



# Rescuing Health

*Ireland as Innovator*

Sean Collins and Team  
30<sup>th</sup> April 2010

## International Context

*“In 2010, Ireland budgets to spend 42% of its entire income on illness care... and according to current science, a minimum of 20% or €3 billion<sup>1</sup> of this will be spent on ‘preventable’ illness”*

*More than 20 years ago, the American Surgeon General's report on Nutrition and Health (1987) asserted that at least half of all deaths in the USA were related to faulty diet and stated: "... the convergence of similar dietary recommendations that apply to prevention of multiple chronic diseases. Diseases of nutritional deficiencies have declined and have been replaced by diseases of dietary excesses and imbalances- problems that now rank among the leading causes of illness and death, touch the lives of most Americans, and generate substantial health care costs."*

Professor Karol Sikora stated: *“The combination of aging populations, technological progress and an informed, demanding clientele will result in increasing financial strain in all healthcare environments. Predominantly tax based systems, such as Britain’s NHS, are particularly vulnerable to meltdown unless new approaches can be found to return people to health with simpler and cheaper holistic strategies.”*  
(Professor Sikora is Dean of the Buckingham University Medical School and Director of Cancer Partners UK and Professor of Cancer Medicine, Hammersmith Hospital, London.)

*In 2009 President Barack Obama reminded Americans that "we've got to have the American people doing something about their own [health] care."*

*US HHS Secretary Kathleen Sebelius repeated the refrain: "personal responsibility extends to lifestyle; that in order to have a healthier America, a more productive America, we need to make some basic changes in what we eat, how much we exercise, getting our kids up off the couch, turning off the video games." <sup>2</sup>*

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<sup>1</sup> <http://www.budget.gov.ie/Budgets/2010/Documents/whitepaperfin2010.pdf>

<sup>2</sup> [www.pr-inside.com/personal-responsibility-coming-to-health-r1398033.htm](http://www.pr-inside.com/personal-responsibility-coming-to-health-r1398033.htm)

## Concept Summary

The core theme of this initiative is the eradication of *preventable* diseases..... because they are avoidable, we know how to prevent them, they destroy people's lives....and we can no longer afford to pay for them.

## Proposal

- That Ireland adopt an innovative strategy in tackling *preventable illnesses* by calling for engagement by the population with established science-based healthcare recommendations and connecting actions to consequences..
- Within twelve months from the adopting of this proposal, to introduce a national *Participating in Health* Contract with citizens (See Appendix 1, pp 23) based on established scientific health norms and lifestyle medicine research.
- Within six months, to establish a self-financing *Participating in Health* 'Verification' system
- Introduce a 'Mentoring' and education programme specifically to address *preventable* illnesses using creative dedicated media (specialist trainer, internet, radio and TV).
- As this is a global problem, to engage with a major international research partner, to carry out a 5 year controlled study to validate the effectiveness of evidence-based lifestyle medicine in the treatment and eradication of *preventable* lifestyle diseases in Ireland using matched controls from the partner nation.
- As this country currently has a significant and growing *preventable* illness problem, as a relatively small adaptable country, we believe Ireland is uniquely suited to address this. In view of the rapidly increasing numbers of patients here with Type 2 Diabetes, heart-disease, obesity and *preventable* cancers conditions set against our dwindling financial resources, now is the perfect time.

## Benefits

- Eradicate the initiation of *preventable* diseases within 5 years, stabilise patients already dealing with *preventable* diseases and improve the health of the nation as a whole.
- Achieve a minimum of €3 billion in *annual* savings in the Irish healthcare budget within 5 years and deliver approx. 3,200 sustainable self-funding community-based jobs immediately.
- Within 2 years, to substantially improve the quality, availability and access to public healthcare and restore fairness to the Irish healthcare system for the deserving, the children, the elderly and the vulnerable.
- Re-establish Ireland's reputation as an innovative leader on the world stage in tackling and developing effective solutions for an identified significant global problem.
- Re-brand Ireland as a world centre of excellence in the development and application of science in healthcare.
- Facilitate a substantial reduction in private health insurance premiums within two years thereby restoring affordability, stabilising the private health insurance industry and firewalling the financial and disease tsunami that threatens our future.

## Introduction

‘Your Country, Your Call’ was conceived to ‘ignite imaginations and inspire thinking’. The *Health and Sport* Category asked for a transformational project involving “*Living well, keeping fit for life, and applying science to our lives*”.

This submission will describe an important aspect of Irish life, incurring ever escalating and unaffordable expenditure, where science has yet to be comprehensively applied and which, when corrected, offers wide-ranging and substantial benefits and opportunities including improved health, financial savings, jobs, economic stimulation, fairness and international credibility.

## The Problem

### Ireland’s Health Dilemma

Healthcare costs in Ireland have spiralled upwards over the past ten years. From 1998 to 2010, expenditure rose from €3 billion to €15 billion and is now budgeted to consume over 40% of Ireland’s national income.

An A&E consultant on the RTE Frontline programme with Pat Kenny<sup>3</sup> recently delivered a telling indictment:

“Most avoidable (*preventable*) deaths are felt to occur in our overcrowded bigger emergency departments, the central emergency departments... and the problem as far as I’m concerned, is not just the avoidable deaths (because they are less than only 1 or 2%). We believe, or most emergency medicine consultants believe that a majority of avoidable deaths are occurring *because* of overcrowding in our larger emergency departments. It’s not just about time-critical life or death stuff. It’s the brutality of our emergency departments that matters both to the staff and the patients. It is the brutalising conditions... ..Things are going into meltdown!”

Sara Burke (Health Policy analyst) panellist on the same programme stated “A&E is symptomatic of problems across the health system, not just hospitals.”

The only options in resolving overcrowding are to provide more facilities (obviously impossible due to budget constraints) or reduce the patient load... and this is what this proposal will describe... an evidence-based and fair mechanism to successfully address this in a relatively short period of time.

As well as A&E problems, Ireland struggles with soaring levels of *preventable* diseases including obesity, vascular diseases, Type 2 Diabetes and certain cancers.

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<sup>3</sup> RTE 29<sup>th</sup> March 2010

We believe that part of the problem of addressing *preventable* illnesses lies with our health agencies trying to provide subsidised, free, or insured healthcare to *all* citizens on an *unconditional* basis, regardless of whether those citizens adhere to or followed science-based recommended health guidelines. The solution to this problem lies readily within our sphere of influence.

### ***Preventable* Illnesses – An International Phenomenon<sup>4</sup>**

According the World Health Organisation (WHO), seven of the top twelve leading risks to health - high blood pressure, high cholesterol, obesity, physical inactivity and insufficient consumption of fruits and vegetables - together with alcohol abuse and smoking, account for more than *half* of the global burden of disease.

Five out of the ten leading global disease burden risk factors identified by WHO Health Report 2002 are strongly related to diet and physical activity. Together with excess alcohol and tobacco use, these *preventable* risks play a key role in the development of chronic diseases, which frequently involve overlapping risk factors and chronic conditions. Ireland has been matching the trends evidenced in most other developed countries.

WHO states “**There is good evidence that a change in dietary habits, physical activity and tobacco control can produce *rapid* changes in population risk factors and disease-burden prevalence for these chronic diseases!**”

There is a consensus among the specialist support groups, relating to cancer, vascular disease and Type 2 Diabetes, that anywhere from 40-60% of these conditions are lifestyle in origin and therefore potentially *preventable*.

### ***Preventable* Illnesses and their Origins**

*Preventable* illnesses might be described as those which scientific research has shown, in the main, to be capable of being prevented or avoided by daily lifestyle choices and behaviours of the individual. Whilst the causes of these diseases are complex, most scientists agree that they originate, with few exceptions, from lifestyle factors including tobacco, alcohol/substance abuse, sedentary lifestyle/lack of physical exercise, excess processed foods diets, low consumption of fruit and vegetable, excess consumption of unhealthy fats and sugars, chronic stressful lifestyle and to a far lesser extent, genes.

Bald tires don't cause accidents...unless they happen to coincide with a wet road, high speed, a moment's inattention and a child running from behind a car. In general, no single element can be said definitively to have caused the accident. However, when elements interact as negative co-factors, you have a disaster.

Unlike the flu or a cold, with few exceptions, people don't 'catch' heart disease, Type 2 Diabetes, obesity or most cancers. These evolve progressively over a 10-30 year timescale and generally develop from the compounding of the consequences of countless micro-moments of indecision such as: “Will I have a second helping...or

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<sup>4</sup> <http://www.who.int/dietphysicalactivity/publications/facts/riskfactors/en/>

have I had enough?”, “I’m peckish. Will I have a burger...or an apple? “Will I have a cigarette...or will I stop today once and for all?”, “Will I watch TV...or go for a walk or to the gym?”, “Will I wear sunscreen...or risk it today?”, “Will I wear a condom...or risk unprotected sex?”, “Will I buy little Johnny that packet of crisps...or some fruit?” and so on.

This document suggests that the genesis of *preventable illness* lies in what triggers someone to make healthy micro-decisions...or not? Psychologists agree that, on balance, decision conflicts are decided by the attraction of potential pleasure...or the threat of significant pain... and/or by habits.

The financial crisis and forced reallocations of healthcare in Ireland has even resulted in potential conflicts with the Constitution of Ireland.

