmes in our local area. We have always included a needs assessment for the area in those submissions. One of those recommendations has been transient sites, which work very well in other countries. I refer to Traveller needs. Some Travellers are quite happy to be in a standard house, some are happy to be in a halting site while others are happy in a group housing scheme. Approximately 95% of Travellers in Cork are in local authority housing or rented accommodation but that is not by choice. We have argued for years in our submissions that the preferred choice of accommodation of Travellers is halting sites, transient sites or Traveller-specific group housing schemes. Unfortunately, our submissions went to the wind at the best of times. However, I have been delivering Traveller culture awareness training to student architects in University College Cork for the past five or six years, particularly addressing Traveller-specific accommodation. We do not need to reinvent the wheel. There are brilliant and workable Traveller-specific schemes throughout the country. The fact that there are so few of them keeps us in crisis all the time, particularly where accommodation needs are concerned.

Deputy Marcella Corcoran Kennedy: Is it to do with the planning process?

Ms Breda O'Donoghue: Of course it is. It all has to do with the planning process. There is no other excuse. We have the funding and people need this specific accommodation. What we do not have is planning permission.

Chairman: That is a very short answer but a very clear one on which we can reflect. We will return to the issue of accommodation. It is our final module.

Dr. Mary Favier: I wish to address the issue of cross-agency training, which would be very welcome. There is great potential for cultural awareness training on many issues, not just those concerning Travellers. It would be appropriate in many different fora. However, the best evidence would have to be applied. That evidence shows that this training should always be provided using resources delivered by those who are affected, in this case Traveller groups themselves. In any other niche type of education, the evidence always indicates that this is how the education is best provided, whether in the context of an undergraduate setting, GP training or in postgraduate education in which the ICGP is involved.

I also refer to the issue of accommodation and resources. I have been involved in Traveller health for the best part of 20 years as a GP. I can attest that accommodation issues have been front and centre in the past five to eight years. It has so much to do with housing, but it is also

about austerity in a wider context. Resourcing issues are manifest in a lack of GPs, with new GPs leaving and not enough being trained. As a result there is a shortage of appointments. Vulnerable patients, who are more likely to need walk-in services or may default from an appointment and need to be offered another one in a timely fashion, can no longer be accommodated. Patients wait a week to get an appointment with me. There is very little flexibility because of a shortage of GPs and a shortage of training. Other austerity measures, for example, concerning medical cards have disproportionately affected Travellers. The validation of medical card lists is done in a broad sweep. A cardholder can receive paperwork with which to check his or her medical card even though it was renewed and a new plastic card issued only three months previously. This disproportionately affects Travellers who do not receive the correspondence.

Chairman: Dr. Favier is describing red tape.

Dr. Mary Favier: Yes. We spend substantial time chasing and renewing them. There are disproportionate effects and the effect on accommodation is highly pertinent because it brings significant health risks. Some 80% of Travellers live in non-winter-proofed accommodation, leading to more condensation and respiratory illnesses. It also contributes to the infant mortality rate and to later presentations with chronic obstructive pulmonary disease. Travellers in such accommodation live in fuel poverty and spend disproportionate amounts trying to heat inappropriate accommodation, which has a knock-on effect on presentations to general practice. Unless we address these systemic and ingrained problems, everything will have a knock-on effect and this always means the most vulnerable in society, of which Travellers are part, are disproportionately affected.

Deputy Joan Collins: My question is for the ICGP. I was on the Sláintecare committee and we discussed GP accessibility and the number of GPs relative to the population, which has been affected by austerity. It means the most vulnerable people are left at the end of the queue. My own partner had to wait a week and a half for an appointment in the primary healthcare unit in our area. This affects certain people in the Traveller community even more. Not only do letters go to different addresses but postmen sometimes do not go into a halting site. What do Dr. Favier and Dr. Cox think is needed? I have tabled questions on GP training and the numbers going through the colleges. We can talk about services for the Traveller and Roma communities but we need to know what it will all cost. Will this committee or this Parliament insist that the necessary money be given to provide these services? Funding for services for the Traveller community has not increased for the past ten years. We are hoping for crumbs off the table in the shape of the Dormant Accounts Fund to do work the witnesses do in the area of social inclusion.

This committee needs to identify the issues and address them with funding. The all-Ireland Traveller health study found that 90.3% of children were reported as having problems, with asthma the most common condition. What needs to be put in place to deal with that and how much will it cost? Can the services be integrated into other services? The HSE submission and questions from Pavee Point referred to jobs in primary healthcare projects. Members of the Traveller community work between six and 12 hours a week and do not have pensions. We will have to examine how many nurses will be needed to play the critical role between the community and the primary care units, and how much will be needed to fund them. It could mean that more than €10 million will be needed. It is not good enough to have studies, programmes and assessments without getting down to the nitty-gritty and match the needs with money. The responsibility lies with Departments and other bodies.

