Irish Heart Foundation

Irish Heart Foundation

Pre-Budget Submission 2020

www.irishheart.ie

Introduction

The Irish Heart Foundation is calling on the Government to take a total of 32 actions to improve cardiovascular health and reduce the rates of death and disability from stroke and heart disease in the next Budget. These actions will save lives and reduce hospital admissions, as well as creating healthcare savings and efficiencies.

To successfully meet our chronic disease challenge, Ireland must do more to tackle one of its largest - and most costly - components: cardiovascular disease. This submission identifies cost-effective measures to improve cardiovascular health outcomes and futureproof services in the face of rapidly increasing rates of cardiovascular disease caused mainly by our ageing population.

As a patient organisation, the main interest of the Irish Heart Foundation is in the effectiveness of health and social care services in terms of prevention, treatment, care and support. Many cardiovascular disease patients use medical, rehabilitation and social care services concurrently. Set against the background of Budget 2019, therefore, is healthcare reform. The actions in this pre-Budget submission align with Slaintecare priorities to increase equity, promote the health of our population to prevent illness, to provide the majority of care at or closer to home, to create a system where care is provided on the basis of need, not ability to pay, to move our system from long waiting times to a timely service and to create an integrated system of care, with healthcare professionals working closely together.

We believe that Budget 2020 is an opportunity for the Government to tackle one of the most critical public health issues of our time: obesity. Later in 2019, the Irish Heart Foundation will launch its comprehensive Children's Health Manifesto, that sets out the roadmap to tackle childhood obesity. Similarly, our new strategy has identified childhood obesity as the biggest threat to the health of our children and this emphasis is heavily reflected in the volume of recommendations in this pre Budget submission.

The submission is broken down into five parts:

- Obesity
- Stroke services
- Heart Disease
- Tobacco Control
- The Built Environment

Part 1: Obesity

Budget actions to tackle obesity

Aim	2020 Action	Investment
Increase investment in preventive health, as well as translating effective actions into established, scaled up practices	Amend criteria for eligibility to apply for Strand 2 of the Healthy Ireland Fund to include non-statutory organisations	No cost
Increase the impact of the Sugar Sweetened Drinks Tax (SSDT) on child health and obesity levels	Extend the scope of the SSDT to milk products with added sugar Develop information collection processes on products that are liable for the SSDT Ringfence the funding from the SSDT for measures to tackle childhood obesity and support children's health	Low cost implementation. Increasing the scope of the SSDT to currently ineligible products will generate additional revenue
Rebalance the Tax system – address VAT anomalies relating to unhealthy foods	Government undertake a consultation on the adjustment of VAT rates on food and drink, with a view to addressing the anomalies that exist. This can feed into ongoing work at EU Level on the EU Action Plan on VAT	Low cost consultation
Develop the evidence base to support health and well-being	Research to commence immediately on other evidence based fiscal measures to support healthy eating and lifestyles as per National Obesity Plan recommendations	Low cost
Encourage consumption of nutrient dense foods	Research to commence immediately on the most effective methods of funding healthy food subsidies in the Irish context	Low cost

Ensure post-primary schools have equipment, infrastructure and facilities available to cook, prepare and serve meals to students	A national audit of post primary schools in respect of the equipment, infrastructure and facilities available to cook, prepare and serve meals to students in addition to dining facilities to be conducted in the 2019/2020 school year A revision of the design guidelines for post-primary schools to provide a better range of kitchen and eating facilities, which facilitate the preparation, cooking and eating of meals The inclusion of refrigeration facilities and associated equipment in a national audit of schools' participation in the School Milk Scheme to be conducted in the 2019/2020	DES could not cost this, but it would be a low cost audit for the Department to implement No – Low cost No – low cost
Ensure all learning centres have access to potable drinking water	A national audit of all learning centres in respect of the availability of potable drinking water to be conducted in the 2019/2020 school year	DES could not cost this, but it would be a low cost audit for the Department to implement
Extension of the School Meals Programme	The extension of the Hot School Meals Pilot Scheme The development of a pilot scheme for the school meals programme to cover youth services, early years settings and after-school programmes to address the issue of food poverty for children and young people availing of those services	€2.5 million €3.2 million (together these measures amount to a 10% increase in expenditure on the School Meals Programme in Budget 2020 from the 2019 budgetary allocation of €57.6 million)

Reduce Food Poverty amongst disadvantaged communities and low income families	As part of the cross-departmental Strategy for Babies, Young Children and their Families and the work programme on food poverty, evaluation of the potential to introduce a scheme similar to Healthy Start in Ireland, including costs that would be associated with it and best practice in implementing a similar scheme in Ireland	Low cost research
Ensure adequate workforce capacity for children's health and wellbeing programmes, services and supports	Resource and develop Child Health & Wellbeing service according to the 10-year Sláintecare Plan	€8,292,780
Legislate and make policy reforms to support healthy and active lifestyles	Introduction of a Public Health (Advertising) Bill	Low cost legislation
		€13,992,780

1.1 Obesity in Ireland

> *"Lifestyle factors such as smoking, drinking, levels of physical activity and obesity continue to be issues which have the potential to jeopardise many of the health gains achieved in recent years. However, inequalities in health are closely linked with wider social determinants including living and working conditions, issues of service access, and cultural and physical environments. Taken together with an ageing population, adverse trends, if not addressed now, will lead to an unhealthy and costly future."*[1]

[1] Department of Health. (2018). Health in Ireland Key Trends 2018. [Online] Available from: https://health.gov.ie/wp-content/uploads/2018/12/Key-Health-Trends-2018.pdf p1

Problem

Many Irish people are engaging in, or affected by, unhealthy behaviours:

- In 2017, 70% of adult men and 53% of adult women were overweight or obese[2]
- One-in-five children at 5 years old are unhealthily heavy for their height (15% overweight and 5% obese)[3]
- Children from low income families have been found to be over twice as likely to be obese and 54% more likely to be overweight than those from high income brackets.[4]
- In Ireland, less than 30% of children use active transport to and from school[5]
- Ireland had the third lowest proportion of schools that provided fresh fruit on their premises in the WHO Europe region at 23% after Albania (0%) and the former Yugoslav Republic of Macedonia (17%)[6]
- The Growing Up in Ireland study reported lower levels of fruit and vegetable consumption, and higher consumption of energy dense foods such as crisps, sweets, and non-diet fizzy drinks among children from lower SES backgrounds[7]

Solution

To achieve the Government's vision to turn the tide of the overweight and obesity epidemic, to increase the number of people with a healthy weight and set us on a path where healthy weight becomes the norm, prevention programmes need a significant investment. Similarly, measures identified in A Healthy Weight for Ireland – Obesity Policy and Action Plan 2016 – 2025 must be implemented and adequately funded.

1.1.2 Obesity prevalence

The prevalence of childhood obesity in Ireland is currently derived from both the Growing Up in Ireland longitudinal study coordinated by the ESRI and participation in the World Health Organisation (WHO) Europe Childhood Obesity Surveillance Initiative (COSI). Since 2006, when the WHO survey began, the measured weights of children aged 7-9 years in Europe has been collected systematically. This has enabled inter-country comparisons and a better understanding of the progression of childhood overweight and obesity, clearly showing that childhood obesity remains a major public health problem across the WHO European Region.

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[2] Department of Health. (2017). HEALTHY IRELAND SURVEY 2017 Summary of Findings. [Online]. Available from: https://health.gov.ie/wp-content/uploads/2017/10/16-048825-Healthy-Ireland-Survey-18-October_for-printing.pdf

[3] ESRI Growing Up in Ireland Study Team. (2019). Growing Up in Ireland: THE LIVES OF 5-YEAR-OLDS. Infant Cohort. Report 9. [Online]. Available from: https://www.esri.ie/system/files/publications/SUSTAT71.pdf

[4] ESRI Growing Up in Ireland Study Team. (2017). Growing Up in Ireland: Health & Development at 7/8 years of age. Available from: http://www.esri.ie/pubs/SUSTAT63.pdf

[5] WHO Regional Office for Europe. (2018). *WHO European Childhood Obesity Surveillance Initiative: overweight and obesity among 6–9-year-old children. Report of the third round of data collection 2012–2013.* [Online] Available from: http://www.euro.who.int/__data/assets/pdf_file/0010/378865/COSI-3.pdf?ua=1

[6] WHO Regional Office for Europe. (2018). *WHO European Childhood Obesity Surveillance Initiative: overweight and obesity among 6–9-year-old children. Report of the third round of data collection 2012–2013.* [Online] Available from: http://www.euro.who.int/__data/assets/pdf_file/0010/378865/COSI-3.pdf?ua=1

[7] Williams, J., Murray, A. McCrory, C. & McNally, S. (2013). Growing Up in Ireland. Development from birth to 3 years. Dublin, Government Publications

Over this time-frame, the results have shown a stabilisation in the prevalence of overweight and obesity in both boys and girls. This stabilisation, however, is still at an unacceptably high level as the current combined prevalence of overweight and obesity in Irish children, measured by COSI shows:

- measured in 1st class (aged 6-7) as 16.9%
- measured in 4th class (aged 9-10) is 20.2%
- measured in 6th class (aged 11-12 years) is 20.6%.[8]

Although there has been some evidence of the stabilisation of rates of overweight and obesity in childhood, this trend hides the fact that rates of childhood obesity are continuing to increase among disadvantaged groups, widening health inequalities further. Children in disadvantaged schools have a higher prevalence of overweight and obesity in comparison with children in non-disadvantaged schools. In addition, overweight and obesity rates among children older than 8 years in disadvantaged schools seem to increase as they grow up.

In a written submission to the Joint Oireachtas Committee on Children and Youth Affairs by Dr Cathal McCrory, Senior Research Fellow, The Irish Longitudinal Study on Ageing (TILDA), the stark socio-economic inequalities in childhood obesity that are evident at a very early age were highlighted. In the submission, Dr McCrory noted that

> *"studies have consistently shown that childhood overweight and obesity is more heavily concentrated in lower socio-economic status (SES) households. Although there is some tentative evidence that rates of childhood overweight and obesity may have stabilized in recent years in some high-income countries, this trend has not occurred at an equal pace across all socio-economic groups and may have exacerbated socio-economic inequalities. Data from the Growing Up in Ireland infant cohort shows that 9 percent of children from lower secondary educated maternal backgrounds are obese at 3 years of age compared with 4 percent of children from degree educated maternal backgrounds."*[9]

Further research referenced by Dr McCrory in his submission[10] noted that longitudinal patterns indicates that:

- Children from lower SES backgrounds are more likely to be overweight/obese at any age for which figures are available
- Children from lower SES backgrounds are more likely to become overweight or obese if previously non-overweight
- Children from lower SES backgrounds are more likely to maintain overweight/obese status over time.

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[8] Bel-Serrat S, Heinen MM, Murrin CM, Daly L, Mehegan J, Concannon M, Flood C, Farrell D, O'Brien S, Eldin N, Kelleher CC [2017]. The Childhood Obesity Surveillance Initiative (COSI) in the Republic of Ireland: Findings from 2008, 2010, 2012 and 2015. Dublin: Health Service Executive [Online]. Available from: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/heal/heal-docs/cosi-in-the-republic-of-ireland-findings-from-2008-2010-2012-and-2015.pdf

[9] Dr Cathal McCrory, Senior Research Fellow, The Irish Longitudinal Study on Ageing (TILDA), Trinity College Dublin. (2018). Written Submission to the Joint Committee on Children and Youth Affairs: Tackling Childhood Obesity. [Online]. Available from: https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_children_and_youth_affairs/submissions/2018/2018-08-22_submission-dr-cathal-mccrory-senior-research-fellow-the-irish-longitudinal-study-on-ageing-tilda-trinity-college-dublin_en.pdf

[10] Ibid - research referenced: McCrory, C. et al (in preparation). Socio-economic inequalities in measured body mass index trajectories in 41,399 children in three European countries

These figures are extremely concerning from a population health perspective given that obesity tends to track and children who are overweight / obese in childhood are more likely to maintain this status into adolescence and adulthood. Indeed, research indicates that 55% of obese children will become obese adolescents, and 80% of obese adolescents will become obese adults.[11]

The annual Healthy Ireland Survey involves in-home, face-to-face interviews with a sample of approximately 7,500 individuals representative of the Irish population aged 15 and over. The Survey collects height, weight, waist circumference and Body Mass Index measurements every second year, which allows calculation of overweight and obesity prevalence across the adult population. The baseline measurements in 2015[12] indicated that 37% were overweight and 23% were obese. Overall, 68% of adult men and 53% of adult women were overweight or obese. Measurements were repeated in 2017[13] and 39% were overweight and 23% were obese. Overall, 70% of adult men and 53% of adult women were overweight or obese.

1.1.3 Why childhood overweight and obesity is an important public health issue

The prevalence of childhood obesity in Ireland is unacceptably high, with approximately 1 in 5 primary school children overweight or obese. Obesity in childhood can lead to increased risk of diabetes, hypertension, coronary heart disease and stroke in later life. The medical consequences of obesity previously only seen in adulthood are now being seen in children and adolescents. As a chronic relapsing condition, government action on the environmental, social and material barriers to prevention and management of obesity is key for the children's health, prevention of complex chronic conditions and the economy.

Research by the World Obesity Federation predicts that by 2025, 241,000 schoolchildren in Ireland will be overweight or obese and as many as 9,000 will have impaired glucose intolerance; 2,000 will have type 2 diabetes; 19,000 will have high blood pressure; and 27,000 will have first stage fatty liver disease.[14] The consequences for the future health of these children will be dire.

According to the WHO, 65% of the diabetes burden, 23% of heart disease and between 7% and 41% of certain cancers are attributable to overweight and obesity.[15] Similarly, the risk of coronary heart disease, ischaemic stroke and type 2 diabetes grows steadily with increasing body mass.

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[11] Simmonds M, Llewellyn A, Owen C, Woolacott N. (2016). Predicting adult obesity from childhood obesity: a systematic review and meta- analysis. Obesity reviews. 2016;17(2):95-107

[12] Department of Health. (2015). HEALTHY IRELAND SURVEY 2015 Summary of Findings. [Online]. Available from: https://health.gov.ie/wp-content/uploads/2015/10/Healthy-Ireland-Survey-2015-Summary-of-Findings.pdf

[13] Department of Health. (2017). HEALTHY IRELAND SURVEY 2017 Summary of Findings. [Online]. Available from: https://health.gov.ie/wp-content/uploads/2017/10/16-048825-Healthy-Ireland-Survey-18-October_for-printing.pdf

[14] World Obesity Federation. (2017). Ireland National Infographic. Available from: http://www.obesityday.worldobesity.org/fullscreen-page/comp-it36nur2/068a7dcd-eb0d-4dd7-9cf6-1220ddc79ef0/60/%3Fi%3D60%26p%3Doa2r2%26s%3Dstyle-j84eeb5h

[15] World Health Organisation (2009). Global Health Risks - Mortality and burden of disease attributable to selected major risks. Available from: http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf

Eight per cent of children who participated in the Cork Children's Lifestyle Study[16] were classified as having high blood pressure. Twice as many overweight/obese children had high blood pressure when compared to normal weight children. The findings of the Bogalusa Heart Study[17] showed that three quarters of obese children remain obese as adults and are therefore at much greater risk of an adult life dominated by chronic disease and then of premature death.