Section 4, paragraph 1: “The State pledges itself to safeguard with *especial care* the economic interests of the *weaker* sections of the community, and, where necessary, to contribute to the support of the infirm, the widow, the orphan, and the aged.”

However, particularly since the onset of the recession, the HSE has been struggling to maintain medical services for those affected by *preventable* illnesses, but in the process, have been forced to reduce or compromise health services to the vulnerable! We believe the only person with the capacity to positively influence micro decisions affecting health is the individual themselves provided they have the motivation and supports.

### **Health Predisposition**

Fortunately, the human body is predisposed towards automated health and recovery. Minor ailments, and even sometime major illnesses, generally resolve themselves when provided with an optimum physical and psychological environment. It is over 20 years since Dr Dean Ornish, M.D. published the results of scientific landmark studies in *Lancet*<sup>5</sup> and other medical journals demonstrating unequivocally that when patients with established heart disease engaged in a low fat, moderate exercise, reduced stress lifestyle, they could, in most cases, halt and in many cases, actually reverse established heart disease. More recently in 2005, his team further demonstrated stabilisation and reversal of prostate cancer<sup>6</sup> (with obvious implications for other hormone based diseases such as breast cancers!).

Yale Surgeon Caldwell Esselstyn published similar results in the *American Journal of Cardiology* in 1999<sup>7</sup>. Reported in the August 2006 issue of *Diabetes Care*, a National Institute of Health (NIH) funded study found Dr. Neal Barnard’s lifestyle program to be three times more effective than the American Diabetes Association

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<sup>5</sup> Ornish D, et al. 1990. Can lifestyle changes reverse coronary heart disease? The Lifestyle Heart Trial. *Lancet* 336(8708):129-33

<sup>6</sup> ] Ornish D, et al. 2005. Intensive lifestyle changes may affect the progression of prostate cancer. *Journal of Urology*. 174:1065-70.

<sup>7</sup> Esselstyn CB Jr. Updating a 12 -Year Experience With Arrest and Reversal Therapy for Coronary Heart Disease (An Overdue Requiem for Palliative Cardiology) *The Am J of Cardiology* 1999 August 1; 84:339-341

dietary guidelines at controlling blood sugar. Another study by the Finnish Diabetes Prevention Study Group lead by Jaakko Tuomilehto, M.D. (published in 2001 in the *New England Journal of Medicine*) described a similar effective programme for preventing diabetes.

The 2009 Nobel Prize for Medicine went to Dr. Elizabeth Blackburn for discoveries regarding telomeres (markers of ageing). Following delivery of a three-day intensive education seminar, Dr Ornish tracked patients with slow-growing prostate cancers. These men learned to eat differently, take moderate exercise and manage stress with relaxation methods such as yoga, breathing exercises or meditation at least six days a week. After three months, these men who learned to take charge of their own health saw a 30 percent increase in the activity of telomerase -- the enzyme which increases the life-span of chromosomes and cells with obvious implications for patient longevity.<sup>8</sup>

Replicated published science has shown that in most cases, lifestyle medicine, if applied rigorously, can produced significant results within ninety days!

### **Motivation and Lifestyle Changes**

People will generally do far more to avoid pain than to gain pleasure. Unless the threat of pain is substantial or imminent, human nature is to assume ‘It won’t happen to me...I’ll get away with it this time’ or go into denial. Until wheel clamps appeared on the streets and vehicle were physically removed, parking spaces were unavailable on St Stephen’s Green in Dublin... or in many cities in Ireland. Parking tickets fluttered like daffodils on the windscreens. Until plastic bags cost 25 cents, they were thrown away. Until smoking was banned in the work place and a publican could be fined €3,000 for that cigarette, smoking didn’t stop in pubs... or offices. As soon as accumulating traffic points could lead to the loss of a driving licence, speeding curtailed! The same occurred with drink driving.

Until a ‘no nonsense’ approach was adopted, the needs and rights of the majority were subjugated to those of the few. Ultimately what changed people’s behaviours was the system calling a halt and connecting actions to consequences.

In the now famous words of Michael O’Leary of Ryanair: “What part of non-transferable, non-refundable do you not understand!”

### **Procrastination**

A difficulty in human motivation is any delay or disconnection between such actions and consequences. One cigarette doesn’t cause cancer. Speeding doesn’t necessarily cause an accident. A cheese pizza won’t make you fat. It is only when combined with repetition, passing of time and factors including genes and health status that they become significant in the development of *preventable* diseases. Credit cards do the same with money. The ‘pain’ of paying is pushed off into the (preferably distant) future. This disconnection facilitates procrastination in changing lifestyle or making

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<sup>8</sup> Ornish, D., et al., Increased telomerase activity and comprehensive lifestyle changes: a pilot study. *The Lancet Oncology*, 2008: p. doi:10.1016/S1470-2045(08)70234-1.

different daily health choices and decisions....today! Instead we have...“I’ll do it after Christmas” or “When the kids finish school” One more cigarette or pizza won’t make a difference!

However, given adequate motivation, this type of challenge has already been shown to be correctable here in Ireland. A majority of Irish people are required to pay for their dental care. Consequently, they take good care of their teeth. The potential for pain, both physical and financial, resulting from ignoring science, has loomed large in successfully motivating transformed behaviours!

### **Attempting the Impossible**

For decades, countries including Ireland, the USA and the United Kingdom have tried to provide healthcare entitlement as a ‘right’ to their citizens. Each General Election in Ireland brought ever greater promises of “Healthcare for all – Insurance cover for all”. Despite our current financial crisis, political parties are already feeling the pressure to promise even more... and it is here that we come to the crux of the matter; ultimately health cover is insurance cover..... and has to be paid for.

Even though we have seen attempts at providing *unconditional* healthcare potentially bankrupting major developed countries and large organisations, we persist in forging ahead. Some years back, Howard Schultz, Chairman of the giant global coffee chain Starbucks reported that his company faced double-digit health insurance costs, expecting to spend \$200 million on health care just for its U.S. employees — more than the total amount it was spending on coffee!<sup>9</sup> General Motors Corp. chairman and chief executive G. Richard Wagoner in 2005 reported \$1,500 as being the amount of money added to the price of every single vehicle to cover health care.... graphically detailing how rising medical bills were eating into his company's bottom line and ultimately threatening the viability of his and many other major U.S. firms.

In Ireland, attempts to offer *unconditional* health insurance have only resulted in soaring medical costs, long waiting list for important treatments, the elderly and the sick left waiting in hospital corridors. Scarce and vital resources for conditions including mental and physical disability, Cystic Fibrosis, Motor Neuron Disease, etc. have been siphoned away or rationed. Similarly care for the elderly has being curtailed. The injustice here is well described in the lyrics of the Christy Moore song *Motherland*<sup>10</sup> describing the “the nameless, the innocent and the blameless” being asked to pay for the consequences of “the lust and the avarice, the bottomless cavernous greed”. There has never been, nor will there ever be, a justification to push a vulnerable person out of the way to demand treatment for a preventable condition!

### **Insurance Concepts**

Insurance is a risk management strategy primarily used to hedge against the risk of contingent loss. It is defined as the ‘equitable transfer of the risk of a loss, from one entity to another, in exchange for a premium, and can be thought of as a guaranteed and known small loss to prevent a large, possibly devastating loss’.

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<sup>9</sup> [www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?DR\\_ID=32603](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=32603)

<sup>10</sup> by Natalie Mercant

***Preventable illnesses do NOT meet the criteria for insurance!***

Core principles of an insurance contract are:

**Indemnity** – Insurance is a contract of indemnity, where the insurance company indemnifies the insured, against certain risks, for a consideration known as premium.

**Utmost good faith** – means that the insured and the insurance company will not wilfully *hide* anything from each other.

**Mitigation** – means the insured will *behave responsibly* and will take due care so that the risk of loss or the loss is minimized.

Well intentioned as attempts by successive governments have been to offer free health cover for all, insurance was never intended to enable people to ignore medical and scientific recommendations (including those relating to tobacco and alcohol use, diet, exercise or stress management).

Ireland would never dream of offering *unconditional* motor insurance to its citizens. Why? Because we have no control over a driver's day to day behaviours. Society requires NCT testing to ensure roadworthiness, driver testing to ensure competence, adherence to the Rules of the Road, sobriety and so on. We demand that drivers secure their own motor insurance, recognising that one of the key motivators towards safe driving is the threat of increased premiums by accumulating penalty points, etc. Insurance is meant to be affordable for safe drivers...and very expensive for reckless drivers! In summary, insurance can only ever be intended for those unpredictable catastrophic events which, on balance of probability, might not be reasonable anticipated...and never for *preventable* events!

**Suppressing Motivation – The Dark Side?**

Intuitively *unconditional* healthcare seems like a good thing. It has proven popular at ballot boxes the world over. On the 23<sup>rd</sup> of March 2010, President Obama signed into law a new health bill in the US, bringing many more Americans into the health insurance net. The most common (and possibly valid) criticism of this measure was “Who is going to pay for all this?” Based on recent history in western healthcare, the only conclusion can be that medical costs will continue to escalate and premiums will become even less unaffordable (as has been happening here in Ireland). This issue may well threaten a second term for President Obama!

The dark side of *unconditional* healthcare is that, by failing to attach conditions to personal healthcare, society has inadvertently removed one of the *prime* motivating factors that strongly influences those micro-moment of indecision mentioned earlier. People are allowed to sustain the delusion “Even if things go wrong, medicine will weave its magic... or, at the very least, someone else will pick up the tab!”