Chairman: The Deputy is looking for a price tag for closing the health gap between the

general population and Travellers. There were also questions on the terms and conditions of people providing a valuable service in primary healthcare units. Who would like to start to respond to those questions?

Ms Siobhán McArdle: I am happy to start. On the role of support workers, we recognise they are part-time and that there is a barrier to sustaining and retaining people long term in those roles and attracting new people to the role of project workers with respect to the lack of a career structure.

I will hand over to Ms De Brun who will outline the new initiatives being taken to develop a career structure and support people in their education and development in order that we can embed this model in the way primary care services are delivered.

Ms Concepta de Brun: I acknowledge the role Traveller primary health care project workers perform is invaluable. We would not be able to deliver the services without them. The peer support model works. However, as it has developed and grown since 1994, it has been stuck in a social protection, poverty culture. I do not say that lightly. A person would be reluctant to take up a full-time job if it would affect their medical card eligibility. Recent increases in the minimum wage resulted in some workers not having their medical cards renewed because they were over the income threshold. The option for them, therefore, was to reduce their hours and, thus, their income, to retain their medical card or to leave. The infrastructure on which all the successful work has been done proves that it works but it needs investment in planning for the delivery of existing and future services.

Another element to the start of this investment has been our work in partnership with Pavee Point and Maynooth University to deliver pre-capacity training through 100 hours of education. I understand the interviews for members of the Traveller community to participate in that course in the university are taking place today. We are hopeful 15 members of the Traveller community will achieve a FETAC level 5 to level 6 standard in their first year and that this time next year, they will start a FETAC level 8 qualification course. The HSE has committed to finding the people who complete that course meaningful grade 4 minimum salary posts. We ask the committee to examine other Departments and statutory bodies following suit on this as a broader range of posts need to be made available. While we started this process with Maynooth University in providing training in youth and community work through a five-year plan, a big picture approach needs to be taken under the public sector duty heading to ensure Travellers are employed across all Departments and statutory agencies.

It is important all Departments participate in intercultural health and training. The HSE is providing intercultural health, which the Deputy availed of with respect to the south east group. While we offer it, it is not mandatory. However, if one is in any way committed, one will do it.

We have worked closely with the ICGP and the school of nursing and midwifery to ensure culturally appropriate training as well as racism and discrimination training are part of the core curriculum. Those relationships in developing that work date back 20 years. Professionals receive that accredited module when they come into the system but we need to examine if there is more we can do and more we can offer. We are heavily reliant on Traveller and healthcare projects to deliver that training.

Chairman: What is the response from the GP point of view to the price tag question in terms of GPs providing a service they would ideally wish to be able to provide?

Dr. Tony Cox: Addressing the number of GPs is a major priority for us. We have taken 194 young doctors into the four-year GP training programme. We had aimed to take in more than 200 and the ultimate aim in the next one to two years is to take in up to 240 but even if we had 240 doctors in training, that would just about address the turnover. GPs are getting a little older and it is becoming increasingly more challenging to encourage younger GPs to stay in general practice or to work in general practice full-time. They do not seem to like the idea of working in isolated, single-handed practices. Only 2% of them in a recent survey said that this is what they wanted to do. They like to have a blended career where they work in hospitals and universities as well as in general practice. That is a challenge to try to get the number in training up to where it needs to be. We need approximately 5,000 GPs in the GMS. We do not have that; we have approximately 3,500. We have approximately 1,800 practice nurses but we need at least 4,000 and perhaps even 5,000 because a practice nurse is an essential part of the community care team and the practice team.

Reference was made to chronic disease management and asthma, in particular. There is a programme of care for children aged zero to six but that is just a GP visit card that entitles them to the services of a doctor. It does not entitle them to other services outside that. A GP visit card is a bit of a joke in terms of accessing all the services that are needed and to which everyone should have access. That is something we are concerned about. We are trying to set up a practice nurse training programme to encourage more to come into the service and we are trying to establish that with an academic body in Dublin. We approached Sláintecare and the HSE for support on that. We are trying to grow our GP numbers and practice nurse numbers because they are an essential part of the healthcare provision in the community.

As members will probably be aware, there will be a chronic disease management programme for the older age group starting next year. There was a recent agreement in that regard. That is due to launch early in the new year. It is chronic disease management for respiratory disease in general, cardiovascular disease and diabetes. It will start with the over-75s and as the years go by, that will be extended to the lower age groups. The next group will be those aged between 65 and 74 and so on.

Chairman: I thank Dr. Cox very much. The issue with Travellers is that they do not get to older age.

Dr. Tony Cox: No.