1.1.4 The costs of obesity

Chronic diseases are major drivers of healthcare costs and associated economic losses. The key demographic trends underlying the increasing prevalence of chronic disease in Ireland are the ageing population and the high rates of overweight and obesity across the population.[18]

The total lifetime costs of childhood obesity in the Republic of Ireland are estimated to be €4.6 billion, with the direct healthcare associated costs estimated at €1.7 million.[19]

If body mass index (BMI) was reduced by 1% the lifetime cost of childhood overweight and obesity would be reduced by €270 million. A BMI reduction of 5% would reduce the lifetime costs by €1.1 billion.[20]

The estimated excess lifetime cost attributable to childhood overweight and obesity is €16,036 per person.[21]

Safefood research estimates that 55,056 children currently living in the Republic of Ireland and 85,688 on the whole island will die prematurely due to overweight and obesity.[22]

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[16] Cork Children's Lifestyle Study continues with strong community support. Department of Epidemiology and Public Health, UCC http://www.ucc.ie/en/epid/research/foodhealth/

[17] Cardiovascular disease risk factor variables at the preschool age. The Bogalusa Heart Study. (1978) Circulation. 57(3):603-12.

[18] Smyth B., Marsden P., Donohue F., Kavanagh P., Kitching A., Feely E., Collins L., Cullen L., Sheridan A., Evans D., Wright P., O'Brien S., Migone C. (2017) *Planning for Health: Trends and Priorities to Inform Health Service Planning 2017. Report from the Health Service Executive.* ISBN 978-1-78602-037-6 [Online] Available from: https://www.hse.ie/eng/services/news/newsfeatures/planning-for-health/planningforhealth.pdf

[19] Ivan J. Perry, Seán R. Millar, Kevin P. Balanda, Anne Dee, David Bergin, Laura Carter, Edel Doherty, Lorraine Fahy, Douglas Hamilton, Abbygail Jaccard, André Knuchel-Takano, Laura McCarthy, Adam McCune, Grace O'Malley, Laura Pimpin, Michelle Queally and Laura Webber. (2017). What are the estimated costs of childhood overweight and obesity on the island of Ireland? Safefood. ISBN: 978-1-905767-75- 5 Available from: http://www.safefood.eu/SafeFood/media/SafeFoodLibrary/Documents/Publications/Research%20Reports/Cost-of-childhood-obesity-Report.pdf

[20] Parliamentary Question 20568/18 to the Minister for Health

[21] Ivan J. Perry, Seán R. Millar, Kevin P. Balanda, Anne Dee, David Bergin, Laura Carter, Edel Doherty, Lorraine Fahy, Douglas Hamilton, Abbygail Jaccard, André Knuchel-Takano, Laura McCarthy, Adam McCune, Grace O'Malley, Laura Pimpin, Michelle Queally and Laura Webber. (2017). What are the estimated costs of childhood overweight and obesity on the island of Ireland? Safefood. ISBN: 978-1-905767-75- 5 Available from: http://www.safefood.eu/SafeFood/media/SafeFoodLibrary/Documents/Publications/Research%20Reports/Cost-of-childhood-obesity-Report.pdf

[22] Ibid

1.2 Healthy Ireland

In July 2016, the Government approved the creation of a Healthy Ireland Fund and an initial allocation of €5 million was provided in Budget 2017. The aim of the Healthy Ireland Fund is to stimulate and support innovative, cross-sectoral, evidence-based projects, programmes and initiatives that support the implementation of the key national policies in areas such as Obesity, Smoking, Alcohol, Physical Activity and Sexual Health. The Fund, which is primarily administered by Pobal on behalf of the Department of Health, is currently arranged into two strands:

- Strand 1 is for actions that are locally based and therefore targets funding at Local Community Development Committees (LCDC) and Children and Young Persons Services Committees (CYPSC).
- Strand 2 is targeted at national level programmes through statutory organisations.

Of the funding that was provided in Budget 2017 for the first year of the Healthy Ireland fund:

- 382 actions were delivered under strand 1, a total of 2,456 organisations were reported to be involved in the implementation of local priority actions and an estimated 770,000 people were reported to have benefitted. These actions generally targeted health inequality, especially people living in areas of social disadvantage (71% of actions), people with disabilities (45%), people from new communities including refugees and asylum seekers (39%) and members of the Traveller community (36%).
- The total number of people reported as benefitting from national actions under Strand 2 was 130,735. The number of organisations benefitting was reported as 1,785, and almost two thirds of actions (63%) reported a focus on people with disabilities and/or chronic illnesses (including mental health issues) and over half of actions (54%) were focused on people living in areas of social disadvantage.[23]

Since the initial Budget 2017 allocation of €5million, a further €10million was provided across Budget 2018 and 2019. This allocation was also supplemented by funding from the Departments of Children and Youth Affairs and Rural and Community Development, as well as receiving an extra €1million from the revised estimates process to boost community engagement.[24] However, the Department has not yet provided a breakdown of the actions or the numbers of those who have benefitted.

While the establishment of the Healthy Ireland Fund is important to support the implementation of key national policies, particularly obesity, there are a number of issues and concerns with the scheme and how it operates, namely:

- How to translate effective intervention components into practice and scale up interventions. The WHO has argued that interventions to address childhood obesity, for example, need to be developed in a way that can be embedded into ongoing

[23] Parliamentary Question 17758/19 to the Minister for Health
[24] Parliamentary Question 17758/19 to the Minister for Health

practice and existing systems, rather than through interventions that are resource-intensive and cannot be maintained in the long-term[25].

- The narrow eligibility criteria of Strand 2 which is currently targeted at national level programmes through statutory organisations only, excluding large swathes of health organisations with national programmes and expertise in the field.

The Irish Heart Foundation is calling for:

1. ***Amendment of the criteria for eligibility to apply for Strand 2 of the Healthy Ireland Fund to include non-statutory organisations***

1.3 Obesity: A whole of Government Approach needed

An integrated, consistent and effective cross Government approach is needed to tackle obesity. While an Obesity Policy Implementation Oversight Group (OPIOG) has been established under the auspices of the Department of Health to ensure the implementation of the National Obesity Policy and Action Plan, critical cross-Departmental buy-in to many of the actions in the report has been severely lacking. While interventions are possible in every setting of childhood, for example, in the home, crèche, preschool and school, these interventions require more than just the Department of Health.

1.3.1 Sugar Sweetened Drinks Tax (SSDT)

The SSDT commenced on 1 May 2018. The yield for 2018 totalled €16.51m and the estimate for 2019 is €35m.[26]

The SSDT legislation was amended in the Finance Act 2018 to bring defined categories of drinks that do not contain at least 119 milligrams of calcium per 100 millilitres within scope of the tax. The legislative amendments, which came into effect on 1 January 2019, impacted on sugar sweetened plant protein drinks and drinks containing milk fats, that fall within CN Code heading 2202. These drinks, that were previously excluded from taxation, are subject to SSDT if they have a total sugar content of five grams or more per 100 millilitres and do not carry nutritional information indicating a calcium content of at least 119 milligrams per 100 millilitres. The types of drinks within CN Code heading 2202 that were impacted by the legislative changes are those covered by five specific subheadings including

a) Plant protein drinks such as those based on soya, nuts, cereals and seeds
b) Drinks containing milk fats[27]

Currently, information is not available on the number of products affected by the imposition of a calcium threshold and Revenue does not maintain a list of products that are liable to SSDT.

[25] World Health Organisation. (2016). *Consideration of the evidence on childhood obesity for the Commission on Ending Childhood Obesity: Report of the Ad hoc Working Group on Science and Evidence for Ending Childhood Obesity.* Geneva, Switzerland: World Health Organisation

[26] Parliamentary Question 11546/19 to the Minister for Finance

[27] Parliamentary Question 11548/19 to the Minister for Finance

While the inclusion of these products is welcome, the Irish Heart Foundation remains concerned about the exemption of some milk products with added sugars from the tax. Whilst the specific health benefit criteria, defined as containing at least 119 milligrams of calcium per 100 millilitres, does extend the scope of the tax to certain drinks, there are still milk products with added sugars that are exempt. These should now come under the scope of the tax.

Whilst there was a resounding welcome for SSDT, it is clear that to bolster and develop its contribution to tackling childhood obesity, bolder actions must be taken. To date, the Department of Finance has refused to ringfence of the SSD tax revenues on the basis that it "reduces the flexibility of the Government to prioritise and allocate funds as necessary at a particular time. This constrains expenditure decisions and can distort the allocation of resources resulting in reduced value for money and sub-optimal outcomes."[28] However, despite this, the Department themselves have identified a number of historical and current precedents which show that this is not only possible but practicable:

- €168 million of the Tobacco Products Tax has been paid as an Appropriation-in-Aid to the Department of Health since Budget 1999.
- Motor Tax was paid into the Local Government Fund (this was the case up until end 2017, motor tax is now brought to account in the Exchequer).
- Lighthouse dues are collected by Revenue (€6m in 2017) and sent to the Department of Transport, Tourism and Sport.
- The environmental levy on plastic bags – provided for under Department of Communications, Climate Action and Environment legislation was also ringfenced and yielded revenue of €7m in 2017.

The Irish Heart Foundation strongly believe that where obesity is costing the Irish State €1.13billion[29] in direct and indirect costs and 55,056 premature deaths will occur because of childhood overweight and obesity[30], mechanisms similar to those employed with ring-fencing the plastic bag levy can be employed for the SSD tax. This must be done as a matter of priority in Budget 2019.

The Irish Heart Foundation is calling for:

2. ***The scope of the SSDT to be extended to milk products with added sugar.***

3. ***Information collection processes to be developed on products that are liable to the SSDT.***

4. ***Ringfencing of the funding from the SSD tax for measures to tackle childhood obesity and support children's health.***

[28] Response to Parliamentary Questions 22028/18 to the Minister for Finance 22nd May 2018. Available from: https://www.kildarestreet.com/wrans/?id=2018-05-22a.238&s=hypothecate#g239.q
[29] Department of Health. A Healthy Weight for Ireland- Obesity Policy and Action Plan 2016-2025. Dublin: The Stationery Office. Available from: http://health.gov.ie/wp-content/uploads/2016/09/A- Healthy-Weight- for-Ireland- Obesity-Policy-and-Action- Plan-2016-2025.pdf
[30] Ibid

1.3.2 Addressing VAT anomalies

The taxation of food in Ireland is not uniform. In general, most food sold is subject to VAT at the Zero rate, but there are many exceptions specified in the legislation where the Standard, Reduced rate or Second Reduced rate is to be applied.[31]

This has resulted in an unacceptable situation where foods that are high in fat, sugar and salt are generally subject to the standard 23% rate, some products were charged at a reduced rate of 13.5%. A cursory glance at Revenue's VAT database draws attention to an illogical situation in which foods such as hot takeaway food, croissants, chocolate chip biscuits and jam doughnuts are charged 13.5% VAT and others, including chocolate spread and frozen pizza, have a zero VAT rating.

The VAT system should be used to disincentivise the purchase of unhealthy food and make healthy food the cheaper option. We should no longer perpetuate a situation where food and drink products which fall into the category of healthy staples are taxed in the same way as non-essential, often unhealthy treats. The Healthy Ireland framework references the need for a whole-of-government and whole-of-society approach to influence the broader determinants of health and that governance for health considerations will be led at the highest level of Government – this measure would demonstrate the commitment of the Department of Finance and meet their commitments under the framework.

Currently, food is not defined in the Value-Added Tax Consolidation Act 2010, but Revenue provide guidance on the applicability of VAT on food and drink in their tax and duty manual. The Irish Heart Foundation believes that it is essential that eligibility criteria for VAT rates on food and drink products include a nutrient profiling model to identify unhealthy food products.

The Irish Heart Foundation recommend that the Government undertake a consultation on the adjustment of VAT rates on food and drink, with a view to addressing the anomalies that exist. While there is ongoing work at EU Level on the EU Action Plan on VAT, which aims to introduce more flexibility for Member States to change the VAT rates they apply to different products, national work on VAT food and drink rates cannot wait. Currently it is estimated that the overhauled VAT regime will not apply until 2022. Ireland must explore ways it can employ its national competences to adjust the VAT rates to address these anomalies.

Such an approach to tackling VAT and food is supported by public opinion. Research on Irish public attitudes towards policies to address obesity from Safefood and the HRB Centre for Health and Diet Research previously found that VAT measures had the second highest level of support of fiscal measures at 78.9%, behind subsidies for fruit and vegetables at 86.2%.[32]

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[31]Revenue. (2017). VAT on Food and Drink. Tax and Duty Manual. Available from: https://www.revenue.ie/en/tax-professionals/tdm/value-added-tax/part03-taxable-transactions-goods-ica-services/Goods/goods-food-and-drink.pdf

[32] Heery, E., Delaney, M., Kelleher, C., Wall, P. and McCarthy, M. (2014). Attitudes of the Irish Public Towards Policies to Address Obesity. Safefood & HRB Centre for Health and Diet Research. ISBN: 978-1-905767-44-1 Available from: http://www.safefood.eu/SafeFood/media/SafeFoodLibrary/Documents/Publications/Research%20Reports/Safefood-Attitudes-Report-Final.pdf

The Irish Heart Foundation is calling for:

5. ***A consultation to be undertaken by Government on the adjustment of VAT rates on food and drink, with a view to addressing the anomalies that exist. This can feed into ongoing work at EU Level on the EU Action Plan on VAT.***

1.3.3 Other Fiscal Measures

1.3.3.1 Developing the evidence base

Action point 1.8 of *A Healthy Weight for Ireland: Obesity Policy and Action Plan 2016-2025* commits to developing proposals on the rollout of evidence-based fiscal measures to support healthy eating and lifestyles and Action point 1.10 commits to a review of evidence for fiscal measures on products that are high in fat, sugar and salt to reduce their consumption. Both of these points are identified for action within the 2016-2018 timeframe but remain to be acted upon. In response to parliamentary questions, the Minister for Health has advised that "the question of considering further fiscal measures similar to the Sugar Sweetened Drinks Tax is being kept under review by the OPIOG during this early implementation phase of the Sugar Tax."[33]

However, given that the introduction of a sugar tax in Ireland was first discussed at policy level by the Special Action Group on Obesity (SAGO) at their inaugural meeting in June 2011, where it was agreed to further research the issue, and the tax did not come to fruition until 2018, it is important that preparatory research is undertaken to develop evidence for potential future measures. To advance Government policy in relation to action points 1.8 and 1.10 of the Obesity Plan, we would urge the Department of Finance to examine and research further evidence-based fiscal measures to address obesity and promote healthy eating.

The Irish Heart Foundation is calling for:

6. ***Research to commence immediately on other evidence based fiscal measures to support healthy eating and lifestyles.***

1.3.3.2 Subsidies

> *"Unfortunately, fruit and vegetables remain out of budget and inaccessible to many low-income families, and low-cost processed food might seem an easy option for busy parents. However, plans to address the affordability and accessibility of healthy foods remain insufficient, and parents and caregivers often lack the nutritional knowledge, parenting advice, and support to make healthy mealtimes a priority."*[34]

While the introduction of the SSDT may lead to a reduction in unhealthy beverage consumption, associated strategies are also needed to encourage consumption of nutrient

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[33] Parliamentary Question 11553/19 to the Minister for Health

[34] The Lancet Child & Adolescent Health. (2017). *No one is exempt in the fight against childhood obesity.* Editorial. VOLUME 1, ISSUE 2, P79, OCTOBER 01, 2017. [Online]. Available from: https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(17)30068-8/fulltext

dense foods on the other side. In that regard, it is important that public health policymakers collaborate with agriculture, food and trade policymakers to ensure that all citizens have access to nutritious and affordable food.

Using a detailed mathematical model, researchers from the University of Bath predicted the likely outcomes of three different policy scenarios to reduce unhealthy food consumption for both the UK and US. For both countries, their findings suggest that subsidies strike the best balance between effectiveness in changing behaviours and long-term monetary benefits to society. In the results they found that subsidies (a 10% discount) on healthy foods (fresh fruit and vegetables, fish and lean meats) was the most effective policy, reducing the percentage of overweight people from 57% to about 13%, at a cost of about £991m. When accounting for the saving to the NHS of not having to treat as many overweight related conditions, the net benefit of the policy equated to £6 billion in the long run.[35] This supports an earlier systematic review of the evidence on Healthy Food Subsidies and Unhealthy Food Taxation which concluded that taxes and subsidies should preferably be used in tandem.[36] This review found strong evidence across the research that taxation and subsidy policies can be effective for improving population dietary behaviours. The majority of studies summarised in this review showed evidence of effectiveness at increasing the consumption of healthier foods and lowering purchases of food high in fat, sodium, and sugar.