The first clue a person should receive of a major lifestyle based *preventable* illness should NOT be a diagnosis (often irrevocable) of that condition. Current healthcare entitlement strategy inadvertently facilitates such denial! Apart from the devastation these illnesses bring into people's lives, the medical and financial costs of these to both families and the State are overwhelming and unsustainable.

Entering into a formal contract with the State and agreeing to engage with and follow evidence-based scientific health guidelines in order to qualify for public healthcare ...or alternatively opting out and agreeing to fund one's own healthcare, is a *mind-focussing* event and offers a highly potent motivator in terms of changing personal lifestyle decisions, and thereby halting *preventable* illness at its source.

## A New Solution

### ***Participating in Health Contract***

This document proposes the introduction of a new formal contract between the State and its citizens whereby those wishing to qualify to have access to the public health purse would be required to agree to follow internationally accepted personal health guidelines (see Appendix 1, pp 23) and to evidence such efforts. Citizens who would opt out, or to choose to disregard such health guidelines, would be free to do so, but would be expected to carry adequate insurance to cover the eventuality of their requiring medical care, specifically in relation to their increased risk for *preventable* illnesses.

Following an initial notice period of 12 months to allow for clarification, education and discussion, interested people would be invited to sign up to the Contract. Apart from those 'exempt' and automatically covered under this proposal (see Appendix 4, pp 25), those signing a contract with the State would agree to follow health guidelines and to work proactively towards achieving internationally agreed health norms. They would also agree to evidence this through a national health markers Verification scheme. In return, the State would provide them with health insurance to cover their reasonable medical expenses.

To ensure nobody was left untreated, if a person, having opted out...or by materially breaching their contract having forfeited their *health participation* status, found themselves lacking the funds to pay for their own illness care, a special National Reserve Fund would loan them the funds (at normal interest rates) to pay for their medical expenses. In the event of a person being without assets or means, they would be expected to give equivalent value back in community services. This is deemed inherently fair in that they would have had at least one year prior notice in which to inform themselves about the *Participating in Health* scheme...and how to qualify for medical cover.

### **Verification**

What psychologists describe as the Hawthorn Effect<sup>11</sup> says that what is measured, changes. As mentioned, this initiative proposes an independent verification system so that people might authenticate their *Participating in Health* status on a regular basis by confirming certain basic health measures adherence (see Appendix 8, pp 27).

Such verification would then allow the Irish State to go to the international health insurance industry saying “We have 3 million people, with this age profile, with this range of known pre-existing conditions, all of whom are contracted to follow agreed science-based health guidelines and to evidence same. Please give us your best price to cover all of them!” This would then allow insurers to work with calculable risks, offer competitive pricing and ensure equitable health cover for all.

Those choosing to opt out would pay insurance premiums commensurate with their chosen lifestyle/risk profile, thereby correcting the existing inequity.

### **Doing the Minimum**

In this national emergency, it seems reasonable to ask people do their *absolute best* to support their country, in ways that lie within their capability, and in an area from which they potentially will derive considerable benefit. Nobody who excels in sport does so by doing ‘the minimum’. They study the science and apply it rigorously. Even Nelson Mandela, in his autobiography *Long Walk to Freedom*, described spending an hour a day in his prison cell running on the spot and doing calisthenics to maintain his physical and mental wellbeing. Health excellence is about doing all that is possible, within one’s capability. Linus Pauling said “No evidence compels the conclusion that the minimum required... comes close to the optimum of anything that sustains good health!”<sup>12</sup>

## **Creating Jobs**

### **Verifications Centres**

Based on the assumptions set out in Appendix 28 (pp 40), initially it is proposed to establish approximately 1,200 verification centres based in cities and towns throughout Ireland. People entering into the *Participating in Health* Contract would attend at such a centre, verify their identity and sign a legal contract with the State. They would also provide basic health information (see Appendix 8, see pp 27) including weight, height, blood pressure, waist measurement, etc. (all of which measures are capable of being noted and recorded by trained non-medical staff). This information would also be recorded centrally and confidentially.

Each person would then receive a written confirmation of their Contract and verification of their *Participating in Health* status. Participants would pay a verification fee of €40 for adults and €15 for children. (For safety reasons, young children might be separately verified at a GP’s surgery.) It is assumed such suitable

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<sup>11</sup> [http://en.wikipedia.org/wiki/Hawthorne\\_effect](http://en.wikipedia.org/wiki/Hawthorne_effect)

<sup>12</sup> Pauling, L., *How To Live Longer And Feel Better*, Pub. Avon Books 1987, at p.4.)

verifiers could be recruited from the ranks of the unemployed and trained for the task. To comply with public service recruitment restrictions, it is proposed that Verifiers would be trained independent contractors (possibly trained by FAS, the national training agency), licensed for a period of 4 years, after which time they could tender for renewal of their area contract.

### **Health Mentoring**

It is also proposed that each Verifier would work with another person known as a Health Mentor (see Appendix 7, pp 27 ). Their job would be to a) witness the signing of the *Participating in Health* Contract, b) confirm the accuracy of information recorded and c) to provide information to clients on health-creation resources available (both from media and/or locally). This mentoring programme would deliver approximately a further 1,200 new jobs, again nationally distributed within the community. The status of such mentors would similarly be as independent contractors, licensed for a period of 4 years, after which time they could tender for renewal of their area contract. They would be paid from the verification fees.

### **Administration & Management Jobs**

The scale verification fees already described would allow for payment of approx. €35,000 p.a. to each of the two personnel at each centre, leaving approximately €800 p.w. to pay for the running and administration costs of the centre. It is further envisaged that approximately 800 additional jobs would be created in central management, administration, IT and security, with these positions also being similarly based on a 4 year contract and funded via a charge on each centre of approximately €400 per week per centre.

### **Initial Savings**

On the assumption that these 3,200 self-funding permanent jobs would be filled from the ranks of the currently unemployed, this would save in the region of €50 million p.a. for the exchequer.

### **Credibility**

The Irish government proposes that we borrow €20-25 billion each year for the next 5 years to fund the re-stabilisation of our economy. In this context, is it credible for us to claim we mean business, if, quite apart from the human misery resulting, we persist on spending €3-5 billion a year on *preventable* illness? Conversely, what will it say to the international community about the seriousness of our intent when we deal with this unnecessary haemorrhage of both human and financial resources?

### **Appropriate Medical Insurance**

Actuaries deal with the financial implications of risk and uncertainty. They mathematically calculate the likelihood of events and quantify the contingent outcomes in order to minimize losses associated with undesirable events. An Irish actuarial group could readily calculate what level of premiums a person who follows science based recommendations might reasonably be asked to pay to cover the probability of illness and its costs. Similarly, they could calculate premium levels for those who might decide *not* to follow science based lifestyle recommendations. Once people have been give reasonable notice and support, it is then simple to appropriately allocate the cost of *preventable* illness care to where it belongs.

### **Twelve Months Notice**

Following an education, support system and grace period of 12 months, nobody would have any excuse for ignoring scientific lifestyle recommendations. They would have been given the reasonable option to engage into....or opt out of the *Participating in Health* project.

This proposed reconfiguration of health policy will ensure improved health, fairness and extra resources becoming available for those unable to care for themselves and/or who are entirely blameless for their condition. A 'No fault' clause under this programme would mean that, whatever someone's lifestyle was prior to these measures, no blame or fault would attach provided they had signed up to working towards *Participating in Health* status. Once the programme is fully rolled out and following the grace period, every capable citizen would be deemed to have become personally responsible for their lifestyle actions and their consequences.

Ireland can be the very first country to call a halt to the provision of free or subsidised healthcare to those who choose to ignore international science based health recommendations. Doing so will enable the State to meet its constitutional and moral obligations to prioritise the provision of medical services to the vulnerable, the deserving and the needy and dramatically reduce expenditure.

This country can be the first to require that those who choose to disregard science based health recommendations must personally fund health insurance policies to specifically cover the consequences of their decisions.

This single statement of policy will catapult Ireland to the centre of world attention.

## **Related Issues**

### **Is this Reasonable?**

At a time of scarce resources, is it reasonable to ask people who want access to the public health purse to a) inform themselves about personal healthcare and b) take all reasonable science based steps to eliminate known health risks?

This document advances the principle that *access* to healthcare is everyone's birthright in this democracy. However as already stated, such access should *not* be at the expense of deserving, the vulnerable and the needy. Wheelchair bound athletes in the Special Olympics have demonstrated what is possible in humans when there is motivation and determination.

### **National Health Education and Promotion Medium**

Given the financial and logistical problems facing Irish healthcare, concurrent with the introduction of the new health mentoring programme, it is proposed that Ireland introduces a science-based health education medium. Many major international universities already provide free health programming to enable ordinary people to inform themselves about the origins of *preventable* illnesses, and effective means of avoiding these. The same resources are potentially available for prioritisation and delivery by our own universities.

With so much of our national income being spent on illness care and a significant proportion of that being spent on *preventable* or 'discretionary' diseases, quite apart from this particular proposal, is this not a time to gather a national taskforce from within our academic resources to staunch this haemorrhage?

The provision of specific and science-based information by the State, promoted via the health mentoring programme already described, removes the "I didn't know" excuse from people. The costs of such a TV, Radio or Internet based channel could substantially be self-funded by advertising and sponsorship from organisations in health related industries including health promotion, healthy foods, sports, gyms, fitness centres, etc.