Chairman: We need to start earlier. It would be helpful for us to have a quantification of the resources for this group, as sought by Deputy Joan Collins. Perhaps the ICGP could provide the information. Are there any Travellers who are GPs or nurses and are there any measures in place to bridge that gap between people in the profession and those who aspire to get into those lines of work?

Dr. Mary Favier: I will add to what was said about the resourcing issues. For historical and complicated reasons, Travellers tend to congregate and coalesce in their living circumstances in areas that are deprived. That is usually to do with circumstances such as where halting sites are placed or allowed or where they have been illegal. Areas of high urban deprivation have specific needs. There is a very easy win in terms of providing cohorts of funding to those particular general practices. There has been some move towards that in recent funding streams but it needs to be substantially higher. Travellers are part of the population for GPs in areas of blanket deprivation, as opposed to pocket deprivation, and we need to have more GPs in those areas and they need to take more time.

Chairman: Is Dr. Favier suggesting an area-based premium?

Dr. Mary Favier: Exactly. It would allow flexibility of appointments and a little wriggle room. It would allow staff to take more time to fill in the form for patients who do not have literacy skills. There needs to be an understanding and awareness that one just needs to allow a little bit more slack. That is not just the case for Traveller patients but for many patients who are challenged in those areas. More funding would very quickly provide a win-win.

Chairman: Does Dr. Favier wish to comment on the recruitment of people from a Traveller background into medicine and nursing?

Dr. Mary Favier: I have no knowledge of any Traveller doctors or even nurses. It is crying out for that.

Chairman: Are there none?

Dr. Mary Favier: None that I know of. Perhaps others know better.

Ms Breda O'Donoghue: I am aware of Traveller nurses but they do not self-identify for obvious reasons. I do not know of any GPs or doctors.

I wish to respond to what was said about the price tag and the closing of the gap. We have two full-time equivalent primary healthcare workers in Cork city, who work part time. We have four workers who work part time. It is not enough. We are not reaching all of our community and we are not able to do enough for the community. What we have is a good number of people that we have trained over the years who have done development courses but they do not have academic skills that would allow them to go for a job interview. They have not been to UCC. I would always be one to bat for experience. I am referring to where somebody with lived experience of certain circumstances cannot work with people in such circumstances because he or she does not have an academic qualification. For us, that is a major challenge at present.

Chairman: Recognition of experience.

Ms Breda O'Donoghue: Recognition of experience.

Chairman: Maynooth is a good example.

Deputy Joan Collins: Ms O'Donoghue is saying she has four part-time equivalents for two full-time jobs. What does her community need?

Ms Breda O'Donoghue: At least double that.

Deputy Joan Collins: That is what we need to consider.

Chairman: We would be very open to ideas and suggestions from the delegates following today's conversations.

Deputy Éamon Ó Cuív: The first question I have is to seek information. Some like to go to support workers of their own sex when seeking advice and so on. Are there many more women than men acting as Traveller-led support workers? I suspect so. Is it working better with women? Do we need to ensure more men are engaged as support workers to get men to engage? I do not know the answers; I am taking the questions out of the sky. Obviously, we want to get all Travellers to engage with the health services. Is there a disparity between the number of women engaging and the number of men engaging through Traveller-led services?

Is there a disparity between the number of women leading the services and the number of men leading them? We need to examine this. The delegates might tell me whether this is an issue.

I always believe in taking something positive from any meeting. Many very interesting issues can be raised, and many good suggestions have been made. I wish to focus on an issue that keeps coming up, namely, the bureaucracy encountered in gaining access to a medical card. The medical card office is the most unforgiving in the country for anybody dealing with it. It is utterly unforgiving. If one does not answer a letter within a 28-day deadline, one must start all over again on the 29th day. People lose heart as a consequence. Those who are most remote from the system lose heart fastest.

I am interested in getting a little more feedback on the number of Travellers who are issued with letters but who do not act on them because they have moved on or who throw them aside because they are removed from the system. Many people, including settled people, throw them aside also. The more removed a person is from the system, the more likely it is that the letter will be thrown aside as a bother and will be forgotten about. In such circumstances, a person will go to the general practitioner only to be told the card has expired. How significant is this issue?

I will go through all my questions. The second issue I wish to raise concerns the statistics we have been given. They indicate that 13% of Travellers finish secondary school and that 57% of male Travellers only get a primary education. Ordinary literacy skills, such as reading and writing, are an issue. We all come across this. The older the cohort, the greater the issue. It matters when trying to fill out a complicated medical card form and such documentation. Is there information and evidence indicating people simply give up?