The Irish Heart Foundation is calling for:

7. ***Research to commence immediately on the most effective methods of funding healthy food subsidies in the Irish context***

1.3.4 Healthy Eating in Schools: School facilities

1.3.4.1 Food Preparation facilities in Schools

The Department of Education and Skills has no plans to conduct an audit of the cost of providing post primary schools with the equipment, infrastructure and facilities required to cook, prepare and serve meals to students, in addition to dining facilities for students.[37] Current Department guidelines provide for a standard range of serving and eating facilities in the design of new Post Primary schools. Although there is provision for a kitchenette, 25m² in area, off the General Purpose/Dining area, these are not intended to provide full commercial type canteens where food is prepared or cooked.

As the demand for school places grows, resulting in an increase in the development of new schools, design guidelines for post-primary schools should allow for facilities where food can be prepared and cooked, as well as ensuring adequate capacity for dining space.

The Irish Heart Foundation is calling for:

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[35] Flores, M., & Rivas, J. (2017). *Cash incentives and unhealthy food consumption.* Bulletin of Economic Research, 69(1), 42-56. [Online]. Available from: https://onlinelibrary.wiley.com/doi/epdf/10.1111/boer.12085

[36] Niebylski, Mark L. et al. *Healthy Food Subsidies and Unhealthy Food Taxation: A Systematic Review of the Evidence. Nutrition* 31.6 (2015): 787–795.

[37] Parliamentary Question 11565/19 to the Minister for Education and Skills

8. ***A national audit of post primary schools in respect of the equipment, infrastructure and facilities available to cook, prepare and serve meals to students in addition to the facilities in which they can eat to be conducted in the 2019/2020 school year.***

9. ***A revision of the design guidelines for post-primary schools to provide a better range of kitchen and eating facilities, which facilitate the preparation, cooking and eating of meals.***

1.3.4.2 Drinking Water

Tap drinking water systems are automatically included in new school buildings and extension projects. The Department has dedicated guidelines for Design Teams setting out the standards to be implemented for these construction projects and for all remediation projects. For existing school buildings, the availability of tap drinking water supplies is covered by the Department's Emergency Works Grant Scheme under the "mechanical" category. However, mechanical components of a building incorporate, among other things, all water systems, including tap drinking water supply. It is also open to schools to apply for remediation works under the Department's Summer Works Scheme which, likewise, has a "mechanical" category.[38]

There is still no clarity on how many schools across the country do not have access to potable drinking water. No audit of learning centres on the availability of potable drinking water has been undertaken, despite the National Obesity Policy and Action Plan indicating that all learning centres would have access to potable water. The Department of Education and Skills currently carry no specific information on whether, and how many, schools have contacted the Department in respect of the availability of drinking water nor the number of applications that have been made for financial support to address issues in which a school does not have a tap drinking water supply. The Minister has advised that:

> *"Given the range of components under the mechanical category in my Department's Grant Schemes, records of the detail of the individual grants approved are not held. As it is open to schools to apply for funding to address drinking water issues in their schools, I have no plans for an audit to be carried out."*[39]

The Irish Heart Foundation is calling for:

10. ***A national audit of all learning centres in respect of the availability of potable drinking water to be conducted in the 2019/2020 school year.***

1.3.5 School Meals

The school meals programme provides funding towards the provision of food to some 1,580 schools and organisations benefitting 250,000 children at a total cost of €57.6 million in 2019 representing an increase of €3.6 million over the previous year.[40]

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[38] Parliamentary Question 11569/19 to the Minister for Education and Skills
[39] Parliamentary Question 11569/19 to the Minister for Education and Skills
[40] Parliamentary Question 11559/19 to the Minister for Employment Affairs and Social Protection

The School Meals Programme is operated by the Department of Employment Affairs and Social Protection to meet the food costs of groups currently operating school meals projects. Priority for funding is currently given to schools which are part of the Department of Education and Skills' initiative for disadvantaged schools, 'Delivering Equality of Opportunity in Schools' (DEIS). The models of provision can range from the provision of full canteen services to the purchase of pre-prepared meals from specialist school meals suppliers or local suppliers.

In the 2017/2018 academic year there were 1,214 schools benefitting from the scheme; 367 of these schools do not have DEIS status.[41] The Irish Heart Foundation welcomes the extension of the School Meals Programme to non-DEIS schools, recognising that many children who are at risk of poverty or disadvantage are not all attending DEIS schools.

As part of Budget 2019, the Department of Employment Affairs and Social Protection announced a pilot scheme from September 2019, providing Hot School Meals in 36 schools for an estimated 7,200 children at a cost of €1 million for 2019 and €2.5 million in a full year. The pilot takes account of the fact that the majority of schools don't have kitchen/canteen facilities and that the food is prepared off-site in such instances.[42] The focus of the pilot will be on primary schools and currently there are no plans to extend it to youth services, early years settings and after-school programmes. In respect of the practical operation of the scheme:

- Schools will be selected having regard to geographical spread, numbers enrolled, range of suppliers and the overall budget available for the pilot in 2019 and 2020.
- Schools will identify a supplier who will supply, prepare and deliver the hot meals in line with HACCP and food safety regulations in compliance with the Healthy Ireland nutrition standards for school meals.
- The practical details of the delivery and service of the meals will be worked out on an individual basis during meetings between each school, their supplier and officials from the Department.[43]

As previously mentioned, the school meals programme is not universal and priority is given to DEIS schools, as decided by the Department of Education and Skills. Moreover, "the settings where children most at risk of experiencing food poverty are, early years settings for young children and youth services for teenagers, do not form part of the School Meals Programme."[44] Recognising this, and both the initial extension of the school meals programme to some non-DEIS schools and the hot school meals pilot announced in Budget 2019, the Irish Heart Foundation would welcome a further pilot scheme to roll out the school meals scheme to cover youth services, early years settings and after-school programmes.

[41] Parliamentary Question 11559/19 to the Minister for Employment Affairs and Social Protection
[42] Parliamentary Question 11561/19 to the Minister for Employment Affairs and Social Protection
[43] Parliamentary Questions 19002/19 and 19003/19 to the Minister for Employment Affairs and Social Protection
[44] Children's Rights Alliance. (2017). *Pre-Budget Submission 2018.* July 2017. Available from: https://www.childrensrights.ie/sites/default/files/submissions_reports/files/Children%27s%20Rights%20Alliance%20Pre-Budget%20Submission%20_DSP.pdf p8

The cost of increasing the programme is presented in Table 1. Looking at the expenditure from the school meals programme, a 10% increase in expenditure in Budget 2020 from the 2019 budgetary allocation of €57.6 million, could fund a pilot, as well as meet the costs of the extension of the Hot School Meals Pilot Scheme to more schools.

Table 1: Cost of increasing expenditure on the school meals programme[45]

Increase	**Cost €m**
5%	2.8
10%	5.7
15%	8.6
20%	11.3

The Irish Heart Foundation is calling for:

11. ***The extension of the Hot School Meals Pilot Scheme to a further 36 schools for an estimated 7,200 children at a cost of €1 million for 2020 and €2.5 million in a full year. This is in recognition that a report on the scheme will not issue until the pilot is complete and the outcomes evaluated, but that the merit of such a scheme cannot be ignored and further expansion should be provided for.***

12. ***The development of a pilot scheme for the school meals programme to cover youth services, early years settings and after-school programmes at a cost of €3.2m to address the issue of food poverty for children and young people availing of those services.***

1.3.6 Department of Agriculture, Food and the Marine School Scheme in Ireland

The EU School Milk Scheme merged with the EU School Fruit and Vegetables Scheme on 1 August 2017 to form a Single School Scheme under a joint EU legal and financial framework: Applicable since the 1 August 2017, the school fruit, vegetables and milk scheme combines the 2 previous schemes (school fruit and vegetables scheme and school milk scheme) under a single legal framework.[46]

Table 2 shows the number of schools and the number of children participating in the School Milk Scheme for the last five academic years. It should be noted that not every child in every school is participating in the school milk scheme and similarly, it should be noted that there was a change in the methodology of calculation by the Department following the change in the EU Regulatory framework with effect from August 2017. In accordance with the six-year Statement of Strategy for the implementation of the School Scheme in Ireland (1 August 2017 – 31 July 2023), the Department projects that 700 schools and 120,000 children will participate in the School Fruit and Vegetables Scheme in the 2018/19 school year.[47]

[45] Parliamentary Question 14733/19 to the Minister for Employment Affairs and Social Protection
[46] School fruit, vegetables and milk scheme: https://ec.europa.eu/agriculture/school-scheme_en
[47] Parliamentary Question 11572/19 to the Minister for Agriculture, Food and the Marine

Table 2: The number of schools and the number of children participating in the School Milk Scheme for the last five academic years[48]

	2017/2018*	**2016/2017**	**2015/2016**	**2014/2015**	**2013/2014**
Number of Schools	531*	691	782	899	1061
Number of Children	69,514*	38,536	42,544	47,791	51,160

In the eight school years preceding the 2017/18 school year, participation in the School Milk Scheme in Ireland had decreased by more than 50%. This led the Minister for Agriculture, Food and the Marine to commission research to identify the barriers to the uptake of the Scheme. The research identified a number of reasons for the decrease in participation levels, including: an increase in water consumption (31%); price perceived as too expensive (15%); parental contribution required for non-DEIS schools (15%); children do not consume milk at home (23%). The research also highlighted issues regarding facilities and equipment, including the frequency of delivery, particularly in rural areas, and the quality of milk where deliveries of milk are made outside the school grounds in the early hours of the morning.[49]

A number of initiatives are being implemented by the Department[50] to address these barriers, including but not limited to:

- A targeted recruitment campaign by the National Dairy Council (NDC)
- Enhanced accompanying measures/educational resources
- Increasing the parental subsidy by 60% to make the scheme more affordable for parents.
- Trialling a new method of delivery of milk to schools.
- The NDC is addressing the issue of frequency of deliveries in contracts with individual suppliers.

However, the Irish Heart Foundation would note that more needs to be done in respect of facilities and equipment. While the frequency of deliveries is important in respect of ensuring that the volume of milk that is being delivered is adequate and appropriate, if there are barriers in schools with relation to refrigeration facilities, this must be addressed to ensure that schools are able to participate in the scheme.

The Irish Heart Foundation is calling for:

13. The inclusion of refrigeration facilities and associated equipment in a national audit of schools participation in the School Milk Scheme to be conducted in the 2019/2020 school year to determine the success to date of the Irish six year Statement of Strategy for the Implementation of the School Scheme in Ireland covering the period 1 August 2017 - 31 July 2023.

[48] Parliamentary Question 11570/19 to the Minister for Agriculture, Food and the Marine
[49] Parliamentary Question 11571/19 to the Minister for Agriculture, Food and the Marine
[50] Parliamentary Question 11571/19 to the Minister for Agriculture, Food and the Marine

1.4 Early Years

> *"The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health to educational achievement and economic status."*[51]

Step 9 of the Ten Steps Forward to prevent overweight and obesity in A Healthy Weight for Ireland: Obesity Policy and Action Plan 2016-2025, gives the commitment to:
"Allocate resources according to need, in particular to those population groups most in need of support in the prevention and management of obesity, with particular emphasis on families and children during the first 1,000 days of life."

1.4.1 Healthy Start

Healthy Start is a UK-wide statutory scheme providing a nutritional safety net to pregnant women and children under the age of four in low-income families in receipt of certain benefits or tax credits. Pregnant women or mothers with a child under four years old in the UK can get Healthy Start vouchers to help buy some basic foods. This means-tested scheme provides vouchers to spend with local retailers. One £3.10 voucher per week is available to pregnant women and children over the age of one and under four years. Two £3.10 vouchers (£6.20) per week can be obtained for children under the age of one.[52]

The Government recently published *First 5* - a Whole-of-Government Strategy for Babies, Young Children and their Families (2019-2028). As part of this cross-departmental approach, the Department of Health is working with the Department of Children and Youth Affairs on establishing a work programme on food poverty.[53] It is important that this work includes all possible initiatives that can begin to address health inequalities and food poverty.

The Irish Heart Foundation is calling for:

14. As part of the cross-departmental Strategy for Babies, Young Children and their Families and the work programme on food poverty, evaluation of the potential to introduce a scheme similar to Healthy Start in Ireland.

1.5 Re-build workforce capacity for children's health and wellbeing

The Government workforce needs capacity building in protecting children's health and wellbeing, including prevention specialists, developing skills within the clinical health workforce and in other government departments such as education, housing, transport, sport and recreation, local government and planning. This will assist them to play a vital role in addressing the social determinants that affect health outcomes.

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[51] Marmot M. (2010). Fair Society, Healthy Lives. The Marmot Review. Strategic Review of Health Inequalities in England post-2010. London. Available from: http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf p22

[52] See https://www.healthystart.nhs.uk/healthy-start-vouchers/

[53] Parliamentary Questions 18168/19 and 18169/19 to the Minister for Health

A population-based approach based on progressive universalism is required for prevention. This is the stated basis of the National Healthy Childhood Programme with key parent-professional interaction at contact points antenatally and throughout the child's early years.[54] However, this Programme needs to be adequately resourced to ensure the issues pertaining to a healthy weight for children are addressed at each contact point. In that regard, while identification of unhealthy weight of children is important, it is critical that health professionals have access to effective services, supports and programmes they can refer patients into. The Irish Heart Foundation believes that the focus on prevention must now emphasise the need to translate effective intervention components into practice and scale up interventions.

The Committee on the Future of Healthcare Sláintecare Report proposes that funding be provided for an additional 900 generalist nurses to work in the community "to free up PHNs to do child health work as part of the current Nurture-Infant Health and Wellbeing programme and the HSE's National Healthy Childhood Programme. Given the known importance of in utero health, child health and wellbeing services need to start with the mothers and parents, providing antenatal support including mental health, better developed midwifery services, breastfeeding and parenting supports including peer supports."[55] This proposal comes under the Slaintecare recommendation to resource and develop a universal child health and wellbeing service, at a cost of €41m over the first five years.

The Irish Heart Foundation is calling for:

15. Resource and develop Child Health & Wellbeing service according to the 10-year Sláintecare Plan, with €8,292,780 investment in Budget 2020

1.6 Legislative and policy reforms

The Irish Heart Foundation recommends further law and policy reforms to support healthy lifestyles to build on the successes of smoke-free laws and the Public Health (Alcohol) Act 2018.
In that regard, there is a need to:

- Expedite the introduction of the calorie posting legislation to the Oireachtas as a matter of priority
- Introduce and/or support legislation in the Oireachtas that will ban junk food advertising to children
- Make the health and wellbeing of people and communities a priority in our planning laws, including connecting pathways to make walking and cycling easier, as well as introducing guidelines to reduce the proliferation of fast food outlets near schools or creches.