### **International Lifestyle Medicine Study Partner - Ireland as a 'Framingham'**

As this is a global problem, it is also proposed that Ireland engage with a substantial international research partner to conduct a 5 year study to validate the effectiveness of evidence-based lifestyle medicine in the treatment and eradication of *preventable* lifestyle diseases in Ireland using matched controls from the partner nation.

This would be similar to The Framingham Heart Study in the US which is a long-term ongoing cardiovascular research project on the residents of the town of Framingham, Massachusetts. The study began in 1948 with 5,209 adult subjects from Framingham, and is now on its third generation of participants. Prior to it, almost nothing was known about the origins of hypertensive or arteriosclerotic cardiovascular disease. Much of the now-common knowledge concerning heart disease, such as the effects of diet, exercise, and common medications such as aspirin, is based on this longitudinal study. It is a project of the National Heart, Lung, and Blood Institute, in collaboration, since 1971, with Boston University.

As *preventable* illness poses similar problems globally, this offers an astonishing opportunity for Ireland. The preliminary research work is already done. Whether we like it or not, Ireland has no choice but to reduce expenditure and to deal with its '*preventable*' illness problem. Five years from now, if we are still producing fresh cohorts of patients with *preventable* illnesses (perhaps 100,000 additionally each year), at that juncture, our national borrowing capacity will have been exhausted and we will NOT have the money to treat them. Ireland will have another major crisis. We are small enough to be able to prove that these conditions can be halted... and big enough to 'evidence' what can be done.

We can view the cessation of *preventable* illness as an insurmountable problem.... **or as possibly one of the greatest opportunities of the 21st century!**

In looking to address this problem, what the international health research community currently lacks is a large scale controlled study to validate existing findings concerning the effectiveness of lifestyle medicine before implementing them on a large scale in their home countries. The data from such a study in Ireland, with matched controls in another country, rigorously supervised by an international group of eminent scientists, would provide the rationale and justification for changes in much large countries such as the USA or UK.

Right from the end of the first year, data would be reported in real time, with live access to the health markers of the nation and also individual counties (adjusting constantly with data coming from the validation centres) and accessible on the internet. This would also provide an early warning system for the Irish health authorities of future illness crises *before* they occur. This would also make personal healthcare a matter of national and county pride....and foster healthy competition (and fun)!

From this study would emerge effective protocols with obvious potential application in other countries. As the need to stem the tide of *preventable* illness is common to all Western countries, as mentioned, it would be vital that such a study would include matched controls from the study partner nation.

#### **Motivation for a Study Partner**

It is impossible for health agencies in a large country such as the US or UK, to propose something on this scale without substantial evidence of efficacy. Ireland cannot afford what it is currently doing, let alone fund the future. We can confront the problem of *preventable* illness as a considered decision, and get the international kudos for doing so.... or we can be forced to do by the circumstances of running out of money. If we will have to do it anyway, we can decide to do it at a time of our choosing and in a manner that serves us. There is considerable potential benefit for us in entering into such a research agreement. The eyes of the developed world would rest on Ireland for the next 5 years.

The development by our academic community of evidence-based effective protocols capable of successfully addressing the global '*preventable* illness' problem would not only result in furthering Ireland's interests abroad but also potentially stimulate health tourism in the future.

Nobody has done this before with a country. Ireland has the potential at minimal costs and with support from a large international partner, to become the *Framingham of Preventable* Illness, thereby placing it centre stage.

## **Extra Benefits**

### **Private Health Insurance in Ireland**

This sector has seen premiums rising at an intolerable rate. Since the global financial downturn, people are dropping private health insurance and shifting to reliance on the public health sector. In turn, this has forced insurers to raise premiums for remaining clients, driving even more people into the public health sector!

When implemented, this proposal can enable private health insurers to adopt a 'no nonsense' approach with customers. They can insist on adherence to science-based personal health guidelines from their customers as a prerequisite to providing economic health cover. By doing so, they can stabilise their own finances and regain the ability to profitably offer reasonable premiums.

Customers opting out would pay proportionally more for that privilege and pay the 'real' cost of covering their lifestyle choices.

Historically we have been paying €16 billion p.a. for our healthcare (or somewhere about €3,800 p.a. for every man, woman and child in the country!). If someone can buy private health cover from VHI for €1,200, why are we not insuring the nation with the international insurance market? What blocks this is the contradiction of trying to provide insurance...without conditions.... An obvious impossibility!

### **Support as Part of the Ultimate Solution**

Psychologists agree that most destructive lifestyle behaviours are, in fact, maladaptive coping strategies attempting to deal with modern challenges of poverty, injustice, unemployment, poor self-esteem, isolation, depression, unhappiness, loneliness, boredom and so on. A key part of the mission of this project must be for our academic teams to develop and facilitate more effective and creative ways to support people in developing the skills to cope effectively with these issues, and in the process, bring more happiness into their lives..

### **The Future Tide of *Preventable* Illness**

Closely related to the concepts in this proposal is the reality that with more than 370,000 unemployed, many people are experiencing chronic stress. Apart from unemployment and money problems, these stressors include dysfunctional relationships, negative equity, repossessions and so on. Common responses include dropping regular exercise/gym memberships, eating cheaper more processed low quality foods, less fruit and vegetables, watching more TV, depression, late stage evaluation of medical conditions, discontinued health insurance, substance abuse.... all of which sow the seeds of a future disease tsunami and further unaffordable health costs. This proposition can contribute to preventing such a future wave before it forms by proactively engaging and encouraging people in their own health care.

### **The National Psyche**

In recent years, the Irish have received repeated and sustained blows to their national pride and self-belief. They have witnessed what seems like an endless stream of abuse, dishonesty, cronyism, duplicity and corruption. Many people, especially older citizens, are fearful regarding future availability of healthcare. An endeavour such as

this offers tangible practical ways for Irish people to engage, deliver results in 3-5 years, show what Ireland can do, help restore self respect and change our children's future for the better.

### **Stemming 'Brain Drain' Emigration**

Many young graduates have already left in the past year. Others are voicing their unwillingness to wait around to pay massive future taxes and national loan repayments for, as they see it, the 'sins of reckless parents'. In particular, they will not want to pay the medical costs of an ageing population with '*preventable*' illnesses. The *Participating in Health* Contract can demonstrate to them evidence of a fresh new culture, of people pulling their weight, paying their fair share and rewarding effort thereby, making Ireland a more attractive place for them to live in the future.

### **Inward Investment**

As a small nation, Ireland will require substantial inward investment to survive and thrive in the future. Such inward investment depends, not just on the quality of graduates and general workforce, but also on the economics of doing business here. Unless the cost of both national and individual healthcare is brought under control, yet another factor will be thrown (unnecessarily) into the mix of discouraging future inward investment.

### **Health Care in the Context of Ireland's Economy**

The so called Celtic Tiger was based substantially on 'bubble' and 'windfall' economics (stamp duty on property, VAT and income taxes on construction, etc.) which most commentators agree is not coming back. Ireland is forced to budgeting more than 40% of its income on 'illness care', an economic sectors which has proven most resistant to cost reduction!

A major research study entitled *The Societal Costs of Potentially Preventable Illnesses*<sup>13</sup> was published in the UK in 2006 by the National Social Marketing Centre. This comprehensive project formed part of the preparation for the UK Public Health White Paper, 'Choosing Health'.

It identified that at least 20% of expenditure on 'illness care' is *preventable* (see Appendix 24, pp 36) and that for every £1 of expenditure on '*preventable*' illness' care in the UK, £5.80 was lost elsewhere in the economy!

Based on their findings, this proposal suggests that a minimum of €3 billion of Irish Health expenditure is spent on '*preventable*' illnesses... along with consequential further losses to the Irish economy of at least €17 billion p.a. (relating to lost taxes, family expenses, employer losses, etc.)

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<sup>13</sup> <http://www.nsmcentre.org.uk/component/remository/NSMC-Publications/The-Societal-Costs-of-Potentially-Preventable-Illnesses/>

### **Health as a New Specialist Area of Economic Activity**

Economic success lies in identifying a significant and substantial need in the marketplace and developing effective means of meeting that need impeccably.

Such an opportunity is glaringly apparent in the global struggle to deal with *preventable* illness which increasingly threatens the lives and well being of millions, along with the financial stability of many large economies such as the US. With so many of our traditional areas of enterprise under threat (See appendix 27, pp 38), this is a time for Ireland to identify a new areas of specialization that lies within capability, is affordable and in which Ireland has the capacity to excel.

Within 5 years, Ireland can be a world leader. No new factories are needed. No planning permissions needed. No environmental impact studies. No massive high technology! The opportunity is already here. We already have what is required.

### **Why Ireland?**

Apart from its traditional reputation for outdoor activities, culture, scenery and good food, Ireland is ideally suited to take on this challenge. We have available:

- ✚ Pre-existing and respected academic resources.
- ✚ An 'out of control' problem to solve. (e.g. 1 in 5 obese, etc.).
- ✚ State of the art knowledge.... about the problem and potential solutions.
- ✚ The psychological and physiological knowledge and skills to support an entire population in behavioural and lifestyle modification.
- ✚ The means to financially motivate people to adopt science-based healthy lifestyles (or pay for the alternative themselves).

In the process of developing and testing health protocols, Ireland can also rapidly re-brand itself as a centre of global innovation.

