Irish Nurses and Midwives Organisation
Working Together

Opening Statement

to

The Oireachtas Committee

on

The Future of Healthcare

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1. INTRODUCTION

1.1 Chairperson and members of the Committee

On behalf of the Irish Nurses and Midwives Organisation, and the 40,000 members we represent, I wish to begin by thanking you for affording us this opportunity to meet, and engage with you, on the hugely important work of this Committee and the potential, supported by the political system, it offers to reform our inequitable health system.

1.2 In that regard the INMO wishes to state that the work of this Committee must be the first step in a radical, comprehensive, transformational and sustained process of change. This must lead to a seamless universal single tiered health service with access based solely on health need rather than ability to pay. In putting forward this view we accept that moving from our current, two-tiered inequitable, system will require, at a minimum, up to 15 years. This change will also require political consensus, stretching far beyond the normal electoral cycle, and will necessitate future governments, and oppositions, accepting the process of change complete with the funding, and resource requirements, necessary to deliver that change.

1.3 The INMO also supports the view that, in the context of a single tiered service, it must be funded at a minimum of 10% of GDP (12% to 14% during the transitional period). In addition we must have a separate funding stream, spanning five to seven years, providing for the necessary capital investment to improve existing health infrastructure and develop new community based health facilities.

1.4 It will also be necessary, in terms of delivering a quality assured, accountable and responsive service, that we have a simplified and lean organisational structure. Funding and real accountability must be devolved to frontline managers, (primarily nurse/midwife and health professional managers), who can respond to changing need, demographics and demand much more flexibly than the current bureaucratic and layered management structure.

2. CURRENT REALITIES

2.1 Our written submission has detailed the very bleak journey our public health service has endured in recent years. I will summarise as follows:

- over €4 billion cut from health funding, which is an unprecedented contraction, of expenditure, in any OECD country;
- loss of over 2,000 beds;
- public supports for vulnerable people undermined i.e.:
  - older peoples services privatised;
  - mental health services curtailed;

- silent, but hugely damaging, cuts in disability services; and

- very severe contraction, despite commitments to primary care, to public health and community nursing, home care/home help and related services.

2.2 Injurious, unmanaged and unmeasured contraction in staffing levels resulting in:

- a loss of over 5,000 nursing/midwifery posts, (13.5% of workforce), with the system still working with 4,000 (approx.) less nurses/midwives than it had in 2009 compromising patient care on a daily basis;

- a loss of 3,500 general support and care staff;

- a reduction of 1,200 in the number of clerical/administrative staff.

It is acknowledged that during this period there were some increases including:

- an increase in the number of medical personnel by over 1,500; and

- a small increase (800) in the number of allied health professionals.

2.3 The impact of this unmanaged contraction, driven solely by budget considerations regardless of its outcome upon patient care or the ability of the health service to meet demand, has been completely underestimated by the political system and this is evident in:

- record levels of admitted patients on trollies in overcrowded EDs and wards;

- record numbers of patients on waiting lists; and

- waiting lists for services in the community.

2.4 This Committee must be acutely aware that this contraction resulted in the forced emigration of our young, recently graduated, health professionals in the nursing/midwifery and other allied health fields. In considering any real transformation, for our health service, the first challenge will be to attract back these health professionals while we also educate additional numbers and ensure they remain upon qualification.

2.5 Furthermore this Committee must recognise that the morale amongst nursing/midwifery staff has never been lower. They feel totally disrespected, by their employer, and their professional judgement is, on a daily basis, set aside or ignored, by senior management, whose continuing focus is solely on budgets and numbers and not on the needs of patients/service users.

2.6 Against this reality the transformation required must begin with the replacement of lost staff, together with the recruitment of additional staff, which will require sustained investment. If you do not have nurses/midwives, and other frontline staff, you do not have a health service that is fit for purpose.