[54] HSE. (2018). Tackling Childhood Obesity A written submission from the Health Service Executive to the Joint Committee on Children and Youth Affairs. [Online] Available from: https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_children_and_youth_affairs/submissions/2018/2018-08-22_submission-health-service-executive_en.pdf

[55] Houses of the Oireachtas Future of Healthcare Committee. (2017). Slaintecare Report. May 2017. [Online]. Available from: https://webarchive.oireachtas.ie/parliament/media/committees/futureofhealthcare/oireachtas-committee-on-the-future-of-healthcare-slaintecare-report-300517.pdf p63

The Irish Heart Foundation is calling for:

16. **A range of legislative measures to protect public health, particularly among children and young people, including an end to advertising of unhealthy food and beverages directed at under-18s.**

Part 2: Stroke

Budget actions to invest in Stroke services

Aim	2020 Action	Investment
Ensure that endovascular stroke centres providing thrombectomy are developed in conjunction with emergency services to provide access for all suitable stroke patients regardless of location	The 3 year incremental plan for the new and replacement equipment from 2020-2022 inclusive to be expedited, making the remaining €6.4m available in the Capital Plan for 2020	€6.4m
Ensure that every hospital treating stroke has a properly functioning service whereby 90% of stroke patients spend 90% of their hospital stay in a stroke unit	Investment to meet the current 180 stroke bed deficit	€10,350,000
Roll out Early Supported Discharge programmes nationally for stroke patients	The national roll out of ESD for stroke patients, beginning with Year 1 of the phased roll out, including addressing staffing deficits in the six existing teams, at a cost of €1,290,481 in 2020	€1,290,481
Implementation of the National Neurorehabilitation Strategy to develop neurorehabilitation services from acute, post-acute and community services across the country	Dedicated funding for the MCRN demonstrator project in CHOs 6 & 7, with initial funding for phase 1	€4,585,214
		€ 22,625,695

2.1 Background

Stroke is a medical emergency and urgent treatment is essential. Following a stroke, people need urgent access to high quality acute care and should be supported afterwards with rehabilitation, psychological support and longer-term social care provision where required.

Around 8,000 people will be hospitalised due to stroke in Ireland this year with an average

age of onset of 74 years[56]. At least 1,700 stroke patients will die, with 1,000 being discharged to nursing home care and the remainder returning home. It's estimated that well over 60,000 people are living with the effects of a stroke in Ireland.

Small upfront funding to improve acute services, rehabilitation and home care would reduce overall costs and shift the balance of spending from a point after which the recovery of stroke sufferers can best be influenced, into services that will save more lives, reduce disability and use resources more efficiently.

Currently, there is no guarantee that all patients with stroke will have access to evidence-based treatment and care that has been proven to save lives and reduce disability. In fact, we know many will not:

- According to the IHF/HSE National Stroke Audit 2016, only 29% of stroke patients are admitted to a stroke unit and just over half receive any treatment in a unit. This is in spite of ESRI research borne out by the achievements of the National Programme showing that the more patients that can avail of stroke unit care, the greater the human and cost effectiveness.
- Research shows that over 3,000 stroke patients could benefit from Early Supported Discharge programmes[57] that would improve outcomes whilst reducing overall costs by freeing up 24,000 acute bed days a year. However, in spite of the weight of evidence in favour of ESD at home and internationally, service development has been limited since initial pilots were instigated.
- A health technology assessment by HIQA has recommended the development of emergency clot removal treatment called thrombectomy which is associated with major reductions in stroke death and severe disability, but this has not developed into a full national service.
- No hospital treating stroke in Ireland meets minimum international standards in the delivery of rehabilitation services[58].

The Government has an opportunity to vastly improve access to stroke treatment and support across Ireland, so more patients survive, avoid significant disability and live well after stroke. A concerted national approach is needed to ensure evidenced-based stroke treatment and care is available nationally and the new five-year stroke strategy must be properly resourced to do so.

2.2 Thrombectomy

Thrombectomy has become world-wide standard of care for acute stroke patients since 2015. HIQA, in their January 2017 Health Technology Assessment of thrombectomy[59] found

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[56] McElwaine, P., McCormack, J., Harbison, J. on behalf of the National Stroke Programme. *Irish Heart Foundation/HSE National Stroke Audit 2015*. December 2016

[57] Early Supported Discharge is an intensive approach to rehabilitation that involves patients receiving therapy services such as physiotherapy and speech and language therapy in their own homes, rather than in hospital. Evidence from Ireland and internationally shows it improves the likelihood of a good recovery, is cheaper than keeping people in hospital and frees up beds for those who need them most.

[58][58]McElwaine, P., McCormack, J., Harbison, J. on behalf of the National Stroke Programme. Irish Heart Foundation/HSE National Stroke Audit 2015. December 2016

[59] HIQA, Health Technological Assessment of national emergency endovascular service for mechanical thrombectomy in

that a national emergency endovascular service providing mechanical thrombectomy would be cost-effective.

In line with this investment and commitment to the ongoing development of thrombectomy is the need to ensure equitable access to the new standard of care treatment in acute stroke. Ensuring equitable access to and benefit from mechanical thrombectomy will require the existing regional variability in access to thrombolysis and stroke services to be addressed. Therefore, investment must be supported by revamped ambulance and air ambulance services to admit eligible patients countrywide up to 12 hours after symptom onset so that all hospitals treating acute stroke should have access to a referral pathway, with rapid assessment and transfer of suitable patients.

In 2018, 375 patients presented or were referred to Beaumont Hospital and Cork University Hospital for thrombectomy[60]. Based on international observations, up to 800 patients might be suitable for this highly specialised and effective time dependent treatment. To maximise its lifesaving impact, there must be sufficient staff and resources in place. Currently, however, there is a need for replacement and new Biplane Angiography equipment. The 2019 HSE Capital Plan included a four-year incremental plan for this[61]:

Table 3: 4 Year Incremental Plan to fund new and replacement Biplane Angiography equipment

Year	**Cost**	**Total**
2019	€0.5m	
2020	€1.5m	
2021	€4.5m	
2022	€0.4m	
		€6.9m

The Irish Heart Foundation welcomes that the replacement and new equipment has been included in the HSE Capital plan for 2019. However, the incremental phasing of this funding does not only delay putting the service on a fully national footing. There have been well publicised concerns that the near-obsolete equipment being used could break down depriving stroke patients of the service for up to ten months.

The Irish Heart Foundation is calling for:

17. The 3-year incremental plan for the new and replacement equipment from 2020-2022 inclusive to be expedited, making the remaining €6.4m available in the Capital Plan for 2020.

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the management of acute ischaemic stroke. 25 January 2017. Available from: https://www.hiqa.ie/sites/default/files/2017-02/Mechanical-Thrombectomy-technical-report.pdf

[60] Parliamentary Question 11606/19 to the Minister for Health

[61] Ibid

2.3 Stroke Units

Access to stroke unit care is estimated to reduce mortality and severe disability from stroke by around 25%. The Irish Heart Foundation/HSE National Stroke Audit 2015 found that just 29% of stroke patients are admitted to a unit and 52% spend any portion of their hospital stay in one. In addition, almost one in four hospitals in Ireland treating stroke do not meet the minimum organisational standards required to operate a stroke unit.

2.3.1 Stroke Beds

The National Stroke Audit identified 150 stroke beds in Ireland, a deficit of around 250 beds nationally for the current population on the basis of recommendations contained in the UK National Clinical Guidelines for Stroke. However, the HSE report that there are currently 220 stroke unit beds housed within 22 stroke units in Ireland.[62] However, the Stroke Alliance for Europe (SAFE) report[63] estimated that stroke incidence will increase by 59% by 2030. The HSE have advised that in order to manage this predicted increase, it may in fact be necessary to plan for 600 stroke unit beds into the future.[64] To meet the current staffing requirements for approximately 400 stroke unit beds, costs are estimated by the HSE to be €23 million.[65] Therefore, the investment required to meet the current 180 stroke bed deficit would be expected to be €10,350,000. It is also important to note that further investment in patient equipment and monitoring equipment would be required in all hospitals, and these infrastructural needs must also be identified and met.

The Irish Heart Foundation is calling for:

18. Investment to meet the current 180 stroke bed deficit, at a cost of €10,350,000.

2.4 Early Supported Discharge (ESD)

International studies show that 25-40% of all stroke patients can benefit from Early ESD programmes.[66] In their 2012 Cochrane Review of ESD , Fearon, Langhorne & the Early Supported Discharge Trialists also concluded that: *'appropriately resourced ESD services provided for a selected group of stroke patients can reduce long-term dependency and admission to institutional care as well as reducing the length of hospital stay ….with no observed adverse impact on the mood or subjective health status of patients or carers.'*[67]

The 2014 Economic and Social Research Institute (ESRI), Royal College of Surgeons in Ireland (RCSI) and Irish Heart Foundation report *Towards Earlier Discharge, Better Outcomes, Lower Costs: Stroke rehabilitation in Ireland* concludes that almost half all of stroke sufferers in Ireland – over 3,000 people each year, could avail of ESD, resulting in

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[62] Parliamentary Question 11608/19 to the Minister for Health

[63] The Burden of Stroke in Europe, King's College London for the Stroke Alliance for Europe 2017. Available from: http://www.strokeeurope.eu/downloads/The_Burden_of_Stroke_in_Europe_Report_-_Appendix.pdf

[64] Parliamentary Question 20548/18 to the Minister for Health

[65] Ibid

[66] Fearon, P., Langhorne, P. (2012) Early Supported Discharge Trialists. Services for reducing duration of hospital care for acute stroke patients. Cochrane Database of Systematic Reviews 2012, Issue 9. Art. No.: CD000443.

[67] Fearon, P., Langhorne, P. (2012) Early Supported Discharge Trialists. Services for reducing duration of hospital care for acute stroke patients. Cochrane Database of Systematic Reviews 2012, Issue 9. Art. No.: CD000443.

annual savings of some 24,000 bed days.

Currently there are six teams providing Early supported Discharge for stroke patients in Ireland. However, there exists staffing deficits across each of these six ESD teams, the total full year costs of meeting this amounting to €765,040.[68]

In recent years, the National Stroke Programme has proposed a 3 year phased ESD roll out to establish ESD teams in 14 hospitals covering approximately 60% of the population. The estimated costs of a national roll out of ESD for stroke patients, including addressing current staffing deficits in the existing teams has been estimated at €2,329,363:[69]

Table 5: Costs of 3 year Phased ESD Roll out

Year	**Funding Cost**	**Total**
2020	€1,290,481	
2021	€649,299	
2022	€389,583	
		€2,329,363

The Irish Heart Foundation believes that in the first instance, the current ESD teams should be funded to ensure the necessary staffing requirements for an ESD team are met. Therefore, Budget 2020 should ensure that funding is made available for these posts, with immediate recruitment. Similarly, as per the NCPS plan to consolidate and develop ESD teams, Budget 2020 should develop the next phase of ESD teams in 2020.

The Irish Heart Foundation is calling for:

19. The national roll out of ESD for stroke patients, beginning with Year 1 of the phased roll out, including addressing staffing deficits in the six existing teams, at a cost of €1,290,481 in 2020.

2.5 Neurorehabilitation Plan

The HSE published the implementation plan for the National Neurorehabilitation Strategy on 20th February 2019, eight years after the launch of the original policy document. The three-year framework outlines a ten-step plan to develop neurorehabilitation services from acute, post-acute and community services across the country. While the publication of this long-awaited implementation plan is welcome, the plan will do nothing to improve access to neurorehabilitation unless it is accompanied by dedicated investment to support implementation. Furthermore, even though the plan outlines a three-year framework for the development of neurorehabilitation services across both hospital and community networks, much of the detail still needs to be decided. However, in the interim, a

[68] Parliamentary Question 11611/19 to the Minister for Health
[69] Parliamentary Question 11612/19 to the Minister for Health

demonstrator project has commenced in CHOs 6&7, which has been divided into phase 1 and phase 2, the costs of which include:

- A community neurorehabilitation team in both CHO 6&7
- Development of inpatient neurorehabilitation services at both Royal Hospital Donnybrook and Peamount
- Enhancement of services at the National Rehabilitation Hospital.

The cost of phase 1 is estimated at €4,585,214 and phase 2 is estimated at €7,738,332.[70]

The Irish Heart Foundation is calling for:

20. Dedicated funding for the MCRN demonstrator project. Initially, phase 1 should be funded at a cost of €4,585,214 in Budget 2020.

[70] Parliamentary Question 11614/19 to the Minister for Health

Part 3: Heart Disease

Budget actions to tackle heart disease

Aim	2020 Action	Investment
Overcoming geographical gaps in the Model of Care for Heart Failure	Address the geographical gap in the provision of heart failure services in the South/South West hospital group, where no structured services currently exist	€750,000
Further roll out of Heart Failure community projects	Further implementation of heart failure integrated care projects in the community, as per the business plans of the National Clinical Programme for Heart Failure	€966,000
Ensure adequate capacity for cardiac rehabilitation for patients for which cardiac rehabilitation is recommended	Provide adequate national capacity for cardiac rehabilitation for patients for whom cardiac rehabilitation is recommended	€9.6 million
Implementation of the new Out of Hospital Cardiac Arrest (OHCA) Strategy	The establishment of the OHCA Strategy Implementation Office	€250,000
		€11,566,000

3.1 Heart Failure

3.1.1 Background

Heart failure remains a major public health issue with high recurrent hospital admission, regional disparities in services and outcomes, and disconnected care. The overall prevalence rate of heart failure in Ireland is approximately 2% which equates to approximately 90,000 people with a five year mortality rate of 36%[71]. Over 10,000 cases of Heart Failure are diagnosed annually in Ireland[72] and the total cost of heart failure to the State is estimated at €660 million each year.[73] In 2012, Heart Failure accounted for 231,042 hospital bed days

[71] James S, Barton D, O'Connell E, Voon V, Murtagh G, Watson C, et al. Life expectancy for community-based patients with heart failure from time of diagnosis. International Journal of Cardiology. 2015;178:268-74.
[72] Department of Health and Children. Changing Cardiovascular Health. National Cardiovascular Health Policy 2010 - 2019. 2010; Parliamentary Questions No 17253/17-17258/17 to the Minister for Health
[73] The Heartbeat Trust. The cost of heart failure in Ireland. The social, economic and health implications of Heart Failure in Ireland. Dublin: The Heartbeat Trust, 2015

and re-admission rates for heart failure range between 24% to 44%.

Problem

Heart failure (HF) is a debilitating condition and once a person has been admitted to hospital with it there is a high chance of readmission. 250,000 people are at immediate risk of developing heart failure, with increases in demand for chronic disease management at community level. There are also varying levels of heart failure service throughout the country

Solution

Five areas have been identified for developing heart failure services in Ireland[1]:

1. Ensuring there are sufficient resources to implement the National Clinical Programme for HF, adequately funding both general practice and hospital care
2. Ensuring that patients with symptoms of HF are diagnosed without delay
3. Continuing to develop a coordinated national programme between the hospital and community to provide greater continuity of care and encourage patient self-management
4. Supporting a national HF prevention programme
5. Ensuring that community-based peer support is available to all HF patients

3.1.2 Gaps in the Model of Care for Heart Failure

The HSE have advised that it is not currently possible to quantify the figure that would be needed to fully implement an updated integrated Model of Care (MoC) for Heart Failure. However, an exercise to establish these costs is planned as part of the review and update of the MoC.[74] An audit of existing services has been conducted and the results are being studied currently, with a service gap analysis also planned.[75]

However, of the 12 HF units, there is just one in the whole of Munster located in Limerick, compared to six serving Dublin. The inability of patients in counties Cork and Kerry in particular to access what is internationally regarded as a basic standard of care has been described as a 'gaping hole' in services by the clinical lead of the HSE's national HF programme, Professor Ken McDonald. Priority must be given to overcoming geographical gaps in services.

The costs associated with establishing a heart failure service/specialist team in a model 3 or 4 hospital where no existing heart failure services exist are approximately €375,000 per hospital. This funding would be for the appointment of a Consultant Cardiologist with an interest in heart failure, two clinical nurse specialists and the provision of B-type Natriuretic Peptide testing and based on the implementation of the existing model of care.[76] Therefore, to establish a HF service in Cork University Hospital and University Hospital Kerry where no HF services exist, an investment of €750,000 is necessary.