### **Potential Jobs and Stimuli elsewhere in the economy:**

- ✚ Agriculture and health foods production
- ✚ Diet and nutrition classes
- ✚ Gymnasiums, health and fitness coaching jobs, exercise programmes.
- ✚ Psychologists, therapists and counsellors in stress management, behavioural change and motivation
- ✚ Research post in Irish universities, part-funded by the international research partner
- ✚ Media companies producing information and instructional materials for TV, radio and internet targeted at an international health audience (with obvious implications for future health tourism)

### **The Looming Threat!**

As an island nation, Ireland is disproportionately dependent on multinational organisations for jobs and for exports. Some multinational companies have already left. Others have been downsizing. In attempting to understand the thinking of multinationals at this time, we considered the recent comments of Paul Rellis, Managing Director of Microsoft Ireland:

When asked on RTE Radio<sup>14</sup> “How does Ireland now measure up to other countries that Microsoft operates in?” he replied

“It’s a very challenging point in the world right now. You see the world being completely reset, and economies all across the world emerging, and becoming challengers to countries like Ireland, and not just challengers from a cost point of view, but from an innovation point of view, and that’s why I think that, when we benchmark Ireland with the rest of the world now, we can’t just look at cost, we’ve got to look at innovation and how much innovation is going on here, so this whole smart economy or innovation economy strategy has, I think, become paramount to this country, and its not just a question of, any more, willing us to become an innovation economy. It’s about us, right now, saying “We must to become an innovation economy...to compete!”

.....The message that has been coming out is that things have been reset, completely reset and so they won’t get back to the heights that they were, or we shouldn’t assume, and that’s my view, that they’ll get back to those heights, so the key, though, is really re-setting people’s minds.... ..and the question we’ve got to ask ourselves is “Will we compete through innovation?” and I think we will ..and I think we can! .....

(RTE interviewer) “All the same, the future is bright?”

(Rellis) “I think if we put innovation on the top of our agenda, we have a good chance of a bright future. We don’t have a birthright to this.... but we have a good chance.”

In the above we might read a clear challenge...noting the hesitancy in Mr Rellis’s response to the last question. Nothing is guaranteed.... There is a lot of ‘quality’ competition out there... and Ireland needs to innovate.... To gets its costs under control...and become a leader...

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<sup>14</sup> 26<sup>th</sup> April 2010 - Morning Ireland

## Action

### Steps to Implementing this Proposal

1. Explore the core concept of eradicating *preventable* illnesses with stakeholders and its practicality and urgency
2. Assuming consensus, adopt the concept as a policy
3. Draw up a detailed plan and timescale for action
4. Source the international research partner & agree terms and responsibilities
5. Establish expert groups to agree definitions and health norms
6. Draw up the *Participating in Health* contract
7. Announce and publicise the new policy (with minimum of 1 year lead-time)
8. Establish the new education and support medium
9. Define the Verification and Mentoring system
10. Create the management and admin structure
11. Recruit and train 3,200 people as verifiers, mentors and administration staff.

Allowing for discussion and refinement of the concept, we believe the project could be launched and first assessments be happening by January 2012 (20 months from the date of this proposal).

### Political Reality

The next Irish general election must take place by 14<sup>th</sup> July 2012, at the latest, so the practicality of this proposal must include an awareness of the political environment.

To succeed, every politician must be able to sell the new proposition to their constituents. We believe this can readily be done on the following basis:

- It's fair
- It creates jobs
- It potentially stimulates many areas of the economy
- Improves A&E access for all and reintroduces fairness
- It will improve availability and quality of general medical care for the majority of people
- Brings down the cost of the national health budget substantially by addressing *preventable* illnesses

- Most people will be healthier because they will have a new motivation and greater real supports in self-care
- Can switch off *preventable* illnesses for future generations
- It's inclusive. Everyone gets the chance to participate
- It puts Ireland on a world map

### **Political Cooperation**

This is an area where cross-party agreement is required. No political party would endorse the sustaining of *preventable* illnesses. To compete in the next election on issues such as 'Insurance for all' can only be detrimental to the medium and long term welfare of the people and the economy. By considering and engaging with the concepts of this proposal, political parties can agree a prior consensus view and avoid being pressurised into disastrous promises.

This proposal complements existing strategies and policies within the HSE and the Department of Health. Implementation does not require new legislation. It only requires a fair and reasonable clarification of the current implied contract between citizen and State whereby publicly-funded healthcare must be earned by responsible behaviour so that services can be maintained for the majority.

## **Summary**

Ireland can be the first country in the world to adopt a 'zero tolerance' policy towards anything that science shows to be a significant co-factor in the initiation of *preventable* illness.

In doing so, Ireland saves money, creates sustainable jobs, restores integrity, stimulates the economy, improves the overall health of the nation, rescues our health system, changes the future for our children and re-brands Ireland as an innovator.

Although he was talking about 'Cloud Computing', Paul Rellis, Managing Director of Microsoft Ireland might well have been referring to our opportunity in tackling *preventable* illness when he said:

*"There is no leader in the world right now. No reason it can't be us"!*

## Appendices

### Appendix 1

#### *The Participating in Health Contract*

This contract applies only to those who want the State to subsidise or pay the costs of their medical care. It does not require anyone to change lifestyle, to stop smoking, to start exercising or change their diet or behaviours.

In consideration of the State providing free or subsidised healthcare coverage from the public purse, the citizen will agree to follow internationally accepted science-based health behaviours as follows:

1. Complete cessation of tobacco use
2. Refrain from use of all illegal/recreational drugs
3. Moderate alcohol usage (maximum 14 units p.w. for women & 21 units p.w. for men)
4. Aerobic exercise 4-5 hrs p.w. plus anaerobic (weights, etc.) 1-2 hrs p.w.
5. Weight management/obesity avoidance (BMI under 25)
6. Stress management (meditation, yoga, socialisation, etc.)
7. Health screening re any family genetic issues
8. 5-7 servings fruit & vegetables per day plus increased fibre
9. Reduced consumption processed foods, excess salt and sugars
10. Eliminate food products containing trans fats
11. Avoid excess sun exposure & use of sun screen protection
12. Attend GP once a year (or at least twice if outside health norms)
13. Compliance - Follow doctor's advice/keep medical appointments
14. Avoiding risky behaviour (unprotected sex, bingeing on food or alcohol, reckless speeding, anti-social behaviour)

The contract will allow for any pre-existing status or condition, but unless medically exempt, will include a commitment to achieve movement of **at least 10% p.a.** towards established health norms including weight, BMI, blood pressure etc. each year.

Contract obligations commence after first assessment and participants will be required to have health norms verified every year to confirm status. They will have access to a health mentor and education. Fees for Verifications will be payable only by those outside health norms.

The State will establish and publish reasonable international health norms, provide free medical coverage for those within health norms and those working proactively towards health norms, set Verification fees, provide 100% refund of Verification fees to those inside health norms, provide subsidies for approved health activities.

## **Appendix 2**

### **‘No-Nonsense’ Eligibility Clauses**

On the principle that if someone wants something from the State, they must evidence pulling their weight, the following is proposed:

1. Medical Cards only to be available to those certified as compliant with the *Participating in Health* contract.
2. Funding under the drugs payment scheme only to be available to those certified as compliant with the *Participating in Health* contract.
3. Parents to be responsible for the state of their children’s health (age of cut-off to be agreed) and to be personally liable for the costs of their children’s medical care if they chose to opt out of the Scheme.
4. Sick benefit and pay from employers and the State to be limited to those compliant with the *Participating in Health* contract.

## **Appendix 3**

### **Categories**

1. Those certified as ‘Exempt’
2. People who opt into the contract and are inside health norms
3. People who opt into the contract and are outside health norms
4. People who opt out of the contract
5. People who opt into the contract and are inside health norms
6. People who have opted in but are non-compliant

## Appendix 4

### Criteria for Exemption

Exemptions would apply *only insofar* as a person lacks the capacity to engage in the *Participating in Health* contract... or that such participation might reasonably be deemed detrimental to, or pose significant risk to their health/wellbeing, their GP to be the final arbitrator.

1. Age under 5 years and over 75 years
2. Psychosis, poor or diminished sense of reality, developmentally delayed, psychoneurosis, major personality disorder, significant psychiatric disturbance, illnesses requiring use of psychotropic substances
3. Severe epilepsy, dementia, Alzheimer's, Down's syndrome, etc.
4. Spinal cord injuries, paraplegia, disability, Parkinson's, etc.
5. Diseases of the nervous system and conditions with no origins in lifestyle such as Multiple Sclerosis, Motor Neuron Disease, Cystic Fibrosis, Cerebral Palsy, etc.
6. Current active cancers (diagnosis/treatment within past 12 months)
7. Current heart disease (significant event within past 3 months)
8. Current cerebro-vascular disease (event within last 9 months)
9. Type 1 Diabetes (if certified by GP)
10. GP Certification (subject to appeal both ways)

## Appendix 5

### Those who Decline to Participate

For those who 'opt out' or decline to participate, it is proposed is to have an actuarial group arrive at an annual premium for a personal insurance policy to cover such 'opt-outs', reflecting the real risks facing a person *unwilling* to adhere to international health norms, or medical best practice, or to confirm such. It is a fair way of ensuring that those who opt out, exercise free informed choice, yet pay the real costs of their health care and engage with their responsibilities.