3. TRANSFORMATION - WHAT IS REQUIRED?

3.1.1 *Background*

3.1.2 In calling for this major organisational transformational programme the INMO recognises that it must be in tandem with how, and who, delivers care ,and where that care/support is provided in the context of devolved funding and accountability arrangements.

3.1.3 The fundamental principle of our new, and changed, health system, must be a guarantee, to any service user, that they will receive integrated care whether they need it in the home, in a primary care setting, an acute hospital or a long term care environment. There can be no silos in terms of budgets, or who delivers care, which, currently, are real, and growing, barriers to meeting the needs of patients and service users.

3.1.4 Against this background we would make the following points to the Committee:

(i) ***Organisational Reform***

In the context of 11 years of organisational reform, with no improvement, the INMO, as part of this transitional programme, believes the following must take place:

- simplified organisational structures from:
  - Department of Health; to
  - regional health authorities; to
  - individual local units/areas.
- there is no cohesion, or accountability, with current structures which include:
  - Department of Health;
  - centralised HSE;
  - seven Hospital Groups;
  - nine Community Health Organisations;
  - 17 Mental Health Areas; and
  - numerous Section 38/39 Service Providers.

This will always result in a lack of transparency, and accountability with frontline staff not having the necessary autonomy, with responsibility, to shape service delivery to meet patient/client need.

(ii) ***Transforming Models of Care***

This overhaul must result in nursing/midwifery and medical staff being empowered, with accountability, to deliver care at the most effective level.

(a) In that regard the INMO puts forward the following framework:

- the single tiered service would see all new appointments, to Consultant and General Practitioner posts, involve a public only contract including an obligation to work rosters on a five over seven day basis;

- existing post holders, in Consultant / General Practitioner posts, who do not wish to change their contract must be allowed to retain same. All new appointments should be replaced with public only contracts; and

- this will require an increase in the number of Consultants to our public health service. This can be partly funded by a reduction in the number of NCHD posts reducing our current over reliance upon medical staff, undergoing continuing training/education, in the clinical area.

(b) Very significant expansion of the role of the nurse/midwife, in all clinical areas, requiring:

- a significant increase in the number of nurses/midwives, both in the hospital and community, who are empowered to prescribe within agreed protocols;

- the expansion of nurse/midwife led services involving Advanced Nurse/Midwife Practitioners;

- the empowerment of nurses/midwives to order diagnostic tests (i.e. X-rays/bloods) whether they work in a hospital or community setting;

- the mainstreaming of an expanded role with regard to:

  - first dose antibiotic;
  - IV cannulation for fluid balance;
  - out of hours phlebotomy;
  - nurse led discharge; and/or
  - other appropriate roles;

within all care settings.

- The role of the Healthcare Assistant, including their job description and training pathway, must be standardised, nationalised and become the minimum required for entry to this grade.

  - This is an essential part of the frontline reform required which should lead to best practice skill mix ratios such as:

    - 80/20 (RN/HCA) in acute medical/surgical wards; and
    - 50/50 (RN/HCA) in care of the elderly facilities;

    as confirmed by international research i.e. RN4Cast.

4. DEVOLVED FUNDING

4.1 The INMO, as stated, is also calling for reform leading to a practice where funding is devolved to wards/units/community level.

4.2 Currently frontline managers have no input into what funding is required and can work the whole year without ever knowing what funding was given, to their area/unit, which leaves them in an impossible position.

4.3 In simplifying Organisational structures the INMO is also calling for new accountability rules which would see the following:

- the Director of Nursing/Midwifery involved, at all stages, in the formulation of the annual budget for that location/area;

- once the budget has been finalised, for that area/location, it is then devolved to the frontline manager, i.e. Clinical Nurse Manager 2/Head of Physiotherapy, who assume responsibility, and accountability, for the budget, but with complete autonomy as to what services can be delivered, safely, within that budget; and

- Directors of Nursing/Midwifery / Senior Hospital/Area Managers, as appropriate, empowered to seek amended funding levels to reflect changes in service demand/acuity/dependency.