I do not believe this has just to do with ordinary literacy skills. We often ignore what I call bureaucratic literacy skills. This involves a higher level of skill. I know a Department that made a very clever move in this regard. Where a form was developed on one side of the Department, clerical officers or executive officers on the other side were asked whether they could fill it out without knowing what it was about. If, with their bureaucratic literacy skills, they could not fill it out, it was no good giving it to a member of the ordinary public, or even a member of the public with third level education. I wonder to what extent there is a problem with the two levels of literary skill. I refer, in particular, to what I call the bureaucratic literary skill, that is, for form filling and so on. I have been contacted by all sorts of people who find filling forms to be increasingly challenging. To what extent is accessing documents a problem? The volume of documentation required nowadays for the simplest tasks is frightening. I spent a fair bit of time yesterday with somebody who wanted a supplementary grant for a house. The person is a Traveller who was trying to provide information. It seems that the system is more concerned with catching one person who might get something he or she should not get than the 1,000 people who might have got that to which they were perfectly entitled but just could not get the paperwork together. Society seems to have become rigid in that regard.

I do not know how many people have studied the medical guidelines, although they may have done if they deal with medical cards. There are two ways in which one can obtain a medical card, the first of which is according to strict financial guidelines. I heard a case yesterday of a 65 year old who happens not to own their own house. A Traveller could own a caravan, however, and would have no rent. The guidelines, even for those over the age of 65 years, specify maximum weekly earnings of €298. Even on jobseeker's allowance, the basic rate is higher than that. I am sure our guests will tell me that without means, one can obtain the card on a concession, but the guideline figures are very low. The normal ways they help people are

with mortgages; rent, although if one has a caravan, that does not count; and childcare, although in some cases the parents take care of the children and do not pay for commercial childcare. The only other way of obtaining a medical card is in the form of a discretionary one, but the applicant will have to be good with a pen to know what is an eligible expense for a discretionary card. I am highlighting the barriers.

When we take it all together, to what extent is the medical card challenge an issue? One receives a nice little plastic card with a date on it. If a credit card has a date, I know that it will be good until then. In the case of a medical card, however, it might specify an expiry date of 2021 but halfway through 2019, I might be told I will be called for a random check. How much of a help would it be if the cards were issued for five years and the expiry date was the expiry date, unless one could be proven to have defrauded on a massive scale one's entitlement to a medical card? As the man says, the medical card is not worth all that much.

The issue of Traveller self-identification was raised. The concept is nice but I can see the layers of bureaucracy that will apply. There are two problems with self-identification, on which I would like our guests' views. People do not necessarily want to self-identify. Some do but others do not. Some are proud but others are not. Some feel cowed because of what life has taught them. The other point is I can imagine the HSE adding another five pages to the forms to tie one up in that regard.

If our guests consider some of the issues I have raised to be valid, would it be worth our while asking the medical card section to appear before the committee and take a grilling on the issues? That is my punchline. Are our guests facing such issues and if so, should we present those issues to representatives of the medical card section? I am sure our guests could raise other issues.

Chairman: The Deputy is reading all our minds. It would be a good idea to make such an invitation and the clerk to the committee and I have discussed it. In the meantime, while we wait for the invitation to be made, could our guests comment on some of the barrier issues, such as to men accessing healthcare and the bureaucratic barrier we have discussed at length?

Dr. Mary Favier: It is well established that all female patients consult their doctor more often than men, whether because of their own health issues or because they bring children and other family members to the doctor. That is particularly true in the Traveller community because there are particular cultural barriers for Traveller men accessing the services. It is an issue of which we must be aware. Those barriers can range from sitting in the waiting room through to, for example, presenting to younger female doctors. Those are cultural issues and it is for us, as GPs, to be aware of those issues, attempt to circumvent them and understand cultural issues around not wishing to present with mental health issues, for instance.

We have recently rolled out a suicide prevention training programme that has involved almost 500 GPs and a particular part of that relates to the increased risk of suicide in the Traveller community and the issues for men presenting with mental health problems.

The access to services and educational opportunities for women in the Traveller community have come on extraordinarily in the past 20 years. There has been a massive change and Traveller men are only starting to catch up from a health point of view, which is to be welcomed.

Bureaucracy issues fall disproportionately on the women because they often have to deal with trying to sort out all the medical cards and keep on the top of the paperwork and appoint-

ments. As GPs, we would value clarification on the medical card issues because patients can present with a valid, brand new plastic card that is not valid. Practices such as ours are long established and we know the patients well so there are many workarounds but in out-of-hours and GP on-call services, that is a fundamental problem. Situations arise where there are tensions around patients presenting without cards, who has a card and who does not, and whether a card is valid. It needs to be sorted out.

The bureaucracy issues apply on so many levels in respect of literacy. There is a need for cultural awareness that form filling should not be done just for the sake of it. The centralisation of services to what we call the offices off the M50 has proved problematic for patients and is challenging for GPs. We meet significant literacy skill issues in the area of health bureaucracy. There are problems that could be quickly solved, which would make everybody happier.