Those who opt out would no longer qualify for free public medical care, the drug payments scheme, medical cards (see Appendix 2, pp 24), or sickness benefit from private employers or the State. Children from opt-out category families would similarly be required to be covered under a parent's personally-funded health insurance plan.

To ensure nobody is left untreated, if a person or family opts out, or default by materially breaching their contract, or by allowing their health insurance to lapse, find themselves lacking the funds to pay for their own illness care, a Special National Reserve Fund would loan them the funds to pay for their medical expenses. A person being without assets or means would provide equivalent value in community services.

Those who opt out would also be expected to include under their personal health insurance plan provision to reimburse employers for lost productivity due to sickness!

## Appendix 6

### Health Verifier

Following character reference and Garda checks, to be trained by the state training agency, FAS, initially...

#### Requirements:

- ✚ Maintain confidentiality
- ✚ Be responsible for local administration of National Health Measures Verification Programme in a defined area with an allocated panel of people
- ✚ Confirm identity and witness Contract with the State
- ✚ Personally to be a role-model of health to local population
- ✚ Take appointments for Verification sessions
- ✚ Take measures for health norms (see Appendix 8 pp 27)
- ✚ Record data and input to national data base
- ✚ Hold hard copy in secure facility
- ✚ Co-ordinate with Health Mentors
- ✚ Tender for renewal of License after 4 years
- ✚ Confirm Health Insurance Cover for 'opt out' category

Potentially might be based in or operate from local Health Centre (use provided from Dept. of Health / or housed in 'ghost' estate/ libraries?)... To be discussed...

## Appendix 7

### Health Mentor

Following character reference and Garda checks, to be trained by the state training agency, FAS, initially:

#### Requirements:

- ✚ Enter into confidentiality agreement
- ✚ Assist in recording data and input to national data base
- ✚ Provide confirmation of and sign off on Contract and all data collected
- ✚ Promote local health initiatives
- ✚ Be a role model of health in the community
- ✚ Be the local focus/contact for health development projects
- ✚ Promote multi media resources/local health teams/community mentoring
- ✚ Tender for renewal of License after 4 years
- ✚ Co-ordinate with national appointments system

Health education programmes would be delivered via the Internet, Radio or TV from qualified presenters in support of the local Health Mentors.

## Appendix 8

### Recording of Health Norms

Time allocated 20 minutes including all records and appointment confirmation.

#### Data for Recording and Verification

Name  
PPS No  
Sex  
Age  
Weight  
Waist Umbilicus  
Waist: hip ratio (WHO recommendation for body fat)  
Blood Pressure  
Heart rate  
Peak flow breath meter test  
Simple stress questionnaire: health, work, family, sleep, other, etc.  
Use of food/exercise diary  
Confirm non smoking status  
Confirm non use of recreational drugs  
Confirm exercise regimen

## **Appendix 9**

### **Criteria for a Health Participations Status**

1. Sign Contract and comply with terms and health guidelines
2. Attend for Health Criteria Measures Verification annually (if inside healthy norms) and pay fees for same.
3. Attend for Health Criteria Measures Verification bi-annually (if outside norms) and pay fees for same.

*Participating in Health* status might also be used to enable people to secure affordable private health insurance premiums and also qualify for a medical card and/or drug payments scheme (see Appendix 2, pp 24) or sickness benefit.

## **Appendix 10**

### **Criteria for Forfeiting Health Participation Status**

1. Decision to opt out of Contract with the State
2. Failing to demonstrate best efforts towards norms, i.e. 10 % p.a. improvement in modifiable markers annually (unless exempt by GP)
3. Use of tobacco products
4. Illegal drug abuse
5. Significant drunk driving conviction (50% over legal limit)
6. Significant speeding conviction (50% over legal limit)
7. Convictions for dangerous drugs possession or usage
8. Repeated sexually transmitted diseases
9. Multiple lone parent pregnancies (with obvious defined exceptions)
10. Multiple fathering of children outside stable relationship
11. Abuse of A&E departments or personnel (if convicted in courts)

## **Appendix 11**

### **Groups Likely to Object**

1. Civil Liberties: Is this fair? Is this the Nanny State?
2. Irresponsible parents
3. Parents with 'out of control' young adult children
4. Tobacco companies
5. Processed food companies
6. Alcohol companies
7. Soft drinks companies
8. Illegal drug dealers
9. People who want others to pay for their self-abusive behaviours
10. Commercial concerns that derive their income from illness care (private medical facilities, drug companies, and other allied industries - a powerful lobby group with government!)

## Appendix 12

### Groups Likely to Be Pleased

1. Employers (less sick time, more productivity, cheaper health cover)
2. People with new jobs (sustainable and located in the community)
3. Politicians (3,200 sustainable new long term jobs in the community)
4. Heart, Cancer, Obesity and Diabetes organisations
5. Speciality groups such as Cystic Fibrosis (CF), Multiple Sclerosis (MS), Motor Neuron Disease (ND), Cerebral Palsy, etc. (more resources available)
6. Health Food manufacturing and distribution companies
7. Gymnasiums and health/sports clubs
8. Psychologists, counsellors, psychotherapists, personal trainers, life coaches
9. Those who want fairness (who have no responsibility for their illness . . . more resources now become available)
10. Workers/employers/entrepreneurs who want to pay less taxes
11. People who want to be able to access emergency medicine easily
12. Farmers (new opportunities in diversifying)
13. Doctors, nurses (more time and space to care for people)
14. HSE (reduced misallocation of resources on *preventable* illnesses)
15. Minister for Finance (less money out/substantially self-funding)-  
(Unemployed people cost exchequer €15-20,000 each!)
16. Minister for Health (more healthcare resources available, at less cost)
17. Employment Minister (more sustainable jobs created)
18. Private health insurer companies – incentive towards stability and affordable premiums
19. Senior citizens/Aged support groups
20. Patient advocate groups
21. Families and friends of future potential victims of heart attack, stroke, diabetes and cancer. (Doesn't have to happen!)
22. Employers: less heart attacks, strokes, diabetes, cancer, productivity lost
23. Revenue commissioners receiving taxes and economic activities of *preventable* illness 'escapees'.
24. Staff at A&E departments weary of being attacked and abused.
25. People who want everyone to share the taxation burden equitably
26. People no longer having to wait on trolleys

## **Appendix 13**

### **National Health TV/radio/DVD Channel**

Give the logistical problems of providing communication, motivation and support to a large cohort of people, propose a Health TV/Radio channel, initially funded by the state but intended to offer 'up the minute' programming on healthy eating, exercise, stress management, medical breakthroughs, etc., ultimately funded by sponsorship/advertising from the relevant health agencies, health care companies, sports and leisure industries. TV/radio Channel would provide the 'meat' for promotion by the Health Mentors. This would have obvious spinoffs into other sectors such as media production stimulating further economic activity.

## **Appendix 14**

### **Possible State *Subsidised* Aids to Wellness**

Introduce the concept of 'Green' prescriptions as already exists in New Zealand. Propose that GPs, nurses and Health Mentors might be enabled to write 'Green' prescriptions (covering 50% of the costs) for such things gym memberships, fitness coaching, motivation classes, healthy eating classes, vegetable production, stress reduction, smoking cessation, Weight Watchers, Veggie vouchers, cookery/nutrition classes, food, chemical and alcohol dependency programmes, child care for time off for classes/gym (single moms etc.), sport activities, health channel on TV with subsidised advertising and programs by producers.

This measure would provide a highly significant stimulus to the economy at large. The 50% subsidy would also ensure that such services would be delivered 'inside' the tax net rather than in the 'black' economy.

## **Appendix 15**

### **The 'Nanny State' Argument**

In general the term 'Nanny' State refers to situations where the state is characterized as being excessive in its efforts to protect. This proposal is the antithesis of this, in that it proposes that every capable person take responsibility for their own actions... and for the consequences of those actions. This initiative seeks to foster a culture where health is valued, self-care is rewarded, and society looks after the vulnerable and those who cannot care for themselves.

This proposal looks to reverse the current distortion of forcing people with MS, MND, CF, Cerebral Palsy to wait...while the system is forced to prioritise scarce resources (physical and financial) to people affected by *preventable* illness

## Appendix 16

### Some Thoughts on Stress

A report by the Small Firms Association has shown that small businesses in Ireland lose on average €550 million a year through absenteeism. According to Patricia Callan, Assistant Director of the Small Firms Association, in cash terms, absenteeism costs small businesses with sick pay schemes an estimated €550 million per annum, based on average earnings of €110 per day or €28,600 per annum. “This takes no account of other direct costs such as the requirement to replace absent staff with other workers or overtime payments, and the cost of medical referrals; or of the indirect costs such as the effect on productivity and quality, the increased work pressure on other colleagues, and the admin time in managing absence”. The overall cost in reality could be in excess of €1 billion”.

Stress has arisen as a key cause of absence from work replacing back pain as the most commonly cited problem on medical Certificates”, stated Callan. “This is a particularly concerning development, as aside from absenteeism, stress can lead to a less productive workforce, faulty decision-making, and ultimately the possibility of legal action being taken against the company for negligence or constructive dismissal.

Stress has been shown to lead to anxiety, panic attacks, and maladaptive behaviours including smoking, over eating, poor self care, inactivity, withdrawal, depression and suicide.