5. STAFFING LEVELS/SKILL MIX

5.1 The greatest damage done to the health service, in recent years, has been the totally unmanaged contraction of staff numbers. This, in turn, is a major reason for the broken spirit and morale of frontline staff, particularly nurses and midwives, at this time.

5.2 As we embark on this transformational programme we must introduce an evidence based approach to staffing our health service at levels which optimise the wellbeing of patients.

5.3 This process, is already underway through the work of the Taskforce on Nurse Staffing and Skill Mix, in Adult Medical/Surgical wards. The further roll

out of this approach to staffing is fundamental to the transformational programme and the next area planned is Emergency Department Nurse Staffing.

This work must be accelerated as we use evidence based mechanisms, as determined by the frontline manager i.e. CNM2, to determine appropriate staffing/skill mix requirements.

6. HEALTH SERVICE STAFF - RECRUITMENT / RETENTION / RECOGNITION

6.1 It is self-evident, and very regrettable, that, to date, neither the HSE, or the Department of Health or the whole of government has done enough to address the loss of our best and brightest young professionals.

6.2 Therefore the Public Service Pay Commission must be accelerated and FEMPI unwound together with the early renegotiation of the Lansdowne Road Agreement (LRA) in order to garner trust, within staff, to deliver this radical transformation.

6.3 In addition it is the INMO's belief that the crisis, with regarding to nursing/midwifery recruitment/retention, requires unique measures to be brought forward immediately to reduce current excessive workloads and improved patient care.

6.4 Finally, on this issue, no matter what model of healthcare is used the reality is that all health systems are labour intensive and must be staffed by committed, dedicated and flexible people. This must be recognised with the Health Service being an employer of choice offering excellent pay and conditions.

7. FUNDING

7.1 As we state, in our written submission, the latest OECD figures confirm, in 2013, that the government's allocation, to public health spending, was 7.2% of GDP.

The OECD figures also indicate that, when this public expenditure is combined with private health expenditure, the overall health spend, in this country, approximates to 10% of GDP.

7.2 However the manner and nature of this expenditure, which clearly reinforces the two tiered structure, only serves to guarantee faster access to diagnostics and treatment for those who can either afford private insurance or direct out of pocket expenses. This is inherently unfair and inequitable.

7.3 Therefore,in calling for this public health spend of no less than 10% of GDP, and 12% to 14% during transitional years, we recognise that this must be done with:

- total transparency so that it secures and maintains the confidence of all citizens and taxpayers;

- the phased abolition of all tax reliefs pertaining to private health insurance;

- the ending of any contracting for services to provide direct care; and

- the phased ending of subventions to private nursing homes (recognising this will take an extended period due to existing contracts/bed stock and the need to develop new publicly funded direct facilities).

7.4 In recognising the challenge that meeting future health costs will bring, we would draw the Committee's attention to recent papers, produced by the Nevin Economic Research Institute (NERI), which reminded us all that in the next three decades the number of persons, over 65, will move from 606,000 to 1.8 million in 2046. In addition we face the growing epidemics of obesity/alcohol abuse which will also increase demand upon our health service.

7.5 Against this stark reality the political system, must fully understand the implications, of these demographic/lifestyle changes. All taxpayers must also understand we cannot reduce general taxation levels **and** provide the type and extent of health service the population will need.

8. CONCLUSION

8.1 Our call today, to this Committee, is to begin the revolution necessary that will deliver a single tiered health system, within 15 years, which will serve all the people of this country equally and in a world class manner. In calling for this we also recognise that health service structures, and how all health service staff work, must also be subject to transformation.

8.2 No vested interest should be allowed to halt the pace of progress necessary to prepare for the growing demand that will be made upon our health system.

8.3 To deliver this change will require the health service, including its funding and structures, to be removed, completely, from the traditional electoral cycle and budgetary practices.

We ask you to make these recommendations safe in the knowledge that all future generations of Irish citizens will live in a more equal society, with regard to healthcare, and we will, as a result, have healthier communities and a stronger economy.

Thank you.