Chairman: It may be helpful for the committee to communicate with the section of the HSE that deals with this. I am always cheered to hear anyone say that an issue would be easy to deal with and that will not only be a recommendation but an action for the committee. I thank Dr. Favier. Would anybody else like to comment on the points made by Deputy Ó Cuív?

Ms Breda O'Donoghue: I echo everything that the Deputy said and multiply it by a thousand. I know of Traveller families whose first child turned 16 and, until then, had been part of the parents' application form. It becomes a whole new ball game and application form at that stage. Every document that is needed has to be copied. It is a frightening and traumatic experience for some Travellers who have no literacy in their family. It is a process that is repeated over and over again.

On the question about support work for Traveller women and men, the Traveller Visibility Group has a Traveller men's health development worker and he has a number of men's groups around the city. There are not as many of those as there are Traveller women's groups but there are some and those men are looking for more information and development courses. Men are still very much behind but, as Dr. Favier said, we are seeing them catch up a bit.

Chairman: Ms O'Donoghue is amplifying the issues around bureaucracy.

Ms Breda O'Donoghue: Absolutely.

Chairman: And the disparities between men and women. As part of the HSE family, does Ms De Brun have any questions or comments?

Ms Concepta de Brun: On the issue of men's health, the majority of the primary healthcare project workers are women. For every four workers, there is probably only one man and even that has only happened in the past five to six years. We have begun to engage with men and get them in the door but we are way behind in comparison with the experience within primary healthcare projects for women Travellers. One is in a situation where one is discussing sensitive information about people's personal lives. One is not just going to go to anybody. We have a situation where we are upskilling and engaging more young Traveller men. We also need the older Traveller men in there but they are a little more difficult to reach. We have not given up and we are trying.

Chairman: What about the medical card?

Ms Concepta de Brun: The Traveller healthcare project workers spend a significant portion of their time assisting families to fill in those forms.

Chairman: Could that time be better spent on other matters?

Ms Concepta de Brun: In my view, anyone filling in a medical card application needs help.

Chairman: It would seem to be wasting valuable GP time as well. There is merit in examining this issue, in particular, and drilling down because of the bureaucracy but also the interface with the Traveller healthcare project workers as well. That is a specific issue.

Ms Siobhán McArdle: One other matter we wanted to speak about was how to engage with older persons. Ms Deirdre O'Reilly has a good example of this in that it is not just gender that can be a barrier but age as well. There is some good work happening in Kerry and in other projects where, having engaged older project workers, they are reaching out to older people and looking at the more specific issues to do with ill health in the older members of the Traveller community.

Ms Deirdre O'Reilly: It is one of the ways in which primary healthcare programmes have been developed. We have a mental health primary healthcare worker in Kerry. It is still true, sadly, that members of the Traveller community do not reach the same age as my father did of 87. The death rate is shocking. In the Kerry project, they have started a small project with one community healthcare worker who is a woman. She is doing community health in a slightly different way. She visits the other people who deem themselves to be the older members of their community. They share information and do many kinds of different things that might have happened in the club in the past. Apparently, this has been quite successful for encouraging people who are not well to go to hospital.

Two male primary healthcare workers also work specifically with national organisations such as Pavee Point looking at the issues facing men's health, how best to respond to that and to support Traveller men.

Chairman: It sounds like there is much good practice out there. It seems to have been upped in scale. We kind of know the answers but it is the scale of the response that needs to be looked at.

Ms Siobhán McArdle: The HSE can always be accused of being bureaucratic but we know what works in the projects. The Traveller health units ensure all information is culturally appropriate, uses plain English and involves service users in the Traveller community in designing forms or information that will help people access health services. This has been found to be successful. We would again like to scale this up and use it in other parts of the health service to ensure people are enabled to access the range of health services.

Deputy Gino Kenny: Over the past ten years, what has been the prevalence in the Traveller community of access to rehabilitation support for substance abuse, in particular alcohol or drugs? I suspect it goes under the radar to a certain degree. Where there is desperation and lack of hope, what usually follows is substance abuse. I can say that from my own experience living in Clondalkin.

Ms Siobhán McArdle: I do not have the statistical data to hand but the Deputy is right that it is one of the causal factors of mental ill health in the Traveller community. Taking a mental health promotion approach, the Small Changes - Big Difference programme has been a positive initiative in the Traveller community and through the Traveller health units to try to address both building awareness of substance abuse and misuse, and the causative relationship to mental health and to more serious addiction issues. Through the national Traveller advisory forum,

there was the development of culturally appropriate mental health materials to support positive mental health initiatives, which would include information on addiction and substance misuse. Over the past two to three years there has been a positive uptake through the project on that and building awareness of the relationship between those behaviours and the impact then on health. I ask Ms de Brun to provide more detail.