[74] Parliamentary Question 11618/19 to the Minister for Health
[75] Parliamentary Question 11617/19 to the Minister for Health
[76] Parliamentary Question 11616/19 to the Minister for Health

The National Clinical Programme for Heart Failure have advised that there are currently local plans to recruit Consultant Cardiologist(s) to support the implementation of a heart failure service for the South/South West Area.[77]

3.1.3 Heart Failure community projects

In a 2016 Report, *Impact of living in the community with heart failure*[78], allied healthcare professionals identified a significant need for more community resources, referral systems and education for healthcare professionals. The National Clinical Programme on Heart Failure currently operates a number of successful pilot projects on virtual clinics – a facility to support GPs to manage heart failure patients in the community. At a time of a "growing community of often unsupported heart failure sufferers trying hard to cope with inadequate services, barriers to proper care, [and] a dearth of community supports"[79], a service to enable specialists and GPs to discuss cases is hugely important. The aim of the virtual clinics is stated to "reduce need for referral to outpatient department, increase confidence of GPs in managing heart failure in the community and improve GP-specialist team interaction."[80]

Over the past three years progress has been made to seed and expand the Heart Failure Integrated Care Virtual Consultation Service in the Ireland East Hospital Group (IEHG) catchment area. The HSE has funded the continuation of this service in Carlow-Kilkenny for 2019. This funding amounts to €156,000. Full year costs to continue this service beyond 2019 are €217,000. Under the estimates process for 2019 the IEHG and the National Clinical Programme for Heart Failure submitted business plans to support the continuation of this service and its expansion on the East Coast. The current cost of this business plan is €486,000. A business plan has also been submitted to roll out the service to the Dublin North (Mater Hospital) catchment area. This plan is costed at €263,000. Plans for the extension of the service beyond the St. Vincent's Hospital and Mater Hospital catchment areas to the rest of the country has not yet been costed, as it is unlikely in the short term.[81]

The Irish Heart Foundation is calling for:

21. ***Removing the geographical gap in the provision of heart failure services in the South/South West hospital group, where no structured services currently exist at a cost of €750,000.***

22. ***Further implementation of heart failure integrated care projects in the community, as per the business plans of the National Clinical Programme for Heart Failure, at a cost of €966,000.***

[77] Parliamentary Question 11618/19 to the Minister for Health
[78] Department of Psychology, Division of Population and Health Sciences, Royal College of Surgeons in Ireland (RCSI) for the Irish Heart Foundation. Impact of living in the community with heart failure. Experience of heart failure patients, their families and allied healthcare providers. 2016
[79] Ibid p5
[80] See Heart Failure Virtual Clinic: http://www.ehealthireland.ie/Case-Studies-/Heart-Failure-Virtual-Clinic/
[81] Parliamentary Question 11619/19 to the Minister for Health

3.2 Cardiac Rehabilitation

Problem
Cardiac rehabilitation services currently only meet 39% of the rehabilitation needs for the core conditions of acute coronary syndrome, revascularisation and heart failure and the unmet need for rehabilitation services for the other cardiovascular conditions recommended in guidelines is far greater, with only 22% - 33% of the need being met.

Solution
Increasing participation in cardiac rehabilitation is a great investment. Cardiac rehabilitation reduces repeat heart attacks and unnecessary hospital admissions, boosts recovery and productivity, saves lives and lowers health costs.

3.2.1 Background

Despite the fact that HIQA reported that cardiac rehabilitation is one of the most cost-effective methods of educating patients and giving them the skills needed to self-care for cardiac conditions, no additional funding was made available to date in 2019 to develop cardiac rehabilitation around the country.[82]

A HSE needs assessment for cardiac rehabilitation research completed in November 2016 showed capacity to provide cardiac rehabilitation for fewer than 5,000 patients compared with a need to accommodate almost 13,000 annually following an admission with coronary heart disease or heart failure alone – equating to an ability to meet 39% of need.

Geographical disparities are also apparent with need compared to capacity by county varying from 9% to 75%. Referrals for cardiac rehabilitation were 41% below their target figure and HF patients were a particularly under-represented group comprising only 5% of referrals.

There were significant reductions in staffing; whole time equivalent posts had fallen by 62.7% since 2009. Some of the centres with the lowest capacity compared to need were operating nearly single handed and had minimal other services available to them or were reliant on good will only to provide a service. Requirement for services is likely to increase due to population factors which are driving a predicted increase in cardiovascular disease of 4-5% per annum. This equates to an additional 25% of unmet need in the next 5 years alone.

The study concludes that not only does cardiac rehabilitation reduce mortality and hospitalisations, it is cost effective and has the potential to save money and reduce pressures on acute services by saving an estimated 6,090 inpatient bed days.

Cardiac rehabilitation services should be expanded to be widely accessible and specifically inclusive of heart failure patients. In order to provide adequate national capacity for cardiac rehabilitation for patients for whom cardiac rehabilitation is recommended, €9.6million will

[82] Parliamentary Question 11620/19 to the Minister for Health

be required annually.[83] Budget 2020 must make this funding available given its cost effectiveness and significant human benefit.

The Irish Heart Foundation is calling for:

23. The provision of adequate national capacity for cardiac rehabilitation for patients for whom cardiac rehabilitation is recommended.

3.3 Out of Hospital Cardiac Arrest (OHCA)

Out-of-hospital cardiac arrest (OHCA) is the term used to describe events where cardiac arrest occurs unexpectedly and is responded to by statutory emergency medical services (EMS). Death from OHCA is frequent but not inevitable if resuscitation is attempted when the patient collapses.

The Out of Hospital Cardiac Arrest (OHCA) Strategy, completed earlier this year, aims to save 400 additional lives by 2023 by ensuring that 15% of the Irish population is trained to provide early, effective CPR and to increase the percentage of patients receiving timely defibrillation to at least 30%.

Recommendations were made around six objectives, including optimising:

- Early recognition of OHCA and early dispatch of emergency resources
- Early, effective CPR
- Timely defibrillation
- Pe-hospital advanced life support
- Post Resuscitation Care
- Appropriate rehabilitation and aftercare

The HSE has accepted a robust implementation plan for the Strategy, including the establishment of a Strategy Implementation Office with a full-time coordinator. It was agreed that this post will be overseen by an independent OHCA Governance Implementation Group which will monitor quality improvement against each objective as well as overall implementation.

However, the implementation groups haven't been appointed whilst funding has not been provided to establish the project office. Without the appointment of a Governance Implementation Group consisting of representatives from the principle stakeholder organisations, the transformations required to improve survival will not be achievable. And in the absence of funding for the establishment of a project office to support the executive lead and to coordinate the actions of the Governance Implementation Group, the capacity of the Governance Group to achieve the transformations required to improve OHCA survival will be severely limited.

The OHCA Strategy team has estimated that an allocation of approximately €250,000 would be sufficient to fund the establishment of a project office and to support the work of the Governance Implementation Group in 2020. This in turn would unlock the added value of

[83] Parliamentary Question 11621/19 to the Minister for Health

coordinating our national approach to OHCA management and help achieve a meaningful increase in cardiac arrest survival.

The Irish Heart Foundation is calling for:

24. ***The establishment of the OHCA Strategy Implementation Office, at a cost of €250,000.***

Part 4: Tobacco Control

Budget actions to reduce smoking rate

Aim	2020 Action	Investment/Revenue
Reduce the level of smoking in Ireland	Introduce an annual tobacco tax escalator on a pro-rata basis so 20 stick packs of cigarettes cost at least €20 by 2025, with equivalent rates for roll your own tobacco and heated tobacco products	No estimate available. Aim to reduce overall revenue by reducing smoking rate
Provide further smoking cessation services and support for smokers seeking to quit	Increase funds being directed to tobacco cessation programs to €50 million in 2020	€50 million investment
Reduce the profitability of the Tobacco Industry in Ireland	Introduce a levy on tobacco industry profits, with revenue used to support smokers to quit	Estimated revenue forecast ranges from €11,401,544 to €35,475,440
Reduce the number of Tobacco Points of Sale (POS) in Ireland	Increase the tobacco retailer license fee from a once-off payment of €50 per entity to an annual fee of €500 per retail outlet that sells tobacco	No information available
Reduce the level of cigarette smuggling	Provide additional support for revenue in tackling the illicit tobacco trade	Increased resources (staffing and funding) for Revenue

4.1 Tobacco Taxation

4.1.1 Background

According to the latest Healthy Ireland survey[84], 20% of the current population are smokers. Although the rate of smoking is declining here, bold action is needed if we intend to achieve the Government's objective of a Tobacco Free Ireland of a smoking prevalence of less than 5% by 2025.

Tobacco use is still the leading cause of preventable death in Ireland with almost 6,000 smokers dying each year from tobacco related diseases[85]. Smoking causes heart disease, stroke, cancer, COPD and a range of other diseases. It can also trigger serious asthma

[84] Department of Health (2018) Healthy Ireland Survey 2018 [Online] Available at:https://health.gov.ie/wp-content/uploads/2018/10/Healthy-Ireland-Survey-2018.pdf

[85] HSE: "Smoking- The Facts" [Online] Available at: https://www.hse.ie/eng/about/who/tobaccocontrol/kf/

attacks in children and adults. One in two smokers will die of a smoking-related illness[86]. With 20%, or an estimated 800,000, of the current population still smoking, a significant proportion of our society will die due to tobacco related diseases.

Evidence shows that the most effective way to reduce demand for cigarettes is through taxation[87]. Therefore, we are recommending that tax on 20 cigarettes at the most popular price category should increase annually on a pro-rata basis so that the overall cost of a pack reaches €20 by 2025.

Below, table 6 sets out the most popular price category (MPPC) for a pack of 20 cigarettes (displayed in cents) following the €0.50 tax increase from budget 2018 and the additional €0.30 trade increase during the year.

Table 6: Price of MPPC for a pack of 20 cigarette sticks in 2018[88]

Enforcement Day	Pre Budget MPPC	Tax Increase	Trade Increase during Year	Post Budget MPPC	Excise Duty	Total Tax (inc VAT)
01-May-18	1,220.00 (€12.20)		20.00	1,220.0 (€12.20)	728.37	956.50
10-Oct-18	1,220.00 (€12.20)	50.00	30.00	1,300.0 (€13.00.)	769.01	1,006.49

According to elasticity modelling results from Revenue, the price elasticity of demand for taxed cigarette consumption in Ireland ranges from -1.6 to -2.0, averaging at -1.8. The interpretation is that a 10 per cent *increase* in the price of cigarettes is associated with a *decline* in the consumption of taxed cigarettes of 18% on average.[89]

The Revenue paper says: "…recent falls in prevalence rates indicate that a major part of the responsiveness now driving the elasticity may be from smokers quitting (or reducing smoking) rather than substitution to other products. The elasticity results have policy implications. They suggest that a tobacco tax increase could lead to an overall reduction in the Exchequer receipts associated with cigarettes."

The Government's stated purpose in imposing increases in tobacco tax is as a health measure to reduce the smoking rate and thereby the high burden of chronic disease caused by tobacco in Ireland. Just as falling prevalence rates demonstrate the effectiveness of this policy, reduction in tax receipts resulting from less smoking should equally be viewed as a measure of success.

If the Government is serious about one of its flagship health policies, achieving a Tobacco Free Ireland which is defined as reducing the national smoking rate to 5% or less by 2025, the Minister for Finance has to be serious about imposing measures that will dramatically

[86] HSE (2019) "Reasons to Quit Smoking"[Online] Available at: https://www2.hse.ie/wellbeing/quit-smoking/reasons-to-quit-smoking/smoking-facts-and-figures.html

[87] World Health Organisation: Raise taxes on tobacco [Online] Available at: https://www.who.int/tobacco/mpower/publications/en_tfi_mpower_brochure_r.pdf

[88] Parliamentary Question 137 to 139 of 16/10/2018

[89] Kennedy, S. Pigott, V. and Walsh, K. (2015). Economics of Tobacco: An analysis of cigarette demand in Ireland. [PDF]. Available at: https://www.drugsandalcohol.ie/25305/1/economics-of-tobacco-2015.pdf

reduce tobacco tax receipts by reducing smoking rates. Any failure to maximise the reduction in smoking that can be achieved through fiscal measures in order to maximise tobacco tax receipts would suggest that the priority is to raise revenue rather than to protect public health.

Consequently, to deliver on national policy, the Minister should pursue a dual policy of significant additional annual increases in tobacco tax, coupled with greatly enhanced support for the vast majority of smokers who want to quit.

We propose the introduction of an annual tobacco tax escalator that will increase the price of a pack of 20 cigarettes from the current retail price of €13 to at least €20 by the 2025 deadline for a Tobacco Free Ireland. If delivered on a pro rata basis, this would result in an increase of €1.17 per pack in Budget 2020. In tandem with this, we are also calling for a more than fourfold increase in funding for tobacco control measures to €50 million.

Australian tobacco tax escalator

Table 7: Price and tax share as % of a 20-cigarette pack of the most sold brand[90]

Year	Australian prices AUD $[91]	AUD/EUR exchange rate average[92]	Australian Prices EUR €	Ireland Prices Eur €[93]
2018	26.36	0.632851	16.68	12.70
2016	21.00	0.672243	14.12	11.30
2014	17.05	0.679508	11.59	10.00
2012	13.63	0.806041	10.99	9.30
2010	11.98	0.693333	8.31	8.55

Calculations

Australia: Price of a 20-cigarette pack of the most sold brand
Winfield 25s $32.95 x 0.8 (to get price of a 20-pack) = AUS$26.36

In addition to the conclusions of the Revenue report, the impact of significant tax increases in Australia provides a strong evidence base for similar action here. In 2017-18, just under one in seven (13.8%) adults over 18 years of age were daily smokers in Australia.[94] This success has been driven by a range of public health measures such as plain packaging, the indoor smoking ban and by significant annual tax hikes on tobacco. In December 2013, the Australian Government introduced a long-term escalating tobacco tax regime and began implementing staged annual 12.5% tobacco excise increases and excise equivalent customs duty on tobacco and tobacco-related products. This was subsequently followed by

[90] World Health Organisation. (2017) WHO report on the global tobacco epidemic 2017, Tobacco taxes and prices – Appendix IX
[91] World Health Organisation. (2017) WHO report on the global tobacco epidemic 2017, Tobacco taxes and prices – Appendix IX
[92] OFX (2019). Yearly Average Exchange Rates. [Online]. Available at: https://www.ofx.com/en-au/forex-news/historical-exchange-rates/monthly-average-rates/
[93] Parliamentary Question 137 to 139, 16/10/2018
[94] Australian Bureau of Statistics. (2019). National Health Survey: First Results, 2017-18. [Online]. Available at: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2017-18~Main%20Features~Smoking~85

additional 12.5% increases on 1 September 2014 through to 2018 and will continue to 2019 and 2020 inclusive[95].

As seen in Table 8, Australia's smoking rate declined between 1995 and 2018. Over this time, the retail prices of the leading cigarette brands increased.