## Appendix 17

### Some Key Facts – Cancer

A survey by Cancer Research UK shows that many people are unaware of the *preventable* causes of cancer. Chief executive Alex Markham said, "We estimate that half of cancer cases could be prevented. There is no magic pill to prevent us getting the disease, but there are many things we can all do in our daily lives to improve our chances of avoiding it.

According to the International Union against Cancer (UICC), 43% of cancer cases can be prevented through healthy lifestyles established in childhood. The UICC and member organizations (including the Irish Cancer Society) recently launched a five-year campaign, “Today’s children, tomorrow’s world”, which underlines the importance of cancer prevention (<http://campaign.uicc.org>). Targeting parents, health-care professionals and policymakers, the campaign presents a common theme: fostering healthy habits during childhood can help prevent cancer later in life.

More than 15,000 new cases of cancer in Ireland this year will cost the country €440m, new figures revealed in 2009. Research by cycling star Lance Armstrong’s Livestrong foundation warned of the crippling economic cost of treating patients in hospital, buying expensive drugs and loss of earnings and carers’ fees. According to the study, the Global Burden of Cancer, the disease will cost some €213bn for the world as a whole. The survey also highlights a €150 billion spending gap for cancer

treatment in 2009, with high-income countries making up 94% of global expenditure on the illness. Launching the report in Dublin at an international cancer summit organised by Livestrong, Armstrong said tackling the disease needed to become a worldwide priority. "There is obviously an economic impact and I think we have to shift the way that we view this fight," he said. "We have to change the approach. It's no longer about spending money, it's actually investing in the health and wellness of our communities and our countries."

Over 500 politicians, health officials and business leaders gathered in Dublin last year for the Livestrong summit to work out a global strategy for fighting the disease. Armstrong, who successfully battled testicular cancer, launched the three-day event. "Nobody's going to have walked away from this summit and have cured this disease, but I think we can walk away with an idea of how to effect change," the seven-time Tour de France winner said.

Read more: <http://www.breakingnews.ie/ireland/eycwmhqlgboj/#ixzz0jgqLJW6L>

## Appendix 18

### Some Smoking Facts<sup>15</sup>

- 7,000 people die from smoking-related disease in Ireland every year.
- 90% of lung cancers are caused by smoking.
- 50% of all smokers will die from smoking-related diseases.
- Smokers have an increased risk of cancers, heart disease, strokes and many other diseases.
- Smokers lose an average of 10-15 years from their life expectancy.
- Smoking is the single most important *preventable* cause of illness and death.
- It costs €1bn per year to provide health services for smokers.
- A non-smoker living with a smoker has a 25% increased risk of lung cancer and a 30% increased risk of heart disease.
- ETS exposure increases the risk of stroke by 82%.
- ETS in the workplace increases the risk of heart disease, lung cancer (by 40%) and increases absenteeism, the rate of consultation with doctors and prescription drug usage.
- ETS in non-smoking pregnant women causes a reduction in birth weight. Being in a room in which there are smokers means being exposed to at least 50 carcinogenics and other chemicals that increase blood pressure, damage the lungs and cause abnormal kidney function

Smoking remains the greatest cause of *preventable* death and illness in Ireland and the number of smokers here remains unacceptably high, a major international conference in Dublin has heard.

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<sup>15</sup> [http://www.business2000.ie/cases/cases\\_9th/case14.htm](http://www.business2000.ie/cases/cases_9th/case14.htm)

The conference, 'Working together towards a tobacco-free society', was told that smoking continues to cost our health system millions of euro every year. Furthermore, a recent study from the Department of Health found that the number of smokers in Ireland had **increased from 27% in 2002 to 29% in 2007**. Also speaking at the conference, consultant respiratory physician, Prof Luke Clancy, who is director general of the Research Institute for a Tobacco Free Society (RIFTFS), emphasised that smoking is a 'real threat' to public health. "Smoking can cause cancer, heart disease, stroke, bronchitis and emphysema, in addition to reducing fertility and complications during pregnancy, not to mention the resulting burden it has on our healthcare system and society at large", he said.

## Appendix 19

### Rising Obesity Levels: A Cancer Time Bomb

"The right to eat your way to obesity and early death has become the new American dream"<sup>16</sup>

Dr Jimmy Devins, Fianna Fáil TD for Sligo-North Leitrim, told the Dáil recently that we now have the fattest children in Europe, that this was "a time bomb" that will "explode in all our faces".

According to recent research, 38 per cent of Irish people are now overweight, with a further 23 per cent clinically obese. One in five children is now considered overweight or obese. Dr Devins suggested that walking and jogging would not cost the State anything, and "those who claim they cannot find the time, know well they can easily find it". It is really that simple.

See National Taskforce on Obesity Report<sup>17</sup>

## Appendix 20

### Vascular Disease

Twenty five Irish organisations, led by the Department of Health and Children and the Irish Heart Foundation, have pledged their commitment to cut cardiovascular disease, the biggest disease killer in Ireland. The European Heart Health Charter, a new EU-wide policy document on cardiovascular disease (CVD) prevention, makes the commitment that every child born in this millennium has the right to live until the age of 65 without suffering from cardiovascular disease. Prof Eoin O'Brien, president of the Irish Heart Foundation said: "**CVD is still the leading cause of death here in Ireland and across Europe, accounting for half of all deaths.** It is estimated that the total cost of CVD to the Irish economy is **€866 million**, across Europe this figure is €169 billion, averaging €347 for every citizen."

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<sup>16</sup> Editor Sunday Tribune 4<sup>th</sup> April 2010 (pp 18)

<sup>17</sup> <http://www.dohc.ie/press/releases/2005/20050516.html>

Michael O'Shea, chief executive of the Irish Heart Foundation, said that the charter strongly recognises that lifestyle is not a matter of the individual alone and that policy makers have a role to play. "There is a real urgency that cuts across government and society, we must work together on tackling food poverty issues; the impact of marketing of foods to children and creating a physical environment to support more activity," said Mr O'Shea. Governments, and health organisations that sign the charter commit to reduce considerably the burden of CVD in their own country and across Europe. The charter sets out to define minimum requirements for a heart healthy environment and proposes practical tools for implementation, including 'Heartscore' that will help assess risk of CVD and create awareness.

## Appendix 21

### Type 2 Diabetes

#### Type 2 Diabetes

Diabetes is poised to be Ireland's next health care crisis, according to expert doctors. They blame the current care system, which they say is **short-sighted and inefficient**.

Professor John Nolan, of St James's in Dublin, Dr Domnhall O'Halloran of Cork University Hospital, and Dr Richard Firth of the Mater Hospital, made their comments on the eve World Diabetes Day, November 14.

The three doctors recently worked on a study of the cost of treating type 2 Diabetes in Ireland. Type 2 diabetes mostly appears in adults and can be a result of lifestyle such as poor diet and lack of exercise. In the United States there is already an epidemic of this form of diabetes, and the three Irish doctors are warning that Ireland faces the same prospect. The government must re-evaluate diabetes treatment as a matter of urgency, they say in a press statement.

"Life-threatening complications of diabetes such as heart disease and stroke are costing the taxpayer almost €600 million per annum," the doctors say. "These costly interventions could largely be **avoided** if the government adopted a preventative approach to the disease."

Their study was called CODEIRE (Cost of Diabetes-Ireland). Professor T.J. McKenna and Sandra Redmond, a health economist with pharmaceutical company GlaxoSmithKline, also worked on the study. They found that diabetes costs €2,468 for every patient in Ireland every year. Two thirds of the cost is spent on dealing with complications of the disease.

Ireland has 250,000 diabetes patients, and it is suspected that another 100,000 could be undiagnosed. Kieran O'Leary of the Diabetes Federation of Ireland agreed with the specialists' call, saying that diabetes care is 'significantly under-resourced'. The International Diabetes Federation predicts that diabetes incidence globally will have risen by 71% by 2025. Type 2 accounts for nine out of 10 cases. (2 year to see a diabetic nurse educator in public care or endocrinologist in Ireland!!)

A report published by the Institute of Public Health in Ireland (IPH) and released on Monday 9 July 2007, predicted a 26% increase in diabetes in Northern Ireland and a 37% increase in the Republic over the ten year period (2005-2015). The [new report entitled, Making Diabetes Count: What does the future hold?](#) is the second such report from the authors - The Irish Diabetes Prevalence Working Group. Dr Kevin Balanda, Associate Director of the IPH, explained, "Taking into account population change and assuming the most realistic scenario that obesity rates will continue to rise in the same way it has over the last decade or so, the forecast is that the population prevalence of diabetes in adults in 2015 will be 6.3% or 84,226 people in Northern Ireland and 5.6% or 193,944 people in the Republic. This represents an increase of just over 17,100 in Northern Ireland and 52,800 adults for the Republic respectively between 2005 and 2015. The vast majority of this increase is for Type 2 diabetes and it is clear to us from our research that an increase in obesity is the key driver of changes in the prevalence of Type 2 diabetes in the adult population."