Ms Concepta de Brun: There are some details through the national drug treatment centre board data systems, which we could make available to the committee. We do not have them to hand. There is an ethnic identifier. The centre can identify the number of Travellers attending its services, which is to be welcomed.

We rely on local relationships with the drugs task forces to deliver local needs approaches within the services. For example, the drugs task force in Clondalkin has worked very closely with Travellers there to develop a culturally appropriate response to counselling. We hope we will get the money to fund that soon. The background to that is that it is counselling for people who are affected by alcohol and substance misuse in particular. That model represents a local response. We would like to see other Traveller health units engage with their drugs task forces and that moneys for addiction services would be invested in a similar way but we are not there yet.

Chairman: I ask the witnesses to let us know if there is a price tag associated with any of those because we can include those in our deliberations.

Ms Breda O'Donoghue: Our project has a drug and alcohol programme. At least 50% of Traveller men in our area, Cork city, have turned to alcohol and substance misuse. We have made direct links between that and the loss of Traveller culture. Travellers no longer living on halting sites or within the extended families, Travellers who have ended up in homeless services and felt very isolated, and Travellers who are using our service are telling us that their culture has gone and they have nothing to cling on to. All their norms and traditions are gone and substance abuse is making up for that.

We have a brilliant Traveller counselling service. Thomas McCann is a Traveller man who runs a counselling service. Is that the answer? Travellers in general do not use services. I do not know if it is right to provide more services until we know what types of services are needed.

Deputy Fiona O'Loughlin: I apologise for being late. I had the opportunity to read through the documentation prior the meeting. I was held up at a meeting in my constituency. The witnesses are all very welcome. The ongoing engagement is really important.

We have touched on health literacy, something that the Oireachtas Joint Committee on Education and Skills has examined in terms of educational outcomes for vulnerable groups. Representatives of the Traveller community took part in that. In about three weeks time we will also look at issues relating to literacy. We will include health literacy in that, as opposed to just literacy. That is really important. It was really positive to see from the submissions that the Traveller community has workers working so well within the community. They said it was hard to recruit the Traveller health workers although they seem to be doing a really good job. It was very interesting to see that number of Traveller women going for BreastCheck and the test for cervical cancer is far higher than the number in the settled community. Are there lessons to be learned from that about how it was possible to encourage women to go for these important tests that we all need to do? Are there lessons to be applied to other aspects of Traveller health to encourage them to get involved? I take the point that there was more success in respect of

Traveller women's health and those lessons need to be applied to the men.

Ms Concepta de Brun: There are just under 300 Traveller staff employed in the 27 primary healthcare projects and they amount to 69 whole-time equivalent posts. The majority of the workers are on between eight and 12 hours, to retain their medical cards. We take a very proactive approach to health literacy. Most of the work that we do with the Traveller primary healthcare projects is literacy proofed. We work very closely to try to get where possible accreditation through the FETAC system. Much of what we do is rooted in education. We need to be sure that we have the right people at the table when we are developing programmes in partnership with each other. We also call in experts. When we worked with the Asthma Society of Ireland we would have had doctors and nurses and specialists in diabetes at the table. We would not have gone off to do it ourselves.

If there was to be investment in this model because it works, the question would be whether services would need to be enhanced in primary care as well as improving the terms and conditions for the workers and if investment needed for men's health as well because only one-fifth or fewer of those workers are men. It is then a matter of considering the work coming through on mental health, health and well-being and other care groups and how to enhance that work by expanding that model.

Chairman: We would be very happy if Ms De Brun wrote to us as a committee with those proposals because we want to come up with concrete proposals and ideas.

Ms Concepta de Brun: We have a 100% turnout for BreastCheck and cervical screening. Our statistics in the Traveller population are second to none and we are beavering away at the men's screening programme where we have overachieved on our targets this year but we still have more work to do with the Traveller men. That peer support model could easily be replicated for regeneration board areas of deprivation in all urban and rural areas. The peer support model works. Where there are poor health outcomes for other economically disadvantaged groups the learning that the Traveller community has could easily be shared.

Chairman: It is a good model but it needs to be scaled up.

Ms Concepta de Brun: It could be moved into other groups.

Dr. Tony Cox: In response to Deputy Gino Kenny's question about substance misuse and alcohol and drugs, as a GP dealing with a patient who has that dual diagnosis the question is whether it is a mental health or substance abuse problem or a combination of the two. Certainly, the access to services is challenging for GPs, mental health services certainly; if they feel there is a hint of a substance misuse problem they are not really as interested or as engaged as one would want them to be. Accessing addiction services is then very challenging and difficult. The Traveller community and the community in general are resistant to accessing addiction services. As a GP on the ground, I would appeal for more access to addiction services. I really feel that is a challenge and there is a gap there.

Chairman: There are also issues with dual diagnosis.