Table 8: Smoking rate and price of leading retail brands in Australia over period 1995 - 2018[96]

Year	1995	2001	2004-05	2007-08	2011-12	2014-15	2017-18
Smoking rate	23.8%	22.3%	21.3%	19.1%	16.3%	14.7%	13.8%
Retail price of leading cigarette brand in Australia[97]							
Year	**1995**	**2001**	**2004-05**	**2007-08**	**2011-12**	**2014-15**	**2017-18**
Winfield 25s AUS$	5.11	8.70	10.30	11.70	17.15	23.65	29.60
Benson & Hedges 25s AUS$	5.20	8.95	10.60	12.00	17.95	25.45	31.50
Peter Jackson 30s AUS$	5.66	9.95	11.70	13.10	18.90	27.25	33.80
Longbeach 40s AUS$	7.01	12.75	14.95	16.70	24.80	34.70	43.40

These annual tax increases had a significant impact on smokers' motivation to quit. Between 2007 and 2016, more and more smokers cited smoking costing too much as the primary factor that motivated change to smoking behaviour, rising from 35.8% in 2007 to 51.8% in 2016[98]. A 2016 Australian budget document stated that:

> *Increases in tobacco excise over the last two decades have contributed to significant declines in the number of people smoking daily*[99]

This commitment by the Australian Government to increase tobacco taxation on an annual basis was reaffirmed in 2016 when it announced that it would implement a further four annual 12.5% increases in tobacco excise and excise equivalent customs duties, with the first taking effect on the 1st of September 2017.[100] This measure, along with changes to the duty free tobacco allowance is expected to raise $4.7 billion in net revenue from 2016 to 2020.[101]

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[95] The Department of Health. (2018). Tobacco excise. [Online]. Available at: https://www.health.gov.au/internet/publications/publishing.nsf/Content/tobacco-control-toc~excise

[96] The Department of Health. (2018). Smoking prevalence rates. [Online]. Available at: https://www.health.gov.au/internet/publications/publishing.nsf/Content/tobacco-control-toc~smoking-rates

[97] The Cancer Council Victoria. (2017). The price of tobacco products in Australia. [Online]. Available at: https://www.tobaccoinaustralia.org.au/13-3-the-price-of-tobacco-products-in-australia#x4.

[98] Australian Institute of Health and Welfare (2017) National Drug Strategy Household Survey 2016: detailed findings. Data tables: Chapter 3 Tobacco. Available here: https://www.aihw.gov.au/reports-data/behaviours-risk-factors/smoking/data

[99] Australian Government. (2016). Promoting health by reducing smoking. [PDF]. Available at: https://archive.budget.gov.au/2016-17/factsheets/tax/09-TFS-Tobacco.pdf

[100] Australian Government. (2016). Budget 2016-17. [PDF]. Available at: https://archive.budget.gov.au/2016-17/glossies/Budget2016-17-Tax-Super.pdf

[101] Parliament of Australia. (2016.) Tobacco excise increase. [Online]. Available at: https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201617/Tobacco

The Irish Heart Foundation is calling for:

25. A commitment to increasing tobacco taxation annually on a pro-rata basis so that all packs of 20 cigarettes cost at least €20 by 2025. This would require an increase of €1.17 on a pack in 2020.

4.1.2 Roll-your-own cigarettes

An increase in tobacco taxation on cigarettes can lead to consumers switching to other tobacco products however, such as Roll-your-own (RYO) cigarettes. This is reflected in data showing that RYO consumption increased eight-fold between 2003 and 2016[102]. Since 2005, driven by an increase in RYO consumption, Tobacco Product Tax (TPT) receipts on 'Other Smoking Tobacco', or Roll Your Own (RYO) products have risen from €26m to €110m at the end of 2018[103].

In the midst of regular Budget increases on manufactured cigarettes, the excise on RYO tobacco has remained substantially lower. This has made RYO cigarettes more appealing, particularly to younger smokers. Indeed, the highest prevalence of RYO smokers is among under 25 year-olds who account for 45% of the market[104]. Therefore, to maximise the health impact of tax increases on cigarettes, there is a need for action to close the price gap with RYO.

The consumption of RYO cigarettes is a significant public health issue as they expose smokers to similar levels of carcinogens as manufactured cigarettes[105].There is also evidence to show that the risks are higher for RYO smokers in terms of particular cancers such as cancer of the oesophagus, mouth, pharynx and larynx. Although price has been shown to be the main reason for smoking RYO, they are also chosen as they are thought be healthier than manufactured cigarettes with less risk.[106]

The Irish Heart Foundation recommends that Budget 2020 significantly narrows the price variability and price gaps between products in the tobacco market. This recommendation is in accordance with the views of the Tobacco Free Ireland Programme and National Tobacco Control Office of the HSE, who note that: "Taxation policy on RYO cigarettes should be reviewed to minimize the price differential between RYO and manufactured cigarettes."[107]

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[102] HSE (2018) The State of Tobacco Control in Ireland [Online] Available at: https://www.hse.ie/eng/about/who/tobaccocontrol/the-state-of-tobacco-control-in-ireland%E2%80%932018-report.pdf

[103] Department of Finance (2018)General Excise Paper – Alcohol Products Tax, Tobacco Products Tax, and Betting Duty [Online] Available at: https://assets.gov.ie/4447/131218111459-39f9e3ace54f4567a170c3571cf9997e.pdf

[104] Evans, David S and O'Farrell, Anne and Hickey, Paul (2017) Roll your own cigarettes in Ireland: key patterns and trends. Dublin: Health Service Executive

[105] Shahab, L., West, R., McNeill, A., A comparison of exposure to carcinogens among roll-your-own and factory-made cigarette smokers. Addiction Biology, 2009. 14(3): 315-320

[106] Evans, David S and O'Farrell, Anne and Hickey, Paul (2017) Roll your own cigarettes in Ireland: key patterns and trends. Dublin: Health Service Executive

[107] The Tobacco Free Ireland Programme &National Tobacco Control Office, Health Service Executive. (2017). Roll Your Own Cigarettes in Ireland. Key Patterns and Trends. Available from: https://www.hse.ie/eng/about/who/tobaccocontrol/rollyour-own-report-2017.pdf

The Irish Heart Foundation is calling for:

26. An equivalent annual tobacco tax increase on RYO and the adoption of a taxation policy that acknowledges the substitution impact and adjusts tax rates accordingly to remove incentives to switch to a cheaper alternative.

4.1.3 Heated Tobacco Products Taxation

Heated tobacco products (HTPs) are tobacco products that produce aerosols containing nicotine and other chemicals, which are inhaled by users, through the mouth. HTPs differ from electronic cigarettes in that they contain tobacco. They produce nicotine-infused vapour by heating tobacco up to 350°C by using a battery-powered heating system. [108] The majority of tobacco companies have introduced their own version of HTPs onto the market and are attempting to engage with consumers' health concerns by claiming that HTPs are significantly reduced risk products – a claim that is scientifically unsubstantiated.[109]

Although they have yet to appear on the Irish market, they have been launched in a number of EU Member States and have been considered in various forms for tax purposes. Revenue has indicated that under current legislation they would be treated for excise purpose as 'other tobacco category' were they be launched in the Irish market.[110]

Despite the marketing claims of tobacco companies, the WHO states that there is currently no evidence to demonstrate that HTPs are indeed less harmful than traditional cigarettes. If Revenue were to treat HTPs as 'other tobacco category' under excise purposes, then they would be subject to lower excise tax compared to conventional cigarettes given the high excise gap on per stick basis between the 'other tobacco category' and the 'cigarettes' category.

In the 2018 general excise paper, the Tax Strategy Group advised that it would be the prudent option from a public health perspective to insert a definition of HTPs in the legislation for the purpose of applying the standard excise duty on these products.
As there is no evidence to demonstrate that HTPs are less harmful than conventional tobacco products, it is our recommendation that the government enact this and apply HTPs with the standard excise duty so that no excise gap emerges between these products and standard cigarettes.

The Irish Heart Foundation is calling for:

27. The application of the standard excise duty rate of cigarettes to be applied to Heated Tobacco Products

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[108] World Health Organisation. (2018). Heated tobacco products (HTPs) information sheet. [Online]. Available at: https://www.who.int/tobacco/publications/prod_regulation/heated-tobacco-products/en/

[109] WHO. Heated tobacco products (HTPs) market monitoring information sheet [online] Available at: https://www.who.int/tobacco/publications/prod_regulation/htps-marketing-monitoring/en/

[110] Department of Finance. (2018). Tax Strategy Group General Excise Paper 2018. [PDF]. Available at: https://www.gov.ie/en/publication/b7b3c0-tax-strategy-group-0618-general-excise/

4.2 Tobacco cessation measures

The rate of smoking in Ireland currently stands at 20%, which means we have in the region of 800,000 current smokers. However, research shows that 83% of smokers in Ireland regret starting and would like to quit[111].

But despite an estimated annual cost of smoking to the State totalling €1,653 million[112], the State spent just over €11.8 million[113] in 2017 on smoking cessation measures including medications, quit services, the national quitline and mass media campaigns. Given that revenue raised from tobacco tax totalled almost €1,400 million[114] in the same year, less than 1% of the additional tax handed over by smokers went towards measures to help them quit.

To achieve a reduction in Ireland's smoking rate and help the vast majority of smokers who want to quit, adequate cessation services must be put in place. This requires a dramatic increase in the level of funding being directed annually to tobacco cessation services. The investment should provide greater access to a range of evidence-based cessation services to support smokers to quit.

4.2.1 Background

Table 9 below provides a breakdown of the funding directed to smoking cessation measures in 2017.

Table 9: The amount of funding spent on tobacco cessation measures by service in 2017[115]

Year	Service	€	%
2017	Smoking Cessation Medications	8,504,801	72
	Social Marketing	1,668,000	14
	National Quitline	259,724	2
	Smoking Cessation Staff Costs	1,371,129	12
	Total	**11,803,654**	**100%**

Investing in adequate cessation measures is critical if we intend to achieve the Tobacco Free Ireland objective by 2025. The effect that Nicotine Replacement Therapy (NRT) and

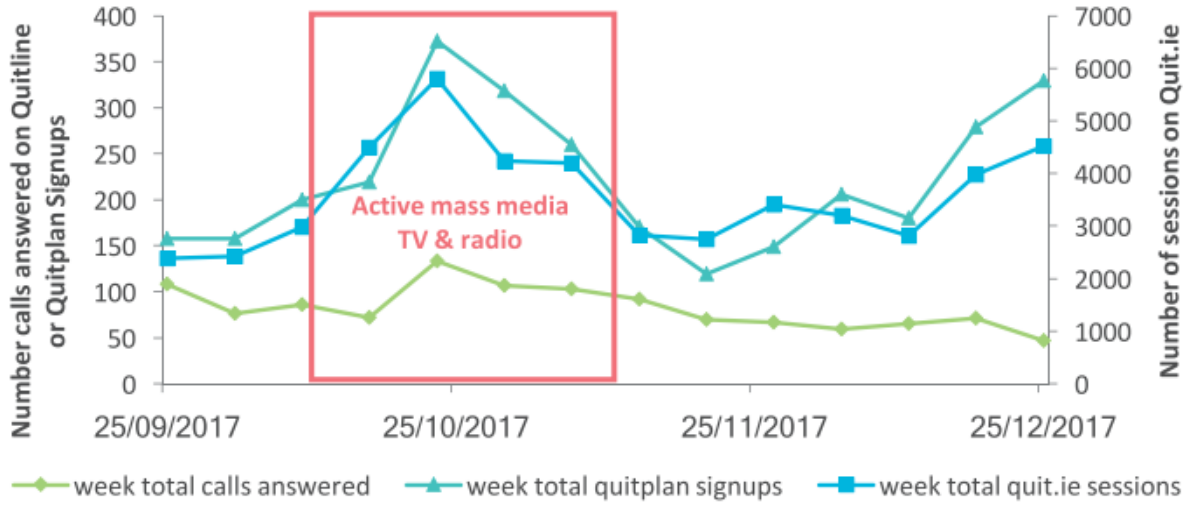
[111] HSE (2019) "Reasons to Quit Smoking"[Online] Available at: https://www2.hse.ie/wellbeing/quit-smoking/reasons-to-quit-smoking/smoking-facts-and-figures.html
[112] ICF International (2016) An assessment of the economic cost of smoking in Ireland [Online] Available at: https://health.gov.ie/wp-content/uploads/2016/08/An-assessment-of-the-economic-cost-of-smoking-in-Ireland.pdf
[113] Parliamentary Question 46154/18 on 22/11/2018
[114] Revenue (2019) Excise receipts by commodity. [PDF] Available at: https://www.revenue.ie/en/corporate/documents/statistics/excise/net-receipts-by-commodity.pdf
[115] Parliamentary Question 46154/18 on 22/11/2018

behavioural interventions have in helping smokers to quit has been proven. A 2018 Cochrane Review indicated that all forms of NRT made it more likely that a person's attempt to quit smoking would succeed. The chances of stopping smoking were increased by 50 to 60%.[116]

Moreover, the 2017 Health Information and Quality Authority Health Technology Assessment of smoking cessation interventions showed that maximising the use of NRT and varenicline, a prescription medication used to treat nicotine addiction, is the most cost-effective smoking cessation strategy. In addition, it determined that all behaviour-based interventions were effective and compared with a control group behaviour therapy was the most effective intervention increasing the likelihood of a successful quit attempt almost 2-fold. [117] In summary, the paper concluded that people who smoke and are making a quit attempt can increase the likelihood of effectively becoming smoke-free by over 2-3 fold through accessing help and using a smoking cessation intervention.

The role of mass media campaigns in raising the awareness and overall demand for smoking cessation measures, such as Quitline, is also highly important. Figure A below from the 2018 State of Tobacco Control in Ireland report shows that a mass media campaign that was active on television from the 23rd of October to 12th November 2017 and on radio from the 23rd of October to the 5th November 2017 resulted in a 56% increase in calls to the QUIT helpline, an 89% increase in sessions on the QUIT website and 102% increase in QUIT Plan sign-ups, following commencement of the mass media campaign. [118]

Figure A: Demonstration of the impact of mass media campaigns on demand for Quit services, September-end to December 2017



[116] Can nicotine replacement therapy (NRT) help people quit smoking? (Cochrane Review) 2018 https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0010505/ 17

[117] Health Information and Quality Authority (2017), 'Health Technology Assessment of Smoking Cessation Interventions'. https://www.hiqa.ie/sites/default/files/2017-04/Smoking%20Cessation%20HTA.pdf

[118] HSE (2018). The State of Tobacco Control in Ireland. Available at: https://www.hse.ie/eng/about/who/tobaccocontrol/the-state-of-tobacco-control-in-ireland%E2%80%932018-report.pdf

In Australia, the rate of smoking currently stands at 13.8%, down from 16.3% in 2011-12. In addition to high annual tobacco tax increases, its National Tobacco Strategy[119] prioritised a range of evidence-based cessation services to support smokers to quit. [120]

These included increasing the availability and range of smoking cessation services such as Quitline and web-based programs, particularly for segments of the population with a high rate of smoking prevalence. Moreover, systems were developed to encourage health professionals to make every contact count and improve the management of smoking cessation practices for all patients in healthcare facilities. Similar measures like these should be rolled out in Ireland and resourced with adequate funding to achieve real results.

To maximise impact, additional funding should be targeted at communities with the highest smoking rates. The burden of tobacco related diseases and death is being borne by the poorest in society. Evidence from the 2018 Healthy Ireland survey[121] indicates that smoking rates are higher in more disadvantaged areas (26%) than in more affluent areas (16%). While the level of overall smoking in Ireland has dropped over the past several years, the decline has been more pronounced among people with higher incomes. This has exacerbated the health gap between the socio-economic groups.

In light of the effectiveness of cessation services, the high proportion of smokers who want to quit and the lack of assistance available to them in spite of their high additional tax burden, we believe a major injection of funding for cessation measures in Budget 2020 is fully justified.

The Irish Heart Foundation is calling for:

28. ***Increasing the level of funding for tobacco cessation services more than fourfold from the current total of €11.8 million to €50 million in 2020.***

[119] Commonwealth of Australia. (2012). National Tobacco Strategy 2012-2018. [PDF]. Available at: http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/D4E3727950BDBAE4CA257AE70003730C/$File/National%20Tobacco%20Strategy%202012-2018.pdf

[120] The Cancer Council Victoria. (2016). National policy and progress in encouraging and supporting cessation. [Online]. Available at: https://www.tobaccoinaustralia.org.au/chapter-7-cessation/7-20-towards-a-national-cessation-strategy#x6.