## **Appendix 22**

### **Consequences of not Addressing *Preventable* Illnesses Now**

Disease burden rising....whilst resources shrink  
Ongoing increasing unfairness towards the vulnerable  
We cannot afford this ... country is losing €20- 25 billion p.a.  
Taxpayer will revolt... or leave... unless clear vision of correction evident  
Health costs will drive investment out of Ireland & inhibit inward investment  
Private health insurers going broke/premiums becoming unaffordable  
People dropping private health insurance in favour of the State cover!!  
More former private insurers moving to the public purse  
Pensions thrashed ... lost value ... in trouble ....  
Future generations are facing substantial debt & negative equity.  
Deteriorating physical health of nation  
All Govt Budgets to be slashed substantially over next 5 years  
Ireland further perceived as incapable of own health organisational today, let alone  
with future diminished resources  
Ireland further seen as financial management basket case  
Contributes to national despair and hopelessness  
Competitiveness falling (Like GM, Microsoft, etc)  
Stress & recession leading to deteriorating health behaviours  
We miss the 'opportunity of the century' to lead the world in solving a global crisis

## Appendix 23

### The Dark Side of Illness care

1. Many leaders in medicine/politics/industry are poor role models of optimum health (Michael O’Leary might say: “What part of unfit and overweight do you not understand!”)
2. Drugs & medical device industries are big employers... and exporters
3. Caring for sick people is ‘good’ for an economy. 1,000,000 sick people needed to keep 150,000 in jobs
4. Smoking brings in revenue €1 billion p.a.
5. Political correctness and unwillingness to confront self-abusive behaviour
6. Denial of real cost to economy and to the ‘truly’ sick people
7. Tackling irresponsible behaviour is bad for votes every 4 years!
8. 42% of our total national income now goes to pay for inadequate illness care and the misery of inequitable distribution of healthcare continues

## Appendix 24

**Table 1** Comparison of societal cost impacts including transfers but not taxes in the UK (2005 Figures)<sup>18</sup>

Behaviour/ Illness	Total Societal Cost	Cost to individuals/ households	Cost to public health/ Care	Costs to other public services	Costs to employers	Intangible social costs
Alcohol	£48.9b	£17.3b	£3.2b	£5.0b	£7.3b	£16.1b
Smoking	£41.5b	£18.9b	£2.7b	£1.1b	£2.0b	£16.8b
Obesity	£25.4b	£14.9b	£1.5b	£0.1b	£1.5b	£7.4b
CVD Total (CVD 1/3)	£32.7b £10.9b	£2.4b £0.8b	£1.7b £0.6b	NA NA	£2.2b £0.7b	£26.4b £8.8b
Mental Health / Illness	£73.3b	£15.6b	£9.1b	£10.2b	£4.2b	£34.4b
<b>Total</b>	<b>£200b</b>	£67.5b	£17.1b	£16.4b	£15.7b	£83.5b

<sup>18</sup> [http://www.nsms.org.uk/images/CoreFiles/NSMC-R10\\_societal\\_costs.pdf](http://www.nsms.org.uk/images/CoreFiles/NSMC-R10_societal_costs.pdf)

## Appendix 25

### Some Key Areas of Illness Related Expenditure in Ireland

Coronary Heart Disease (CHD)	(€1,200,000,000)
Hormone related Cancers	(€ 800,000,000)
Cost of alcohol related conditions	(€ 2,600,000,000 <sup>19</sup> )
Cost of smoking	(€ 3,650,000 to €1.8 billion <sup>20</sup> )
Cost of Type 2 Diabetes	(€ 580,000,000 <sup>21</sup> to €900 million)
Cost of Obesity	(€400,000,000 <sup>22</sup> )
Cost of Depression	(€280,000,000)
Cost of Depression (work days)	(€170,000,000)
Suicide (passed out road accidents!)	(€800,000,000 <sup>23</sup> )
Drink Driving	(€3,700,000,000 <sup>24</sup> )

(Note: The above are estimates only and subject to verification. They do however suggest the likely cost to the economy and the Exchequer of lifestyle and *preventable* illnesses)

Note: Strokes: Up to 10,000 people suffer stroke annually and there are an estimated 30,000 people in the community with residual disability from stroke.

CHD: Approximately 10,000 people die each year from cardiovascular disease (CVD). 22% of premature deaths (under age 65) are from CVD.<sup>25</sup>

## Appendix 26

### How Many People Follow a Healthy Lifestyle?

Data from the 2000 Behavioural Risk Factor Surveillance System -- a survey of America's health behaviours estimates affirms that people who eat right, exercise and do not smoke are far less likely to develop heart disease, cancer, diabetes and other chronic and deadly conditions.

Findings: Some 76 percent said they didn't smoke, 23 percent incorporated at least five fruits and vegetables in their daily diets, Twenty-two percent exercised at least 30 minutes a day, five or more times a week, Forty percent maintained a healthy weight, defined as a body mass index (BMI) of 25 or less

Amazingly, only 3 percent met all four goals!

<sup>19</sup> Dr Mick Loftus in Irish Examiner 20 Jul 2005 p. 5

<sup>20</sup> [http://www.business2000.ie/cases/cases\\_9th/case14.htm#03](http://www.business2000.ie/cases/cases_9th/case14.htm#03)

<sup>21</sup> <http://lib.bioinfo.pl/pmid:17274175> (Department of Endocrinology, St. James's Hospital, Dublin 8, Ireland.)

<sup>22</sup> National Taskforce on Obesity 2005

<sup>23</sup> Crisis: The Journal of Crisis Intervention and Suicide Prevention. Vol 28(2), 2007, 89-94.

<sup>24</sup> <http://historical-debates.oireachtas.ie/D/0584/D.0584.200404280022.html>

<sup>25</sup> [www.irishheart.ie/iopen24/defaultarticle.php](http://www.irishheart.ie/iopen24/defaultarticle.php)

## Appendix 27

### Ireland's Traditional Economic Areas

Whilst many hope for a rapid return to the economic norms of the Tiger years, we believe the context in which consider this proposal in relation to many of Ireland's existing economic sectors might be as follows:

- **Health/Illness Care** – Unaffordable today in its present form, let alone in prospect of its likely escalation. Unless source of *preventable* illnesses halted, will result in greater inequalities and poorer quality health services.
- **Construction** – General existing housing stock adequate for some years to come, especially in context of net emigration of young people.
- **Pharmaceutical/Medical devices** – These are important sectors (40% of our exports). Such overreliance leaves us vulnerable! Our attractiveness as a location is under pressure due to rising costs, time scale required for new patents & generics. Also China, India & Eastern Europe and developing countries becoming increasingly sophisticated in their offerings in terms of tax regimes, high quality/low wage production and research. Both the major medical companies *and* the manufacturing countries are especially highly incentivised in their strategies this time of recession.
- **General Manufacturing** – There is an ongoing global move towards Eastern Europe and other less heavily regulated cheap-labour countries.
- **Financial Services** – Ireland reputation, at best, has been significantly tarnished and at worst, severely damaged by the now almost daily revelations of under-regulated financial mismanagement.
- **Tax Regimes**: Ireland has been named as a Tax Haven.<sup>26</sup> Our creative tax strategies are now either being condemned... or emulated. The past creativity shown by Ireland in offering such incentives could only ever create a 'windfall' flow of jobs and services. As a developing country, we could be tolerated, but as a developed economy, this will longer be tolerated by other developed countries who are themselves under severe pressure.
- **Education**: In the future, as well as core education facilities, we need new areas of specialisation. Why not take on lifestyle medicine and health as this is of vital importance in the developed world, and an area with which Ireland can be especially identified! This is potentially a very green industry with no negative trade implications, no expensive technologies, no need for factories, no expensive or 'dirty' materials etc. We can carve out a unique niche within 3-5 years!!

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<sup>26</sup> <http://www.tribune.ie/business/news/article/2009/feb/01/tax-haven-ireland-on-obamas-hit-list/>

- **Tourism.** The quality tourists are gone...or are going. The era of the Quiet Man, Ryan's Daughter days and Clancy Brothers brand of tourism is drawing to a close, if it has not already gone. To compete effectively, we need a new branding. Health and lifestyle tourists from Europe are there for the asking if we are centre stage and can offer an evidence based model!
  
- **Health:** Both internally and externally we are currently perceived as not being capable of delivering health services to even our own people despite massive escalations in expenditure. Why not completely reverse this perception?

## Appendix 28

### Estimate for Economics of Assessment & Mentoring System

#### Assumptions:

Total Population	4,200,000
Likely 'opt outs'	790,000
Likely old, young & exempt	410,000
Likely 'opt ins'	3,000,000

Assessment centre is productive for 30 hrs per week x 47 weeks= 1,410 hrs p.a.

Of 'Opt ins': Assume 1,000,000 'within norms' and 2,000,000 'outside norms'

Assume 'inside norms' have 1 assessment each year and 'outside norms' have 2 assessments p.a.

Number of assessments required annually = 5,000,000

Assuming 20 minutes average per assessment, Assessment centre hours required: 1,650,000 p.a.

Assessment centres required = 1,170

Number of assessors required	1,170
Number of health mentors required	1,170
Admin & inspect orate (+33%)	772
Total new jobs	3,112

Adult fees	€40 for 20 min assessment
Children fees	€15 per 20 min assessment

1,000,000 children @ €15.00 = €15 million p.a.

2,000,000 adults @ €40.00 = €80 million p.a.

Assume average revenue per assessment = €32.00

82 Assessments per week per centre @ €32 average = €2,602 income per week

Provides for approx. salary of €35,000 p.a. for each assessor/mentor, €800 p.w. to cover costs and €400 p.w. per centre towards central overheads.

Note: These are crude estimates but varying models suggest that more people engaging will leads to more jobs. Less people engaging will lead to more people self-funding their healthcare. Either way, the State benefits!

## **Development Team**

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