Senator Jennifer Murnane O'Connor: I apologise for not being present earlier. Several meetings are clashing.

It is great that there is such good feedback on the model. While we all need to ensure there is awareness and information, funding will be the biggest issue. There is a good model that

the witnesses know they can work with and pass on to other counties, but where will the funding come from? Have the witnesses been in talks with the HSE or other agencies? Funding is crucial. Do the witnesses have proposals for this? Have they talked to other agencies about rolling it out across the country?

Ms Siobhán McArdle: The model we described is countrywide. The 27 primary Traveller primary healthcare projects are in every county. There is a Traveller health unit across every part of the CHOs. They were developed initially for primary healthcare, incorporating things like health promotion and accessing GP services. In more recent years we have moved towards looking at specific targeted approaches. For instance, on the basis of the all-Ireland health survey, there have been targeted approaches to identify the chronic health conditions driving morbidity and lowering life expectancy. Even more recently we have looked at mental health.

The challenge is that we are still looking at the same cohort of staff within those projects. The ask for us is investment. Every year we make applications to the Government for expansion of those services. We have seen investment in mental health services for members of the Traveller community, but it is only the start. There is need for further investment to ensure that the good models that work in primary care can be expanded across other care groups to ensure that the different members of the Traveller community - not just the women who are supporting their children's health particularly, but also men and older people in all age groups - are attracted to working within and providing supports for the community.

Senator Jennifer Murnane O'Connor: I understand there is limited funding in certain areas. Many areas are looking for funding and cannot get it even with the existing model. There are different types of models and some areas have more funding than others. It is like everything: funding will go to one area quicker than to another. In my area funding is crucial. Mental health is a major issue as are life expectancy and homelessness - an area I address all the time. We need more funding in these areas; we need more information and awareness. When fighting a case for someone who is homeless, I find there are no extra services for them. We are hitting our heads against a stone wall all the time. I know there is a certain service, but not to the scale needed. Overall, we need to look at funding. We need to look at all the areas that need to be addressed. It is good that it is working in certain areas. I think it is all down to funding, awareness and information.

Ms Breda O'Donoghue: Sometimes it is not about the funding but what can be done with the funding. We are very limited in our project. We work with KPIs. We are very conscious that our funding has to go in certain directions all the time. We no longer feel that is working. We need to be able to branch out into different areas. What we are doing with the primary healthcare programme is great and the care-support workers are brilliant. However, the problem is with what they are limited in doing. That is the challenge for us at the moment.

Senator Jennifer Murnane O'Connor: The witnesses are doing a great job and fair play to them all; it is excellent. Again, it is about everybody working together and information and awareness. It is so important everyone knows we are there to help and that there is information and help there when one needs it. That is what it boils down to.

Chairman: We are coming to the end, but I have a few questions. One question, which is for the Irish College of General Practitioners and the HSE, in particular, is whether you think there is prejudice among HSE staff and GPs towards Travellers. What is your honest opinion on that? What happens when that arises? Are the appropriate measures, such as disciplinary action and so on, followed through?

The second question is a very practical one. We had the Department of Health in two weeks ago, and it said it was down to the HSE to publish the health action plan. Is that the HSE's understanding of that? When is that going to come out?

Do you accept there is a Traveller health crisis? When would you expect Traveller health and the general population's health to be one and the same? Will it be in two years, five years, ten years or 20 years? I do not mind who answers those questions and in what order, but I would like to hear from you all.

Ms Siobhán McArdle: I would hate to think there is prejudice, but I would be realistic in saying that if people who use our health services tell us they feel they face barriers and prejudice, then it is there. At a local level, if that comes back to a public health nurse or people say it is there, there are good local working relationships and generally people will share that experience and it can be addressed at a local level. The training programmes are the key, both in educating our healthcare professionals and in maintaining and ensuring that people are regularly getting cultural awareness training. In terms of data around specific incidence of prejudice, I do not have that data. It is certainly something we can look at.

Chairman: Has anyone ever been sacked because he or sh was racist?

Ms Siobhán McArdle: I could not say. There is legislation to protect against discrimination, and that certainly would be enforced. We would support service users, or any member of the population who experiences prejudice or discrimination in the way they access services, to ensure it is brought to our attention. I do not have that data, but we can certainly find out for the committee if that would be of use. The training approach would be the known way.

Chairman: You think that is the way. What about the health action plan? When will health be at the same level?

Ms Siobhán McArdle: It is a HSE action. It is part of the health actions under the National Traveller and Roma Inclusion Strategy, NTRIS. It is one of 30 actions that are health related. It is at the final stage of preparation, and my understanding is it is due to be published at the end of this year.

Chairman: You have been around the block a long time but in terms of the work, and I am not being in any way ageist, when do you think Traveller health and that of the general population will be comparable?