[121] Department of Health (2018) Healthy Ireland Survey 2018 [Online] Available at:https://health.gov.ie/wp-content/uploads/2018/10/Healthy-Ireland-Survey-2018.pdf

4.3 Introduce a Levy on Tobacco Industry Profits

Problem

The tobacco industry worldwide makes billions in profits every year from its deadly products, which contributed to 5,899 deaths in Ireland in 2017[122]. However, even with the introduction of tobacco control policies around the world and forecasts from health officials that smoking rates in the developed world could plummet to single digit levels, big tobacco remains a thriving, profitable and growing industry for its shareholders[123]. Over the past three decades, shares of tobacco companies on the FTSE 100 have brought back record yields, out-performing all other typical consumer industry staples[124].

When tobacco companies earn a significant proportion of profits from high prices and reinvest them in product innovation, marketing and lobbying activities, this undermines tobacco control measures. It is the stated objective of the Irish Government to reduce the smoking rate to 5% by 2025, which requires an estimated 75% reduction in smoking prevalence between 2019 and 2025. The tobacco industry in Ireland has continually lobbied against tax increases, while at the same time increased its own prices year-on-year, depriving the Government of tax revenue which could have been collected.[125]

Solution

In 2012, we first proposed the capping of tobacco industry profits[126] in order to ensure the tobacco industry would contribute to addressing the harms caused by their product. In 2014, a recommendation to introduce a levy on the tobacco industry was included in the Department of Health's Tobacco Free Ireland action plan[127]; however there has been little progress to implement this recommendation.

The use of levies to achieve policy objectives is relatively common in Ireland. Levies have been imposed on the banking sector at various times to raise revenue including in 1981, 2003 and most recently as part of Budget 2014.[128] The market power enjoyed by the four

[122] HSE (2018) The State of Tobacco Control in Ireland [Online] Available at: https://www.hse.ie/eng/about/who/tobaccocontrol/the-state-of-tobacco-control-in-ireland%E2%80%932018-report.pdf

[123] Davies, R. (2017) How big tobacco has survived death and taxes [Online]. The Guardian. Available at: https://www.theguardian.com/world/2017/jul/11/how-big-tobacco-has-survived-death-and-taxes

[124] Collinson, P. (2019) The best investment of the past 35 years? Sadly, it was cigarettes [Online] The Guardian. Available at: https://www.theguardian.com/money/2019/jan/26/the-best-investment-of-the-past-35-years-sadly-it-was-cigarettes

[125] See Howell, F. (2012) 'The Irish tobacco industry position on price increases on tobacco products'. Tobacco Control, 21(5), 514-6.

[126] For a discussion of the rationale for a profit levy and the possible structuring of such a levy see, Branston, J.R. and Gilmore, A. (2015) 'The extreme profitability of the UK tobacco market and the rationale for a new tobacco levy'. University of Bath. http://opus.bath.ac.uk/43061/1/The_extreme_profitability_of_the_UK_tobacco_market_and_levy_V4.5_final.pdf

[127] The Tobacco Free Ireland Action Plan (2014) includes the commitment to: 'Introduce a tobacco industry levy or similar mechanism which could be ring fenced to fund health promotion and tobacco control initiatives including support to end the illegal trade'. http://health.gov.ie/wp-content/uploads/2015/03/Tobacco-Free-Ireland-Action-Plan..pdf

[128] Department of Finance (2015) Tax Strategy Group 15/05 'General Excise Duties (Tobacco, Alcohol, Betting and Others). Available at: http://www.finance.gov.ie/sites/default/files/TSG%2015%2005%20General%20Excise%20Duties%20%28Final%29.pdf.

main industry players enables them to manipulate tobacco prices. Based on this market feature and on the very negative health effects of tobacco use, it is our recommendation that efforts are made to make the tobacco industry pay more for the harms created by their products.

4.3.1 Background – Tobacco profit levy on the tobacco industry

The tobacco industry in Ireland is immensely profitable and given the economic cost of tobacco consumption, measures should be taken to ensure the tobacco industry is compelled to make a more significant contribution to rebalance its impact on the Irish economy. Research from Branston (2015)[129] for the Irish Heart Foundation and Irish Cancer Society suggests that the tobacco industry makes somewhere between €110 million and €150 million in profits annually. The research indicates that tobacco manufacturers and importers also enjoy consistently high profit margins of up to 60%, compared to only 12-20% in most consumer staple industries.

Given that the tobacco industry earns extraordinary profits and has a history of passing on tax and price increases to the consumer, we suggest a profit-based levy that will make it impossible for the industry to simply shift the levy increase onto the retail purchase price.

Unlike a levy based on revenue (potentially calculated on a fee per stick basis), a levy calculated on the profit of the tobacco industry could not be passed on to consumers. The difference between existing tobacco taxation and such a levy is that the industry would be providing money directly to the state to reduce the societal harm caused by tobacco. The financial burden of tobacco cost the Irish exchequer €1.6 billion in 2016 and cost the Health Service €460 million.[130] While estimates of corporate profits will be imperfect, in practice all taxes fail to raise as much in practice as in theory. That is, no tax will ever generate its full yield due to tax avoidance and tax evasion.

Tobacco remains a legal product and we are not suggesting that the tobacco industry should be unable to make an ordinary level of profit on the manufacture and sale of tobacco. However, tobacco companies should not be allowed to enjoy extraordinary profits. Revenue from the levy could be hypothecated to further improve smoking cessation services and tobacco control so that, in effect, it is a contribution by the tobacco industry towards partially meeting the costs faced by society by the sale of their products and can be used to prevent future harm.

The most recent information we have on tobacco manufacturers' profitability tells us that despite legislation directed at encouraging the smoker to quit, the supply side has been relatively untouched, and this has allowed the industry to earn very high profit margins in Ireland. This is despite the high financial and social costs caused by smoking.

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[129] Branston, J.R. (2015) The profitably of the Irish tobacco market and the benefits of a new levy on tobacco company profits. Other. University of Bath.

[130] HSE Tobacco Free Ireland Programme Implementation Plan 2018-2021
https://www.hse.ie/eng/about/who/tobaccocontrol/tobaccofreeireland/03849-hse-tfi-plan-2018-2021-proof-08.pdf

Branston (2015)[133] calculates the estimated yield in 2012 from a 10% profit levy as ranging from between €11.4 million to €14.2 million and a yield from a 25% levy as ranging from between €28.5 million to €35.5 million. Given that tobacco industry profitability is notoriously difficult to calculate, the table below offers a number of different profit estimations based on the data that are available. The Government would have access to more detailed information on tobacco industry profits as they require all companies to present profit information for corporation tax purposes.

Table 10: Estimated Profitability of the Irish Tobacco Market

	2010	**2011**	**2012**
Low scenario (€)	130,595,268	121,782,100	114,015,451
High scenario (€)	151,844,467	146,717,406	141,901,761

Source: Branston (2015)[133]

Table 11: Estimated Yield from Tobacco Profits Levy

	2010	**2011**	**2012**
10% levy – low scenario profit estimate (€)	13,059,527	12,178,210	11,401,544
10% levy – high scenario profit estimate	15,184,447	14,671,741	14,190,176
25% levy – low scenario profit estimate	32,648,817	30,445,525	28,503,863
25% levy – high scenario profit estimate	37,961,117	36,679,352	35,475,440

Source: Branston (2015)[133]

The methodology used for these calculations, including the derivation of profit levels, is available upon request.

Tobacco levies in other jurisdictions

In the US, the tobacco industry pays a user fee[131] under the Family Smoking Prevention and Tobacco Control Act 2009. The Act requires domestic manufacturers and importers of tobacco products to submit data needed to calculate these 'user fees' for tobacco products. This levy is independent of the wider US fiscal regime and its proceeds are controlled directly by the US Food and Drug Administration (FDA), meaning the tobacco industry has no control over the money or how it should be allocated.

The FDA spends the majority of tobacco user fees on key activities led by the agency's Centre for Tobacco Products (CTP), which is funded solely by tobacco user fees[132]. The user fees are calculated on the costs of tobacco regulation and then apportioned to tobacco companies according to their market share in the U.S. The fact that the U.S. has successfully

[131] Food and Drugs Administration (2018) Family Smoking Prevention and Tobacco Control Act Table of Contents [Online]. Available at: https://www.fda.gov/tobacco-products/rules-regulations-and-guidance/family-smoking-prevention-and-tobacco-control-act-table-contents

[132] These included activities related to public education (including public education campaigns and communicating CTP activities); regulatory science (including research, product review, and developing the science to support regulations and guidance); and compliance and enforcement (including tobacco retailer inspections; manufacturer and import inspections and enforcement; promotion, advertising, and labelling surveillance; and outreach and small business assistance). See: http://gao.gov/products/GAO-14-561

introduced a special levy on the tobacco industry highlights that there is no real impediment to introducing a similarly principled charge in Ireland.

In addition to the US, other countries are also acting on the conviction that the tobacco industry needs to contribute more towards smoking related diseases and resulting productivity losses that its products cause.

Actions going forward

Previous Tax Strategy Group papers from the Department of Finance discussed the introduction of a Tobacco Industry levy. Drawing on the conclusions of the British Treasury in 2015 following its public consultation on introducing a tobacco levy, the Department noted that a levy of this type "is not without complications and may have impacts on other areas of the economy."[133] However, it is important to note that the model examined by the British Treasury and that being proposed in this Pre-Budget Submission are different. For that reason, we propose that the Department of Finance undertake an immediate assessment of the proposal to introduce a levy on tobacco industry profits

Spotlight: The British Tobacco Levy Proposal[134]

Policy Description:
"The Tobacco Levy would be a new direct tax on tobacco manufacturers and importers. It would work by setting a target amount of revenue, assumed to be £150m, which would then be apportioned to each company on the basis of their market share."

Rationale not to introduce:
"Evidence from the consultation, supported by evidence from changes to tobacco duties in recent years, was clear that manufacturers and importers would pay for the levy by fully passing on the Levy to consumers by raising retail prices."

Difference between British proposal and tobacco industry profit levy:
The policy examined by the British Treasury is akin to a tobacco duty on sales, whereas a levy on profits would be completely different. Unlike current tobacco duties, the levy on tobacco company profits would have the effect of raising revenue in a way that cannot be passed on to the consumer. This is unlike anything that has been done before and would complement Government policy to make Ireland tobacco free by 2025.

We welcome the actions of the Minister to date which has seen increases in the price of a packet of cigarettes, thus "raising revenue and contributing to the continued decline of smoking prevalence".[135] However, Branston and Gilmore (2015) explored tobacco profitability in the UK market and found that in the period since 2009, tobacco companies have made profits in excess of £1bn each year and these are increasing despite declining

[133] PQs 231 & 232 of 02/05/2017
[134] HM Treasury (2015). Tobacco levy: response to the consultation. September 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464795/PU1814_Tobacco_Levy_final_v3.pdf p6
[135] PQs 231 & 232 of 02/05/2017

sales.[136] Furthermore, they concluded that revenue based levies (such as that examined by the British Treasury) suffer from being paid on sales volumes, translating to costs being passed on to the end consumer, without any impact on industry profitability.

The Minister for Finance has stated that "the Government has agreed that pricing is a key means of reducing tobacco consumption."[137] It is important that tobacco products are subject to high levels of taxation given the importance of price controls in smoking cessation. However, these controls as a means of curbing consumption alone are undermined when the capacity of tobacco companies to generate and maintain a significant proportion of profits from high pricing still remains. Consistent with the research undertaken by Branston (2015), we believe that the introduction of a profit-based levy would be complementary to existing tobacco control policy as it would not interfere with pricing policies or the prerogative of Government to set additional excise duties on tobacco.

The Irish Heart Foundation is calling for:

29. The introduction of a profits levy on the tobacco industry, as recommended by the Department of Health's Tobacco Free Ireland Action Plan[138].

4.4 Tobacco retailer licence fee

If an entity in Ireland sells or intends to sell tobacco products by retail whether over the counter or from a self-service vending machine, then they must register with the National Tobacco Control Office (NTCO)[139]. Each applicant registering with the NTCO must pay a once-off application fee of €50 and this fee only applies to an entity rather than a specific retail outlet[140]. Therefore, a tobacco retailer with several retail outlets only has to register and pay one single administration fee to sell tobacco in all its outlets.

Increasing the tobacco retailer license fee from a once-off payment of €50 per entity to a minimum annual license fee of €500 per outlet in which they sell tobacco would create a much more robust system. This fee would support further development and the maintenance of the HSE retailer database.

4.4.1 - Background

The license fee paid by retailers is derisory and, in many ways, has facilitated the sale of tobacco products in far too many retail outlets, which does not apply in many other jurisdictions. A retailer selling tobacco forms the most crucial element of the tobacco supply chain, linking tobacco manufacturers and wholesalers to consumers. And while the ban on

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[136] Branston, J. R. and Gilmore, A., 2015. The extreme profitability of the UK tobacco market and the rationale for a new tobacco levy. University of Bath. http://opus.bath.ac.uk/43061/

[137] PQs 231 & 232 of 02/05/2017 spell PQs in full

[138] Department of Health (2015) Tobacco Free Ireland Action Plan [Online]. Available at: https://health.gov.ie/wp-content/uploads/2015/03/Tobacco-Free-Ireland-Action-Plan..pdf

[139] National Register of Tobacco Retailers. About the Register. [Online] Available at: http://www.tobaccoregister.ie/about-the-register/about-the-register.html

[140] National Tobacco Control Office, HSE 2019, email, 22 May, <info.tobaccoregister@hse.ie>

point of sale advertising[141] places tobacco products out of sight, it does not limit the availability of tobacco products for purchase.

There is growing evidence from Australia that greater retail availability of tobacco, as measured by retailer density and proximity, is associated with greater overall smoking prevalence, including increased likelihood of youth initiation and reduced cessation amongst existing smokers[142]. In Ireland, there are currently 13,243 retail outlets registered to sell tobacco on the National Register of Tobacco Retailers[144], meaning that there is an estimated one tobacco retail outlet for every 360 people.

In New South Wales, Australia, for example, a study on retail outlet density and smoker perceptions and behaviour found that 88% of smokers reported daily retail availability of tobacco within walking distance, leading to a conservative estimate of one tobacco outlet for every 77 smokers. It concluded that some groups of smokers appear vulnerable to the availability of tobacco, and that a reduction in the availability of tobacco would likely benefit smokers who wish to quit[143]. Research from the US exploring the effects of alcohol retailer density on drinking behaviours identified a similar trend as it linked greater density around University campuses to higher rates of alcohol consumption and drink driving[144].

This greater level of tobacco retailer density is often found in disadvantaged communities and areas that are largely populated with young people such as schools and universities where there is already a higher than average rate of smoking. Studies from Australia[145], the US[146], and Canada[147] that examined the relationship between socioeconomic status and tobacco retailer density, found a clear link between the two, with one study from Western Australia[148] identifying that the most disadvantaged suburbs and towns had more than five times the number of tobacco outlets than more affluent areas.

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[141] Department of Health (2009) Guidance for those selling Tobacco Products. [PDF]. Available at: https://health.gov.ie/wp-content/uploads/2014/03/tobacco_products_guidance.pdf

[142] Department of Health and Human Services (2017) Why Retailers Stop Selling Tobacco and Implications for Tobacco Control [PDF], Available at: http://www.smokefreetasmania.com/wp-content/uploads/2014/11/Final-draft_-why-retailers-stop-selling-tobacco-full-report_DHHSstyle-29052017-1.pdf

[143] Paul, Christine L et al. (2010) Anywhere, anytime: Retail access to tobacco in New South Wales and its potential impact on consumption and quitting. Social Science & Medicine. Vol. 71, No. 4. PP 799-806.

[144] Treno, AJ, Grube, JW and Martin, SE. (2003). Alcohol availability as a predictor of youth drinking and driving: a hierarchical analysis of survey and archival data. Alcoholism: Clinical and Experimental Research. Vol. 27, No. 5, pp 835-40, DOI: 10.1097/01

[145] Dalglish, E, McLaughlin, D, Dobson, A, and Gartner, C (2013). Cigarette availability and price in low and high socioeconomic areas. Australian and New Zealand Journal of Public Health. Vol. 37, No. 4, doi: 10.1111/1753-6405.