Ms Siobhán McArdle: I do not have a crystal ball. We know there is a gap, and we know what we need to do to address it. Changes that look at population change, or demographic change, take a longer period of time than three to five years. We are talking about a generation. However, we know specifically the things that need to happen like uptake in engagement with primary care services in terms of managing chronic disease, engaging with the mental health service to be aware of the services that are available and, at the individual level, supporting each individual to access the health services that are needed. After that, what that means for the population, trends and data will tell us, but I suppose the specific focus at the moment is that members of the Traveller community, children, adults and older people, know the services are available to them and that they are enabled and facilitated to access those services.

Chairman: Thank you very much.

Dr. Mary Favier: On the issue of prejudice, it is well established that Travellers experi-

ence prejudice and racism in our society. It is well established that they experience it in all aspects of society, particularly in institutions and in the delivery of care. I am sure it is also their experience in general practice. I would like to think that from a general practice point of view, because we tend to be embedded in communities, we know people for extended periods of time. We know their histories and we know their context and, therefore it is less likely to be an issue, but I cannot say that it does not happen. We need to accept reality and focus on ways that we can potentially change it. In terms of ways we can change it, the committee spoke about the health action plan. We would ask from a general practice point of view that it would be integrated clearly into a primary care and general practice setting and that we would not have this silo, with a glossy brochure, and where implementation would not just be integrated-----

Chairman: Have you been consulted about this?

Dr. Mary Favier: -----into general practice but integrated with the Traveller community in terms of how it perceives that it should be rolled out.

You talked about the statistics and when we can expect health statistics to improve. Our first challenge is to make sure they do not get worse. There has been such a structural undermining of some of the systemic supports, whether it is in the number of primary care workers in the Traveller area, whether it is the medical card issue or whether it is the accommodation crisis. There are statistically more Travellers who are homeless. The number is huge. They all impact in the broadest sense on health outcomes. That is the most important one. I imagine it could be 25 years. Again, I do not have a crystal ball, but it will be incremental, and there has to be an integrated approach.

Chairman: Thank you very much.

Ms Breda O'Donoghue: To answer the first question, yes there is prejudice within practically all services as far as I am concerned. I am speaking as a Traveller woman who has experienced those prejudices. I work in a Traveller organisation and I deal with the community on a daily basis and people tell us that they experience those prejudices.

On the national plan, we have concerns that it does not seem to have a pathway and a structure at the moment. We also think that it can only work if it is in partnership with the likes of the Traveller organisations, the HSE and primary healthcare.

Chairman: What is your impression to date in terms of that partnership?

Ms Breda O'Donoghue: That is exactly what it needs to be, namely, a partnership. People need to have an equal say on yet another programme or plan that is being rolled out and not just to be there. I do not want to sit on another committee as an advisory person. I want to be able to have a say. I want my voice heard at the table, and I want to be able to have a say in the decision that is being made at the end of that meeting. That is what I feel would work and what would help the national health advisory plan to work out and run a lot better.

Chairman: Okay. Dr. Favier said she thought it might be 25 years. How does that sound from your point of view?

Ms Breda O'Donoghue: If it is 25 years, the chances are I will not be alive to see it, so I am hoping it will be a lot sooner than that.

Chairman: There are practical things we can do.

Ms Breda O'Donoghue: Yes, there are. As I said earlier on, we are not reinventing the wheel here. We are 1% of the population. These are very easily fixable issues and problems.

Chairman: That was echoed throughout the presentations. While the facts and figures are stark, there were also very practical ideas and proposals put forward from both sides today, and we would hope to capture that in the report.

Thank you so much for your time this morning. I hope you feel it was well spent. We intend it to be and to act on it in big and small ways.

Deputy Éamon Ó Cuív: You just touched on an issue at the very end and that is that society can be patronising. I have noticed when one is talking about disadvantaged groups that they are often patronised as if they did not have the same latent intelligence that the rest of society has. In certain ways, I have often noticed that they would buy and sell the whole lot of us who are good at pushing pens. Therefore that real partnership is vital because no one knows it like the Traveller community. Nobody has actually walked the walk. The big challenge for us, as settled people, is to ensure that everybody is treated equally and has an equal input, rather than an agency saying that it consulted and heard what people said in a box-ticking exercise. It must be a real partnership. My experience would tell me that is often not the case.

Chairman: We will give the last word to Deputy Ó Cuív; I find it is wise to do that. I thank the Deputy.

The committee will invite representatives of the HSE and Department of Employment Affairs and Social Protection back before the committee under the heading of a different module to talk about the whole issue of medical cards, which came up frequently here and seems to be a practical barrier and one we might be able to do something about. Is that approved? Approved. I thank the members of the committee and our guests for their time and energy.

The joint committee adjourned at 1.05 p.m. until 11 a.m. on Tuesday, 12 November 2019.