[146] Fakunle, D, Morton, CM, and Peterson, NA (2010). The importance of income in the link between tobacco outlet density and demographics at the tract level of analysis in New Jersey. Journal of Ethnicity in Substance Abuse. Vol. 9, No. 4. doi: 10.1080/15332640.

[147] Chaiton, MO, Mecredy GC, Cohen, JE, and Tilson, ML. (2013). Tobacco retail outlets and vulnerable populations in Ontario, Canada. International Journal of Environmental Research and Public Health. Vol. 12, No. 12 doi: 10.3390/ijerph10127299

[148] Wood, LJ, Pereira, G, Middleton, and N. Foster S (2013). Socioeconomic area disparities in tobacco retail outlet density: a Western Australian analysis. The Medical Journal of Australia. Vol. 198, No. 9.

Further studies have reported an association between the density of tobacco retail outlets and proximity to schools with youth smoking rates[149] [150]. This proximity had an additional impact in that a high density is associated with a greater likelihood of experimental smoking among young people[151].

A substantial increase to the license fee in Ireland would act as a strong deterrent for retailers and reduce the number of points of sale across the country for a product that is already low in demand. In Australia, where the rate of smoking is 13.8% or just under one in seven people, the retail tobacco license regulations vary across states and territories. At the start of January 2007, the state of South Australia increased its tobacco retailer license fee 15-fold from A$12.90 to A$200 per annum[152].

This increased license fee was associated with a significant reduction in the number of tobacco licenses purchased or renewed in the subsequent years, which in turn led to the total number of tobacco licenses to fall by nearly a quarter (23.7%) in just two years. These results show an increase of the license fee from a low base (which Ireland has) is a potentially effective method of reducing tobacco points of sale when the consumer demand for cigarette products is low.

Not only does reducing the level of density of tobacco retail points limit the exposure of tobacco to already current smokers, research indicates that it diminishes the potential for greater uptake among never-smokers such as adolescents[153] and helps improves the likelihood of successful smoking cessation among moderate and heavy smokers[154].

The current pervasive availability of tobacco in Ireland is at stark contrast with the public health goal of denormalising smoking and achieving a Tobacco Free Ireland by 2025. If we wish to reduce the level of smoking in Ireland, strong tobacco control policies should be matched by sensible regulations limiting the number of points of sale.

The Irish Heart Foundation is calling for:

30. The increase of the tobacco retailer license fee from a once-off payment of €50 per entity to an annual fee of €500 per outlet where tobacco products are sold.

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[149] Lipperman-Kreda, S, Grube, JW, and Friend, KB (2012). Local tobacco policy and tobacco outlet density: associations with youth smoking. Journal of Adolescent Health. Vol. 50, No. 6, pp 547-552. doi:10.1016/j.jadohealth.2011.08.015

[150] Scully, M, McCarthy, M, Zacher, M, Warne, C, Wakefield, M, and White, V (2013). Density of tobacco retail outlets near schools and smoking behaviour among secondary school students. Australian and New Zealand Journal of Public Health. Vol. 37, No. 6, doi: 10.1111/1753-6405.12147

[151] McCarthy, WJ, Mistry, R, Lu, Y, Patel, M, Zheng, H and Dietsch, B (2009). Density of Tobacco Retailers near schools: Effects on tobacco use among students. American Journal of Public Health. Vol. 99, No. 11, doi: 10.2105/AJPH.2008.145128

[152] Bowden JA, Dono J, John DL, et al. (2014). What happens when the price of a tobacco retailer licence increases? Tobacco Control 2014;23:178-180.

[153] Shortt, NK, Tisch, C, Pearse, J, Richardson, EA, and Mitchell, R. (2016) The density of tobacco retailers in home and school environments and relationship with adolescent smoking behaviours in Scotland. Tobacco Control. Vol. 25, No. 1, doi: 10.1136/tobaccocontrol-2013-051473

[154] Halonen, JL, Kivimaki, M, Kouvonen, A, Pentti, J, Kawachi, I, Subramanian SV, and Vahtera, J (2014). Proximity to a tobacco store and smoking cessation: a cohort study. Tobacco Control. Vol. 23, No. 2. doi: 10.1136/tobaccocontrol-2012-050726.

4.5 Increased resources (staffing and funding) to support revenue in combating illicit trade

Overestimating the tobacco smuggling rate has been the tobacco industry's main tactic for years in seeking to prevent tobacco tax increases that reduce smoking rates and thereby their profits. In fact the correlation between high prices and high levels of smuggling does not exist in Western Europe[155]. Cigarette smuggling is not caused principally by "market forces". It is mainly caused by fraud, by the illegal evasion of import duty.

However, in addition to its cost to the State, smuggling can negate the impact of tobacco tax increases by providing a supply of cheap tobacco, including to younger smokers. Revenue estimates that illicit tobacco accounted for some 13% of total cigarette consumption in Ireland during 2018, approximately 453 million of 3.7 billion cigarettes smoked. This level of illicit consumption represents a potential loss to the Exchequer of approximately €211 million (Excise & VAT).[156]

Consequently, tobacco smuggling is an issue that has to be addressed effectively as part of any tobacco control strategy.

4.5.1 National Actions to tackle illicit trade

Revenue has developed considerable expertise in recent years in combating the illicit tobacco trade and as a result the smuggling rate was reduced from 16% in 2009 to just 10% in 2016 as Table 12 shows. However, the rate increased to 13% in 2017 and remained at that level last year in spite of seizures of more than 67 million illicit cigarettes and almost 2,000kgs of smokeless tobacco.[157]

Table 12: Illegal Cigarette Packs in Ireland

Year	Illegal Packs
2009	16%
2010	15%
2011	15%
2012	13%
2013	12%
2014	11%
2015	12%
2016	10%
2017	13%
2018	13%

It is timely therefore that Revenue is planning to implement a new national action plan to combat illicit tobacco will be implemented by Revenue in the near future. In order to be effective, the Revenue plan must be adequately funding. This should include increased

[155] *Cigarette smuggling in Europe: who really benefits?* Luk Joossens, Martin Raw, https://tobaccocontrol.bmj.com/content/7/1/66
[156] Revenue. (2019). Tobacco Products Research Surveys 2018. [PDF]. Available at: https://www.revenue.ie/en/corporate/documents/research/tobacco-products-research-results-2018.pdf
[157] Revenue. (2019). Annual Report 2018. [PDF]. Available at: https://www.revenue.ie/en/corporate/press-office/annual-report/2018/ar-2018.pdf

resources including staffing and equipment for investigations; more effective control of tobacco industry supply chains; and a clear target for reducing the size of the illicit market.

4.5.2 Tobacco industry misinformation on the size of the illicit market

The tobacco industry has spent years attempting to muddy the waters when it comes to the rate of illicit tobacco. In Ireland, as in other countries, the industry routinely both exaggerates the extent of illicit trade and misrepresents the nature of the illicit market, particularly by inflating the proportion of illicit cigarettes and tobacco products that are counterfeit, and under-estimating the proportion that are genuine manufactured tobacco.[158]

A document produced by Japan Tobacco International (JTI) stated that the rate of illicit tobacco in 2013 was 25% in Ireland.[159] Minister for Finance, Michael Noonan TD, rejected the industry figure in May 2014[160], stating:

> *I do not accept the validity of those other surveys, as they are not representative of the entire smoking population, do not take into account legal personal imports from other jurisdictions and are frequently based on empty pack surveys...*
>
> *In looking at higher estimates of the level of illicit consumption that come from other sources, it also needs to be borne in mind that the tobacco industry claims must be viewed in terms of their interest in minimising tax increases while imposing significant price increases of their own.*

In some quarters – particularly amongst those who oppose tobacco tax increases as a public health measure – lower revenue from tobacco taxes has been used to suggest there has been an increase in illicit tobacco in recent years. However, the recent Revenue Commissioners' (2015) Economic of Tobacco: An Analysis of Cigarette Demand in Ireland highlights that lower rates of smoking in Ireland (18% in the 2015 Healthy Ireland survey) account for lower revenue yields:

> *the analysis supports the view that reduced prevalence, and not illicit trade, may be the driving force behind falling cigarette clearances in more recent years. Given falling prevalence rates, the share of taxed consumption that can explain total cigarette consumption in Ireland has increased in 2014 (p.22-3).*[161]

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[158] See ASH UK Briefing for World No Tobacco Day – 31 May 2015 Illicit Tobacco: What is the Tobacco Industry Trying to Do? http://www.ash.org.uk/files/documents/ASH_961.pdf

[159] Japan Tobacco International, The Illicit Tobacco Trade Review 2013, http://www.stopillicittobacco.com/public/images/illicit-tobacco-trade-review-2013.pdf

[160] Dáil Éireann, Parliamentary Debates, Department of Finance, 13 May 2014, http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/dail2014051300056?opendocument#WRD05600

[161] Revenue Commissioners (2015) Economic of Tobacco: An Analysis of Cigarette Demand in Ireland. Available at: www.revenue.ie/en/about/publications/economics-of-tobacco.pdf. Accessed 18 May 2016.

4.5.3 Tobacco industry supply chain control

Much of the commentary on the illicit tobacco market focuses on counterfeit tobacco (cigarettes manufactured without authorisation of the rightful owners, with intent to deceive consumers and to avoid paying duty). It is important to note that Revenue surveys consistently find that the illicit market in Ireland is dominated by contraband tobacco products (normal commercial brands of cigarettes bought duty paid or duty free outside the country and smuggled here), rather than counterfeit products.

The 2018 survey shows that, of the 13% of packs found by the survey to be illegal 78% of these were classified as contraband (normal commercial brands of cigarettes bought duty paid or duty free outside the country and smuggled here); 21% classified as illicit whites (cigarettes manufactured for the sole purpose of being smuggled into and sold illegally in another market); and only 1% were classified as counterfeit (cigarettes manufactured without authorization of the rightful owners, with intent to deceive consumers and to avoid paying duty).[162]

There continues to be concern worldwide about complicity by the tobacco industry in the illicit market. In 2013, the UK Parliament's Public Accounts Committee accused tobacco multinationals of deliberately oversupplying European markets, with the tobacco then being smuggled back into the UK. Committee Chair Margaret Hodge said:

> *The supply of some brands of hand-rolling tobacco to some countries in 2011 exceeded legitimate demand by 240 per cent. HMRC must be more assertive with these manufactures. So far it has not fined a single one of them.*[163]

In November 2014, British American Tobacco was fined £650,000 by HMRC for deliberate over-supply of cigarettes to Belgium.[164]

According to a recent Parliamentary Question to the Minister of Finance[165], Revenue currently has three mobile x-ray scanners, a 'backscatter van' scanner, and a specialist vehicle that contains both x-ray and radiation detection technology. The 'backscatter van' scanner is Revenue's most recent acquisition at the cost of approximately €750,000[166], having been delivered in delivered in December 2018. The cost of the scanner was part-funded by the European Anti-Fraud Office (OLAF).

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[162] Revenue. (2019). Tobacco Products Research Surveys 2018. [PDF]. Available at: https://www.revenue.ie/en/corporate/documents/research/tobacco-products-research-results-2018.pdf

[163] Reported in The Telegraph (10 0ctober 2013) 'Tobacco firms fuelling black market, MPs say'. http://www.telegraph.co.uk/news/uknews/crime/10367315/Tobacco-firms-fuelling-black-market-MPs-say.html

[164] See ASH UK Briefing for World No Tobacco Day – 31 May 2015 Illicit Tobacco: What is the Tobacco Industry Trying to Do? http://www.ash.org.uk/files/documents/ASH_961.pdf

[165] Parliamentary Question No. 146 25/06/2019

[166] Oireachtas. (2018). Committee of Public Accounts, Thursday, 15 November 2018. [Online]. Available at: https://data.oireachtas.ie/ie/oireachtas/debateRecord/committee_of_public_accounts/2018-11-15/debate/mul@/main.pdf

To combat the threat posed by illegal cigarette smuggling, we recommend that the government provide sufficient funding for Revenue to purchase additional backscatter vans.

The Irish Heart Foundation is calling for:

31. Increased resources, including additional staffing and equipment, to support Revenue's National Action Plan in combatting cigarette smuggling.

Part 5: The Built Environment

Budget actions to increase access to physical activity

Aim	2020 Action	Investment
Increasing people's physical activity through investment in active travel.	The allocation of 20% of the 2020 capital budget to walking and cycling	€411million

Problem
Not enough Irish people are being physically active for a health benefit.

Solution
Invest more in creating walking and cycling friendly communities that support people to actively travel (walk, cycle or use public transport).

4.1 Background

Active travel is a cost-effective way of increasing people's physical activity and improving their heart health.

The 2018 WHO European Childhood Obesity Surveillance Initiative report on overweight and obesity among 6–9-year-old children analysed the physical activity environment across the WHO region, based on the third round of data collection. Of special importance was the poor physical activity environment in Irish schools in comparative terms as Ireland had the lowest percentage of schools meeting the goal of at least 1 hour physical education per week (at 86%).[167] Furthermore, in 1986, almost 50% of Irish primary schoolchildren either cycled or walked to school, with another 20% using public transport.[168] By 2016, some 60% of these children were being driven to and from school, a complete reversal in just three decades. Today, only one in four primary students walk or cycle to school.

[167] WHO Regional Office for Europe. (2018). *WHO European Childhood Obesity Surveillance Initiative: overweight and obesity among 6–9-year-old children. Report of the third round of data collection 2012–2013.* [Online] Available from: http://www.euro.who.int/__data/assets/pdf_file/0010/378865/COSI-3.pdf?ua=1
[168] INRIX. (2018). INRIX 2018 Global Traffic Scorecard.[Online]. Available from: http://inrix.com/scorecard/

4.2 The role of Transport Strategy

> *"We require a transformation in how citizens and businesses travel on a daily basis.*
> *Walking, cycling and public transport must become the default choice for most and that requires infrastructure investments and the provision of safe, fast, frequent, reliable, clean and affordable options."* - Report of the Joint Committee on Climate Action March 2019[169]

The physical and built environments, including transport and infrastructure planning, the availability of transport networks and the design of streets, can all affect the health and well-being of individuals and communities. Budget 2020 could greatly assist the promotion of active lifestyles and support people to meet the recommended levels of daily physical activity by enabling people to incorporate physical activity into their daily routine.

One of the first principles in creating high quality, sustainable, healthy neighbourhoods is prioritising walking, cycling and public transport and minimising the need to use cars. Improving and protecting health and wellbeing should be one of the high-level objectives of transport strategy in Ireland and, as such, should be funded accordingly. This is in line with the Government's Healthy Ireland public health framework.

Funding and local planning processes should reflect the higher priority now attached to active travel by a large coalition of Government, transport authorities and health and environmental advocates. In the UK, health, travel and environmental groups have previously called for 10% of transport budgets to be committed to walking and cycling. However, the Irish Heart Foundation would go further and recommend that 20% of the capital budget would be allocated to walking and cycling.

The Irish Heart Foundation is calling for:

32. The allocation of 20% of the 2020 capital budget to walking and cycling, at a cost of €411million[170].

[169] Report of the Joint Committee on Climate Action. (2019). *Climate Change: A Cross-Party Consensus for Action*. March 2019. [Online]. Available from: https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_climate_action/reports/2019/2019-03-28_report-climate-change-a-cross-party-consensus-for-action_en.pdf

[170] Based on figures provided in Parliamentary Question 20458/18 to the Minister for Transport, Tourism and Sport

Irish Heart Foundation

Irish Heart Foundation
17-19 Rathmines Road Lower, Dublin 6.
Phone: +353 1 668 5001
Fax: +353 1 668 5896
Email: info@irishheart.ie
www.irishheart.ie

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